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Family Matters: Integrating Trauma Treatment into Functional Family Therapy for Traumatized Delinquent Youth

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This article describes an innovative family systems approach to the treatment of posttraumatic stress disorder (PTSD) among traumatized youth involved with the juvenile justice system. The first section presents the rationale for taking a family systems approach to respond to this problem and describes the ways in which family processes and parent–child relationships reciprocally affect one another in the aftermath of traumatic events. The second section outlines the key features of Functional Family Therapy (FFT) and makes the case for why this evidence-based intervention provides a firm bedrock upon which to build a targeted trauma-focused adaptation. The third section of the article outlines the FFT-Trauma Focused model and describes the methods of its flexible and individualized implementation with families of traumatized delinquent youth.

Keywords trauma, family, intervention, delinquency, PTSD

A significant body of research has established that there is a relationship between trauma and delinquency (see Kerig, 2012). Many youth involved in the juvenile justice system have undergone traumatic experiences—in some studies, the proportion is as high as 90%—and these youth are disproportionately likely to evidence symptoms of posttraumatic stress disorder (PTSD). Although our understanding of the underlying mechanisms linking trauma and delinquency is still in its infancy, longitudinal research demonstrates that exposure to trauma is a significant predictor of antisocial behavior and cross-sectional research confirms the interrelationships among trauma, PTSD, and mental health problems among delinquent youth (Kerig & Becker, 2010).

Why Focus on the Family System When Intervening with Adolescent Trauma?

Trauma is an experience that involves, affects, and is affected by the entire family system. Families are dynamic systems in which parents and youth reciprocally affect one another; therefore, the experience of trauma is best viewed not as a discrete event that occurs to an individual family member, but as a disturbance to a web of relationships that radiates both inward and outward. As Figley (1989) described, these effects may be experienced *simultaneously* by family members, *vicariously* experienced by one through

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another, *intrafamilially* when one family member traumatizes another, or *chiasmally* when one family member's PTSD has contagion effects on the others.

Trauma is a Family Matter

For many families of delinquent youth, the trauma itself is a family event—for example, in our samples we have learned of neighborhood shoot-outs, natural disasters, and murdered loved ones that traumatized all members of the family simultaneously. Moreover, for the many families of juvenile justice-involved youth who are economically disadvantaged, traumatic events come in waves and do not comprise a single, isolated, individually-focused event. Poverty, community violence, and exposure to environmental hazards all conspire to make life in disadvantaged neighborhoods potentially traumagenic for the entire family (Evans, 2004).

Even when a traumatic event is directly experienced only by the youth, having harm come to a child can be a traumatizing experience for a parent. For some, guilt over perceived failure to protect a child from harm underlies this reaction. Especially poignant in this regard have been our experiences with fathers whose distress over their daughters' sexual assaults has been extreme, debilitating, and associated with symptoms of PTSD. Associated with this anguish is an increased risk of potentially retraumatizing responses, such as attempting to reestablish a "just world" by construing the daughter as causally to blame. Vicarious trauma also comes into play for the siblings of traumatized youth, for whom knowledge of a horrifying event having occurred to a brother or sister, and witnessing of that sibling's and the parents' accompanying distress, also might result in symptoms of posttraumatic stress.

Trauma Tends to Run in Families

The intergenerational transmission of trauma is not well-understood, but research does show that parents who develop PTSD are likely to raise children who are susceptible to the disorder (De Bellis, 2001). A number of factors might contribute to this phenomenon. First, an underlying biological vulnerability might account for the fact that some adults and children exposed to a traumatic event develop PTSD, although others do not (Nugent, Amstadter, & Koenen, 2008). First, shared heritable traits such as anxiety-proneness and stress reactivity might increase the vulnerability of some family members to the effects of trauma and leave them more likely than others to react adversely to negative life events. Second, traumatized parents who utilize the kinds of maladaptive strategies for coping with stress that are associated with the development of PTSD (e.g., avoidance, numbing, dissociation) and who experience negative mental health sequelae of PTSD (e.g., substance abuse, aggression) may model these behaviors for their children and thus inadvertently increase the likelihood that youth will employ these same problematic strategies when attempting to come to terms with their own traumas.

Third, trauma may interfere with parenting capacities in ways that adversely affect child development, such as by decreasing parents' emotional availability and responsivity to children's needs (Appleyard & Osofsky, 2003). Maladaptive defensive processes also may come into play when a parent's past emotional pain is reawakened by a child's trauma (Silverman & Lieberman, 1999). The rush to quell these intolerable emotions can interfere with a parent's ability to validate and empathize with a youth's experience. One of the most powerful factors that protects parents who have been maltreated in childhood from re-enacting that abuse is the capacity to retain full emotional awareness of their own early experiences and thus to empathize with the distress of their child (Egeland, 1988).

However, parents who cope with trauma through experiential avoidance may respond in ways that are nonempathic and invalidating, creating an "atmosphere of emotional constriction and emotional blindness that interferes with proper attunement between family members, particularly the attunement of parents to children" (Catherall, 1998, p. 195). For example, during a family session one parent turned to a youth who had just revealed a traumatic experience reminiscent of the parent's own history of abuse and remarked sarcastically, "Oh, poor *you*."

Parental trauma also may contribute to distorted perceptions of the child and to parent–child boundary violations such as parentification, enmeshment, and projective identification (Kerig, 2005; Silverman & Lieberman, 1999). Children of traumatized parents who succumb to these boundary violations demonstrate characteristic effects associated with their sense of *self* (e.g., over-identification with the parent or perceived responsibility to make up for the parent's losses); *cognition* (e.g., preoccupation with the parent's trauma or a sense of foreboding regarding its impending repetition); *affect* (e.g., anxiety, dysphoria, guilt); and *interpersonal functioning* (e.g., difficulty establishing intimacy overcoming loss) (Kellerman, 2001).

Trauma Begets Trauma

Likely related to these dynamics is the little-understood phenomenon of *revictimization*, the finding that those who have been traumatized in childhood are at elevated risk for experiencing subsequent traumatic events (Hosser, Raddatz, & Windzio, 2007). The fact that disadvantaged families live in high-risk environments, and therefore are disproportionately likely to encounter recurring traumatizing experiences, must be considered among the possible explanations for this effect. However, there also may be psychological processes involved, such as the effects of PTSD themselves interfering with family members' capacity to recognize and adaptively react to threatening situations, especially when these are reminiscent of, and therefore trigger reactions to, a previous trauma. Due to the hypothalamic-pituitary-adrenal axis overreactivity that ensues, the sequelae of recurrent trauma can be likened to developing an internal fire alarm with a hair trigger (Ford, 2009; Nader, 2008). Following the repeated experience of multiple false alarms, or alarms that have no utility because a child has no means to escape the danger they portend, the alarm loses its signal value and the body and mind, fatigued by continual hyperarousal, begin to shut down and cease reacting to even accurate indications that danger is present. To add further insult to injury, the numbing defenses that increased the likelihood that PTSD developed in the first place also increase the likelihood that a youth will fail to avoid subsequent dangerous situations, which may lead others to perceive this revictimization as his or her "own fault" (Wolfe, Rawana, & Chiodo, 2006).

Family Processes Affect the Processing of Trauma

Models of normal family processes emphasize that all families inevitably must cope with change and stress, whether or not of traumatic proportions, and that different families do this differently. For example, McCubbin and Figley (1983) offered an influential early model of family coping that involved the family's *vulnerabilities* (e.g., the presence of ongoing stressors or pressures), *structure* (e.g., levels of cohesiveness, adaptability, organization, and communication), *strengths* (e.g., resources for resisting stress such as the ability to adjust to change), *coping strategies* (e.g., problem-solving skills), and *appraisals* (e.g., subjective beliefs about the event). These appraisal processes comprise an important means by which families make meaning out of events, solve problems, and adapt to challenges.

Unfortunately, however, cognitive processing itself is adversely affected by exposure to trauma, leading to a tendency toward impulsive, inefficient, and inaccurate reasoning, which might distort family members' ways of making meaning of the experience (Perry, 2001).

In this regard, Catherall (1998) offered a model of family processes related to trauma that focuses on three dynamics. The first of these involve *consensual distortions*, such as *maladaptive beliefs* (e.g., that the world is unsafe, that self-worth may be only earned through trial, and that the meaning of life is to suffer), along with disturbed *family myths* (e.g., that a parent is fragile and must be protected) and *dysfunctional family rules* (e.g., that speaking openly about feelings has destructive power). The second dynamic involves *disrupted caregiving* (e.g., parental emotional inaccessibility or parentification of children). The third dynamic, *traumatic sequences*, comprises processes specific to trauma and include *replication of themes* (reenactments, projections, and blurring of psychological boundaries); *ongoing perceived threat* (anxiety, distrust, and insecurity); *"survivor missions"* (child perceived responsibility for playing the role of family "rescuer"); and *symptomatic family members* (the stress on one another caused by family members' PTSD). By disallowing authenticity, recognition of one another's perspective, and open sharing of emotions, these maladaptive family processes ultimately result in a lack of genuine emotional connection among family members.

Families are Sources of Resilience for Traumatized Youth

Lest our focus seem to linger on the dark side of families, we should not lose sight of the loyalties, connectedness, affection, and bonding that are sources of resilience in even the most multiply stressed and disadvantaged families (Walsh, 2003). In this light, McCubbin and Figley (1983) identified 11 characteristics of families who cope well with stress: acknowledgement of the stressor; family-centered locus of the problem; solution-oriented problem-solving; tolerance for and patience with one another; commitment to and affection for the family; open communication; family cohesion; flexible family roles that allow individuals to rely on one another when one is functioning poorly; willingness to use and seek resources within and outside the family; absence of violence; and (particularly relevant for antisocial families) abstaining from maladaptive strategies such as substance use to cope with stress.

Parent involvement is critical to the success of youth trauma treatment. Research shows clearly that involvement of parents contributes to the effectiveness of evidence-based trauma treatment for youth and that parental supportiveness is an important mediator of child outcome (Cohen, Mannarino, & Deblinger, 2006). The majority of this work, however, has focused on dyadic parent–child relationships rather than the entire family system. Family system models posit that even more powerful effects are attained from involving all members of the family in treatment and harnessing their strengths to elicit and support change. A premiere example of such a systems model is Functional Family Therapy (FFT; Alexander, Robbins, Waldron, & Neeb, in press).

Why Utilize FFT as the Basis for a Family-Focused Trauma Treatment?

FFT is an evidence-based model for intervening with juvenile delinquency that has garnered a significant amount of empirical support (Alexander et al., in press). Thus, in setting out to develop a family-based trauma model, rather than "starting from scratch"

we perceived distinct benefits to grounding this work in an intervention that already enjoys a strong evidence base, particularly for the treatment of challenging antisocial families. Although other promising family models for the treatment of trauma have been described in the clinical literature (e.g., Catherall, 1998; Figley, 1989; Saltzman, Babayan, Lester, Beardslee, & Pynoos, 2008), and these informed and enriched our approach substantially, these protocols themselves have not yet been empirically supported and are not oriented toward delinquency specifically. Similarly, although other interventions have been developed for the treatment of trauma among juvenile justice-involved youth (described in other contributions to this issue), these have been designed for implementation in institutional or foster care settings. An intervention that can retain youth in the family home, such as FFT, promises not only to be more cost-effective but to eliminate the potential iatrogenic effects of incarceration.

"Targeting" FFT for Trauma

Although FFT has not been identified previously as an evidence-based treatment for trauma, the high prevalence of PTSD among the delinquent youth FFT has served over the past decades, coupled with the high rates of effectiveness FFT has achieved, suggest the possibility that "generic" FFT already may be enjoying some success with families affected by trauma; indeed, there are features of the FFT approach that make this particularly likely to be the case. So, one might ask, why fix something that is not broken? Our belief is that the FFT therapist who views families with a trauma-informed lens will be more perceptive and efficacious in working with this particularly challenging population.

The idea of offering targeted versions of treatments to respond to specific presenting problems aligns with the state-of-the-art trend toward modularization, in which components of a core intervention are individualized and tailored to the particular characteristics of each youth and family. This approach provides a method for achieving a balance between the need for fidelity to a manualized treatment while allowing the flexibility needed to match the treatment to the needs of the client (Kerig, Sink, Cuellar, Vanderzee, & Elfstrom, 2010; Mazzucchelli & Sanders, 2010), and has been associated empirically with enhanced effectiveness of a number of interventions for youth (e.g., Curry & Reinecke, 2003). In one version of modularization, components of other evidence-based interventions are integrated with an existing treatment and are brought to bear as they are relevant for particular youth with specific needs (e.g., Kerig, Volz, Moeddel, & Cuellar, 2010). Unlike eclecticism, this integrative approach involves not mixing and matching treatment strategies ad hoc, but rather bringing additional validated techniques into a coherent and carefully conceptualized theoretical core. This strategy has been used to good effect with other forms of targeted FFT developed to date, including those focused on gangs, substance abuse, and child welfare. With this model in mind, we set out to develop a targeted version of FFT specifically for the treatment of delinquent youth who demonstrate symptoms of PTSD.

Essential Characteristics of the FFT Approach

The FFT treatment process is structured around five distinct phases. The first of these is *Engagement,* in which the focus is on increasing the likelihood of family participation, and *Motivation*, in which family strengths are harnessed to motivate them toward change. The third phase, *Relational Formulation*, utilizes the development of an understanding of family members' unique relational needs. The fourth phase, *Behavior Change*, involves

the implementation of a highly individualized treatment plan to match the unique relational styles and needs of the family. The fifth phase, *Generalization*, focuses on preventing relapse by helping the family to broaden the skills learned to relationships outside the family system. Although it would be beyond the purview of this article to provide a detailed outline of FFT (for that, the reader is referred to Alexander, 2009 and Alexander et al., in press), some of the key features that characterize the FFT model—and that suggest its potential efficacy for responding to trauma—deserve mention.

Emphasis on engagement and motivation. The importance of engagement and motivation to the FFT model is indicated by the fact that over half of the *FFT Clinical Training Manual* (Alexander, 2009) is devoted to these processes. These strategies comprise a contribution to family systems treatment that is unique to FFT, and likely account for the extraordinary success that FFT has achieved in retaining even the most difficult antisocial families. The overarching goal of the FFT engagement phase is to create positive expectations for the treatment, and the therapist's warmth, respect, and communication of optimism and confidence that the family will succeed are instrumental. In addition, the therapists' modeling of a nonblaming and nonjudgmental attitude is important in shifting the family's focus away from individual fault-finding and toward the thoughts, feelings, and relationships that underlie problematic behaviors. Essential to achieving these goals is the establishment of a *balanced alliance* with all family members, and the use of techniques such as *changing meaning* through reframing of toxic interpretations, and *interrupting and diverting* negative interactions.

Strengths-based relational focus. At the core of the FFT approach is the deeply-held belief that all families and all family members have potential strengths that can be brought to the surface and harnessed. Not only is the FFT approach strength-based, but it goes even further in ascribing to family members possible *noble intent* that underlies even their most misguided and pathogenic strategies for resolving family problems. Families respond well to this reframing, even when they are dubious that the positive motive motivations attributed to them are "true." Merely opening up the possibility that this is so, especially with families experiencing hopelessness and helplessness, enhances motivation to continue on the therapeutic journey. By the same token, what the family usually initially construes as an individual problem ("this kid is acting up") is patiently, persistently, recast as a *relational* issue among all the members of the family.

Acceptance of diversity in family forms. Another strength of FFT is its explicit appreciation for the fact that there is a diversity of ways in which families might function effectively. The FFT model appreciates that adequately-functioning families may take various forms, including those in which youth are highly independent and self-sufficient and in which parents exhibit little in the way of authority or control. This is articulated explicitly in the FFT concept of *matching to relational functions*. As FFT frames it, the job of the therapist is not to change family members' relational functions in regard to one another, but to recognize, match, and employ those functions in the service of helping families to "be better at being who they are." As a consequence, the FFT approach is decidedly less prescriptive than other approaches when it comes to family structure and the FFT therapist avoids attempting to shape families toward a presumed "adaptive" model constituted of subsystems or demarcated by firm boundaries, with parents "in charge" and youth "in line." Instead, it is accepted as a reality that in some families youth and parents may be quite autonomous from one another, whereas others will seek close contact. Similarly, in some

families, parents are "one-up" and in charge, whereas in other families the power structure of parent–child relationships is symmetrical or even reversed, with the parent "one-down." These role-reversals are common among traumatized families, in which children may have taken over parental functions in an attempt to maintain the integrity of a stressed family system (Kerig, 2005).

Brevity and strategem. Many of the problems that bring traumatized youth and families into treatment would benefit from long-term, depth-oriented psychotherapy. However, in reality the majority of these families are disadvantaged and do not have the resources or the tolerance to engage in such lengthy work. FFT is pragmatic regarding the extent to which traumatized families can and will participate in treatment, and accordingly is brief and strategic in its approach. In addition, in keeping with its strengths-based focus on promoting family competency, FFT strives to give families the strategies they need to become equipped to solve their own problems rather than fostering their continued reliance on professional support.

Flexibility is fidelity. The state of the art in manualized treatments for trauma is their use in ways that are creative, flexible, and adapted to the individual needs of the client and family. In the FFT approach, flexibility and individuation are built into all aspects of the treatment process, matched as they are to each family's unique relational functions, behavior change needs, and circumstances. Rather than striving for "flexibility *with* fidelity," the FFT therapist is taught to construe flexibility *as a form of* fidelity to the treatment. Given the diversity of issues, relational constellations, and functioning levels seen among traumatized youth and families involved in the juvenile justice system, this flexibility and adaptability are well-considered.

The treatment team approach. Another way in which FFT is well-adapted to the treatment of family trauma is its emphasis on therapists working together as members of a treatment team who meet weekly to discuss, consult, and confer on cases with an expert consultant and with one another. The team approach not only allows a wider net of support to be built around clients, but also has special benefits for clinicians working with trauma for whom vicarious traumatization is a distinct danger (Saxe, Ellis, & Kaplow, 2007).

The FFT-Trauma Focused Model

Tuning into Trauma

Before beginning to work with children and families who have been affected by trauma, clinicians undergo training in trauma awareness to help prepare them to perceive and accurately interpret behaviors and relational dynamics that derive from posttraumatic stress. Trauma awareness training gives clinicians a set of lenses through which to view families and to respond to them more effectively.

What is "trauma?" Although the terms "PTSD" and "trauma" often are used interchangeably in the clinical literature, one of the first steps in preparing therapists to work with traumatized youth and families is psychoeducation regarding what is—and is not—meant by our use of the term "trauma." It can be tempting to presume that any youth who has gone through an experience that meets DSM-IV's Criterion A (e.g., an event involving actual or threatened death or injury and which evokes fear, helplessness, or horror must

be "traumatized" and thus have PTSD. To the contrary, research shows that only approximately 36% of children who experience an extremely stressful event develop symptoms consistent with a PTSD diagnosis (Fletcher, 2003). Variables that increase the likelihood of PTSD include aspects of the event such as its proximity to the child; its intensity; the extent to which it was sudden and uncontrollable; the degree of violence or gruesomeness involved, and the extent to which intentional malice is inferred (Kerig, Fedorowicz, Brown, & Warren, 2000).

Although Functional Family Therapy-Trauma Focused (FFT-TF) is specific to the treatment of youth who meet criteria for PTSD, however, three major caveats are in order. A first concern is that the Criterion A definition of traumatic events is not developmentally sensitive in that it does not refer to the kinds of experiences that might be the most upsetting from a child's point of view. One such experience is the loss of an attachment relationship; for example, despite the benevolent intentions of social services agencies concerned to offer an abused child protection, the threat of removal from the family home may be more terrifying to children than any fear of direct physical harm from the parent. Therefore, in assessing whether adverse events were in fact traumatic, clinicians are guided to inquire as to the appraisals that the youth made of those events and whether these evoked extreme distress. Secondly, research shows that a significant proportion of youth who have experienced traumatic events meet only partial criteria for a PTSD diagnosis, and yet their functioning is severely negatively affected (Cohen & Scheeringa, 2009). In order to be developmentally sensitive to the expression of traumatic reactions in children, clinicians are guided to elicit parent and youth reports of each of the symptom clusters indicative of PTSD—re-experiencing, hyperarousal, avoidance—and, as newer research suggests is particularly relevant to delinquent youth, the separate cluster of numbing (Kerig, Bennett, Thompson, & Becker, 2012), and to assess whether a child's emotional and behavioral functioning is significantly compromised by any of these symptoms. Careful history taking also is used to reveal whether the onset of symptoms followed after an adverse life experience and thus is likely related to trauma (Cohen & Scheeringa; Kerig, Arnzen Moeddel, & Becker, 2011). Of special note, symptoms of re-experiencing (e.g., flashbacks, nightmares, re-enactments) seem to be unique to the diagnosis of PTSD and rarely does a youth meet criteria for the diagnosis in their absence; thus, the presence of re-experiencing symptoms can be considered pathognomonic (Cohen & Scheeringa).

Third, it is common in this population for youth and parents to have experienced chronic, repeated interpersonal traumas rather than the single incident stressors that the DSM-IV diagnostic criteria were designed to capture (Terr, 1991). In addition to the classic signs of PTSD, chronic trauma also leads to a more diverse and pervasive symptom array featuring difficulties with affect regulation, cognitive processing, and interpersonal relationships, a constellation that has been termed complex PTSD, and that calls for a specific set of treatment strategies and considerations (Ford & Courtois, 2009).

How does trauma affect family members' functioning? How parents respond to traumatic events affects a youth's functioning, and a youth's functioning in the wake of trauma in turn affects the other members of the family. However, individuals will differ according to whether they characteristically respond with one of the stress system's three response strategies: to *fight*, to *flee*, or to *freeze* (Nader, 2008). The fight response evidences itself in a high level of emotionality, irritability, and hypervigilence; the flight response in avoidance, isolative behavior, and attempts to escape; and the freeze response in emotional constriction and behavioral inhibition (Blaustein & Kinniburgh, 2010). These different styles of reaction may lead family members to find one another's behavior confusing, frustrating,

and even aversive, and lack of convergence in family members' responses is a common source of strain. Clinicians are encouraged to conceptualize family members' responses to trauma as lying along a number of underlying dimensions and to consider the implications of these dimensions crossing or clashing with one another. One such dimension is *over-arousal*, evidenced by a high level of emotional reactivity, versus *underarousal*, in which numbing and constriction are most evident. Research also suggests an underlying dimension of *externalizing* versus *internalizing*, with some individuals displaying symptoms that are turned inward (avoidance, anxiety, withdrawal) and others turned outward (irritability, anger, displaced aggression). Yet other family members may vacillate between these coping strategies and present with labile and unpredictable emotional reactions. Although in the case of juvenile-justice involved youth it might be expected that an "fight" response is most common, underneath the surface bravado may be a youth who feels vulnerable, hurt, and betrayed, and one whose acting out is in fact a cry for justice and redress in the face of an unresponsive environment (Ford, Chapman, Mack, & Pearson, 2006). The concept of there being hidden meanings, functions, and even noble intentions behind even the most aversive behaviors is central to the FFT perspective.

Engagement and Motivation with Traumatized Families

Assessment of relational functions and hierarchies in the context of trauma. The assessment of relational functions and hierarchies contributes important insights for the creation of a treatment plan with traumatized families. A not-uncommon occurrence among youth who have experienced trauma is to perceive their parents as psychologically vulnerable and unable to "handle" direct discussion about the traumatic experience the youth has undergone; not uncommonly among these families, the youth is correct. FFT-TF accepts as a reality the fact that some adolescents are more mature, higher functioning, and capable of emotional independence than their parents. Although the ideal is to bring parents forward so that they can engage in open discussion and active coping with traumatic events, including by addressing the personal issues that their child's trauma might be triggering, we listen to youth when they express the concern that, "She'll just fall apart." Keeping mum about the trauma, even if this results in serious psychological distress and behavioral dysregulation, may be a child's way of protecting an enmeshed or one-down parent. Assessing the level of autonomy versus contact-seeking in the parent–child relationship also guides the therapist in important ways regarding how much to expect youth to be willing to confide in family sessions and, on the other side of the coin, how much to expect parents to tolerate a child wanting to keep his or her own confidence.

Matching. In matching, the therapist is guided to relate both to autonomous youth with due acknowledgement of their independence and to one-down parents with due appreciation for the fact that they are overwhelmed by the expectation that they take charge and take care of their stressful family system. Matching also involves the therapists' striving to use the family's own language and norms and demonstrating a deep respect for and desire to understand them as they are. A very helpful insight into the mindset of many traumatized delinquent youth, and likely their parents, is Ford et al.'s (2006) victim coping model, which describes traumatic victimization as an assault to the self involving the loss of personal integrity and control. In a desperate attempt to regain a sense of agency, traumatized youth may adopt a "survival coping" mode in which a tough façade of defiance and callousness masks an inner sense of hopelessness and shame. If the environment does not respond to the youth's unmet needs, defiance may give way to desperation and a perceived

justification to take any means necessary to defend the self against a hostile world. In this mode, termed "victim coping," the youth's stance toward the world is colored by a sense of profound distrust of others and pessimism about the future. The FFT-TF approach to matching, therefore, also can involve dispelling rather than conforming to clients' expectations. Especially for traumatized youth involved with the juvenile justice system, who may enter the room expecting a dour authority figure who will elicit a litany of their misbehaviors, the FFT therapists' use of irreverent humor, informality, and willingness to "join" with the family can be disarming in ways that are disequilibrating and encourage youth to open their minds to this intriguing and unexpected person.

To talk or not to talk about the elephant in the room. Often among families that have experienced trauma, an implicit or even explicit rule has been created to "not talk about it." This clearly creates a challenge for the therapist. Just as they attempt to avoid reminders of the trauma, traumatized families may avoid treatments that suggest that they will have to talk about "it." However, a key component of most evidence-based treatments for PTSD is what Silvern, Karyl, and Landis (1995) referred to as "straight talk"—that is, countering avoidance by talking directly about the event without euphemisms or minimizations, and by encouraging the therapeutic processing of the event through the use of exposure and narratives. How does the therapist proceed in a way that respects family members' defenses while not reinforcing their maladaptive aspects? Therapists are guided to frame family members' "conspiracy of silence" as an understandable, once functional, and perhaps even noble attempt to protect themselves and others from pain. In the absence of more adaptive strategies for coping with the trauma, family members did just what they needed to do at the time by putting the experience into a "we can't go there yet" box. As time has gone on, however, the functionality of that strategy has diminished given that it also contributes to a diminution of their ability to communicate with one another, move past the trauma, and experience joy. Therefore, although the message is one of "well done for taking care of yourselves and one another the best way you could up to now," family members are offered hope that the therapist can offer them more adaptive strategies for coping. Consistent with the strategies used by many other trauma-focused therapies, family members are reassured that the therapist will help them to develop emotion-coping tools before they are asked to talk about matters that distress them (e.g., Blaustein & Kiniburgh, 2010; Cohen et al., 2006). In addition, through plain-spoken and matter-of-fact references to the family's traumatic experience, the therapist conveys both the confidence that the family will be able to address the issue directly and the belief that doing so will be tolerable and even helpful. In this way, the therapist communicates respect for the fact that the family may not be ready to talk about the issue, as well as comfort with doing so whenever they are ready.

Whose trauma? A fundamental way in which family therapy differs from more individually-focused trauma treatments is that it is the entire family system who is the "identified patient." It may be particularly hard for some parents who themselves have led hard lives, and whose own pain has not been responded to, to feel empathy toward their child's hurt and to be generous about allowing their children to receive care that they themselves did not receive (Kerig, 2005). Thus, an important goal of FFT-TF is to frame the traumatic experience in terms of *relational themes* that involve interactions among family members and not the misbehaving youth alone. However, working simultaneously with multiple traumas among diverse family members is challenging (Kerig, Sink, et al., 2010). As Cohen et al. (2006) emphasized in the context of intervening with the parents of traumatized children, the therapist must navigate between the need to attend to individual

family members' experiences, particularly parental histories of trauma, without becoming pulled into the temptation to view the problem or to treat it as an individual therapy issue. To this end, parents' negative feelings and past behavior are reframed in a strengths-based way, as protective strategies they needed to adopt in order to function as parents despite their unresolved pain.

Relational themes in the context of trauma. A powerful way in which engagement and motivation set the stage for the family's willingness to embark on behavior change is the reframing of problem behaviors as relational issues. The explicit acknowledgement that all family members have been affected by a trauma—even if it was experienced directly only by one of them, but especially if multiple family members have undergone trauma—is usually received as a much-appreciated acknowledgement of the family's reality. To provide examples of such themes, we conducted an online survey in which we queried FFT therapists about relational themes that they had found effective in working with traumatized families (Kerig & Bennett, 2010). Half reported formulating such themes, which included *shared experience* (e.g., "This whole family has had a major loss and you are all attempting to deal with it in your own way"; "You have all made it through some difficult experiences together"); *survival* (e.g., "You have all endured so much and yet here you are still fighting back"; "You are like warriors in that you rely not only on your inner strength but the strength of each other to hold together and move forward"); *family-ness* (e.g., "You are learning together how to be a family again after what has happened"; "Despite what has gone on and how it has made you all anxious and uncertain, you are still taking your chances together in this world"); *hurt* (e.g., "Underneath the anger is hurt that hasn't been heard"); *courage* (e.g., "Something you all have in common is that you have the courage to be here and to deal with the pain and the anger and loss"); *striving for mastery* (e.g., "Acting out is one way to feel a sense of control, and to keep fighting for control in an unsafe and scary world is a sign of strength and resilience"); and *protection* (e.g., "Your not talking about it to this point has been a way to help you stay together and protect one another from feeling pain"; "Some things are too overwhelming for your family to talk about right now but you are finding ways to reach out and stay connected with one another nonetheless").

Behavior Change

Thus far, what we have described are classic FFT techniques with a twist of trauma flavor. Where FFT-TF most diverges from the "generic" version is in the behavior change phase, in which the family's new-found motivation to change is harnessed in the service of healing from trauma. As in FFT generally, therapists know the family is ready to shift to behavior change when there are indications of balanced alliances, decreased negativity and self-blame, increased family bonding, more positive attributions of one another's behavior, and a more hopeful attitude. In addition, the therapist looks for indications that the family is able to acknowledge that trauma has played a central role in their lives and has some relationship to the behavior problems that brought them into treatment. Persistent denial, avoidance, or emotional distancing suggests that the family will be resistant and unresponsive to the trauma treatment component and thus is not ready or able to benefit from taking the next step.

The strategies used in the trauma modules derive from an integration of key elements of a number of evidenced-based treatments, most notably Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen et al., 2006), Cognitive Processing Therapy

(CPT; Chard, 2005), Attachment, Self-Regulation, and Competency (ARC; Blaustein & Kinniburgh, 2010); and seminal family-based models (e.g., Figley, 1989) but adapt those models for the treatment of antisocial youth and families, with the unique dynamics and issues of this population firmly in mind. Moreover, in keeping with FFT's flexibility and individualization to the unique needs of the family, these behavior change modules are implemented in the order and with the length of time required to best meet the needs and match with the characteristics of each youth and family. Thus, the therapist is guided to view the five trauma-specific behavior change modules—*normalization, affect regulation, communication, cognitive processing,* and *integration*—as goals to strive for rather than as a rigidly laid out curriculum to be administered in a predetermined order. As with other modularized treatments, the ordering, pacing, and length of time spent lingering on each of these modules is determined by the core issues and unique treatment needs presented by each specific family.

Normalization and harnessing of strengths. The purpose of the initial phase of behavior change is *normalizing* the family's experience and helping them to reconstrue their responses to the traumatic experience in a strengths-based way. To avoid engaging in a didactic process (which antisocial teenagers in particular tend to respond poorly to given their dislike of lectures and desire to see their own experiences as unique), we enfold psychoeducation about trauma into our reframing of family members' behavior as strength-based and relational. Our ultimate goal, therefore, is to help family members to understand that their reactions and symptoms are understandable, were adaptive at the time, and were even sources of resilience for them. We thus take care to discuss how the experience of traumatic life events affects the brain, body, and mind—as well as the system of family relationships—in ways that are congruent with their own personal experience and symptom presentation rather than as generic and academic. Figley's (1989) strategies for reframing PTSD symptoms in adaptive ways are extremely useful here; for example, flashbacks are a sign of "vivid recall ability" and are useful indicators of the need for trauma work; guilt is an indication of selflessness and humanity; substance use is an attempt at self-care and avoiding being a burden to others; increased family conflict is a sign that this family is normal and is responding the way any family would; and an acting-out child indicates his or her love and concern by bringing attention to the needs of this traumatized family.

Affect regulation. In keeping with our promise to families that we will not ask them to wade into deep waters without first assuring that they can swim, we begin behavior change in earnest by focusing on helping family members to learn strategies for coping with their own and one another's strong emotions. We continue to match to family members and to emphasize family strengths and adaptivity by identifying and building on any positive coping strategies they already demonstrate, including ways in which they currently calm themselves and/or help one another to feel better. Borrowing from de Shazer's (1988) solution-focused strategy of calling attention to "exceptions," we ask: What was different about that one time in your lives, that one day, or that one moment, in which you were able to "deal," and how can the conditions that facilitated that successful experience, albeit brief and rare, be expanded into the present?

Our approach to teaching affect regulation attempts to avoid didacticism and instead to intrigue and engage family members in an experiential process of learning what uniquely works for them, given their unique personalities and relational functions in the family. Rather than teaching families a predetermined set of emotion regulation strategies, our

job is to help them find which of the myriad strategies available provides the best fit for them. This framing of the task helps to avert the common response of many adolescents (and adults) who reject standard affect regulation exercises, such as belly breathing and progressive muscle relaxation, by saying "I've already tried that" or "I'd feel stupid doing that." Among the techniques on this affect regulation menu are meditative breathing, mindfulness, visualization, distress tolerance, and physical activity and exercise (Kabat-Zinn, 1990; Miller, Rathus, & Linehan, 2006). The use of metaphors can be valuable for engaging family members here, with the therapist's attunement to the interests and style of each family member utilized to conceptualize the task in ways that fit with their own unique identity (e.g., a father proud of his mechanical skills learning to regulate his "oil temperature gauge;" a youth who dreams of being a "guitar-god" visualizing the controls on his "amplifier"). Importantly, the therapist continues to utilize an understanding of family members' relational functions by matching affect regulation techniques to those functions and by attending to the ways in which an individual's self-calming strategies of choice might impact the feelings and behavior of other family members.

Creating safety and opening channels of communication. Quickly following upon the heels of affect regulation (or preceding it for families whose affectively charged and provocative exchanges are a source of such immediate stress that they threaten to derail any other work), we establish emotional safety in the room by engaging families in learning more effective communication and conflict resolution strategies (e.g., Foster & Robin, 2002). This process begins during the engagement and motivation stage when the therapist models, elicits, and supports positive communication and actively interrupts and diverts negative communication patterns. However, tensions can run high and emotional buttons are easily pushed, particularly for families that have experienced trauma. Therefore, it is important to reduce the sources of negative reactivity that are triggered by negative, blaming, unclear, and emotionally provoking exchanges. Before asking families to share their thoughts and feelings, we strive to establish an atmosphere in the room in which they feel it is safe to do so and in which they can have confidence they will be heard.

Dispelling unhelpful cognitions. One of the core therapeutic tasks in evidence-based treatments for trauma is to uncover and dispel the unhelpful attributions that lead to traumagenic or "manufactured emotions" (Chard, 2009) such as guilt, self-blame, shame, and the perception that one is now permanently "damaged goods." Many of the most empirically well-supported treatments for PTSD focus on the creation of a trauma narrative, which serves a number of purposes including therapeutic exposure, reduction of avoidance, uncovering unhelpful cognitive attributions, and creation of a coherent life story that is not fragmented, disorganized, and associated with intolerable affects. However, a number of considerations must be made regarding whether a trauma narrative is indicated in family treatment (Ford & Saltzman, 2009). For example, caution must be exercised regarding the possible vicarious trauma that could result from family members sharing gruesome or disturbing elements of a traumatic experience. This particularly is the case when siblings take part in family sessions or when parents are emotionally fragile and/or struggling with their own unresolved traumas. In addition, it is a matter of current debate in the trauma treatment literature as to whether this form of exposure is necessary, sufficient, or ideal but optional, and whether the focus need be on the past and the recollection of what happened during the traumatic event, or on the present and how the trauma currently is affecting the family (Chard, 2009; Ford, 2010; Hassija & Gray, 2010).

The role of trauma narratives in FFT-TF. Although the benefits of creating a coherent integration of the experience through narratives have been evident in a number of approaches (e.g., TF-CBT and ARC), we also note persuasive empirical evidence that the benefits of cognitive therapy can be achieved without the creation of a trauma narrative (Resick et al., 2008). Therefore, given the possible contraindications for trauma narratives in family treatment, and in keeping with the cautions recommended by leading trauma clinicians (Blaustein & Kinniburgh, 2010; Ford & Courtois, 2009), our approach suggests that the use of narratives in FFT-TF should be individualized to the needs and level of functioning of the family. For families that demonstrate the ability and willingness to talk directly about the traumatic experience, and with parents whose response to the earlier phases of treatment yields evidence of their capacity to withstand the emotional impact of hearing the narrative, the creation of a trauma narrative is ideal. For families who do not demonstrate the capacity to approach this task without extreme trepidation and emotional dysregulation, arousal, or defensive numbing, a trauma narrative is contraindicated. In addition, our decision about whether to move forward with a trauma narrative is influenced by the extent to which the traumatic event is a source of ongoing contention and emotional heat in the family system; for example, we would refrain from encouraging a daughter to construct a trauma narrative about her sexual assault with a parent who remained adamant in the belief that the rape was "all her fault" for being such a "slut."

The assessment of the family's capacities is ongoing throughout treatment but is revealed particularly by the family's responses to the affect regulation module and whether they are able to utilize the tools we introduce to their toolboxes. To build the necessary underlying capacities to manage upsetting feelings and directly confront the distressing details of a traumatic event in a parent or a child who is completely lacking in these skills would take a longer-term treatment than the FFT-TF model is able to provide—and yet we believe these capacities are not necessary for the treatment to move forward and succeed. Instead, for families for whom recounting the trauma would be overly stressful, the creation of a narrative begins and ends with a description of how each family member views the trauma as having affected themselves as individuals as well as the family as a whole in the present; this is the impact statement.

Eliciting family members' cognitions, attributions, myths, theories, and rules: The impact statement. Whether the focus is on the past and the recollection of what happened during the traumatic event or on the present and how the trauma has affected their lives, the main purpose of narrative work in FFT-TF is to uncover underlying beliefs that might contribute to the development of PTSD. The function of the narrative is "not primarily archeological (i.e., unearthing the past)" (Ford & Cloitre, 2009, p. 49) but is instead to understand how processing of the traumatic event is affecting functioning in the present. In order to access these beliefs while avoiding the potential resistance or iatrogenic effects that could ensue from compelling family members to recount the traumatic event itself, we start by asking each family member to construct an *impact statement* regarding how they believe that they as individuals—and their family as a whole—is different because of the traumatic experiences they have undergone. These statements are independently generated by each family member, although given the low rates of literacy among antisocial families, creative means other than writing may need to be offered (e.g., the use of drawings, computer clip-art, song lyrics, or audiorecordings). Following the creation of each family member's impact statement, the treatment team meets to review and discuss them, looking particularly for evidence of *overaccommodated* beliefs (Chard, 2009), statements that represent extreme overgeneralizations about the trauma and its implications for the self, the world, or the

future (e.g., "this happened to me because I am no good;" "now that this has happened to our family, we will never be the same"). In addition, the team studies the narratives in order to look for *shared versus conflicting* family members' "theories" about the causes and meanings of the traumatic event. As Walsh (2003) emphasized, these family belief systems or "myths" have a formative role in determining the effects of a traumatic experience on its members; however, lack of convergence in family members' points of view is a common source of trauma-related strain (Saltzman et al., 2008).

Processing of unhelpful beliefs. Based upon the family appraisals and belief systems uncovered through the impact statements, the therapist uses the techniques laid-out in the TF-CBT and CPT manuals to engage families in countering them. Socratic questioning is a valuable strategy in this regard in that it prevents family members from feeling judged, criticized, or that they are being told they are "wrong" to feel the way they do. Instead, the therapist invites family members on a journey of scientific curiosity to determine the "evidence" for various beliefs. This is a process that should be engaged in with a spirit of intrigue rather than heavy-handedness and calls for all the creativity, playfulness, and adaptability a therapist can bring to the endeavor. This sentiment is very much in keeping with the overarching FFT philosophy in which "humor and joy" are considered essential parts of the process (Alexander et al., in press). As a further consideration in adapting these techniques to this population, our experience has been that antisocial families generally respond poorly to "homework" and structured worksheets such as those offered in the CPT and ARC manuals; however, such resources can provide helpful mechanisms for engaging in cognitive processing with families who are willing to utilize them. In general, we have found families of antisocial youth to respond better to the highly personalized, creative, and experiential strategies exemplified in the TF-CBT approach (e.g., Kerig, Sink et al., 2010).

Achieving integration of the traumatic experience and representational coherence. The cognitive processing of impact statements leads family members to experience increasing cognitive dissonance and lack of ego syntonicity with their original constructions (Chard, 2009). When this shift has taken place, family members create a co-constructed impact statement in which they assist one another in conveying their revised understanding of who they are as individuals and as a family. A new level of empathy and insight into one another's interpretations helps family members to nudge one another should unhelpful beliefs continue to creep into the narrative and to remind one another of the more adaptive interpretations that have been shown to hold greater truth. Gentle humor and the use of metaphors that often arise in the context of the cognitive processing ("That's your old 'I'm a magnet for misery' theory peeking through!") contribute to making this a warm, mutually responsive, and enjoyable experience. The narrative concludes with family members' articulations of their expectations and hopes for the future. For many families, this focus on a present and future orientation is sufficient to the purpose; however, additional deeper processing that allows for an integration of the traumatic memories into the family's shared life history can be of further benefit.

The trauma narrative. When indicated by a family's willingness and capacity to benefit from engaging in direct discussion of the traumatic event, we involve them in the cocreation of a family trauma narrative. For families who are less verbally-oriented, a visual depiction of the family timeline is useful, as inspired by the FOCUS Program (described in Saltzman et al., 2008). For verbally-oriented families, a narrative can be elicited through

use of Figley's (1989) five questions: *What happened? Why did it happen? Why did we act as we did at the time? Why have we reacted as we have since it happened?* and *What if something like this happens again?* In addition to revealing individuals' experiences of the trauma, the joint narrative elicits and underscores their shared experience as a family. The family narrative also provides further opportunities for uncovering and dispelling stubbornly held unhelpful cognitions and conflicting beliefs, as well as for identifying the family's strengths and sources of resilience in order to construct what Figley (1989) called a "healing theory." Further benefits for families who are able to move forward with the trauma narrative include all the therapeutic gains that accrue from therapeutic re-exposure, including redressing the pathogenic processes of avoidance, the fear that remembering will bring unbearable pain, and the lack of coherence that comes from unintegrated internal representations of experience (Blaustein & Kinniburgh, 2010; Cohen et al., 2006; Ford, 2009). Additional benefits to the family system include the eradication of family secrets, "hushed" words, and unnamed elephants in rooms.

Generalization

The goal of generalization is to help the family maintain treatment gains and avert relapse through planning for the future, connecting with community resources, and practicing new skills in real-world contexts. Relapse prevention includes preparing for the inevitable reminders that will trigger reactions to the traumatic event in the future (e.g., the anniversary reaction is a powerful one that often operates under the level of consciousness, triggered as it can be by such subtle cues as the change of seasons). In turn, connecting with community resources can help to foster a sense of belonging among family members whose traumatic experiences have led them to feel ashamed, ostracized, or alienated from others. Religious communities can be particularly important to families whose spiritual beliefs have been shaken by the experience of trauma. Connecting to community resources also may involve a family member finally accepting a long-rejected referral for his or her own individual psychotherapy. It might be the highest compliment to the intervention should a deeply wounded family member decide on the basis of this positive experience that therapy indeed can help, and that it is high time that he or she embarked on a personal journey of recovery. In this way, the FFT-TF work may be only the start of a longer process that leads to a more complete healing from trauma.

FFT-TF: A Good Fit with Best Practices

The FFT-TF approach maps extremely well onto the best practice principles proposed by Ford and Cloitre (2009) for the treatment of PTSD in complexly traumatized youth. These principles include: (a) prioritizing safety; (b) building a relational bridge to engage and retain the youth and caregiver in treatment; (c) maintaining a relational focus; (d) staying strengths-based; (e) focusing on enhancing self-regulation competencies; (f) retaining sensitivity to various family members' trauma histories and taking care to determine how, when, and with whom to uncover traumatic memories; and (g) preventing and managing relational strife within the family system. With these considerations in mind for the treatment of traumatized youth and families, we believe that the trauma-informed clinician will be a more effective and adherent Functional Family therapist.

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References

Alexander, J. F. (2009). *FFT clinical training manual*. Seattle: Functional Family LLC.

Alexander, J. F., Robbins, M., Waldron, H., & Neeb, A. (in press). *Functional family therapy*. Washington, DC: American Psychological Association.

Appleyard, K., & Osofsky, J. D. (2003). Parenting after trauma: Supporting parents and caregivers in treatment of children impacted by violence. *Infant Mental Health Journal*, *24*, 111–125.

Blaustein, M. E., & Kinniburgh, K. M. (2010). *Treating traumatic stress in children and adolescents*. New York: Guilford.

Catherall, D. R. (1998). Treating traumatized families. In C. R. Figley (Ed.), *Burnout in families: The systemic costs of caring* (pp. 187–215). Boca Raton, FL: CRC Press.

Chard, K. M. (2005). An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood sexual abuse. *Journal of Counseling and Clinical Psychology*, *73*, 965–971.

Chard, K. M. (2009, December). *Cognitive processing therapy for sexual abuse*. Training conducted at the Mayerson Center for Safe and Healthy Families, Cincinnati Children's Hospital, Cincinnati, OH.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford.

Cohen, J. A., & Scheeringa, M. S. (2009). Post-traumatic stress disorder diagnosis in children: Challenges and promises. *Dialogues in Clinical Neuroscience*, *11*(1), 91–99.

Curry, J. F., & Reinecke, M. A. (2003). Modular cognitive behavior therapy for adolescents with major depression. In M. A. Reinecke, F. M. Dattilio, & A. Freeman (Eds.), *Cognitive therapy with children and adolescents* (2nd ed., pp. 95–127). New York: Guilford.

De Bellis, M. D. (2001). Developmental traumatology: The psychobiological development of maltreated children and its implications for research, treatment, and policy. *Development and Psychopathology*, *13*, 539–564.

de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy*. New York: Norton.

Egeland, B. (1988). Breaking the cycle of abuse: Implications for prediction and intervention. In K. D. Browne, C. Davies, & P. Stratton (Eds.), *Early prediction and prevention of child abuse* (pp. 87–99). New York: Wiley.

Evans, G. W. (2004). The environment of childhood poverty. *American Psychologist*, *59*, 77–92.

Figley, C. R. (1989). *Helping traumatized families*. San Francisco: Jossey-Bass.

Fletcher, K. (2003). Childhood posttraumatic stress disorder. In E. J. Mash & R. A. Barkley (Eds.), *Child psychopathology* (pp. 330–371). New York: Guilford.

Ford, J. D. (2009). Neurobiological and developmental research: Clinical implications. In C. A. Courtois & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp. 31–58). New York: Routledge.

Ford, J. D. (2010). Just think about it: How can cognitive therapy contribute to the treatment of Posttraumatic Stress Disorder? *Clinical Psychology: Science and Practice*, *17*, 128–133.

Ford, J. D., Chapman, J., Mack, M., & Pearson, G. (2006). Pathways from traumatic child victimization to delinquency: Implications for juvenile and permanency court proceedings and decisions. *Juvenile and Family Court Journal*, *57*(1), 13–26.

Ford, J. D., & Cloitre, M. (2009). Best practices in psychotherapy for children and adolescents. In C. A. Courtois & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp. 59–81). New York: Routledge.

Ford, J. D., & Courtois, C. A. (2009). Defining and understanding complex trauma and complex traumatic stress disorders. In C. A. Courtois & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp. 13–30). New York: Routledge.

Ford, J. D., & Saltzman, W. (2009). Family systems therapy. In C. A. Courtois & J .D. Ford (Eds.), *Treating complex traumatic stress disorders* (pp. 391–414). New York: Routledge.

Foster, S. L., & Robin, A. L. (2002). *Negotiating parent-adolescent conflict*. New York: Guilford.

Hassija, C. M., & Gray, M. J. (2010). Are cognitive techniques and interventions necessary? A case for the utility of cognitive approaches in the treatment of PTSD. *Clinical Psychology: Science and Practice*, *17*, 112–127.

Hosser, D., Raddatz, S., & Windzio, M. (2007). Child maltreatment, revictimization, and violent behavior. *Violence and Victims*, *22*, 318–333.

Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. New York: Dell.

Kellerman, N. P. F. (2001). Psychopathology in children of holocaust survivors: A review of the research literature. *Israeli Journal of Psychiatry and Related Sciences*, *38*, 36–46.

Kerig, P. K. (2005). Revisiting the construct of boundary dissolution: A multidimensional perspective. In P. K. Kerig (Ed.), *Implications of parent-child boundary dissolution for developmental psychopathology: Who is the parent and who is the child?* (pp. 5–42). New York: Haworth

Kerig, P. K. (2012). Trauma and juvenile delinquency: Dynamics and developmental mechanisms. *Journal of Child and Adolescent Trauma*, *5*, 83–87.

Kerig, P. K., Arnzen Moeddel, M., & Becker, S. P. (2011). Assessing the sensitivity and specificity of the MAYSI-2 for detecting trauma among youth in juvenile detention. *Child and Youth Care Forum*, *40*, 345–362.

Kerig, P. K., & Becker, S. P. (2010). From internalizing to externalizing: Theoretical models of the processes linking PTSD to juvenile delinquency. In S. J. Egan (Ed.), *Posttraumatic stress disorder (PTSD): Causes, symptoms and treatment* (pp. 33–78). Hauppauge, NY: Nova.

Kerig, P. K., & Bennett, D. C. (2010). *Results of the Functional Family Therapy Trauma Survey*. Technical report, University of Utah, Salt Lake City, Utah.

Kerig, P. K., Bennett, D. C., Thompson, M., & Becker, S. P. (2012). "Nothing really matters": Emotional numbing as a link between trauma exposure and callousness in delinquent youth. *Journal of Traumatic Stress*, *25*, 1–8.

Kerig, P. K., Fedorowicz, A. E., Brown, C. A., & Warren, M. (2000). Assessment and intervention with PTSD in children exposed to violence. *Journal of Aggression, Maltreatment Trauma*, *3*, 161–184.

Kerig, P. K., Sink, H. E., Cuellar, R. E., Vanderzee, K. L, & Elfstrom, J. E. (2010). Implementing Trauma-Focused CBT with fidelity and flexibility: A family case study. *Journal of Clinical Child and Adolescent Psychology*, *39*, 713–722.

Kerig, P. K., Volz, A. R., Moeddel, M. A., & Cuellar, R. E. (2010). Implementing the Expect Respect dating violence prevention program in diverse contexts: Flexibility with fidelity. *Journal of Aggression, Maltreatment, and Trauma*, *19*, 661–680

Mazzucchelli, T. G., & Sanders, M. R. (2010). Facilitating practitioner flexibility within an empirically supported intervention: Lessons from a system of parenting support. *Clinical Psychology: Science and Practice*, *17*, 238–252.

McCubbin, H. I., & Figley, C. R. (1983). *Stress and the family*. New York: Brunner/Mazel.

Miller, A. L., Rathus, J. H., & Linehan, M. M. (2006). *Dialectical behavior therapy with suicidal adolescents*. New York: Guilford.

Nader, K. (2008). *Understanding and assessing trauma in children and adolescents*. New York: Routledge.

Nugent, N. R., Amstadter, A. B., & Koenen, K. C. (2008). Genetics of post-traumatic stress disorder: Informing clinical conceptualizations and promoting future research. *American Journal of Medical Genetics*, *148C*, 127–132.

Perry, B. D. (2001). The neurodevelopmental impact of violence in childhood. In D. Schetky & E. P. Benedek (Eds.), *Textbook of child and adolescent forensic psychiatry* (pp. 221–238). Washington, DC: American Psychiatric Press

Resick, P. A., Galovski, T. E., Uhlmansiek, M. O., Scher, C. D., Clum, G. A., & Young-Xu, Y. A. (2008). Randomized clinical trial to dismantle components of cognitive processing therapy for posttraumatic stress disorder in female victims of interpersonal violence. *Journal of Consulting and Clinical Psychology*, *76*, 243–258.

Saltzman, W. R., Babayan, T., Lester, P., Beardslee, W. R., & Pynoos, R. (2008). Family-based treatment for child traumatic stress. In D. Brom, R. Pat-Horenczyk, & J. D. Ford (Eds.), *Treating traumatized children* (pp. 240–254). New York: Routledge.

Saxe, G. N., Ellis, B. H., & Kaplow, J. B. (2007). *Collaborative treatment of traumatized children and teens*. New York: Guilford.

Silverman, R. C., & Lieberman, A. F. (1999). Negative maternal attributions, projective identification, and the intergenerational transmission of violent relational patterns. *Psychoanalytic Dialogues*, *9*, 161–186.

Silvern, L., Karyl, J., & Landis, T. Y. (1995). Individual psychotherapy for the traumatized children of abused women. In E. Peled, P. G. Jaffe, & J. L. Edelson (Eds.), *Ending the cycle of violence* (pp. 43–76). Thousand Oaks, CA: Sage.

Terr, L. C. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry*, *148*(1), 10–20.

Walsh, F. (2003). Family resilience: A framework for clinical practice. *Family Process*, *42*, 1–18.

Wolfe, D. A., Rawana, J. S., & Chiodo, D. (2006). Abuse and trauma. In D. A. Wolfe & E. J. Mash (Eds.), *Behavioral and emotional disorders in adolescents* (pp. 642–671). New York: Guilford.