

Use of lifeline technique in cognitive-behavioral-systemic family therapy

Uso da técnica da linha de vida em terapia familiar sistêmica cognitivo-comportamental

Mariana Pasquali Poletto ✉
Christian Haag Kristensen
Rodrigo Grassi-Oliveira
Mariana Gonçalves Boeckel

Realizado na Pontifícia Universidade Católica do Rio Grande do Sul

SUMMARY

Intrafamily violence when precocious, chronic and recurrent may lead to the development of mental disorders, including Posttraumatic Stress Disorder (PTSD) and Complex Trauma. The effects of exposure to intrafamily violence commonly are not limited to childhood and adolescence, and may impact psychological, social and occupational functioning in adulthood. The most effortful intervention to these cases involves individual psychotherapy (cognitive-behavioral psychotherapy) and family psychotherapy (systemic and cognitive-behavioral). In the cognitive-behavioral-systemic approach, the lifeline technique can be characterized as a useful strategy in the evaluation of the temporal course of the exposure to stressor events, as well as the adaptive and maladaptive answers from the members of the family system. The aim of this paper is to present a brief family psychotherapy process with a family exposed to multiple situations of intrafamily violence with the use of lifeline's technique as a therapeutic approach.

Keywords: Posttraumatic Stress Disorder, Cognitive-Behavioral-Systemic Family Therapy, Violence, Lifeline Technique

✉ marianappoletto@gmail.com

Relational family trauma is characterized by the occurrence of an interfamilial event perceived by the child as a breach or violation of physical or emotional safety by their caregivers, e.g. having alcoholic parents, witnessing domestic violence, suffering sexual abuse and others. Exploiting relational ruptures is needed to make the reinforcement of relational and attachment connections possible among members of the traumatized child's family (Sheinberg & True, 2008).

The maintenance of complex trauma symptomatology decurrently from intrafamily violence is an answer to maladaptive behavioral patterns between the family members (Kiser et al., 2010) due to the expectation of the recurrence of the trauma, insecurity feelings and difficulties to deal with its own emotions (van der Kolk, 2005). Precocious exposure to violence and the daily social contact with the aggressor, concurrent to instability of parental relationships generate alterations in personal relationship abilities and worldview of these individuals. The context in which the abuse occurs may affect the recovery after the event, being the psychotherapy process and effective resource to diminish the negative post-traumatic consequences (Stalker et al., 2005).

The symptoms described in victims of complex trauma by perpetrators within the family are a response to maladaptive behavior patterns among family members (Kiser et al., 2010). The context in which the abuse occurs may affect the individual's recovery after the event, being the psychotherapy process an effective strategy to reduce the negative posttraumatic consequences in chronic PTSD and complex trauma victims (Stalker et al., 2005). It is noted the relevance of family therapy to make possi-

ble the identification of strong points and weaknesses on family support, parenting skills and other family characteristics that may encourage the coping strategies of abused child (Faust, 2000). Thus, family therapy is an effective treatment approach for children or family members exposed to abuse or assault with posttraumatic symptoms, by using cognitive-behavioral techniques (Faust, 2000; Kolko, Iselin & Gully, 2011) such as changes in parenting practices.

Memory redefinition and the development of coping strategies and behaviors in the present integrate traumatic experiences through ressignificance, development and resolution of these traumatic memories (Levin, 2009). An important narrative technique for traumatized families is the storytelling. Storytelling consists in the process of family engagement to report their experiences to each other. This narrative form provides a facilitated therapeutic family discussion, leads to the construction of a theory shared by all members about the experienced events and the reason why it happened, and allows each member to view the family life history through their and other members' perspectives (including emotions), which results in a shared and integrated understanding of the events and family's autobiographical memory (Kiser et al. 2010).

The narrative considers the uniqueness of human experiences and how humans incorporate and give meaning to them through the consolidation of these experiences. With the development of the narrative, it is possible the establishing of linguistic exchanges and consequently the development of meanings (Lahm Vieira, Boeckel and Rava, 2011). Guided by the prerogative that the therapeutic narrative (Kiser et al., 2010; Lahm Vieira, Boeckel & Rava, 2011) as

a useful strategy to reconstruct traumatic memories and the use of the time line to screen the life history looking for significant events, (Goldberg & Bezerra, 2012), we developed the lifeline technique. This technique consists in the elaboration of a panel using cardstock and pens, temporally delimiting the occurrence of the traumatic events.

The importance of the traumatic events' illustration in an organized way throughout the family life's history is based on interactions between time and space such as numerical cognition and visual-spatial attention, suggesting that humans represent time as space in a unified way. The terminology "mental timeline" is used to inform about the time-space interactions, considering that time is plotted on a continuum from one end to another, being represented spatially and relatively, from points or reference ranges (Bonato, Zorzi & Umiltá, 2012).

Cognitive-Behavioral Family Therapy (CBFT) can also integrate assumptions of systemic perspective, considering relationships circularity and reciprocity (Dattilio, 2001). Both cognitive-behavioral and systemic family therapies are premised on multidirectional and reciprocal influence of behaviors and relational movements, and the fundamental principle understanding the behaviors in their particular context (Dattilio, 2011). CBFT techniques that underlie the systemic concept of circularity can be used to ensure the questioning and possibility to change identified thought patterns in the therapeutic context, such as problem solving, dramatizations and use of empathy, in addition to the identification of intergenerational thought and behavior patterns. Furthermore, both practices emphasize the communication process among family members (Dattilio, 2011).

Thus, Family CBT settles on the interaction among family members, considering cognitions, emotions, actions and relationships. Family members tend to be on systemic homeostasis to satisfy their needs, and cognitive processing of family members such as assignments, expectations and standards accompany and influence the cognitive distortions of family life. Family problems arise when cognitive processing blocks family members' satisfaction. This therapeutic approach aims to work in the cognitive components of the problem as an effective and efficient strategy to modify dysfunctional patterns in emotional, relational and behavioral levels (Dattilio, 1997, 1998, 2000, 2001, 2002; Dattilio & Epstein, 2005). From this arises the Cognitive-Behavioral-Systemic Family Therapy (Dattilio & Nichols, 2011), which allows the use of skills in mediating emotionally intense reactions and facilitates effective communication and behavior change, facilitating the changing process (Dattilio & Nichols, 2011).

Cognitive-Behavioral-Systemic Family Therapy consists in an approach few referenced, however, frequently present in clinic practices. This new psychotherapy approach integrates systemic comprehension of family functioning, guiding therapeutic interventions during session. Cognitive-behavioral aspects set the structure of the sessions and homework, give space to other cognitive and behavioral techniques and establish clear objectives to the treatment.

Family relationships are included in the treatment of the identified patient, aiming to break patterns of violence, whereas the way the family plays roles in their relations within the family initiates, maintains or exacerbates the problems manifested by the patient. Therefore, the impact of abuse can be

decreased by an organized context which provides the appropriate support (Friedberg, 2006). Abused children who need to develop their own parent resources to feel safe and secure tend to believe that the risk of violence or abuse remains, which leads to the persistence of posttraumatic symptomatology (Faust, 2000).

Treatment initially focuses on affective regulation and strengthening of social bonds, since they undergo important negative alterations related to stressors (Cloitre et al., 2004, van der Kolk et al., 2005). Working the family system assists in the restructuring of distortions on the history of violence, enhances individual and relational resources (Friedberg, 2006), being good therapeutic alliance and empathy stimuli for the development of affective trust in the identification of the patient with others, restoring existing bonds and expanding interpersonal relationships (Friedberg, 2006).

Thus, this paper aims to present the use of the lifeline technique as a therapeutic strategy in a family exposed to multiple situations of family violence. For such, it provides clinical vignettes with a case of brief family psychotherapy under the theoretical cognitive behavioral perspective and systemic understanding.

METHOD

Patients were treated at Centre of Studies and Research in Traumatic Stress (NEPTE). NEPTE is an outpatient research on trauma and stress that provides assessment and psychological care for individuals who are victims of trauma, as well as development of assessment and intervention in the area. This Center is linked to the Post Graduate Program

in Psychology and to the Institute for Biomedical Research, both referring to the Pontifical Catholic University of Rio Grande do Sul (PUCRS). Patients assessed by NEPTE undergo clinical and neuropsychological evaluation to detect post-traumatic symptoms and other psychiatric disorders arising from the exposure to trauma. In case of a diagnosis of PTSD, the patient is directed for treatment protocol with cognitive behavioral therapy for PTSD at the Center's clinic, and in case of other mental disorders arising from the traumatic events, the patient is directed for cognitive-behavioral therapy, targeting remission of the disorder and decrease of post-traumatic symptoms. Moreover, when family demands are evidenced, especially when several ways of violence had occurred in the family system, they are directed to family psychotherapy.

The family presented in this article came by means of the service demands of a daughter who had post-traumatic symptoms. However, they were headed to family psychotherapy due to reports from multiple situations of violence by family members throughout its history and several post-traumatic symptoms in different members. Given the identified demands, the referral was to cognitive-behavioral-systemic family psychotherapy (Dattilio & Nichols, 2011).

The family was composed by seven members, which include the mother, two sons and three daughters, from the countryside. The family system presented throughout the psychotherapeutic process is composed by the mother (54 years old) and three daughters (24, 17 and 18 years), all diagnosed with Bipolar Affective Mood Disorder, on pharmacological treatment. The family has come to the city in attempt to stay away from the abusers. The father

was very authoritarian and physical and sexually abusive with the mother, beside emotionally neglect their children. From the family's narrative, we were able to suppose that the older sons have a diagnostic hypothesis of Antisocial Personality Disorder, demonstrating violent behaviors and transposing rules since their first childhood. These sons abused physically and emotionally the mother, who were unable to set clear limits to the filial subsystem in the history of the family's life cycle, neglecting their emotional and bonding needs.

Still, the sons abused emotional, physical and sexually their sisters. Therefore, the sisters and the mother, part of the family presented in this study, demonstrate a co-depending functioning, beside inversion of family roles (maternal, filial and fraternal), relating to each other in ways to perpetuate the violence. The mother presents severe dissociative symptoms, and the youngest daughter presents low self-esteem, difficulty to establish relations and with her self-care.

On the first meeting, traumatic situations were identified in family history, previously described. The violence is trans-generational, with history of emotional neglect, physical, psychological and sexual abuse. It is identified that the current demand for psychotherapy assistance is explicated by the family due to the violence of the brothers. It is reported by the mother that her youngest daughter has been sexually abused by the brothers. Some traumatic events of physical aggression were described by the mother, with significant emotional detachment. The history of maltreatment is associated with higher development of dissociative symptoms such as depersonalization, reduced consciousness to environmental sounds, derealization, emotional blunting

and feeling of detachment (Briere 2006; McCaslin et al., 2008).

The assaults dates and their contexts were questioned, and at this time the mother replies that "my memory is out there", referring to another family member. The daughter in question was called in order to identify the dosages of medication used by each family member. The service contract on family care was signed by the younger sister, his mother and sister at NEPTE, and the family was oriented that in the next session all family members should participate. After this first session, the case was discussed with NEPTE team and was defined the development of a lifeline with the family, aiming the organization of the life history and the strengthening ties within the family. For the first lifeline construction session, it was designed a specific consent term.

RESULTS AND DISCUSSION

The construction of the lifeline technique began in the second psychotherapy session. Traumatic events were organized chronologically from the family history. The objective of this was to recover the family history, the situations that triggered important changes in family functioning resulting from traumatic situations, as well as coping strategies. PTSD psychoeducation by cognitive model was realized, and it was highlighted the therapeutic relevance of traumatic memories' recall and narrative, while validating family emotions. A straight line was drawn in a white cardboard while the mother was beginning the narrative of family formation, this way integrating the narrated facts to the lifeline.

At this session the mother reported marrying her ex-husband soon after meet him and also reported the

onset of physical aggression during her first pregnancy. She described him as being “controlling, alcoholic and distant from family” since they met. After the beginning of lifeline family construction, the mother used the lifeline to report a total of thirteen pregnancies, five of which resulted in miscarriage, one in death of the newborn by the negligence of the midwife and seven in successful births, being two children “taken by force” by its maternal grandmother. The pregnancies dates and the births were discussed mainly between the mother and the eldest daughter, who discussed more assertively the family history.

The remembrance of newborn’s death generated in the mother the expression of emotions and a detailed report about the traumatic memory. This memory was integrated in the family autobiographical memory in the concrete lifeline. It allowed the reorganization of mother’s memory about the event, the reassignment of responsibilities on the newborn, the impotence in facing death and the real emotional valence of the importance of this situation for other family members. Traumatic memories may be inadequately elaborated and poorly integrated with respect to time, space, place and previous memories of the trauma, as well as to other autobiographical memories (Ehlers & Clark, 2000; Boals & Rubin, 2011). The reconstruction of the narrative of these events reduces post-traumatic symptoms due to the similarity with the natural trauma coping strategy. Therefore, traumatic memory is reconstructed with the aid of a therapist who supports and encourages repetition of these events’ narrative. These features facilitate the traumatic memory’s integration and organization, decentralizing it in autobiographical memories and family’s life history (Peri & Gofman, 2013).

The third session began with the encouragement from the mother and therapist for her daughters to participate in the structuring of lifeline with accounts of their perceptions, feelings and experiences. The eldest daughter exposed her memory of suffering multiple beatings and emotional abuse as a child, and identified one of the most important situations of emotional abuse at the age of seven. The younger girls were encouraged by her mother to report the abuses and aggressions and then reported multiple and consecutive emotional, physical and psychological abuse by the brothers throughout their life. One daughter reported experiences of sexual abuse by her brother. The emotions of the patients were validated and the identified repercussions of experiencing traumatic events in family members were reviewed, being allocated at the lifeline in cardstock.

After the recovery of this memory to construct the lifeline, the patient felt physically sick and dizzy, and asked to leave the room. The psychological trauma in childhood influences emotional regulation development. Extreme difficulties in the regulation are associated with somatic complaints and childhood trauma, being emotional neglect and abuse considered predictors of these difficulties and also of somatic complaints (Guleç et al., 2013). After that, the patient returned to the room and, in order to strengthen the family, more functional aspects throughout history were screened, especially the effective strategies in protecting from violence.

At the fourth session, severe physical abuse, significant emotional abuse, and multiple sexual abuses occurred in infancy were integrated into the lifeline by the youngest daughter. From the lifeline, it were identified situations in which the daughters did not

know how to express their feelings about sexual abuse, or the emotions they felt when they were left alone with their negligent father. Anger, shame, defeat and fear feelings over the years were described by daughters, result of continuous traumatic experiences involving emotional and physical abuse in public, threats and exposure to hostile family environment (Perplechikova & Kaufman, 2010) over the years they lived with their father and brothers.

The sister who seemed to be more functionally adapted given the history of violence, and that in the moment presented less posttraumatic symptoms, reported chronic feelings of powerlessness by “let it happen”, characteristic of complex trauma (van der Kolk, 2005). This daughter placed herself as a caregiver, “it was me who took care of the girls, I was their mother.” Still, this daughter associated her low self-esteem and insecurity to these crippling and violent relationships during the process of building positive beliefs about herself. In that moment it was possible to notice higher levels of emotional adjustment in family members. The lifeline was being built, the family history was being retold, the psychotherapist was doing psychoeducation about the activities inherent to trauma and the emotions were being named.

Inadequate behavior patterns that influence cognitive distortions of family life (Dattilio, 2011; Dattilio & Nichols, 2011) were identified in the fifth session, in which were described patterns of abusive relationships and trans-generational neglect, alcohol abuse and violent behavior of the girls’ father, abusive sons’ aggressive and offensive behaviors and conflicted family relationships. At the sixth session the daughter who was blamed by the brothers for the father’s disappearance described hatred fe-

elings for the abusers and the place where the abuses occurred, avoiding talking and hearing about it outside the therapeutic setting. The patient reported excessive self-blame for not knowing that the abuse was wrong, even that the trauma had occurred when she was four years old. When asked about their emotions about the abuses, they weren’t able to answer what they felt. Because of this failure of naming emotions, they express somatic symptoms (Cloitre et al., 2009; Faust, 2000) during the sessions and in their day-to-day.

For the emotional dysregulation treatment, which aims to modulate emotional skills, including cognitive restructuring, the girls’ discomfort was properly validated and named (Schmid & Goldbeck, 2010) during the session. Nonetheless, in the following week a daughter reported worsening of traumatic symptoms and another daughter reported an important autonomy improvement. Continuing in the temporal organization of events, ineffective attempts of marital separation were identified. The mother reported a husband attempt of harming “the girls”, and then she decided to separate, but they continued to live together. This maintenance of proximity to the aggressor placed the mother in a situation of victimization. Talk during that session about this way of relating reinforced the therapeutic relationship and prompted the questioning about self-victimization presented by the mother throughout her life.

Given the victimization report, the seventh session focused on the violence through generations and the repetition of abusive patterns, using lifeline technique to identifying ways of relating through the family life history that could indicate violence or neglect as well as the unmet emotional needs. It was searched in the family lifeline and in mother’s fa-

mily of origin parental attitudes of neglect and carelessness that established and maintained this victimization. The mother reported not knowing how to identify the asking for care, affection and security, since she didn't have adequate models. Ways of setting limits "I had explosions" "explosions?" "I was mad" "what happened?" "I screamed, pulled their ear, beat, pushed, pinched. That's the way you will learn so" and emotional intimacy capacity were identified throughout the therapeutic process and properly expressed in the lifeline (Levin, 2009), seeking association between trauma and the development of domestic violence maintenance behaviors.

It could be noted the family relational trauma strengthening over the years by maintaining family relationships that confirm each member's shared and complementary beliefs (Friedberg, 2006), in which men are potential aggressors and violence should be answered with violence. The belief that they are not able to take care of themselves and that at some point they will be abused or neglected are expressed constantly. This is observed through the constant mother's search for others to solving her problems with the children, such as the story of the running away from home of her six year-old daughter: "She would come back. I would not go out to look for her. Someone would bring her. "

The initially identified patient presented complex trauma symptoms through time, such as difficulties in emotional regulation, somatic symptoms, dissociation and difficulties in regulating sleep, hunger and self-care. Misinterpretations were identified by the therapist throughout the lifeline technique use, through Socratic questioning and evidence checking. From that, the change of reported patterns of maladaptive interpersonal relationships was aimed,

leading the family in developing more appropriate strategies to solve problems. After the reporting of the most common dysfunctional options used by the family, it was suggested by a family member a more assertive way of communication.

The family tried to make the therapist responsible for the security and emotional validation of the system members, due to a difficulty in recognizing and naming the family system emotions, e.g. the mother reported that thinks the reason for her five year-old daughter to run away from home would be to draw her attention. During the session, it was seen that the daughter was frightened and scared to go home. Still, properly ways of showing affection were shaped, and the management of problems within the family tried to be transferred to the therapist, as the mother's questioning "and what you want me to do?" (concerning the revictimization of a member), being properly returned to the family: "I want nothing, I don't have to want. What do you think you have to do as a mother?"

This family is constantly seeking for a sick member throughout the life history, trying to delete it from the system in an attempt to exclude the symptom, the unspoken violence. Therefore, this family symptom intensifies the emotional dysregulation, the disorganized and fragmented traumatic memories and can be observed intense attempts to confirm abandonment beliefs and victimization. Systemic-Cognitive-Behavioral Family Therapy considers the reciprocal responses of family members in maintaining symptom, recognizing changes in a member of the system as amplifiers of changes in other members and in the system as a whole. Thus, for each sister's or mother's change, the other do opposite movements, seeking homeostasis and symptoms

maintenance, confirming beliefs associated with vulnerability through self-destructive behaviors.

Cognitive-Behavioral-Systemic Family Therapy practice used cognitive restructuring to permit the adjustment of family and family members' vulnerability beliefs, questioning its validity over the use of lifeline technique and seeking functional and adaptive behaviors to activating situations. Therefore, the relevance of lifeline technique for temporal organization of traumatic events, establishment of new relationship patterns, problem solving strategies and development of emotional regulation could be noted. The use of this technique facilitated the trauma's narrative in a noninvasive way, allowing questions about the abuse and violence trans-generational patterns, since the beginning of the psychotherapeutic process.

FINAL ACKNOWLEDGMENTS

The lifeline technique use with this family allowed the reporting of multiple traumatic events suffered by perpetrators within the family in a safe environment capable of validating their emotions, reorganizing temporally the life history of this family, which was continuously and chronically exposed to physical, sexual and emotional abuse, neglect, and illness of parental figures. The clarifications on various family life events were conducted with date's visualization, proper accountability on the traumatic events and debates on the traumatic memories accuracy of the members. Empathy among family members was developed through listening to the reports related to traumatic experiences, and through the strengthening of linkages.

Trans-generational thought and behavior patterns identified in the therapeutic context were open to

discussion and change. Still, empathy development and dysfunctional functioning modification patterns improved the communication process among family members. This process arose as a way of validating or rejecting feelings, thoughts and behaviors, allowing the relationships and interactions planning among family members. The lifeline allowed a narrative construction in a collaborative manner, the reorganization of fragmented memories, the patterns identification and modification of relationship, the transgenerational functioning, the validation of emotions and increased emotional regulation. Then, this technique is an excellent therapeutic tool in psychotherapy and can be used both with individual patients and families in situation of violence.

REFERENCES

- Boals, A., Rubin, D. C. (2011). The Integration of Emotions in Memories: Cognitive-emotional Distinctiveness and Post-traumatic Stress Disorder. *Applied Cognitive Psychology*. *25*, 811-816. Doi: <http://dx.doi.org/10.1002/acp.1752>
- Bergman, J. S. (1996). Pescando Barracudas: A Pragmática da Terapia Sistêmica Breve. [Fishing for Barracuda: Pragmatics of Brief Systemic Theory] Porto Alegre: Artes Médicas.
- Bonato, M., Zorzi, M., Umiltà, C. (2012). When time is space: Evidence for a mental time line. *Neuroscience and Biobehavioral Reviews*. *36*, 2257–2273. doi: <http://dx.doi.org/10.1016/j.neubiorev.2012.08.007>
- Brewin, C. R. (2011). The Nature and Significance of Memory Disturbance in Posttraumatic Stress Disorder. *Annu. Rev. Clin. Psychol.*, *7*, 203–227. doi: <http://dx.doi.org/10.1146/annurev-clinpsy-032210-104544>
- Briere, J. (2006). Dissociative symptoms and trauma exposure: Specificity, affect

- dysregulation and posttraumatic stress. *J Nerv Ment Dis.* **194**, 78–82. doi: <http://dx.doi.org/10.1097/01.nmd.0000198139.47371.54>
- Cloitre, M., Stolbach, B. C., Herman, J. L., van der Kolk, B., Pynoos, R., Wang, J., Petkova, E. (2009). A Developmental Approach to Complex PTSD: Childhood and Adult Cumulative Trauma as Predictors of Symptom Complexity. *Journal of Traumatic Stress.* **22**(5), 399–408. doi: <http://dx.doi.org/10.1002/jts.20444>
- Cloitre, M., Stovall-McClough, K., Miranda, R., Chemtob, C. (2004). Therapeutic alliance, negative mood regulation, and treatment outcome in child abuse-related posttraumatic stress disorder. *J Consult Clin Psychol.* **72**(3): 411–6. doi: <http://dx.doi.org/10.1037/0022-006X.72.3.411>
- Cloitre, M., Cohen, L., Edelman, R., Han, H. (2001). Posttraumatic stress disorder and extent of trauma exposure as correlates of medical problems and perceived health among women with childhood abuse. *Women Health.* **34**(3), 1–17. doi: http://dx.doi.org/10.1300/J013v34n03_01
- Dattilio, Frank M. (2011). Manual de terapia cognitivo-comportamental para casais e famílias. [Cognitive Behavioral Therapy With Couples and Families] Porto Alegre: Artmed,
- Dattilio, Frank M., Nichols, Michael P. (2011). Reuniting Estranged Family Members: A Cognitive-Behavioral-Systemic Perspective. *The American Journal of Family Therapy*, **39**, 88–99. doi: <http://dx.doi.org/10.1080/01926187.2010.530169>
- Dattilio, F. M., Epstein, N. B. (2005). Introduction to the special section: The role of cognitive behavioral interventions in couple and family therapy. *Journal of Marital and Family Therapy*, **31**, 7–13. doi: <http://dx.doi.org/10.1111/j.1752-0606.2005.tb01539.x>
- Dattilio, F. M. (2002). Homework assignments in couple and family therapy. *Journal of Clinical Psychology*, **58**, 535–547. doi: <http://dx.doi.org/10.1002/jclp.10031>
- Dattilio, F. M. (2001). Cognitive behavior family therapy: Contemporary myths and misconceptions. *Contemporary Family Therapy*, **23**, 3–18.
- Dattilio, F. M. (2000). Families in crisis. In F. M. Dattilio & A. Freeman (Eds.), New York: Guilford. *Cognitive behavior strategies in crisis intervention.* **2**, 316–338.
- Dattilio, F. M. (1998). Cognitive-behavioral family therapy. In F. M. Dattilio (Ed.), New York: Guilford. *Case studies in couples and family therapy*, 62–84.
- Dattilio, F. M. (1997). Family therapy. In R. L. Leahy (Ed.), New York: Jason Aronson. *Practicing cognitive therapy: A guide to interventions.* 409–450.
- Ehlers, Anke., Clark, David M. (2000). A cognitive model of post-traumatic stress disorder. *Behaviour Research and Therapy.* **38**, 319±345. doi: [http://dx.doi.org/10.1016/S0005-7967\(99\)00123-0](http://dx.doi.org/10.1016/S0005-7967(99)00123-0)
- Faust, J. (2000). Integration of Family and Cognitive Behavioral Therapy for Treating Sexually Abused Children. Response: Family Systems and CBT. *Cognitive and Behavioral Practice.* **7**, 361–368.
- Ford, J., Courtois, C., Steele, K., Hart, O., Nijenhuis, E. (2005). Treatment of complex posttraumatic self-dysregulation. *J Trauma Stress.* **18**(5): 437–47. doi: <http://dx.doi.org/10.1002/jts.20051>
- Friedberg, R. D. (2006). A Cognitive-Behavioral Approach to Family Therapy. *Journal of Contemporary Psychotherapy.* **36**, 159–165. doi: <http://dx.doi.org/10.1007/s10879-006-9020-2>
- Ginsburg, G. S., Siqueland, L., Masia-Warner, C., Hedtke, K. A. (2004). Anxiety disorders in children: Family matters. *Cognitive and Behavioral Practice*, **11**, 28–43. doi: [http://dx.doi.org/10.1016/S1077-7229\(04\)80005-1](http://dx.doi.org/10.1016/S1077-7229(04)80005-1)

- Guleç, M. Y., Altintas, M., Inanç, L., Bezgin H., Çigdem, K., Esra, K., Guleç, H. (2013). Effects of childhood trauma on somatization in major depressive disorder: The role of alexithymia. [brief report] *Journal of Affective Disorders*, **146**, 137-141. doi: <http://dx.doi.org/10.1016/j.jad.2012.06.033>
- Herman, J. L. (1992). Complex PTSD: a syndrome in survivors of prolonged and repeated trauma. *J Trauma Stress*.**5**(3):377-91. doi: <http://dx.doi.org/10.1007/BF00977235>
- Kernsmith, P. (2006). Gender Differences in the Impact of Family of Origin Violence on Perpetrators of Domestic Violence. *Journal of Family Violence*. **21**(2), 163-171. doi: <http://dx.doi.org/10.1007/s10896-005-9014-y>
- Kessler, R. C. (2000). Posttraumatic Stress Disorder: The Burden to the Individual and to Society. *J Clin Psychiatry*. **61**(5), 4–12.
- Kiser, L. J., Baumgardner, B., Dorado, J. (2010). Who Are We, But for the Stories We Tell: Family Stories and Healing. Psychological Trauma: Theory, Research, Practice and Policy. *American Psychological Association*, **2**(3), 243-249.
- Kolko, D. J., Iselin, A. M. R., Gully, K. J. (2011). Evaluation of the sustainability and clinical outcome of Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT) in a child protection center. *Child Abuse & Neglect*. **35**, 105-116. doi: <http://dx.doi.org/10.1016/j.chabu.2010.09.004>
- Lahm-Vieira, C. R., Boeckel, M. G., Rava, P. G. S. (2011). Reviewing Narrative's Interventions: Tools for the therapeutic context. *Nova Perspectiva Sistêmica. Rio de Janeiro*, **40**, 99-114.
- Lee, R. D., Walters, M. L., Hall, J. E., Basile, K. C. (2008). Behavioral and Attitudinal Factors Differentiating Male Intimate Partner Violence Perpetrators With and Without a History of Childhood Family Violence. *Journal of Family Violence*. **28**, 85-94. doi: <http://dx.doi.org/10.1007/s10896-012-9475-8>
- Levin, E. (2009) The challenges of treating developmental trauma disorder in a residential agency for youth. *J Am Acad Psychoanal Dyn Psychiatry*. **37**(3), 519-38. doi: <http://dx.doi.org/10.1521/jaap.2009.37.3.519>
- McCaslin, S. E. et al. (2008). Trait Dissociation Predicts Posttraumatic Stress Disorder Symptoms in a Prospective Study of Urban Police Officers. *The Journal of Nervous and Mental Disease*, **196**(12), 912-918. doi: <http://dx.doi.org/10.1097/NMD.0b013e31818ec95d>
- Pearlman L., Courtois C. (2005). Clinical applications of the attachment framework: relational treatment of complex trauma. *J Trauma Stress*. **18**(5), 449-59. doi: <http://dx.doi.org/10.1002/jts.20052>
- Perepletchikova, F., Kaufman, J. (2010). Emotional and behavioral sequelae of childhood maltreatment. *Curr Opin Pediatr*. **22**(5): 610-5. doi: <http://dx.doi.org/10.1097/MOP.0b013e32833e148a>
- Peri, T., Gofman, M. (2013). Narrative Reconstruction: An Integrative Intervention Module for Intrusive Symptoms in PTSD Patients. *Psychological Trauma: Theory, Research, Practice, and Policy*. Advance online publication. doi: <http://dx.doi.org/10.1037/a0031965>
- Roestel, C., Kersting, A. (2008). Simple and complex post-traumatic stress disorders. Diagnostic and therapeutic approaches. *Nervenarzt*. **79**(7), 845-54; quiz 55.
- Schmid, M., Goldbeck, L. (2010). Cognitive behavioral therapy for adolescents suffering from complex trauma disorder. *Prax Kinderpsychol Kinderpsychiatr*. **59**(6), 453-76.
- Sheinberg, M., True, F. (2008). Treating Family Relational Trauma: A Recursive Process Using a Decision Dialogue. *Family Process*. **47**(2), 173-195. doi: <http://dx.doi.org/10.1111/j.1545-5300.2008.00247.x>

- Shonkoff, J., Boyce, W., McEwen, B. (2009). Neuroscience, molecular biology, and the childhood roots of health disparities: building a new framework for health promotion and disease prevention. *JAMA*. **301**(21), 2252-2259. doi: <http://dx.doi.org/10.1001/jama.2009.754>
- Stalker, C. A., Gebotys, K. H. (2005). Insecure attachment as a predictor of outcome following inpatient trauma treatment for women survivors of childhood abuse. *Bulletin of the Menninger Clinic*. **69**, 137-156. doi: <http://dx.doi.org/10.1521/bumc.69.2.137.66508>
- Stalker, Carol A.; Palmer, Sally E.; Wright, David C.; Gebotys, Robert. (2005). Specialized Inpatient Trauma Treatment for Adults Abused as Children: A Follow-Up Study. *Am J Psychiatry*. **162**, 552-559. doi: <http://dx.doi.org/10.1176/appi.ajp.162.3.552>
- van der Hart, O., Nijenhuis, E. R. S., Steele, K. (2005). Dissociation: an insufficiently recognized major feature of complex posttraumatic stress disorder. *J Trauma Stress*. **18**(5): 413-23. doi: <http://dx.doi.org/10.1002/jts.20049>
- van der Kolk, B., Roth, S., Pelcovitz, D., Sunday, S., Spinazzola, J. (2005). Disorders of extreme stress: the empirical foundation of a complex adaptation to trauma. *J Trauma Stress*. **18**(5): 389-99. doi: <http://dx.doi.org/10.1002/jts.20047>
- van der Kolk, B. (2005). Developmental trauma disorder. *Psychiatr Ann*. **35**(5), 401-8. doi: <http://dx.doi.org/10.1017/CBO9780511777042.008>
- van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., Spinazzola, J. (2005). Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma. *Journal of Traumatic Stress*. **18**(5), 389-399. doi: <http://dx.doi.org/10.1002/jts.20047>
- Waring, J. D., Payne, J. D., Schacter, D. L., Kensinger, E. A. (2010). Impact of individual differences upon emotion-induced memory trade-offs. *Cognition and Emotion*, **24**(1), 150-167. doi: <http://dx.doi.org/10.1080/02699930802618918>

Received in october 7, 2013
Reviewed in november 16, 2013
Accepted in january 28, 2014