The Color-Coded Timeline Trauma Genogram

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This article describes how to construct a color-coded timeline trauma genogram (CCTTG) in order to get a larger picture of a family’s trauma event(s) currently and historically. The CCTTG serves as a tool to help clients make sense of how trauma events have impacted their family’s individual interactional and intergenerational structural, functional, and relational patterns, strengths, and vulnerabilities. It also serves as a valuable tool for the therapist to use in joining with clients and gathering information, and as a springboard to guide the process of therapy. [Brief Treatment and Crisis Intervention 4:57–70 (2004)]

KEY WORDS: color-coded timeline trauma genogram, focused genogram, trauma, assessment tool.

For any given person, one cannot predict the future impact of a trauma just by the nature of the event alone.

(Schwarz, 2002, p. 3)

The genogram is a tool that has been written about extensively (Bowen, 1980; Gerson, 1987; Jolly, Froom, & Rosen, 1980; McGoldrick & Gerson, 1985; McGoldrick, Gerson, & Shellenberger, 1999; Pendergast & Sherman, 1977; Rogers & Durkin, 1984; Rogers & Holloway, 1990; Rogers & Rohrbaugh, 1991; Rogers, Rohrbaugh, & McGoldrick, 1992; Smoyak, 1982; Sproul & Gallagher, 1982; Starkey, 1981; Wachtel, 1982; Woolf, 1983). It has become a widely-used comprehensive systemic assessment device for gathering large amounts of information in a relatively concise and time-effective way. Through the use of systemic questions, information is gathered in order to get a larger picture of the family’s current and historical structural, functional, and relational patterns. The genogram interview also provides an opportunity to gain insight into the family’s strengths and vulnerabilities, as well as intergenerational transmission of behavior patterns. Additionally, the genogram can serve as a discovery process for clients (Kramer, 1985) and as a tool to start the therapeutic alliance process (McGoldrick & Gerson, 1985).

Since the genogram was developed primarily out of the family systems theory of Murray Bowen (1978), it has changed and grown in its use, structure, and application. The general genogram has been expanded and modified as its application has moved beyond the Bowen model to varying theoretical orientations, developing into the focused genogram (DeMaria,
The focused genogram is designed to keep the therapist and client(s) focused, and allow for an in-depth exploration through one theoretical orientation or for one topic through semistructured interview questions. These questions serve as a starting point for further exploration to learn more about the complexity of the family. The focused genogram can be theory guided, such as the solution-focused genogram (Kuehl, 1995, 1996); topic guided, such as the spiritual genogram (Frame, 2000) and the cultural genogram (Halevy, 1998; Hardy & Laszloffy, 1995), including foci such as the anger genogram, the attachment genogram, and the emotional genogram (DeMaria, Weeks & Hof, 1999); or population guided, such as a genogram with lesbian clients (Magnuson, Norem, & Skinner, 1995) or spinal cord injured patients (Engelman, 1988). These are just some examples of the focused genograms in existence today.

The color-coded timeline trauma genogram (CCTTG) was developed in response to increasing abuse and violence in families, schools, businesses, and communities, as well as mass disasters (natural and human made) and the trauma of war. The CCTTG provides therapists with a tool for approaching this aspect of today’s family life. Recent statistics estimate that the lifetime prevalence for trauma exposure in the United States is 89.6% for adults (Everly, Flannery, Eyler, & Mitchell, 2001). The estimated prevalence of trauma exposure for children and adolescents is 40% (Ford, Ruzek, & Niles, 1996). These statistics do not include the September 11, 2001, attacks, which most likely will raise the percentages substantially. Additionally, they do not include the war in Iraq, which has impacted American families of soldiers and whole communities.

Today, much focus has been on dealing with individual trauma assessment and treatment. There are several trauma assessment instruments that can be used effectively after traumatic events have occurred. Examples of these (Richardson, personal communication, October 28, 1999) are the:

- Brief Psychiatric Rating Scale (Faustman, 1994)
- Brief Symptom Inventory (Derogatis, 1993)
- Hamilton Anxiety Rating Scale (Hamilton, 1959)
- Self-Rating Anxiety Scale (Zung, 1971)
- Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961)
- Scale for Suicide Ideation (Beck, Kovacs, & Weissman, 1979)

There are two additional instruments that have been found to be effective after trauma events: the Lewis-Roberts Multidimensional Crisis Assessment Scale (Lewis & Roberts, 2001) and the Crisis State Assessment Scale (Lewis, 2002). This selected sample of assessment instruments has been chosen based on standardization, as well as reliability and validity.

Critical incident stress debriefing (CISD) and critical incident stress management (CISM) have been found to be useful with children and adults after a variety of traumatic events (Yule & Udwin, 1991), although there is much controversy as to the effectiveness of CISD, suggesting that its use might increase posttraumatic stress disorder (PTSD) in adults (Canterbury & Yule, 1999). Individual therapy has proven to be effective, especially if treatment techniques such as art therapy (Bunjavec & Kuterovac, 1994) or eye movement desensitization and reprocessing (EMDR) (Chemtob et al., 1998; Shapiro, 1991; Tinker & Wilson, 1999) are used in conjunction with traditional talk therapy. Group therapy has also been found to be helpful when large numbers of people are involved (Gillis, 1993; Yule, 1999; Yule & Williams, 1990). Psychoeducational meetings/classes/workshops have also
been found to be very helpful (Eth, 1992; Yule, Perrin, & Smith, 1999). Additionally, psychotropic medications have been used effectively with emotions such as anxiety and helplessness associated with the traumatic event (Blom, 1986; Pynoos & Eth, 1986). Apparently simple interventions such as leaflets have also been found to be useful (Yule, Hodgkinson, Joseph, & Williams, 1990). Thus far, however, little focus has been placed on systemic trauma assessment and intervention tools. The CCTTG can serve as a systemic trauma assessment and intervention tool for systemic therapists. It can assist them in assessing the nature of the trauma, the affective, cognitive, and behavioral responses to the trauma, the predisposing factors that increase trauma reactivity, and possible trauma transmission of family patterns across generations. It also enables clients to gain new insight and understanding of ways in which their own and their family's trauma experience and history continue to affect their current level of functioning, structure, and relationships. Therefore the CCTTG is particularly helpful to the therapist who works with clients reporting multitraumatic events of one or more family members, since it serves as an effective clinical summary of a large amount of information quickly and effectively which may point to potential problems. It is important that the therapist who uses the CCTTG is knowledgeable and well trained in dealing with trauma survivors. Therapists can achieve this knowledge through supervision, workshops (e.g., on the neurobiological impact of trauma or on treatment and assessment strategies when working with trauma survivors), seminars (e.g., on how to work most effectively with rescue workers), and other kinds of training (e.g., EMDR, CISM).

Along with clinical training and preparedness to deal with the impact that traumatic events have on families, the systemic therapist should be knowledgeable about the possibility of developing vicarious traumatization. This has been described by Pearlman and Saakvitne (1995) as a process, not an event. It includes our affects and defenses against the affects. That is, it is our strong reaction of grief and rage and outrage which grow over time as we hear repeatedly about the torture, humiliation, and betrayal people perpetrate against others, and also our sorrow, our numbing, and our deep sense of loss which follow those reactions. (p. 32)

Therapists need to understand that vicarious traumatization is a reaction to the client's traumatic experience, not to the client (Pearlman and Saakvitne, 1995). Trauma supervision as well as education and good self-care can serve somewhat as a buffer against developing vicarious traumatization; however, it is important that systemic therapists understand that vicarious traumatization is a job hazard in working with families that have experienced traumatic events (Pearlman and Saakvitne, 1995).

Trauma Theory

Natural as well as human-made traumatic events are believed to result in stressors. According to Quarantelli (1985), natural traumatic events are perceived as not malicious and therefore as less traumatizing than human-made traumatic events. Human-made traumatic events are perceived to be particularly distressing when the intent is identified by the victim and/or the victim's family as malicious or “sadistic in intent” (Salter, 1995). For example, the torture of prisoners of war in Iraq might be perceived as both malicious and sadistic and therefore very traumatizing to these prisoners. Additionally, the duration and intensity of the traumatic event is believed to influence the impact the event will have on the victim.
and his/her family (Schwarz, 2002). Traumatic events such as war are also particularly painful. For civilians, this includes losing loved ones, property, homes, and communities. For soldiers, it involves seeing others get injured or die and, worse, having to kill or be killed.

When dealing with the effects of a traumatic event (natural or human made) on the family as a whole, family subsystems, and individual family members, it is important to identify the primary and the secondary victims of the traumatic event(s). For the purpose of this paper, primary victims are identified as those family members who: (a) were directly abused, raped, injured and/or tortured, (b) directly observed or witnessed threats and harm to others, (c) heard threats and harm to others, and/or (d) were in hiding and within physical proximity of being at risk, afraid for their own and others’s safety. During this time, the person or persons generally experienced intense fears, helplessness, or horror. Secondary victims are identified as those individuals, couples, and families who were confronted with a traumatic event or events by witnessing helplessly (in person, through television and/or radio, or through the graphic description of an experience by a person with whom they were emotionally engaged) the threat to the emotional and/or physical integrity, or the death, of a person. There is an empathic engagement with the traumatic event which transforms the person’s inner experience about human nature and the world (Pearlman & Saakvitne, 1995). Primary and secondary victims should be assessed for signs and symptoms of PTSD and posttraumatic stress (PTS). The Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR) (APA, 2000) defines PTSD as follows:

The person has been exposed to a traumatic event in which both of the following are present: (1) the person experienced, witnessed, or was confronted with an event or events that involved acute or threatened death or serious injury, or a threat to the physical integrity of self or others; (2) the person’s response involved intense fears, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior. (p. 467)

The DSM-IV-TR (2000) further identifies seven avoidance and numbing responses associated with PTSD:

- Efforts to avoid thoughts, feelings, or conversations associated with the trauma;
- Efforts to avoid activities, places, or people that arouse recollections of the trauma;
- Inability to recall an important aspect of the trauma;
- Markedly diminished interest or participation in significant activities;
- Feelings of detachment or estrangement from others;
- Restricted range of affect (e.g., unable to have loving feelings);
- Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span) (p. 468).

The DSM-IV-TR also states that the symptoms need to be in existence for a minimum of one month, causing significant clinical impairment and impacting social functioning, in order for a diagnosis of PTSD to be made. In situations where the symptoms have existed less than one month and/or are not causing clinical impairment or impacting social functioning, the diagnosis of PTS is made.

Individual differences need to be considered when assessing the impact of traumatic event(s) on families (as a whole, subsystems, and individual members). For example, some people can experience multiple or repeated traumatic events, such as repeated school violence or abuse, and be less impacted than people who experience a single traumatic event. It is
believed that people’s resources (e.g., community support, peer relationships, family support, religious/spiritual values, social values, education/job satisfaction) and ability to access these resources influence the way they are affected and deal with a traumatic event. For example, the very young and very old are often not able to access available resources and are more dependent on others and therefore more vulnerable to being negatively affected by the traumatic event. Individual histories such as ethnic cultural background, family of origin, previous trauma, and socioeconomic status all influence the impact of traumatic events. Research has shown that stress buffers are variables (e.g., sense of humor, optimism, self-esteem, self-complexity) that serve as a protective mechanism in situations of severe stress, such as trauma (Linville, 1987; Martin & Lefcourt, 1983; Roth & Holmes, 1985; Wiebe & McCallum, 1986). Resiliency (an individual’s ability to cope, bounce back, and keep on growing both emotionally and psychologically in situations of challenging and often traumatic situations [Walsh, 1998]) (McFarlane, 1988; Ursano, 1981; van der Kolk & Fisler, 1994) serves as a protective mechanism against the negative impact of trauma, whereas predisposing factors are believed to negatively influence the degree to which a person is impacted by traumatic events. Predisposing factors include such things as: (1) mental health issues, especially major mental illness, (2) previous trauma and abuse histories, (3) poor coping skills, (4) relationship problems, and (5) other life stressors (e.g., life-cycle transitions, health-related issues, loss [of a loved one, a relationship, a job]) (Jordan, 2002).

Reasons for Using a Color-Coded Timeline Trauma Genogram

The CCTTG serves as a systemic clinical tool that is used to assess the larger effect of trauma, both currently and historically, on the structure, relation, and function of the family as a whole and in terms of family subsystems and individual family members. This tool “can be viewed both horizontally across the family context and vertically through the generations” (McGoldrick & Gerson, 1985, p. 3), and can be used effectively with individuals, couples, and families that have experienced recent trauma, have a history of trauma, or have a history of trauma with new trauma recently experienced. The CCTTG is useful for single and multitrauma events in which one or more family members are primary or secondary trauma victims. Couples/partners who are both primary trauma victims are identified as a dual trauma couple, whereas families that have multiple primary trauma victims are identified as multitrauma family systems.

The CCTTG has a set of questions that the therapist should ask; however, these questions should serve only as a starting point for further topic exploration. Similar to other focused genograms, the questions on the CCTTG “should be explored slowly and thoroughly” (DeMaria, Weeks, & Hof, 1999, p. 27). It is important to understand that the CCTTG does not serve as a substitute for, but can contribute to establishing, clinical rapport. As an assessment tool, it should permit a better understanding of the impact that the trauma has had on the family (whole, subsystem, individual members) (DeMaria, Weeks, & Hof, 1999). For many marriage and family therapists, assessment is not a separate process from therapy, but rather is typically seen as an interactive and ongoing process between the therapist and the family, to explore family dynamics and foster insight into present and historically driven patterns of behaviors. The CCTTG therefore serves two primary functions: as a comprehensive, systemic, clinical assessment tool for the therapist, and as a systemic discovery process for the client(s). The trauma CCTTG can help to gather
large amounts of information, focusing specifically on the family’s trauma history and the impact it has had on the interactional and intergenerational structure, function, and relationship patterns of the family, as well as family resources, history, and predisposed factors of families and intergenerational transmission of PTS behavior patterns. Information can be gathered in a relatively concise and time-effective way, allowing the therapist to assess and get the “big picture” concerning a family’s trauma event experience both currently and historically. For the client, the construction of the CCTTG serves as a discovery process for gaining understanding about the impact of the trauma event on the family (whole, subsystem, and individual). Family members are asked questions about past and present trauma in relation to shifts in family relationships, structure, and function. Additionally, questions are asked about the trauma in relation to themes, myths, rules, and emotionally charged trauma issues from previous generations passed on to the present, as well as questions about possible evolutions that families might have gone through. Based on the answers to these systemic questions, the CCTTG can also serve as a way to introduce a systems perspective to the client, who may then understand the problem as bilateral or systemic, and not an individual problem. This is important, since families often enter therapy presenting with one member as the identified person (IP)—generally the one who has been most affected by the trauma and, according to the family, is most in need of help.

Construction of the Color-Coded Timeline Trauma Genogram

The CCTTG can be constructed in the context of individual, couple, and/or family therapy, and the therapist needs to assess the appropriateness of having all family members present during the construction. There might be situations in which the whole family should be involved, based upon the client’s age; individual family members’ trauma history, readiness, and appropriateness; and the type and severity of trauma. This could be through individual therapy (e.g., a female dealing with repeated molestation by her biological father), couple therapy (e.g., the impact of a rape on a couple’s emotional and physical intimacy), or family therapy (e.g., its collective experience of a natural or human-made traumatic event). At times, despite the decision to do a CCTTG within the context of family therapy, the therapist might select to explore specific trauma events of individual family members alone or involving only a family subsystem. Careful therapist assessment to determine whether individuals or only a subsystem within the whole family should be involved in constructing the CCTTG is important to make the instrument the valuable assessment tool it is designed to be and a discovery process for the client.

The therapist should help the client see the rationale for doing a CCTTG (e.g., to gain insight into the immediate players in the family and the impact of past and present traumatic events on the broader system), to receive feedback about the client’s readiness and the appropriateness of the instrument to the whole family, family subsystems, or only an individual family member. For example, the CCTTG should be simplified when used with a child by not focusing on traumatic events across generations but being limited to traumatic event(s) experienced by the child; additional information pertaining to the intergenerational transmission of trauma can be gathered by interviewing the parents separately. Some clients might perceive their own and their family’s history to be irrelevant to the present trauma issue. Other clients might be hesitant about addressing family secrets and digging up
the past. This process needs to be conducted carefully, as does the explanation of the construction of the CCTTG. Then, with the help of the client, the therapist constructs a basic genogram to have a graphic representation of the (generally three-generational) systems (McGoldrick et al., 1999). After the basic genogram has been completed, the CCTTG questions serve as a springboard to the slow and thorough exploration of topics related to the trauma. The therapist relies on the client to provide reliable information, recognizing that trauma memory can be distorted according to how it is stored in the brain (Goleman, 1995). Additional information from other family members or, in cases of mass trauma, the media can be valuable. Circular questions are particularly helpful in cases of couple or family therapy. The therapist should carefully observe the client’s nonverbal behavior such as facial expressions and body posture, as well as family dynamics. This information can provide additional valuable information for the therapist as to what other questions to ask.

Relationship symbols should be used to illustrate closeness, distance, and conflict between family members resulting from natural and/or human-made traumatic events. Relationship lines are two-directional and can be classified as:

-健康的relationship
-estranged or cut-off relationships
-embraced relationships
-diffused relationships
-conflictual relationships

For example, in a family with a history of childhood sexual abuse by the father, in which all the girls in the family have been sexually abused, the relationships between the girls and the father might be illustrated as conflictual or diffused and conflictual. The relationship with the mother might be illustrated as enmeshed. It is important to assess the relationship of different family members with one another prior to as well as after the traumatic event, especially if it is a one-time event. In cases of couple and family therapy, it is important to determine the similarity or divergence of perceptions of a trauma event by family members, both currently and prior to the event.

Based on Lewis’s (1989) suggestion that color coding be added to the basic genogram to indicate specific traits and/or characteristics, the CCTTG uses color coding to identify different kinds of traumatic events experienced by individual family members. For example, red is representative of childhood sexual abuse, green of school violence and trauma, yellow of tornadoes, blue of floods, etc. Additionally, family members represented on the CCTTG should be identified as primary or secondary trauma victims, through the use of the letters P and S, respectively. These letters should be placed inside each square or circle of the CCTTG.

The CCTTG is constructed by placing a vertical timeline on the left side of the genogram, based on the Friedman, Rohrbaugh, and Krakauer (1988) timeline genogram. The timeline should capture the traumatic events of previous generations all the way to the present. The vertical axis will start and end with different years for each CCTTG, unique to each family trauma-event history. For example (see below) for one family member the vertical axis might start with 1980 (the birth of that person), go to one 1991 event (the death of his/her father—the first trauma event), to another 1991 event (his/her mother’s three suicide attempts—the second, third, and fourth trauma events), then to a 1994 event (the grandfather’s death, which was particularly traumatic as he had been the stabilizer of the family). In 2001, the sixth trauma event could be the terrorist attack on the World Trade Center, as a result of which...
this person had firsthand experience of the destruction of lives and property. Finally, in 2003 he/she may have been called up to military service in the Iraq war, where he/she saw death repeatedly and feared for his/her life—yet another traumatic event. It is important that when constructing the CCTTG, individual trauma time lines descend from birth to death with an opportunity to identify each traumatic event:

1980: Birth
1991: Dad, a police officer, was killed in the line of duty
1991: Mother attempted suicide three times
1994: Grandfather died
2001: While living in New York, witnessed the terrorist attack on the World Trade Center firsthand
2003: Soldier (Army Reserve) serving in Iraq

The color coding of the CCTTG, in conjunction with the trauma timeline, can reveal patterns such as: (1) multitrauma events (e.g., repeated childhood sexual abuse, child abuse, rape); (2) family patterns of traumatization (e.g., traumatization of most females in the family by childhood sexual abuse or relationships with abusive partners); (3) dual couple trauma (e.g., history of childhood abuse or experience of a flood or fire by both partners); and (4) multifamily trauma as a result of natural (fire, hurricane, tornado, flood) or human-made (street crime, bombing, terrorism) traumatic events. With the CCTTG depicting these events in color, along with the timeline and relationship lines, it often provides, for the first time, a full view of past and present trauma experienced by the family, along with insight into the transmission of family patterns across generations; emotional reactivity toward one another previously not understood; and values, beliefs, and attitudes. Family boundaries, relationships, and function may also be better understood.

Additional Questions

After the basic genogram has been constructed with color coding (identifying who has experienced what kind of trauma, as well as which family members are primary and secondary victims) and the relationship lines have been placed, additional questions pertaining to the trauma (past and/or present) should be asked. These questions should first address pressing concerns, such as safety issues or self-destructive behaviors. Other questions to ask when constructing the CCTTG are:

How long was the trauma exposure? What was each person’s experience? Were family members or friends injured or killed? Was rescue or safekeeping prolonged? Was there destruction of property or buildings (e.g., school, homes, workplace)? Was there a group affiliation with the victim(s), and/or shared characteristics, interests, or attributes with the victim(s)?

Was the trauma exposure in a situation of war? If so, were family members soldiers or civilians? Where? How long? Were there situations in which they had to kill others? Did they witness the injury and/or death of others? Were there situations in which they were captured by the enemy and imprisoned? Were they tortured or did they witness or hear about the torture of others around them? Were there times when they feared for their lives?

Was the traumatic event a terrorist attack, or a mass human-made disaster? Were family members, friends, or the community directly affected? Were family members primary or secondary victims? Were they rescue workers? How long were they exposed to the terrorist event or the mass human-made disaster? Were fellow rescue workers injured or killed in the
line of duty? How long did they provide rescue services? Were their efforts rescues or recoveries (of bodies)? What kind of training (if any) did the rescue workers have prior to assisting? What support services (e.g., debriefings) were made available to rescue workers? Were rescue workers local residents or were they sent from other locations? If the latter, what kind of support services were made available to them upon their return home? Were the rescue workers’ families, employers, and/or communities supportive of their rescue activities? Were there ongoing threats? If so, for how long? What kinds of threats?

What kind of early intervention services were accessed? By whom? How helpful have they been?

What kind of long-term services were accessed? By whom? How helpful have they been?

What kind of family and community support was available to them? How comfortable did they feel telling others about their experience? Did they feel the need to protect others from their experience? Is there anyone that they can openly talk with about the traumatic experience? What has been most helpful? What has been least helpful?

What kind of behavioral, cognitive, emotional, and/or psychological changes have they observed in themselves or other family members since the traumatic event? How has their memory been impacted? How long did/have these changes lasted? How much have these changes impacted their daily activities?

How do they think the traumatic event(s) have impacted their worldview? their perception of human nature? their spirituality? their inner connection with self and others?

How have they and their family been able to modulate their affect? Do any of the following apply to them and their family?:

- denial versus acceptance
- despair versus hope
- secrecy versus sharing
- guilt versus forgiveness
- burden versus relief
- isolation versus forgiveness
- passivity versus taking charge
- fear versus courage
- loss versus renewal
- senselessness versus meaning

Have they or any member of their family changed plans for the future (e.g., going to college, moving, getting married)?

Is there any substance abuse occurring in their family? If so, how much? When? By whom? When did it start?

Is there any child and/or spouse/partner abuse, currently or in the past, in their family? If so, when did it start? Who is(are) the perpetrator(s) and who is(are) the victim(s)?

Are they thinking about harming themselves or others? Are they aware of other family members who are thinking of harming themselves or others?

Have there been any other traumatic events that we have not yet discussed? Has there been a history related to the trauma such as threats or acts of violence?

Does anybody in the family have a history of emotional or psychological problems? antisocial personality disorder? paranoid personality disorder? depressive or anxiety disorders?

How was their health prior to the traumatic event?

How has this family dealt with transitions such as the birth of a child, death of a family member, marriage, divorce, etc.?

How has the family structure and functioning changed since the traumatic event(s)? Have relationships with the family changed? How?

How do they believe that their family’s ethnic/cultural background, social values, religious/spiritual values, education, and/or job satisfaction impacted their ability to cope with the traumatic event(s)?
As the information is gathered and carefully documented, the family might gain insight into the effects of the trauma or traumatic event(s) on the family’s function, structure, and relationships which they previously were not aware of. It presents an opportunity for families to renegotiate their relationships (Bowen, 1978; Williamson, 1981).

Sometimes, additional questions might be raised when constructing the CCTTG. For example:

- How have other family members not present in the session been impacted by the trauma event?
- What strengths and skills does this family already possess which allow them to do as well as they are doing?
- Are there any vulnerabilities that this family is dealing with which have slowed down the healing and recovery process of the trauma event(s)?

It is important to carefully assess who in the family are primary and secondary victims, as well as whether families have dual or multifamily trauma victims.

**Insight, Growth, and a Springboard for Therapy**

The fully constructed CCTTG can serve as a tool for families to gain insight into their situation. Questions such as: “What insight did you gain from doing this CCTTG?” can be helpful in assessing what the family has learned and can result in a decrease in family conflict. A follow-up question can focus on how much the family has grown as a result of constructing the CCTTG. The question might be: “What did you learn about yourself and other family members from doing the CCTTG that can help you in your healing process?” Other helpful questions are adapted miracle questions (de Shazer, 1988) and might include: “If you had a magic wand and you could change the impact

the traumatic event had on your family in any way you wanted to, how would your family look? How would the interactions and relationships between family members be different? What would be the same? What else would be different?” These and similar solution-oriented questions serve as a springboard to explore what the family would like to have changed and to assess what each person in the family is willing to do to create that change. The development of the CCTTG can help therapists organize information about the trauma history of the family as a whole, as a subsystem, and as individual members and gain some understanding about the structure, function, and relationships of the family and how the traumatic events is impacting the family immediately, how it has been transmitted intergenerationally, and what change is desired.

**Conclusion**

The CCTTG serves as an assessment tool for the systems therapist, as well as for clients, to help them gain insight into their own trauma history and trauma event experienced across multiple generations. Additionally, the CCTTG is designed to assist the therapist and clients to gain insight into the effects that traumatic events might have, or have already had, on the family structure, function, and relational patterns, strengths, and vulnerabilities. The CCTTG also serves as an assessment tool for predisposing factors, resources, and history of family members who have experienced one or more traumatic events contributing to the development of PTSD and PTS. It also can serve as a tool that assists systemic therapists and families (whole, subsystems, individual members) to link traumatic events to intergenerational transmission of behavior patterns. Finally, as part of the construction of the CCTTG, other topics of concern previously not raised might be discovered.
There are some limitations to using the CCTTG. Some clients might be too overwhelmed, not feeling safe or ready to explore their own and their family’s traumatic events. Some clients might be severely depressed or even suicidal, which will require attention prior to considering the appropriateness of constructing a CCTTG. Other safety issues such as child abuse, spouse abuse, and substance abuse will all need to be addressed immediately and in the ongoing process of therapy. In situations of an ongoing traumatic event, it is not appropriate to develop a CCTTG. A therapist’s level of expertise in working with primary and secondary trauma victims needs to be considered carefully, to ensure that at least minimum standards of care are provided. Additionally, therapists need to be aware that a job hazard exists in a possible development of vicarious traumatization.

There is a need to do more research on when the CCTTG is most effective. Single versus multitrauma family systems should be researched, especially if the trauma is a result of family traumatic events. Studies need to be conducted on specific populations, such as primary and secondary victims of: (a) a natural disaster, such as a flood, tornado, (b) a catastrophic school shooting such as the Columbine High School shooting, (c) family violence, such as child abuse, spouse abuse, (d) terrorism, such as September 11, or (e) war. The issue of when the CCTTG is most beneficial to both primary and secondary trauma victims should be carefully assessed. Both quantitative and qualitative research is needed; anecdotal stories are not enough in an era of accountability and consumerism.

References


