The Scripto-Trauma Genogram: An Innovative Technique for Working with Trauma Survivors’ Intrusive Memories

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This article focuses on how to construct the Scripto-Trauma Genogram and how to use it with trauma survivors who struggle with intrusive memories. Clients develop Acute Stress Disorder (ASD) and Posttraumatic Stress Disorder (PTSD) after a traumatic event, based upon personal factors, predisposing factors, peridisposing factors, postdisposing factors and resiliency factors. Clients with ASD or PTSD, as well as trauma survivors who do not quite meet all the diagnostic criteria for ASD or PTSD, often report struggling with intrusive memories, which are believed to be brief sensory fragments of the traumatic event and are experienced as intensely as they were during the traumatic event. [Brief Treatment and Crisis Intervention 6:36–51 (2006)]

KEY WORDS: trauma, genogram, intrusive memories, Acute Stress Disorder, Posttraumatic Stress Disorder.

They will fail to cope psychologically with their problems until they have a sense of security in their bodies. In losing control of their bodily functions they are not the competent people they were before. (Kolb & Multicipassi, 1982, p. 985)

Over the past 15 years, there has been increased interest in advancing the field of traumatology. Research foci in the field included the physiological impact of trauma (Rothschild, 2000; van der Kolk, 1994); the psychological impact of trauma (Holmes & Silver, 1998; Jordan, 2004; Matsakis, 1992); Acute Stress Disorder (ASD) and Posttraumatic Stress Disorder (PTSD); treatment methods (e.g., Critical Incident Stress Debriefing, individual intervention, defusing, Crisis Management Briefing, mobilization and staff consultation, precrisis preparation) (Everly & Mitchell, 1999); treatment assessment (Roberts, 2000, 2005); treatment intervention (e.g., the trauma genogram) (Jordan, 2004); Eye Movement Desensitization and Reprocessing (Shapiro, 1995); and treatment modalities (e.g., individual, couple, family, and group) (Everly & Mitchell, 1999). Treatment methods for trauma-related problems have been addressed in the literature for over 100 years; however, treatment methods for PTSD have been addressed only in the last two decades, when PTSD was first identified in the Diagnostic and Statistical Treatment Manual III (American Psychiatric Association, 1980). Thus far, there is no evidence that one method is superior over another. This is in part related to the methodological rigor used when assessing these methods, which varies greatly from study...
to study; however, it also may be related to the challenge of working with clients who experienced a traumatic event. PTSD can be depleting, and therapy can make people with PTSD feel overwhelmed and can trigger flashbacks and panic attacks and cause some to feel retraumatized. Therefore it is important that the treatment method be chosen carefully, assuring that it is a tolerant process in which people do not decompensate but are able to maintain daily functioning.

It is estimated that 60% of males and 51% of females in the United States are exposed to trauma (Kessler, Sonnega, Bromer, Hughes, & Nelson, 1995), whereas the estimated prevalence of trauma exposure for children and adolescents is 40% (Ford, Ruzek, & Niles, 1996), so it is important to continuously develop treatment methods for trauma victims and their families. Traumatic events involve a threat of death and injury of self and/or others, during which the person feels powerless in the process. Traumatic events can be short-term, single exposures such as car accidents, assault, rape, natural or human-made disasters, or long-term repeated exposure, such as child or spouse abuse and war.

Reactions after a traumatic event include Acute Stress Reaction (ASR) and PTSD. The Diagnostic and Statistical Manual of Mental Disorders—Text Revision (American Psychiatric Association, DSM-IV-TR, 2000) has described ASR and PTSD as follows:

The person has been exposed to a traumatic event in which both of the following were present: (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, (2) the person’s response involved intense fear, helplessness, or horror. (p. 468)

The diagnosis of ASD is given if the disturbances (e.g., persistent reexperiencing of the traumatic event, symptoms of anxiety or increased arousal, dissociative symptoms, or avoidance of recollection of the traumatic event) last for at least 2 days and do not exceed 4 weeks and occur within 4 weeks of the traumatic event (DSM-IV-TR, 2000).

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

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma;
2. efforts to avoid activities, places, or people that arouse recollections of the trauma;
3. inability to recall an important aspect of the trauma;
4. markedly diminished interest or participation in significant activities;
5. feelings of detachment or estrangement from others;
6. restricted range of affect (e.g., unable to have loving feelings);
7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span). (p. 468)

The onset and duration of PTSD can be acute (duration of symptoms is less than 3 months), chronic (the symptoms last 3 or more months), or with delayed onset (symptoms do not appear until 6 months after the traumatic event) (DSM-IV-TR, 2000).

People who develop ASD or PTSD after a traumatic event are believed to be influenced by five factors: (a) individual factors, (b) predisposing factors, (c) peridisposing factors, (d) postdisposing factors, and (e) protective factors (Jordan, 2005). Individual factors include personal, familial, and cultural history (Nader, 1994), as well as spiritual beliefs and values (Hettler & Cohen, 1998; Woodcock, 2001), age, gender, socioeconomic status, physical, psychological and relational history, along with community practice. Predisposing factors involve, but are not limited to, past experiences of trauma such as exposure to aggression and violence.
(actual and vicarious, chronic, and acute) (Epps, 1997, p. 49). It also involves previous coping mechanisms such as dissociative reactions (Brewin, Andrews, & Valentine, 2000). Wiger and Harowski (2003, pp. 50–51) identified these additional predisposing factors: (a) personality disorders, (b) poor coping abilities and strategies, (c) difficulty learning from previous experiences, (d) low self-esteem, (e) unstable work history and lack of finances, (f) chemical dependency, (g) legal problems, (h) chronic mental health issues (e.g., obsessive compulsive disorders, anxiety disorders, paranoia, PTSD, depression), (i) past and/or present legal problems, (j) impulsivity, and (k) all-or-nothing thinking. Peridious factors include proximity to and duration of exposure to the terrorist attack, as well as perceived threats to safety of self and others, including possible injury or loss of life. It generally includes extreme fear, helplessness, and horror and, at times, dissociation and subjective interpretation of the terrorist attack (Jordan, 2005). Postdisposing factors include the level of support available to the person after the traumatic event but are not limited to the level of family, friends, and other support received. These factors include available and accessible resources, that is, educational material about normal reactions after a terrorist attack and also intervention services such as psychological debriefing as long as it is not used as a blanket intervention and after careful initial screening (Mitchell & Everly, 2000). Finally, protective factors include resiliency and stress buffers (Eaton & Roberts, 2002). Resiliency is an individual’s ability to cope, bounce back, and keep on growing emotionally and psychologically after challenging and traumatic events (Walsh, 1998). Stress buffers have a “cushioning” effect in situations of trauma, promoting a lower level of distress than would be present in the absence of stress buffers.

It is believed that after a traumatic event, people are left with memories ranging from intrusive (spontaneously triggered, unwanted memories, which can best be described as generally brief sensory fragments of the traumatic event) (Ehlers & Steil, 1995; Mellman & Davis, 1985; van der Kolk & Fisler, 1994) to ruminations such as “Why me?” “why my family?” (Murray, Ehlers, & Mayou, 2002) and evaluative thoughts about the traumatic event “Why didn’t I do anything?” “Others were heroes. Why wasn’t I braver?” (Reynolds & Brewin, 1998, 1999). Intrusive memories, rumination, and evaluative thoughts about the traumatic event are all common with ASD and PTSD but are also experienced by people who do not meet all ASD or PTSD diagnostic criteria. Rumination and evaluative thoughts about the traumatic event, unlike intrusive memories, do not appear to trigger intense emotional and physiological reactions (Ehlers, Hackman, & Michael, 2004; Holmes & Silver, 1998). Intrusive memories can take various forms, such as flashbacks, nightmares, and intrusive images (American Psychiatric Association, 1994). Tulving (2002) identified intrusive memories as lacking one of the defining features of episodic memories. More specifically, an intrusive memory lacks the awareness that it is something from the past (autonoetic awareness). Sensory impressions and emotions are reexperienced as if they were occurring in the present and not as a memory of something from the past. Intrusive memories are generally experienced as some kind of present threat having a “nowness,” with physical reactions and motor responses as were experienced at the time of the traumatic event (Brewin, Dalgleish, & Joseph, 1996; Ehlers & Clark, 2000; Ehlers et al., 2004; Foe & Rothbaum, 1998). The intensity is representative of the intensity the person experiences during the actual trauma event (Steil & Ehlers, 2000). These sensory fragments involve visual images, smell, taste, sound, and bodily sensations such as pain (Ehlers & Steil, 1995; Ehlers et al., 2002; Mellman & Davis, 1985). This reaction originates in the brain, which is responding as if the person was still experiencing the traumatic
event, and the autonomic nervous system is activating, that is, hyperarousal of faster respiration, increased heart rate, increased blood pressure, dilated pupils, pale skin color, and decreased digestion (for possible quick movement leading to possible fight or flight reaction). These protective reactions in a traumatic event become distressing symptoms during intrusive memories (Rothchild, 2000), and therefore it is not surprising that the intensity of an intrusive memory is experienced with the same intensity that the person experiences during the actual trauma event (Steil & Ehlers, 2000) and is generally experienced through short sensory fragments (bodily sensation, sounds, smell, taste, and visual images) of the traumatic event (Ehlers et al., 2002). Research has shown that visual images are the most common intrusion across traumatic events and not bodily sensations such as pain from a gunshot or the smell of burned flesh after a fire (Ehlers et al., 2002).

According to Christianson (1992), intrusive memories are not random memories, nor are they the most traumatic experience of the traumatic event. Instead, it is believed that intrusive memories are the stimulus that signaled the traumatic event (Ehlers et al., 2004). More specifically, it appears that it is the part of the traumatic event that lets the victim know that something bad is going to happen. For example:

A young woman driving to work on a motorcycle early one morning was in a head-on collision with a car and almost lost her life. She spent many months undergoing multiple surgeries, and eventually was left with a permanent disability. For months after the accident, she reported having flashbacks of the two headlights she saw just seconds before she was hit. She complained that these flashbacks were spontaneously triggered and unwanted.

These intrusive memories have also been described as “warning signal intrusions” because they are perceived as a way to see and then avoid future traumatic events (Ehlers et al., 2002). Intrusive memories could therefore be interpreted as having functional significance in that they serve as a warning for future similar traumatic events (Hackmann, Ehlers, Speckens, & Clark, 2004). This might also explain why intrusive memories are experienced so intensely, they are representative of imminent threat and danger (Ehlers & Clark, 2000). In situations of ongoing trauma intrusions, there are also warning signal intrusions, which not only signal the onset of the trauma but also signal the time when the meaning changes for the worse. For example:

On September 11th 2001, the onset of trauma for many in the World Trade Center was not the two planes crashing into the towers, because many were not aware of what had happened. People in the levels below the point of impact did report flashbacks of the flames and destruction that they first saw when they first opened the doors to the staircases. For some, it meant finding a different staircase. For others, it meant climbing over debris and gravel as they tried to get to street level to exit the towers. Some also reported that they made it out of the towers only moments before the tower collapsed. They reported flashbacks of the rumbling sound seconds before they heard the towers collapse.

In this example, the original warning signal intrusion was the staircase on fire and the debris, which signaled for many that something terrible had happened and that they needed to get out of the tower. For these individuals, the traumatic event was not over when they got out of the tower, as the collapse of the towers was an extension of the traumatic event. The rumbling sound before the collapse signaled that this traumatic event was going to get...
worse, so many of these people “ran for their lives” when they heard this sound.

The belief that intrusive memories are warning signals given just prior to the traumatic event and continue as the traumatic event gets worse was supported in a research study by Hackmann et al. (2004), who interviewed PTSD clients regarding their intrusive memories. The findings revealed that 92% of the participants reported having warning signal intrusion. In this study, the warning signals were identified as follows: (a) 55% identified the onset of the trauma (such as in a school shooting or a student with a weapon) and (b) 37% identified the moment when a traumatic event became more traumatic (such as when they found out that peers or teachers had been shot and killed). According to Hackmann et al., these warning signal intrusions do not necessarily occur during the time of the traumatic event but can develop when additional information is provided (the death of people as part of the traumatic event) as well as by recognizing that they might have been at great risk of being hurt. Intrusive memories can then be interpreted as a warning signal of impending danger and can be viewed as an adaptive device, as safety might be questionable after a traumatic event (e.g., after the tsunami hit Indonesia, there were a number of large and small earthquakes). Declarative memory (facts, concepts, and ideas) will need to be added to the sensory fragments of the traumatic event, to put “their experience into words, constructing a chronology, constructing a meaning . . . recall and recount the traumatic event in a cohesive narrative” (Rothchild, 2000, p. 29). The process of adding declarative memory to sensory fragments of a traumatic event is part of the natural recovery process. However, those who do not recover spontaneously should, with the guidance of a mental health professional, elaborate and reconstruct their trauma memories. The Scripto-Trauma Genogram can be a helpful tool in this process.

The Scripto-Trauma Genogram can assist clients in the elaboration and reconstruction of their trauma memories and intrusive memories. Emphasis in this process should be placed on (a) memory intrusion and nowness, (b) updated information about the traumatic event, and (c) incorporating the updated information (Ehlers and Clark, 2000). In addition, the Scripto-Trauma Genogram serves as an information-gathering (such as trauma history, family support, safe place to live) and joining tool.

The Scripto-Trauma Genogram

The Scripto-Trauma Genogram is one of the many focused genograms used by therapists today. It is designed to be used by therapists working with clients who have experienced a traumatic event. More specifically, it serves as a tool to help the client place the traumatic event in its proper place (i.e., the past). It assists the client to separate the past from the present and acknowledge that the trauma is over, and that she/he survived.

Reasons for Using the Scripto-Trauma Genogram

The Scripto-Trauma Genogram is based on van der Kolk’s and Saporta’s (1993) report that “numerous studies for the past one hundred years have established a causal relation between the inhibition of expression of traumatic experience and psychophysiological impairment. These studies have demonstrated a marked increase in symptoms of the respiratory, digestive, cardiovascular, and endocrine system in people with PTSD” (p. 209). The Scripto-Trauma Genogram can contribute to rapport building but should not be viewed as a substitute for it. This is particularly important in situations of human-made trauma, in which clients’ perceptions about themselves, others, and the world have been affected. Considering that many clients...
who have experienced human-made traumatic events (e.g., the suicide bombers in Israel; the terrorist attacks on a school in Beslan, Russia; the attacks on the World Trade Center in New York and the Federal Building in Oklahoma City; school shootings such as those at Columbine High School in Littleton, Colorado, and Red Lake High School in Bemidji, Minnesota; domestic violence; assault; rape; and incest) might have greater difficulties trusting self, others, and the world. If these clients are pushed to move too quickly with a therapist with whom they have not developed a trusting relationship, they may once again confront the traumatic event(s) alone. Therapy might then no longer be therapeutic due to the client’s feeling worse. Therefore, the process of developing a trusting therapeutic relationship (which would include unconditional positive regard [viewing and thinking about the client in a positive and respectful manner], congruence [the honest and genuine presence of the listener], and empathy [seeing the world through the client’s perspective] should not be rushed. Only when the client feels that the therapist is trustworthy, should the Scripto-Trauma Genogram be introduced and started.

Although the secondary function of the Scripto-Trauma Genogram is to continuously strengthen the therapeutic relationship after it has been securely developed, its primary function is to be an assessment and treatment tool. It should be used with clients (individuals, couples, and families) with ASD and PTSD, as well as those who do not meet diagnostic criteria for ASD or PTSD but are struggling with intrusive memories. The purpose of the Scripto-Trauma Genogram is to assess how the narrative of the traumatic event(s) (current and historical) has/have impacted their own and their family’s (family as a whole, subsystem, and individual family members) interpersonal and intergenerational structure and function. Information can be gathered in a relatively concise and time-effective way, allowing the therapist to assess and get a “larger picture” of the client’s function and position within his/her family of origin and the impact the traumatic event(s) has/have on the client’s function and interpersonal relationships. The Scripto-Trauma Genogram is of great value in providing valuable information about the past and present family structure, function, and interpersonal relationships, “both horizontally across the family context and vertically through the generations” (McGoldrick & Gerson, 1985, p. 3). This information is important for assessing if in the past, after the traumatic event(s), and in the present when the client rescripts the traumatic event(s), family resources are available to the client, such as family care and support. The therapist can assist the client in rescripting the traumatic event, which should result in client functional changes. For the clients, the construction of the Scripto-Trauma Genogram serves as a way to explore (a) their trauma history and the impact on their family (past and present), (b) their trauma script of the traumatic event, and (c) their intrusion memory, with the goal of updating their narrative and incorporating the updated information. Additionally, the Scripto-Trauma-Genogram serves as a tool for the client to identify resources that will assist in the positive outcome of therapy.

Pennebaker (1997) has identified writing as a valuable tool for trauma victims when used under the guidance of a therapist to determine the pacing and maintain safety. It is believed that victims of a traumatic event might try to avoid processing the experience through rumination, avoidance, or not allowing oneself to feel or talk about what happened. The reason for that might vary from survivor guilt to fear of feeling and then being so overwhelmed that they cannot manage their feelings, or wanting to protect others, or fear of how others might respond to them or even judge them. It is
believed that avoidance of dealing with traumatic events can result in increased intrusive memories (Pennebaker, 1997). Writing has been used as a tool to organize and sort out the memories of the traumatic event, making it easier “to remember, bring order, detachment, and meaning to it” (Schiraldi, 2001). Writing has two other functions: first it slows down the process, as writing is slower than talking, and second because it is on paper, it is no longer only in the person’s mind. Third, it was faced within the safety of the therapeutic relationship, therefore creating an opportunity to find new ways of looking at the traumatic event (Murray, Lamnin, & Carver, 1989). Matsakis (1992) advocates writing about the traumatic event—about what happened before, during, and after—and supports the idea of using prompts such as photos for this process. She also encourages imagining and then writing down what others might have thought about each stage of the event. To decrease the level of distress, she encourages reviewing the traumatic event as if it was watched through a two-way mirror. This presents an opportunity to create some distance and to pretend that the traumatic event is happening to somebody else, which can result in less distress. However, as in any trauma work, using writing as a tool to deal with the traumatic event should not be rushed and should be used only when a trusting therapeutic relationship has been established. This trusting therapeutic relationship is important as the therapist helps the client manage his/her emotions and memories to eventually gain control (Matsakis, 1992).

**Construction of the Scripto-Trauma Genogram**

The construction of the Scripto-Trauma Genogram can begin after several assessments have been conducted and the client has developed an “anchor” and learned how to “resource their body.” The client’s safety should be assessed and assured before starting the Scripto-Trauma Genogram. This means assessing client safety regarding (a) their living situation, (b) school/work environment, (c) interpersonal relationships, (d) self-destructive behaviors such as substance abuse and sexual acting out, and (e) suicidal/homicidal ideation. Issues such as suicidal/homicidal ideation should be assessed on an ongoing basis during the construction of the Scripto-Trauma Genogram. Additionally, clients should be assessed for having experienced disassociation and increase of emotional and sensory experiences prior to and throughout the process of developing the Scripto-Trauma Genogram. This is important because in clients with PTSD, dissociation can be a constant and can occur alone or in conjunction with flashbacks (Rothchild, 2000). Furthermore, it is important to remember that, according to Rothchild (2000) “flashbacks cannot occur without some form of traumatic disassociation,” whereas “dissociation can occur without flashbacks” (p. 65). Finally, clients should be assessed for ASD and PTSD, which can be done by using self-report questionnaires such as the Impact of Event Scale-Revised (Weiss & Marmar, 1997), the most often used PTSD measure; the Mississippi Scale for Combat-Related PTSD (Keane, Caddell, & Taylor, 1988), used to measure combat-related PTSD; the Keane PTSD Scale of the MMPI-2 (Keane, Malloy, & Fairbank, 1984), a combat veteran scale; the Penn Inventory for Posttraumatic Stress (Hammerberg, 1992), used with accident victims, veterans, and general psychiatric patients; the Posttraumatic Diagnostic Scale (PTDS) (Foa, Cashman, Jaycox, & Perry, 1997) that can be used with several populations, including veterans, accident victims, sexual and nonsexual assault survivors, and survivors of a range of other traumatic events; and the PTSD Checklist developed by researchers at the National Center for PTSD in Boston to be used with motor vehicle accident
victims. The purpose of these assessment instruments is to determine the significance of the traumatic distress clients are experiencing. Increasingly, research studies (e.g., Schutzwohl & Maercker, 2000) have shown that clients who do not meet full DSM-IV-TR criteria for ASD or PTSD continue to experience debilitating distress, and it appears that clients with ASD, PTSD, and debilitating distress could benefit from rescripting their traumatic event(s) through the use of the Scripto-Trauma Genogram.

After the preliminary assessment has been completed, the therapist should help the client develop an anchor. The anchor concept is rooted in neurolinguistic programming (Bandler & Grinder, 1979) and can serve as a tool used by clients to get a break from the traumatic event. To help the client work through traumatic events, an observable/concrete resource should be used as an anchor. This could be a safe person (a family member, a teacher, a friend), a pet (a cat, a dog, a horse), an object (a tree in the yard where they grew up), or a place such as the beach or the mountains. The anchor should not be an internal resource such as self-confidence or self-esteem. The purpose of the anchor should be described to the client as a tool for lowering hyperarousal when dealing with the traumatic events. It may also be used as a tool to help the client get a different impression of the traumatic event(s). The anchor can be developed by asking the client to identify (a) what “being safe” means and (b) a person, pet, object, or place that helps with feeling safe and without fear. The client should then be asked to draw the anchor and to respond to the following question: Is there only one thing, or are there many things, that makes the person, pet, object, or place feel safe? Then the client should be asked to list the various qualities or conditions that make the person, pet, object, or place feel safe. After the anchor has been identified and discussed, it can be used by the therapist when the client’s arousal becomes too intense as she/he processes through the traumatic experience. The therapist simply changes the focus from the traumatic event to the anchor, by saying, “Tell me more about _________ (the anchor).” The anchor serves to decrease the hyperarousal and eventually will enable the client to talk about the traumatic event without reaching hyperarousal. The greatest challenge for therapists and clients using the anchor is interrupting the client’s story about the traumatic event; however, the decrease in hyperarousal seems to outweigh the challenge.

Additionally, the therapist should help the client to use his/her body as a resource (body awareness, Rothchild, 2000) in preparation for dealing with traumatic events in order to achieve greater calming but more importantly to help clients be anchored in the here and now versus the traumatic event. Body awareness refers to clients who have experienced traumatic events becoming aware of their body’s reaction to outside stimuli (touch, sound, smell, taste, sight, and sound) and inside stimuli (muscles, connective tissue, visceral) (Rothchild, 2000). Body sensations are the physiological reactions (not the emotional reactions) and include but are not limited to such things as breathing (e.g., speed and depth), skin temperature and humidity (e.g., dry, moist), heart rate/pulse (e.g., thready, slow, regular, irregular, strong), breathing (e.g., shallow, deep) muscle tension (e.g., relaxed, contraction), sensation (e.g., pain, burning, itching), posture (e.g., rigid, relaxed, fidgety), balance (e.g., dizzy, shaky, unsteady, weak, strong) (Rothchild, 2000). The goal is to help the client gain body awareness and learn how to pay close attention to their sensations, especially those with PTSD and panic or anxiety attacks, as they often perceive all of their body sensations as signifying danger, or they are unable to determine the difference between sensations that signify danger and those that signify safety (Rothchild, 2000). For clients with ASD and PTSD, body sensations can trigger intrusive
memories and pull the client back to the time of the onset of the traumatic event or when the traumatic event got worse. The goal is to help the client experience the current body sensations and not feel the traumatic event body sensations.

The Scripto-Trauma Genogram can be started after the above assessments have been conducted, the client has identified his/her anchor, and learned to use his/her body as a resource. The Scripto-Trauma Genogram generally takes several sessions, and serves as a way to assess and treat. “This process of construction is proposed based on the belief that therapists do not compartmentalize assessment and treatment, but rather each interaction between the therapist and client(s) contributes to the assessment and thus to the ongoing development of the Scripto-Trauma Genogram” (Jordan, 2004). The Scripto-Trauma Genogram can be constructed in the context of individual, couple, and/or family therapy. There might be situations when the whole family should be involved based upon the client’s and other family members’ interpersonal relationships, personal safety, and age and individual family members’ trauma history and readiness and appropriateness to start processing traumatic events. At times, despite the decision to do a Scripto-Trauma Genogram within the context of family therapy, the therapist might select to explore specific trauma events of individual family members alone, only those involved, or a family subsystem. When doing couple or family therapy, careful therapist assessment is necessary to determine who in the system should be involved in constructing the Scripto-Trauma Genogram. This helps assure that the Scripto-Trauma Genogram is used as originally designed, serving as a valuable assessment and treatment tool.

The therapist should help the client(s) to see the rationale for doing a Scripto-Trauma Genogram (one that makes sense to the client(s)) and receive the client’s feedback about his/her readiness to do the Scripto-Trauma Genogram. Some clients might perceive their own and their family’s history as not being relevant to the present trauma issue. Other clients might be hesitant about addressing family secrets, such as past child and spouse/partner abuse, or digging up the past. The process of introducing the Scripto-Trauma Genogram needs to be conducted carefully, as does the explanation of the construction of the Scripto-Trauma Genogram. Then, with the help of the client(s), the therapist constructs a basic genogram, which involves mapping how family members are related, both biologically and legally. It is a basic graphic representation of the multi, generally three-generational family system, where figures are used to represent people (McGoldrick et al., 1999). After the family structure has been mapped out, family information should be recorded and lines delineating family relations should be added last. Relationship lines should be used to illustrate closeness, distance, and conflict between family members. They should be two directional and include:

- ——→ healthy relationship
- — — → estranged or cut off relationship
- ————→ enmeshed relationship
- ————→ diffused relationship
- ^^^^^^→ conflictual relationship

After the client(s) places the relationship lines, focus should be on the client’s individual, predisposing, and protective factors (Jordan, 2005). Questions related to individual factors should include, but are not limited to, the following:

- Tell me about important events (positive and negative, not including traumatic events) in your life.
• How did you deal with these important events? Did they impact the way you function? Did they impact your position and role in your family? Did they impact how you engage in interpersonal relationships with others (in your family, friends, partners [emotional and physical intimacy])?
• Tell me about important events (positive and negative, not including traumatic events) in your family of origin.
• How did your family (as a whole or as individual family members) deal with these important events? Did they impact the way your family (as a whole or as individual family members) has been and is presently functioning? Did they impact family members’ positions and roles in your family? Did they impact how your family engaged in interpersonal relationships with others (in your family, friends, partners [emotional and physical intimacy])?
• Tell me about your own and your family’s cultural history.
• What are your own and your family’s spiritual beliefs and values? How important are your own and your family’s spiritual beliefs and values? Do they provide comfort and support?
• Tell me about your own and your family’s living environment (such as inner city, suburbia, etc.). Were finances a source of concern in your family of origin? Are they for you now? Who lived in your household while you were growing up? Who does now? Were your basic needs (food, shelter, clothing, etc.) met while you were growing up? Are they now?
• Tell me about your physical health while you were growing up. How is it now? (Were there any major illnesses, hospitalizations, etc.?)
• Tell me about your psychological history. Were you ever in therapy? If so when? Why? Were you or somebody in your family ever suicidal or homicidal?
• Tell me about your relationship (include relationship with parents, siblings, friends, partners, children) history. How are the relationships now? Who is the person(s) in your life that you most trust? Who is the person that you can most depend on? Is it okay to ask others for help?
• How much are you involved in the community? How much is your family involved in the community? Are you (your family) willing to access community resources? Which resources have you (your family) accessed in the past? How valuable were these services?

Questions related to predisposing factors should include, but are not limited to, the following:
• Have you in the past been exposed to aggression or violence that you would not identify as traumatic?
• Have you ever been diagnosed with a personality disorder?
• How would you identify your coping abilities and strategies?
• Have you been able to learn from previous experiences?
• How would you describe your self-esteem?
• What has your work history been like? What have your finances been like?
• Have you abused substances (alcohol, illegal drugs, etc.) in the past? Have you abused substances as a way to cope? Do you have a history of chemical dependency?
• Have you had/or are you presently having legal problems?
• Have you been diagnosed with chronic mental health issues (e.g., obsessive compulsive disorders, anxiety disorders, paranoia, PTSD, depression)?
• Tell me about your impulse control.
- Would you or others describe you as an all-or-nothing thinker?

Finally, protective factors should be included with questions asked to assess whether the clients have been resilient in the past and if they have stress buffers, which will help clients cope better with traumatic events. Resiliency questions might include:

- Did you have a secure attachment developed with your caretakers while you were growing up?
- How do you cope in situations of stress?
- While growing up or now, did you present with either behavioral or emotional problems?
- Have you in the past and are you today able to receive comfort from others? If so, please give an example.

Stress buffer questions would include, but are not limited to, the following:

- What do you do to keep physically fit?
- What is your general level of optimism?
- How would you describe your sense of humor?
- How would you describe your level of self-esteem?
- How would you describe your level of self-complexity?
- In stressful or trying situations, what coping skills do you use?

Research has shown that individual, predisposing, and resiliency factors all influence the way clients deal with exposure to one or more traumatic event(s), and it is therefore important that some or all of the questions identified for the three factors be asked.

A trauma timeline (Jordan, 2004) is then added to the genogram, beginning with placing a vertical axis on the left side of the genogram. The vertical axis serves as a timeline and can go back many years. Individual trauma lifelines expand downward from birth to death with an opportunity to identify each traumatic event. The vertical axis will start and end with different years, varying for each Scripto-Trauma Genogram, unique to the client(s) trauma event history. For example, a client timeline might look as follows:

1982: birth/abandoned in the hospital.
1982: placed with relatives, sexually abused by cousin, removed from home.
1982: placed in foster care—removed after sexual abuse by other foster child.
1982: placed in new foster home.
1984: adoption disrupted—placed in residential care.
1998: date rape.
1999: restraining order after physical abuse by boyfriend.
2001: worked in the World Trade Center (barely escaped from tower one).
2004: shark bite.

After the timeline has been constructed, the client’s anchor (as previously identified by the client) is reviewed and identified as a resource for dealing with traumatic events. The client should be instructed that the anchor can be used when the client feels overwhelmed as she/he focuses on a traumatic event. Additionally, the client is instructed to be aware of body sensations and that the therapist will periodically ask him/her to scan his/her body.

The client is then asked to decide which (in case of multiple trauma events) traumatic event they would like to address. After she/he identifies the traumatic event, she/he is instructed
to write a narrative of the most distressing moments (nowness/hotspots) of that traumatic event. The client should be encouraged to recite the written verses because research has shown this to be more reliable (Solomon & Johnson, 2002). They should be instructed to (a) not worry about grammar, spelling and/or sentence structure, (b) write about the deepest thoughts and feelings of the traumatic event(s) that are most distressing, and not about wishful thinking, and (c) remember that healing takes time and to let the therapist know if writing the scripted narrative becomes overwhelming. Not focusing the narrative on the recollection of what happened before, during, and after the traumatic event is based upon research showing that during severe stress such as in a traumatic event(s), clients are believed to encode only important and not blow-by-blow experiences (Christianson, 1992; Easterbrook, 1959; McNally, 2003). It is believed that clients do “remember the gist” (e.g., they were in the hotel room when the tsunami hit, they were in the World Trade Center before it fell, they were hiding in a classroom during the school shooting, they were in a car accident, they were raped at a friend’s house, two blocks away from their home) of the traumatic event (Ehlers et al., 2004, p. 408). Therefore, when using the Scripto-Trauma Genogram, clients should only be asked to address the most traumatic moment(s) of the events that are most distressing (nowness/hotspots) for them. During the process, and after the client has written the narrative, the therapist should help the client become aware of his/her intrusive memories and body sensations. Part of the reconstruction is helping the client become aware of his/her intrusive memory triggers. Clients should also receive psychoeducation about intrusive memories from the therapist and learn to discriminate between harmful (then) and present (now) triggers. Some researchers (Ehlers & Clark, 2000; Ehlers et al., 2004) believe that clients benefit from bringing up flashbacks repeatedly, to practice discriminating between harm and nonharm, as well as now and then experiences. This can be achieved through continuing checks for body sensations during flashbacks to gain awareness of sensations experienced during situations of harm and danger when sensations are nonharmful. The therapist can assist the client by saying such things as “be aware of your posture,” “allow yourself to be aware of your breathing. Is it shallow, elevated, etc.”? Some clients will need assistance with the vocabulary to describe their sensation or will be unsure and need help to become more aware. The majority of the clients will, however, find the checking on their body arousal not only to be rewarding but also to serve as an additional anchor as they experience the sensations in the here and now. Generally, clients cannot get stuck in the past as they process their body sensation in the current time. Some clients do benefit from being reminded that body sensations can trigger intrusive memories. Clients should be reminded that “they experience their body sensation now, but it is only a memory that they feel now, as the traumatic event occurred in the past.” This process should not be drawn out but done fairly quickly not focusing too much on any one body sensation. The more often the client engages in this experience of becoming aware of his/her body sensation, the greater the decrease in anxiety and increased calmness. Therefore, body sensation awareness questions as described above should be used regularly. Each time the client reports hyperarousal, the therapist will use the anchor identified by the client to decrease the hyperarousal.

After the client has been introduced to the body awareness check, arousal level has been checked, hyperarousal has been decreased through anchoring (if needed), and the client reports being at a comfortable level of arousal, the client’s written narrative will be discussed.
Throughout this process, clients should be encouraged to do quick body checks on their body sensation and to put them in the proper timeframe and context. As part of this discussion process, there should be an exploration of intrusive memories that the client might have experienced. At this point, questions related to peridisposing and postdisposing factors should be asked. Those relating to peridisposing factors might include:

- When the traumatic event occurred how close were you to it?
- Did you or somebody you know get hurt?
- Did you fear for your own or other’s lives?
- How long did the traumatic event last (seconds, minutes, hours, days, etc)?
- During the traumatic event, which moments created the greatest stress?

Postdisposing questions might include:

- What kind of support did you receive after the traumatic event was over? Who were the people that provided that support?
- What kind of resources did you access?
- Were any intervention services offered? If so which ones? Which were most helpful? How long was it before those services became available?

The therapist should also assess how the client has dealt with the trauma and difficulties he/she might have experienced as a result of the traumatic event. Family structural, functional, and interpersonal relationships should be assessed as well.

The next task is to bring updated information into the narrative (Grey, Young, & Holmes, 2002). Some updated information, such as described above, will have been obtained through the awareness check and through anchoring. Additional information can be gathered using verbal techniques (e.g., verbal reminder, in which the client verbally identifies a corrective narrative such as, “I did survive the school shooting, and my arm is all healed.”) and imagery techniques (image transformation, in which the client is asked to update a traumatic image [such as lying on the floor, unable to move, and dying] to the present image [able to walk, sit, stand, etc.]). Additionally, informational updates about posttraumatic events can be obtained via the news media and/or through communication with family members, friends, neighbors, etc., in order to update the impressions that the client holds about the traumatic event (cause, circumstances, outcome). This is another way for the client to update his/her narrative of the traumatic event[s]. It is important to remember that the scripted narratives cannot be constructed by the therapist but can, however, be a cocreation in which the client and therapist “create meaning and generate knowledge together” (Anderson & Swim, 1995, p. 5). Although the therapist and client can co-create a new meaning, it is important that the final narrative is a rescript from the client, not the therapist (Ehlers & Clark, 2000). It is believed that clients’ active incorporation of the rescripted narrative of the traumatic event can replace intrusive memories with both episodic and declarative memories (Ehlers & Clark, 2000). The final task in this process is for the therapist to explore with the client how the reconstruction of the narrative of the traumatic event has impacted him/her and his/her family. This process will be repeated if the client has identified other traumatic events on their Scripto-Trauma Genogram. The actual timeframe involved in creating the Scripto-Trauma Genogram as well as the process of dealing with intrusive memories and rescripting a narrative of the traumatic event might vary based upon the client’s personal, predisposing, peridisposing, postdisposing, and resiliency factors. This process is also influenced by the client’s family of origin’s structure, function, and interpersonal relationships.
Conclusion

The field of traumatology is rapidly expanding, with an increased understanding that traumatic events can lead to ASD, PTSD, or debilitating symptoms that do not meet DSM-IV-TR ASD or PTSD standards. There is increased understanding of the biology of trauma and the impact that personal, predisposing, perdisposing, postdisposing, and protective factors have, as well as the different treatment techniques. The Scripto-Trauma Genogram is one of these treatment techniques that can be used effectively with trauma victims who have intrusive memories and are unable to resolve them spontaneously, and it is one of the many focused genograms in existence today. It goes beyond constructing a focused genogram and trauma timeline to specific interventions with the goal of assisting the client to rescript the narrative of the traumatic event. It therefore serves not only as an information-gathering and assessment tool but also as a treatment technique.

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References


