

The Legacy of Inherited Trauma: Case Studies

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Abstract

The social work field has long recognized through both clinical experience and empirical studies that traumatic events affect not only the individual who experienced the trauma, but also others who have significant relationships with the traumatized individual [1]. Figley [1] defined secondary traumatic stress as the experiencing of emotional duress in persons who have had close contact with a trauma survivor, which may include family members as well as therapists [2-5]. Employing a family-centered approach with the two individual clients, an illustration of assessment and treatment of inherited trauma is provided.

Keywords: *Intergenerational; Trauma; Transmission; PTSD*

“The world is a very dangerous place. It has felt like a battlefield as long as I can remember. I’ve always felt that way,” said Alan.

“I always knew something was wrong, but it was a secret in the family. I don’t know the details, but I am sure my mother was sexually assaulted and that it was my job to protect her and not leave her. I also learned I am always in harm’s way, just the way she was,” Sondra shared.

1. Introduction

Both of these clients can be understood as suffering the legacy of inherited trauma from their respective parents. The social work field has long recognized through both clinical experience and empirical studies, that traumatic events affect not only the individual who experience the trauma, but also others who have significant relationships with the traumatized individual [1]. Figley [1] defined secondary traumatic stress as the experiencing of emotional duress in persons who have had close contact with a trauma survivor, which may include family members as well as therapists [2-5]. These case analyses are a

novel way to illustrate the implicit and explicit manifestations of inherited trauma within a family. While anecdotal, these case illustrations provide a significant addition to the dialogue on inherited trauma; how a clinician might screen, assess and intervene with potential intergenerational trauma. Employing a family-centered approach with these two individual clients, an illustration of assessment and treatment of inherited trauma is provided.

2. Literature Review

Van der Kolk [6,7] explains trauma as “the result of exposure to an inescapably stressful event that overwhelms the person’s coping mechanisms.”(pg.66). Traumas may be acute (a one-time experience, such as being saved from a burning building) or chronic (repeated sexual abuse). Trauma may result in post-traumatic stress disorder (PTSD), for which the DSM-5 provides the following criteria: re-experiencing the event, alterations in arousal, avoidance, negative alterations in cognition and mood [8]. The duration of these symptoms (which cause clinically significant distress or impairment in social, occupational or other important areas of functioning) must occur for one month or longer. In addition, the disturbance cannot be attributed to a substance or medical condition [8].

2.1 Intergenerational trauma transmission

After an individual has experienced profound levels of trauma, the emotional after effects of intense anxiety can be picked up by those who are the emotionally closest to them; often their family members. Early family theorists noted that this can result in creating high emotional reactivity and shared sense of trauma [9,10]. It has been well established that trauma and its varying aftermath manifestations travels down through multiple generations [11-19]. Stein characterized this dynamic as the free floating overflow and circulation of trauma injuries felt deeply by children (vertical trauma transmission) [20,5].

There is evidence that traumatic events that have impacted not only individuals, but entire communities that have faced natural disasters, political violence, and police brutality, such as South Africans and apartheid, Survivors of Khmer Rouge, Hurricane Katrina survivors and New Yorkers after 9/11, have resulted in multigenerational trauma [21-24]. There are also racial and ethnic groups in the United States who have experienced severe traumatic events that have been transmitted to new generations (e.g., Native Americans, Japanese Americans, and African Americans) [25-29]. Some researchers argue that the diagnosis of PTSD is too narrow and the DSM should include other diagnoses such as developmental trauma disorder and intergenerational trauma [6,29].

The largest empirical studies of intergenerational transmission have been in Holocaust survivors [2,6,17,18] studied holocaust survivors and found that children carry the trauma physically and emotionally and concluded that an individual is 3 times more likely to experience PTSD if one their parents also suffered from it. Danieli [2] conducted numerous other studies of adult children of Holocaust and found both indirect and direct trauma related transmission and suggested that the trauma will be passed down as the family legacy, whether or not survivors talked about it directly or kept silent [2,3]. Yehuda, Bierer & Schneider [18] studied adult children (n=100) of Holocaust survivors and found that the entire family may be at a higher prevalence for both current and lifetime PTSD symptoms. Traumatization of later generations can occur through stories central to the family narrative, or just as pronounced, through keeping the trauma too potent to speak about [18]. There is a continuum of how PTSD parenting styles can be at extreme; withdrawn/secretive at one end, and over stimulating behaviors

at the opposite end [5]. As Kellerman [14] points out, with over 500 neurobiological and genetic studies published, there are substantive questions about how the trauma of a parent can be genetically or psychosocially transmitted. Reviewing the genetic transmission of trauma, (and cortisol levels) studies have shown that trauma and HPA stress reactivity are possible through epigenetic mechanisms [31-36]. Longitudinal studies in families affected by PTSD have found that more than 30% of the genetic variance associated with PTSD is related to a heritable component in the nervous system [33,37]. Aside from the genetic model, intergenerational trauma transmission (ITT) has been conceptualized as behavioral and familial (how children are socialized around trauma experiences and behaviors) and the psychodynamic model (unconscious content, memories, anxieties modeled unconsciously by parents) [14]. A common theme underlying the majority of theories on how family trauma patterns are transmitted are based on the notion of psychological transference between parents and children, at both conscious and unconscious levels [38,39]. Adelman [40] noted that memories can be transmitted directly and indirectly from one generation to the next by sharing of stories and trauma-organized parenting styles.

Whether genetic or psychosocial, whether at a community level or individual family level, adult offspring whose parents have suffered acute trauma have consistently presented as more vulnerable to suffering high anxiety, PTSD and subthreshold PTSD [2, 5,18,29, 41,42].

2.2 Veteran experiences as trauma transmission

Alan's narrative is not unique. He is part of the experience of veteran families who carry the trauma of the returning soldier. The literature points to the fact that transmission does not occur in all veterans' families, but is more likely to take place among veteran fathers who developed PTSD [42-44]. There can be direct transmission of PTSD symptomatology, such as numbness, dissociation, and acute anxiety which have been modeled and transmitted to the child [45-49].

Ahmadzadeh & Malekian, [50] studied veterans (n=141) and demonstrated the associations between fathers' combat-related PTSD and children's psychological difficulties and behavioral problems. This is consistent with a study of returned POWs' with PTSD whose adult offspring developed PTSD as well [42].

Palosaari [51] studied children and their parents (n=240) who had directly or indirectly been affected by war-torn Gaza. The fathers who had war experience were more likely to participate in psychological maltreatment of their children, and their children were more likely to manifest attachment insecurity and a range of serious mental health problems, including post-traumatic stress. Beckham, Braxton, Kudler, et al. [46] studied 40 children of 28 Vietnam War veterans with PTSD and found that 78% of children had at least one elevated scale on the Minnesota Multiphasic Personality Inventory; 40% used illegal drugs, 45% reported significant PTSD signs and 83% elevated hostility scores. O'toole, et al [43] studied 125 sons and 168 daughters of veterans with PTSD, and concluded that there is a significant effect of fathers' war-related PTSD on the chance that their children will develop symptoms; specific to PTSD, rather than other mental health disorders.

Caselli and Motta [52] studied 40 male Vietnam veterans and their families, concluded that child behavior problems were in response to dad's PTSD. The above research of this population has demonstrated that a veteran's PTSD can indeed be transmitted to the next generation.

2.3 Alan and his Dad

As assessment begins with Alan, there are numerous inquiries into when his PTSD-like symptoms started. He does not remember a time when he was at ease. He also does not remember a time when he was unaware of his father's combat service, subsequent physical deformities and emotional challenges. As Alan was growing up in the later 1970's, his father had been suffering from PTSD after his return from the Vietnam War. His father served three tours and had extensive battle experiences, and ultimately returned home without his right arm and blind in his right eye. Alan's dad came home "deformed" and "scary and frightening" to his 5 year old son. Alan Sr. was not diagnosed or treated for his PTSD and anxiety after his return, and his parenting style was consistently anxious and aggressive. As far back as Alan Jr. can recall, his father spoke of his combat traumas and how one always has to be on the alert, "because this is a dangerous world. You can't depend on anyone but yourself out there." He grew up being on the alert that no one makes fun of his father, and feeling his father needed him to be his "ally" and "foxhole buddy."

Alan grew up merged with his father and identified as a caretaker and protector of dad because dad had not "adjusted well to losing his arm, and eye and was always very jumpy and very anxious." Alan Jr. remembers a constant sense of feeling different and fearing his dad's anxiety and the "terror I used to see in strangers eyes when they saw my deformed dad." He began to understand that he had transferred a battle mentality to his neighborhood, school, and worldview. He was quick to fight with others, but also quick to avoid any conflict or unknown situation. Alan had internalized his father's memories, his affect and his worldview. In therapy, he has said that he feels "as if I had been to the war" sharing his dad's startle response and nightmares and other PTSD-like symptoms. Revisiting Alan and his father's experience of PTSD, Alan was flooded with stories, affects, behavior, attitudes that were all anchored in combat trauma and subsequent PTSD.

In this scenario, the clinician used Bowen's cornerstone concept of enhancing differentiation [10,39]. Alan has not been in the war; Alan has not been in danger for his life. The set of interventions would focus on moving Alan out of the enmeshed boundary he has had with his father in which trauma was the shared emotional glue. From a less systemic and more psychodynamic approach, the work involved helping Alan accept differentiating from his father; i.e.; to leave the PTSD behind was to separate from father and perhaps betray his father. This counseling work employed both systemic transgenerational interventions and psychodynamic insight-oriented work to help Alan tolerate fear, guilt and separating from his father. These goals were achieved over time, and as he allowed himself to separate, Alan experienced fewer and less intense PTSD-like symptoms.

2.4 Childhood sexual abuse as trauma transmission

Distinct from PTSD that originated with the concept of veteran's returning from WWI with "shellshock," and combat trauma" post WWII, and PTSD (post-Vietnam), the notion of PTSD broadened among mental health clinicians to include the exposure of interpersonal trauma on the home front. . Through the 1970's, battered wife syndrome was introduced [53] and in the 1980's, rape trauma syndrome [54]. In fact studies into childhood sex abuse demonstrated that the highest cause of trauma in women is childhood sexual abuse, and that as much as 17%-33% of women have a history of sexual abuse [55]. One study estimated that 35%-50% of women in the general population have experienced sexual abuse [56], and another study by Aciero, Resnick, Kilpatrick, et al. [56] estimated that 61% of all sex abuse in women happens before 18. The

nature of trauma inflicted by a one known to a child is different than combat trauma, and quantitative and qualitative research has indicated that it resulted in anxieties more closely linked to trust and intimacy [57-60].

Maternal sexual abuse history indicates a strong potential for the intergenerational transmission of PTSD like symptoms, as well as child sexual abuse in the next generation [61-64]. McClosky and Bailey studied [63] girls (n=179) whose mothers were sexually abused and found that they were 3.6 times more likely to be sexually victimized themselves and also suffer a variety of mental health and substance abuse challenges. Ancharoff, et al., [45] performed a longitudinal, multigenerational study which determined that a mother's childhood sexual abuse history may be one of the most important factors in the likelihood that her child will experience trauma and sexual abuse during childhood [65-67].

Many studies have been conducted to explore the different behaviors presented by mothers who have suffered sexual abuse in their own childhood. Some survivors have had difficulties maintaining a balance between discipline and affection with their children [67-69]. Other studies, demonstrated that mothers with childhood sexual abuse trauma had a more negative view of themselves as parents [70-71]. Some maternal childhood sexual abuse survivors evidenced "significantly more disturbed attachments" to their daughters, marked by unpredictability, maternal depression, and/or high anxiety. [72]

2.5 Sondra and her Mom

Sondra, a 28 year old African-American woman comes into therapy describing high anxiety, a sense of self-doubt, a sense that she could not trust her own take on anything, and deeply held fear of being intimate. She initially presented as saying, "I think there is something wrong with me- I don't trust my own judgment. I can't read people in social situations." She has had several sexual encounters, has suffered a panic attack in each, and has subsequently avoided any intimacy. As she provided examples, she also described symptoms that met the majority of DSM criteria for PTSD: intrusive thoughts of danger, hypervigilance about potential danger, nightmares, numbing or feeling "out of it." She explained that she never knows when anyone is telling her the truth and she feels like she is on high alert and ill-equipped to deal with people. In a third session, she said, "I feel like something happened to me, but I know it didn't." What did she feel might have happened to her? "Maybe I was molested as a child and I just don't remember it." What makes her feel this way? "I am afraid of men, don't trust them, and just the idea of being intimate is very scary to me."

When her family life was explored; has anything ever happened to anyone in her family? She reported suspecting that her mother may have a secret along these lines, but understood it was a conversation her mother is unable or does not want to have. When she has tried to understand what she now sees as depression and withdrawal, fear/disgust of men, her mother has responded that it has been a very rough life- "I came up the rough way" and then she will not say any more. Her mother has always been withdrawn and secretive, and very overprotective of Sondra, especially when it came to men.

Using an intergenerational approach, Sondra's reflections on her mother's traumas yielded insight that she has long identified with her mother and felt protective of her mother. The potent secrecy between her mother and herself, kept Sondra confused and ill at ease when with her mother, but ill at ease about separating from her mother. The illustration of Sondra's perceptions and affect represents the extreme of the conspiracy of silence; a concept originating in Holocaust research, [2] where sensitive subjects are avoided to prevent further trauma. However, the result is muddled communication, confusion and a

sense of secrecy and avoidance towards taboo subjects. Sondra received clues about her mother's past trauma that did not match up with the verbal or affective narrative. This can leave the offspring with a sense of self-doubt, anxiety and insecurity about their own PTSD-like symptoms.

After several more sessions, Sondra decided to pursue the mystery and was informed by an aunt that in fact, Sondra's mother had been sexually abused by an uncle for 5 years through her latency and early adolescent years. When Sondra's grandmother was confronted with this by Sondra's mother and oldest sister, they were told they must be wrong and not to bring it up again. The uncle was never confronted, and Sondra's mother moved out at 14 years old to live with her oldest sister and avoid further contact with her uncle. They never spoke of it again.

3. Discussion

From a family systems perspective, and in particular, a Bowenian perspective assisted both Alan and Sondra to better differentiate from their traumatized parent. Though each was seen in individual counseling, the line of assessment and interventions were family-centered, focusing on the cornerstone concept of differentiation. Families, as Bowen has stated, can be an undifferentiated ego mass [38]. When boundaries are diffuse, there may be adult content and jagged emotional material and affect that is free-floating. Children being fully dependent and attuned to their parents have incorporated the trauma and its aftermath into their neurological and psychosocial functioning [37]. Bowen's theory guided the central questions related to intergenerational trauma transmission? : Has the internalized family narrative been an anxious system, marked by trauma and trauma sequelae?

Sondra experienced an implied sense of trauma and the secrecy that surrounded it. She reported a sense of foreboding and danger about keeping the secret, or confronting the secret in her family. If secrets have been the primary mechanism, clinicians may unwittingly collude with the denial, thus reinforcing the silence. Alan's therapy focused on his need (implicit and explicit) to hold onto his father; his fear of differentiating from his father's trauma meant leaving his father alone in the foxhole. Sondra feared that revealing her mother's traumatic childhood sex abuse history would be experienced as a betrayal by her mother. Key reflections with Sondra's focused on her internalized sense of her mother's frailty and the fear that facing the possible secret in this family would be too powerful for her mother to tolerate. In each case, Bowenian areas of reflection focused on identifying the clients' perceived risk of differentiating; emotionally separating from the "injured" parent. When, in each case, clients were respectively encouraged to consider that keeping this narrative alive, might be a way to stay attached, each client began to develop more differentiated behavioral and emotional patterns from the injured parent, and in turn, saw reduction of their respective PTSD –subthreshold symptomatology.

As Bowen noted that "the task of differentiating a self in one's family system can seem overwhelming..." [39]. Yet his model brought forth the mindfulness of helping the family members to develop more adaptive emotional boundaries, discriminate between thinking and feeling, aiding the client to acknowledge the powerful undertow of anxiety in the family, and assisting them to be more differentiated and subsequently less emotionally reactive. This was facilitated with each client by using a genogram to reflect the emotional norms and conflicts that have been vertically transmitted to each client. In each client story, as with Alan and Sondra, there numerous and complex intervening variables of how trauma may be transmitted, e.g. cultural, class and religious norms about what is spoken of and what is shrouded in secrecy. Other variables we often know

little about include: the contribution of child characteristics such as temperament, curiosity or independence, and how these may be a predictor of development or moderation of secondary traumatic stress.

4. Conclusion

Whether a client's presentation of trauma legacy stems from a genetic source, an interpersonal or intrapsychic or all three in equal amounts, this is a burgeoning dynamic that warrants further attention. It was of utmost help to include a family centered approach once it was evident that some portion of their trauma exposure originated in their family of origin. A clinician providing individual or family therapy should include screening and assessment about the level of trauma expressed explicitly or implicitly from the prior generation. This area of assessment should be part of any client presenting their own trauma aftermath as well as those who may have borne witness to trauma sequelae in their family of origin. Future research should include both quantitative and qualitative research that examines how trauma is vertically transmitted, assessed and treated.

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