Intergenerational Transmission of Trauma

Amanda Geiger

University of San Francisco – School Counseling Program

**Abstract**

Trauma that results from child abuse, domestic violence, and other distressing life events has been widely studied for decades. This literature review seeks to answer questions regarding whether a mother’s past or current trauma can be transmitted to their offspring and how the child will be affected. For example, even if the child isn’t directly impacted by trauma in their own life, how does their mother’s experiences affect them throughout their life? Are these children at risk for internalizing and externalizing behaviors as well as insecure attachment? Can a supportive relationship in another area of their life help mitigate the affects of inherited trauma? Specifically, researching the child’s attachment style, the mother’s parenting style, and the mental and physical health outcomes of the child pre and postnatal. There will be a discussion on the relevance of trauma in regards to the field of developmental counseling and how intergenerational trauma may affect youth in the community’s school counselors serve. Firstly, the goal of this review is to bring more awareness to the complex issue of the intergenerational transmission of trauma. Secondly, how school counselors can take preventative measures to ensure they are connecting the affected students and their families with the proper services and encourage their school district and community to become trauma informed.

**Introduction**

The American Psychological Association defines trauma as, “an emotional response to a terrible event like an accident, rape or natural disaster” (“Trauma and Shock”, 2017). Short term effects usually result in shock and denial, while, “long term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea” (“Trauma and Shock”, 2017). Also, as a result of trauma, an individual may be at risk for developing post traumatic stress disorder (PTSD), depression, anxiety, and other mental and health problems. Long term exposure to trauma can also be detrimental to a person’s overall physical health and can affect their development throughout their life. Using a tree as a metaphor – the roots are represented by the traumatic event(s) that occur in one’s life. The trunk of the tree is the mental health effects of trauma (depression, PTSD, etc.). Moving on, finally, to the branches which are represented by the symptoms of the before mentioned mental health challenges – hyper vigilance, startle response, detachment, poor concentration, flashbacks, loneliness, dissociation, panic attacks, etc. The water that continues to help this trauma tree to grow even bigger is represented by labeling, misdiagnosis, improper treatment, or lack of treatment.

**The Transmission of Trauma**

Think of the intergenerational transmission of trauma as a family trauma tree – that has been growing for generations continuing the cycle over and over again. Some families, especially those impacted by institutionalized racism, poverty, crime, etc., are continuously impacted by trauma and the transmission continues until the cycle is broken. As school counselors, we need to support and educate the communities we serve to be trauma informed in order to plant seeds of change and new beginnings for students and their families. There are two types of trauma transmission, the first being “direct and specific” where the mental health challenges in the survivor parent leads directly to the same in the child (Kellerman, n.d.). The second being “indirect and general” where a presenting issue or disorder in the parent leads them to be incapable of being emotionally present for their child which can result in, “a general sense of depravation to the child” (Kellerman, n.d.). Both types of transmission can lead to the repetition of the trauma cycle by engaging in negative relationships, the cycle of abuse/maltreatment, and puts them at risk for developing PTSD, depression, and other mental health disorders (Dunning, n.d.).

**Review of Literature**

**Attachment Styles**

Attachment style refers to the way in which an individual relates to others and one’s dominate style is usually formed within the first two years of life (“What is Your Attachment Style”, 2016). Individuals who have experienced trauma are more likely to have an anxious/avoidant or anxious/ambivalent attachment style (Ammerman et al., 2012). These forms of attachment are often referred to as “insecure” and manifest in children in various ways. Children with anxious/ambivalent attachment are often confused, insecure, and may be distrustful or suspicious of their parent – at the same time they can be clingy and desperate for attention (“What is Your Attachment Style”, 2016). While those with ambivalent attachment are independent and at times may pull away and resist their parents.

 Ammerman, Shenk, Teeters, Noll and Van Ginkel (2012) studied the effects of maternal childhood trauma and the effects on their children’s development. Their sample included mothers who were a part of a home visitation prevention program which was being used to improve outcomes for the mothers and their children. The mothers included were all considered low-income, young (average=22), and most were unmarried (80%) (Ammerman et al., 2012). The study primarily sought to compare and contrast depressed mothers and non-depressed mothers. They determined that depressed mothers showed impairments in parenting, smaller social networks, and higher levels of psychiatric symptoms which were also linked with insecure attachments (Ammerman et al., 2012).

 Additionally, a research study completed by Iyengar, Kim, Martinez, Fonagyand & Strathearn (2014) sought to determine the relationship between unresolved maternal trauma and child attachment. Iyengar et al. used the adult attachment interview to define the attachment style of first time mothers in order to see the effects of “reorganization” on attachment. Reorganization is defined as, “a process whereby the speakers are actively changing their understanding of the past and present experiences and moving toward attachment security” (Iyengar et al., 2014). Results showed that mothers with unresolved childhood trauma who had an insecure attachment were likely to pass on their attachment style to their child. Conversely, mothers who were classified as “reorganizing” had a secure attachment style and so did their child. This study shows that mothers, specifically, who are working to resolve their childhood trauma are more likely to pass on a secure attachment style than mothers who were not. As counselors, we should be supportive and encouraging for mothers impacted by trauma to seek mental health treatment.

 In regards to attachment, another study looked to find a connection between scores on the Adverse Childhood Experience (ACE) assessment and resilience (Arincorayan, Applewhite, Garrido, Cashio & Bryant, 2017). This study used a large sample size of 250 service members and included a 3-part survey, the ACE, and a resilience scale. Those who scored at least 3 on the ACE moved on to the next portion where they determined close and secure relationships in their life. This research discussed the positive association between secure attachments and resilience. Results showed that by building supportive relationships one can, “mitigate the negative effect of childhood trauma by helping to build resilience” (Arincorayan et al., 2017). Proving even more that counselors and other school leaders may serve an important role in a child’s life that can often lead to higher resilience rates and secure attachment.

**Parenting Styles**

 There are four main parenting styles: authoritative, authoritarian, permissive, and neglectful. Each different style has separate characteristics that present a variety of outcomes for children. Every parent and child relationship is different and there is never a “perfect” way to parent a child (Hughes, 2013). However, mothers, specifically, who have been impacted by trauma tend to have more issues with self-esteem, self-efficacy, and generally hold more negative attitudes about themselves (Schwerdtfeger, Larzelere, Werner, Peters & Oliver, 2013). Therefore, this tends to be reflected in their parenting style which is overall more “punitive” than mothers who do not have a trauma history. (Schwerdtfeder et al. 2013). Additionally, past trauma is often associated with unpredictability in parenting and is usually classified as authoritarian parenting. This style is usually categorized by low nurturance/warmth and high demandingness; it can also include verbal hostility which is shown to predict child’s risk of developing oppositional defiant disorders (Schwerdtfeder et al. 2013).

 However, research also indicates that mothers who have been impacted by trauma are often “hypersensitive” to stimuli which could lead to the continued use of abusive or ineffective parenting styles due to unresolved or unnecessary stress carried by the mother (Schwerdtfeder et al. 2013). Additionally, an observational study by Lyons-Ruth and Block (1996) used a sample of 45 mothers who experienced sexual abuse trauma who had children (18 months old). The mothers who had a history of abuse and unresolved trauma were determined to have significantly higher rates of restricted maternal affect and decreased involvement with their infants (Lyons-Ruth & Block, 1996). This research shows that mothers who have experienced trauma may have a lower threshold for stress and use verbal hostility at higher rates, which are often associated with authoritarian parenting. Overall, the stress caused by the trauma the mothers experienced may lead to unsuitably strict or harsh strategies or “maladaptive” parenting styles (Schwerdtfeder et al. 2013).

**Mental and Physical Health Outcomes**

As previously discussed, a mother who is impacted by unresolved trauma can transmit their symptoms to their children in various ways. This section will continue to discuss the transmission of trauma as it relates to mental and physical health outcomes for the child. Mental health being defined as an individual’s psychological and emotional well-being. The transmission of trauma can begin as early as utero where the fetus is susceptible to stress and other teratogens. In a 2017 study by Madigan, Wade, Plamondon, Maguire, and Jenkins, 501 community mother-infant dyads were interviewed shortly after birth and again at 18 months. Madigan et al. (2017) asked the mothers about their adverse childhood experiences and sought to measure the physical and emotional health of the infants. Results showed that four or more adverse childhood experiences were related to significantly increased risk for biomedical and psychological problems (Madigan et al., 2017). It was reported that the, “potential mechanisms of intergenerational transmission included…prenatal and perinatal complications and postnatal psychosocial risk (maternal depression, single parenthood, marital conflict)” (Madigan et al., 2017). The main physical issues that were detected during pregnancy were diabetes, hypertension (mother), loss of fetal movement and immediately after – low birth weight and intensive care (Madigan et al., 2017).

 Additionally, the intergenerational transmission of trauma continues to affect the child as they age – specifically if the mother has been affected by “betrayal trauma (BT)”. BT is when the trauma was as a result from, “abuse by a person close to the victim” (Babcock Fenerci, Chu, & Deprince, 2016). In a 2016 study by Babcock Fenerci et al., mothers who experienced BT had children who experienced both internalizing and externalizing problems. These findings show why it is critical to assess for maternal trauma when supporting children who are symptomatic. As counselors, it is important to complete family interviews to determine whether the transmission of trauma could be impacting the household.

 Furthermore, in combination with ineffective parenting styles and transmitted trauma children are at risk for other mental health issues. A sample of mothers (488) who were “at risk for child maltreatment” were recruited when their children were born an were assessed from birth-36 months and then again at preadolescence (9-11) (Delker, Noll, Kim, & Fisher, 2014).

The results of the study showed that the children (during preadolescence) struggled with self-regulation indirectly caused by the mother’s pre-exposure to trauma (Delker et al., 2014). Self-regulation development is shown to be responsible for the ability to, “regulate behaviors, cognitions, and emotions…include[ing] executive function such as planning, controlling attention, and inhibiting behaviors that interfere with goals or norms.” (Delker et al., 2014). Therefore, a mother’s trauma may have lifelong effects on their offspring and have long-term developmental consequences.

**Conclusion**

In conclusion, the intergenerational transmission of trauma can have detrimental effects on the offspring of affect mothers and families. However, the effects of trauma can be mitigated through the proper mental health support and education. The cycle of trauma and abuse can affect families for generations and without intervention can continue to impact their physical and mental health. School counselors should be aware of the effects of trauma and how the intergenerational transmission of trauma can affect children without having experienced trauma first hand. In order to provide children and families with the support they need – counselors need to advocate for their schools to be trauma informed through personal development education. Next, counselors and teachers should work together to provide a motivational support system for students and their families. Additionally, they should work to include the parents of students as much as possible and continue to build trusting relationships with families and the community. Counselors must continue to learn about how the seeds of trauma are planted during childhood, how they develop into tree over a lifetime without the proper supports, and how we can support their growth in a positive direction towards recovery.

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