Hidden Obstacles to Treatment in Child and Adolescent Psychiatry: An Introduction to Intergenerational Trauma

Chris Bampton, BA (Hons Psych), BMBS, FRANZCP

Case (Part 1)

Angel, a 15-year-old adolescent girl from a middle-class Asian immigrant family, lives with her parents and 13-year-old sister. She presents to an outpatient child and adolescent mental health service with symptoms of depression, some symptoms of anxiety, regular cutting, and a history of several suicide attempts by overdose. She smokes marijuana on a regular basis but does not drink alcohol. She has no pertinent medical, past psychiatric, or social history. The family denies any family history of diagnosed mental illness. However, the family mentions that Angel's grandparents experienced trauma.

Angel starts taking a selective serotonin reuptake inhibitor (SSRI) medication for treatment of depression and anxiety, and she attends both weekly individual cognitive-behavioral therapy (CBT) and a group program for self-harm based on dialectical behavior therapy (DBT). Her parents are appropriately involved in her treatment.

Despite high levels of intervention, Angel remains depressed and anxious, continues smoking marijuana, and continues to engage in self-injurious behaviour. The clinical team decided to explore Angel's grandparents' history of trauma.

Introduction

The purpose of this article is to illustrate barriers to the treatment of children and adolescents with mental health problems that may not be evident in standard psychiatric assessment. In this case, the presence of intergenerational psychological trauma, which is manifested in parental factors, grandparental factors, and the sociocultural background.

Intergenerational psychological trauma is also known as transgenerational trauma, developmental trauma, historical trauma, or secondary traumatization. It is conceptualized as trauma symptoms that are exhibited in the immediate victim or witness to trauma and passed on to others—in particular dependents—who were not exposed directly to the trauma.

Intergenerational trauma is a well recognized phenomenon in many professional areas, especially those specializing in family violence, torture, child abuse, and psychodynamic psychotherapies. It is less well recognized in psychiatry due to its absence in diagnostic manuals.[1]

The prevalence of intergenerational trauma is unclear, in part due to lack of this diagnostic recognition in psychiatry. However, one study established that grandchildren of Nazi Holocaust survivors in Canada were over-represented in child psychiatry clinics by 300%.[2]

Building on the summary by Milroy,[3] for this paper, intergenerational trauma is defined by the author in the following manner:

> The presence of significant psychological or physical trauma (including loss or grief), which results in negative changes in the psychological and physical functioning of an individual. These changes impact upon the person's ability to manage relationships. These changes subsequently effect the psychological functioning of the traumatized individual's children or dependents. These children may then develop negative psychological patterns which may be passed on again to further generations.

However, we also need to define what is meant by psychological trauma in the context of this article. The US National Institute of Mental Health[4] describes it as:

'. . . an emotionally painful, shocking, stressful, and sometimes life-threatening experience. It may or may not involve physical injuries, and can result from witnessing distressing events.

Expanding on this, Herman[5] championed a pivotal change in the conceptualization of trauma, dividing the entity into 'simple trauma' and 'complex trauma.' Simple trauma is familiar to psychiatrists, corresponding to *DSM* and *International Classification of Diseases* (ICD) classifications of single events of great magnitude, and long-recognized in war veterans and disaster survivors. In contrast, complex traumas may not be as overwhelmingly threatening to the body or psyche, but occur repeatedly over a protracted period of time, and are associated more commonly with domestic violence and sexual abuse. Complex trauma is often knowingly perpetrated by a caregiver, which is qualitatively different from natural disasters, accidents, war, and torture.

Simple trauma is akin to the spiral fracture of a skier's shin twisted beyond its limit in a single incident. Complex trauma is likened to the stress fracture of a marathon runner resulting from repetitive impacts.

Historical Aspects

One of the earliest conceptualizations in psychiatry of intergenerational trauma appeared in observation of traumatic themes in children of Holocaust survivors in family therapy clinics in Canada.[6] This was followed by research demonstrating that, relative to clinical controls, adolescents with parents who were Holocaust survivors scored higher on measures of conduct problems, personality problems, and immaturity/inadequacy, and exhibited lower levels of personal functioning.[7] Further research found increased vulnerability to posttraumatic stress disorder and other psychiatric diagnoses in adult children of Holocaust survivors.[8] However, subsequent findings have only partly supported this. A later meta-analyses demonstrated intergenerational transmission of Holocaust trauma to children and grandchildren but only in clinical samples, not in wider samples, concluding that intergenerational trauma was one part of a complex stress-diathesis model.[9]

Erikson[10] and others have expanded on this framework and applied it to other major disasters affecting populations at large, such as floods and nuclear disasters. More recently, research has focused on the intergenerational effects of terrorism. An example of this is the study of cortisol levels in mothers and infants where the mother was at or close to the World Trade Center during the September 11, 2001 attacks. Mothers who developed trauma symptoms (and their infants) showed lower cortisol levels than mothers who did not report trauma symptoms.[11]

Similar observations were described by Fraiberg in *JAACAP* in 1975,[12] investigating feeding, sleep, toileting, and behavioural difficulties in infants and toddlers of mothers who had experienced trauma, such as parental mental illness and child abuse. This research also documented successful treatment with psychoanalytic techniques delivered to the mother-child dyads.

Recently, the concept of intergenerational trauma has also been prominent in understanding the collective histories of indigenous and cultural minorities, such as First Nations[13] and Australian Aborigines.[3]

Etiological Concepts

In the literature, intergenerational trauma has been examined from a variety of standpoints including biological, psychological, and sociocultural. Most recently there have been the early stages of synthesis of these varying approaches via epigenetic studies.[14,15] Unfortunately, at present there remains a lack of cohesive theory as to the mechanism by which simple trauma is transformed into complex trauma. However, Attachment Theory has provided one of the more accepted and evidence-based understandings of transmission of trauma from parent to child. Bowlby,[16] and later Main and Solomon,[17] developed this theory which describes the function and development of interpersonal relationships. Ainsworth famously categorized the parent-child relationship into patterns of attachment that were set by the age of 11-24 months,[18] and her group also demonstrated a child's attachment style is best predicted by parental attachment style. 'Secure attachment' is

the most common pattern (62% of the normal population)[19] and is regarded as most adaptive. For those who are securely attached, significant relationships are a source of comfort and emotional stability. 'Insecure attachment' is less common and has two subtypes: avoidant (15%), those who avoid reliance on others; and ambivalent (9%), those who oscillate between clinging to and rejecting others.[19] Insecure attachment causes interpersonal issues, but only has weak association with psychiatric illness. 'Disorganized attachment' is the final type (15%).[19] It arises from profoundly adverse parenting experiences and is more strongly associated with increased psychiatric morbidity.[20]

If, then, we use attachment as a mechanism for transmission of trauma, the following pattern may be observed. An adult with secure or insecure attachment (but lacking major psychological morbidity) may be traumatized by a simple trauma or loss. The changes in their behavior because of trauma may manifest in changes to parenting style which are experienced as complex trauma by their children; this results in less healthy attachment in the next generation. This may then manifest in either overt psychopathology, or more disrupted attachment, which may then be passed on again to further generations as demonstrated in Figure 1.

The diagram in Figure 1 illustrates three generations. However, transmission may be over more or fewer generations. When there are intermediary stages, the parent may act as a silent or partially silent "carrier" of intergenerational trauma. This explains cases for which there is an apparent absence of gross psychiatric history in the intervening generation if an in-depth interpersonal history of family members is not explored.

A useful analogy is Newton's Cradle (Figure 2). The system is stable initially, but a trauma (or force) is introduced to the system generating a change. Although each unit in the chain of events is impacted, intermediate units show little or no change, only the last unit in the chain shows clearly observable change.

Figure 1: Transmission of Intergenerational Trauma With Progression of Simple Trauma to Complex Trauma

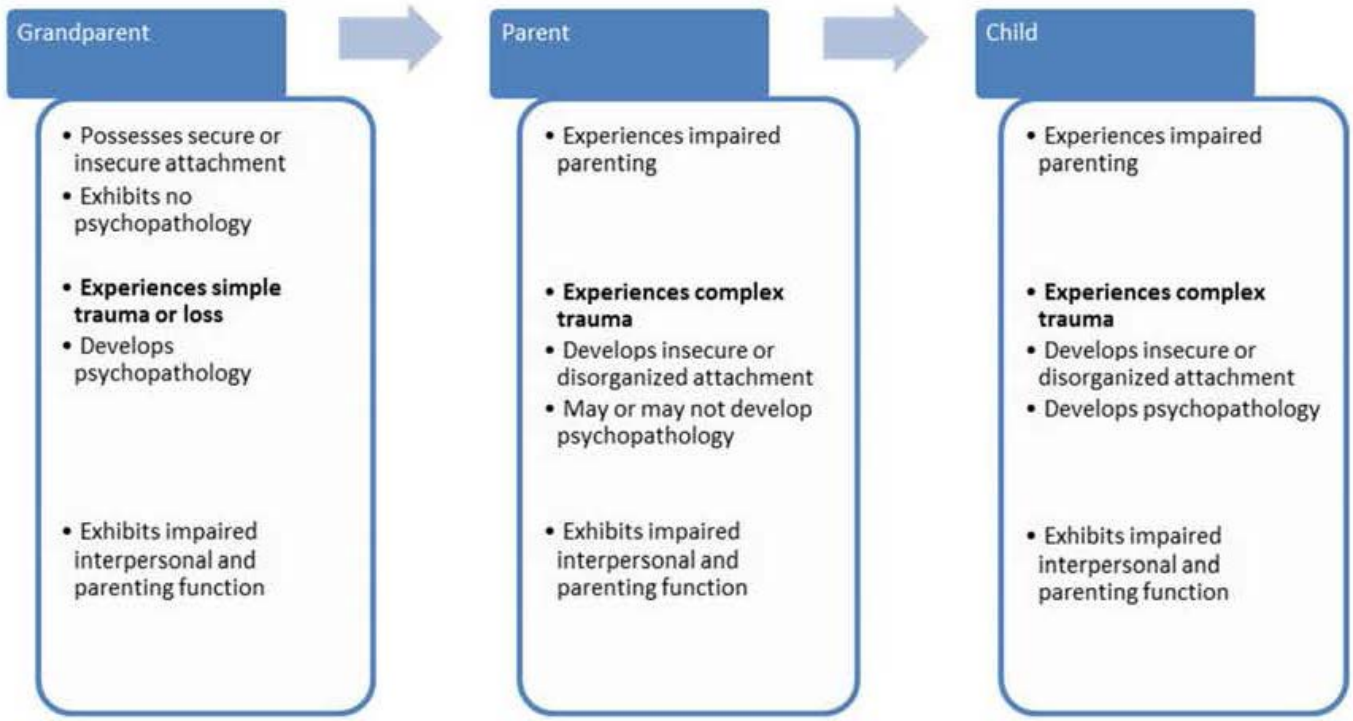
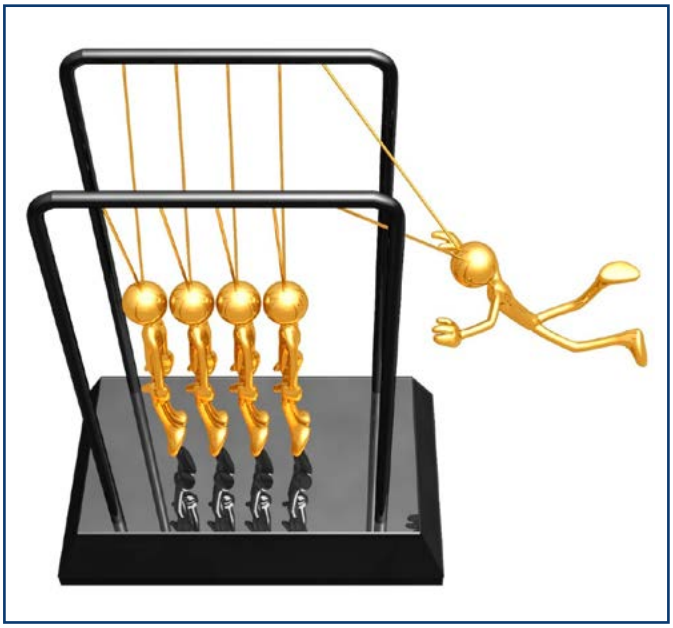


Figure 2. Newton's Cradle



Note: *Figure 2. [Scott Maxwell] © 123RF.com. 'Employee Newton's Cradle', Image ID:4380024. Used with permission from https://www.123rf.com/photo_4380024_employee-newton-s-cradle.html*

Case (Part 2)

Further history is taken from Angel's parents. Angel's mother describes her own early childhood as quiet and family-oriented. Angel's mother's father went to war when she was 8-years-old, and when he returned, this pre-morbidly mild-mannered man was described as 'changed'. Domestic violence, social withdrawal, and alcoholism characterized family life for Angel's mother in her teenage years. There is insufficient information to identify Angel's mother's attachment style as a young child, however, it appears her interpersonal style shifted dramatically as a result of family dysfunction. Angel's mother describes her relationship with Angel as intense and argumentative, similar to her own relationships with her parents.

Angel's father describes his upbringing as privileged but miserable. His father was often away on business, and he recalls that his father did not engage in parenting even when he was home. His mother was an alcoholic and may have suffered from undiagnosed depression following multiple family deaths and he describes his relationship with her as emotionally empty. His own childhood was focused on academic achievement, which was the only part of his life in which his parents took an interest. He tends to avoid talking about or dealing with emotions, in keeping with a possible insecure avoidant attachment. Taken as a whole, Angel's parents' styles, though quite different, both make them unavailable to her in terms of emotional support.

The family is referred for family therapy. This allows the parents to reflect upon the relationships they had with their own troubled parents and how these relationships shape their current parenting style. Angel's parents decide to endeavor to be more available to her, and Angel gains some understanding of why her parents struggle to support her, giving her more willingness to seek them out.

Three months later the family reports Angel has improved significantly. She is no longer depressed. She still experiences anxiety at times of stress but can access support from her parents when needed. She is no longer self-harming, and her substance use has decreased.

Management

Identifying intergenerational trauma is done by observing factors beyond the identified client and located *within relationships* in the family, sometimes decades or generations prior to symptom onset. It is important to take a detailed family history, initially focusing on parental mental health, addictions, losses, and other life events impacting family (war, forced dislocation, loss of culture). This needs to be expanded to understand the impact on previous generations and how this may have influenced parent-child interactions.

This case has been illustrated with family therapy. However, there are many interventions that may be helpful either with the parents alone or with the whole family. These include family therapies, attachment-based therapies (such as mentalization-based treatment), or any therapy which promotes parental reflective function or improvements in interpersonal function. Additionally, individual trauma-oriented therapy for parents may also be useful.

In the classic 1947 *Lancet* paper, Platt[21] espoused the importance of history-taking over examination and investigations, a position that has continued into later generations despite advances in medical science.[22,23] Medicine remains an imprecise science, psychiatry even more so; as such, history taking, despite its subjective limitations, remains our most potent tool. Assessment of a child or adolescent often involves direct history-taking with the child and history-taking with the family or school about the child, but an often-neglected area is history-taking about the systems around the child.

An intergenerational perspective can reconceptualize blame, shifting it away from the identified patient whilst also avoiding shifting blame to parents (or grandparents). Instead, causation is linked to etiological factors in the environment. Parents do the best they can for their children *with the physical and psychological resources they have*. It is important for health care providers to support families in understanding trauma. Blame serves to undermine relationships, which impedes family function and perpetuates the problem.

In this age, where psychiatry remains reliant on descriptive rather than etiological classifications, traumatic stress is one of the few psychiatric diagnoses with clear causation; as such, we should be thorough in identifying or ruling out its presence.

Take Home Summary

When faced with unclear diagnoses, complex comorbidities or treatment resistance, consider historical trauma in the patient's family. The assessment of intergenerational trauma lies in highly detailed family history. Systemic and relational psychotherapies are the main treatment options.

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About the Author

Chris Bampton, BA (Hons Psych), BMBS, FRANZCP, is a consultant child and adolescent psychiatrist for the Auckland District Health Board, New Zealand. He is the director of advanced training in psychotherapy for New Zealand for the RANZCP and has a small private practice in psychotherapy.

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