Working with the Legacy of Transgenerational Trauma

DMH Restraint and Seclusion Prevention Initiative
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What is a "**trauma**" ?

"Psychological trauma is the **unique individual experience of a [single] event, a series of events, or a set of enduring conditions**, in which:

- The individual's **ability to integrate his or her emotional experience is overwhelmed** (i.e., the ability to stay present, understand what is happening, tolerate the feelings, or comprehend the horror), and/or
- The individual **experiences (subjectively) a threat to life, bodily integrity, or sanity."**

Saakvitne et al, 2000

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What is "traumatic" depends upon our vulnerability

Because children are so dependent on their caretakers for survival and safety, many experiences are traumatic for them that might not traumatize an adult

- "Frightened and frightening" parents, attachment trauma (Lyons-Ruth)
- Neglect, separation, abandonment (Perry)
- Exposure to domestic violence or war, witnessing violence
- Accidents, medical crises, surgery, invasive procedures
- Death of a parent or parent figure
- Secondary effects of parental PTSD, intergenerational trauma (Yehuda)

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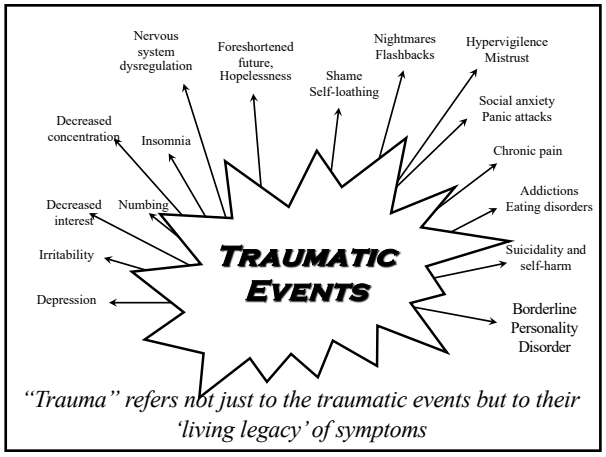

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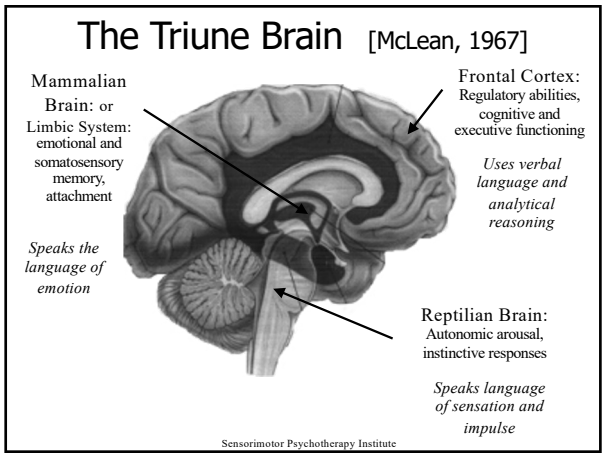

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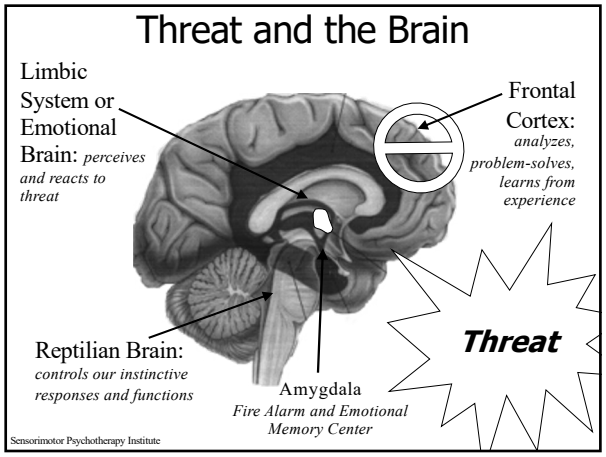

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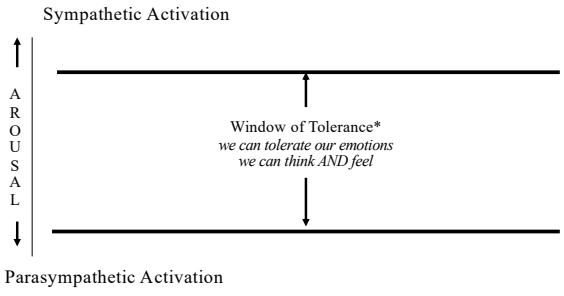
When caregivers offer safe, secure attachment,



Ogden and Minton, 2000; Fisher, 2009

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What if the parent has no window of tolerance? What if the parent grew up in a traumatic environment? What if the parent has PTSD?

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"The infant, instead of finding a haven of safety in the relationship, is alarmed by the parent. . . [and] because an infant inevitably seeks the parent when alarmed, ***any parental behavior that alarms the infant places it in an irresolvable paradox in which it can neither approach, shift its attention, or flee."*** *Main & Solomon, 1986*

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"It's unbearable to **be** *in her presence, and it's unbearable not to be."*

"Mary"

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The result is Disorganized Attachment

- Researchers labeled the attachment style associated with maternal behavior that was **"frightened"** or **"frightening"** (Liotti, 1999) as "disorganized attachment."
- **Disorganized attachment is characterized by approach-avoidance behavior** in infants and toddlers: like abused children, they seek closeness, then back away, become aggressive or shut down
- **Disorganized attachment at age 1 is a statistically significant predictor of diagnoses of Borderline Personality Disorder and Dissociative Identity Disorder** in adulthood (Lyons-Ruth, 2001)

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"Frightened and Frightening" Caregiving

Frightened Behavior
Backing away
Frightened voice
Dazed expression
Exaggerated startle
Withdrawn
Non-responsive

Frightening Behavior
Looming, attack postures
Sudden movements
Mocking, teasing
Intrusive
Emotionally reactive
Loud, startling noises

Lyons-Ruth, 2000

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Maternal Unresolved Attachment = Disorganized Attachment in the Child

•The mothers of disorganized infants have their own histories of trauma, loss, attachment failure, or separation. Even in the absence of specific trauma, these mothers frequently exhibited PTSD and dissociative symptoms

•**"[Rather than arousing impulses to calm and comfort, . . . the activation of the attachment system arouses in these parents strong emotions of fear and/or anger.** Thus, while infants are crying, 'unresolved' parents may interrupt their attempts to soothe them . . . with unwitting, abrupt manifestations of alarm and/or anger." (Liotti, 2004, p. 477)

Fisher, 2007

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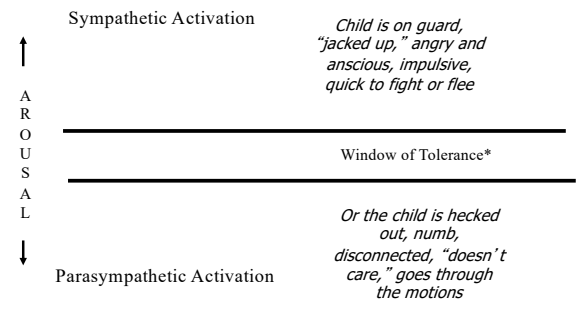
When the parent is frightening or is dysregulating instead of regulating,



Ogden and Minton, 2000; Fisher, 2009

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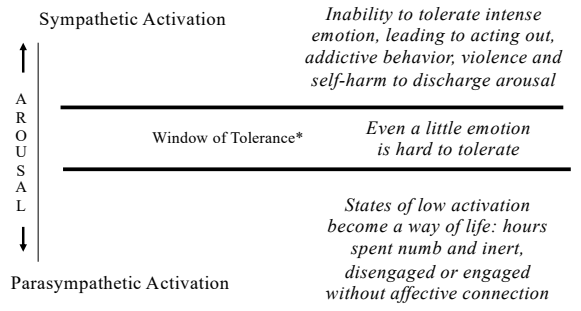
'Affect Intolerance' = under- or over-activity of stress response system



Ogden and Minton, 2000; Fisher, 2009

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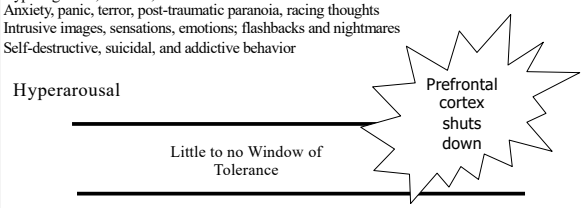
Autonomic Adaptation to a Threatening World

Hyperarousal-Related Symptoms:
Frontal lobe shutdown leads to impulsivity, risk-taking, poor judgment
Hypervigilance, mistrust, resistance to treatment
Anxiety, panic, terror, post-traumatic paranoia, racing thoughts
Intrusive images, sensations, emotions; flashbacks and nightmares
Self-destructive, suicidal, and addictive behavior



Hypoarousal-Related Symptoms:
Flat affect, numb, feels dead or empty, "not there"
Cognitive functioning slowed, "lazy" thinking
Preoccupied with shame, despair and self-loathing
Passive-aggressive, victim identity

Ogden and Minton (2000); Fisher, 2009
*Siegel (1999)
Sensorimotor Psychotherapy Institute

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Intergenerational Trauma - Cindie

- Cindie is now 70 years old, a child of divorce, and now a retired professional, married, with two adult children
  - Cindie's mother had survived abuse by her mother and displayed disorganized attachment: dysregulated, needy, angry when her needs were not met, intensely enmeshed with her daughter and her many boy friends
  - Cindie's father was a World War II veteran who lived with his mother, went to work each day, and was shut in his bedroom whenever he was home, avoiding Cindie and his mother
  - Her grandmother was very strict and controlling but was the most stable parent figure in her life

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Intergenerational Trauma – p. 2

- Both parents were very dysregulated: Cindie's mother was hyperaroused and intrusive. Her father was hypoaroused and avoidant. Her grandmother regulated adults and children using fear
- There was no parent to provide protection, soothing and comfort for a child. Without protection, Cindie was abused by at least one of her mother's boy friends
- Her parents' dysregulation and their survival responses created a frightening environment for Cindie, reinforced and confirmed by the sexual abuse
- But to understand Cindie, we have to understand the intergenerational trauma and environment

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Cindie's symptoms: abuse or intergenerational trauma?

- Cindie came for treatment with the following symptoms: depression, inability to stop crying, anxiety, inability to sleep, need for constant reassurance, suicidal ideation
- **Highly sensitive to distance and misattunement,** she would call her therapist multiple times a day and would become even more distressed if there was no return call
- At the same time, **she fought reassurance and comfort,** trying to repeatedly convince the therapist that it was hopeless and there was no point to her living
- Was she a borderline? A sexual abuse survivor? Or a victim of intergenerational trauma?

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What do we know about intergenerational trauma?

- Rachel Yehuda and her colleagues (1998) studied a group of Holocaust survivor parents and their adult children. She also assessed the adult children for any other trauma. What she found was:
  - If the parent had PTSD, the adult child was more likely to suffer from PTSD
  - If the adult child had been traumatized but had a parent without PTSD, the adult child was less likely to have PTSD
  - If the father had PTSD, adult daughters were more likely to suffer from depression

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Mechanisms of intergenerational trauma

In Yehuda's study, not all the survivor parents had spoken of their experiences with the child. But subsequent studies show there are more subtle ways trauma may be passed along the generations. One study found that, *"Parents with unresolved trauma experience dissociative phenomena. They show frightened emotional expressions to the child . . . . The child responds with emotional and behavioral disorganization and disorganized attachment behavior. Maternal cognitions and representations also impact caregiving behavior. . . [through] unrealistic expectations of the child and distorted attributions of child intentions."* *(Dozio, 2020, p. 2)*

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". . . the rhythmic pattern behind mother-infant interactions (visual, tactile, vocal) [is]negatively affected when mothers are traumatized. ***Mothers cannot modulate their stimulation and their response to their infant's needs, leading to overstimulation or on the contrary, to neglect of the child.*** *Both behaviors can be traumatic for the infant who will have difficulty self- regulating …to protect himself from becoming over-whelmed by hyperstimulation or the absence of stimulation from the mother."* *(Dozio et al, 2020, p. 2)*

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What does this mean for treatment?

- **Focus on traumatic events will not address the impact of transgenerational trauma.** Because intergenerational trauma is a set of conditions, not discrete events, we have to treat the effects, not the memories
- When clients have a combination of remembered childhood traumas and transgenerational trauma, we have to look at their symptoms to determine best treatments:
  - **If they suffer primarily from nightmares and flashbacks, focus on the event is warranted**, preferably using EMDR
  - **If they suffer primarily from depression and anxiety, we should treat those as trauma symptoms**

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What does it mean for treatment? p. 2

- **Treating anxiety and depression as trauma symptoms means that we combine empathy, psychoeducation and skill-building** so that the skills have meaning
  - If clients are suicidal and self-harming, we need to educate them too. Research shows a strong association between self-harm or suicidality and a trauma history. **Helping clients understand their impulses as trauma-related fight responses takes away some of the power of those impulses**
  - If clients lack self-care, contextualizing their neglect as a symptom of traumatic neglect will help. They have internalized it and now they neglect themselves

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What does it mean for treatment? p. 3

- **Transgenerational trauma is transmitted primarily through the nervous system**
  - A dysregulated parent is anxiety-provoking for the child. When the parent startles, it is frightening. When the parent is afraid to leave the house or to answer the phone or to drive after dark, children are frightened.
  - Because a child's Window of Tolerance is dependent upon the parent's, a traumatized part cannot soothe
  - And if the child is dysregulated by the parent, the effects of any current trauma are exacerbated

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Addressing Triggers/Triggering

•Trauma patients generally come to treatment because of post-traumatic triggers that stimulate anxiety, intrusive memories, overwhelming emotions, depression, and/or suicidality. Transgenerational trauma is no exception

•**The first goal of treatment should to empower clients by helping them recognize when they are triggered and to begin anticipating being triggered**

•With greater understanding comes decreased fear and shame. With more self-awareness and the language of triggering to describe what is happening, their capacity for managing dysregulation in the face of triggering can potentially increase

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Brainstorming: How can you tell when you are triggered?

- Triggered reactions = sudden, intense, and hard to shift
- Anxiety, fear
- Increased heart rate
- Pit, tightness, clenching in stomach
- Shallow breathing, hyperventilation, holding the breath
- Obsessive thinking
- Response disproportional to event, major change in previous state
- 0-to-60 reactions
- "I'm doing something I shouldn't/didn't want to do"
- Hypertension
- Muscle tension (either whole body or specific areas)
- Twitches, tics
- Jumping to conclusions
- Jumping to "worst case scenario"
- Feeling that 'the sky is falling'
- Sense of not belonging, being on the outside looking in
- Fear of abandonment
- Feeling small

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To treat trauma, we have to increase activity in the prefrontal cortex

"In order for the amygdala to respond to fear reactions, the prefrontal region has to be shut down. . . . [Treatment] of pathologic fear may require that the patient learn to increase activity in the prefrontal region so that the amygdala is less free to express fear."

LeDoux, 2003

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Simple ways of "waking up" the prefrontal cortex

- **Evoking curiosity: before we try to problem-solve with patients, we first need to help them be curious.** What triggered the shame? The impulses to self-harm or purge? What is the patient hoping for? How does s/he hope to feel after acting out?
- **Providing accurate information** to counter patient interpretations: "Let me explain why you might be feeling this way. . ." or "why the cutting brings relief . . ."
- **Helping patient achieve more distance from the symptoms:** universalizing or reframing the symptoms, re-contextualizing them as "feeling [or body] memories" or "long slow flashbacks"

Fisher, 2013

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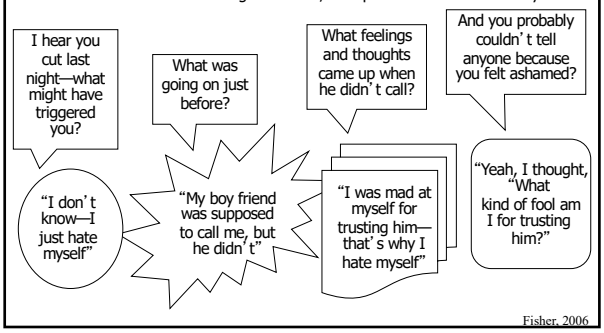
Connecting Symptoms to Triggers

In the context of client's having cut herself, therapist tries to evoke curiosity:



Fisher, 2006

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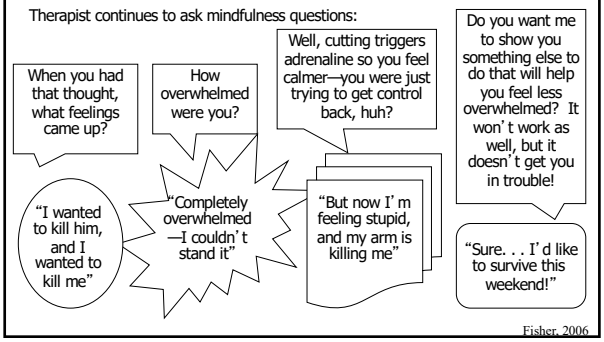
Connecting Symptoms to Triggers, cont.



Fisher, 2006

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Social engagement is a prerequisite for feeling safe

•**The social engagement system as described by Steven Porges is a neurobiological system** that relies upon the "muscles that give expression to our faces, allow us to gesture with our heads, put intonation into our voices, direct our gaze, and permit us to distinguish human voices from background sounds." (Porges, 2004, p. 21)

•**The social engagement system is naturally engaged when human beings feel safe,** and it goes offline when we are not

•**Neglect and trauma interfere with social engagement**: blunted affect, frozen facial expressions, monotone speech alert us to its absence in our clients

Ogden, 2004; Fisher, 2015

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Make use of "social engagement"

•**'Regulating' a dysregulated client requires using the "social engagement system"** as we instinctively do with children. As the client describes events, feelings, reactions, the therapist makes use of the physiological components of communication: gaze, facial expression, body language, turning and tilting of the head, the larynx for vocal tone

•"Tracking" the client's moment-to-moment responses and adjusting the quality of our social engagement accordingly brings us into 'synch' with the client. **Like a parent, our only goal must become dyadic dancing** with the client, capitalizing on whatever creates a positive moment or avoids dysregulation Fisher, 2014

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