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# ADULT-ONSET TRAUMA AND INTERGENERATIONAL TRANSMISSION: INTEGRATING EMPIRICAL DATA AND PSYCHOANALYTIC THEORY

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This article addresses the tension in psychoanalytic thinking regarding adult-onset trauma and its potential effects on children who were not directly exposed to the same parental trauma. Psychoanalytic theory emphasizes early attachment trauma as predictive of the response to trauma later in life. This emphasis on early trauma delayed recognition of adult-onset trauma-related disorders and the development of adequate trauma-focused treatments. Presently, the confluence of findings from multiple disciplines, including trauma studies, biological research, and epidemiological data from across the globe, demonstrates the potentially devastating impact of adult-onset post-traumatic stress disorder (PTSD) following exposure to trauma, such as war, terror, and assaultive violence. Empirical evidence highlights the critical role of post-trauma family and social support in recovery from PTSD or, alternatively, in delayed PTSD. Given the numbers of servicemen returning from combat zones with post-traumatic disorders and other populations around the globe exposed to extreme political violence, new effective trauma-focused treatments are needed. Integration of perspectives within psychoanalytic theories and “cross pollination” among the fields of psychoanalysis, attachment studies, cognitive-behavioral psychology, neuroscience, and trauma research will enhance innovative and effective interventions that harvest beneficial therapeutic elements from multiple approaches.

Keywords: adult-onset; attachment; Holocaust survivors; intergenerational transmission; intersubjectivity; post-traumatic stress disorder (PTSD); trauma; veterans

This article is focused on the impact of adult-onset trauma in patients who have been exposed, as adults, to events such as life-threatening assault, act of terrorism, war, torture, genocide, or other extreme danger, and on the closely related issue of intergenerational transmission in children of survivors who were not directly exposed to the same trauma as their parents.

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A review of the history of the attitudes of the mental health professions towards Holocaust survivors and Vietnam veterans offers sobering lessons about the constraining effects that psychoanalytic conceptualizations had regarding the recognition of the impact of traumatic reality on adult survivors of past catastrophes. Failure to incorporate new clinical observations and to revise theoretical models compromised adequate treatment for survivors of the Holocaust and, later, for veterans of the Vietnam War.

Adult trauma is associated with the risk of intergenerational transmission of a wide range of bio-psychological effects to the children of survivors. Research in various populations has led to the recognition of transmission of “historical trauma” (Sotero, 2006; SAMSHA, 2014) in Native Americans (Brave Heart, 2003), survivors of the Armenian genocide (Kupelian, Sanentz, and Kassabian, 1998), American Japanese interned in the United States during WWII (Nagata, 1998; Harth, 2001), survivors of the Khmer Rouge regime in Cambodia (Field, Muong, and Sochanvimean, 2013), and others. Both relational and biological processes might be implicated in the mechanisms of such transmission. For example, evidence exists for genetic aberrations, for differences in stress hormones, and other bio-psychological vulnerabilities in the (unexposed) children of trauma survivors (Flory, Bierer, and Yehuda, 2011; Lambert, Gikzerm, and Hasbun, 2014; Yehuda et al., 2014). However, there is still a need for better integration of evidence from various empirical disciplines with psychoanalytic and attachment theory and research.

Boulanger (2002) offers a psychodynamic model “to explain the profound and sometimes irreversible impact that being abruptly confronted with almost certain death can have on individuals of widely divergent character types” (p. 46). Boulanger emphasizes the importance of differentiating the developmental outcomes of childhood trauma and the consequences that are observed in adults who faced catastrophes. Both the subjective experience, as well as the psychodynamic meaning of adult-onset trauma, she states, require their own consideration in order to allow appropriate psychoanalytic practice. The impact of traumatic experiences on children is different from the influence observed in adults exposed to overwhelming events. When a child is overwhelmed with fear, they defensively dissociate and contingent selves are formed as a protection against fragmentation (p. 48). The trauma becomes part of self-experience, which is embodied in different self-states (Davies and Frawley, 1994; Davies, 1997; Bromberg, 1998). The resulting split-off, trauma-related representations leave other self-states relatively free to engage a less frightening world. However, the capacity to dissociate decreases with age (Boulanger, 2008) and trauma in adults is, therefore, less effectively dissociated. For adults, in the moment of trauma, psychic structure as it had been until then is threatened (Kohut, 1984; Laub and Auerhahn, 1989; Hermann, 1992). The dissociative process in response to massive trauma in adulthood does not create additional vertical splits. Rather, the self experiences itself in ways that are profoundly disturbing and foreign to it, which do not happen within the range of expectable life experiences. In such moments of trauma, as described by Krystal (1978), “overwhelmed by the terror of annihilation, the self, unable to act in its own best interests, loses its capacity to reflect on what is happening, growing numb and lifeless.” Boulanger states that unlike the child, the adult survivor of a catastrophe knows that the experience happened. In fact, after the trauma ends, memories of it become a continued source of an assault as vivid and

recurring images, sensations, thoughts, behaviors, and fears concerned with the trauma pervade the survivor's life in sleep and during waking hours. Therefore, despite attempts to defend against it, adult-onset trauma pervades every self-state and manifests in daily life in a spectrum of phenomena, ranging from symptoms and fragments of intrusive experiences, through various degrees of enactments in relationships, in social and political attitudes, and in pervasive life themes (Peskin, Auerhahn, and Laub, 1997; Tummala-Narra et al., 2012). In other words, trauma in adults is less well separately contained due to the relative absence of the capacity to create new vertical splits.

These psychoanalytic conceptualizations are consistent with the definition of post-traumatic stress disorder (PTSD) as in the *DSM-5* as well as in the *ICD-10* classification. Further, support for the pervasive impact of dissociation in adults comes from studies which show that dissociation during or immediately following trauma is associated with increased risk for the onset of PTSD (Halligan and Yehuda, 2000; Breh and Seidler, 2007). The pervasive presence of trauma-related symptoms and enactments in a survivor parent, in turn, permeates the relational intersubjective field and might lead the trauma survivor's child to perceive the parent as fearful or frightening (Hesse and Main, 2006), thereby interfering with the quality of the attachment relationship. These points will be further elaborated in the discussion of intergenerational transmission of trauma.

### PSYCHOANALYSIS AND HOLOCAUST SURVIVORS

A conspicuous lack of attention by psychiatry to the effects of the Holocaust on the survivors and their needs for rehabilitation persisted for the first decades after the end of WWII (Krell, 1997). While German physicians after WWII might have had various reasons to deny the damage caused by Nazi persecution (Brainin, 1998), it must also be acknowledged that the theoretical psychoanalytic framework available to them at that time did not consider possible such extensive damaging psychological effects in formed adolescents and young adults. Freud doubted that "a terrifying experience can of itself produce a neurosis in adult life" (Ernest, 1968, in Krell, 1997, p. 10). Rappaport (quoted by Krell, 1997, p. 10) concluded, "The insistence of investigators on finding some latent predisposition for the personality breakdown betrays their unwillingness to imagine the impact of the terror." Psychological "defects" observed in survivors were attributed to personality problems from before the war, and the mere fact that one could become so damaged by experiences during the war was taken as proof of an unsound state before the traumatic events of the Holocaust. Eissler expressed the issue poignantly in the title of his paper (in German) "The murder of how many of one's children, must one endure symptom-free, in order to prove a healthy constitution?" (Eissler, 1963).

It also took several decades for the trauma of the Holocaust to enter public discourse in Israel (Stern, 2000; Friedman-Peleg, 2014; Felsen, in preparation), and to be addressed by Israeli psychiatrists (Davidovitch and Zalashik, 2007), as well as by American psychotherapists (Danieli, 1984). With few exceptions, even mental health professionals who were themselves survivors did not address the trauma of the Holocaust. Dasberg, a child survivor and psychiatrist, stated that the survivors themselves, and the children of the survivors, could not yet, at that time, face their own and their parents'

losses and dehumanization: “So all of us, Germans and Jews alike, have our reasons, irrational as they may seem, for keeping silent about our past and present memories of the Holocaust” (Dasberg, 1991, p. 30).

### ATTITUDES TOWARD VIETNAM VETERANS

In her paper “Oscillating Between Denial and Recognition of PTSD,” Solomon (1995) describes a pattern of denial of PTSD that was repeated in the history of mental health and a tendency to disregard the lessons that accumulated after each war. She points out that, even after the introduction of the diagnosis of PTSD to the *DSM III* in 1980, the assumption of “the primacy of predisposition”, emphasizing the influence of early relationships on personality vulnerability to stressful events, was applied to Vietnam veterans and constituted a more “acceptable” form of denying the impact of the trauma of combat. Solomon quotes Haley (1978), who reported that the files of traumatized veterans were full of childhood and family details, while the patient’s military history was rarely considered in otherwise comprehensive psychiatric workups. Haley stated that veterans received erroneous diagnoses and improper treatment because they triggered “unbearable negative effects and countertransference resistance in the therapist” (Solomon, 1995, p. 274). Similarly, Blank (1985, in Solomon, 1995) identified mainstream attitudes of the mental health profession at that time as wholesale denial of the very existence of long-term post-traumatic reactions, with inevitable misdiagnoses and failure to provide suitable treatment to the veterans.

Constrained by their theoretical convictions, professionals were unable to accurately see the clinical phenomena that they were observing. Bourne, an American military psychiatrist stated (Bourne, 1970) “The most significant psychiatric finding of the [Vietnam] conflict has been that the number of casualties has remained surprisingly low. *Many of those seen by psychiatrists in Viet Nam have problems unrelated to the direct stresses of war . . . Only five percent of psychiatric admissions have been diagnosed as having ‘combat fatigue’*” (p. 482–483, italics added). These statements, which were later retracted when the extent of stress reactions among Vietnam veterans became evident (Bourne, 1972), were similar to attitudes towards Holocaust survivors, and compromised the availability and development of adequate treatment and support for Holocaust survivors, for veterans, and for their families.

### TRAUMA STUDIES: ADULT-ONSET TRAUMA

The introduction of the diagnosis of PTSD into the *DSM-III* led to a “torrent of research” (Bonanno and Mancini, 2012) on PTSD and other post-traumatic reactions. Evidence from different populations exposed to various traumatic events has been examined. Review papers and meta-analyses using multiple samples are particularly important in order to understand the outcomes of different types of traumatic events (for review articles and meta-analyses, see Porter and Haslam, 2001; Norris, Friedman et al., 2002; Norris, Tracy et al., 2002; Turner, 2004; Neria, Nandi, and Galea, 2008; Norris, 2009; Lambert et al., 2014).

Empirical findings have led to the recognition that not all those exposed to a traumatic event develop chronic PTSD. Estimates for the prevalence of PTSD vary between 10–40% for the first year after exposure (Neria et al., 2008). A third of those who initially develop PTSD recover spontaneously, and another third shows persistent symptoms (Kessler et al., 1995). The prevalence of PTSD in the general population in the United States is 8% (Breslau, 2009). Much higher rates are observed in populations exposed to disasters, and especially high rates of post-traumatic reactions are observed in the aftermath of human-perpetrated violence (Norris, Friedman et al., 2002; Norris, Tracy et al., 2002; Neria, Baravova, and Halper, 2010). Findings from the WHO mental health surveys (Karam et al., 2014) showed that PTSD related to multiple (four or more) traumatic events, such as often occurs in situations of prolonged exposure to war and political violence, was associated with greater dysfunction and impairment and with higher rates of co-morbidity than PTSD following a single traumatic event.

A meta-analysis of 160 disaster samples (Norris, Friedman et al., 2002; Norris, Tracy et al., 2002) showed that, in addition to PTSD, there are other negative outcomes of exposure to trauma, such as other specific psychiatric disorders (observed in 77% of the samples) including depression and anxiety, non-specific psychological distress (observed in 39% of the samples), health problems and concerns (23%), chronic problems in relationships, and difficulties related to work and occupation (10%). Of great relevance for models of interventions are the findings that subjective feelings of social embeddedness, as well as the level of actual and perceived social support, were observed in many studies to be the most critical factor determining recovery from post-traumatic reactions or, alternatively, for developing delayed post-traumatic reactions. For example, a longitudinal study of residents who were exposed to a fireworks disaster found that late-onset PTSD was associated with severe disaster exposure, and with the number of reported stressful life events and perceived lack of social support after exposure. (Smid et al., 2012). Similarly, a longitudinal study of Dutch former peace-keeping soldiers found that even after controlling for PTSD symptom severity in the initial assessment, the degree of supportive social interactions after deployment was significantly associated with fewer PTSD symptoms at follow up two years later. Examining both positive and negative social interactions, a higher degree of negative social interactions was significantly associated with more PTSD symptoms at follow up (Dirkzwager, Bramsen, and van der Ploeg, 2003). From yet another direction, studies of mental health of refugees show that the post-trauma difficulties of adjusting to a new society might contribute as much to mental health problems of refugees as the overwhelming experiences of war and violence in their country of origin (Mollica et al., 1999; Lopes et al., 2003; Turner et al., 2003; Knipscheer and Kleber, 2006). Longitudinal studies in a variety of populations exposed to different kinds of traumatic stress suggest that stressful life events and perceived lack of social support may contribute to PTSD symptom progression and that intervention to address stressors and enhance perceived and actual social support in the aftermath of a disaster may be a target for secondary prevention of late-onset PTSD.

Post-traumatic symptoms can persist for decades (Amir and Lev-Wiesel, 2003). A meta-analysis of 70 studies (Barel et al., 2010) showed substantially more PTSD symptoms in Holocaust survivors compared with their peers 60 years after the end of WWII.

Long-term effects of WWII, including higher rates of PTSD symptoms, depression, and anxiety, have been shown in samples of Finnish children evacuated and separated from their families (Pesonen et al., 2007; Andersson, 2011); British children evacuated from home (Foster, Davies, and Steele, 2003; Waugh et al., 2007), and German war children (Teegen and Meister, 2000; Kuwert et al., 2007). Field et al. (2013) reported high prevalence of PTSD and other mental disorders 35 years later in Cambodians who survived the Khmer Rouge regime as children.

Research suggests that positive adaptation and coping can exist alongside problems in interpersonal functioning (Westphal et al., 2011; Tummala-Narra et al., 2012). Some costs of adaptive functioning under traumatic stress include sealing-over, “hardening” (Shuval, 1957–1958; Robinson, Rapaport-Bar-Sever, and Rapaport, 1994; Bar-On et al., 1998) or “steeling” (Rutter, 2012), which might interfere with the capacity to enjoy life after the trauma ends and can compromise the family atmosphere and intergenerational relationships (Lamoureux et al., 2012; Shklarov, 2012).

### EVIDENCE FOR INTERGENERATIONAL TRANSMISSION IN ADULT CHILDREN OF HOLOCAUST SURVIVORS

The largest body of studies of intergenerational transmission to date is about children of Holocaust survivors. Significant differences in the psychological profile of children of survivors, albeit within the normative range, were observed in many studies, revealing higher levels of anxiety, depression, guilt feelings, and self-criticism than among control groups (Felsen, 1998). Children of survivors showed evidence of greater difficulties separating from their parents, lower marital satisfaction (Brom, Kfir, and Dasberg, 2001), and less positive self-representations as parents (Scharf, 2007). PTSD was observed to be more prevalent among children of survivors in comparison to controls, in the absence of differences in traumatic exposure, suggesting that children of survivors might be prone to a more catastrophic reaction in response to stressful events (Yehuda et al., 2007). Some children of survivors were also observed to have more psychopathological reactions to traumatic stressors, such as exposure to war trauma (Solomon, Kotler, and Mikulincer, 1988) and serious illness (Baider et al., 2000). Recent studies show that children of Holocaust survivor mothers might have been subjected to early (perhaps fetal) developmental programming via epigenetic mechanisms, which affect the trajectory of health outcomes in later life (Flory et al., 2011; Keinan-Boker, 2014). Specific differences in the arena of attachment and in manifestations of psychological separation-individuation were observed between children of survivors and controls, including differences in identification with the parents (Felsen and Erlich, 1990), perceived obstacles in separating from the parents (Zilberfein, 1995), and differentiation of self (Giladi and Bell, 2013). The findings indicate that Holocaust background is a risk factor for increased difficulties, evidenced by statistically significant differences between children of survivors in comparison with non-Holocaust related peers. However, the observed differences characterizing the children of survivors remain within normative range, indicating the presence of a psychological profile of vulnerabilities and strengths and particular psychological concerns, among children of survivors, but no psychopathology. Consistent

with the aforementioned observations, a meta-analysis (van Ijzendoorn, Bakermans-Kranenburg, and Sagi-Schwartz, 2003) found no evidence for differences with regards to general level of adjustment, specific mental health symptomatology, or stress levels in comparisons between nonclinical samples of children of survivors and comparison groups.

It can be concluded that what was observed in the literature about intergenerational transmission in Holocaust survivors' families are themes of relational experiences which reflect perceptions of deficient parental relational competence (Lenoff, 2014). These include the impact of directly experiencing parental intrusive memories and parental distress, instances where parental reactions manifested numbing and detachment at significant joyful points in their children's lives, and various manifestations of parental inability to provide care and to communicate to the children a sense of being emotionally understood (Wiseman, 2008; Wiseman and Barber, 2008). The experiences of not being understood by others, not understanding others, and the lack of *shared* understanding, were discussed by Wiseman and Barber as representing a sense of "failed intersubjectivity" (The authors referred to intersubjectivity as an existential reality that contextualizes all experiences.) Scharf and Mayseless (2011) also examined long-term effects related to intergenerational transmission in the second and the third generation in Holocaust survivors' families. Based on in-depth interviews with adult children of survivors and their adolescent children, three themes were identified which included a focus on survival issues, perceived lack of emotional resources in the parents, and a sense of coercion to take care of the parents' needs and please them without a way to express autonomous wishes. Scharf and Mayseless posited that such relational themes represent disorganizing experiences shown to be carried across the generations.

Over-protective parenting style was also observed to be associated with parental trauma and shown to interfere with the development of autonomy in children (Bar-On et al., 1998; Brom et al., 2001; Kellerman, 2001). Lastly, a rejecting parenting style (reported as experiences of emotional neglect and emotional abuse) has been identified in some families of survivors (Yehuda, Halligan, and Grossman, 2001). Although least researched in the literature, rejecting parenting experiences are not uncommonly described in clinical settings. In my clinical experience, I have encountered quite a few children of survivors who have confided such experiences, and their distress is compounded by intense guilt and shame. Having such negative feelings and memories about their Holocaust survivor parents who suffered so much is mixed with guilt, with fear of being morally judged for "blaming the victims," and with expectations of being discredited.

A set of studies of survivors of the Khmer Rouge regime which examined post traumatic reactions, parenting styles, and symptoms among the children of survivors, corroborated conclusions from the studies of transmission in Holocaust families. The results of the studies revealed high rates of PTSD among survivors of the Khmer Rouge regime who were living in Cambodia and in the United States. However, maternal exposure to trauma was not necessarily associated with transmission of symptoms to the daughters. Rather, daughters' symptoms of anxiety and depression were associated with maternal PTSD symptoms, and this association was mediated in the relationships with

symptomatic mothers by role-reversing parenting style (Field et al., 2013). Fields and colleagues concluded that parents who suffer might, implicitly and explicitly, communicate their emotional vulnerability, “instilling inordinate concern for their welfare in their children” (p. 484). Such intense concerns and the associated role-reversal mediate intergenerational transmission of trauma-related effects from survivor parents to their children.

Overall, findings show a great degree of variation with regard to the transmission of secondary traumatic stress and other effects related to parental trauma. Studies support the conclusion that specific aspects of the relationships with trauma survivor parents and particular styles of parenting and family communication (Scharf, 2007; Wiseman and Barber, 2008; Scharf and Mayseless, 2011; Giladi and Bell, 2013) might constitute elevated risk for vulnerabilities in their children, especially when parents continue to suffer from persistent post-traumatic symptoms.

### **EVIDENCE FOR IMPACT OF TRAUMA IN FAMILIES OF CURRENTLY RETURNING MILITARY SERVICEMEN**

Recently returning military servicemen are showing high rates (upwards of 26%) of post-deployment psychiatric problems (Tanielian et al., 2008). Studies also show serious detrimental effects on the families of veterans with PTSD (Nelson Goff et al., 2007; Sayers et al., 2009). Consistent with the National Vietnam Veterans Readjustment Study (Kulka et al., 1988), findings show that combat trauma leads to substantial long-term impact on family functioning in many veterans who develop post-traumatic disorders. Meta-analysis of studies show that severity of PTSD symptoms in one spouse is correlated with symptoms in the (unexposed) partner, and post-traumatic psychopathology in parents predicts adverse outcomes in children (Dekel and Goldblatt, 2008). Trauma symptoms predict lower marital satisfaction in both the veterans and their partners (Nelson Goff et al., 2007). Marital discord was reported by over half of partnered veterans, and PTSD was associated with problems in re-negotiating the veteran’s spousal and parental roles in the family (Sayers et al., 2009). These data demonstrate the disruption in the relational system of the family and its potential influence on intergenerational transmission of trauma in families of military veterans with post-traumatic reactions.

### **INTEGRATING RESEARCH FINDINGS WITH PSYCHOANALYTIC AND RELATIONAL THEORY**

Contemporary psychoanalytic theories emphasize the co-construction of reality through the early relationships of the infant and child with the parents (Stern, 1985; Tronick, 1989, 2007; Tronick et al., 1998; Lyons-Ruth, 1999; Lyons-Ruth et al., 2006). Psychological and relational patterns that emerge from the relational matrix between children and their caretakers are viewed as forms of learning and adaptation that take place in a particular intrasubjective context. Fosshage (2011) states: “Current advances in cognitive science, neuroscience, human biology advances in genome research and infant attachment and dream research are providing evidence with increasing specificity

of the exceedingly complex interplay of constitutional and environmental elements in development. We can now say that with an assortment of temperamental dispositions, evolution-derived 'biases' or 'values' (Edelman, 1987, 1989, 1992), self and interactive regulatory capacities, strength of motives, and physical and cognitive capacities, babies develop through experience within a complex array of relational systems," adding: "each baby is unique, each family system is unique, and each child's experiential world is unique" (p. 438).

As infants vary in temperaments, and as parenting practices range from more optimal to psychopathological within each parent-child dyad and within each family relational system, childhood experiences can range from optimal to traumatizing. Consequently, the emergent developmental outcomes, which can also be viewed as intergenerational transmission of psychological adaptations, might be more or less adaptive for later social contexts (Brandchaft, 2007; Lenoff, 2014).

Adult-onset trauma interferes with optimal parenting practices, compromising parental "relational competence" (Lenoff, 2014), by introducing disturbing affects and automatic, dysregulated responses that are trauma-related rather than appropriate for the here-and-now. Even the opposite of such manifestations, the conscious attempts by parents to shield their children from certain knowledge of parental traumatic experiences, can leave felt "holes" in the child's sense of their own capacity to understand the relational field and in their feeling of a shared understanding. These relational deficits which intrude into the intergenerational relationships via symptoms of PTSD and trauma-related relational themes, might lead to experiences of failed intersubjectivity in intergenerational relationships.

It has been suggested (Bar-On et al., 1998; Krell, Suedefeld, and Soriano, 2004; Wiseman and Barber, 2008; Scharf and Mayseless, 2011) that the reverberations of intergenerational transmission of trauma in families where there is no abuse or neglect might be expressed in the subjective, relational world of the children of survivors, rather than in measures of mental health and external adaptation. Studies utilizing content analyses identified specific themes of difficult relational experiences, discussed as "disorganizing experiences" (Scharf and Mayseless, 2011) and "failed intersubjectivity" (Wiseman, 2008) in the childhood recollections of children of survivors.

A seminal review by Cortina and Liotti (2010) offers an integration of the emerging current understanding regarding the differences between attachment and intersubjectivity. Examining evidence from different perspectives, including studies of other primates, studies in developmental psychology and a variety of psychoanalytic and relational models, the authors articulate the different evolutionary functions of attachment and intersubjective (mindreading/mentalizing) abilities. The functions of attachment are discrete, involving protection seeking, primarily in sexual and parental relationships, aiming to ensure intensive parental care and protection. The main function of intersubjectivity is more general, to communicate, at intuitive and automatic levels, with members of the same species in order to facilitate complex social understanding and cooperation.

The findings in children of Holocaust survivors suggest that parental exposure to extreme interpersonal trauma that was not experienced in the parents' own early attachment relationships, might not interfere as much with the attachment system and its

protective functions, but specifically with intersubjectivity, where automatic and intuitive communication of trauma-related contents takes place intergenerationally and colors the intrasubjective experience of the children of survivors.

Studies using attachment theory and instruments derived from it (Hesse and Main, 2006) provided evidence for the intergenerational transmission of effects related to unresolved (unintegrated) early trauma in parents' lives, which was associated with disorganized (disoriented) attachment style in their children. From another perspective, empirical trauma studies established a robust relationship between parental post-traumatic reactions and children's psychological distress and behavioral problems (for a meta-analysis, see Lambert et al., 2014). PTSD symptoms (in particular hyperarousal and detachment) were observed in various traumatized populations to detract from emotional intimacy in both spousal and parental functioning, and were related to poorer mental health in children (Nelson Goff et al., 2007; Sayers et al., 2009). The overarching conclusion from many different perspectives is that traumatic events in the life of the parent, the child, or both often have damaging effects on the quality of existing attachments because they introduce "unmanageable stress in the infant-parent relationship" (Lieberman, 2004, p. 336). Lieberman, consistent with Boulanger (2002, 2008), emphasizes the importance of paying attention to the impact of real and terrible events and cautions against emphasizing early attachment experiences over the contribution of the severe effects of trauma in the life of the child or the parent, at any time when such trauma occurs.

#### **DISCUSSION: WHY LESSONS LEARNED SHOULD NOT BE FORGOTTEN**

In her review of the history of professional attitudes towards adult-onset trauma, Solomon (1995) poses the question, why were lessons learned after terrible wartimes repeatedly forgotten again. In order to meet the needs of current trauma survivors, it is important to resist social and professional tendencies to deny the impact of adult-onset trauma. Such denial had tragic consequences for the availability of adequate social and professional support for Holocaust survivors and for Vietnam veterans. The vast body of empirical knowledge which has accumulated since the introduction of the diagnosis of PTSD in 1980, needs to be integrated into psychoanalytic theory. The denial of late-onset trauma, under the assumption of the "primacy of predisposition," should not be perpetuated. Yet the persistent tendency to emphasize early attachment experiences over the potentially devastating impact of adult trauma is exemplified in an exchange between Topalian (2013) and Orenstein (2013) regarding Topalian's paper "Ghosts to Ancestors." Topalian discusses intergenerational transmission of trauma in a patient whose mother, like the therapist's own mother, was a survivor of the Armenian genocide. In her response, Orenstein references Holocaust survivor parents and states: "When they [Holocaust survivor parents] failed in their parenting functions, this was more likely related to their own childhoods than to their Holocaust experiences. Parenting, as one of the most challenging of adult functions, cannot be reduced to trauma inflicted by an enemy but would have to be traced to the caretaker's experiences with their own

caretakers” (p. 25). This view resurrects the assumption of primacy of predisposition and disregards research evidence from several decades of trauma studies demonstrating the impact of “external” reality of interpersonal trauma, as well as the critical role of social support during and after the trauma, in the development of post-traumatic reactions and in recovery. As Lieberman (2004) pointed out, there is some irony when the focus on early attachment experiences leads to the privileging of internalized personality features over the reality of trauma “because Bowlby . . . revolutionized clinical thinking by calling attention to the importance of real-life events such as separation, loss, abuse, and maltreatment (i.e., exposure to interpersonal trauma) in the ontogenesis of psychopathology. At the time, this emphasis on the importance of reality contributed to Bowlby’s ostracism from then prevailing psychoanalytic ideas, which focused on subjective experience . . . ” (p. 348). At present, findings from attachment studies are corroborated and supported by progressively more specific findings from trauma studies, biological and epigenetic studies, and research in cognitive and affective neuroscience, which elucidate the interaction between internal and external reality in the construction of subjective and intrasubjective experience. The interaction between individual parameters and the external influence of traumatic events has been shown beyond doubt to determine both the destructive impact of adult-onset trauma and the conditions that support recovery. Traditional psychoanalytic models of development do not adequately address adult-onset trauma (Carr, 2011). Therefore, the evolution of effective psychodynamic treatments for adult-onset trauma requires integration of research-based evidence into psychoanalytic thinking.

Contemporary psychoanalytic conceptualizations recognize that traumatic events might influence the quality of the attachment relationship, facilitate or restrict emotional communication in the parent-child relationship, and affect the child’s confidence in the availability and responsiveness of the attachment figure (Lieberman, 2004, p. 346). Diverse current theoretical perspectives share a view of psychopathology as adaptive efforts “to endure the unendurable and to make sense of the nonsensical” (Brown et al., 2012, p. 109). Pathology is understood as deficits in affect regulation or relational skills, or as distorted cognitions, reflecting implicitly and explicitly learned behavior that was aimed at adapting to a particular relational environment (Fosshage, 2011). This view allows for change in psychotherapy since learning can change and new learning can replace older patterns.

Psychoanalysis, as a discipline, has often been slow to assimilate new ideas (Josephs, 2014). However, recent years have witnessed dramatic changes in psychoanalytic theory and practices. The integration of findings from multiple disciplines and related fields has led to the development of innovative trauma-focused treatments which incorporate elements from multiple approaches, including cognitive-affective, prolonged exposure, narrative therapy, and relational psychoanalysis.

While cognitive-behavioral interventions, especially prolonged exposure, have been observed to be the most effective in reducing symptoms of PTSD, these therapies have been shown to have high dropout rates (SAMSHA, 2014). It has also been suggested that psychodynamic therapies might address crucial aspects of complex interpersonal trauma that these therapies do not target, such as intimate relationship

problems, general life functioning, and underlying personality problems that may have developed as the result of repeated trauma.

Research findings have meaningful implications for clinical practice with survivors of adult-onset trauma. The importance of addressing more than symptoms of PTSD is highlighted by the observation that post-trauma difficulties in relationships, and in general life functioning, play a pivotal role in the maintenance of PTSD symptoms in veterans (Possemato et al., 2014). After controlling for combat traumas, post-deployment factors, including employment, alcohol use, social support, and stressful life events were shown to independently predict PTSD severity. Treatment recommendations based on these findings must include an emphasis on restoring relational and intersubjective competencies, which might be addressed by psychodynamic and psychoanalytic therapies, in conjunction with adjunctive treatment modalities. Family therapy, as well as vocational rehabilitation and addictions treatment, must be included in addition to therapies that target the core symptoms of PTSD, in order to improve combat veterans' functioning and well-being.

Recognizing the importance of addressing problems in relationships, in addition to symptom reduction, recent therapies have incorporated interventions with couples into the treatment of trauma survivors. Barrett (2014) outlines specific strategies for integrating individual and couples' therapy and educating families about their reactive feedback loops. She points out that cognitive and self-regulation skills that are learned in individual psychotherapy will be better transferred into real life if spouses of trauma survivors are engaged in the treatment, and can help practice it outside the therapy room. Monson et al. (2012) designed Cognitive-Behavioral Couples Therapy for PTSD, to simultaneously treat PTSD symptoms and enhance relationship satisfaction for patients and their partners.

Regardless of evidence-based efficacy, some treatments seem unpalatable for some patients, (Benish, Imel, and Wampold, 2008). In an attempt to apply psychodynamic therapy where cognitive therapies might not be helpful, Carr (2011) designed a short-term psychoanalytic intersubjective therapy for treatment of combat-related post-traumatic stress, based on Stolorow's (2007) understanding of trauma. Integrating theoretical, philosophical, and psychoanalytic constructs with personal experience, Stolorow describes the alterations in the sense of self after experiencing catastrophic loss and the profound alienation from "normals," those who had not experienced trauma. He emphasizes the critical lack of a "relational home" in which the reverberations of trauma can be expressed and shared, and states: "Lacking an intersubjective context within which they could be voiced, my feelings of sorrow and horror lived largely in my body, devolving into vegetative states of exhaustion and lethargy" (p. 25). Grieving requires an intersubjective context within which the trauma survivor can feel understood, can understand and express their own experience, and re-establish a sense of relatedness. Building on these principles and taking into account the realities of military life, this six-phase intersubjective treatment approach focused on empathic introspection and contextualization of affect, tailored for servicemen who can be deployed on short notice. Carr commented that Stolorow's ideas about trauma "fundamentally changed how I work with traumatized military personnel. I no longer looked for intrapsychic deficits

to understand the traumatized person's reaction to a recent trauma. Instead, I began to focus on the patient's subjective experience of the recent trauma itself" (p. 474). Similarly focusing on experience-near feelings and thoughts and on the elaboration of a coherent representation of internal states, Fonagy and Bateman (2006) developed mentalization therapy for trauma where, within the interactional attachments between therapist and patient, the process of the therapist's mentalization about the patient's mind fosters the patient's mentalization and drives therapeutic change.

Recent integrative treatments creatively incorporate psychoanalytic insights, research evidence, and clinical interventions from multidisciplinary approaches and tailor specific and effective trauma-focused therapies. The divide between psychoanalytic theories and empirical research, which delayed development of adequate treatment for adult-onset trauma, is being bridged by contemporary psychoanalytic approaches, changing the psychoanalytic understanding of adult-onset trauma. In Carr's words, "Stolorow verbalized what I had intuitively known, that an event that happens in adulthood can in and of itself shatter one's world experience" (2011, p. 474).

Research shows that providing appropriate interventions to survivors of adult-onset trauma and bolstering adequate family and social support can restore their personal, spousal, and parental functioning and help survivors of trauma regain their relational home.

Interventions that enhance relationships between trauma survivors, their spouses, and children, protect children, in turn, from intergenerational transmission of effects associated with parental post-traumatic reactions.

Contemporary psychoanalytic thinking about adult-onset trauma is no longer bound to the divisive choice between "external" empirical findings and intrasubjective meanings, but integrates diverse perspectives and even conflicting "truths" about the complexities of trauma and recovery. Findings from trauma studies, as well as psychoanalytic conceptualizations regarding adult-onset trauma, emphasize the central role of the availability of a relational, adequately responsive intersubjective matrix for the capacity to achieve intrapsychic and interpersonal reintegration following traumatic exposure. This contextual and co-constructionist view has led to a more nuanced understanding of the impact of adult-onset trauma and of recovery. Such a contextual view must now also include a much more acute attention to the forces that shape professional attitudes and conceptualizations of adult-onset trauma and requires that we confront "our own never finished business of avoiding denial while living in an age of genocide and under the aura of uncontained destructiveness" (Gerson, 2009, p. 1341–1357). The availability of appropriate treatment for current and future trauma survivors depends on learning from past failures in order to avoid the repeated tendency, reflected in past and present formulations, to deny the reality of traumatic catastrophes.

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