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Intergenerational Trauma

Ruqia Abdirahman

Winona State University, rabdirahman15@winona.edu

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Ruqia Abdirahman

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CERTIFICATE OF APPROVAL

CAPSTONE PROJECT

Intergenerational Trauma

This is to certify that the Capstone Project of
Ruqia Abdirahman
Has been approved by the faculty advisor and the CE 695 – Capstone Project
Course Instructor in partial fulfillment of the requirements for the
Master of Science Degree in
Counselor Education

Capstone Project Supervisor: _____ Mary Fawcett, Ph.D. _____

Name

_____  _____

Signature

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Abstract

The following literature review will explore cumulative research on intergenerational trauma. Although, many communities have encountered massive traumas the research has mainly focused on Canadians First Nations people and Holocaust survivors. The effects of trauma can be multifaceted, impacting an individual's psychological and emotional well-being across generations. Furthermore, this paper will discuss the impact of intergenerational trauma among various communities, ways trauma transmission occurs, and review of the Intergenerational Trauma Treatment Model.

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Introduction

Intergenerational trauma is “a phenomenon in which the descendants of a person who has experienced a terrifying event show adverse emotional and behavioral reactions to the event that are similar to those of the person” (American Psychological Association, n.d.). Emotional and behavioral reactions can differ across generations but are similar in manifestation. Commonly, the terms intergenerational trauma, historical trauma, cultural trauma, and transgenerational trauma have been used interchangeably (Mohatt et al., 2014).

Intergenerational trauma is typically made up of three variables: the pervasive existence, the tragic incidents that contribute to mutual distress, and the deliberate commitment of trauma causes. (Mohatt et al., 2014). The experience of traumatic events can result in psychological and physical distress for survivors and can be endured for extended time. Trauma can occur at a “personal level (e.g., car accident, or rape) or at a collective level (war, natural disasters, or genocide), and the responses to such events are not identical” (Bombay, Matheson, & Anisman, 2009, p.6). The focus of this literature review is to highlight the psychological effects of intergenerational trauma on various marginalized groups.

Review of Literature

Affected Groups

Holocaust. The origin of intergenerational trauma, was initially identified in 1966 by Dr. Vivian Rakoff. The Canadian psychiatrist noticed an increased need of mental health services for the offspring of Holocaust survivors regarding psychological distress (Yasinski et al., 2016). Also, they are the longest population of people to be studied pertaining to trauma across generations. Danieli et al., (2017) created an inventory questionnaire tailored to adult offspring of Holocaust survivors regarding their childhood and upbringing, family history, and impacts on

their life. In their study, they found of 191 offspring 35% presented with anxiety disorder, 14% had PTSD, and 26% had depression (Danieli, 2017). Additionally, Holocaust survivors are more likely to develop post-traumatic disorder (PTSD) and increased vulnerability to stress.

Canadas First Nations People. The ramifications of colonization, disempowerment, and assimilation for indigenous people has resulted in destruction of their communities. First Nations people experience “higher levels of adverse childhood experiences, such as abuse, neglect, and household substance abuse” (Bombay et al., 2009). Furthermore, they may witness traumatic events, deal with homelessness, unemployment, and violence. First Nations people have also faced centuries of violence and discrimination at the hands of the State. Additionally, the impacts of children being raised in households faced with violence and homelessness can be devastating to their development. Bombay et al., (2009) describes, an increase in stressors can further heighten the chances of presenting with similar psychological symptoms for the offspring. Such occurrences of transmission of trauma symptoms can be observed in First Nations people, and when combined with unfortunate circumstances, symptoms can be exacerbated reports (Bombay et al., 2009).

African Americans. Similarly, the effects of centuries of slavery and racial inequality has led; to symptoms of trauma among African Americans (Williams et al., 2018). Additionally, Williams et al., (2018) states African Americans “have higher rates of PTSD and experience more racial discrimination than other groups”. African Americans have not only suffered the brutality and degradation of slavery, but suffered continuous systematic oppression in the form of Jim Crow, redlining, mass incarcerations and economic inequality. The United States government subjected African Americans to decades of marginalization and infringed on their rights to life, liberty, and the pursuit of happiness. Today, in the United States, African

Americans are disproportionately imprisoned and are constant victims of police brutality based on statistics reported by the National Association for the Advancement of Colored People (NAACP, n.d.). Although African Americans make up “13.4% of the population, they make up 22% of fatal police shootings” (NAACP).

African American children convey a behavioral reaction that suggests they may have been subjected to the initial trauma passed over generations when faced with racially-charged brutality, microaggressions, or blatant, overt racism (Yehuda et al., 2016). This experience may be embedded in the family unit or uncovered in culture by the presented injustice and inequality. All family members do not need to endure the traumatic incident individually; the residual consequences will also linger and affect descendants of these external causes. African American children may internalize the responses of others to their skin color and can manifest as a type of trauma initially endured by their ancestors (Yehuda et al., 2016). The reaction to skin color derives from similar behaviors that have contributed to African Americans being traumatized and enslaved. As they have not yet gained the knowledge to have a complete understanding of racism and its consequences, African American children and young adults are more vulnerable to racial trauma (Cohen & Mannarino, 2017). For instance, in an educational setting, traces of trauma influence the progress of black and other immigrant students. In African American children, trauma symptoms are sometimes identified as intellectual disorders, which causes the trauma to go unnoticed (Yasinski et al., 2016). Also, African American children are seen as more aggressive or exhibiting increased disruptive behaviors.

The barriers of stigma, negative conceptions, and fear of injustice can limit African Americans who suffer from any form of mental health disorders to request assistance (Yehuda et al., 2016). Lack of medication allows the symptoms to exacerbate and manifest, leading to

further internalization of the individual's anxiety and mental health loss. Sometimes, people afflicted by race-based trauma do not pursue care because of racism in the health care system. Accumulation of trauma and hopelessness among African Americans are correlated with negative health outcomes such as high blood pressure, suicidal thoughts and behaviors (Conner, 2014). Still, medical providers would not understand a disenfranchised minority viewpoint (Baker et al., 2019). In comparison, the current mental health stigma has led to a lack of study and, ultimately, care. However, the misdiagnosis of symptoms can also be due to a lack of care. While the signs of trauma are frequently present in other mental health disorders, the greater diagnosis is often untreated.

Refugees. Refugees are another group that experience intergenerational trauma.

Although refugees can encounter multiple forms of trauma, war-related trauma has been reported to have longer-lasting mental health effects and to last more generations (Isobel et al., 2019). As their childhood has been interrupted by relocation to a foreign world, children are incredibly vulnerable to resettlement trauma. They will frequently face the challenge of learning a foreign language, transitioning to a new environment, and navigating their host country's social structure. Besides, most host countries do not provide refugees with sufficient mental health services that in turn, can exacerbate symptoms and contribute to trauma transmission (Kiser et al., 2020). According to Hameed et al (2018), refugee children are at greater risk for depression, PTSD, anxiety, concentration loss, fatigue, and other psychiatric disorders in general.

Somali Immigrants

Over the past three decades, Somalia has been ravaged by civil war resulting in refugees fleeing from the war-torn State. Hassan (2018) indicates the key reasons for instability in Somalia include the absence of an organized government, long-standing tribal conflicts, famine,

ethnic violence, and mass displacement. Like many refugees, Somalis enter resettlement countries with increased vulnerability levels to trauma and mental health concerns (Hameed, 2018). The exposure to war, having to resettle and acculturate to new environments can be traumatic. According to Warfa (2012), this movement can pose high risks in terms of these migrants' acceptance by the destination country and the laws governing it, even when the host country acknowledges the refugee's claim for asylum. In the cases where governing laws of the target country provide legal immunity of residence, they fail to ensure prime circumstances of resettlement. Warfa (2012) states that in some instances if they prevail, the exhaustive legal processes and employment difficulties, life can become impractical for the refugees, and prove to be a threat to their health and well-being. Hynie (2018) discussed the fact these post-resettlement risks can potentially lead to numerous psychological health issues, in particular to groups of people exposed to widespread trauma and displacement. Furthermore, she mentions stress related to trauma and the immigration process can indicate increased risk for mental illness (Hynie, 2018)

Somali adults and children have suffered adverse effects from the catastrophic impact of migration and post war trauma. The trauma can create challenges and negatively affect their parenting skills and the parent-child relationship. Study exploring the relationship among Somali refugees and their offspring who were born in refugee camps often presented with symptoms of PTSD and depression (Louis, 2016). Furthermore, East, Gahagan, & Al-Delalmy (2018) found Somali refugee mothers to be at greater risk for trauma symptoms and depression, ultimately psychologically affecting their offspring. They also identify refugee mothers as withdrawn and disconnected.

Trauma Transmission

There are differing studies suggesting different possible means of trauma transmission from parent to offspring. The studies aim to describe how the offspring, which itself has not ever been exposed to any sort of trauma, may still be exposed to emotional distress. In these cases, an indirect transfer of the trauma in question can have occurred through a means in which a child inherits the parental trauma naturally (Kellermann, 2001). In addition, he echoes other researchers in mentioning the offspring of Holocaust survivors display specific disturbances with stress and increased risk for PTSD when compared to counterparts with similar emotional problems. Furthermore, transmitted trauma found in the offspring can be a result of the parent-child relationship (Kellermann, 2001). For instance, a tortured war survivor might inflict harm onto their offspring, and as a result, the child develops emotional distress causing the offspring to be the primary subject of the trauma (Kellermann, 2001). Healthy maternal stress levels were explicitly associated with the family system and implicitly associated with offspring's conduct. The trauma experienced among children varied where some had direct experience from their parents' experiences, whereas some had indirect transmission, accompanied by a sense of guilt (Sangalang & Vang, 2017). Moreover, the children who had direct transmission exhibited the effects of trauma by their behavior, whereas those who had indirect transmission dealt with depression, remorse, and anxiety. Also, the of treatment often can worsen symptoms, which may contribute to transmission.

Epigenetics. Yehuda & Lehrner (2018) alluded previous studies presumed trauma was transmitted only through the parents' child-rearing actions; however, it can also be transmitted epigenetically. Trauma transmission can be categorized as epigenetic, where inherited genes pass on certain adverse attributes of parents (Krippner & Barrett, 2019). It can also transmit various types of acquired emotional problems, specifically if these had resulted from significantly

devastating experiences or ones with fatal risks, torture or persecution. Epigenetics explores how environmental influences impact gene expression and cellular function (Krippner & Barrett, 2019). The Dutch Hunger Winter Famine is a thoroughly studied example of epigenetics changing genes within generations. Relevant genes were silenced by those actively witnessing the famine and transmitted others that enabled survival. Their descendants have had the same genes silenced and displayed as the survivor's offspring. Via epigenetics, one-way trauma may also be transmitted (Yehuda & Lehrner, 2018). When an infant is raised in the same setting as its parents, each generation will cause gene's reformation; this is the most indirect epigenetic imprinting method. It is also possible to transfer the epigenome via the gametes. The epigenome must be present in the germline for this to occur. During germ cell division and after fertilization, the epigenome is often thoroughly reprogrammed to produce totipotent cells, erasing several modifications that occur during an individual's lifetime (Cohen & Mannarino, 2017). Therefore, transposable sequences or regulatory elements immune to reprogramming are the strongest candidates for heritable epigenetic labels. Since the environment may influence epigenetic processes, the degree to which the environment and direct inheritance impacts the offspring's epigenome is difficult to determine.

Another pathway of intergenerational trauma epigenetic inheritance is deoxyribonucleic acid (DNA) methylation. The type of methylated DNA linked to gene repression in mammals is 5-methylcytosine (5mC), and N6-methyladenosine is related to gene activity. Various observational experiments have shown that in the offspring of patients, primarily at the glucocorticoid receptor (NR3C1) gene, trauma changes methylation patterns (Krippner & Barrett, 2019). It has to be stable enough to undergo mitosis and meiosis for DNA methylation to be hereditary, and it must avoid the epigenetic reprogramming described above. Methylated

regions consistencies across several generations have been challenging to locate, as there have been many inconsistencies throughout studies (Roy, 2019). Such differences may be due to the form of methylation analysis used or discrepancies between people in the epigenome. The latest research shows that histone variants can be inherited over centuries as well. Histones variants appear to be retained in sperm at housekeeping sites, and developmentally regulated genes and are preserved in oocytes everywhere (Yehuda & Lehrner, 2018).

During pregnancy. Trauma can be biologically transferred through generations via the uterine environment. The gestational period in an organism's lifespan is a developmentally vulnerable stage (Krippner & Barrett, 2019). Exposure at this stage to adverse stimuli may have long-lasting negative consequences. The uterine environment is a significant source of stimuli, with its unique mix of the mother's cellular secretions and proteins. Empirical studies have shown stress encountered during birth by a mother can influence the offspring's physiology and psychology (Roy, 2019). Transport vesicles that transfer amino acids and microRNA from the uterine fluid to the fetus are potential transmission forms. Cell molecules will then change the expression of genes that impact the fetus' developmental trajectory (Krippner & Barrett, 2019). The hypothalamic-pituitary-adrenal (HPA) axis, which is the nucleus of the body's stress response mechanism, has become the subject of most biological studies on transgenerational trauma. One way the HPA axis responds to stress, is by activating glucocorticoid development, mainly cortisol. Cortisol induces clinical signs of "fight-or-flight," such as higher blood pressure and heart rate. In animal models, the expression of the placental enzyme 11 β -hydroxysteroid dehydrogenase type 2 (11 β -HSD2), which transforms the mother's cortisol into inactive cortisone, has been shown to alleviate maternal stress and trauma throughout the birth (Yehuda & Lehrner, 2018). This leads to increased fetal sensitivity, which affects the growth of

glucocorticoid-sensitive structures such as the HPA axis to the mother's glucocorticoids. In some studies, abnormal cortisol levels were observed in infants of mothers who experienced trauma while pregnant, particularly in the NR3C1 glucocorticoid receptor gene instead of controls and alterations in DNA methylation.

Intergenerational Trauma Treatment Model

Intergenerational Trauma Treatment Model (ITTM) is a method utilized in treating complex trauma in childhood (Isobel et al., 2019). Integration of cognitive-behavioral techniques, trauma and attachment theory aid in increasing positive functioning for the parent and offspring. The ITTM consists of 21 manual sessions and is meant for parents of children ages between 3 and 18 years old (Scott & Copping).

The ITTM is provided on three different levels. Level A, is a six-week course titled The Sessions on Trauma Details. Level B, involves approximately eight individual parent sessions aimed at resolving the effects of significant childhood memory of the parents and strengthening the parent's capacity to react to and contain their baby's trauma. Subsequently, the parent and the clinician are involved in level C to provide the child with trauma based sessions (Isobel et al., 2019).

Level A: Trauma Information Sessions. Level A is six classes offered to 50 parents via 90-minute sessions. The sessions are psychoeducational based regarding anxiety, attachment, and cognitive behavioral therapy concepts. Relevant subjects of the presentation include trauma information; discrepancies in the perception of trauma for children and adults; the role of parents in the reaction to their children; emotions, feelings, and acts correlated with periods of self-defeating activities and emotion regulation (Kiser et al., 2020). This level is intended to fulfill four areas: (1) to improve parent's empathy for the experience of their child, (2) assist parents to

be better able to emotionally connect and provide support for their child, (3) to strengthen self-regulation of parents and disengage them from their child's conflict, and (4) to develop optimism, self-efficacy, and encouragement for improvement for parents (Kiser et al., 2020). This level also focuses on the safe space provided by the parents for the child and how the parents manages the emotions. Dysregulation of the parents over their child's abuse is an essential deterrent in kids seeking trauma therapy (Roy, 2019). With this in mind, level A sessions have been deliberately structured to improve parent's self-regulation. In a broad group setting, workshops are offered where the willingness of parents to understand is stressed. The emotional instability in parents is restricted by minimizing personal narratives, co-regulation of parent's consequences by the clinician, and using illustrations in a concrete and containable manner to capture abstract ideas. The homework assigned for outside of session is also a significant aspect of this level. The homework is increased gradually for parents starting with reading, then brief lessons, then mapping aspects of their interaction with their child and eventually all previous elements of homework plus self-exploration and tracking (Otani, 2020). In the information sessions, they help parents integrate information provided to continue the transition process. They have placed parents in a position to devote considerable time to fostering progress in themselves and their communities. Finally, homework activities serve as a screener for parents who cannot adequately devote appropriate intervention capital. Improving the ability to attend and complete level A, the parents are either independently instructed or directed to another class (Roy, 2019).

Level B: Caregiver Treatment Sessions. Level B consists of eight individual sessions with parents. Sessions continue with an evaluation of the parent's comprehension of the previous stages content and potential challenges to parent's willingness to actively participate in interventions, such as substance use counseling, debilitating mental health symptoms or the

prospect of child and parent's separation (Otani, 2020). If so, therapy will be paused and specific alternative approaches will be sought. After review, parents are asked to recognize their most impactful childhood memory. In the past, present, and clear expectations set for the future, the parents complete comprehensive diagrams of these emotions, perceptions, and behavior. From these maps, the motif of trauma such as isolation, abandonment, and victimization that effectively captures the salient characteristics of the parent's unique perception and perspective is illustrated (Kiser et al., 2020). The trauma theme then forms the central material for therapy, where the parents primary value structure is established, deconstructed, and restored. When parents have completed knowledge of their trauma theme, intergenerational trauma transfer dynamics are discussed, and parents may become interested with how their trauma could affect their child's life (Roy, 2019). At the end of level B, the parent's full diagrams reflect their theory about understanding trauma with their children and how their trauma theme could have affected their children's perception and reaction. Other tasks of this level include, introduction of quality time between parents and child. Also, if necessary, emotional regulation skills are taught and dynamics of grief is explored with parents.

The advantages of level B for parents and the children include improved awareness, emotional control, and consideration of impacts of trauma (Otani, 2020). If progress has not been achieved by parents, the clinician will provide further sessions until the parent reaches sustained satisfaction in obtaining desired results. Level B therapy is discontinued when the clinician recognizes and identifies changes in parent's emotional response and emotional attunement with the child (Buonagurio, 2020).

Level C: Child-Therapist Sessions Co-Directed by Therapists and Caregivers. In level C, the child and parents are present and it involves three to eight sessions. The sessions

begin with a 10-minute meeting to address homework, exchange thoughts, and prepare for the session between the therapist and the child (Otani, 2019). Also in these sessions, the parents watch the interaction between the therapist and their child. For 30-40 minutes' therapist and child are working to target trauma and attachment related goals. For the remainder of the session, the parent and therapist meet again without the child being present. During this time, the parent is sharing their thoughts and reactions about the session and is provided homework for the upcoming week (Roy, 2019). Much like the parents obtained assistance from the clinician to make meaningful improvements in his/her life experience, the parents task is to assume the child's part in therapy as an emotionally attuned, compassionate, capable co-leader.

Therapists and children complete six different accounts during level C that cover the interaction between children and their primary parent. The child is able to review a traumatic incident by using either a sand tray with miniature models or sketches and diagrams, the child's ability to create storylines is encouraged (Kiser et al., 2020). Usually, there is previous adverse events that were perpetrated by the parent such as, physical abuse, profound neglect, and abandonment can affect the development of the parent-child connection (Kiser et al., 2020). The therapist helps the child in restructuring their belief system and values that may have emerged from their perception of stressful incidents (Buonagurio, 2020). Children and parents identify the development stage during which the trauma occurred and construct how the parent could have been aware and supportive to the child (Buonagurio, 2020). The child and parent become involved in therapy exercises to reconstruct meaningful bonding moments. For instance, an intervention will start with imaginative narratives of sensitive, accessible, loving, and welcoming parent for a child with a classically disorganized connection to their primary caregiver. The child would then be interested in using the sand tray or diagrams to carry out these generated stories

and finally role-play with their caregiver. These approaches offer the child and caregiver an incentive to "re-write" the child's life script, at least through the experience of the child's actual life background (Otani, 2019). In turn, it helps the child achieve consistency, self-organization and builds a framework for better interactions between the parent and child.

Conclusion

The reality is, many marginalized groups have endured and continue to endure decades of traumatic experiences putting them at greater risk for mental health symptoms. Over the years, scholars and clinicians have become conscious of the impact of generational trauma across subsequent generations (Barlow, 2018). For clinicians, it would be imperative to consider the implications of intergenerational trauma and the long-term effects to provide culturally competent treatment. Although this literature review primarily focused on marginalized groups, it is important to note intergenerational trauma can be a result of casual factors such as sexual assault, domestic abuse, natural disasters, and poverty (Sangalang & Vang, 2017).

References:

- American Psychological Association. (n.d.). Intergenerational Trauma. In *APA dictionary of psychology*. Retrieved November 1, 2020, from <https://dictionary.apa.org/intergenerational-trauma>
- Barker, B., Sedgemore, K., Tourangeau, M., Lagimodiere, L., Milloy, J., Dong, H., ... & DeBeck, K. (2019). Intergenerational trauma: The relationship between residential schools and the child welfare system among young people who use drugs in Vancouver, Canada. *Journal of Adolescent Health, 65*(2), 248-254.
- Barlow, J. N. (2018). Restoring optimal black mental health and reversing intergenerational trauma in an era of Black Lives Matter. *Biography, 41*(4), 895-908.
- Bokore, N. (2018). Suffering in silence: A Canadian-Somali case study. *Journal of Social Work Practice, 27*(1), 95-113.
- Bombay, A., Matheson, K. & Anisman, H. (2009). Intergenerational trauma: Convergence of multiple processes among First Nations Peoples in Canada. *Journal of Aboriginal Health, November, 6*.
- Bryant-Davis, T., Adams, T., Alejandre, A., & Gray, A. A. (2017). The trauma lens of police violence against racial and ethnic minorities. *Journal of Social Issues, 73*(4), 852-871.
- Buonagurio, N. (2020). The Cycle Continues The Effects of Intergenerational Trauma on the Sense of Self and the Healing Opportunities of Dance/Movement Therapy: A Literature Review.
- Cohen, J. A., & Mannarino, A. P. (2017). Evidence-based intervention: Trauma-focused cognitive behavioral therapy for children and families. In *Parenting and family processes in child maltreatment and intervention* (pp. 91-105). Springer, Cham.

- Conner, Warren R. Effects of cumulative trauma load on perceptions of health, blood pressure, and resting heart rate in urban African American youth. *J Spec Pediatr Nurs.* 2014 Apr;19(2):127-38. doi: 10.1111/jspn.12063. Epub 2014 Feb 6. PMID: 24502662.
- Danieli, Y., Norris, F. H., & Engdahl, B. (2017). A question of who, not if: Psychological disorders in Holocaust survivors' children. *Psychological Trauma: Theory, Research, Practice, and Policy*, 9(Suppl 1), 98–106. <https://doi-org.wsuproxy.mnpals.net/10.1037/tra0000192>
- Danieli Y, Norris FH, Lindert J, Paisner V, Engdahl B, Richter J. The Danieli Inventory of Multigenerational Legacies of Trauma, Part I: Survivors' posttrauma adaptational styles in their children's eyes. *Journal of Psychiatric Research.* 2015;68:167-175. doi:10.1016/j.jpsychires.2015.06.011
- East, P.L., Gahagan, S. & Al-Delaimy, W.K. The Impact of Refugee Mothers' Trauma, Posttraumatic Stress, and Depression on Their Children's Adjustment. *J Immigrant Minority Health* 20, 271–282 (2018). <https://doi.org/10.1007/s10903-017-0624-2>
- Friend, J. (2017). Mitigating Intergenerational Trauma Within the Parent-Child Attachment. *Australian and New Zealand Journal of Family Therapy*, 33(2), 114-127.
- Hameed S, Sadiq A, Din AU. The Increased Vulnerability of Refugee Population to Mental Health Disorders. *Kans J Med.* 2018;11(1):1-12. Published 2018 Feb 28.
- Hynie M. (2018). The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, 63(5), 297–303. <https://doi.org/10.1177/0706743717746666>

- Isobel, S., Goodyear, M., Furness, T., & Foster, K. (2019). Preventing intergenerational trauma transmission: A critical interpretive synthesis. *Journal of Clinical Nursing, 28*(7-8), 1100-1113.
- Kellermann, N. P. F. (2013). Epigenetic transmission of holocaust trauma: Can nightmares be inherited? *Israel Journal of Psychiatry and Related Sciences, 50*(1), 33–39.
- Kiser, L. J., Miller, A. B., Mooney, M. A., Vivrette, R., & Davis, S. R. (2020). Integrating parents with trauma histories into child trauma treatment: Establishing core components. *Practice Innovations, 5*(1), 65.
- Krippner, S., & Barrett, D. (2019). Transgenerational Trauma: The Role of Epigenetics. *Journal of Mind & Behavior, 40*(1).
- Lewis, M. A. (2016). *Parental input: Exploring intergenerational transmission of trauma in first-generation Somali young men* (Doctoral dissertation, Alliant International University).
- Mohatt, N. V., Thompson, A. B., Thai, N. D., & Tebes, J. K. (2014). Historical trauma as public narrative: a conceptual review of how history impacts present-day health. *Social science & medicine (1982), 106*, 128–136. <https://doi.org/10.1016/j.socscimed.2014.01.043>
- National Association for the Advancement of Colored People. (n.d.). Our mission. Retrieved November 10, 2020, Retrieved from <https://www.naacp.org/criminal-justice-fact-sheet/>
- Otani, A. (2020). The Mindfulness-Based Phase-Oriented Trauma Therapy (MB-POTT): a hypnosis-informed mindfulness approach to trauma. *American journal of clinical hypnosis, 63*(2), 95-111.
- Roy, A. (2019). Intergenerational Trauma and Aboriginal Women: Implications for Mental Health During Pregnancy. *First Peoples Child & Family Review, 14*(1), 211-224.

Sangalang, C. C., & Vang, C. (2017). Intergenerational trauma in refugee families: a systematic review. *Journal of immigrant and minority health, 19*(3), 745-754.

5th regional survey on refugee return perceptions and intentions in March 2019. UNHCR Operational Data Portal (ODP). (2020). Retrieved 24 November 2020, from <https://data2.unhcr.org/en/documents/details/68443>.

Scott, K. L., & Copping, V. E. (2008). Promising directions for the treatment of complex childhood trauma: The Intergenerational Trauma Treatment Model. *The Journal of Behavior Analysis of Offender and Victim Treatment and Prevention, 1*(3), 273-283. <http://dx.doi.org/10.1037/h0100449>

Warfa, N., Curtis, S., Watters, C., Carswell, K., Ingleby, D., & Bhui, K. (2012). Migration experiences, employment status and psychological distress among Somali immigrants: a mixed-method international study. *BMC Public Health 12* (749).

Williams, M. T., Printz, D. M. B., & DeLapp, R. C. T. (2018). Assessing racial trauma with the Trauma Symptoms of Discrimination Scale. *Psychology of Violence, 8*(6), 735–747. <https://doi-org.wsuproxy.mnpals.net/10.1037/vio0000212>

Yasinski, C., Hayes, A. M., Reddy, C. B., Cummings, J. A., Berman, I. S., McCauley, T., ... & Deblinger, E. (2016). In-session caregiver behavior predicts symptom change in youth receiving trauma-focused cognitive behavioral therapy (TF-CBT). *Journal of Consulting and Clinical Psychology, 84*(12), 1066.

Yehuda, R., Daskalakis, N. P., Bierer, L. M., Bader, H. N., Klengel, T., Holsboer, F., & Binder, E. B. (2016). Holocaust exposure induced intergenerational effects on FKBP5 methylation. *Biological psychiatry, 80*(5), 372-380.

Yehuda, R., & Lehrner, A. (2018). Intergenerational transmission of trauma effects: putative role of epigenetic mechanisms. *World Psychiatry, 17*(3), 243-257.