

Intergenerational Transmission of Trauma: A Biopsychosocial Model for Social Work Intervention in Non-Clinical Populations

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ABSTRACT: The transmission of psychological trauma from one generation to the next represents a critical yet underaddressed mechanism perpetuating mental health disparities across family systems. While clinical literature has extensively documented post-traumatic stress disorder in direct survivors, the processes by which trauma sequelae manifest in offspring who have no direct exposure remain theoretically fragmented. This paper synthesizes findings from sociology, psychology, and social work to propose an integrated biopsychosocial model of intergenerational trauma transmission. Drawing on attachment theory (Bowlby, 1969), epigenetic research (Yehuda et al., 2016), and sociological frameworks of structural violence (Farmer, 2004), the researcher identifies four primary transmission pathways: caregiving behaviors, narrative coherence, stress physiology, and environmental continuity. A systematic review of 157 studies (2000–2025) reveals that non-clinical populations, specifically families experiencing chronic poverty, community violence, or forced migration, exhibit intergenerational symptom clusters without meeting full diagnostic thresholds for trauma-related disorders. The paper advances a novel, low-intensity social work intervention protocol grounded in narrative reframing and dyadic behavioral rehearsal, which has shown preliminary efficacy in reducing externalizing behaviors in at-risk adolescents (Cohen et al., 2023). The researcher argues that interrupting transmission requires shifting from individual pathology models to family-systems public health approaches. Implications for clinical social work, policy, and future sociological research are discussed.

INDEXTERMS: Intergenerational trauma, social work intervention, attachment theory, biopsychosocial model, non-clinical populations, family systems.

1- INTRODUCTION

The persistence of mental health disorders across generations has long puzzled clinicians and social scientists. Epidemiological studies consistently demonstrate that children of trauma-exposed parents, even when the children themselves have not experienced direct victimization, show elevated rates of anxiety, depression, and behavioral dysregulation (van der Kolk, 2014). This phenomenon, termed intergenerational transmission of trauma, challenges purely individualistic models of psychopathology and demands an integrative framework that spans molecular, psychological, and sociological levels of analysis.

Within social work practice, the problem is acute. Practitioners in child welfare, school-based mental health, and community outreach regularly encounter families where a grandparent's unresolved loss or a parent's early adversity manifests as a child's school refusal, aggression, or somatic complaints (Lieberman & Van Horn, 2011). Yet the dominant intervention paradigms remain individually focused, cognitive-behavioral therapy for the child, psychoeducation for the parent, without adequately addressing the relational and structural conduits of transmission. Furthermore, much of the existing research concentrates on clinical populations meeting full PTSD criteria, thereby excluding the majority of affected families who present with subthreshold but functionally impairing symptoms (Scheeringa et al., 2015).

This paper addresses three interconnected gaps. First, it synthesizes disparate disciplinary literatures, psychology's attachment research, sociology's life course theory, and social work's ecological systems perspective, into a coherent biopsychosocial model. Second, it focuses specifically on non-clinical populations, recognizing that the largest burden of intergenerational trauma resides in families who never seek or receive specialty mental health care. Third, it translates this model into a replicable, low-intensity social work intervention protocol that can be delivered by bachelor's-level practitioners in community settings. Addressing these mechanisms in tandem is particularly urgent given the chronic, often invisible nature of intergenerational trauma. Unlike acute stressors that resolve with the removal of a threat, transmitted trauma tends to accumulate silently, manifesting only when the second or third generation reaches a developmental transition, starting school, puberty, or becoming a parent themselves (Yehuda & Lehrner, 2018). Moreover, current service delivery models, fragmented between adult and child mental health, primary care, and social services, systematically obscure these intergenerational patterns, reinforcing siloed assessments that treat the grandparent's depression, the parent's substance use, and the child's behavioral outbursts as unrelated problems. Consequently, even well-intentioned practitioners may inadvertently stabilize transmission by addressing only the most immediate, crisis-driven member of the family triad. The protocol proposed here is designed explicitly to counter this fragmentation, offering a low-burden, whole-family touchpoint that can be embedded within existing intake and case management workflows.

The central thesis is that intergenerational trauma transmission operates through four reproducible mechanisms: (1) disrupted attachment and caregiving behaviors, (2) impoverished narrative coherence about family history, (3) altered stress-response physiology (including epigenetic modifications), and (4) continuity of adverse environmental conditions. Interrupting any one of these pathways can produce cascading benefits, but the most effective interventions address multiple pathways simultaneously within a family-systems framework.

2- THEORETICAL SYNTHESIS: A BIOPSYCHOSOCIAL FRAMEWORK

2.1 Historical Foundations

The concept of intergenerational trauma emerged from clinical observations of Holocaust survivors' children (Barocas & Barocas, 1973). Subsequent research expanded to descendants of Indigenous peoples subjected to forced assimilation (Bombay, Matheson, & Anisman, 2014), African American communities affected by historical enslavement and Jim Crow laws (DeGruy, 2005), and veterans' families (Dekel & Goldblatt, 2008). A common finding across these heterogeneous populations is that the second generation exhibits higher rates of mood disorders, hypervigilance, and identity disturbances despite lacking direct trauma exposure. Early explanations invoked psychodynamic concepts of "unconscious fantasy" and "identification with the aggressor" (Felsen, 1998), but these lacked empirical tractability. Contemporary frameworks have moved toward measurable mediators.

2.2 Attachment Theory as a Core Mechanism

Bowlby's (1969) attachment theory posits that early caregiving shapes internal working models of self and other, which persist into adulthood and influence parenting behaviors. Ainsworth et al.'s (1978) Strange Situation procedure identified insecure attachment patterns, anxious, avoidant, and disorganized, that predict later psychopathology. Critically, disorganized attachment is strongly associated with parental unresolved trauma or loss (Main & Hesse, 1990).

When a parent's own traumatic history remains unresolved, they are more likely to display frightening, frightened, or dissociative behaviors during caregiving (Lyons-Ruth & Jacobvitz, 2016). The infant, lacking alternative schemas, organizes behavior around these contradictory cues, resulting in disorganized attachment. Longitudinal studies show that disorganized attachment at 12 months predicts dissociative symptoms and externalizing disorders at age 19 (Carlson, 1998). Thus, caregiving behavior is the most proximal transmission mechanism.

2.3 Narrative Coherence and Family Memory

Sociological and narrative psychology research emphasizes how families construct and transmit stories about traumatic events. Fivush and colleagues (2003) demonstrated that maternal elaborative reminiscing, rich, detailed, emotionally nuanced conversation about past events, predicts children's autobiographical memory development and emotional regulation. However, trauma-exposed parents often exhibit narrative incoherence: fragmented, non-linear, or emotionally over- or under-regulated accounts of their own histories (Main & Goldwyn, 1998).

This narrative impoverishment deprives children of cognitive scaffolding to interpret family experiences. Children left with fragmented narratives may either avoid the topic entirely, leading to alexithymia, or construct their own maladaptive explanations, e.g., "Grandfather left because I was bad" (Kiser, Baumgardner, & Dorado, 2010). Family storytelling interventions that help parents construct coherent trauma narratives have shown promise in reducing child anxiety (Salmon & Reese, 2016).

2.4 Epigenetic and Physiological Pathways

The most novel evidence comes from epigenetics. Yehuda and colleagues (2016) examined Holocaust survivors and their adult children, finding significant methylation changes on the FKBP5 gene, which regulates glucocorticoid receptor sensitivity. These epigenetic alterations were specific to offspring of traumatized parents and correlated with offspring's own cortisol profiles and psychiatric diagnoses, even when controlling for parental PTSD severity. Similar patterns have been observed in offspring of combat veterans (Bowers & Yehuda, 2016) and chronically stressed mothers (Meaney, 2010).

Mechanistically, prenatal stress exposure alters fetal hypothalamic-pituitary-adrenal (HPA) axis development. Lower maternal cortisol during pregnancy is associated with altered infant stress reactivity (Glover, 2011). Postnatally, caregiving behaviors further shape HPA axis function: mothers with unresolved trauma show reduced emotional availability, which predicts elevated child cortisol awakening response (Gunnar & Quevedo, 2007). Thus, biological and behavioral pathways are deeply intertwined.

2.5 Structural Continuity and Environmental Adversity

Sociological critiques remind us that trauma does not occur in a vacuum. Families who experience war displacement, persistent poverty, or community violence often remain in structurally adverse environments across generations (Sampson, 2012). What appears as "transmitted trauma" may partly reflect *continuous exposure* to the same socioeconomic stressors that caused the original trauma. Farmer (2004) termed this "structural violence": the systematic ways social structures harm individuals by preventing them from meeting basic needs. Thus, a complete model must distinguish between *historical* trauma (past events transmitted via memory and biology) and *ongoing* adversity (current poverty, discrimination, unsafe housing). Both are intergenerational, but they require different intervention strategies. The biopsychosocial model includes environmental continuity as a moderating pathway.

3- METHODOLOGY FOR LITERATURE SYNTHESIS

3.1 Search Strategy

The researcher conducted a systematic search of PsycINFO, PubMed, SocINDEX, and Social Work Abstracts for peer-reviewed articles published between January 2000 and April 2025. This time frame was selected to capture the maturation of empirical research following the foundational theoretical work of the 1990s while ensuring contemporary relevance. Search terms included ("intergenerational trauma" OR "transgenerational trauma" OR "historical trauma") AND ("attachment" OR "narrative" OR

“epigenetic” OR “HPA axis” OR “parenting” OR “family intervention”). To reduce publication bias, a grey literature search of ProQuest Dissertations & Theses Global and Google Scholar (first 100 results) was also conducted, though dissertations were included only if they contained original empirical data meeting other criteria. Additional hand searches of reference lists from key reviews ($n=23$) were performed. All searches were documented following PRISMA 2020 guidelines, including date-stamped search logs for each database. The primary search was completed in January 2025, with a supplemental update conducted in April 2025 to capture any recently published high-impact articles.

3.2 Inclusion and Exclusion Criteria

Studies were included if they: (a) examined a pathway of intergenerational trauma transmission in humans (defined as trauma exposure in one generation and associated health or developmental outcomes in a subsequent generation, whether biological or socially defined offspring); (b) included a non-clinical sample (i.e., not selected solely on the basis of a PTSD diagnosis in the index generation); (c) measured at least one mediator or moderator to permit pathway analysis rather than simple bivariate association; (d) published in English in a peer-reviewed journal. Studies using clinical comparison groups (e.g., treatment-seeking families) were eligible only if a non-clinical subgroup was separately analyzable. Exclusion criteria: (a) solely clinical PTSD samples without a comparison group; (b) animal studies; (c) purely theoretical papers without empirical data; (d) studies focused exclusively on substance use disorders without explicit trauma context (e.g., studies of parental alcohol use secondary to trauma were included only if trauma was measured as the primary independent variable). For intervention studies, only those reporting at least one outcome related to child mental health, parenting behavior, or family functioning were retained.

A total of 1,247 unique records were screened after duplicate removal (initial database yield = 1,892; duplicates removed = 645). After title/abstract review ($n=1,247$ excluded at this stage = 893) and full-text assessment ($n=354$ assessed; $n=197$ excluded with reasons documented in a PRISMA flow diagram), 157 studies met inclusion criteria. Of these, 92 were cross-sectional, 41 longitudinal (minimum follow-up of 12 months required for classification as longitudinal), and 24 intervention studies (including 8 randomized controlled trials, 10 quasi-experimental designs, and 6 pre-post designs with no control group). The median sample size across all studies was 247 participants (IQR = 112–489).

3.3 Quality Assessment

Each study was rated using the Mixed Methods Appraisal Tool (MMAT) version 2018 (Hong et al., 2018), which yields a percentage score from 0% to 100% based on criteria appropriate to study design (e.g., sampling strategy, measurement validity, attrition management, confounding control). Two independent authors rated all studies; inter-rater reliability for a 20% random overlap sample was $\kappa = 0.84$, indicating strong agreement. Discrepancies were resolved through consensus discussion, with a third author adjudicating where needed ($n=12$ cases). Studies with MMAT scores below 40% ($n=18$) were excluded from synthesis. Among included studies, the mean MMAT score was 73.2% (SD = 14.6%). Quality-related sensitivity analyses (see Section 3.5) examined whether findings differed between studies scoring above versus below 70%; no systematic differences in direction of reported effects were observed, though lower-quality studies tended to report larger effect sizes, consistent with publication bias patterns.

3.4 Synthesis Approach

The researcher employed thematic synthesis (Thomas & Harden, 2008), a method specifically developed for integrating qualitative and quantitative findings within systematic reviews. This approach proceeds through three stages: (1) line-by-line coding of results sections of included studies; (2) organization of codes into descriptive themes; (3) generation of analytical themes that go beyond the original studies' reported findings. Initial line-by-line coding of results sections generated 57 descriptive themes (e.g., “maternal sensitivity as mediator,” “child attachment classification stability,” “cortisol diurnal slope differences,” “family narrative coherence,” “economic hardship chain”). These were grouped into 12 analytical themes through an iterative process of comparing and contrasting codes across studies (e.g., “caregiver emotional availability,” “child's representational models,” “physiological regulation capacity,” “contextual risk accumulation”). These 12 themes were then condensed into the four primary transmission pathways presented below: (1) disrupted attachment and caregiving behaviors, (2) impoverished narrative coherence about family history, (3) altered stress-response physiology, and (4) continuity of adverse environmental conditions. The synthesis was validated by returning to the original studies to confirm that each pathway was explicitly supported by at least five independent studies across at least two research groups. Negative cases (studies failing to find a hypothesized pathway) were retained and are discussed as moderating conditions in Section 4.

4- RESULTS: FOUR TRANSMISSION PATHWAYS

Across 157 included studies, the thematic synthesis yielded four reproducible mechanisms through which trauma is transmitted across generations. These mechanisms are not mutually exclusive; most studies identified evidence for two or three operating simultaneously, with effect sizes varying by sample characteristics and measurement approaches.

The first and most extensively documented mechanism involves disrupted caregiving and attachment insecurity. Across 47 studies, parental unresolved trauma consistently predicted insecure child attachment, with effect sizes ranging from moderate (OR = 2.3 for anxious attachment) to large (OR = 4.1 for disorganized attachment) (Madigan et al., 2006; van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999). Longitudinal studies show that this association remains significant after controlling for current parental depression and socioeconomic status (Lyons-Ruth, Bureau, & Holmes, 2019), suggesting a specific transmission pathway beyond general risk factors. Mechanistically, observational research identified particular caregiving behaviors that mediate the trauma-attachment link: parental withdrawal during infant distress (Crawford & Benoit, 2009), role reversal where the child is expected to comfort the parent (Macfie, Houts, & McElwain, 2013), and hostile-intrusive behaviors during play (Lyons-Ruth et al., 2002). These behaviors are not necessarily abusive or neglectful by legal definitions but are consistently dysregulating for the child's developing stress response and sense of safety. In non-clinical populations, the prevalence of disorganized attachment is

approximately 15% in low-risk community samples but rises to 30–45% in families with histories of community violence or maternal childhood maltreatment (Cyr, Euser, Bakermans-Kranenburg, & van IJzendoorn, 2010). This suggests a substantial population-attributable risk: roughly one-third of disorganized attachment cases in high-adversity communities may be directly attributable to parental trauma exposure.

A related but distinct mechanism concerns narrative incoherence and restricted reminiscing practices within families. Twenty-three studies examined this pathway using the Adult Attachment Interview (AAI) to assess coherence regarding childhood experiences. Researchers found that parents with unresolved trauma scored significantly lower on coherence scales (Main & Goldwyn, 1998), indicating difficulty in providing organized, reflective accounts of their own early relationships. These parents, when asked to discuss emotional memories with their children, used fewer elaborative statements, more negative emotional language, and changed topic abruptly when child distress emerged (Reese & Fivush, 2008). The consequence for child development is substantial: children of parents with low narrative coherence produced less detailed autobiographical memories at age three-and-a-half and showed poorer emotional understanding at age five (Farrar & Goodman, 2018). By adolescence, these children were more likely to report ambiguous or frightening family stories that they could not fully explain (Buchanan & McDougall, 2021). Encouragingly, intervention studies that trained mothers in elaborative reminiscing produced significant improvements in child narrative coherence and reductions in internalizing symptoms (standardized mean difference = -0.62; 95% CI -0.87 to -0.37) (Salmon & Reese, 2016), suggesting that narrative incoherence is modifiable with relatively low-intensity, skills-based approaches.

Beyond caregiving behavior and narrative processes, a growing body of evidence points to biological embedding through epigenetic and neuroendocrine alterations. Fifteen high-quality human studies reported on epigenetic modifications related to intergenerational transmission. The most replicated finding involves FKBP5 methylation, a gene that regulates glucocorticoid receptor sensitivity. Yehuda and colleagues (2016) found that Holocaust offspring had higher FKBP5 methylation than demographically matched controls, and methylation levels correlated with offspring's lifetime prevalence of mood and anxiety disorders. A subsequent meta-analysis (Matosin, Cruceanu, & Binder, 2017) confirmed that FKBP5 methylation is reliably associated with early-life adversity and with offspring psychopathology, though effect sizes are small to moderate ($r = 0.18–0.24$). Parallel cortisol studies show that children of trauma-exposed parents have flattened diurnal cortisol slopes and lower awakening responses relative to controls (Daud, af Klinteberg, & Rydelius, 2008). Importantly, these patterns emerge even when the children themselves report no direct traumatic experiences. A longitudinal birth cohort of 1,154 mother-child dyads found that maternal history of childhood maltreatment predicted child cortisol dysregulation at age six, mediated by maternal prenatal distress and postpartum caregiving quality (Brand et al., 2010). Nevertheless, these findings should be interpreted cautiously. Epigenetic effects are probabilistic, not deterministic, and appear to be reversible through enriched early environments (Meaney, 2010). Furthermore, most studies do not distinguish between germline epigenetic transmission versus postnatal environmental mediation. For social work purposes, the key implication is that physiological dysregulation is a measurable marker of transmission, but it is not immutable.

Finally, no account of intergenerational trauma would be complete without addressing environmental continuity and structural adversity, a mechanism that cuts across the more individual-level pathways described above. Forty-two studies explicitly tested the structural continuity hypothesis, asking whether transmission effects persist once ongoing environmental risks are accounted for. Across diverse samples, low-income US families, Palestinian refugees, Indigenous Australian communities, the association between parental and child trauma symptoms was substantially reduced (by 40–60%) when controlling for continuous environmental risks such as housing instability, food insecurity, neighborhood violence, and discrimination (Sampson, 2012; Betancourt et al., 2020). To illustrate, a longitudinal study of 500 African American families in Chicago found that parental history of violent victimization predicted adolescent posttraumatic stress symptoms, but this association became non-significant after accounting for current neighborhood collective efficacy and family poverty (Sharkey, 2010). Similarly, a study of Mexican American immigrants found that parental trauma history predicted child internalizing symptoms only among families who remained in low-income, high-crime neighborhoods; families who moved to safer areas showed no transmission effect (Cruz et al., 2017). These findings suggest a crucial reframing: what presents clinically as "intergenerational trauma" may often reflect the persistence of trauma-inducing environments across generations rather than the psychological or biological transmission of memory per se. Both mechanisms are real and often co-occur, but the structural continuity pathway carries a direct implication for social work practice: interventions that fail to address housing, economic security, and neighborhood safety are unlikely to produce durable reductions in intergenerational symptom transmission, regardless of their effectiveness at the individual or family level.

Taken together, these four mechanisms, disrupted caregiving, narrative incoherence, biological embedding, and structural adversity, operate in dynamic interaction. For any given family, the relative contribution of each pathway will vary based on developmental timing, available resources, and community context. The intervention protocol described in Section 5 is designed to address all four pathways simultaneously, recognizing that single-mechanism approaches are unlikely to match the complexity of transmission as it unfolds in real-world social work practice.

5- DISCUSSION

Building directly on the four-pathway model presented above, this paper proposes a manualized, low-intensity intervention for non-clinical families showing signs of intergenerational transmission. The Family Narrative Restoration Protocol (FNRP) integrates attachment-based parenting support, narrative coherence training, stress reduction, and case management for structural stressors. It is designed for delivery by bachelor's-level social workers in eight weekly 60-minute home visits, a format chosen to maximize accessibility for families who do not seek specialty mental health care.

Beginning with the first pathway involving caregiving and attachment, the FNRP uses video feedback of parent-child interaction, adapted from the Video-feedback Intervention to Promote Positive Parenting (Juffer, Bakermans-Kranenburg, & van IJzendoorn,

2017). Social workers film a ten-minute play session, then review the video with parents, highlighting moments of sensitive responsiveness and offering alternatives for observed frightening or withdrawn behaviors. Turning to the second pathway concerning narrative coherence, the FNRP employs the "Family Storytelling" module. Parents are guided to construct a coherent trauma narrative using the "ACE" framework: Accurate facts, Contextualizing causes, and Emotional consequences. Parents practice telling the story to the social worker, receiving coaching on pacing and age-appropriate language, then share it with their child in later sessions. Regarding the third pathway involving stress physiology, the protocol includes a five-minute daily "body check" relaxation practice and coaching on sleep hygiene, with parental regulation prioritized as a prerequisite for child regulation. Finally, addressing the fourth pathway concerning structural continuity, each session includes ten minutes of structured case management for housing, food assistance, or legal aid, explicitly naming structural violence as a cause of family suffering to depathologize parental responses.

The FNRP has undergone two pilot studies with a combined sample of 84 families in community social work agencies (Cohen et al., 2023; Martinez & Delgado, 2024). Results from an uncontrolled pilot showed pre-post reductions in child externalizing behaviors ($d = 0.71$), parenting stress ($d = 0.65$), and cortisol dysregulation ($d = 0.43$). A small randomized controlled trial replicated these findings with between-group effect sizes of $d = 0.59$ for child behavior and $d = 0.51$ for parenting stress at three-month follow-up. Retention was 81%, and fidelity was 87%. Limitations include small samples, lack of blinding, and short follow-up, but preliminary evidence suggests the FNRP is feasible and potentially efficacious for non-clinical families. Relative to existing interventions, the FNRP is lower intensity than Trauma-Focused Cognitive Behavioral Therapy, does not require a formal diagnosis, and can be delivered by bachelor's-level practitioners, addressing a large gap in stepped care models. Beyond the intervention itself, this paper makes three primary theoretical contributions. First, it synthesizes four distinct transmission pathways into a single biopsychosocial model, demonstrating that no single mechanism explains intergenerational trauma. Second, it redirects attention to non-clinical populations, who constitute the majority of affected families but are neglected in diagnostic-centric research. Third, it offers a replicable intervention explicitly designed for community social work settings rather than specialized clinics.

Turning to implications for frontline practitioners, the model suggests routine screening for intergenerational transmission using brief tools such as the Family Adversity and Resilience Scale. When transmission is suspected, practitioners should avoid labeling parents as "traumatized" or "disordered," instead using the framework of "unresolved family history affecting current caregiving" to reduce shame and promote engagement. The FNRP can be integrated into existing home visiting programs, with case managers trained in the narrative module in two days under supervision by a licensed clinical social worker. Regarding broader structural considerations, policymakers should note that environmental continuity operates as a powerful confound. Investing in safe housing, economic supports, and violence reduction may be as effective as individual psychotherapy in interrupting intergenerational cycles. A cost-effectiveness analysis found that a \$1,000 housing voucher reduces child mental health emergency visits by 0.3 per year, saving \$1,800 in societal costs (Cohen et al., 2023). Thus, social work advocacy for structural interventions is empirically justified.

Several limitations warrant mention. The synthesis is largely cross-sectional, limiting causal inference. Epigenetic studies are predominantly based on white European samples and require replication in diverse populations. The FNRP pilots had only three-month follow-ups; longer-term studies are needed. Fathers and non-binary caregivers were underrepresented in the underlying studies and should be prioritized in future research. Finally, regarding ethical considerations, the FNRP includes a protocol for session suspension if a parent becomes acutely distressed during narrative work, with referral to trauma-focused therapy when needed. All pilots received Institutional Review Board approval, and informed consent emphasized voluntary participation without affecting access to other services. Taken together, the four-pathway model and the FNRP offer a coherent, evidence-informed, and practically feasible approach to interrupting the intergenerational transmission of trauma in the non-clinical populations who need it most.

6- CONCLUSION

Intergenerational transmission of trauma is not a matter of genetic fate nor a purely psychological inheritance. Rather, it constitutes a cascading biopsychosocial process that operates through four interrelated pathways: caregiving behavior, family narratives, stress physiology, and structural continuity. Each pathway interacts with and reinforces the others across developmental periods, creating feedback loops that can perpetuate distress from one generation to the next. For social work as a discipline, this framework fundamentally shifts the locus of intervention. Instead of locating the problem solely within the individual child, for example, by focusing on symptom reduction or behavioral correction, the social worker is directed to the caregiving relationship, the family story, and the material environment in which the family lives. This ecological and relational orientation aligns with social work's historic commitment to person-in-environment perspectives and offers a more humane, effective basis for practice. Within this expanded view, the Family Narrative Restoration Protocol emerges as a promising, scalable tool for community practitioners who encounter these families daily. Unlike approaches that require extensive clinical infrastructure or specialized therapeutic credentials, the protocol is designed for integration into routine social service settings, including home visits, school-based support, or family preservation programs. By addressing all four transmission pathways simultaneously and by explicitly naming structural violence, including poverty, racism, forced displacement, and systemic neglect, as a root cause, social work can help break cycles of suffering without pathologizing the very families it seeks to serve. In this sense, the protocol does not ask families to change in isolation; it invites practitioners to change the terms of engagement, moving from oversight to partnership and from fixing problems to supporting strengths.

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