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Intergenerational Trauma and Resilience among Im/Migrant Families: Child Mental Health Outcomes and Psychosocial Mechanisms of Transmission

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Abstract

Research Background: Psychological stressors leading to poor mental health outcomes accumulate throughout the migration process. The impact of a parent or caregiver's posttraumatic stress on non-traumatized children is significant and may lead to adverse development and mental health outcomes. Research Objectives: The objective of this review is to explore both the consequences of parental trauma transmission on descendants' psychological adjustment and well-being, and the mechanisms through which trauma has been transmitted among im/migrant populations. Methods: Criteria outlined in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement guided this systemic review. The questions guiding this review are: (a) What are the consequences of parental trauma transmission on the psychological adjustment and well-being of im/migrant offspring? And (b) What are the psychosocial mechanisms of trauma and resilience transmission among im/migrant populations? Each potential study was assessed based on relevance to the review question(s). Results: Parental trauma can lead to adverse mental health outcomes among descendants including increased internalizing and externalizing problems, the adoption of coping behaviors and worldviews, and worsening school performance. Mechanisms that influence trauma transmission include parental trauma symptom severity, the parent-child dyad, social learning, and family stressors. Pathways of resilience exist across socioecological levels to include individual resilience such as coping skills and meaning making, family resilience, structural protective factors, and

social and cultural protective factors. Conclusions: Despite the prevalence of traumatic events throughout the migration process, im/migrant families display strong levels of resilience. Mental health services and providers should incorporate a strength-based approach in designing interventions that are culturally responsive and take into accounts the broader ecological contexts in which im/migrant families live.

Keywords

Intergenerational Trauma, Im/Migrants, Families, Resilience, Mental Health

1. Introduction

The prevalence of mental health challenges among persons who have been forcibly displaced, such as refugees and asylum seekers, is well documented [1] and includes significant levels of depression, anxiety, post-traumatic stress disorder, and non-affective psychosis [2]. Psychological stressors leading to poor mental health outcomes accumulate throughout the migration process [3]. This accumulation of adversity refers to the triple trauma paradigm which includes (1) trauma experienced in the country of origin, (2) traumatic events along the migration journey, and (3) trauma encountered upon resettlement in the host country [4] [5]. Traumatic experiences can include personal trauma, such as intimate partner violence, or collective trauma as in apartheid or genocide [6]. Experiencing a critical threat to health, safety, security, or well-being influences a person's decision to flee from their country of origin [2]. There are also significant mental health effects of torture and trauma which are common experiences for those fleeing violence in their own country [7]. During the migration journey, there is significant risk of violence and trafficking [8]. Upon resettlement, ongoing trauma occurs in the form of acculturation stressors such as economic marginalization, forced separation from family, and racism and hostility, increasing vulnerability and risk of exploitation and exacerbating trauma sequelae [2] [3]. The education of healthcare providers to screen and address potential mental health concerns related to trauma among im/migrants is an important and necessary part of healthcare for resettled im/migrant families.

1.1. Family Systems Theory and Intergenerational Trauma

Family systems theory describes human functioning based on the interactions between people within a family, and the context(s) in which that family is embedded [9]. The interdependence of family members influences the development and exchange of individual and collective behaviors, values, and beliefs. Family systems theory can be applied to understand how the well-being of one member impacts the functioning of other family members through the study of intergenerational trauma [6] [10]. The impact of a parent or caregiver's posttraumatic stress on non-traumatized children is significant and may lead to adverse development and mental health outcomes

[10].

Intergenerational trauma research initially focused on survivors and descendants of the Holocaust. A meta-analysis reviewing 14 studies on offspring of Holocaust survivors found that, compared to control groups, this population had higher levels of depressive symptoms, posttraumatic stress, anxiety disorders, attention deficiency, and greater perceptions of taking on parental pain and burden [11]. Offspring of Holocaust survivors may develop behaviors that mirror parental traumatization includes feelings of fear, mistrust, and hypervigilance to anticipate disaster [12]. In addition to the consequences of trauma transmission on subsequent generations, mechanisms through which trauma transmission occurs have been studied. Parenting styles that encompass dysfunctional communication and impaired family functioning increase the risk of trauma transmission between Holocaust survivors and their offspring. For example, punitive disciplinary behaviors, overprotectiveness, and parent-child role reversal contribute to a parent-child dyad rooted in displaced emotions and insecure attachment.

Studies with Holocaust survivors and their descendants provided foundational findings for intergenerational trauma reinforced by research in epidemiology, psychology, and psychiatry, supporting the heritability of trauma [6]. Fazel [13] cautions against generalizing findings of intergenerational trauma research among Holocaust descendants to contemporary forcibly displaced groups, as each population is likely to have distinct and unique experiences of trauma [4]. One suggested approach to evaluation and study of intergenerational trauma is the use of a culturally enhanced bioecological model to understand unique cultural components of the meaning of trauma and subsequent parenting behaviors [14]. Research on the transmission of trauma among refugees, asylum seekers, and survivors of forced displacement is emerging. The objective of this review is to explore both the consequences of parental trauma transmission on descendants' psychological adjustment and well-being, and the mechanisms through which trauma has been transmitted among im/migrant populations. With increased understanding about the consequences and mechanisms of intergenerational trauma transmission, this body of research can be reframed through the lens of resilience and posttraumatic growth.

2. Methods

The questions guiding this review are: (a) What are the consequences of parental trauma transmission on the psychological adjustment and well-being of im/migrant offspring? And (b) What are the psychosocial mechanisms of trauma and resilience transmission among im/migrant populations? Each potential study was assessed based on relevance to the review question(s). Studies were not required to investigate both questions.

Articles were identified through searches in PubMed, PsychINFO, JSTOR, and GoogleScholar, and by checking the reference lists of relevant articles. Criteria outlined in the Preferred Reporting Items for Systematic Reviews and Meta-

Analyses (PRISMA) statement guided this systematic review. The search strategy applied a combination of key terms associated with three categories: (1) the population of interest (im/migrant, refugee, asylum seeker, displaced persons), (2) the topic of interest (intergenerational trauma and/or resilience), and (3) the outcome of interest (child/descendant mental health, mechanisms of transmission, risk/protective factors). Figure 1 summarizes the search results and the inclusion and exclusion of articles.

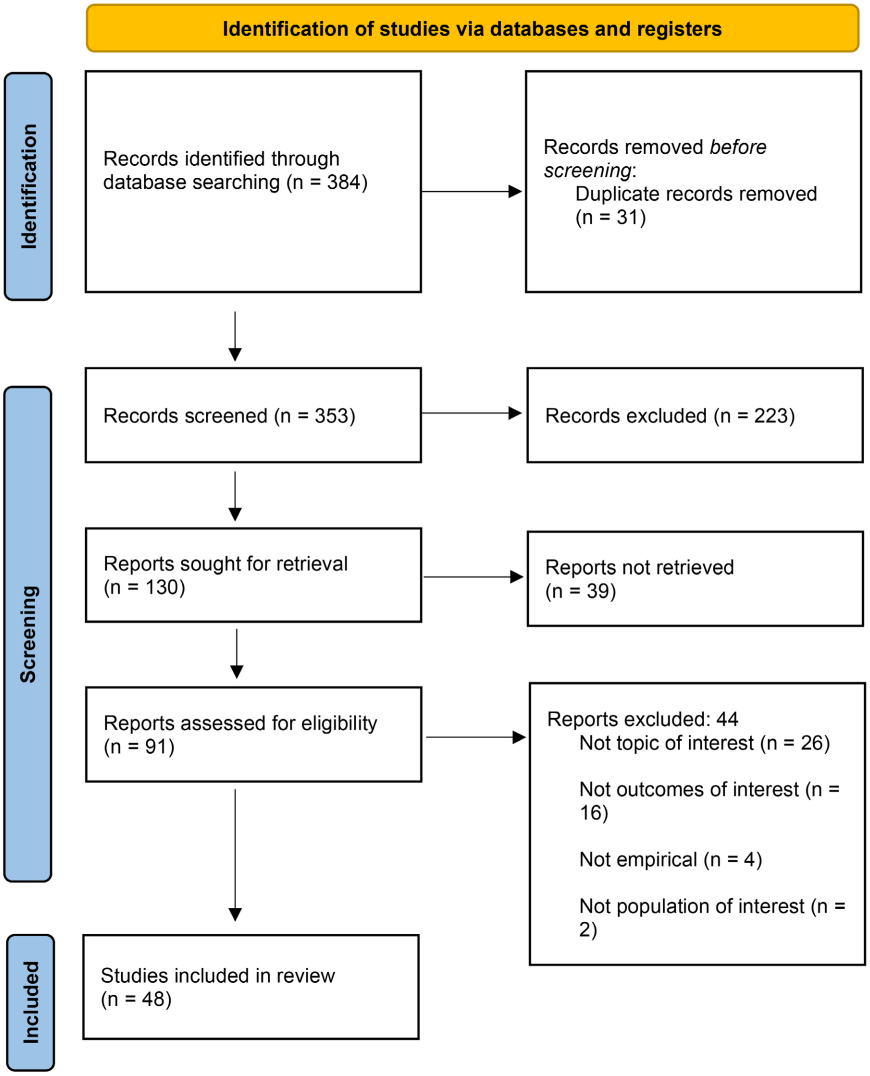

Figure 1. PRISMA diagram.

2.1. Inclusion Criteria

Included peer-reviewed studies focused on im/migrant or forcibly displaced populations regardless of country of origin or cultural group. Participant experiences of personal and/or collective trauma were included. Study designs were not limited to qualitative, quantitative, or mixed methods, with scoping and systematic reviews included.

2.2. Exclusion Criteria

Studies were excluded if their populations of focus were non-migrant populations (e.g., military veterans) or Holocaust survivors and their offspring due to limitations addressed by Fazel [13]. If no direct information was collected from individuals or groups, and/or studies lacked empirical findings, they were excluded. The current review focused on psychosocial mechanisms of trauma transmission as supported by a family system theoretical framework, excluding studies exploring biological or epigenetic transmission of traumas.

2.3. Methods of Analysis

Study analyses involved a hybrid approach using both inductive and deductive methods of analysis. Inductive methods focused on specific observations and identifying patterns within data. In contrast, deductive analysis tests an existing theory by collecting information and data to support or reject the hypothesis. Existing literature about intergenerational mechanisms of trauma transmission provided foundational knowledge to identify mechanisms further described in the reviewed studies.

3. Results and Analysis

3.1. Descriptive Results

Forty-eight articles were retrieved in this systematic review. Regarding research design, 12 studies used qualitative methods, 18 used quantitative methods, and 10 used mixed methods. Five studies were systematic reviews, and one was a scoping review. Most studies were cross-sectional (67%), while 8% were longitudinal. Participant demographics included refugees (75%), asylum seekers (20%), immigrants (20%), and displaced genocide survivors (10%). Participants were displaced/migrated from various geographic regions including the Middle East, Latin America, Eastern Europe, Southeast Asia, Eastern Africa, and the Balkans.

3.2. Consequences on Children's Mental Health and Well-Being

As illustrated in **Table 1**, a prominent theme of this review involves the effects of parental trauma transmission on the mental health and well-being of children. Mental health outcomes among children are often conceptualized according to their capacity for psychosocial functioning and adjustment. In child psychology, psychosocial function refers to the ability of a child to adapt to their surrounding environment. Adaptive ability implies the individual has sufficient resources to respond adequately to the demands of the environment and achieve his or her objectives. A similar outcome includes sense of coherence (SOC), or an individual's capacity for internalized meaningfulness, comprehensibility, and manageability when faced with adverse experiences [15]. Children with higher levels of SOC believe that the appropriate resources are available and may be mobilized to cope with challenges when confronted with stressors. In contrast, when a child feels incompetent in managing stressors, there is an increased risk for psychological

distress later in life [16]. Parental trauma was found to be negatively associated with adolescents' sense of coherence [16]. In Southeast Asian refugees, as the degree of parental trauma increased among the sample population, their offspring's SOC decreased [16].

Table 1. Consequences on descendants' mental health and well-being.

Category	Description	Number (%) of Articles
Psychological adjustment	Experiences of emotional distress can increase the difficulty for a child to tolerate unexpected changes to their environment, accurately interpret social interactions, and identify and regulate their emotions.	6 (12.5%)
Internalizing problems	Internalizing problems include depressive symptoms, secondary traumatic stress, anxiety disorders, attention deficiency, psychosocial stress, and social withdrawal. Emotions and inner states reported were horror, fear, sadness, shame, anger, stress and anxiety, low self-worth, and guilt.	26 (54%)
Externalizing problems	Externalizing problems include disruptive, hyperactive, and aggressive behaviors as well as conduct problems, social hostility, and peer conflict.	14 (29%)
Survival strategies/Coping behaviors	Children develop adaptive behaviors and world views resembling that of the traumatized parent. Survival strategies and coping behaviors can include engagement in, or ambivalence to, risky health behaviors.	8 (17%)
School performance	Lower-than-average school performance via grade point average and eligibility for upper secondary education was found and yields further concern about later-life mental health outcomes.	2 (4%)

Factors inhibiting psychosocial functioning include experiences of emotional distress that increase the difficulty for a child to tolerate unexpected changes to their environment, accurately interpret social interactions, and identify and regulate their emotions. Emotional distress was the most common type of child outcome found from a scoping review of literature on intergenerational trauma among Latinx communities [6]. The significant prevalence of emotional distress throughout the current literature review supports this finding and its consequences on a child's psychosocial functioning [17].

Six of the studies in this review found results that showed an association between parental trauma and the general psychosocial functioning/adjustment of their children. Psychosocial functioning is often measured through parental reporting of child internalizing and externalizing symptoms via scales such as the Child Behavior Checklist and the Strengths and Difficulties Questionnaire (SDQ). Dalgaard *et al*., [18] utilized the SDQ to study the prevalence of emotional symptoms, conduct problems, hyperactivity and inattention, peer-related problems, and prosocial behaviors among children of refugee families. The SDQ symptom

scales can be combined into an Internalizing dimension and an Externalizing dimension, producing a total score that indicates difficulties with psychosocial functioning [18]. The mean for the SDQ Total Difficulties Score from a refugee sample was tested against the known mean from Danish norms (6.42 for boys and 5.45 for girls). For all participants, the mean scores were significantly higher among the refugee sample than the Danish norms: for boys ($M = 11.69$ $SD = 6.50$), $t(15) = 3.242$, p = .005, and for girls ($M = 12.86$ $SD = 6.60$), $t(13) = 4.201$, $p = .001$. This finding confirms the study's hypothesis that a significant difference between refugee children's mean scores and the Danish host country norms might indicate a negative impact of parental trauma on non-traumatized refugee children [18]. The following subthemes elaborate on the prevalence of internalizing and externalizing problems among im/migrant children as influenced by parental trauma.

3.2.1. Internalizing Problems

Twenty-six of the forty-eight studies (54%) acknowledged the impact that parental trauma has specifically on internalizing behaviors among offspring of im/migrants. Internalizing problems are categorized as emotional symptoms and expressions often turned inward toward the individual [19]. Internalizing problems found across studies include increased depressive symptoms [20]-[22], anxiety disorders, attention deficiency, psychosocial stress, autonomic hyperreactivity, and identity confusion [23] among children of traumatized im/migrant parents [24]-[26]. In a qualitative study, Bezo and Maggi [27] found a prevalence of emotions and inner states that impacted the daily lives of second and third generations of Ukrainian survivors of the Holodomor genocide. The emotions and inner states reported were horror, fear, sadness, shame, anger, stress and anxiety, and low self-worth [27]. Stress and anxiety, and low self-worth were only reported among women descendants [27]. Feelings of regret and doubt were associated with a perception of inadequate personal achievement and contributed to decreases in self-worth [27]. Another study corroborated these findings, reporting that "stressors triggered by mass trauma experiences can leave lasting emotional wounds on communities" in the form of increased anger and aggression, shame, diminished self-worth, feelings of terror and fear, grief, and numbness [28].

Higher rates of secondary traumatic stress and posttraumatic stress disorder (PTSD) were also found among im/migrant offspring despite children not having experienced the traumatic event directly themselves. Sack, Clarke & Seekley [29] found PTSD to be significantly related across parent-child generations, suggesting that PTSD symptoms among refugees may cluster in families. For example, "survivors of the 1988 earthquake in Armenia commonly reported nightmares with images related not only to the earthquake, but to the Armenian Genocide that their ancestors had experienced" [30]. About one-third (35.7%) of participants from second, third, and fourth generations of Armenians reported symptomatology compatible to at least subclinical traumatic reactions, supporting intergenerational trauma transmission across many generations [31].

Findings from a study by Berg and colleagues found an association between

post-traumatic stress in mothers and an increased use of psychiatric services by foreign-born refugee children, as well as Swedish-born children with refugee parents [32]. Particularly high risks were seen in more recently arrived refugee adolescents and for diagnoses of internalizing problems such as anxiety and depression [32]. When contradictory findings indicated less contact with psychiatric services, explanations were proposed to include "an underutilization of mental health services, the existence of barriers to care, and an unmet need for healthcare, rather than lower levels of mental health problems" [32].

Children of traumatized parents were also found to develop increased feelings of guilt [33] and high levels of empathy and identification with their parent's suffering [34]. In a case study referenced by Dalgaard & Hviid [35], the child of a traumatized immigrant mother was perceived to be "sharing and taking over his mother's worries and meaninglessness" which impeded his own ability to imagine potential futures for himself [35]. Meanwhile, some im/migrant children may develop feelings of guilt and betrayal for pursuing a trajectory that "makes the most of the resources available to them" in their resettled country, rather than enveloping the lived experiences of their parents [35].

Offspring participants described the impact of heightened emotional distress as affecting their ability to make time for personal development and to nurture interpersonal relationships. Feelings of fear and mistrust influenced subsequent feelings of isolation and a general wariness of others [27] [28]. Social withdrawal and isolation were found to be a common internalizing behavior among descendants of im/migrant parents who have experienced trauma [28]. Additionally, results found by Peltonen *et al*., [36] suggest that children whose mothers scored high in posttraumatic stress showed poorer emotional processing, or the ability to perceive and reason about other people's emotions. Children with poor emotional processing are likely to have social and interpersonal difficulties [36]. Overall, "traumas experienced by caregivers can alter children's own capacity to form trusting social bonds," an important aspect of psychosocial functioning [6].

3.2.2. Externalizing Problems

Psychosocial functioning is also influenced by the presence of externalizing problems which refers to "a grouping of behavior problems that are manifested in children's outward behavior and reflect the child negatively acting on the external environment" [37]. Fourteen studies (29%) discussed an association between parental trauma and externalizing problems among im/migrant offspring [38] [39]. Externalizing outcomes included disruptive, hyperactive, and aggressive behaviors [40]. In Southeast Asian refugees, higher levels of antisocial and delinquent behavior were reported among foreign-born children [11]. Increased child conduct problems [41], hyperactivity, social hostility [27], and peer conflicts [25] are additional externalizing problems reported among offspring of traumatized im/migrant parents [24]. In one study, findings demonstrated an association between parents' refugee status and serious violence among Vietnamese youth, mediated by peer delinquency and parental engagement [42].

3.2.3. Living in Survival Mode: Coping Behaviors and Worldviews

Poor mental health outcomes also include the development of adaptive behaviors and worldviews resembling that of the traumatized parent [23]. Bezo and Maggi observed participants in "survival mode" despite an absence of active threat or danger [27]. Survival mode involves a "constant need for survival and self-preservation that precludes the ability to live in the present and enjoy life" and includes feelings of fear and mistrust, hypervigilance in anticipation of harm or disaster, social hostility, and indifference toward others [27].

Survival strategies may also include risky health behaviors such as alcohol or substance misuse [6] [27] [28]. During the Holodomor genocide, the appearance of Ukrainian men as strong, in good health, and independent was used as a pretext for execution [27]. Therefore, behaviors such as alcohol abuse became adaptive for men to appear weak and of poor health as a mechanism of survival. This weakness and passivity were then learned and reinforced by each successive generation, leading to an ambivalence toward risky health behaviors [27]. Risky health behaviors and other alternative strategies to survival can increase vulnerability to situations of high risk and additional trauma exposure across generations [43].

Studies show stigma surrounding mental health is another example of a worldview adopted by children of traumatized im/migrant parents. Mental health stigma affects help-seeking behaviors and the inexpression of mental health experiences [44]. Some children of im/migrant parents adopt views of mental health as stigmatized and taboo, impeding on their likelihood of accessing mental health services. Negative coping strategies such as risky health behaviors or even suicidality were identified by participants as a byproduct of the cultural stigma associated with mental illness and negative attitudes toward people suffering from emotional distress, creating layers of suppressed emotions until it erupts into severe repercussions [44].

3.2.4. School Performance

In a study among refugee children resettled in Nordic countries, participants were found to carry a high burden of familial posttraumatic stress and to perform poorly in school [45]. An association between the two was explored, and results showed that children exposed to both parental posttraumatic stress and maternal posttraumatic stress, respectively, had a lower mean grade point average, SD = −0.14, 95% CI [−0.22, −0.07], SD = −0.15, 95% CI [−0.22, −0.07], and higher odds of not being eligible for upper secondary education, OR = 1.25, 95% CI [1.14, 1.65], OR = 1.37, 95% CI [1.00, 1.55] [45]. Although the impacts on children's grade point average and eligibility for upper secondary school were moderate, these results demonstrate that intergenerational effects of psychological trauma include consequences for educational performance [45]. These studies suggest that "parents who suffer from PTSD-related symptoms may be hampered in their ability to motivate, encourage and support their children in schoolwork" [46]. School performance in Grade 9 has been associated with a range of specific later-life mental health outcomes in Sweden, such as self-inflicted injuries, suicide,

alcohol-related disorders, and substance abuse. Hence, lower-than-average school performance is one pathway by which consequences of parental posttraumatic stress may impact mental health in their offspring [45].

3.3. Mechanisms of Parental Trauma Transmission

As research has expanded upon child consequences of parental trauma transmission, it is important to explore how these outcomes are occurring. Mechanisms of trauma transmission refer to processes or events that drive, amplify, or buffer against the transmission of parental trauma and the development of adverse psychosocial outcomes among children. The following subthemes were developed for analysis purposes; however, it is important to note mechanisms of trauma transmission co-occur and interact with each other to influence risk and resilient outcomes (see Table 2).

Table 2. Psychosocial mechanisms of trauma transmission.

Category	Subcategory	Description	Number (%) of Articles
Parental trauma symptoms		Severity of trauma symptoms rather than trauma exposure is related to adverse child outcomes. Symptom clusters include depressed mood, withdrawn/detached, and volatility/panic.	28 (58%)
Parent-child dyad	Emotional attunement	Refers to the ability for parents to recognize, understand, and meet the needs expressed through their child's display of emotions. Trauma symptoms and displacement can interfere with a parent's capacity for reflective functioning, parental sensitivity, and emotional availability.	11 (23%)
	Attachment	Decreased parental emotional attunement may cause children to develop insecure or disorganized attachment styles because of the inconsistent response to their emotional expressions of needs.	9 (19%)
	Parenting style	Various findings indicate a potential risk of trauma transmission through harsh/hostile parenting styles, overprotective parenting, and role-reversal/parentification.	18 (37.5%)
	Parent-child conflict	Parental trauma exposure and dissonant acculturation increase risk of parent-child conflict. Retrieval cues exacerbate a parent's response to conflict, while language barriers hinder conflict resolution.	6 (12.5%)
	Communication	When communicating about parental trauma history, unfiltered communication, open communication, and silence/secrecy have varying influences on trauma transmission. Modulated disclosure is an adaptive form of communication.	13 (27%)
Social learning		Children may observe and imitate a traumatized parent's behaviors, worldviews, and strategies for navigating the world.	3 (6%)
Family stressors		Acculturation stressors and structural vulnerability can exacerbate parental PTSD symptoms and increase stress and tension within the household.	15 (31%)
Resilience and protective factors	Individual resilience	Coping skills and meaning making related to parenthood are sources of strength within the individual.	4 (8%)
	Family resilience	Adaptive family functioning, including family flexibility and cohesion, is associated with intergenerational resilience.	10 (21%)

Continued

Structural protective factors	Resource availability, advocacy, and cultural humility are examples of political and organizational contributions to health equity and resilience.	6 (12.5%)
Social/cultural protective factors	Meaningful social support, including peer and community support and a large family network in the resettled country, is associated with posttraumatic growth. Cultural factors including religious practices, cultural traditions, and maintaining a collective identity promoted well-being.	13 (27%)

3.3.1. Severity of Parental Trauma Symptoms

The severity of trauma symptoms, not actual trauma exposure, has been found to influence the transmission of parental trauma to subsequent generations [6]. In a study of asylum seeking and refugee mothers resettled in the Netherlands, higher levels of maternal posttraumatic stress symptoms (PTSS) were associated with a higher level of psychosocial problems of infants, but not with delays in their mental or psychomotor development [17]. This finding supports the distinct relation between parental trauma symptoms and the psychosocial functioning of children. In a systematic review, Flanagan and colleagues identified four studies that tested direct effects of parental trauma on second-generation outcomes or indirect effects of parental trauma, via symptomology, among refugee and asylum-seeking families [4]. Parental trauma, having two traumatized parents, trauma sequelae, PTSD and symptom severity were reported as covariates of, or risk factors for, transmission [4]. Twenty-eight (58%) of our reviewed studies, including two systematic reviews, explored the severity of posttraumatic stress symptoms (PTSS) or parental distress as predictive of child mental health outcomes [39] [47].

The Harvard Trauma Questionnaire (HTQ) is the most widely used screening measure for trauma-related symptoms in clinical and research work among refugees worldwide [48] and assesses symptoms of PTSD and culture-specific expressions of functional distress. East and colleagues identified HTQ items that can be categorized into three PTSD symptom clusters for refugees: depressed mood, withdrawal and detachment, and volatility and panic [21]. Each of these components of parental PTSD symptomology had varying disruptive effects on children's psychosocial adjustment across studies.

The depressed mood cluster is categorized by melancholic thoughts, feelings and anhedonia [21]. Depressive symptoms interfere with parents' emotional engagement, playful interactions, and verbal responsivity toward their child. In one study, mothers' past torture experiences were significantly related to their depressive symptoms and related to all 3 indices of child functioning (child depressive symptoms, bullying victimizations, and higher levels of perceived racism) [21].

The withdrawn and detached cluster of posttraumatic stress involves avoidance of activities with others, alienating oneself from social interaction, and anxious behaviors such as being frightened in the presence of strangers or new places [6]. Parental withdrawal and avoidance in the context of the parent-child dyad might signal indifference of the child and thereby adversely affect the child's self-worth

and esteem [21]. Experiences of past traumatic events by migrant mothers were significantly related to their current symptoms of withdrawal/detachment [21]. In contrast, child adjustment variables were not related to mothers' withdrawal/detachment symptoms [21]. Dalgaard and Montgomery [25] discuss Middle Eastern parents' description of how "the traumatized parent withdraws from family life either physically or with regard to parenting when symptoms are acute" as a strategy to keep their children unaware of their trauma symptoms. These studies suggest varied influence related to withdrawal/detached parental symptoms. Future research may benefit from the differentiation between the impact of parental withdrawal and detachment symptoms, and withdrawal strategies to shield children from other acute symptoms.

The posttraumatic stress symptoms of hyperarousal and volatility include angry outbursts, panic attacks, and irritability which often take the form of punitive parenting. Traumatized Middle Eastern parents describe themselves as "short-tempered, irritable, and impatient with their children" [25]. Among refugee mothers experiencing PTSS, symptom severity was significantly associated with higher levels of insensitive, unstructured and hostile parent-child interactions [4] [17]. Forty-eight percent of Cambodian refugee patients had anger directed toward a nuclear family member (NF-type anger) in the last month, with anger directed toward children being particularly common (49%) among patients with children [49]. NF-type anger was significantly associated with PTSD severity [49].

Forty-one percent of quantitative studies in a scoping review conceptualized parental trauma as emotional distress, most commonly through self-reported PTSD symptom criteria and trauma-specific symptoms such as dissociation, trauma related appraisals, and clinical ratings of trauma symptom severity [6]. One study found that maternal dissociative symptoms predicted future infant neglect and involvement in the child welfare system [6]. Trauma symptoms may also include anger with subsequent trauma recall, and intrusive thoughts. In Hinton's study of NF-type anger, the severity of anger was assessed by "intensity, frequency, somatic symptoms, acting-out behaviors, trauma associations, and catastrophic cognitions… almost always resulting in somatic arousal (e.g., causing palpitations in 91% of anger episodes) and often in trauma recall and fears of bodily dysfunction" [49].

In contrast to the above outcomes, Dalgaard *et al*., [18] were unable to confirm an association between parental symptoms of PTSD, anxiety and depression, and children's psychosocial adjustment and attachment security. However, they suggested the high level of parental symptomology in the sample contributed to a limited variance detected.

Some studies found parental PTSS or distress levels to influence child outcomes indirectly, mediated by a secondary mechanism or pathway [22] [24] [34] [38] [50]. For example, Bryant *et al*., [24] suggest the greater the primary caregiver symptoms of PTSD, the harsher their parenting, leading to adverse effects on

child's mental health outcomes via parenting style.

3.3.2. Parent-Child Dyad

Trauma compromises a person's capacity for emotion regulation, mentalization, and other skills that are important to cultivating meaningful and reciprocal relationships. In a systematic review, results found disrupted interactions between the parent-child dyad to be a significant mechanism of trauma transmission with diminished parental emotional availability, insecure attachment, and maladaptive parenting reported as covariates [4]. The results of this review support these findings.

a) *Emotional Attunement.*

In a sample of asylum-seeking and refugee mothers experiencing posttraumatic stress symptoms, lower scores were found on all emotional availability scales [4] [17]. This suggests difficulty with emotional attunement, or the ability for parents to 1) recognize, 2) understand, and 3) meet the needs expressed through their child's display of emotions. Some parents tend to emphasize how they care for their children's physical and practical needs while very few mention their children's emotional needs [25].

Reflective functioning refers to the ability for a parent to step back from their own experiences in order to recognize the emotional experiences of their children [50]. In a study of refugee mothers with children born of conflict-related sexual violence (CBSV), there were lower levels of reflective functioning capabilities compared to a control group of mothers who had either experienced conflict-related sexual violence but did not conceive a child as a result or who experienced other war-related traumas [50]. Results indicated less awareness of the emotional experiences of their children among mothers with CBSV, while wider findings were considered for all refugee mothers included in the sample [50]. Reflective functioning requires the parent to make an attempt to understand their child's display of emotions. In this study, mothers with CBSV were not actively attempting to discern their child's needs underlying the externalizing behavior, and hence scored lower [50].

Once a parent can recognize the emotional response of their children, parental sensitivity refers to their ability to understand and respond to the underlying needs communicated through their child's distress. Less sensitive parents may not accurately interpret their child's display of emotions, and thus respond in ways that reinforce undesirable behavioral strategies [50]. PTSD symptom level was significantly associated with parental sensitivity toward children, indicating increased levels of parental sensitivity when PTSD symptoms were lower [51].

Overall, traumatized parents living in survival mode may perceive ongoing threats or danger with the potential to interfere with their capacity to consider their children's perspective and interpret their thoughts and feelings accurately [51]. Feelings of uncertainty and despair are identified by one mother as challenges to directing her attention towards anything else, including her son's needs [18]. Additionally, mothers who have been displaced from their homes leave

behind the support of extended family members who, in many cultures, traditionally assist with childcare [50] [52]. Constant time with their child can lead to enmeshed mother-child relationships and may create a blurring between the mother and child's needs, with the potential for lower parental sensitivity [50]. Finally, findings show that the ongoing stressors and uncertainty of the asylum process may culminate alongside the mental well-being of a parent, contributing to decreased reflective functioning capabilities [50]. Collectively, studies support the transmission of parental trauma through reduced emotional attunement within the parent-child dyad [17] [25] [50] [51].

b) *Attachment.*

Attachment theory explains why decreased parental emotional attunement amplifies adverse outcomes among children [25]. Parental emotional attunement and sensitivity supports a child in discovering their own mind and how to get their needs met [50]. According to Anderson and Van Ee [50] when a child can reasonably anticipate that his or her needs will be met, they will feel secure with their caregiver. Parents who are sensitive and accurately respond to their child's display of emotions are creating a secure dyadic attachment. Decreased emotional attunement of traumatized parents may cause children to develop an insecure or disorganized attachment style [17]. Subsequently, studies have shown dyadic attachment to affect psychosocial adjustment of adolescents, as operationalized by self-esteem, life satisfaction, social skills and relational competence [16].

c) *Parenting Styles.*

Interactions between parent-child dyads are largely dependent on the parenting style, or the approaches a parent uses when engaging with and raising their child. Various parenting styles have been suggested as potential mechanisms of trauma transmission, including harsh, overprotective, and role-reversal parenting [20].

d) *Harsh/Hostile Parenting.*

Various studies found parental PTSD levels or psychological distress as predictive of harsh parenting and reduced warm parenting [24] [47]. The harsh or hostile parenting scale, derived from the Early Childhood Longitudinal Study of Children, includes items regarding negativity, use of physical discipline, and rigid enforcing of rules [24]. Other sources define hostile or harsh parenting to involve behaviors that are violent, aggressive, and include profanity and threats [4] [23]. Some parents described difficulty "containing their own frustration and agitation, or could not tolerate their children's demands, and thus projected their aggression onto their children" [26]. Spanking was a specific discipline type associated with poorer child emotional processing [36]. Bryant *et al*., [24] found PTSD in refugees to be associated with harsh parenting styles, as a mediator for significant indirect PTSD associations with adverse childhood mental health outcomes.

e) *Overprotective Parenting.*

Due to adaptive hypervigilance and perceptions of the world as unsafe, parents who have experienced trauma may become overprotective toward their children in attempts to shield them from such dangers [18] [26] [34] [53]. An overprotective

parenting style serves to discourage independence, interfering with the development of a child's autonomy [34] [50]. The Parental Bonding Instrument (PBI) was used in a study with genocide survivors of the Khmer Rouge regime to assess overprotective parenting styles from the child's perspective. The 13-item overprotection scale addresses the extent to which each parent was viewed as controlling as opposed to autonomy giving [34]. Varied results were found identifying overprotective parenting as a mechanism of intergenerational trauma transmission. In one study, preliminary findings supported the role of overprotective parenting as a mediator for the effect of parental trauma symptoms on child's anxiety and depression [54]. When adjusting for the limitation of child reporting of parental trauma symptoms, the mediating role of overprotective parenting in trauma transmission was not significant [34].

f) Role Reversal/Parentification.

Previous research has identified a prevalence of parentification experienced by children within refugee families [26] [55] [56]. This phenomenon refers to a role reversal in which children display care-giving behavior toward their parents and take on adult responsibilities out of need or ability. Four of the studies reviewed discussed the influence of parent-child role reversal on intergenerational trauma transmission, whether as an observed finding or proposed explanation for results.

Literature on role reversal frames this parenting style as an often indirect and unintentional outcome to one's circumstances. Im/migrant and resettled families experience changes in family roles and obligations after displacement that involve an increased dependence on children [57]. Children of a younger age tend to acculturate faster than their parents upon arrival to the U.S. due to socialization and language development in the school setting. Therefore, children often take on the role of cultural broker and mediator between the family and the host society because they can navigate the systems and language [25] [58]. Financial barriers and economic exclusion are frequently experienced by im/migrant families, making the need to contribute to the household income an added responsibility and obligation taken on by children [59]. After resettlement, some traumatized parents may find little sense of purpose or meaning in their own lives compared to their hopes for their children [59]. Children often experience this as an enormous burden, but they also accept it as a new family obligation [59].

Emotional parentification refers to children taking care of the emotional needs of the parent [34] [60]. When parental symptoms are acute, children may respond by caring for them in a way that mirrors typical parental caregiving behavior such as offering food, comfort, or physical proximity [25]. The child may become burdened by a sense of responsibility for the emotional welfare of the parent at the expense of his or her own needs [34]. Overall, parent-child dyads with im/migrant parents who have experienced trauma are more likely to develop a role-reversal relationship, increasing the risk of parental trauma transmission [34].

g) Parent-Child Conflict.

Child mental health outcomes including psychological distress, anxiety,

depression, and trauma, have been found to be associated with higher levels of family conflict [20]. According to a study in this review, family conflict was positively correlated with parental trauma exposure [20]. Hinton and colleagues analyzed various causes of parent-child conflict as reported by parent participants [49]. Many of the precipitating causes were perceived by the parent through the lens of their trauma experiences. For example, one of the most frequent causes of parent-child conflict (30%, n = 19/64) involved the child staying out late past their curfew. Some parent participants identified this as a cause of worry due to their perceptions of the world as unsafe following the Khmer Rouge period. Aspects of the parent-child conflict were also found to resemble a traumatic event experienced by the parent, referred to as retrieval cues [49]. For example, an emotion-type retrieval cue may occur when the behaviors of a child are perceived to be "disrespectful", (such as yelling at parent, e.g., upon being asked to do a chore) resulting in the recall of traumatic events involving feelings of shame and degradation. A somatic-type retrieval cue may occur when body sensations experienced with anger during a conflict (palpitations, dizziness, etc.) are reminiscent of similar sensations caused by past experiences of food deprivation or slave labor. These retrieval cues are suggested to exacerbate the parental response to conflict via anger directed at their children, previously noted as a potential mechanism of trauma transmission [49].

Studies have found that problems in parent-child relationships stemming from parental trauma may escalate further due to dissonant acculturation, or a lack of shared culture between parents and children [20] [49]. Frequent explanations for family conflict among South Asian immigrant families involve intergenerational differences between parents born in South Asian and children born in the resettled country [28]. Observed trends also indicate that im/migrant children acculturate to the language and culture of the resettled country at a faster rate compared to their parents. Whether a child is born or socialized in the resettled country, cultural gaps can lead to parent-child conflict. Culture maintains a vast influence over one's expectations, values, and practices. Therefore, cultural differences between parents and children may lead to disagreements over expectations regarding a child's autonomy and parental control [20]. While a lack of shared language, values, and culture may cause disputes to occur and escalate, language barriers were also noted to hinder conflict resolution, making it difficult to communicate and understand differing perspectives [33] [49]. Family cultural conflict is a significant risk factor for determinants of poor mental health outcomes and demonstrates how parental trauma exposure and differences in cultural expectations relate to parent-child conflict as a mechanism of trauma transmission [28].

3.3.3. Communication Styles

In the study of intergenerational trauma among Holocaust survivors, communication styles have been found to influence the transmission of trauma between parents and their offspring, particularly regarding the ways parents discuss their past trauma or explain their posttraumatic symptoms [12]. Studies among im/migrants

and other displaced populations analyzed similar communication styles including silence and secrecy, unfiltered communication, open communication, and modulated disclosure.

Dalgaard *et al*., [18] investigated communication styles among Middle Eastern refugee families and found a significant association between an unfiltered communication style and the development of insecure attachment among children, supporting unfiltered communication as a mechanism of intergenerational trauma transmission. Unfiltered communication represents disclosures that are accidental rather than made through a conscious pattern of communication. For example, parents may report not speaking of the traumatic events directly with their children but are observed to openly discuss their experiences when their children are within hearing range [61] [62]. When coding for unfiltered communication, Dalgaard and colleagues also included children who witness parents' traumatic symptoms but who have not been provided with age-appropriate explanations of why their parents act in this manner. The findings from studies in this review suggest that incoherence or contradictions between the child's implicit knowledge of the past and the parent's explicit perception of what the child knows is associated with insecure attachment and feelings of ambiguity and uncertainty in children of traumatized im/migrant parents [18] [63].

If unfiltered communication exists in the middle, silence/secrecy and open communication styles sit at two opposing ends of the spectrum. Varying results were found regarding an association between both extremes and child outcomes. Silence was more commonly discussed in association with child mental health difficulties. Some parent participants referenced difficulty thinking or talking about the past, while others described a desire to shield their children from knowledge of their traumatic experiences to avoid exposing them to the same horrors. Many refugee youth have observed their parents' reluctance to talk about their trauma, leaving them decontextualized from their family and community and impacting their identity development [62]. One child of Khmer Rouge survivors explained how her mom's "silence around her personal history often leaves me with doubts on how to begin telling my own" [33].

Bezo & Maggi [27] did not assess open communication directly, but they describe the passing down of stories about the Holodomor genocide to second and third generations as influencing adverse mental health outcomes and transmitting maladaptive behaviors or coping strategies to descendants. On the other hand, Dalgaard and colleagues found no significance for open communication or silence/secrecy as a mechanism of trauma transmission [35] [63]. Demographic variables were found to impact the outcomes derived from open and secretive communication styles. Open communication about traumatic material from the past was associated with anxiety in children with direct trauma exposure [61]. Among children 12 years old or younger, an open style of communication was associated with increased anxiety, while a restrictive style of communication was associated with internalizing symptoms in adolescent girls [61]. Overall, instead

of communication style, factors such as direct trauma exposure of the child and the child's age emerged as influential of the degree of parental disclosure that leads to intergenerational trauma transmission for refugee children.

Modulated disclosure was proffered as a style of communication associated with secure attachment and a potential buffering effect for intergenerational transmission of trauma. Modulated disclosure refers to "a style of intrafamily communication in which parental sensitivity to the child's cognitive and emotional needs is seen as more important than the content of what is disclosed" [61]. Findings support a strategy in which the amount of disclosure and open communication is adapted to the developmental capacity of the child [33] [61]. Modulated disclosure has been found to be associated with psychological adjustment in non-Western refugee children [61]. In families where both parents provided age-appropriate reasons and meanings to past trauma, children suffered significantly less from PTSD and marginally less from psychological distress, and family relationships were strengthened [63]. Results of Dalgaard and Montgomery's literature review indicate that "while some level of disclosure and open communication between parents and children may be universally beneficial, a modulated approach can be culturally embedded, and thus vary across cultures while still having the same adaptive qualities" [61].

3.3.4. Social Learning

Social learning is a critical factor throughout child development that "informs a child's construction of the world around them and the means through which to navigate their surroundings" [64]. By observing others who are already embedded in the culture, children come to think and act like them [64]. Children learn methods of communication, emotional expression, means to acquire needs, displays of love, and hierarchical and gender roles as they are modeled for them. In the context of intergenerational trauma, social learning is considered a potential mechanism of trauma transmission when children observe and imitate a traumatized parent's behaviors and strategies of navigating the world [21]. For example, a mother's volatile trauma symptoms might model explosive behaviors for their children, "predisposing their child to act out aggressively and thereby provoking bullying from peers and classmates" [21]. In a systematic review, a significant majority of qualitative studies examined intergenerational trauma through cycles of violence including the perpetration of socially learned harsh parenting styles, intimate partner violence, and substance misuse [6]. Studies have supported the social learning of parenting behavior as key in perpetuating cycles of abuse where a child who received harsh parenting inflicted the same treatment towards their own children [6]. In a study with Mexican American adolescent parents, participants described their experience of early maltreatment as contributing to a normalization of violence in their dating relationships as well as hindering their own ability to parent their children [6]. In addition to the adoption of externalizing behaviors, Bryant and colleagues found parents who presented with high anxiety to have children with increased levels of anxiety as well due to the parents'

repetition of negative appraisals about the world and the modeling of anxious behaviors to their children [24]. Other studies found descendants of traumatized family members to develop maladaptive behaviors via social learning. For example, second and third generations of survivors of the Holodomor genocide describe observing reverent attitudes toward food and adapting stockpiling behaviors due to the significance of forced starvation and food confiscation experienced during the genocide [27].

3.3.5. Family Stressors

Family systems theory includes consideration for a child's relationship with both their micro- (parents, teachers, and peers) and macro-environment (community, culture, and systems) to fully understand family functioning and its impact on child development [41]. Studies within this review have found acculturation stressors and structural vulnerability as increasing the risk for trauma transmission among immigrant families via family functioning pathways. Acculturation is defined as "the process of cultural and psychological change that arises from contact between two or more cultural groups" upon resettlement [65]. Resettled families experience various acculturation stressors that increase stress and tension within the family unit [47]. This can include uncertainty about one's refugee or asylum status, language navigation, and social pressures to conform to a new culture while attempting to maintain values and traditions of the culture of origin. Many acculturation stressors are reflective of present systems and structures that place people in positions of structural vulnerability, or "the ways life opportunities are constrained within mutually reinforcing power hierarchies" [6]. This includes, but is not limited to, economic exclusion, hindered access to resources, social marginalization, and exploitation and discrimination. Institutional discrimination, xenophobia, and hostile attitudes toward im/migrant communities can further exacerbate the impact of trauma on both mental health and ethnic identity development [30] [52]. In a systematic review about intergenerational trauma in Latinxs, structural vulnerability was explored in the majority of studies (78%) [6]. Seven mothers in one study reflected upon their status in the Netherlands as refugees or asylum seekers, and how inadequate housing conditions and overcrowded spaces inhibited their sense of privacy, comfort, and safety, and impacted their ability to parent [50] [52]. Some mothers expressed concern that their child's immigration status would limit access to resources, services, and education [52]. Even when resources were available, several fathers commented on the many challenges of obtaining knowledge about and access to these services [65]. Language and literacy barriers were noted as significant obstacles to awareness of job opportunities and applying for and securing employment [65]. Among families who experience an accumulation of stressors and perceived racism, some participants reported feeling helpless and hopeless with regard to caring for themselves and their children, as well as a lack of problem-solving and coping skills [25]. According to the research, the lack of agency and autonomy that accompanies structural vulnerability also contributes to feelings of frustration and anger toward authorities [25]. The

accumulation of family stressors due to acculturation and structural vulnerability was found to exacerbate parental PTSD symptoms and additional mechanisms of trauma transmission including parenting styles and parental emotional attunement [6] [24] [50].

3.4. Resilience and Protective Factors

Exploring the consequences and mechanisms of intergenerational trauma has provided an understanding of the risks that contribute to mental health consequences; however, protective factors can promote resilience and mitigate the transmission of adverse outcomes. Resilience refers to "the ability of an individual to withstand the effects of stressful events that would ordinarily lead to pathology" [66]. An individual or family system has the ability to "use its internal resources to enhance physical and relational health to cope, adapt to, and bounce back from adversities" [23]. Emerging studies suggest that the intergenerational transmission of trauma should instead be conceptualized as resilience transmission in order to divert research publication and application away from a deficit framework [63] [67]. For example, Cerdeña *et al*., [6] identify a concern among the literature that "a focus on impaired parenting may unintentionally lead to the conclusion that marginalized individuals make poor parents, rather than the fact that parenting is challenging in marginal [and traumatizing] environments." This literature review analyzed pathways to resilience across all socioecological levels, with interventions at individual, family, and community levels being crucial to promoting resilient outcomes for people of im/migrant backgrounds [65].

3.4.1. Individual Resilience

Individual resilience is depicted as a person drawing on sources of strength from within themself as an individual. Among the studies in this review, individual resilience was found to mitigate the transmission of trauma either proactively through the parent or protectively within the child. A common example of individual resilience among both parties involves the use and implementation of personal coping mechanisms. In one study among fathers of refugee backgrounds, many participants identified personal strategies for managing stress and promoting their well-being including reading, listening to music, watching TV, meditation and gardening despite the limited time they had available to themselves [65]. Other participants "highlighted the importance of physical, mental, and spiritual practices such as yoga and walking as coping mechanisms" [44]. Bhutanese older women described household chores as a passive coping strategy to regulate their emotions, supported by evidence that points to distraction techniques as helping a person manage distress without directly confronting the situation or trying to solve the problem [44].

A coping mechanism referenced by both generations involved the role of arts and literature. Among Bhutanese community members who participated in literature groups, expressive writing in the form of poems, literary pieces, stories,

songs, and books gave meaning to ruminating thoughts, experiences of trauma, and emotional distress, and were used as coping mechanisms to ease stress [44]. Youth members of the Khmer Girls in Action (KGA) organization create visual art and host an annual art showcase involving youth learning, creating, and performing classical Khmer dance, poetry, Theater of the Oppressed, hip-hop dance, and other activities that support their healing justice mission [68]. Individual coping skills support with emotion regulation, distraction techniques, and bring moments of joy and peace to the individual as a way of fostering resilience. KGA staff shared that "taking time to heal is especially critical given contexts of intergenerational trauma and ongoing systemic violence" [68]. Signaling to the importance of attending to individual well-being, KGA staff note "We deserve love and happiness too" [68].

Some parents reported that spending time with their children alleviates or reduces trauma symptoms [25]. The role of motherhood itself was identified by some refugee mothers as empowering and a source of their strength [50] [69]. In one case study, one mother attributes the desire to be a 'good mother' as giving her a sense of meaning and direction [18]. Another study participant described: "[My child] is my motivation in life. [My child] gives me purpose in life, [they] give me an idea of the future, of what will happen tomorrow" [57]. Fathers also derived a strong sense of meaning from parenting and engaged closely with their children [65]. For example, one father reported "What I love about [fatherhood], I think just the beauty of spending time with my son and hearing what he says. The person that he is, and as a two-year-old he's got his own character, his own personality" [65]. Study authors found that parents who were able to identify and articulate this sense of purpose in parenthood had higher levels of emotional availability as a protective factor in contrast to lowered emotional attunement [50]. Trauma recovery involves restoring a sense of identity and meaning and studies suggest this meaning might come from parenthood.

3.4.2. Family Resilience

Studies included in this review found significant results supporting the association between adaptive family functioning, such as family flexibility and cohesion, and positive mental health outcomes among children [25]. Family cohesion, or family bonding, was found to be associated with resilience in both parents and children [13] [22] [25] [55] [57]. A strong bond in parent-child relationships refers to "a sense of belonging, a sense of togetherness, and a sense of hope and meaning in life" [23]. Study participants emphasized family cohesion as "an asset and a source of strength and protection, from both the perceived dangers and challenges associated with life in exile, and as a buffer or a way of protecting children from being negatively affected by parental suffering" [25]. One study found strong family bonds and less hierarchy between parents and children as resilience factors among Cambodian immigrants [23]. Weine *et al*., [59] also found "Bosnian families' togetherness as a very important cultural value [because] when

families' behaviors reflect togetherness, it serves as an affirmation of their ethnocultural identity."

3.4.3. Institutional and Structural Protective Factors

Due to the influence of macro-level factors on intergenerational trauma transmission, it is important for resilience perspectives to emphasize ecological context, instead of focusing solely on the individual or parent-child dyad as central to the patterning of intergenerational trauma [6]. In the context of intergenerational trauma, institutions and structures refer to the design of policies, organizations, and broader systems that contribute to health inequity and adverse outcomes. To counter the impact of acculturation stressors and structural vulnerability on the family unit, successful resettlement would require comprehensive structural resources and support from the resettlement countries so that im/migrant families can exist safely without experiences of ongoing trauma. Research has supported the importance of resource availability and environmental conditions in the process of trauma recovery [6]. For example, one study suggested higher levels of maternal education as relating to reduced effects of intergenerational trauma transmission, requiring increased access to educational opportunities for im/migrant mothers [4]. Both the individual and collective well-being of im/migrant communities require the systems and structures in the resettled countries to adequately address the needs of these families [23].

Some organizations have been developed to assist and empower im/migrants to expand their own understanding of, and solutions to, structural forces threatening their well-being [68]. For example, Khmer Girls in Action (KGA) is a Southeast Asian American women-led organization engaged in healing justice work that involves a focus on transforming institutions that contribute to health inequities, as well as psychological, spiritual, and emotional healing caused by structural oppression [68]. KGA programs advance the political education of youth leaders to identify root causes of intergenerational trauma and structural violence, and to use this civic and political power to advocate for resources supporting health equity [68].

Studies suggest improved structural and systemic support should provide healing and trauma recovery while doing so in a responsible and culturally appropriate way. According to one article, a trauma-informed approach to working with people of refugee backgrounds emphasizes "safety, including advocating for access to basic needs, reducing barriers to service access, and taking steps to optimize physical, emotional, and cultural safety in healthcare settings" [65]. Other findings support the need for health services and practitioners to be considerate of how parents of refugee backgrounds access, understand, and apply health information to address potential barriers involving communication, health literacy, and language limitations [65]. Finally, health and social care services aiming to improve im/migrant mental health should build upon or integrate interventions into existing sources of support already utilized by im/migrant families [65].

3.4.4. Social and Cultural Protective Factors

a) *Social factors*

A significant benefit of structural programming is the opportunity to facilitate social connectedness and belonging. Addressing structural and social marginalization would connect families to wider sources of social support. For many im/migrant families, meaningful social support includes peer and community support and a large family network in the resettled country [4] [70]. Access to a strong sense of community and peer support were suggested as buffers to the effects of parental trauma on second generation outcomes [4]. Among parent participants, social support was found to have a significant impact on PTSD symptoms so that less social support was related to higher PTSD symptom level [34]. Increased social support was significantly related to posttraumatic growth in a sample of Khmer Rouge survivors [34].

In addition to increased access to sources of social support, having a social network of people from the same cultural or ethnic community was found to contribute to the well-being of im/migrant families. Ethnic social support has been identified as a protective factor because it provides refugees who experience mental health challenges an opportunity to relate to others [62]. For example, in a study among resettled Southeast Asian refugees in Canada, the availability of support from both Canadians and members of the same ethnic community each made important contributions to positive mental health; however, the like-ethnic community was a specific determinant of well-being among adult refugees and contributed to children's self-esteem and psychological resilience [71]. Findings of the Southeast Asian Refugee Youth Project also highlighted the importance of having the support of friends of a similar ethnic background to foster empathy and connection [71]. In another study, im/migrant fathers' number of native friends predicted better child mental health [70] [72].

Access to a social network of members of the same ethnic community also increases the likelihood of support seeking behaviors. Seeking out professional mental health support remains taboo and stigmatized in some cultures, with support seeking behaviors often limited to the parameters of family, friends, and members of a person's own community [44]. Youth belonging to the Khmer Girls in Action organization discuss the role of supportive relationships with staff from similar cultural backgrounds on the ease of communication [68]. One participant described: "The stuff I go through at home is not something that I'm going through by myself. I don't have to keep it to myself. I can reach out for help" [68]. Even access to technology and social media was identified as a social support for younger participants from similar ethnic backgrounds to "express emotions and share everyday difficulties of coping with cultural demands, academic difficulties, and cultural conflicts" while helping to promote a sense of community [44].

b) *Cultural factors.*

Religious practices, cultural traditions, and positive cultural narratives were found to be important to the promotion of well-being and the reduction of trauma

transmission through a fostering of collective identity across generations.

Religion and spirituality are important sources of strength and community among im/migrant individuals and their families [52]. Some Hindu rituals involve the participation of extended family members, neighbors, and the larger community, which provides a sense of belonging and agency according to a study with Bhutanese participants [44]. In this study, traditional religious rituals and customs were the most common cultural coping mechanism analyzed [44]. Temples and other sacred sites are described as healing spaces "that provide peace and solace, not only among people experiencing mental distress but also their families" [44]. Another study noticed an association between patients who had reduced or no anger symptoms in the last month and their use of Buddhist techniques such as meditating, practicing "equanimity," or distancing from affect, and enacting the ideal of non-revenge which were learned by going to the temple or listening to local Buddhist programs on television [49]. For many Bosnian teens, attending religious services, saying prayers, reading religious texts, and participating in rituals reconnected them with their cultural heritage [59].

Maintaining ties to one's ethnic identity, or an identity based in part on the culture of origin, can also foster resilience [6] [59] [71]. While acculturation to the host culture may help some immigrants find a sense of belonging in their new homeland, others may feel alienated due to this loss of cultural identity [30]. Children of parents who maintain ethnic pride and cultural identity were found to perform better than children whose parents assimilate fully [71]. Participating in cultural practices, such as performing classical dance and wearing cultural attire, were identified as a "critical form of healing that resists multiple layers of systemic erasure and [invisibilities]" according to descendants of the Khmer Rouge regime [68]. A strong cultural identity "encourages members to reflect on how they stand on the shoulders of their ancestors and their visions for collective thriving" [68]. Omatic therapies can help relieve stress and enhance coping skills among refugees [73]. Another intervention to help families can be home visiting programs [74].

Sharing positive memories and cultural narratives similarly supported resilience pathways [59]. With the emergence of research with non-Western refugees and survivors of displacement, it is essential to consider different cultural values and traditions with regard to intrafamily communication [61]. For example, despite evidence of potential adverse effects of open communication, many families across cultures use the telling of stories and family narratives as a socialization tool to create and maintain individual and collective identity [25] [33] [57] [61]. Functions of family stories may also include "entertaining, inspiring, reminiscing, teaching, passing down family history, illustrating individual traits, and relating. Specific ethnic groups included the functions of dealing with a racist society, providing healing, learning about each other, and revealing God's protective hand" [61]. Across various cultural and ethnic groups including Native American, Palestinian, and Southeast Asian families, studies suggest that growth and resilience are possible when family and cultural narratives are framed in empowering ways. Empowering

narratives focus on collective strengths, messages of hope and justice, and the integration of ethnic and individual identities [33] [63] [67]. Cai and Lee [33] emphasize the importance of, and dependence on, intergenerational communication within families and communities due to "erasure from dominant discourses" in many Western countries.

4. Discussion

4.1. Conclusions

In summary, the results of this systematic review support the following conclusions:

Parental trauma influences the prevalence of internalizing and externalizing problems among children, leading to a lowered capacity for psychosocial functioning and adjustment. Poor mental health outcomes among children also include the development of adaptive behaviors and worldviews resembling those of the traumatized parent. Studies have identified limitations when child internalizing and externalizing problems are dependent on parental reports. Internalizing problems are considered less easily observable and may result in parents underreporting their children's emotional symptoms. Some studies utilize various sources such as reports from teachers, other caregivers, or even self-reports to deter bias from relying solely on parental reporting. Nevertheless, this limitation must be considered when drawing conclusions about children's emotional and mental well-being.

The severity of posttraumatic stress symptoms (PTSS) or parental distress, rather than trauma exposure, is related to adverse child outcomes directly and indirectly via secondary pathways. While PTSS typically involves a set of symptoms established by the DSM-5, it is important to consider cultural variations and idioms of distress used to express and understand symptom presentation and mental health among im/migrant patients. Across cultures and societies, idioms of distress are used to represent expressions of distress in relation to their personal and cultural meaning [75]. For example, in a literature review focused on Cambodian descendants of genocide survivors, some participants identified experiencing an idiom of distress called *baksbat*, which translates to "broken courage" [30]. *Baksbat* refers to a persistent fear following a distressing or life-threatening experience [30]. Cambodian participants in a qualitative study "contextualized *baksbat* within the sociopolitical context of feeling powerless in an authoritarian society, thinking too much about the events of the genocide, and fearing that a similar situation could occur again" [30]. Research supports the importance for a culturally competent practitioner to not only translate the idiom of distress, but to also "understand the social context of the term that communicates the expected symptomology and perceived cause of the symptom" [30]. Additionally, some cultures and languages, such as the Nepali language, might have limited vocabulary to express distress to begin with [44]. According to the authors of one reviewed study, these linguistic limitations "might have contributed to the inability to express

mental health experiences as understood, described, or even experienced in Western culture," and must be taken into consideration when interpreting research results about non-Western ethnic groups that rely on Western measures and approaches [44]. This review was intentional about its consideration for various idioms of distress used in Non-Western cultures to be inclusive of all "socially and culturally resonant means of experiencing distress" [30].

Parent-child interactions are a significant mechanism of trauma transmission and refer to parental emotional attunement and sensitivity, dyadic attachment, parenting styles, and intrafamily communication. Trauma interventions for im/migrants would benefit from addressing the impact of trauma between the parent-child dyad rather than just the individual. Briggs and colleagues examined intervention effects among maltreated mothers who participated in the Healthy Steps parenting intervention, with participants reporting better child socioemotional health relative to maltreated mothers who did not participate [6] [76]. It is also important for parenting behaviors to be considered in their socio-cultural context. Divergence from Eurocentric and Westernized parenting expectations should not be attributed directly to trauma without sensitivity to normative cultural styles of parenting. The results reported in this review require consideration for the challenge of measuring parenting cross-culturally due to a concern that all cultural parenting styles may not be reflected accurately via measures.

Resettled families experience various acculturation stressors that impact stress and tension within the family unit, exacerbating parental PTSD levels and contributing to poorer mental health among children. The Western concepts of posttraumatic stress and posttraumatic growth requires there to be a "post" period after the traumatic event has occurred, implying the trauma is over. With the occurrence of acculturation stressors and structural vulnerability upon resettlement, trauma is ongoing. Diagnoses of PTSD should not precede stabilization and access to basic needs as to avoid pathologizing a person based on their environmental context and stressors rather than their psychopathology. Services and interventions for im/migrant families must acknowledge the intersection between a person's identities and their position in surrounding social systems to allow for a holistic approach to care. For example, Trauma Systems Therapy (TST) is an organizational and clinical model that focuses on both a child's mental health presentation and the social environmental context that may contribute to ongoing symptoms in the aftermath of trauma transmission. The TST adaptation for refugees addresses "multiple barriers to care for refugees and their families through innovative mental health service delivery, multi-tiered approaches to community engagement and stigma reduction, services accessible in the school setting, partnership building, and the integration of cultural brokering throughout all tiers of intervention to provide cultural knowledge, engagement, and attention to the primacy of resettlement stressors." [48] This model exemplifies the importance of designing and evaluating interventions to be culturally sensitive and take into account the broader ecological contexts in which im/migrant

families live.

Pathways to resilience exist across socioecological levels and include individual resilience such as coping skills and meaning making, adaptive family functioning via family cohesion and flexibility, structural protective factors including resource accessibility, and social and cultural protective factors. Mental health interventions should capitalize on individual and collective strengths of im/migrant populations in contrast to focusing on prognoses based on a deficit framework.

4.2. Strengths and Limitations

This review summarizes studies inclusive of various cultural groups. However, all cultural groups are unique, and results cannot be generalized from one group to the next despite shared migration status or traumatic experiences. Future research would benefit from continued exploration of trends among individual cultural groups to inform specific intervention needs and cultural sensitivities.

In this review, studies were included that either did not account for direct traumatization among children or explicitly described traumatic events directly experienced by children. The literature suggests a co-occurrence between the adverse consequences of trauma related variables and family processes and their impact on children's physical and mental health [26]. Conclusions drawn from such studies must be considered with caution as mental health outcomes among children cannot be explained solely by intergenerational trauma transmission.

Most studies included in this review were cross-sectional, while only 8% (n = 4) were longitudinal. Future research on intergenerational trauma would benefit from conducting longitudinal studies to determine causal relations and to better understand the conditions that buffer or enhance the transmission of trauma over time.

This review finds itself uniquely embedded in an expanding body of literature on the topic of intergenerational trauma and resilience among im/migrant families. When the socioecological and interpersonal risks of trauma transmission are understood, future advocacy and research efforts can mitigate observed adverse outcomes through support of pathways to resilience, empowerment, and healing.

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Conflicts of Interest

The authors have no conflicts of interest or financial disclosures.

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