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ORIGINAL PAPER

Intergenerational Trauma and Its Relationship to Mental Health Care: A Qualitative Inquiry

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Abstract
Intergenerational trauma is a discrete form of trauma which occurs when traumatic effects are passed across generations without exposure to the original event. This qualitative study aimed to explore how psychiatrists understand intergenerational trauma in respect to their practice, for the purposes of identifying interventions for addressing intergenerational trauma in public mental health services. Findings revealed that psychiatrists observe intergenerational trauma frequently in their roles and try to opportunistically promote awareness of trauma with adults, and refer families to external services for supportive interventions. They feel powerless when faced with directly intervening with intergenerational trauma and required restructuring of their roles to adequately address it in public settings. Findings have implications for training, advocacy and research on the relationship between trauma and mental illness. Alongside this, there is an indicated need for examination of how systems can ensure access to appropriate services once organisations become trauma-informed.

Keywords Intergenerational trauma · Transgenerational trauma · Relational trauma · Traumatic stress · Prevention · Psychiatry

Introduction

The term 'trauma' refers to events, experiences and their effects upon individuals (SAMHSA 2014). Events with traumatic effects may be relational, occurring by people to other people; environmental, such as accidents or natural disasters; or cultural such as genocide, war, and displacement (Kleber 2019). Regardless of the antecedent, the trauma then lies in the sustained effects of these experiences on individuals. Effects include neurobiological changes in the brain, vulnerabilities to further harm, interpersonal and intrapersonal difficulties, and internalized formulations of self and other (Isobel et al. 2017). Trauma is also known to affect parenting (e.g. Lyons-Ruth and Block 1996; Iyengar et al. 2014). Trauma can contribute to caregivers demonstrating inconsistent affective responses to their children (Schore 2002), leading to dissociative, mood and behavior symptoms in the next generation (Babcock Fenerci et al. 2016; Chu and DePrince 2006).

Trauma and mental illness have recognised interactions (Mueser et al. 2002; Anda et al. 2006) with trauma linked to the development and severity of mental illness across the lifespan (Heim and Nemeroff 2001; Rosenberg et al. 2007; Leverich et al. 2002). Trauma also impacts upon the course of illness, including social and cognitive impacts (eg. Bentall et al. 2014; Longden et al. 2016), leaving experiences of trauma and mental illness entwined and difficult to clinically disentangle. With increased understanding of a relationship between trauma and mental illness; awareness of the prevalence and impacts of trauma for people accessing mental health services is increasingly necessary in all psychiatric settings (Butler et al. 2011; Sweeney et al. 2016; Palfrey et al. 2019). Movements towards Trauma Informed Care have begun in mental health services (Harris and Fallot

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2001; Yatchmenoff et al. 2017). Trauma Informed Care is an approach to service delivery based on recognition of trauma prevalence, that experiencing mental illness can be traumatic, that there is risk of harm occurring in care, and that there are ways that care can be delivered to be sensitive to trauma and minimize further harm (Harris and Fallot 2001; Isobel and Edwards 2017). Within the growing clinical awareness of trauma broadly, there are numerous subtypes or forms of trauma that require specific consideration and understanding. Intergenerational trauma is one such form of trauma that may confound psychiatric treatment (Isobel et al. 2019).

Intergenerational trauma refers to the process of transmission of trauma from parent-figures to their infants or children, resulting in the effects of trauma being experienced by the second generation without exposure the original traumatic experience or event (Hesse and Main 2000). It is a discrete process, which differs from secondary or vicarious exposure (Isobel et al. 2019). Intergenerational trauma is also sometimes called 'transgenerational trauma', when referring to the transmission across one or more generations (Yehuda and Lehrner 2018) or 'historical trauma', when referring to affecting multiple generations of a cultural group (Kirmayer et al. 2014). Intergenerational trauma occurs when parent figures who have experienced trauma transmit the effects of their trauma to their children via interactional patterns, genetic pathways and/or family dynamics (Hesse and Main 2000). Transmission may occur via the second generation learning to think and behave in ways that replicate their caregivers' traumatic adaptations, or by being exposed to the secondary psychosocial effects of these adaptations and themselves similarly having to adapt (O'Neill et al. 2018; Weiss and Weiss 2000). Transmission occurs unintentionally and usually without awareness of the contribution of the original traumatic event (O'Neill et al. 2018). Attachment within intergenerational relationships forms the relational context where understandings of self and other develop (Sroufe 2005), with patterns of learnt security or insecurity known to be replicated transgenerationally (Fonagy et al. 1991; Farnfield et al 2010; Iyengar et al. 2014). Attachment may also mediate intergenerational trauma transmission (Isobel et al. 2019). Intergenerational trauma is transmitted in complicated and subtle ways through attachment relationships, and within family and community groups (O'Neill et al. 2018; Weiss and Weiss 2000). Intergenerational trauma is both an exposure and a vulnerability transmitted relationally (Baranowsky et al. 1998), making it both a familial process and an individual one (Berger 2014).

Intergenerational trauma has been long recognized in second, third and further generations of trauma survivors (Kellerman 2001). There remains some disagreement however, about whether the passed-on aspects are the subsequent generations' traumatic effects, or whether they belong to those of the past (Albeck 1992). There is also increasing consideration of the potential role of epigenetics in this process of transmission (Franklin et al. 2010; McEwen 2017; Ramo-Fernández et al. 2015; Weaver et al. 2005). Adult children of Holocaust survivors are one population who are well recognised as experiencing multigenerational traumatic effects, including a predisposition to Post Traumatic Stress Disorder; difficulties with individuation, self and interpersonal functioning; vulnerability to stress; anxiety; and depression; alongside resilience and cultural strength (Van IJzendoorn et al. 2003; Dekel et al. 2013). Some descendants of Holocaust survivors also report experiences such as persistent nightmares of war and torture, potentially imprinted by the repressed or unconscious memories of their parents or grandparents (Kellerman 2001). Indigenous communities also experience multigenerational trauma, based on events of the past and compounded by ongoing disadvantage and structural inequalities (Boulton 2018). Frameworks of understanding intergenerational trauma experienced by Indigenous groups link the concepts of historical oppression and psychological trauma, to explain how human rights violations intersect with ongoing loss of culture and systemic discriminations (Kirmayer et al. 2014; Gone and Kirmayer 2020). Many of the effects of such traumas are compounded by ongoing economic, social and political oppression that affect individuals and groups multi-systemically (Gone and Kirmayer 2020).

Alongside cultural traumas, there is increasing understanding of the potential for *any* trauma to be transmitted intergenerationally through familial attachment relationships such as parent and child (Schore 2002). This includes sustained traumatic stress, complex trauma, experiences of childhood abuse, domestic violence or any other event or experience leading to sustained traumatic effects, reflected in the next generation by similar traumatic stress response activation and altered perceptions of safety, trust, worldview and self (O'Neill et al. 2018). Effects can also be more specific, for example, dissociative responses to certain stimuli, or more broad, for example, profound feelings of emptiness or shame. How this passing-down or transmission of trauma occurs is theorised, but some aspects remain unclear, including whether it is indeed transmission of phenomena, or a direct component of the original trauma itself (Albeck 1992). It is not known exactly how intergenerational trauma precipitated by attachment based traumas (such as those experienced within families), may differ to that of groups exposed to shared external forces (such as cultural traumas) (Yehuda et al. 2001; O'Neill et al. 2018). However, interpersonal forms of trauma have been linked to increased rates of intergenerational effects compared to combat or war (Lambert et al. 2014), likely mediated by attachment relationships and specific parental behaviors (Babcock Fenerci et al. 2016). Regardless of the

source, intergenerational trauma may be best understood as a transmission of stress, risk and adaptation across generations (SAMHSA 2017), influenced by genetic predispositions, as well as learnt models of parenting, and family, community and cultural perceptions of the world.

Mental illness also has familial patterns and transmission of risks and vulnerabilities (Rasic et al. 2013), impacted by socio-cultural factors (Boursnell 2011). Determining the distinction between intergenerational trauma and intergenerational mental illness can therefore be challenging. Mental illness can predispose families to significant social and economic familial vulnerabilities (van Santvoort et al. 2015) across generations (Benjet et al. 2003). Mental illness is stressful for families (Reupert et al. 2012) and can be a source of sustained traumatic stress. Traumatic stress has structural and functional effects. Prenatal or very early life stress can result in epigenetic modification affecting endocrine functioning and brain development across several generations (Babenko et al. 2015; Buss et al. 2012) including through altered serotonin neurotransmission (Booij et al. 2015), elevating risk for mental illness in adulthood (Babenko et al. 2015). Stress is also a way to conceptualise the effects of trauma, as stress is a recognized physiological phenomenon incorporating adaptation strategies and coping mechanisms that can occur in toxic levels and over time damage the body (SAMHSA 2017). The cyclical nature of trauma and familial adversity (Curran et al. 2016) suggest that familial mental illness and its correlates are both risk factors for, and vulnerabilities of, transgenerational mental illness and that the line between intergenerational trauma and multigenerational mental distress is non-distinct.

In mental health settings, responses to trauma are inconsistent (Read et al. 2005; Frueh et al. 2002; Hiratsuka et al. 2017). Trauma-informed approaches to care have been challenged by poor translation of the principles into practice (Muskett 2014; Yatchmenoff et al. 2017), amplified by defensive responses by healthcare professionals to acknowledging iatrogenic harm (Isobel 2016). While intergenerational trauma is recognised in specialised Indigenous mental health settings (Kirmayer et al. 2000; Ypinazar et al. 2007; Krieg 2009; Menzies 2006), its integration into all mental health contexts is compromised by a lack of diagnostic positioning (Gone 2013) and longstanding resistance to recognising familial roles in the course of treatment (Goldman 1982; Wyder and Bland 2014). Family focused practice in mental health settings is an important form of preventative intervention to address intergenerational impacts of mental illness for families (Foster et al. 2016). However, the medically dominated orientation of many adult mental health services can impede family-focused practice (Lauritzen et al. 2014). Stigma may also keep patients from discussing parenting or familial adversity, leading clinicians to overlook people's family context and be unaware of both positive and negative relationships amongst families.

Due to specific complexities of intergenerational traumatic stress, there are additional challenges to implementing interventions to treat its effects in mental health settings. Individuals may present to services with trauma-like presentations unable to articulate a precipitating event for their traumatic effects or not conscious of the relationship between their current presentation and events of the past (Edwards et al. 2003; Goldsmith et al. 2004). Due to the intergenerational trauma process, usual trauma interventions such as trauma-focused therapies may reduce distress but may not be effective in resolving underlying causes (Isobel et al. 2019). Without awareness of the aetiology of trauma, (Yehuda et al. 2001), any mental health intervention may be ineffective or inappropriate (O'Neill et al. 2018). Therefore, services and clinicians who encounter trauma survivors need an understanding of intergenerational trauma and its particular effects, as well as potential modalities of intervention.

Psychiatrists hold clinical and operational power in services and make critical decisions regarding care and treatment. As clinical leads in mental health settings, there is a need to understand how psychiatrists understand intergenerational trauma. There is no existing literature on psychiatrists' understandings and perspectives on intergenerational trauma. The current study aimed to identify how psychiatrists conceptualise intergenerational trauma; how they perceive intergenerational trauma in respect to their practice; and to identify implications for intervention for intergenerational trauma. The research question guiding the study was: *How do psychiatrists conceptualise intergenerational trauma and how do they perceive its implications for their practice?*

Method

An interpretive qualitative design was used. Interpretive qualitative research is a form of social inquiry that uses reflective reconstruction and interpretation of how people describe and make sense of their experiences to understand a phenomenon (in this case working with intergenerational trauma), in its context (psychiatry and mental health services) (Flick 2018). Ethical approval was gained from the Concord Hospital Human Ethics Review Committee (LNR/17/CRGH/300). The research team had no conflicts of interest. Groups of psychiatrists working in public adult mental health services across Australia were contacted via emails sent through professional network lists. Interested psychiatrists contacted the first author directly for information or to participate. A snowball process then occurred where some participants told their colleagues about the study and those colleagues independently made contact.

Snowballing allowed for greater access to psychiatrists who may otherwise not have participated (Noy 2008). Qualitative research typically aims to sample widely and deeply enough to capture the important aspects and variations of the topic (Elliott and Timulak 2005). While the sample was not intended to be representative of all psychiatrists, attempts were made to recruit participants with a broad range of demographics (for example working in both inpatient and community settings, with varying levels of experience and mixed genders). No participant declined to participate after initial consent.

Semi-structured in-depth interviews were undertaken by the first author, stimulated in-depth discussions and lasted between 40 and 70 min. Such interviews are widely used in health research as they allow for detailed exploration of the views, attitudes, values, beliefs and motives of people towards a topic, while also being flexible in how information is attained (Elliott and Timulak 2005). Interviewers engage participants in an inquiring conversation using open-ended questions based on a flexible guide of topics to be explored (Jamshed 2014). The interview guide developed for this study included psychiatrists' understandings of the concept of intergenerational trauma, its relevance to their role in adult mental health service provision and their experiences in working directly with people who may have experienced it. As is common in qualitative studies, the interview guide provided a flexible rather than prescriptive structure for the interviews (Kallio et al. 2016). Guiding and probing questions were used to encourage participants to elaborate on their accounts of experiences, and to ensure that similar types of information were collected from each participant (Holloway and Wheeler 2010). Guiding questions included 'Do you observe intergenerational trauma within your role?'; 'How do you identify intergenerational trauma in your role?'; 'How do you see intergenerational trauma to interact with mental health?'; And when appropriate, 'what would need to occur for you to be able to respond to intergenerational trauma in psychiatric settings?'. The guide was internally tested through evaluation by the research team (Chenail 2011) and field-tested (Kallio et al. 2016) with the first participant.

Interviews were undertaken between January and December 2018 and were audio-recorded and professionally transcribed verbatim. The number of participants recruited was assessed on an ongoing basis to determine when sufficient breadth and density of data had been achieved. In qualitative studies using in-depth interviews, the larger the sample is, the greater the risk that the complexity and nuance in the data will be lost (Braun and Clarke 2016), subsequently a decision was made to cease recruitment at 13 participants, as their interviews had contributed to a large amount of data and theoretical saturation (Lewis-Beck et al. 2003).

Analysis

Data were analysed using inductive thematic analyses following the processes of Braun and Clarke (2006). Firstly, time was spent reading and re-reading the transcripts to familiarise the researchers with the data. Then, interesting features (or aspects of the data that appeared relevant to the research questions) were systematically 'coded' using NVivo analysis software, QSR International Pty Ltd. Version 12. Subsequently, codes were collated into themes across the data, which were iteratively reviewed, defined, named and described (Braun and Clarke 2006). Themes were developed based on the collated transcripts of all participants, using the judgement of the researchers, guided by the research questions (Braun and Clarke Braun). Themes were determined in relation to the research questions rather than quantifiable measures (Braun and Clarke 2006) of endorsement. Rigour was maintained throughout analysis by iterative review and discussion amongst the researchers.

Findings

Thirteen psychiatrists participated in the study. Eight were consultants or staff specialists, while five were advanced psychiatry trainees. All worked in metropolitan adult public mental health settings, both inpatient and community based, and most also worked in regional, rural or private settings. No detailed demographic information of participants were recorded, to enable participants to speak freely about their roles and practice without concerns about confidentiality. In qualitative research, conventions of confidentiality aim to protect the privacy of all participants, build trust between participants and researchers and maintain integrity of the process (Kaiser 2009). As the relationship between psychiatry and the concept of trauma was noted to be contentious (Isobel 2016), participants were informed that no demographic data would be linked to their responses. Participants were asked what settings they mainly worked in to contextualise their responses for the researchers, but these details were not included in analysis. Of note, however, is that one participant identified an interest in psychotherapy outside of their public role, one had a child and family therapy interest and two worked with Aboriginal populations in their fractional positions. Their age range and self-identified gender were estimated during the interview, but not confirmed. The purpose of this was to monitor the heterogeneity of the sample during recruitment.

The findings demonstrate that the psychiatrists had awareness of intergenerational trauma, particularly when working with groups known to have experienced cultural traumas, but they felt powerless to respond to the intergenerational aspects and effects of trauma within their roles. To be able to respond to intergenerational trauma in their

roles as psychiatrists, would require them to think differently about the type and purpose of their interventions and for expectations and structures of their roles to facilitate them to consider what had happened in their patient's past and the implications for the future. Findings are presented as four themes and supported with illustrative quotes to deepen understanding of the analysis (Corden and Sainsbury 2006). The themes are: *having awareness; feeling powerless; thinking differently; looking backwards and looking forwards.*

Having Awareness

Psychiatrists identified their awareness of intergenerational trauma and perceived this awareness as important to their work in psychiatry. They described observing trauma cycles occurring within their patients' lives. They had differing explanations of how intergenerational trauma occurred and differing descriptions of its clinical presentation. They described clinical examples of patients whose capacity to parent was impacted by their trauma, leaving children vulnerable to traumatic experiences of their own, and patients who had not processed their trauma and therefore replayed attachment patterns with their children. They also described patients who had experienced extreme cultural trauma in their lives, such as war, and then had difficulty parenting their children due to the secondary social effects and sustained mental and emotional distress. Psychiatrists differed in their views on whether trauma in the second generation was a component of the original trauma or new trauma. Some had clear beliefs, while others were unsure of what it was that they had witnessed being transmitted across generations, for example:

> I think if you have parents who have been terribly traumatised then it affects how they treat you and deal with you, patently the trauma is going to be transferred. But it's not really the parents' trauma that's being transferred, what's really happening is the parents are generating trauma for the kiddies and that may well be because of their psychological issues, right? But it is a new trauma. It is a different thing. (P2)

Psychiatrists often referred to intergenerational trauma experienced by cultural groups such as Indigenous people. They recognised this as both an individual and cultural experience, but also one that existed within a wider social context of ongoing enactment of traumatic events and structural discrimination, requiring awareness and vigilance by psychiatrists. Psychiatrists recounted that they feared re-enacting trauma dynamics through their privileged positions or own cultural backgrounds when working with such groups. In this situation, they considered that being aware of these dynamics and potential effects within interactions was essential to delivering culturally sensitive and effective psychiatric care. Some psychiatrists saw their role as helping patients to become aware of the role of intergenerational trauma in their lives. They believed that being aware of the effects of intergenerational trauma could help people make more sense of their lives, including their distress:

> So I think it's important to be aware of it but also help the patient to frame it for themselves because if we understand something then we can get a bit of a better handle of what's going on and you feel like you're in more control of it (P13).

Feeling Powerless

Despite their awareness of, and knowledge about, intergenerational trauma, psychiatrists often felt powerless to intervene and identified there was little they could do about intergenerational trauma working in public mental health systems. Their perceived impotence to act on intergenerational trauma was due to limited knowledge of what, if anything, could assist to break cycles of trauma; a lack of resources to refer patients to for ongoing support, and working within systems that were not structured to respond to the role of trauma in relation to illness and treatment. Even when psychiatrists thought there were therapeutic actions they could take to reduce familial stress or trauma, they felt unsupported to do so within public services where issues of time pressure and patient acuity were prioritised:

> I mean, I don't think we can know how to fix it, but I think there's a lot of ways to reduce the stress, stop the intergenerational stuff, or reduce that; or help people move forward and not be pollinated by those experiences. I think it's mainly like psychotherapeutic stuff really … medications don't really help much. (P7)

While psychiatrists understood there were therapeutic actions they could take with intergenerational trauma, they did not describe directly working with it beyond having an awareness of the phenomena and referring patients to external services. Referral of families to child protection services and family support services were specific examples of intervention strategies. Some believed that people with intergenerational trauma should be proactively kept out of hospital to reduce the potential for iatrogenic harm but this was coupled with the dilemma that familial fractures from intergenerational trauma could negatively impact upon the networks of people that typically support community-based care. Psychiatrists described that intergenerational trauma could be prominent in people's presentations to services but that this created a paradox for them as they felt unable to provide care due to the risk of making things worse through unnecessary hospitalisation, inappropriate treatment or power dynamics:

> I think that the only really valuable thing you can do for intergenerational trauma is family therapy and family work. But I think all of that should also be done in a non-psychiatric setting. I think that with intergenerational trauma any population which is at risk of that needs to not be in hospital. If you've got intergenerational trauma, nothing about the hospital system, nothing about the assessment is a good thing. The only thing that helps in those sort of cases is containment. But then you've got to think, what am I containing? Like, why am I containing this person's distress in this sort of way? You actually end up feeling like the best thing you could do is ignore the issue and move away. And part of that's the helplessness. (P3)

Thinking Differently

Psychiatrists explained that to be able to effectively address or work with intergenerational trauma in their roles, they needed to think differently about patients' presentations. In some situations, this meant considering a patient's current symptoms in a wider context and trying to formulate which issues were related to mental illness and which were related to the person's family context. In other situations, thinking differently about trauma and mental illness meant considering the effect of treatment and hospitalisation on trauma dynamics or thinking about a patient's children and what supports they might need. Thinking differently required conscious consideration by the psychiatrist once they had identified the presence of intergenerational trauma.

Thinking differently also related to the way that mental health and psychiatric systems are constructed, how decisions are made, and how care and treatment are delivered. Psychiatrists described that current systems were not organised to be sensitive to the needs of trauma survivors and that coercive practices, medication-focused treatment or inpatient care could risk invalidating trauma experiences and replicating trauma patterns. This was a particular risk with intergenerational trauma:

> When you're dealing with intergenerational trauma, the invalidation goes back, like, generations. It's incredibly difficult to disentangle…. I feel that there needs to be a completely different approach for these situations because the stuff that we do often makes people worse. (P3)

Psychiatrists considered that even within the broad and growing awareness of trauma in mental health services there may be a need to think differently about trauma that occurs across generations. They acknowledged that the words 'intergenerational trauma' could be stigmatising and oversimplify the complex ways that people are affected by the context in which they develop. Some broadly questioned whether raising awareness of intergenerational trauma in psychiatry was the right approach at all or whether more generic and inclusive language and thinking was required:

> I guess I see the limitations of the term, trauma, as inherently referring to some kind of deficit state or destructive state…negative influence. I think beyond perhaps the word trauma, there is some kind of entity which you could sort of look at in broader terms as just a, developmental influence which I think that is transmitted intergenerationally…if you could call it that, but I think we're getting to a point where the term, trauma, starts to be a little bit limiting or misleading. (P1)

Most psychiatrists described an interest and curiosity about thinking about and responding differently to patients who had experienced intergenerational trauma, but also identified that this would require systemic support and restructuring of resources, outcome measures and risk models for services. They considered that within their current roles they did not have the role flexibility, professional support or time to address intergenerational trauma.

Looking Backwards and Looking Forwards

To work effectively with people who had experienced intergenerational trauma, psychiatrists described the need for a duality of focus where both the past and the future were considered in the present. When thinking about the possibility of working directly with intergenerational trauma in their roles, psychiatrists identified that they would help people frame their past and make sense of it, that they would be aware of the influence of the past on current presentations and that they would engage services to support parenting and children. This included identifying how trauma across generations may be affecting their patients, for example:

> I think the way you approach relationships is developed by the way that you were raised to do that and the interactions you've had in the past, right? So you can see it stretching back. I've met patients' grandmothers who have been sort of adversarial and you can kind of see that the way even their grandmother has been treated as a child has shaped the way she behaves as an adult, which has shaped the way she's raised the mother, which has shaped the way she's raised the daughter and now the daughter is seeing me. (P9)

This awareness also required psychiatrists to contemplate how future generations might be affected by their patients' trauma, and to consider what preventative interventions would be required to support children of their patients. Participants did not consider that they had a role in working directly with children but rather had an opportunity to

engage services who would. They believed that prevention of intergenerational trauma transmission was possible but required targeted intervention with their patients who were parents. They could support this through ensuring their patients' basic needs, such as housing, were met; referring patients to services that could support children directly and by assisting patients to process their own traumatic experiences to minimise unconscious effects. To do this, psychiatrists identified a need for time in their roles to work directly with trauma and families, as well as an increase in services with both a direct and indirect focus on trauma to refer to.

Psychiatrists considered that preventative approaches for trauma were needed with all patients they worked with who were parents, due to the recognised interaction between trauma and mental illness. They understood that often their patients had experienced both trauma and mental illness; that having a mental illness itself could be traumatic and that there was a need to ensure active consideration about the children of all their patients:

> I suppose if we also think about that intergenerational question of people who, for example, have things like schizophrenia or bipolar that are heritable, if someone's parent has one of those mental illnesses, by default there's likely to be a, sort of a disconnect probably—we have to infer that there's going to be some sort of disruption of that attachment and/or potentially trauma to the child. (P11)

Discussion

The findings provide important new knowledge about the perspectives of psychiatrists related to intergenerational trauma and the psychiatric role in intervening in intergenerational trauma. Psychiatrists identified that awareness of intergenerational trauma is important for clinicians and for individuals and families, but that awareness does not necessarily translate to certainty about effective responsive actions. Awareness of trauma in the absence of clinical capacity, inadequate time, limited critical knowledge, lack of supportive services or capability to effectively respond within public mental health system roles, resulted in psychiatrists feeling powerless to intervene effectively. This lack of power was related to their own need for greater understanding of intergenerational trauma and was also strongly influenced by inadequate service structures and a widespread lack of trauma-specific services to support patients with any form of sustained intervention. While individual psychiatrists can identify intergenerational trauma in their patients, their capacity to act is influenced by the wider systems and structures within which they work. It is known that discrepancy between the individual needs of patients and the expectations of society about the role of psychiatry can lead psychiatrists to experience moral distress (Austin et al. 2008). To avoid moral distress and ineffective responses, increased awareness and debate about how intergenerational trauma is positioned within mental health systems and approaches is required.

The findings of the current study challenge suggestions offered elsewhere, of what the psychiatrist role should be in relation to intergenerational trauma. For example, Reinstein (2018) suggests a role for psychiatrists in mitigating traumatic effects of migratory separation through seeking to understand processes of intergenerational resilience, providing opportunities for families to process their experiences, assisting clients to develop narratives around trauma and supporting families to build rituals related to trauma. While these suggestions theoretically align with what is known about intergenerational trauma, they do not acknowledge the socio-political climate in which psychiatrists work, nor the significant limitations placed upon their roles in public mental health settings. In relation to family-inclusive Trauma Informed Care in mental health services, Melendez Guievara et al. (2020) identified that there are barriers that critically limit its implementation. These multilevel barriers include social issues that affect families including stigma, socioeconomic disadvantage and ongoing trauma experiences; as well as service issues such as a lack of staff training, lack of awareness of how to provide effective interventions and a lack of understanding of the interaction of trauma with culture and family dynamics (Melendez Guievara et al. 2020). Similarly, in the current study, despite awareness of intergenerational trauma, the psychiatrists identified structural and cultural barriers to including interventions for intergenerational trauma within their roles. Specifically, the resourcing and priorities of the mental health services within which they worked were not conducive to trauma-informed practice. It is known that trauma-informed approaches require alteration to the structure and culture of organisations before changes to care delivery can occur (Harris and Fallot 2001, Becker-Blease 2017). Focusing only on individual clinicians and their practice in relation to trauma can distract from the political and social contexts that enable trauma to occur and restrict systemic responses (McKenzie-Mohr et al. 2012; Tseris 2013). While trauma-informed psychiatric care is required, there is also a need for detailed consideration of where understandings of intergenerational trauma may fit within wider structures and systems of psychiatric care.

The psychiatrists in this study viewed intergenerational trauma through an attachment-based lens where mental illness or trauma were seen to potentially disrupt critical relationships between parent and child and this was a primary mechanism of transmission of traumatic stress across generations. However, within their roles, the psychiatrists were limited to working with individuals rather than families and

their work consisted of brokerage to ensure external services were engaged to support parenting and children and buffer against traumatic effects. While this is consistent with knowledge that parent–child relationships are likely the critical factor in preventing transmission of trauma (as well as at times facilitating it) (Isobel et al. 2019), it also confirms assertions that mental health services typically only focus on the needs of individuals (Nicholson et al. 2001). For psychiatrists to engage in assessment of families and parenting beyond basic safety provision would require additional skills, knowledge and time, a significant investment of funding and changes to the types of interventions available (Judd et al. 2018). Medically dominated approaches to adult mental health care, delivered by psychiatrists such as those in this study, limit family-focused approaches (Lauritzen et al. 2014). Biomedical approaches also often ignore the social, economic, and historical contexts that shape health and illness experiences (Kelly 2009; Hankivsky et al. 2017; Moncrieff 2007). For example, the diagnostics of trauma ignore the role of culture and intergenerational transmission, failing to connect individual experiences to broader, systemic conditions (Menzies 2006; Hoosain 2018), thereby limiting mainstream options for intervention. Intergenerational trauma is a social as well as personal event and requires a focus on dyads, triads and families, as well as awareness of the community and political factors that influence social disadvantage and resilience. Engaging such a social and political lens also emphasizes a need for a restructuring of psychiatric systems to consider the role of intergenerational trauma and identification of where prevention and intervention may best occur, and who is best positioned to provide it. In this study, psychiatrists were aware of the potential impacts of parental mental illness and associated stress upon children. This finding is encouraging, as children who have a parent with mental illness reportedly have higher rates of trauma than other children (Özcan et al. 2016) and subsequently are more likely to experience affectual or behavioural difficulties (Bosquet Enlow et al. 2011; Chu and DePrince 2006; DeGregorio 2013; Lyons-Ruth and Block 1996). However, although there are several interventions and preventative strategies that can be used to support parents who experience mental illness, they are not consistently implemented by psychiatrists due to a lack of familiarity with the issues and limited availability of resources (RANZCP 2009). Consideration of how preventative interventions for families can be integrated into psychiatrist roles despite resource limitations is required. Increased trauma awareness in mental health services through Trauma Informed Care creates an opportunity to raise awareness of the need for preventative interventions with children of people accessing mental health services, to reduce the transmission of trauma across generations. Prevention approaches need to be focused on trauma processing in the first generation and concurrent attachment interventions aimed at promoting mentalising and differentiation in the second generation (Isobel et al. 2018) and targeting populations where risk of transmission is high, primarily where trauma is known to be prevalent (Judd et al. 2018). With 90% of people accessing mental health services known to have experienced trauma in their lives (Mueser et al. 2004; Phipps et al. 2019; Cusack et al. 2006; Lommen and Restifo 2009), any mental health service provides an opportunity for preventative intervention (Harpaz-Rotem et al. 2006). However, there are ongoing challenges in identifying parents who access mental health services, let alone assessing familial needs (Nicholson and Biebel 2002). Mental health services require systematic and accessible processes for identifying and documenting parental status of patients and ensuring this is incorporated into treatment approaches (Liangas and Falkov 2014). Currently, the most common intervention that mental health services provide for parents is liaison with child protection services (Liangas and Falkov 2014), leaving much scope for more proactive and preventative interventions.

Psychiatrists in the current study noted that identification of the intergenerational impacts of trauma requires looking backwards into patients' past, as well as looking forward to the effects of familial and relational stress upon current and future generations. Children develop in a bio-ecological context (Cantor et al. 2019) where expression of genes, hormones, behaviours and processing of experiences are affected by the ecology of those who interact closely with them. Development occurs within this context, with structural and social factors required to support development, buffer adversity and foster adults' capacity to attune with, co-regulate and support children in their emotional, social and cognitive states (Li and Julian 2012). These mechanisms are a reminder that traumatic events alone are not problematic, but their sustained effects can be. Not all parents with trauma will pass on traumatic effects to their children, and not all trauma-related intergenerational effects will be problematic (Yehuda and Meaney 2018). In this light, environmental and social contributors to intergenerational trauma transmission require public health examination to ensure targeted and broad multi-level approaches to prevention and decreased confusion related to intervention. Understanding the interplay of relational trauma and parental mental illness is of interest, but considering both as potential forms of traumatic stress may aid in enacting prevention and early intervention initiatives for all parents with mental illness and their children.

While there is extensive research on the various impacts of traumas, less attention has been focused on the effectiveness of interventions specific to intergenerational trauma (Fraser et al. 2013). The therapeutic relationship is undoubtedly important. Psychotherapy is known to alter epigenetic mechanisms associated with various mental disorders

(Stahl 2012; Peedicayil 2017), including trauma (Yehuda et al. 2013). Adult-focused interventions are known to have intergenerational benefits (Iyengar et al. 2014). Addressing specific rather than general parenting needs, and recognizing familial needs not directly related to mental health, are key factors for all families in mental health services (Suarez et al. 2016). However, generic attachment or parenting targeted interventions (such as those provided by external services that psychiatrists may refer parents to) that do not directly address parental trauma will likely not be effective in adequately preventing intergenerational transmission (Bailey et al. 2017). Sensitivity to the complexity of family relationships in the context of trauma and mental illness is also required to recognise when a lack of family connection and support may be intentional and protective (Misra et al. 2020). These aspects of knowledge contribute to understanding the potential for psychiatrists to recognise, prevent and respond to intergenerational trauma within their roles. To do so will require increased ownership over possible interventions and overcoming the feelings of 'powerlessness' described by participants. Powerlessness is a component and consequence of trauma (Herman 1992). For psychiatrists to support their clients to enhance their personal power over their lives and self, psychiatrists need to also consider what power they have within their roles to support patients who have experienced intergenerational trauma. To do so requires recognition of the broader implications of power inequalities and abuses of power, including those that occur within healthcare (Mack 1994). Without direct acknowledgement of the importance of power in trauma, adversity, illness and care, powerlessness will likely prevail.

The findings of this study indicate a need to determine an acceptable and sustainable (Hiratsuka et al. 2017) role for psychiatrists working with intergenerational trauma. A role that extends beyond awareness of the phenomenon and brokerage of services, to engaging directly with patients and their families about trauma, including children, in both a preventative and interventional manner. To do so requires caution to ensure that recognition of the intergenerational components of trauma does not stigmatise individuals (Maxwell 2014) through medicalisation (Gone and Kirmayer 2020) or blame; and that it occurs with consideration of the wider social and political contexts of care. Psychiatrists are in a privileged position in their interactions with people to enact preventative interventions for intergenerational traumatic stress of any kind through increased awareness, discussion and assessment, as well as referral to trauma-specific and supportive family services. Implications include a need for trauma specific training, systemic advocacy and advancing research on the relationship between trauma and mental illness. The purpose of seeking and gaining awareness of intergenerational mechanisms of trauma is not purely to identify how or what has affected each patient (Weingarten 2004). Instead, it is to ensure that psychiatry and mental health services have a solid understanding that intergenerational transmission of trauma occurs, and can have significant impact upon people's lives, so that this can be communicated to individuals and incorporated into care. Psychiatrists play an important role in helping individuals understand the ways trauma may affect their lives and health, as well as acting to ensure its ongoing transmission is disrupted.

Conclusion

Intergenerational trauma is a concept that continues to lack clear articulation or clarity in meaning. Despite being of direct relevance to service provision in mental health settings, its relationship to illness, recovery, care and treatment is left to individual interpretation by clinicians, with subsequent impacts upon the care and treatment that patients and families receive. Psychiatrists working in this space experience feelings of powerlessness associated with possessing awareness of the potential impacts of intergenerational trauma, but also lacking time, resources and flexibility in their roles to respond adequately. Within this context, the psychiatrist's role when working with any form of trauma is influenced by personal orientation and limited by the availability of other services with whom they can interact and refer to. For intergenerational trauma specifically, roles predominantly focus on holding and promoting awareness about the presence of trauma in adults, and where possible referring children and families to external services for supportive interventions. While awareness and brokerage provide important opportunistic roles in prevention, there is scope to clarify the use and effectiveness of targeted interventions and approaches for working with intergenerational trauma within psychiatry. Alongside this, there is a need to examine how current systems and structures can ensure access to appropriate services once organisations and individuals become more trauma-informed.

Further research is indicated to clarify the concept of intergenerational trauma, including its relationship to transgenerational mental health and illness, alongside examination of 'what works' in intervention. While further research into how trauma may affect parenting is warranted, it needs to occur in such a way as to not cause harm (Meulewaeter et al. 2019) and there is a concurrent need to weave awareness of intergenerational resilience into this process. Future research is needed to identify protective factors that buffer against the effects of intergenerational trauma and to identify trauma-informed interventions that can be systematically implemented (Narayan et al. 2019). While research on mechanisms, including epigenetics, is important (Gone and Kirmayer 2020), linking individual experiences to

biological processes also requires nuanced and multifactorial approaches (Seligman et al. 2016).

Limitations

This study comprised one group of psychiatrists in an Australian mental health service context. The findings were developed using robust methods to themetise and interpret the available rich data, but cannot be presumed to represent the experiences of all psychiatrists in all settings or contexts. All participants worked in Australian public mental health services and the service structures and models of careof these services cannot be assumed to be the same in other countries or regions.

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Compliance with Ethical Standards

Conflict of interest The authors have no conflict of interest to declare.

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