Title:

The Transmission of Trauma in Refugee families - Associations between Intra-Family Trauma Communication Style, Children's Attachment Security and Psychosocial adjustment

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Abstract

This study explored the transmission of trauma in 30 Middle Eastern refugee families in Denmark, where one or both parents were referred for treatment of PTSD symptoms and had non-traumatized children aged 4-9 years. The aim of the study was to explore potential risk and protective factors by examining the association between intra-family communication style regarding the parents' traumatic experiences from the past, children's psychosocial adjustment and attachment security. A negative impact of parental trauma on children might be indicated, as children's Total Difficulties scores on the Strengths and Difficulties Questionnaire (SDQ) were significantly higher than the Danish norms.

A negative association between children's attachment security as measured by the Attachment and Traumatization Story Task and higher scores on the SDQ Total Difficulties Scale approached significance, suggesting that the transmission of trauma may be associated with disruptions in children's attachment representations. Furthermore a significant association between parental trauma communication and children's attachment style was found.

Keywords: The Transgenerational Transmission of Trauma, Intra-family Trauma Communication, Attachment Security, Refugee children, Mental Health

Introduction

How is trauma transmitted across generations? And how does being raised by traumatized refugee parents who suffer from PTSD affect children without a history of direct trauma exposure? The transgenerational transmission of trauma was first explored with offspring of survivors of the Holocaust; in a series of meta-analyses of 32 samples involving 4418 participants it was concluded that, in nonclinical samples, there was no evidence for the influence of the parents' traumatic Holocaust experiences on their children, and that secondary traumatization only emerged in clinical samples (Ijzendoorn, Bakermans-Kranenburg, & Sagi-Schwartz, 2003). More recently, research on the transmission of trauma has focused on other populations than Holocaust survivors and their offspring, such as victims of other types of trauma and nonwestern refugee populations.

Similarly to the research on Holocaust survivors and their offspring, studies including nonwestern refugee families show divergent results with regard to the impact of a parental trauma history on non-traumatized children. In a study of children of Vietnamese refugees using the Strengths and Difficulties Questionnaire (SDQ), Vaage et al. (2009) found that children of refugee parents born in Norway have significantly lower Total Difficulties Scores than their Norwegian peers, however children's Total Difficulties Scores were positively associated with a paternal diagnosis of PTSD (Vaage et al., 2011). Daud, Skoglund, and Rydelius (2005) compared 15 refugee families from Lebanon and Iraq, where parents had been subjected to torture, with a matched control group of 15 non-traumatized refugee families where the parents did not have a history of direct torture. This study found that children of tortured parents had more symptoms of anxiety, depression, post-traumatic stress, attention deficits, and behavioral disorders compared with the control group. Finally a recent meta-analysis on the association between parents' PTSD severity and children's psychological distress, which included 42 samples found a moderate overall effect size r=.35, indicating that

parental symptoms of PTSD influence children negatively (Lambert, Holzer, & Hasbun, 2014).

From this research it can be concluded that, within clinical populations, there is evidence to suggest that a parental trauma history and subsequent PTSD symptoms can influence children negatively and may lead to their development of psychological distress. However the mechanisms by which the transmission is mediated are yet to be determined. Theoretically disruptions in attachment representations (Almqvist & Broberg, 2003), intra-family communication (Measham & Rousseau, 2010) and parental symptom level (Lambert et al., 2014) have all been proposed as potential mediating mechanisms**.** This paper seeks to identify potential risk and protective factors by examining the bivariate associations between intra-family communication style regarding the parents' traumatic experiences from the past with children's psychosocial adjustment and attachment security in a sample of traumatized Middle Eastern refugee families with children without a history of direct trauma exposure.

Background

In an attempt to move beyond the symptom-focused understanding of what is transmitted from parents to their children, a new research perspective is emerging in which it is proposed that the effect of parental trauma on non-traumatized children is associated with disruptions in attachment representations in both parents and children (Almqvist & Broberg, 2003; Blankers, 2013; De Haene, Dalgaard, Montgomery, Grietens, & Verschueren, 2013; De Haene, Grietens, & Verschueren, 2010a; van Ee, Kleber, & Mooren, 2012). This perspective is based on the finding that parental symptom levels alone cannot account for psychosocial adjustment in offspring (Lambert et al., 2014). The core assumption is that traumatic experiences may influence adults' internal representations of attachment (Salo, Qouta, & Punamäki, 2005), which may compromise their care-giving ability negatively. Almqvist and Broberg (2003) propose that traumatic experiences often lead to a feeling of powerlessness as

a consequence of not having been able to protect the self, and that parental internal representations of the self and self-with-child may become damaged, as the parents are unable to see themselves as a source of protection for the child. This may cause the parent to withdraw from the child, leading the child to display increased attachment behaviors, such as clinging to the parent, which may then result in parents feeling even less capable of fulfilling the child´s needs. As a consequence, further reinforcement of the parent's damaged internal representations of the self-with-child may occur. This effect of trauma on the attachment attitudes of the parents is then hypothesized to cause disruptions in the attachment representations in children, making parental trauma and trauma sequelae a risk factor for insecure attachment representations in refugee children.

Growing up with parents who suffer from various kinds of psychopathology is a known risk factor; parental psychopathology has been linked with negative child outcomes such as psychopathology in children and lower scores on various measures of adjustment (Berg-Nielsen, Vikan, & Dahl, 2002; Luthar, Cicchetti, & Becker, 2000). Furthermore a link between major depression in parents and attachment classification in children has been established (Seifer et al., 1996). With respect to parents who suffer from PTSD, van Ee et al. (2012) studied the association between parental secure base scriptedness (a measure of attachment representations in adults) and parental sensitivity in parent/child interactions using an observational measure. As predicted, a negative association was found, but this association was moderated by parental PTSD symptom level and the number of traumatic experiences that the parents suffered. For highly traumatized parents, higher levels of secure base scriptedness or secure attachment representations served as a key protective factor as these are associated with higher levels of parental sensitivity towards the child. In a study of female Holocaust survivors and their daughters and a matched control group, Sagi-Schwartz et al. (2003) found Holocaust survivors to have significantly fewer secure attachment representations than the

control group. However, they did not find differences in attachment representations between the daughters of Holocaust survivors and the control group. This finding contradicts the theoretical understanding but suggests the need to explore attachment representations in children of survivors of other kinds of trauma, as one may argue that contextual dimensions of attachment representations may be important for the transmission of trauma (Van Ijzendoorn & Sagi-Schwartz, 2008).

Story stem methods are widely relied on to access the inner world of preschool or early school-aged children. In a study of 65 pre-school age children Kelly (2015) found an association between insecure attachment and deficits in language, which supports the theoretical notion of a link between attachment and narrative development in children. This finding supports the use of story stems methods in measuring children's attachment style.

Another potential mechanism by which trauma may be transmitted from parents to their children could be termed: intra-family trauma communication style. Intra-family trauma communication style may be defined as the way in which parents talk to their children about their traumatic experiences from the past, and how they explain their current symptoms of PTSD. Historically, the question of how parents should communicate a trauma history to their children arises from research on Holocaust survivors and their offspring. A phenomenon known as the *conspiracy of silence* was proposed as a central risk factor (Braga, Mello, & Fiks, 2012; Fromm, 2011; Giladi & Bell, 2013; Lichtman, 1984; Sorscher & Cohen, 1997). This proposal originates in psychodynamic theory in which trauma is hypothesized to be transmitted across generations via unconsciously displaced emotions. The basic assumption is that trauma travels from the parents' unconscious mind to the child's unconscious mind unless it is verbalized. This style of communication is known as Silencing.

With the emergence of research on non-Western refugees and survivors of other kinds of trauma and their children, the question of silencing versus disclosure has become relevant again. Many non-Western cultures have different ideals and traditions with regard to intra-family communication (De Haene, Grietens, & Verschueren, 2010c; De Haene, Rober, Adriaenssens, & Verschueren, 2012), and the emphasis placed on verbal expressiveness varies across cultures (Rousseau & Drapeau, 1998).The term *Modulated Disclosure* has been coined to characterize a style of communication that emphasizes the timing and manner in which disclosure takes place rather than the exact content of what is disclosed. *Modulated Disclosure* is characterized by parental sensitivity to the child's emotional needs, resulting in beneficial outcomes. In a qualitative study of 15 refugee families it was concluded that parental "modulated disclosure" of war trauma was positively associated with the child's ability to play creatively and that modulated disclosure is culturally embedded (Measham & Rousseau, 2010). Montgomery (2004) conducted a qualitative study in which it was concluded that the disclosure of parental trauma must be organized with congruence between the children's implicit and explicit knowledge of the family history. She distinguished between the "*story lived"* which can be defined as what the child senses and experiences within the family environment and the "*story told",* which can be defined as what the child is explicitly told and what the child is able to verbalize. The study reported that in some instances, the parents are unaware of the fact that they are indirectly referring to the trauma history, when the children are present. In other cases, the children have accidentally overheard fragments of conversations between the parents, which the parents did not intend for them to hear. In both situations there is a lack of congruence between the children's *"stories lived"* and *"stories told",* which leaves the children with only their imagination to make sense of the things they experience within the family environment including parental posttraumatic symptoms. This style of communication can be defined as: "unfiltered speech". Finally, a

systematic review of the literature on patterns of trauma communication within refugee families found that a majority of studies indicate that a modulated approach to disclosure of traumatic experiences from the past is associated with psychological adjustment in children of traumatized refugee parents (Dalgaard & Montgomery, 2015).

Thus four categories of communication style emerge from previous research. Firstly, there are the two original categories from the research on Holocaust survivor families: Open Communication or Silencing. Open Communication is characterized as a consciously chosen strategy in which parents discuss their traumatic experiences from the past and symptoms of PTSD with their children, and in which parents willingly answer their children's questions in a truthful manner. Silencing is characterized as the situation in which parents never talk to their children about their experiences from the past or their symptoms of PTSD. This strategy may be consciously chosen as a way of protecting the child, or it may reflect the fact that the parents never talk to anyone about these matters. Secondly, more recent research has led to the identification of two additional categories: Modulated Disclosure and Unfiltered Speech. Modulated disclosure refers to a child-focused communication strategy in which parents talk to their children about their traumatic experiences from the past in an age-appropriate manner that is sensitive to the child's emotional needs. Unfiltered Speech refers to the situation in which there is incongruence between the *story lived* and the *story told*, and in which parents are unaware of their own implicit communication about the past and their symptoms of PTSD, creating differences between what the parents think the child knows and what the child actually knows.

Aim

The aim of this study is to explore the transgenerational transmission of trauma in a sample of Middle Eastern refuge families with traumatized parents and their children who

have no history of direct trauma exposure. It is proposed that the transmission of trauma may be associated with disruptions in children's attachment representations and with the intra-family trauma communication style. Thus the aim is to explore the association between psychosocial adjustment in children, children's attachment security and different styles of intra-family trauma communication.

Hypotheses

1) Firstly, based on previous studies (Blankers, 2013; Daud, 2008; Daud et al., 2005) it was hypothesized that there would be an effect of the parental trauma history on the psychosocial adjustment of their children, and that the children's mean scores on The Strengths and Difficulties Questionnaire (SDQ) Total Difficulties would differ significantly from the Danish host country norms, which might indicate a negative impact of parental trauma on non-traumatized children.

2) Secondly, it was hypothesized that there would be a correlation between the child's attachment security score and classification as measured by The Attachment and Traumatization Story Task (ATST) and the child's psychosocial adjustment as measured by the SDQ (parent version).

3) Thirdly, it was hypothesized that there would be a negative correlation between the parental symptom level (PTSD, Anxiety and Depression), as measured by the Harvard Trauma Questionnaire (HTQ) and the Hopkin's Symptom Checklist (HSCL-25), and the child's psychosocial adjustment and attachment security as measured by the SDQ and the ATST.

4) Finally, it was hypothesized that an association would be found between qualitatively derived categories of intra-family trauma communication and attachment security in children. Based on a recent systematic review of the literature on patterns of trauma communication within refugee families (Dalgaard & Montgomery, 2015) it was furthermore hypothesized that

a modulated style of disclosure would be associated with secure attachment style in children. Finally it was hypothesized that incoherence between the child's implicit knowledge of the past and the parent's explicit perception of what the child knows (unfiltered speech) would be associated with insecure attachment in children (Montgomery, 2004).

Method

Inclusion Criteria

The study included 30 Arabic or Farsi speaking refugee families from Iraq, Iran, Lebanon, Palestine, Syria and Afghanistan living in Denmark, where at least one of the parents was referred for treatment of PTSD-symptoms and had a child between 4 and 9 years old. The majority of children included were born in exile, but 7 of the respondent children were born before the family's arrival in Denmark, however they all arrived in Denmark when they were very young (age ≤ 3), and they did not have a history of direct trauma exposure. When the families had more than one child in the relevant age range the oldest child was included as participant.

Exclusion Criteria

The study excluded families who had already started family therapy and children suffering from pervasive developmental disorders or physical disabilities.

Recruitment

Families were recruited via a non-probabilistic sampling strategy in collaboration with 5 different psychiatric rehabilitation centers across Denmark. Families who met the inclusion criteria were approached by either one of the psychologists at the treatment center or by the first author and an interpreter over the telephone. Families who initially expressed an interest in participating received an information letter, written in their native language, and were subsequently telephoned by the first author and an interpreter. When families agreed to participate, appointments were made and the data collection took place either in the

respondents' homes or at their treatment centers. Most families were interviewed in their native language by the first author and an interpreter but 3 families preferred to speak in Danish without the presence of an interpreter. Children completed the Attachment and Traumatization Story Task in Danish. Unfortunately, not all of the participating treatment centers kept a record of how many families were initially approached. However, based on the first author's records and accounts from the psychologists at the treatment centers, it is estimated that about half of the families who met inclusion criteria declined participation. The reasons given for refusing to participate were either that the parents felt strained by their symptoms and that talking about their situation made them feel uncomfortable or because of fear that their child would gain insight into their trauma history or that information about their family would not be kept confidential.

Sample Characteristics

The sample includes 30 families with 30 children; 14 girls and 16 boys aged 4-9 years old (mean= 6.78, *SD*=1.55). Of the 27 children who completed the Attachment and Traumatization Story Task, 12 were classified as Secure, whereas 15 where classified as insecure. The sample consists of 26 two-parent families and 4 single-parent families. The mean number of children within these families was 3.3 (SD=1.62). In nine cases only one parent participated in the qualitative interview.

Measures

Harvard Trauma Questionnaire (HTQ)

The parental PTSD-symptoms were measured by Arabic or Farsi versions of the HTQ. The HTQ is a 30-item cross-cultural instrument designed for the assessment of trauma and torture related to mass violence and its sequelae. Items consist of descriptions of symptoms such as; "Recurrent nightmares", and the participant rates how much he/she is bothered by this on a 4-point Likert-type scale. The questionnaire generates a DSM-IV PTSD

score, a Self-perception of functioning score and a total score. Each score ranges from 1-4, and the recommended clinical cut-off is ≥ 2.00 (Shoeb, Weinstein, & Mollica, 2007).

The Hopkins Symptom CheckList-25 (HSCL-25)

The parental symptoms of anxiety and depression were measured by the Arabic or Farsi versions of HSCL-25. Items consist of descriptions of symptoms such as; "Feeling fearful", and the participant rates how much he/she is bothered by this on a 4-point Likert-type scale. The HSCL-25 generates separate scores for anxiety and depression symptoms, in addition to a total score. Each score ranges from 1-4 and the recommended clinical cut-off is ≥ 1.75.

Both the HTQ and the HSCL-2 are widely used measures and their psychometric properties have been tested in various populations (Kleijn, Hovens, & Rodenburg, 2001; Veijola et al., 2003)

The Strengths and Difficulties Questionnaire (SDQ)

To measure the psychological adjustment of the children, the study employed the SDQ (parent version with impact supplement), which is a widely used brief screening tool available in both Arabic and Farsi. Items consist of descriptions of the child's behavior over the past 6 months such as; "Often loses temper" which the parents rate as; "Not True", "Somewhat True" or "Certainly True". The questionnaire was chosen to allow findings from the present study to be directly comparable with larger samples and because the psychometric properties of the questionnaire have been researched extensively with good results regarding both validity and reliability (R. Goodman, 2001; Thabet, Stretch, & Vostanis, 2000). The SDQ measures emotional symptoms, conduct problems, hyperactivity/inattention, peer-relationship problems as well as prosocial behavior. The four symptom scales can be combined into an Internalizing dimension (emotional problems and peer problems) and an Externalizing dimension (conduct problems, hyperactivity/inattention). Factor analyses

generally support this distinction, and the two dimensions show good convergent and discriminant validity across informants and with respect to clinical disorder (A. Goodman, Lamping, & Ploubidis, 2010). In spite of the brevity of the questionnaire, the SDQ has proven to be a useful tool for detecting psychopathology in children.

The Attachment and Traumatization Story Task (ATST)

In order to study attachment representations in children, the study used a narrative doll-play procedure known as The Attachment and Traumatization Story Task. This procedure has been adapted for use with refugee children from a reliable and validated Story-stem measure; The Attachment Story Completion Task (ASCT) (De Haene et al., 2013; De Haene et al., 2010a; De Haene, Grietens, & Verschueren, 2010b; Verschueren, Marcoen, & Schoefs, 1996). The ATST consists of 6 short story beginnings designed to invoke attachment-related play; two stems (1-2) are constructed to include potential reference to migration-specific stressors, and four stems (3-6) are identical or highly analogous to ASCT stems. More specifically, the stems probe; parental responsiveness to extra-familial threat (soldiers outside the family house; stem 1), parental sensitivity during family separation (family leaving grandparents for another country; stem 2), parental responsiveness to child's fear after nightmare (stem 3), parental responsiveness after spousal conflict; stem 4), parental sensitivity during parent-child separation (parents leaving for one day; stem 5), and parental responsiveness to positive affective communication (child showing drawing); stem 6) (De Haene et al., 2013).The story beginnings are enacted by the administrator using a doll family, which was ethnically matched to the participants. The narrative responses produced by the child are then coded for representational markers of attachment quality. Each narrative is given a score for attachment security and assigned to an attachment style category (Secure, Secure-insecure, Insecure-avoidant, or Insecure-bizarre-ambivalent). The cross-category; secure-insecure was used for classification of narrative responses to specific story stems that

could not be classified as secure or insecure. A global security score can be calculated for the child by summing up the security scores from the individual story stems.

The child's global security category (Secure, Insecure-avoidant, or Insecure-bizarre/ambivalent) is determined based on the most frequent category from the coding of the individual story stems. When an even number occurs between two categories the notes from the coding of each of the story stems must be consulted again to look for markers of secondary categories, in narratives previously placed in a different category. The cross-category is not used in the global classification. The ATST was administered by the first author.

Scoring and categorization of the Attachment and Traumatization Story Task (ATST) were based on verbatim transcripts of audiotaped administrations. The scoring of each narrative response to a story stem was performed independently by 2 independent coders (the third and fourth authors) from information about that child's responses to the other story stems (De Haene et al., 2013). For the purpose of this study, classification codes of insecure-avoidant and insecure-bizarre-ambivalent were combined allowing for a dichotomous distinction between secure and insecure attachment. With regard to the dimensional security score, the inter-rater agreement between the two coders was ICC= .780 and Cohen's Omnibus kappa for the secure/insecure classification was 0.55. When the two coders disagreed a consensus coding was reached, and the consensus data was used in the analyses.

The Parental Qualitative Interview

The aim of the parental qualitative interview was to: 1) capture the parents' accounts of how their own trauma history and current symptoms of PTSD affected both the particular child in question and the family as a whole, 2) acquire a qualitative understanding of the child's developmental history and the parents' perception of their child's psychosocial adjustment, 3) gain insights into the style of communication within the family unit regarding

the parental trauma history and current symptoms, 4) acquire an understanding of the family's relations with the extended family and social networks in exile and the parental perception of the importance of maintaining ties with the family of origin and with their home country's culture. In order to address these themes a semi-structured interview schedule was developed in which the parents were asked open questions about each of the four themes. If answers were short or new themes came up more specific follow up questions were asked. The interviews lasted between 1 and 2 hours.

Procedure

All questionnaires assessing the mental state of the parent were completed by the parent referred for treatment. When both parents were referred, the parents decided who filled out the questionnaires. The SDQ were completed by both parents, when this was possible, however when the interview took place in the respondents' homes, one parent often had to take care of children, while the other parent completed the questionnaire.

Qualitative Analyses

Intra-Family Trauma Communication Styles

Following careful evaluation of the first author's field notes, observations in the interview setting, and analyses of the transcribed parental interviews using the NVivo software package, each family was placed in one of four categories of intra-family communication regarding parental traumatic experiences from the past. During the first round of coding the first author attempted to ignore theoretical knowledge of preexisting categories and worked to develop rich descriptive codes of phenomena within the material. Each interview was coded incident by incident (Creswell, 2012). In the second round of coding, 4 categories emerged that corresponded to the theoretically derived categories described in the introduction. The emergence of categories were based on the initial descriptive codes, and the combination of codes into main categories was based on a principle of avoiding overlaps while maintaining all

distinctive characteristics and ensuring that none of the initial descriptive codes were ignored. In the end, all families' communication styles could be described by one of the categories. In the results section, a brief definition of each category and examples of interview material and observations, typical of each category, are presented. Furthermore prototypical examples are provided of each category. In order to maximize the validity of the qualitative analyses, an external audit was used in the 3rd and final round of coding. The auditor is a licensed psychologist, and the auditing consisted of reading through all the coded material and providing feedback on the categorization of families. The full coding system used is available from the first author on request.

Statistical Analyses

Significance level was set to $p<.05$ (two-tailed). Preliminarily tests of normality, Kolmogorov-Smirnov and Shapiro-Wilk, were carried out for the SDQ Scores, ATST scores, HTQ PTSD Scores, HSCL-25 Anxiety and Depression Scores and scores were found to be in the acceptable range. Statistical analyses consist of one-sample independent means *t*-tests, correlations and point-biseral correlations, and Fisher's exact test.

Missing Data

Three of the participating families did not attend the second appointment and therefore data regarding the child's attachment security is missing. One family could not be assigned to an intra-family communication category, as the interview material was deemed too limited to do so by the first author. Two parents' did not respond to all items of the HTQ and HSCL-25 questionnaires, and thus this data has been excluded from analyses.

Ethics

When the data collection took place at the treatment centers, the respondent families were offered reimbursement of travel expenses, but no other compensation for participation was offered. Following written and oral information regarding the purpose of the study,

participants signed a written consent form. All families were offered treatment by the referring treatment centers regardless of whether they participated in the study or not. The study was reported to the National Committee on Health Research Ethics in Denmark.

Results

Before presenting the results of the statistical analyses, the results of the qualitative analyses of intra-family communication styles are described.

Silencing

This category refers to a consciously chosen strategy of not ever speaking of, or referring to, the traumatic experiences from the past in front of children without a history of trauma exposure. Sometimes the parents report not speaking about their past experiences with anyone at all or they describe strategies for protecting the child against any knowledge of the past traumatic events or current symptoms of PTSD. These strategies include separation from the child when symptoms are acute, telling the child that symptoms are just minor physical problems such as a headache or distracting the child when he/she asks difficult questions. In some cases the category also refers to parents who only told their older children a bare minimum, such as " we experienced the war and therefore we had to flee" or "we did not have a good childhood".

This style of communication is carried out in a consistent manner, and the parents explain their strategy only when their children are not present. Furthermore, within the research settings parents in this category avoid talking about the traumatic experiences or symptoms when their children are present or within hearing range. Five families were assigned to this category.

Figure 1: Silencing

Modulated Disclosure

This category refers to parents who report having, in some way, addressed their traumatic experiences from the past in conversations with their children. This category applies when parents describe a strategy that emphasizes the age-dependent cognitive and emotional needs of their child. This category also includes parents with very young children, who describe their intentions of answering their child's future questions in an age-appropriate manner and explain that they believe that the child will gradually need more and more information. Generally, this category applies to a child-focused strategy in which parents explicitly verbalize how they take their child's perspective into account and try to adjust the level of disclosure to the specific needs of the child. Eleven families were assigned to this category.

Figure 2: Modulated Disclosure

Unfiltered Speech

This category refers to parents who report not speaking of the traumatic events with their children, but who, in the research settings at least, seem unaware of the presence of their child/children, and openly discuss their traumatic experiences from the past, even though their children are within hearing range or even sitting right next to them. This category also applies when parents contradict themselves within the qualitative interview and describe elements of both silencing and disclosure, but in a non-decisive manner that seems more accidental than as if referring to a general and conscious pattern of communication. This category is inspired by what Montgomery (2004) refers to as incoherence between the child's *Story Lived* and the child's *Story Told*. This refers to the children, who experience the parents' traumatic symptoms including verbal flash backs, but who have not been provided with age-appropriate explanations of why their parents act in this manner. Eight families were assigned to this category.

Figure 3: Unfiltered Speech

Open Communication

This category refers to parents who have a consciously chosen strategy of open disclosure of their own traumatic experiences from the past. The rationale given is often that one cannot hide things from children and that children will learn the truth any way. Sometimes the parents in this category describe being so affected by the past themselves that they feel as if trying to hide it would be impossible. Sometimes parents in this category emphasize the influence of mass media and peers in giving a child knowledge of the past, saying that it is better for children if these sensitive issues are addressed by parents. Five families were assigned to this category.

Figure 4: Open Communication

Table 1: Descriptive Statistics

In order to test the first hypothesis (children's SDQ scores differ significantly from the Danish norms), the mean for the SDQ Total difficulties Score from the sample was tested against the known mean from the Danish Norms (6.42 for boys and 5.45 for girls respectively) by using a one-sample independent means *t*-test for boys and girls separately. For both boys and girls, the mean scores were significantly higher 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. Thus the first hypothesis was confirmed.

In order to test the second hypothesis that there would be a correlation between the child's attachment score and classification as measured by the Attachment and Traumatization Story Task and the child's psychosocial adjustment as measured by the SDQ Total Difficulties Score, the correlation coefficient between the children's Global Security Scores and The Total Difficulties scores was calculated, and a borderline significant correlation in the expected direction was found r=-.372 p= .056.

Subsequently, the point-biserial correlation coefficients between Secure/Insecure attachment variable and the SDQ total difficulties scores was calculated. Although a correlation of *r*=. 198, in the expected direction, was found (i.e. Secure attachment was associated with lower Total Difficulties Scores) this was non-significant *p*=. 322. The point-biserial correlation coefficients were also calculated separately for the SDQ Internalizing Scale (Emotional problems +Peer problems subscales) and the Externalizing Scale (Conduct Problems + Hyperactivity subscales). For the Internalizing scale a correlation with the secure/insecure variable of *r*= .013 was found, but this was not statistically significant *p*=.949 and neither was the association between the SDQ Internalizing scale the Global Security Score; *r*=.-.251, *p*= . 207 For the SDQ Externalizing scale a non-significant association was found between scores on the Externalizing scale and the attachment classification *r*=.303, *p*= .124, however a statistically significant association was found between the SDQ Externalizing scale and the Global Security Score *r*=-.388. *p*=.046. Thus the paper's second hypothesis could not be confirmed statistically, however, a statistically significant negative association was found between children's attachment security and externalizing symptoms.

In order to test the paper's third hypothesis; that there would be a negative correlation between the parental symptom level (PTSD, Anxiety and depression) and the child's psychosocial adjustment and attachment security, correlation coefficients were calculated between the child's Total difficulties Scores as measured by the SDQ and Global Security Scores as measured by the ATST and Parental HTQ DSM-IV PTSD Scores, the HSCL-25 Anxiety and Depression scores. Although correlations in the expected direction were found, none of these were significant at the .05 level, and a small and non-significant negative association was found between Parental Anxiety and children's Total difficulties scores *r*=-.210, *p*=.284.

Furthermore the point-biserial correlation coefficients between the Secure/Insecure variable and the parent's symptom scales were calculated, but these were all non-significant at the .05 level and thus the paper's third hypothesis could not be confirmed.

In order to test the paper's fourth hypotheses; that there would be an association between intra-family communication style and attachment style in children, a contingency table was created between the secure/insecure attachment variable and the intra-family communication variable.

Table 2: Intra-Family Communication and Children's Attachment Security

The result of Fisher's Exact Test for the entire contingency table was significant; p=.021. In line with our fourth hypotheses the individual effects of each of the four communication categories on children's attachment style were also tested. Results of Fisher's Exact Test showed that there was a significant association between the child's attachment style (secure vs. insecure) and whether or not the family had an Unfiltered style of communication p= .008. For the Modulated Disclosure style the result was not significant; p=.130 and neither were the results for Open Communication; p=.216 and Silencing; p=.612. Thus the paper's fourth hypothesis was confirmed, as an association between intra-family communication style and attachment security in children was found.

Discussion

The confirmation of the first hypothesis establishes that, according to parental ratings, children of traumatized refugee parents are less psychologically well-adjusted than their Danish peers, which may indicate a general impact of parental trauma on non-trauma-exposed children's psychosocial adjustment, as suggested by previous research (van Ee et al., 2012; Vaage et al., 2011). One may argue that the differences could be due to cultural factors; this, however, doesn't seem plausible, based on previous research in which children of traumatized and non-traumatized refugee parents were compared (Daud et al., 2005). In either

case, the finding has important implications, as it suggests a need for family interventions, and not just individual therapy for traumatized refugee parents with non-traumatized children (De Haene et al., 2012).

The fact that the paper's second hypothesis could not be confirmed statistically is puzzling, and implications of this should be considered carefully. However, the limited power of the study seems a plausible explanation for why the association between children's attachment security as measured by the Attachment and Traumatization Task Global Security Score and psychosocial adjustment as measured by the SDQ Total difficulties score was only marginally significant. The identification of a significant correlation between the SDQ Externalizing Scale and the child's Global Security Score further suggests that the transmission of trauma may be associated with disruptions in children's attachment representations. This is also supported by the high proportion of children (15/27) who were classified in the insecure category. This finding suggests that non-traumatized children with traumatized parents may develop disruptions in attachment representations similar to those seen in traumatized refugee children (Almqvist & Broberg, 2003; De Haene, Verschueren, & Grietens, 2009).

The lack of association between the SDQ internalizing scale and children's attachment representations is surprising. There are, however, some possible explanatory factors. Because of the children's age range, the study employed the parent version of the SDQ, and thus scores ultimately reflect parental perceptions of their children. The Externalizing Scale of the SDQ consists of the subscales: Conduct problems and Hyperactivity problems, which conceptually constitute observable behavior. The Internalizing Scale of the SDQ consists of Emotional problems and Peer problems, which at the conceptual level may be considered less easily observable. When looking at the theoretical assumption, that trauma causes decreased parental emotional availability, one may suggest that the scores

on the Internalizing scale reflect a general tendency for traumatized parents to be less attentive towards problems that are less easily observable and perhaps require emotional availability. Another possible explanation is that the finding reflects a genuine effect in which insecure attachment is more closely linked with externalizing problems. The latter seems theoretically implausible, but in a recent meta-analyses based on 42 independent samples (N= 4.614) Groh, Roisman, van IJzendoorn, Bakermans‐Kranenburg, and Fearon (2012) insecure attachment was found to be significantly more strongly related to externalizing problems than to internalizing problems. A link between insecure attachment and both internalizing and externalizing problems has, however, been established, and thus, the complete lack of an association between insecure attachment and internalizing problems in the present study is inconsistent with both theoretical assumptions and previous research (Brumariu & Kerns, 2010; Lyons-Ruth, Easterbrooks, & Cibelli, 1997). Furthermore, a recent study comparing psychological difficulties among children and adolescents with ethnic Danish, immigrant, and refugee backgrounds employed the youth self-report version of the SDQ and this study concluded that refugee children were at a higher risk for psychological difficulties associated with both externalizing and internalizing than the two comparison groups (Leth, Niclasen, Ryding, Baroud, & Esbjørn, 2014). The tendency for traumatized refugee parents to underreport re-experiencing symptoms in their preschool age children was documented by Almqvist and Brandell-Forsberg (1997). Furthermore Montgomery (2008) found a limited degree of cross-informant agreement between self- and parent assessment of mental health problems in a study of 64 Middle Eastern refugee families with 122 adolescent children, with a majority of children scoring themselves higher than their parents. This finding, suggests that, had self-ratings been possible, the reported symptom level in this study might have been higher. This further supports the need for future research to employ a self-rating measure of

children's psychosocial adjustment and to explore a full mediational model within a larger sample.

The fact that the paper's third hypothesis could not be confirmed can be interpreted in several ways. When the distribution of symptom scores within the sample are examined, the HTQ DSM-IV PTSD mean score was 2.84 (SD= 0.49); a frequency distribution shows that only 3 parents had scores lower than the recommended clinical cut-off ≥ 2.00, and the lowest score was 1.80. For the HSCL-25 Anxiety score the mean score was 3.00 (SD= 0.42) and none of the scores within the sample were below the scientifically valid cut-off ≥1.75. In fact the lowest score within the sample was 2.30. With regard to the HSCL-25 Depression score the mean within the sample was 1.98 (SD= 0.42) and 8 parents scored below the scientifically valid cut-off ≥1.75, and the lowest score was 1.20 (Fawzi et al., 1997). Thus, it is possible to suggest that the relatively high scores and limited variance within the sample scores may account for the null finding. Therefore, it is possible to argue that the impact of parental trauma, anxiety and depression symptoms on children may vary more within less traumatized populations, and that for highly traumatized parents, such as the present sample, where almost all scores are above the clinical cut-of point, the impact on the child is relatively unaffected by minor fluctuations in symptom scores.

The overall confirmation of the paper's fourth hypothesis (the existence of an association between intra-family trauma communication and children's attachment security) has important clinical implications. The study confirmed that the intra-family communication regarding parental traumatic experiences from the past is associated with children's attachment security, and contrary to what is often assumed within the therapeutic literature, an open style of communication does not seem to be more strongly associated with positive outcome in children than the silencing strategy. Furthermore findings from this study confirmed that a parental unfiltered style of communication is associated with insecure

attachment in children, which may have important clinical implications. Based on this finding, one may suggest that interventions in family therapy should target incoherence between the parental explicit strategy of communication and the child's lived reality by increasing parental awareness of what they are communicating. Although the result was not significant, a look at the contingency table suggests that a modulated style of disclosure or a child-focused strategy may be associated with secure attachment in children, which makes sense theoretically as modulated disclosure may be a result of a higher parental capacity to mentalize with their children. In fact many of the quotes reflecting a modulated style of disclosure may also be seen as examples of parental reflective functioning (Slade, 2005). This should be further explored in future research.

Conclusion

This study confirmed that non-traumatized children with traumatized refugee parents are less psychosocially well-adjusted than their Danish peers as measured by the SDQ (parent version). This finding suggests that children may be negatively affected by growing up with traumatized parents suffering from PTSD. The study found a high number of children classified as having an insecure attachment style, and although the overall association between the children's psychosocial adjustment and their attachment security as measured by the ATST could not be confirmed statistically, a significant association was found between the SDQ Externalizing scale and children's attachment security. This supports the hypothesis that the transgenerational transmission of trauma is associated with disruptions in children's attachment representation. The study failed to confirm an association between parental symptoms of PTSD, Anxiety and Depression and children's psychosocial adjustment and attachment security, which may be due to the high level of parent's symptoms in this sample and the limited variance amongst them. Finally the study found an association between intra-family trauma communication and children's attachment security and a specific association

between the Unfiltered Speech style of communication and insecure attachment in children. This finding has important clinical implications.

Taken together the results of the present study suggest the need for future research to explore a full mediational model of the transgenerational transmission of trauma in both clinical and non-clinical samples.

Limitations

The limited sample size and the use of a non-probabilistic sampling strategy both constitute major limitations to the present study. The families who declined participation may possibly constitute a subpopulation suffering from additional problems than the consequences of traumatic experiences. The reasons given for declining to participate may reflect even higher symptom scores or a lack of trust in authorities, both of which would potentially have altered the results of the present study. However as this study did suggest a negative impact of parental trauma on non-exposed children, it is reasonable to assume that the inclusion of families with even more problems would only have strengthened the findings. Furthermore it may be argued, that the lack of cultural and ethnic homogeneity within the sample constitutes a weakness, as it makes inferences about cross-cultural differences less specific.

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