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Collective and Transgenerational Trauma in Psychotherapeutic Treatment: Implications for Refugee and Post-Conflict Contexts

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ABSTRACT

Background: Refugees and populations affected by war, genocide, and forced displacement are exposed not only to individual traumatic events but also to collective and transgenerational forms of trauma. While psychotherapeutic research and practice have traditionally focused on individual trauma-related disorders, growing evidence highlights the relevance of historical, collective, and intergenerational processes in shaping mental health outcomes in post-conflict affected populations.

Objectives: This review aims to synthesize and critically integrate current evidence on collective and transgenerational trauma and to discuss their implications for psychotherapeutic treatment in refugee and post-conflict populations. This article is based on a narrative and integrative review of the literature, drawing on clinical, psychosocial, and public mental health perspectives as well as key theoretical models and empirical findings in the field.

Findings: Collective and transgenerational trauma operates through complex interactions between psychosocial, familial, sociocultural, and structural mechanisms. In refugee populations, ongoing post-migration stressors, discrimination, and social marginalization may reactivate historical trauma and contribute to chronic psychological distress. Trauma-related distress is best understood as a multilevel and temporally extended process shaped by the interaction of individual, collective, and structural factors. While trauma-focused psychotherapies remain central to treatment, approaches focusing exclusively on individual symptom reduction may not fully address the broader collective and contextual dimensions of trauma.

Conclusions: Effective psychotherapeutic care for refugees and post-conflict populations requires integrative approaches that combine evidence-based trauma-focused therapies with attention to collective histories, cultural meaning systems, and community-based support structures. Such approaches are essential for addressing the long-term psychological consequences of collective violence and displacement and have important implications for clinical practice, mental health service planning, and public mental health strategies in European healthcare systems.

1. Introduction

Armed conflict, genocide, forced displacement, and large-scale political violence continue to affect millions of people worldwide, making refugee mental health a major challenge for contemporary healthcare systems. According to the United Nations High Commissioner for Refugees (UNHCR), more than 117 million people worldwide were forcibly displaced as a result of persecution, conflict, violence, or human rights violations, including over 42 million refugees who crossed international borders.[1] The World Health Organization (WHO) has repeatedly emphasized that forced displacement constitutes a major global public mental health concern, as refugees are exposed to a substantially increased risk of trauma-related mental disorders, including post-traumatic stress disorder (PTSD), depression, and anxiety disorders.[2]

Over the past decades, a robust evidence base has demonstrated the effectiveness of trauma-focused psychotherapies in treating PTSD. Cognitive behavioral therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR), and Narrative Exposure Therapy (NET) are among the most widely studied and recommended interventions for trauma-related disorders, including in refugee populations.[2-4] NET, in particular, was specifically developed for survivors of organized violence and multiple traumatic experiences and has shown efficacy in contexts of war, torture, and forced displacement.[5,6]

At the same time, clinical experience and emerging research suggest that these models, which primarily focus on individual traumatic experiences, do not always fully capture the complexity of suffering observed in refugee and post-conflict populations.[7,8] Many individuals from such context have been shaped by prolonged persecution, collective violence, and historical trauma that extend beyond discrete events. Their experiences are often embedded in shared narratives of loss, displacement, and existential threat, which continue to influence psychological well-being across time and generations.

In recent years, increasing attention has therefore been given to the concepts of collective and transgenerational trauma. These perspectives emphasize that the consequences of mass violence and oppression are not limited to directly affected individuals but may extend to families, communities, and subsequent generations.[9-11] Trauma may be transmitted through relational, cultural, and structural pathways, including family dynamics, collective memory, social marginalization, and ongoing political instability.[12,13]

In refugee populations, these processes are frequently reinforced by post-migration stressors such as insecure legal status, discrimination, and social exclusion, which have been shown to exacerbate psychological distress.[14,15] Such conditions may reactivate earlier experiences of threat and contribute to persistent and complex symptom presentations that cannot be fully understood within narrowly defined diagnostic categories.

Clinical experience and emerging research suggest that psychotherapeutic interventions focusing exclusively on individual symptom reduction are often insufficient in such contexts. Refugee patients often present with complex symptom profiles embedded in collective narratives of loss, persecution, and existential threat. When these dimensions are not adequately acknowledged, treatment may be experienced as culturally incongruent, leading to reduced engagement, premature dropout, or limited therapeutic benefit.[7,16]

The aim of this review is to provide an overview of collective and transgenerational trauma and to examine their implications for psychotherapeutic treatment in refugee and post-conflict populations. This article is based on a narrative and integrative review of the literature drawing on clinical, theoretical, psychosocial, and public mental health contributions in the field. Relevant publications were identified through database searches (e.g., PubMed, PsycINFO, and Scopus) and key references in the field. Rather than aiming for exhaustive coverage, the review synthesizes these perspectives and is organized thematically to address conceptual foundations, mechanisms of transmission, clinical manifestations, and implications for treatment. This article seeks to contribute to a more context-sensitive understanding of trauma and support the development or culturally responsive and sustainable approaches to mental healthcare, particularly within European healthcare systems.

2. Conceptual Foundations of Collective and Transgenerational Trauma

2.1 CONFLICT CONTEXTS, COLLECTIVE MEANING SYSTEMS AND COLLECTIVE TRAUMA

Refugee mental health is shaped by a variety of stressors that arise during different phases of migration with psychological vulnerabilities often beginning already before the actual act of migration, during the pre-migration phase.[17] These stressors include, among other things, experiences of violence, persecution, and political instability within broader conflict environments that precede displacement. In contexts of prolonged and long-lasting conflicts, characterized by their severity and longevity, exposure to violence is not limited to discrete events but becomes embedded in everyday life, sometimes across generations.[18] When such conditions remains unresolved, they not only shape individual experience but also entire groups, communities, or societies transforming social life in ways that give rise to collective forms of traumatization.

Genocide, war, ethnic cleansing, systematic persecution, and forced displacement threaten not only physical survival, but also cultural identity, and social continuity.[11,26] Unlike individual trauma, collective trauma is embedded in shared memories, cultural narratives, rituals, and symbols that shape how communities interpret past suffering and anticipate future threats. Under conditions of chronic threat and uncertainty, shared interpretations of the conflict can solidify into entrenched narratives, emotional attitudes, and collective belief systems that shape how societies perceive and respond to the ongoing danger.[19,20,21]

Bar-Tal conceptualizes these shared patterns as a sociopsychological repertoire, defined as a constellation of collectively held narratives, values, and emotional orientations that enable societies to adapt to and function under conditions of sustained conflict.[18] These collective meaning systems impact identity formation, intergroup relations, and perceptions of safety and trust, often persisting long after the original traumatic events have ended. [9, 27]

Collective memories, for instance, often play a central role in this process, sustaining awareness of past violence while shaping expectations of future danger. Among Yazidi survivors of the 2014 genocide perpetrated by the so-called Islamic State (IS), for example, the attacks were widely reported to reactivate memories of earlier massacres, reinforcing a generational sense of existential threat.[22,23] Similar dynamics have been documented among descendants of Holocaust survivors, where family narratives frame remembrance as a moral responsibility and a safeguard against future persecution.[24,25] In such cases, collective memory operates both as a protective orientation toward the future and a mechanism through which historical trauma continues to shape the present.

The effects extend beyond individual psychopathology. Collective trauma can disrupt social functioning at multiple levels, with individual psychological reactions impacting family dynamics, which in turn shape collective memory and cultural norms.[28] When communities perceive their identity, religion, or ethnic belonging as persistently threatened, cultural practices may be altered, suppressed, or strategically reshaped. The historical experiences of many Indigenous communities and more recent persecution of Uyghurs and other Muslim minorities in Xinjiang illustrate how collective trauma may emerge through attacks on cultural continuity, forced assimilation, and identity erasure. [29,30,31]

2.2 COLLECTIVE TRAUMA AND HISTORICAL POWER STRUCTURES

Both the concept of sociopsychological repertoires in prolonged conflicts and historical trauma theory emphasize that sustained collective hardship generates patterned responses that shape group narratives, emotional climates, and social organization.[11,18] These collective adaptations impact how communities interpret threat and, in turn, affect individual psychological well-being.

Historical trauma frameworks extend the analysis of collective trauma by emphasizing the role of power asymmetries and structural inequality.[9,11,32,33] Rather than viewing trauma solely as the cumulative effect of adverse events, these approaches situate collective suffering within enduring systems of domination, colonization, and systematic persecution. In this perspective, trauma is embedded in historical and political trauma structures that shape both exposures to harm and the possibility for recovery.

Brave Heart & DeBruyn, for instance, describe historical trauma among Native American communities as the result of longstanding exposure to multiple, intersecting losses and persistent discrimination.[9] Similarly, Sotero's integrative model conceptualizes historical trauma as unfolding across successive phases: first, large-scale devastation inflicted by a dominant group; second, a broad spectrum of biological, psychological and social responses within the directly affected generations; and third, the transmission of these responses to subsequent generations through environmental, relational, and ongoing discriminatory processes.[11] Importantly, these models highlight that trauma does not end with the initial event but is sustained through ongoing structural conditions.

Such structural power relations shape not only the emergence of trauma but also access to recognition, justice, and reparative processes. In conflict and post-conflict settings, particularly where communities have been deliberately targeted, persistent inequalities may sustain vulnerability long after overt violence has ceased. The absence of accountability, continued marginalization, or restricted socio-political participation can prolong collective insecurity and reinforce transgenerational stress patterns.

Across these accounts trauma reactions are not confined to individual symptom expression but become structured expectations and relational patterns transmitted across generations. Faimon emphasizes the intergenerational legacy of shame, guilt and distrust embedded within the collective memory,[32] while the Aboriginal Healing Foundation characterizes historical trauma as a cluster of traumatic events whose long-term manifestations include maladaptive social and behavioral patterns that originate as survival responses.[33]

Understanding refugee mental health within this framework therefore requires attention not only to discrete traumatic exposures but also to patterned, relational, and identity-based consequences of collective and historical trauma. These processes shape attachment patterns, emotion regulation, identity coherence, and interpersonal trust, domains that extend beyond classical diagnostic categories and symptom-based approaches.

3. Clinical Manifestations in Refugee and Post-Conflict Populations

3.1 TRANSGENERATIONAL TRANSMISSION AND ADULT CLINICAL PATTERNS

If collective trauma becomes embedded within identity, narrative, and relational structures, a further analytical question emerges: Through which mechanisms does it persists across generations? One key framework addressing this question is the concept of transgenerational trauma. Transgenerational trauma describes the transmission of trauma-related distress, vulnerability, and coping patterns across generations, even when subsequent generations were not directly exposed to the original traumatic events.[10,34] This phenomenon has been documented across diverse populations, including descendants of Holocaust survivors, Indigenous communities affected by colonization, and families exposed to genocide, war, and forced displacement.[12,13] Thus, it is not a simple, linear inheritance of symptoms, but rather a dynamic process

shaped by interactions between family systems, sociocultural narratives, and ongoing structural conditions. In conflict-affected populations, clinical symptom profiles often exceed the explanatory scope of single-event trauma models. Although post-traumatic stress disorder (PTSD) remains one of the most frequently diagnosed conditions, especially among refugees and survivors of mass violence, it represents only one aspect of a broader spectrum of trauma-related psychopathology observed in these contexts.[35,36] Individuals exposed to prolonged conflict environments frequently present heterogenous and multilayered symptom constellations that reflect not only individual traumatic events, but also cumulative, collective and prolonged forms of adversity. Epidemiological studies have documented elevated rates of PTSD, depression, anxiety disorders, and somatoform symptoms among refugees compared to non-displaced groups.[35,37]

However, many patients exhibit additional features such as affect dysregulation, dissociation, persistent feelings of shame and guilt, interpersonal difficulties, and disturbances in self-concept. These patterns correspond closely to the diagnostic construct of complex post-traumatic stress disorder (CPTSD), introduced in the ICD-11, which describes the psychological consequences of prolonged, repeated, and inescapable traumatic experiences.[38] They include disturbances in emotional regulation, relational functioning and negative self-concept alongside core PTSD symptoms.[39,40] This framework is particularly relevant for refugee and post-conflict populations, whose trauma exposure often unfolds within prolonged environments of threat, persecution, and structural insecurity.[15]

Multiphase trauma approaches developed for contexts of genocide and displacement further substantiate this perspective.[41] In such environments, trauma rarely constitutes a single, temporally confined event, but unfold across interconnected phases including acute episodes of violence, prolonged periods of human rights violations and displacement, and continued exposure to precarious migration conditions. Across these phases, experiences of violence interact with collective memory, institutional structures, and sociopolitical constraints.[18] Psychological distress therefore accumulates over time and may reflect ongoing instability rather than past exposure alone.

Closely linked to this multiphase understanding are processes of trauma reactivation. Trauma is not solely stored as an isolated individual memory trace but remains dynamically shaped by collective and structural contexts. Ongoing environments that resemble the original conditions of threat may reactivate earlier traumatic experiences. Qualitative analyses among Kurdish Alevi and Yazidi communities illustrate how persistent discrimination, renewed violence, and contemporary sociopolitical developments may reactivate historical trauma across generations. [22,42,41] These findings underscore that trauma is socially regulated rather than static. It persists in interaction with collective narratives, political realities, and ongoing marginalization.

Migration contexts may further intensify these dynamics. A substantial body of research demonstrates that post-migration stressors significantly affect refugee mental health. Pre-migration trauma exposure is consistently associated with elevated rates of PTSD, depression and anxiety.[43-46] At the same time challenges such as insecure asylum status, family separation, unemployment, and discrimination can exacerbate psychological distress. [14, 47] For refugees originating from protracted conflict environments, these experiences may function as continuations or symbolic echoes of earlier experiences of political instability, persecution, or unreliable governance.

From a transgenerational perspective, such conditions may reactivate historically embedded patterns of insecurity and mistrust. Communities shaped by prolonged conflict often develop adaptive orientations towards chronic threat and institutional instability.[19-21] Encounters with discrimination, bureaucratic uncertainty, or social exclusion in host societies may therefore resonate with previous internalized threat schemas and reinforce a sense of shared vulnerability.[7,15,48-50]

Migration may additionally disrupt collective protective mechanisms that previously mitigated distress. In conflict-affected communities, sociopsychological repertoires and collective support systems often function as buffers against psychological stain.[51] Displacement, however, frequently involves the fragmentation of social networks and the loss of shared coping structures, potentially increased vulnerability to mental health problems. Empirical findings from Yazidi populations, illustrate that elevated PTSD prevalence remains among both internally displaced and externally migrated individuals, suggesting that displacement interacts with prior trauma exposure in shaping long-term outcomes.[52]

Adult clinical presentations in refugee and post-conflict populations are thus often shaped by cumulative trauma exposure, ongoing stressors, and transgenerational dynamics. This complexity supports assessment models that move beyond single-event frameworks and attend to the broader social and historical context of distress.

3.2 DEVELOPMENTAL MANIFESTATION IN CHILDREN AND ADOLESCENT

The transmission of collective and transgenerational trauma becomes particularly visible in the developmental trajectories of children and adolescents. Importantly, the absence of direct exposure to violence does not preclude psychological impact. Research from genocidal and post-conflict contexts demonstrates that trauma-related distress may extend to later generations who did not directly experience the original traumatic events. For instance, a mixed-methods study of three generations of Kurdish Alevi families exposed to mass violence and displacement documented trauma-related psychopathology not only among survivors but also among their children and grandchildren, including those raised in the diaspora.[42] More broadly, studies have reported elevated levels of anxiety, depression, behavioral problems, and emotional dysregulation among offspring of trauma-exposed parents.[12,42]

The family system represents a central mediating context through which these effects unfold. The developmental impact of parental trauma is largely transmitted through relational processes that shape children's emotional, cognitive, and interpersonal development. Among the most prominent mechanisms are patterns of communication and narrative transmission. Communication within trauma-affected families may range from silence and overwhelming disclosure, both of which can interfere with children's psychological adjustment.[24,53] Earlier research differentiates between functional communication, in which traumatic experiences are addressed openly, and dysfunctional communication, including silence, taboo, or fragmented narratives.[24] Whereby latter forms are being associated with adverse psychological outcomes.[54,55]

Danieli's concept of a "conspiracy of silence" describes how trauma may be transmitted when survivor parents avoid discussing their experiences and withdraw emotionally.[24] In such contexts, traumatic events are often communicated indirectly or in fragmented form, leaving children to interpret ambiguous or contradictory information.[55] This absence of coherent dialogue may foster confusion, uncertainty and emotional distance within the family system. Qualitative findings from Kurdish Alevi families similarly illustrate how indirect communication and silence surrounding past violence can complicate younger generations efforts to understand family histories while respecting survivors' reluctance to speak.[42] Historical trauma thus remains present yet insufficiently articulated within the emotional climate of the family.

Beyond communication patterns, attachment dynamics and parental adaptation styles further represent another important pathway of transmission. Trauma-exposed parents may experience difficulties in emotional regulation, trust, and attachment security. Such processes may contribute to insecure attachment patterns and heightened vulnerability to stress-related disorders. [34] Parenting practices shaped by unresolved trauma, including emotional withdrawal, overprotection, harsh or inconsistent discipline, or role reversal may disrupt children's developmental trajectories. In such cases, children may become prematurely self-reliant while simultaneously remaining deprived of secure dependency experiences. [24,34]

The relational processes manifest across several developmental domains including self-concept, cognition, affect regulation, and interpersonal functioning.[34] These domains closely correspond to the symptom clusters associated with complex PTSD.[39] Children may develop feelings of guilt or shame, rigid-related beliefs, difficulties in emotional regulation and unstable interpersonal relationships shaped by insecure attachment patterns.

In clinical settings, such developmental disruptions usually become apparent in indirect forms. Children and adolescents may present with school difficulties, psychosomatic complaints, withdrawal or externalizing behaviors that mask underlying trauma-related distress. Without a transgenerational perspective, such manifestations risk being misinterpreted as primary developmental or behavioral disorders rather than expressions of trauma embedded within family and collective histories.

Thus, these findings suggest that transgenerational trauma arises through the interaction of family-based dynamics, sociocultural meaning systems, and structural conditions rooted in histories of collective violence. Rather than constituting a simple inheritance of distress, it represents a dynamic process linking past and present. Importantly, this does not imply that descendants of trauma-affected communities are inevitably harmed by their ancestral experiences. Instead, such histories may heighten sensitivity to stress, relational dynamics, and contextual insecurity, particularly in environments where structural vulnerabilities persist.

3.3 CULTURE-SPECIFIC EXPRESSIONS AND SOMATIZATION

Cultural contexts play a central role in shaping how traumatic experiences are perceived, interpreted, and expressed. Collective histories, sociopolitical environments, and shared narratives affect how communities process experiences of violence and loss and how psychological distress is communicated. As a result, trauma-related suffering may be expressed through culturally specific emotional, behavioral, or somatic patterns. In cross-cultural psychiatry such culture-specific expressions are often described as *cultural idioms of distress*.[56]

This perspective is particularly relevant in refugee populations, which are highly heterogeneous in terms of language, religion, and cultural background. In many context, psychological suffering is communicated through bodily complaints rather than explicit psychological terminology. In clinical practice with Yazidi, Kurdish, and Middle Eastern refugee populations, for instance, somatization frequently represents a socially acceptable way of expressing trauma-related distress, particularly in settings where mental illness is stigmatized or lacks linguistic equivalents.[57] Failure to recognize these symptoms as trauma-related may lead to repeated medical consultations, misdiagnosis, and frustration for both patients and healthcare providers.

At the same time, somatic expressions of distress cannot be understood solely as communication strategies shaped by stigma. In many cases, bodily symptoms are deeply embedded in culturally specific understandings of trauma and illness. Studies among rural Cambodian refugees, for instance, have documented frequent complaints of dizziness and neck pain that were linked to specific bodily sufferings during the Khmer Rouge regime.[58] Such findings illustrate that different cultural groups may develop distinct trauma ontologies that differ from Western biomedical interpretations of symptoms.

More broadly, individuals from conflict-affected populations frequently report chronic pain, headaches, gastrointestinal complaints, fatigue, and cardiovascular symptoms that cannot be fully explained by identifiable

organic conditions.[7,59] Anthropological research attributed such patterns party to *ethnophysiological* models, culturally embedded understandings of mind and body shape how bodily sensations are interpreted and attributed meaning.[60]

Trauma-related distress may also be expressed through culturally specific metaphors and symbolic language. Among West Papuan refugees resettled in Australia, for example, the expression *susah hati* ("difficult heart") describes profound sadness and loss associated with displacement and violence.[61] Similarly, displaced individuals from South Sudan have described traumatic experiences as "wounds in the heart" conveying emotional pain and suffering.[62] Such metaphors provide culturally meaningful ways of articulating distress that may not correspond directly to Western psychiatric terminology.

Beyond linguistic expressions, many cultures employ collective practices to communicate suffering and preserve memory. Rituals, lamentations, and storytelling traditions can function as shared forms of mourning and to communicate suffering and preserve traumatic memory across generations.[25,42] These practices may also shape how younger generations learn to interpret collective suffering and integrate it into their own identities.

Taken together, these observations highlight that somatic complaints and culturally specific expressions of distress should not be interpreted solely as manifestations of somatic symptom disorders. Rather, they often represent culturally meaningful ways of communicating psychological suffering. Recognizing these expressions is therefore essential in clinical assessment. Particularly in refugee populations, physical complaints may constitute an important entry point into discussing trauma-related experiences. Ignoring such culturally mediated expressions risks overlooking relevant aspects of distress and may contribute to diagnostic blind spots or misinterpretations in clinical practice.

4. Clinical Implications for Psychotherapeutic Treatment

The preceding sections illustrate that trauma-related distress in refugee and post-conflict populations often extends beyond the explanatory scope of narrowly symptom-focused diagnostic approaches. Rather than reflecting isolated traumatic events, psychological suffering in these contexts is frequently multilayered, embedded in collective histories, and maintained by ongoing structural stressors.

These characteristics challenge conventional diagnostic frameworks that conceptualize trauma primarily as the consequence of individual exposure. Instead, the findings presented above indicate that trauma-related symptoms are often intertwined with broader sociocultural, historical, and relational contexts. For clinicians, this implies that effective assessment and treatment require attention not only to individual symptomatology but also to patients' histories, cultural frameworks, and familial dynamics.

Recognizing the collective and transgenerational dimensions of trauma is therefore essential for accurate clinical understanding, the establishment of therapeutic alliance and the prevention of re-traumatization.[7,8] At the same time, these considerations raise questions regarding the adequacy of existing psychotherapeutic approaches. Although evidence-based trauma-focused interventions represent a central component of treatment, the complexity of trauma-related disorders in refugee and post-conflict populations often requires therapeutic frameworks that extend beyond individual symptom reduction.

The following section therefore examines established evidence-based interventions and discusses their relevance and potential limitations in contexts where trauma is embedded within collective histories and sociopolitical structures.

4.1 INTEGRATED CLINICAL PERSPECTIVES: EVIDENCE-BASED TREATMENT IN CONTEXT

Evidence-based trauma-focused therapies constitute a central component of treatment for trauma-related disorders. International clinical guidelines recommend trauma-focused cognitive behavioral therapy (TF-CBT), Eye Movement Desensitization and Reprocessing (EMDR), and Narrative Exposure Therapy (NET) as first-line treatments for PTSD.[2,63] These interventions have demonstrated efficacy across diverse populations, including survivors of war, torture, and forced displacement.[3,4,6,65] Although these approaches differ in their specific techniques, they share the central aim of facilitating the processing and integration of traumatic memories through mechanisms such as bilateral stimulation or structured autobiographical narratives.[5,64]

Despite their demonstrated effectiveness, trauma-focused therapies are primarily designed to address individual traumatic events and symptom clusters. Their theoretical foundation typically conceptualizes trauma as arising from discrete experiences that disrupt individual memory processing and produce identifiable psychological symptoms. In populations affected by genocide, prolonged persecution, or forced displacement, however, this individual-centered framework may not fully capture the broader context in which collective trauma is experienced.[7,8] As established in the conceptual foundations of this paper, psychological distress in such populations is often intertwined with collective histories of violence and shared narratives of injustice. In clinical practice this can become evident when traumatic memories remain closely connected to unresolved collective experiences or to the ongoing suffering of family members and communities.

Therapeutic work in refugee and post-conflict contexts requires particular attention to cultural frameworks through which psychological distress is experienced and expressed. As discussed earlier, trauma-related suffering may manifest through culturally specific idioms of distress and explanatory models that differ from Western psychiatric frameworks.[16,59] In these contexts trauma-related suffering often manifests through somatic complaints.[7,58-62,69] Without integrating these symbolic frameworks into evidence-based protocols, clinicians risk

misinterpreting symptoms as purely individual psychopathology, thereby overlooking the collective dimension.

Effective psychotherapy therefore requires a common language through which distress, symptoms, and coping strategies can be discussed meaningfully. Incorporating patients' metaphors, narratives and culturally shaped interpretations into psychoeducation can facilitate this process.[52] Furthermore, validating patients' lived experiences is particularly important for establishing trust which plays a central role in the therapeutic relationship, particularly when historical power asymmetries have shaped a fundamental mistrust toward institutional structures.[17] When structural conditions surrounding patients' suffering are acknowledged it can strengthen the therapeutic alliance and reduce the risk of re-traumatization.[7,8]

For refugees originating from protracted conflict environments, post-migration stressors such post-migration living conditions such as legal status, safety, access to psychosocial support, social integration, and prospects in the host country have a significant influence on the course of trauma-related disorders.[41] They are not merely external factors but function as continuations of earlier experiences of political instability and persecution thereby undermining treatment effectiveness.[14,66-68] When these contextual factors remain unaddressed, symptom reduction achieved in therapy may remain fragile or short-lived.

From a transcultural perspective, psychological symptoms should therefore be understood within its broader social and cultural context rather than being interpreted solely at the individual level. A transcultural psychotherapeutic approach situates distress within patients' family structures, community relationships, migration histories, and sociopolitical environment.[69] Experiences of war, persecution, forced displacement, and ongoing insecurity shape not only symptom expression but also patients' interpretations of suffering and imagine recovery.

In practical terms, this perspective does not replace established psychotherapeutic methods but complements them through cultural adaptation. Therapeutic interventions may include culturally meaningful metaphors, adapted self-observation techniques, and resource-oriented strategies that resonate with patients' sociocultural backgrounds.[52] Such adaptations aim to avoid experiences of shame or failure and to support patients' sense of competence and agency.

Accordingly, transcultural psychotherapy seeks to support patients in integrating culturally shaped identities and experiences within the context of migration and social change. By acknowledging the dynamic interaction between culture, migration, and psychological adaptation, therapy can help patients strengthen coping strategies and develop a sense of agency within their evolving sociocultural environment.

4.2 COMMUNITY-BASED AND PUBLIC MENTAL HEALTH APPROACHES

Large-scale violence and displacement affect entire communities and generate mental health needs that exceed the reach of individual psychotherapy. Even in high-income countries, like Germany, up to half of affected individuals remain untreated, due to barriers such as stigma, limited mental health literacy, a lack of culturally adaptive services, and shortages of trained mental health professionals.[70-78] In refugee and post-conflict contexts, these challenges are often compounded by legal insecurity, socioeconomic hardship, and ongoing exposure to stressors. Under such conditions, professional psychotherapy alone is unlikely to meet the mental health needs of entire populations.

In light of this view, community-based and public mental health approaches have gained increasing attention as complementary strategies for addressing the psychosocial consequences of collective violence. Rather than relying exclusively on specialized clinical services, these approaches seek to anchor psychosocial support within existing social networks and community structures. The underlying premise is that psychological recovery after large-scale traumatic events often involves collective processes of coping and meaning-making. Resilience in this sense emerges not only as an individual capacity but also a through social relationships, shared experiences, and collective support.[79]

Community-oriented interventions typically pursue several interrelated objectives. First, they aim to strengthen existing support networks, including families, neighbors, and community leaders. Second, they focus on building local capacities by training non-specialists to provide basic psychosocial support under professional supervision. Third, they emphasize low-threshold interventions that can be integrated into everyday settings and remain accessible even in contexts with limited mental health infrastructure. In this way, community-based initiatives complement rather than replace specialized psychotherapy and psychiatric care.[80]

Various intervention models illustrate these principles. Task-sharing approaches such as Problem Management Plus (PM+) enable trained lay providers to deliver structured, low-intensity psychosocial support and thereby expand access to care in resource-limited environments.[81] Other models, such as the Community Resiliency Model (CRM), focus on simple body-based self-regulation techniques that help individuals regulate stress responses and that can be shared within social networks.[81] Informal peer support structures and collective rituals and practices of remembrance likewise play an important role by strengthening social cohesion and providing shared spaces for mourning, meaning-making, and social reconnection.[79,80,83] By prioritizing these shared coping mechanisms, community approaches address the symbolic and relational disruptions caused by collective violence.

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Despite their potential benefits, community-based approaches cannot substitute specialized mental health care for severe psychiatric conditions, who often require professional psychotherapy, psychiatric treatment. Moreover, reliance on lay providers may overburden community members who themselves may have experiences trauma. Without adequate training, supervision, and institutional support, volunteers may face emotional exhaustion or secondary traumatization.[84] For these reasons, community initiatives are most effective when embedded within broader mental health systems that ensure access to professional care when needed.[80]

Hence, community-based and public mental health approaches offer important complements to individual psychotherapy in contexts of large-scale violence and displacement. By strengthening local support networks, mobilizing community resources, and facilitating collective coping processes, such approaches can extend the reach of psychosocial support where specialized services alone remain insufficient.

4.3 CLINICAL TAKE-HOME MESSAGES

In summary, effective psychotherapeutic treatment for refugees and post-conflict populations requires an integrative approach that combines multiple levels of intervention:

- the use of evidence-based trauma-focused therapies (e.g., TF-CBT, EMDR, NET), as a foundation for treating trauma-related symptoms,
- contextualization of trauma within collective histories and transgenerational dynamics, allowing clinicians to situate individual symptoms within broader sociocultural and historical frameworks,
- cultural sensitivity and the development of a strong therapeutic alliance, including attention to culturally shaped idioms of distress, explanatory models, and patients' symbolic forms of expression,
- recognition of structural and post-migration stressors such as discrimination, legal insecurity, and social marginalization that may influence symptom persistence and treatment outcomes,
- and the integration of psychotherapy within community-based and public mental health approaches that strengthen local support networks and extend access to psychosocial care.

Such integrative models are particularly relevant for European healthcare systems facing increasing demand for culturally responsive and sustainable mental health services for displaced populations.

5. Discussion

This review highlights that collective and transgenerational trauma are central dimensions of psychological suffering in refugee and post-conflict populations. Trauma-related distress in these contexts cannot be adequately understood through models that reduce it to an individual psychological disorder or single event-based model. Rather, symptoms are often embedded within broader historical, social, and relational contexts shaped by genocide, prolonged conflict, forced displacement, and ongoing marginalization.[7,10,12] When violence affects the symbolic foundations of a community, its effects extend beyond individual symptoms and become embedded in collective memory and intergenerational narratives. This underscores the need for frameworks that account for broader sociopsychological adaptations under conditions of sustained threat. Accordingly, trauma in refugee and post-conflict populations is best understood as a multilevel and temporally extended process. Psychological distress emerges at the intersection of individual exposure, collective histories, family transmission, and ongoing structural conditions, all of which shape how trauma is experienced, interpreted, and maintained over time.

A central implication of this review is that collective and transgenerational perspectives can enrich clinical understanding without replacing established trauma-focused approaches. Evidence-based interventions such as CBT, EMDR, and NET remain essential components of treatment. However, their clinical relevance may be strengthened when traumatic memories, symptom expressions, and therapeutic goals are situated within patients' collective histories, family narratives, cultural meaning systems, and current living conditions. In this sense, the reviewed evidence supports integrative treatment models that combine individual psychotherapy with culturally sensitive, family-informed, and community-oriented approaches.[7,8,59,69]

Such contextualization may also impact therapeutic processes in important ways. Addressing the collective dimensions of trauma may help shift the therapeutic focus from individual pathology toward questions of responsibility, agency, and social context. Symptoms such as hypervigilance, shame, mistrust, emotional dysregulation, or relational difficulties may not only reflect intrapsychic pathology, but can represent understandable responses to collective histories of violence and persistent insecurity.

Another important implication concerns the role of post-migration environments in shaping mental health outcomes. A growing body of research demonstrates that ongoing stressors such as insecure legal status, discrimination, and social exclusion significantly influence the course of trauma-related disorders.[14,15] In many cases, these conditions may function as continuations or symbolic reactivations of earlier experiences of threat and instability.

This perspective aligns with conceptualizations of trauma as a multiphase process, in which past experiences, present conditions, and anticipated future uncertainties interact in shaping vulnerability and recovery. Psychotherapeutic interventions that do not take these contextual factors into account risk addressing symptoms without adequately engaging with their underlying determinants.

From a clinical perspective, these findings support the need for integrative treatment models that combine individual psychotherapy with culturally sensitive and community-based approaches. Interventions that

incorporate patients' cultural frameworks, collective narratives, and social contexts may enhance therapeutic alliance and improve treatment outcomes.[59,69] Effective care may therefore need to operate across multiple levels, integrating individual symptom-focused techniques with approaches that address family dynamics, community contexts, and broader structural conditions. At the same time, community-based and public mental health strategies can play a complementary role by strengthening social support networks and facilitating collective processes of coping and meaning-making.[79,80]

In this context, collective memory and shared narratives should not be understood merely as background factors but as central meaning-making systems through which individuals interpret their experiences. Reframing distress in this way may reduce pathologizing interpretations and help shift therapeutic work toward agency, meaning-making, and the restoration of safety and trust. At the same time, shared narratives of survival, cultural continuity, and community belonging may function as therapeutic resources that remain underused in conventional treatment models.[41]

Beyond clinical practice, the findings of this review also have important implications for health policy. European healthcare systems are increasingly confronted with the long-term mental health consequences of forced displacement. Addressing these challenges requires not only the expansion of psychotherapeutic services but also structural interventions targeting social determinants of mental health, including legal security, housing, employment, and access to culturally appropriate care.[14,36] Without addressing these broader structural conditions, clinical interventions risk remaining limited in their effectiveness, particularly when ongoing insecurity continues to reinforce trauma-related distress.

Despite its contributions, this review has several limitations. As a narrative synthesis, it does not provide a systematic or exhaustive analysis of the literature, and the selection of sources may be influenced by interpretative judgment. In addition, while the review integrates findings from different populations and contexts, empirical evidence on transgenerational trauma remains uneven across regions and cultural groups. Future research should therefore focus on longitudinal and cross-cultural studies that further elucidate the mechanisms of trauma transmission and resilience across generations.

At the same time, caution is warranted to avoid deterministic or reductionist interpretations of transgenerational trauma. Not all descendants of traumatized populations develop psychopathology, and resilience, cultural continuity, and social support can play protective roles. Therapeutic approaches must therefore balance acknowledgment of historical suffering with a focus on individual agency and present-day resources.

6. Future Directions

Several implications emerge for future research, clinical practice, and mental health policy.

First, there is a need for longitudinal and transgenerational studies that extend beyond Holocaust-related research and include diverse refugee populations affected by genocide, colonial violence, and mass displacement. Such studies should integrate qualitative and quantitative methodologies to capture both symptom trajectories and lived experiences across generations.

Second, future intervention research should examine integrative treatment models that combine trauma-focused psychotherapy with family-based, community-based, and public mental health approaches. Evaluating how CBT, EMDR, and NET can be systematically adapted to incorporate collective and transgenerational dimensions represents a key research priority.

Third, European healthcare systems must address structural determinants of mental health, including asylum procedures, housing, employment, and access to care. Without addressing these factors, psychotherapeutic interventions risk being undermined by ongoing insecurity and marginalization.[14,36]

Finally, training and supervision programs for mental health professionals should include education on collective and transgenerational trauma, cultural psychiatry, and ethical considerations when working with survivors of mass violence. Such competencies are essential for delivering safe, effective, and culturally responsive care.

7. Conclusion

Collective and transgenerational trauma constitute fundamental dimensions of psychological suffering in refugee and post-conflict populations. Exposure to genocide, systematic persecution, and forced displacement affects not only individuals but also families, communities, and subsequent generations through complex psychosocial and structural pathways.

While evidence-based trauma-focused therapies such as CBT, EMDR, and Narrative Exposure Therapy remain central to treatment, their effectiveness is enhanced when embedded within integrative frameworks that acknowledge historical trauma, collective memory, and ongoing sociopolitical realities. Psychotherapeutic care that incorporates transgenerational perspectives, cultural sensitivity, and community-based interventions is better equipped to address the long-term mental health consequences of mass violence.

For European healthcare systems, these insights have important implications for clinical practice, service development, and public mental health policy. Addressing collective and transgenerational trauma is not only a clinical necessity but also an ethical imperative in societies increasingly shaped by global displacement and post-conflict migration.

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