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War By Proxy, Trauma by Inheritance: Transgenerational Psychological Effects of Iran–Saudi Proxy Conflicts

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Abstract
The implications of Iran–Saudi Arabia proxy conflicts are evident in transgenerational psychological effects of the population in Yemen, Syria, Iraq, and Lebanon. This paper argues that the psychological toll of protracted warfare extends beyond direct victims, thereby affecting future generations through biological, psychological, and socio-environmental mechanisms. Drawing on research in psychiatry and international relations, it illustrates how trauma from Iran-Saudi Proxy Conflicts can alter stress responses in children, manifest in family dynamics, and become embedded in collective memory. It further highlights how gendered experiences and refugee displacement shape trauma transmission and notes the critical lack of mental health infrastructure across affected regions. The paper posits that culturally informed interventions, community resilience, and policy reforms are significant to address mental well-being alongside post-conflict reconstruction. By adopting a trauma-informed lens and investing in mental health systems, governments and aid organizations can help ensure that the legacy of proxy wars is not one of continued suffering but of recovery and resilience.

Keywords: Transgenerational trauma, proxy war, Iran–Saudi Arabia rivalry, mental health, Middle East conflicts.

Introduction

Iran and Saudi Arabia have long engaged in a regional rivalry often described as a "Middle Eastern Cold War," wherein they support opposing parties in conflicts across the Middle East. In countries like Yemen, Syria, Iraq, and Lebanon, this rivalry has manifested as proxy wars – conflicts fueled by Iran–Saudi competition for influence. These wars have inflicted enormous human suffering, with hundreds of thousands killed or displaced (Ejaz, 2018). Beyond the immediate toll of death and destruction, scholars and clinicians are increasingly concerned with the invisible wounds of these conflicts: the psychological trauma carried by survivors and, crucially, passed down to their children and grandchildren. War leaves not only physical ruins but also deep emotional scars that can haunt future generations (Tanielian, 2018).

The recent research in psychiatry and epigenetics is shedding light on how trauma can be transmitted from one generation to the next. For instance, a study of Syrian refugee families found evidence of genetic imprints of war trauma spanning three generations (Bellis and Zisk, 2014). Such findings underscore that the legacy of conflict endures long after the guns fall silent. In proxy war settings, where violence is protracted and often indiscriminate (Ejaz, 2018), children grow up amid chronic stress and fear, potentially inheriting the unresolved trauma of their parents. This paper examines the transgenerational psychological effects of Iran–Saudi proxy conflicts. It integrates psychiatric literature on intergenerational trauma with conflict studies and regional insights, focusing on Yemen, Syria, Iraq, and Lebanon as case studies.

The paper explores the mechanisms by which trauma is passed down, the gendered dimensions of these effects, the situation of refugees and diaspora communities, and the state of mental health infrastructure in conflict zones of West Asia. Lastly, the policy and practice recommendations to address and mitigate these transgenerational traumas has been given. The goal is to illuminate how "war by proxy" becomes "trauma by inheritance," and why recognizing and healing that trauma is crucial for any lasting peace and recovery in the region.

Conceptual Framework: Transgenerational Trauma in Psychiatry

In psychiatry, transgenerational trauma (also called intergenerational trauma) refers to the phenomenon where the psychological effects of trauma are transferred from those who directly experienced an event to subsequent generations. Classic examples include studies of children of Holocaust survivors who exhibited elevated rates of anxiety and PTSD despite being born after the war (Yehuda & Lehrner, 2018). Such transmission can occur through multiple pathways – biological, psychological, and social. Biologically, severe stress can induce epigenetic changes (chemical modifications to DNA expression) that may be inherited. For instance, maternal trauma during pregnancy has been linked to altered stress hormone regulation in offspring (Jiang, 2019). A recent epigenetic study in Scientific Reports found distinct DNA methylation patterns in Syrian civil war survivors and their descendants, marking the first evidence of an intergenerational epigenetic signature of violence in humans. Notably, children born to trauma-exposed parents showed signs of accelerated biological aging and stress response

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changes, suggesting that the parents' wartime experiences left a biological imprint on the next generation (Bellis and Zisk, 2014).

Psychologically and socially, trauma is also transmitted through family dynamics, narratives, and caregiving patterns. Parents who have endured conflict may suffer from PTSD, depression, or other trauma-related disorders that affect their parenting and attachment with children (Punamäki, 2017). A mother or father traumatized by war might be emotionally less available, overly protective, or prone to anger – responses that shape a child's development and sense of security. Research shows a strong intergenerational link between maternal mental health and child outcomes: children of mothers with PTSD or depression face higher risks of emotional and behavioral problems (Klaric, 2007). This link is especially evident in contexts of violence. For example, an empirical study of Lebanese civil war survivors demonstrated that offspring of war-traumatized parents were 3.7 times more likely to develop PTSD or other disorders if their parents had high trauma-related psychopathology. Crucially, that study found the transmission was mediated by the parent's current mental health status – i.e. if the parent still struggles with trauma symptoms, the child is far more likely to develop problems. (Landstedt,, 2019). This underscores that it is not merely the historical fact of a parent's exposure that matters, but the lasting psychological state of the parent.

Transgenerational trauma can also be reinforced at a collective level. In communities ravaged by war, shared memories of atrocities, loss, and injustice become part of the cultural fabric, influencing the worldview of the next generation. Children often grow up hearing stories of what their family endured or witnessing commemorations of past violence. These collective narratives can instill a sense of inherited grief, anger, or mistrust in young people who never directly saw the war. In Lebanon, for instance, the generation born after the 1975–1990 civil war still lives with its shadow through family testimonies and sectarian tensions that persist. As one psychological study notes, trauma is passed down "through attachment relationships and within family and community groups," creating a shared reality of collective trauma (Banna, 2017).

It is important to emphasize that transmission is not automatic nor immutable. Many children of traumatized parents do not develop psychological problems – often thanks to protective factors like strong social support, community resilience, or deliberate efforts by parents to shield their children. In the Lebanese study above, higher levels of perceived social support and spirituality in the family actually moderated the impact of the parents' war trauma on the children (Landstedt,, 2019). Such findings align with broader research showing that stable, supportive relationships can break the cycle of trauma. This gives hope that interventions can promote resilience even in war-torn families.

All in all, transgenerational trauma in psychiatry is a multi-faceted concept: extreme stress can leave biological traces that are inheritable, but perhaps more commonly, trauma is passed on via psychological pathways – through parenting behavior, family communication (or silence) about the past, and socio-environmental context. The Iran–Saudi proxy conflicts provide a tragic "laboratory" in which to examine these dynamics, as entire populations have been exposed to prolonged violence with insufficient time or resources for healing. Before delving into specific cases, we turn to a brief background on these proxy wars and the regions most affected.

Background: Iran–Saudi Proxy Conflicts and Affected Regions

Iran and Saudi Arabia have been engaged in a strategic rivalry for regional dominance since the Iranian Revolution in 1979. This power struggle has played out in multiple countries, including Yemen, Syria, Iraq, and Lebanon, each of which has suffered protracted instability and humanitarian crises as a result. Local grievances and conflicts have been exacerbated by external funding, arms, and political backing from Tehran or Riyadh (Chen, 2017). The result is protracted wars that deeply penetrate civilian life, increasing the civilian population's exposure to trauma.

Yemen's conflict escalated in 2015 when Houthi rebels took over Sana'a, prompting a Saudi-led military intervention to restore the Sunni-led government. The conflict has raged for over eight years, with Saudi Arabia conducting thousands of airstrikes and Iran accused of supplying the Houthis with missiles and drones. The conflict fragmented Yemen, collapsed its economy, and created what the UN calls the "worst humanitarian crisis in the world". An estimated 233,000 Yemenis had died by 2020 from violence, war-induced disease, and famine, while around 4 million have been internally displaced (Gressmann, 2016).

Syria's civil war began in 2011 as a popular uprising against the Assad regime but quickly became a proxy battleground. Iran, alongside its ally Hezbollah, intervened decisively to prop up Bashar al-Assad's government, providing fighters, weapons, and strategic guidance. Saudi Arabia lent support to various Sunni rebel factions, especially in the early years of the war. The result was a brutal, multisided conflict that continues in parts of Syria today. Over 500,000 Syrians have been killed and more than half the population displaced by the war (Simarud & Crombleholme, n.d.).

Iraq has been a theater for Iran-Saudi competition particularly since the 2003 U.S.-led invasion toppled Saddam Hussein. Iran cultivated strong influence over the new Shia-led political order in Baghdad and supported Shia militias. Saudi Arabia maintained ties with Iraq's Sunni communities and at times was accused of tolerating, if not directly aiding, Sunni insurgent networks in the mid-2000s (Mabon, 2015). The rise of ISIS in 2014 brought new trauma; Iran-backed militias helped fight ISIS, while Saudi Arabia joined the international coalition against ISIS (Helvalı, 2020). Lebanon's people have endured cyclical turmoil: civil war, Israeli invasions, Syrian occupation, political assassinations, an economic collapse since 2019, and a massive port explosion in 2020. In each of these affected regions, civilians have experienced extreme stressors, such as aerial bombardments, street battles, terrorist attacks, displacement from homes, loss of loved ones, and breakdown of basic services. Children have grown up with chronic insecurity, and the prolonged nature of Iran-Saudi proxy conflicts means that multiple generations have been sequentially exposed (Dimitry, 2012).

Mechanisms of Trauma Transmission

How does the "inheritance" of trauma occur? Modern research points to a combination of biological and psychosocial mechanisms through which the impact of war can be passed from one generation to the next. Severe stress can induce physiological changes that affect offspring even before they are born, as per the Developmental Origins of Health and Disease (DOHaD) framework. In war zones, pregnant mothers experience malnutrition, toxic exposures, and extreme fear, which can alter fetal development (Montgomery & Foldspang, 2001)). Stress hormones like cortisol cross the placenta, and maternal psychosocial stress can lead to babies with higher sensitivity to stress and greater risk for emotional difficulties later in life. Trauma-related epigenetic modifications may be transmitted, with studies showing that children exposed prenatally during war exhibited signs of accelerated epigenetic aging, potentially predisposing them to earlier onset of stress-related diseases. Evidence is growing that extreme adversity can leave biological "footprints" that children inherit. For example, Holocaust survivors found changes in a stress-regulation gene (FKBP5) in the blood of mothers who survived Nazi concentration camps and, in their offspring, suggesting an epigenetic echo of Holocaust trauma (UNDP, n.d).

Additionally, a study in Rwanda decades after the genocide noted high cortisol level alterations in the children of genocide survivors (Rieder & Elbert, 2013). The family environment is the most immediate context for a child's psychological development. War can fundamentally alter a survivor's emotional state and capacity to parent. Parents with unresolved PTSD from conflict often experience symptoms like nightmares, flashbacks, emotional numbing, irritability, or explosive anger, which can lead to difficulties in bonding with their children. The traumatized parents might overprotect their children or convey a pessimistic view of the world, impede the child's independence, social confidence, and overall sense of security in the world (Shrira, 2020).

The empirical research supports these patterns, with studies in Gaza finding that maternal PTSD was associated with increased emotional and behavioral problems in children, mediated by the mother-child interaction quality. Maintaining positive parenting despite trauma can lead to better outcomes for children, highlighting the importance of parent support. In conclusion, severe stress can have long-term consequences on offspring, including emotional health, parenting, and attachment (Palosaari,2013). Addressing these issues is crucial to prevent the transmission of trauma and promote a healthier future for all. Silence can also be a mechanism of transmission, as children are perceptive and often sense the "ghosts" that haunt their family. In Lebanon, families rarely discussed the civil war for years, leaving a younger generation detached yet influenced by a past they didn't fully know. In proxy war regions, trauma transmission is often compound, with children inheriting parents' trauma and accumulating their own. For example, a Syrian father traumatized by torture might have a son who directly witnesses bombings or the death of a friend in later years. This additive effect makes the psychological burden in such families quickly escalate. War often erodes traditional support systems, making families silos of suffering more likely to spiral into intergenerational problems. Socioeconomic and cultural disruption contribute indirectly to trauma transmission. Economic hardship can increase familial stress and conflict, compounding trauma (Choi, 2017).

In Iraq and Syria, many children of war have known nothing but disrupted schooling and fragmented communities, impairing their normal social development and creating a context where trauma and aggression can normalize Nakeyar, 2016). In conclusion, the inheritance of trauma in conflict settings is multidimensional, with biological mechanisms, developmental mechanisms, cognitive mechanisms, and structural mechanisms. The research findings from Yemen, Syria, Iraq, and Lebanon provide insights into these mechanisms and their implications for future generations.

Case Studies

Yemen: Conflict, Collapse, and Childhood Trauma

Yemen's civil war (2015–present) provides a stark case of how proxy-fueled conflict can scar a generation. Years of relentless bombing, ground fighting, siege, and famine have taken a severe psychological toll on Yemeni civilians. With Iran viewed as backing the Houthi rebel movement and Saudi Arabia leading a coalition intervening on behalf of the ousted government, the war has been brutal and protracted. In such situation, civilians are caught in between, facing airstrikes from above and hunger and disease on the ground. The trauma exposure of Yemeni children is almost total. In one study of schoolchildren in Sana'a (Yemen's capital, which has been repeatedly bombed by the Saudi-led coalition), 79% of children surveyed exhibited clinically significant PTSD symptoms. This study, conducted in 2016 among displaced children, found alarmingly high rates of nightmares, flashbacks, bedwetting, and acute anxiety in these children, far above rates seen in other war-torn populations. Essentially, four out of five Yemeni children in the sample were living with the psychological manifestations of trauma a crisis of mental health that mirrors the physical humanitarian crisis. Children described constant fear of airstrikes and an inability to sleep due to anxiety that their home might be hit next. Parents reported behavioral regressions in children: clinging, loss of potty-training, and extreme startle responses to loud noises (al-Ammar, 2018).(common, given the backdrop of war). Nationwide, Yemeni society is traumatized. A HRW survey in early 2020 estimated 7 million Yemenis (about one-quarter of the population) suffer from psychological distress or mental disorders due to the war. Yet mental health services are virtually nonexistent: only around 120,000 people (barely 2% of those in need) have any access to mental health care in Yemen (Human Rights Watch, 2020). The rest suffer in silence or seek solace from traditional healers, as formal psychiatric care is extremely scarce. Many hospitals and clinics have been destroyed or shuttered; as of 2020, only about half of health facilities in Yemen were fully functional, and even those rarely have trained mental health professionals. Stigma also remains a barrier – in Yemeni culture, mental illness can carry shame, so families often hesitate to seek help even when it's available (Farhood, 2018). This leaves millions of trauma-impacted people untreated, greatly increasing the risk that their suffering will become chronic and that they will inadvertently pass it to their children. For Yemeni children, the war has disrupted every protective factor. Schools have closed or been repurposed as shelters; many teachers have not been paid in years, leading to a collapse of the education system. Without school, children lack routine and peer support, and they miss out on a sense of normalcy. Many are recruited as child soldiers or forced into labor to support their families, exposing them to further trauma or exploitation. Families have been torn apart: an entire generation of Yemeni kids has grown up at risk of losing parents or siblings either to violence or to

starvation and disease. A heartbreaking statistic: by 2018, an estimated 85,000 children under five died from malnutrition in Yemen (BBC, 2018) each such loss is a trauma for a family and community.

Transgenerational trauma in Yemen is a real concern. Parents who have seen their children die or who have themselves survived horrific events are now trying to raise remaining children amidst continuing war. They may be grief-stricken, depressed, or in constant fear. For example, field reports described mothers in Yemen who, after witnessing their neighbors' home obliterated by an airstrike, would not let their children out of their sight even to play outside, effectively confining them due to fear – a well-intentioned protective move that unfortunately can impede the child's social development and reinforce a message that the world is fatally dangerous. Children, in turn, often feel responsible to cheer up or care for their traumatized parents, a role reversal that can breed anxiety and guilt in the young. If violence subsides, the country will still face the psychological aftermath for decades. Sadly, the war's persistence means many children will reach adulthood before the conflict ends, never having experienced peace. This continuous exposure blurs the line between direct and intergenerational trauma: the war's first-generation victims and second-generation both exist in the same protracted crisis (Devakumar, 2014).

Syria: A Lost Generation Amidst Civil War

In Syria, the intersection of proxy war dynamics and civilian trauma has been stark. The Syrian conflict, now in its second decade, has seen involvement from numerous external actors, with Iran and Saudi Arabia among the most prominent in the early years. The result has been a society saturated with violence. Syrian families have endured chemical attacks on neighborhoods, the flattening of cities like Aleppo and Homs, mass torture and killings, and the rise of ISIS's reign of terror – each layer contributing to collective trauma. The research on Syrian mental health during the war reveals distressing levels of psychological morbidity. A nationwide survey conducted during the war found that over 36% of respondents still living in Syria met criteria for PTSD and 44% screened positive for severe emotional distress. Strikingly, only about 10% of Syrians in that sample showed no significant PTSD or distress symptoms – meaning nearly 90% were psychologically affected. The majority believed the war was the primary cause of their mental health struggles. Risk factors included displacement (half the respondents had been internally displaced at least once) and cumulative exposure to traumatic events like losing one's home or being injured (Samara, 2020). This indicates an enormous burden of trauma in the general population, which will inevitably filter into family life and subsequent generations.

The children in Syria have often been referred to as the "lost generation." A study of Syrian children aged 8–15 in 2017-2018 found 60.5% had at least one probable psychiatric disorder, with PTSD (35%), depression (32%), and anxiety (30%) being most common (Perkins et al., 2018). Over half the children in that sample were internally displaced from their original homes, and a third had directly witnessed traumatic violence. Girls were more likely than boys to exhibit PTSD symptoms, reflecting perhaps vulnerability to certain war stressors or gender differences in reporting (Perkins et al., 2018). These mental health problems manifest as nightmares, aggressive behavior, withdrawal, and somatic complaints (headaches, stomachaches) among Syrian kids. Humanitarian workers frequently observe children who draw pictures of tanks and blood, or who play games "pretending to be snipers" – a sign that war has deeply infiltrated their minds. For Syrian infants and toddlers, the developmental impact is also severe. Many have been born in besieged areas or crowded refugee camps, environments with loud noises, chaos, and highly stressed caregivers. Studies during the war noted delays in language and cognitive development among young Syrian children, likely due to lack of stimulation and the parents' preoccupation with survival (Panter-Brick et al., 2018). The attachment between mothers and infants can be strained when the mother is coping with extreme stress or depression. One qualitative study of Syrian refugee mothers found pervasive feelings of guilt and helplessness about not being able to provide normal childhoods for their kids, which sometimes manifested in overindulgence - giving children candies and sweets whenever possible as a coping mechanism or emotional numbing - some mothers struggled to respond to a child's needs because their own mental energy was depleted by trauma.

The transgenerational effects are already visible. Syrian teenagers who were small children at the war's outbreak have grown up with disrupted education and often with parents who themselves are traumatized or physically absent (death or separation due to displacement). These teens sometimes shoulder adult responsibilities – working to support the family, or caring for younger siblings – which can lead to lost adolescence and psychological strain. Moreover, sectarian narratives fueled by the proxy nature of the war (Sunni vs Alawite/Shia, etc.) may influence youth identity. On the positive side, Syria has a strong cultural notion of sabır (patience/endurance) and community solidarity that has helped some families cope. Stories of resilience abound – neighbors forming support circles, teachers volunteering to run makeshift schools in shelters, and children finding ways to play amidst ruins. These are protective factors that can mitigate trauma transmission (Hines, 2014). However, the sheer scale of trauma is daunting.

Another facet in Syria is the massive refugee exodus – over 5.6 million Syrians fled the country. Many Syrian children are therefore growing up outside Syria, in countries like Turkey, Lebanon, and Jordan (and further abroad in Europe). These refugee children face the dual challenge of past trauma and current displacement. In Lebanese refugee camps, a 2015 epidemiological study found very high rates of mental disorders among Syrian refugee children, with PTSD prevalence around 45% in those living in the most deprived informal settlements. The predictors included exposure to war violence, but also post-migration stresses like child labor and caregiver mental health problems (Banna, 2017). This highlights that Syrian children abroad are not necessarily escaping the cycle of trauma; in fact, new adversities compound the old. In sum, Syria's proxy war has imparted deep psychological wounds on its people. Multiple generations are affected simultaneously: the older generation remembering life pre-2011 and the horrors since; the younger generation knowing only conflict and instability. The risk moving forward is that without widespread mental health support, Syria's recovery will be impeded by a populace grappling with trauma-related problems (violence, substance abuse, family breakdown, etc.). As one report on Syria noted, "the conflict's mental health toll will reverberate for decades", making transgenerational trauma not just a personal family issue but a public health and peacebuilding concern (Nakeyar, 2016).

Iraq: Four Decades of Trauma and the Aftermath of ISIS

Iraq's modern history reads like a chronology of conflicts, each layering new trauma onto the last. The Iran–Iraq War of the 1980s, the Gulf War and sanctions of the 1990s, the 2003 invasion and subsequent insurgency, years of sectarian bloodletting, and the terror of ISIS in the mid-2010s – all have battered the Iraqi psyche. Iran and Saudi Arabia's rivalry has played into these events, especially by shaping sectarian polarization post-2003 (Mabon, 2015). The cumulative impact on mental health is profound: essentially no Iraqi of adult age today has lived a life untouched by war or oppression.

Surveys in Iraq consistently show a high prevalence of mental health issues. A systematic review of civilian studies found PTSD rates ranging widely but often 15–30% in conflict-affected areas, with even higher rates of depression and anxiety in some populations. One national mental health survey noted that over 70% of Iraqis had experienced at least one traumatic event in their lifetime, such as exposure to combat, witnessing killings, or being displaced (Banna, 2017). In the wake of ISIS's defeat, new traumas came to light: mass graves, survivors of sexual slavery among the Yazidi community, and children who had been forced to become child soldiers or executioners for ISIS. These experiences left indelible marks. Yazidi survivors, for example, have extremely high rates of PTSD and suicide attempts compared to those not captured by ISIS. Yazidi mothers who bore children from ISIS rape face stigma and heartbreak, which affects their maternal bonding and the children's sense of identity (if allowed to live with their mothers at all). This is a cruel form of transgenerational trauma where the very existence of the second generation (children of rape) is a living reminder of the mother's trauma, sometimes leading to rejection or community ostracization that harms the child (Ramo-Fernández, 2015) . Iraq's intergenerational trauma is also socio-political. Many older Iraqis who lived through the brutal Saddam era and the horrors of the Iran–Iraq war carry unresolved trauma (e.g., veterans with PTSD, Kurdish families who survived chemical attacks in the Anfal genocide). These individuals became parents to millennials who then went through the 2000s turmoil. A father who fought in the 1980s and suffered might have struggled with his mental health while raising a son born in 1990, and that son in turn might have been psychologically impacted by seeing his father's difficulties and by witnessing the 2006 sectarian violence as a teenager. Later, that son might be a father himself, trying to raise children in a still-fragile Iraq. This illustrates a possible three-generation chain of conflict-related trauma in Iraq (Clukay, 2019).

Moreover, the sectarian dimension (Sunni vs Shia tensions) that Iran and Saudi Arabia exacerbated in Iraq has torn apart mixed-sect communities and even families. Some Iraqi children saw neighbors who used to be friends turn into enemies over sectarian affiliation. The sense of betrayal and distrust can be passed to children as a kind of social trauma inheritance – "We can never trust those people again; look what they did to us." This is a dangerous legacy that can fuel future conflict if not addressed through reconciliation efforts (Chen, 2017). One unique challenge in Iraq is the mental health of combatants themselves and how that affects families. Tens of thousands of Iraqi men (and women) joined militias or the army/police to fight in various conflicts (from fighting insurgents to fighting ISIS). Many have untreated combat trauma. Studies of Iraqi military veterans show high rates of PTSD and substance abuse, which often manifest in domestic violence or inability to reintegrate into civilian life (Herman et al., 2019). Thus, spouses and children of these fighters often suffer secondary trauma – a wife terrified by her husband's rage episodes due to his flashbacks, or children learning to tiptoe quietly to avoid "setting off" their volatile father. In communities with many ex-combatants, the collective trauma can also perpetuate a culture of violence (Catani, 2010). On top of war trauma, Iraqis have faced continuous insecurity and economic hardship. After decades of disruption, basic trust in institutions and hope for the future have been undermined. Young people in Iraq often report feelings of hopelessness and cynicism, having seen promises of peace and democracy repeatedly broken. This mental state can be traced partly to growing up in chaos and seeing their parents disempowered or traumatized. It is a kind of generational learned helplessness that can be as damaging as overt PTSD (Jacob, 202)).

Despite the immense need, mental health infrastructure in Iraq is woefully inadequate. The country has fewer than 2 mental health professionals per 100,000 people (WHO, 2020) far below global standards. Most primary care doctors received little training in mental health. Only a handful of psychiatric hospitals and clinics serve the population, mostly in Baghdad. During ISIS's onslaught, international NGOs provided some psychosocial support in camps, but as emergencies waned, that external support shrank. The Iraqi government has recognized mental health in policy on paper, but implementation is slow and under-resourced. Hence, many Iraqis cope via family and religious frameworks – which can be supportive, but if the whole family is traumatized, there is a limit to how much they can help one another without professional intervention (Daughtry, 2015). Moreover, Iraq illustrates layers of transgenerational trauma from serial wars. The Iran–Saudi rivalry's contribution (fueling sectarian conflict) certainly intensified the psychological fractures. Healing will require not just treating individual PTSD cases, but rebuilding societal trust and cohesion. Without addressing trauma, Iraq risks a cycle where each new crisis re-triggers old wounds and impedes recovery.

Lebanon: Legacies of Civil War and Continuing Strife

Lebanon's case is somewhat different in that the primary war (the civil war of 1975–1990) is now over 30 years in the past, but its shadow looms large. Iran–Saudi competition has influenced Lebanon's post-war period, as mentioned, through Hezbollah versus Saudi-backed factions, which has led to episodes of violence and chronic political paralysis rather than full-scale war. Still, the Lebanese population has endured waves of trauma: a brutal civil war (with massacres, invasions by Israel and Syria, sectarian cleansing in areas), intermittent clashes (2005 assassination of Rafik Hariri and subsequent turmoil, 2006 Hezbollah-Israel war, 2008 internal clashes), and a severe economic collapse since 2019 that has impoverished more than half the population and led to a sense of national despair. Additionally, Lebanon hosts a huge number of refugees (Palestinians since 1948 and Syrians since 2011), adding layers of communal trauma (Siklawi, 2019).

The civil war's transgenerational effects are well documented in sociological studies. Lebanese who were children during the war often describe a childhood of bomb shelters, school closures, and loss. Now adults in their 40s or 50s, many still carry

anxiety and sectarian biases from those formative years. Their children – the post-war generation – grew up in a country nominally at peace but rife with memories of war. A qualitative study on Lebanese youth born after the war found that while these youth didn't personally witness the war, they had absorbed their parents' traumas and fears. Some felt a vague sense of mourning or anger for events that occurred before their birth, because those events shaped their family's narrative and circumstances. For example, a young woman might sense her father's unresolved grief over comrades lost in battle, and that unspoken grief becomes part of her emotional landscape (Modalal, 2019).

'Gender' plays a role in Lebanon's trauma legacy too. During the civil war, many men were fighters and many women were civilians bearing the brunt at home. A lot of women became widows or single parents overnight. The strength of Lebanese mothers in holding families together is often lauded; however, their own trauma (losing husbands, worrying about children's safety) often went unaddressed. Some studies suggest Lebanese war widows developed very high anxiety and overprotectiveness with their children, affecting those children's independence. Conversely, some children had to become caretakers for traumatized parents (Modalal, 2019). There are accounts of teenage boys joining militias not only due to ideology but because they felt pressure to avenge family suffering or to "protect" their community as their fathers did essentially inheriting the fight.

Lebanon also illustrates how new crises retrigger old trauma. The 2006 war between Hezbollah and Israel, though short (34 days), caused many Lebanese who had lived through the civil war to experience flashbacks and relapse into PTSD symptoms they had managed since 1990. Their children saw their intense reactions and realized the war lived within them. More recently, the 2020 Beirut port explosion – an apocalyptic blast in peacetime – reactivated war memories for many older Lebanese "it felt like the war again". Thus, trauma can lie dormant and then surge, affecting how parents behave under stress and how the younger generation learns to respond to disasters (often with fatalism or panic). Another dynamic is the mass emigration of Lebanese, both during and after the civil war. The Lebanese diaspora is huge relative to the population inside. Many families are transnational, with trauma playing a part in the decision to leave or stay. Those who left often carried survivor's guilt or longing for home, which they passed to their children in diaspora. Those who stayed often feel abandoned or resentful of those who left. This has created psychological rifts even within extended families (Sarwan, 2020). A Lebanese American child might grow up hearing how lucky they are to be safe, yet sensing their parent's lingering sorrow about the home country's troubles – a subtle form of inherited trauma tied to exile.

On a population level, mental health data in Lebanon shows high need. Even prior to the recent economic collapse, roughly one in four Lebanese adults was estimated to have a mental disorder in their lifetime, a figure likely worsened by subsequent events. Yet, like elsewhere, services were lacking. Lebanon did, however, make strides by launching a National Mental Health Programme in 2014, integrating mental health into primary care. Some NGOs also run community mental health centers. These efforts have been hampered by the financial meltdown and political instability since 2019, which itself has caused widespread adjustment disorders and desperation (including among youth who see no future). The current young generation in Lebanon faces a different kind of trauma – the slow-burning trauma of economic collapse and state failure, on top of the historical trauma their families carry (Unicef, 2020). Furthermore, Lebanon demonstrates that even after active conflict ends, the psychological fallout can persist across generations, especially if new stressors keep coming. The Iran–Saudi proxy aspect in Lebanon has kept sectarian tensions simmering, meaning the conflict that ended in 1990 hasn't fully been psychologically resolved. For healing, many have called for transitional justice or truth-telling about the civil war (Lebanon controversially granted general amnesty and chose "collective amnesia" as a peace strategy). Without openly addressing that past, the trauma lingered in private. The case underscores that unaddressed war trauma doesn't simply fade with time; it lives on in minds and can be reignited by later events, affecting subsequent generations' mental health and social fabric.

Kurdistan: Fragmented Homeland, Inherited Trauma

The Kurdish populations in Iraq, Syria, and Iran have faced decades of war, persecution, and political instability, which have significantly impacted their mental health across generations. These conflicts have been compounded by regional proxy wars, with Iran and Saudi Arabia backing opposite sides in Middle Eastern conflicts. Transgenerational trauma is highly relevant in the Kurdish context, as families carry not only individual wounds but also collective memories of historical atrocities. Children grow up hearing these stories of persecution and loss, which become part of their identity and psychological environment(Ahmad, et al., 2000). Direct trauma from war and violence has left deep psychological scars on Kurdish communities, leading to high rates of post-traumatic stress disorder (PTSD), depression, anxiety, and other disorders in the immediate aftermath. Women tend to have higher PTSD and depression rates than men in such contexts, often about twice as high due to both the types of violence they endure and cultural factors (Castro, 2019). Former combatants in Kurdish forces have their own direct trauma from years of combat, witnessing the deaths of close comrades in battle and having themselves injured or imprisoned. Indirect trauma from proxy conflicts and instability in the Middle East has been a significant issue for Kurds, who have experienced both physical violence and psychological trauma.

Regional power struggles have magnified the Kurdish people's trauma by creating a context in which violence is protracted and peace remains elusive. The indirect psychological toll includes grief for the loss of normal life, helplessness as global powers dictate one's fate, and a deep-seated distrust in political solutions. Kurdish children have been described by some psychiatrists as "the war-damaged patients of the future", given how early and pervasively conflict touches their lives. They are vulnerable both to direct trauma (e.g. being injured, witnessing violence) and to secondary trauma through their caregivers. Clinical assessments in refugee camps in Iraqi Kurdistan have found large numbers of children with PTSD, separation anxiety, and developmental regressions.Women in Kurdish societies experience war trauma as civilians and sometimes as combatants, facing gender-specific challenges that can amplify psychological harm. (Krajeski, 2014) Yazidi women and girls abducted by ISIS have experienced systematic rape, sexual slavery, and other forms of gender-based violence, leading to extremely high rates of PTSD and depression. Cultural factors modulate the impact for women, as Kurdish and Yazidi cultures are traditionally

conservative about sexuality, thus, survivors of rape often fear "social rejection" or honor-based stigma from their own community. Studies confirm that many formerly enslaved Yazidi women perceived discrimination or rejection after returning, which in turn correlates with worse mental health outcomes. In Kurdish society, women frequently become the primary caretakers of children, the elderly, and wounded family members in wartime, all while coping with their own trauma (Kizilhan, 2017).Research from genocide-affected populations indicates that women's PTSD and depression rates can be more than twice that of men's, which is consistent with Kurdish clinicians' observations that "women increasingly complain of headaches" and somatic symptoms that mask underlying trauma. Culturally, Kurdish women have sometimes been expected to "be strong" for the family, which can lead to unaddressed, internalized trauma. However, many Kurdish women have also been agents of resilience, becoming activists, documenting atrocities and demanding justice. In some cases, taking on such roles has been therapeutic, turning personal trauma into social action, though it also keeps the traumatic memories in public discourse. Former combatants in Kurdish regions represent a group with intense direct trauma exposure and a crucial influence on the next generation. Many veterans bear classic PTSD symptoms, and their families may live in an atmosphere of tension or fear due to the veteran's volatility. Some traumatized ex-fighters withdraw emotionally, leading to children experiencing forms of emotional neglect or confusion, which is a pathway for trauma to affect the next generation. A study on Holocaust survivors and their children has shown altered DNA methylation in genes related to the hypothalamus-pituitary-adrenal (HPA) axis, which could be a molecular echo of trauma, reflecting the extreme trauma exposure of the parent (Zerach & Aloni, 2015).

Transgenerational trauma in Kurdish regions is facilitated by social mechanisms, such as the disruption of schooling, poverty cycles, and absence of normal community life. Many Kurdish children in Iraq spent formative years in refugee or IDP camps, where resources are limited and social support networks are fragmented. This social instability can lead to developmental delays or behavioral issues, which may not be "trauma" in a narrow sense but are indirect results of living in a traumatized society (Yehuda & Lehrner, 2018). Young people who grow up in such conditions often inherit a kind of social trauma, a diminished sense of future, or a normalization of violence and loss. Sociologists observe that in communities where mass trauma has occurred, there is sometimes a collective desensitization or hyper-vigilance that is passed to children. This worldview can manifest as cynicism or aggression in adolescence, potentially leading to perpetuation of violence.Another key social mechanism is the intergenerational transmission of identity and grievance. Kurdish populations, as a persecuted minority in all three countries, have a strong awareness of their ethnic identity and the injustices their group has suffered. Parents and community leaders often impart the narrative of Kurdish struggle to the next generation, which can have positive effects, fostering pride and resilience. However, even Kurdish youth who did not live through certain events carry the emotional burden of those events as part of their social identity.Cultural transmission of trauma can either perpetuate trauma (through constant re-exposure and silence taboos) or help transform it (Krajeski, 202014). In Kurdish communities, culture does both preserve the memory of suffering and forge narratives of resilience.

Gendered Dimensions of Trauma

War and trauma affect men, women, and children differently, affecting generations. Psychological trauma is gendered in Iran-Saudi proxy conflicts because gender roles and experiences affect its impact and transmission throughout families and communities. Due to sexual abuse, domestic violence, spouse loss, and caring for children in upheaval, women suffer disproportionately. Long-term conflict-related sexual violence (CRSV) causes PTSD, despair, and humiliation. The absence or incapacity of men in crisis zones often forces women to supply and protect. Burnout can result from chronic stress, and children may see their mothers in despair or anxiety and be affected. Culturally, women may repress their pain to "be strong" for the family, which might internalise the trauma and cause physical or emotional problems that families fail to understand. Men often experience combat, prisoner torture, or the responsibility of protecting their family in disarray (Farhood, 2018). Social expectations regarding masculinity can prevent males from showing vulnerability or seeking treatment, resulting to substance misuse or hostility. This affects families because war-traumatized males may be irritable, angry, or use alcohol, producing an unstable or abusive home.

Children in such situations may "inherit" trauma by fearing a temperamental parent and believing stoicism is the best way to cope. Many boys in crisis zones become young soldiers, militia members, or informants, bringing trauma from atrocities home. Gender roles affect how trauma is transferred via parenting, with women affecting early childhood emotional security. PTSD and depression in moms closely affect child outcomes, and women often offer emotional support and normalcy to families. In patriarchal settings, fathers may not provide as much emotional care, but wartime experiences damage their children (Sharma, 2011). Fathers' absence can traumatise children, therefore addressing father trauma helps interrupt patterns of anger or detachment. Sex-specific trauma, like ISIS's systematic sexual captivity of Yazidi women, can affect generations. These rape victims' children have conflicting identities and community rejection. Many Syrian men disappeared or were jailed, leaving their wives and children in limbo. Chronic trauma from unresolved sorrow and uncertainty might damage family functioning. Community norms impact trauma response. Women may find social support easier than men, who may isolate. Safe locations for women to get trauma counselling without stigma and acceptable programs for males are needed for gender-sensitive outreach (Samara, 2020).

Refugee Populations and Diaspora Communities

The proxy conflicts in Yemen, Syria, Iraq, and Lebanon have caused one of the greatest displacement crises in history, with millions of refugees fleeing to neighbouring or distant nations. As of 2020, millions Syrian refugees live in Turkey, Lebanon, and Jordan, with many in Europe and North America (United Nations. n.d.). Yemen has fewer external refugees but over 4 million internally displaced people. The pinnacle of Iraq's sectarian bloodshed and ISIS war displaced almost 4 million people and hundreds of thousands overseas. The long-term diaspora of Lebanon implies most Lebanese live abroad. PTSD and

despair are higher in refugees from these situations than in those who stayed. A comprehensive meta-analysis of Syrian migrants indicated 30-50% PTSD and 20-40% depression. PTSD and depression impact 55% and 33% of refugee children (Modalal, 2020).

Refugee parents try to protect their children from the horrors they fled, but the environment often works against them. Camp and dense urban settlement children experience overcrowding, lack of schooling, child labour, and exploitation, adding to their families' trauma. Childhood trauma or language/cultural obstacles often lead to "parentification" of youngsters. Refugee and diaspora communities struggle to preserve their culture, including communal suffering. This can give kids pride, togetherness, and secondhand trauma and rage. Palestinian refugee communities and newer diasporas may experience cultural or historical trauma. Guilty refugee parents may be either lenient or too rigorous, which might affect children's development and carry on. Discrimination and xenophobia in host countries can worsen refugee trauma. Bullying or being branded a terrorist by peers can compound war trauma and exile trauma. Diaspora groups can politically mobilise around their pain, passing it down through generations. When supported, refugees and their children frequently adapt and prosper. Trauma transfer can be stopped via welcoming communities, trauma-informed schools, and work for parents. Children incorporated into strong schools and community activities adapt well and improve their mental health, especially if parents receive language and employment aid, according to studies. Refugee and diaspora families face new problems that change transgenerational trauma. Crossing borders doesn't erase trauma; it depends on whether the new environment is loving or hostile and whether refugees can reconstruct stable lives (Dalgaard, 2017). These people' mental health must be addressed for individuals and to avoid trauma from becoming a hereditary curse in exile.

Mental Health Infrastructure in Conflict Zones

The conflict-affected regions of West Asia need mental health infrastructure and services to prevent transgenerational trauma. These conflicts in the Middle East have left mental health systems undeveloped, underfunded, and overloaded. The war in Yemen has devastated hospitals and caused a lack of healthcare staff in all specialities. Rural populations lack mental health care because most of it is in cities. Syria's pre-war healthcare system included mental health doctors and psychiatric units. Hospitals were bombed, doctors died or fled, and crucial medicines became scarce due to the war. Professionals were few in northwest Syria, home to 5 million people, by 2020 (Bdaiwi, et al., 2020). Camp counselling and tele-psychiatry sessions for local doctors are provided by NGOs. Iraq lacks qualified mental health workers and spends little on it. Less than 100 psychiatrists served a population of ~40 million in 2020 (about 0.25 per 100,000) . The WHO delegate in Iraq noted that Iraq has less than 2 mental health workers per 100,000 people, with a third being non-specialists. The centralised services include Baghdad's largest psychiatric hospital and a few other hospitals with psych departments. Community-based mental health care is new, thus many Iraqis use informal support or nothing. Some post-ISIS localities and youngsters in southern Iraq have high suicide rates amid despair, indicating mental health needs immediate treatment. Due to political instability and other issues, implementation is slow but crucial.

The 2014 National Mental Health Program in Lebanon reforms the system, promotes community treatment, and reduces stigma. However, the recent economic collapse has caused many doctors to emigrate due to low pay and pricey prescriptions. Mental health services are scarce, while demand is considerable. NGOs offer most mental health care, frequently through donor-funded initiatives, because private facilities are too expensive (El-Khoury, 2020). Over a million Syrian refugees in Lebanon strain the system by limiting their access to Lebanese services and creating additional impediments. Poor mental health infrastructure can cause instability and trauma because people with severe PTSD or depression cannot work or care for their children, burdening extended families and social services. Ex-combatants may join new armed groups or continue violence. Untreated trauma can lead to school dropouts, drug misuse, and hostility, hurting their generation (Hoge, 2006). Mind health infrastructure is essential to conflict rehabilitation. Without increased mental health care, society risks a long-term mental health crisis that could cause trauma. Group trauma counselling, school-based psychosocial activities, and psychological first aid training for front-line workers are low-cost solutions (Treatment Improvement Protocol, 2014). Telemedicine and diaspora involvement seem to be closing gaps. To prevent generations of trauma and a future when a large section of the population has unhealed psychological wounds, mental health infrastructure must be strengthened.

Policy and Practice Recommendations

Addressing these transgenerational traumas in Iran-Saudi proxy conflicts requires multi-level interventions. Firstly, the mental health and psychosocial support (MHPSS) should be a standard component of all humanitarian relief operations in conflict zones, with international donors and agencies allocating specific funding for mental health in emergencies. This includes deploying trauma counselors and psychologists to refugee camps and conflict-affected communities, establishing safe spaces for women and children, and providing psychological first aid training for front-line aid workers. Building and strengthening local mental health infrastructure is crucial for war-torn countries. International partnerships can sponsor accelerated programs to train psychiatrists, clinical psychologists, and psychiatric nurses from the local population, including refugees. Also, Task-shifting is critical, as mental health modules should be integrated into medical and nursing curricula and incentivize young professionals to enter psychiatry through scholarships. Tele-mental health should be leveraged, connecting local providers with overseas specialists for supervision and allowing patients to receive therapy via phone/internet where feasible.

Secondly, the community-based and culturally sensitive interventions are also essential for healing from trauma. Encouraging and funding community-based programs such as support groups, peer counseling, and cultural healing practices can help communities process trauma and combat stigma. Utilising culturally resonant methods like storytelling circles, art therapy, and theater can help communities collectively process trauma. Schools should be empowered as sites of intervention to reach children, implement trauma-informed educational practices, and create programs specifically for youth and adolescents. Specialized support for women is necessary, including clinics with female counselors, support groups for war widows or rape

survivors, and economic empowerment combined with psychosocial support. Programs like maternal mental health screenings at prenatal and postnatal care visits can catch issues early and equip mothers with tools to help their children emotionally while they heal themselves. The text emphasizes the importance of engaging men and ex-combatants in mental health interventions during wartime. It suggests developing outreach programs for former fighters or tortured detainees, such as "veterans' support circles" or livelihood programs that include a mental health component. Normalizing the conversation about PTSD and reducing substance abuse through integrated programs can improve family environments and outcomes for children.

Thirdly, policy reforms at the government level should focus on national mental health strategies, including integrating mental health services into primary healthcare, providing insurance or funding mechanisms to make mental health care free or affordable, building monitoring systems to track population mental health, and protecting the rights of those with mental illness. Governments should also recognize mental health as part of post-conflict reconstruction and include psychosocial support in reparations or victim support schemes.

Fourthly, the transitional justice and collective healing are also necessary, with truth commissions, documentation of atrocities, memorialization, and public acknowledgment of suffering helping validate victims' experiences and aid psychological healing. Engaging communities in designing memorials for those lost can humanize trauma and foster post-traumatic growth. Facilitating intergroup dialogues can reduce transmission of prejudice and fear to children. The host nations with large refugee populations should be supported financially and technically to provide mental health services for refugees and integrate them into existing systems. Training clinicians in cultural competence, employing refugees as cultural brokers or peer counselors, and ensuring interpretation services for therapy can help refugees heal and adjust.

Lastly, a continuous research and monitoring on transgenerational trauma are crucial for creating a comprehensive approach to breaking the cycle of war trauma. Moreover, the collaboration between health and education sectors, government and NGOs, local communities and international experts, and conflict parties is essential for humanitarian access.

Conclusion

Iran–Saudi proxy conflicts have inflicted profound psychological wounds that do not end when the fighting does. As we have seen, the legacy of war trauma often lives on in the minds and bodies of survivors' children and grandchildren. In Yemen, Syria, Iraq, and Lebanon, generations are growing up bearing not only their own experiences of violence and loss, but also the emotional imprint of their forebears' suffering. This transgenerational transmission of trauma can perpetuate cycles of violence, sectarian hatred, and social breakdown, as unhealed wounds manifest in new forms. A child who inherits fear and anger may become a teenager susceptible to radicalization or a parent who unknowingly passes on the same fear to their kids. Thus, trauma by inheritance is not just a personal family matter, it is a matter of national reconciliation and security.

Yet, there is reason for hope. Trauma is not an irrevocable sentence; with proper support, individuals and communities can demonstrate extraordinary resilience. The emerging recognition of transgenerational trauma in conflict settings is a positive development, it means stakeholders are beginning to understand that rebuilding schools, houses, and economies, while essential, is not enough. The minds of people must also be rebuilt, and hearts healed. This requires time, resources, and compassion. Importantly, it also requires peace: the continued de-escalation of Iran–Saudi tensions such as the 2020 restoration of diplomatic ties between the two countries provides a window of opportunity to resolve proxy wars like Yemen's and invest in humanitarian recovery. If proxy conflicts can be curtailed, we can at least stop adding new trauma on top of old.

In conclusion, war by proxy in the Middle East has produced deep and interlinked trauma across generations. But acknowledging this truth is the first step towards change. As one survivor put it, "The war is over, but the internal war is just beginning" referring to the psychological battle inside. It is our collective imperative – as local communities, national governments, and the international community to help win this internal war for survivors by providing them the tools to heal and by creating conditions that allow their children to live without the weight of inherited pain. By doing so, we not only repair individual lives but also contribute to breaking the cycle of violence and building a more peaceful, resilient future for a region that has seen too much bloodshed. The trauma of these proxy conflicts need not be the inheritance of the next generation; with concerted action, we can instead bequeath them a legacy of recovery, reconciliation, and hope.

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