Synergy for Justice

INHERITED SCARS: WAR, TRAUMA, AND THE BRAIN

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Intergenerational Trauma and the Neurobiological Legacy of War

War fundamentally restructures human life. During armed conflict, survival becomes the primary objective: securing safety, food, shelter, and protecting family members. Under such conditions, individuals rarely possess the psychological space to reflect on long-term consequences. Yet the end of armed conflict does not mark the end of its effects. Survivors frequently carry enduring psychological and biological injuries that extend beyond the individual, shaping families and future generations.

War-related trauma encompasses far more than direct exposure to violence. It includes forced displacement, bereavement, destruction of homes, conflict-related sexual violence (CRSV), torture, arbitrary detention, and prolonged exposure to fear and insecurity. These experiences commonly result in persistent psychological distress characterised by shame, grief, helplessness, anxiety, and hypervigilance. While survival may be achieved, unresolved trauma often continues to shape identity, relationships, and parenting practices long after the violence has ceased.[1]

Although international frameworks increasingly emphasise accountability, transitional justice, and reparations, implementation remains uneven. Many survivors continue to live with the psychological burden of injustice and impunity. Even in post-conflict settings, individuals exposed to extreme violence frequently experience a chronic sense of threat. This persistence reflects trauma-related alterations in neurobiological stress systems rather than present-day danger, indicating that trauma has become biologically and psychologically embedded.[2]

The Neurobiology of Trauma

Trauma must be understood not only as a psychological experience but as a neurobiological condition. Exposure to overwhelming stress activates a network of brain structures, particularly the amygdala, hippocampus, and prefrontal cortex. The amygdala, responsible for threat detection, becomes hyperresponsive during trauma, producing heightened fear responses and sustained vigilance.[3]

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[1] Herman, J. L. (1992). Trauma and recovery: The aftermath of violence—from domestic abuse to political terror. Basic Books.
Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement. Journal of the American Medical Association, 302(5).
[2] van der Kolk, B. A. (2014). The body keeps the score: Brain, mind, and body in the healing of trauma. Viking.
[3] LeDoux, J. E. (2000). Emotion circuits in the brain. Annual Review of Neuroscience, 23, 155–184.

At the same time, the hippocampus, central to memory integration and contextual processing, may become dysregulated, impairing the ability to distinguish past from present danger. This contributes to intrusive memories and emotional re-experiencing of events. The prefrontal cortex, which enables emotional regulation and executive control, often shows reduced activity under traumatic stress, limiting the capacity to regulate fear responses.[4]

Prolonged or repeated trauma can further disrupt the hypothalamic-pituitary-adrenal (HPA) axis, the body's core stress-regulation system. Altered cortisol regulation has been consistently documented among trauma survivors and individuals with post-traumatic stress disorder (PTSD), affecting immune functioning, emotional regulation, and physical health.[5] Trauma, therefore, becomes a systemic condition, embedded in brain function, physiology, and behaviour.[6]

From Individual Trauma to Intergenerational Transmission

Trauma does not end with those who directly experience it. When unresolved, it can be transmitted across generations through psychological, relational, and biological pathways. Parents affected by trauma may struggle with emotional regulation, attachment, and caregiving consistency. Children raised in such environments often internalise heightened fear responses, maladaptive coping strategies, and distorted perceptions of safety, even without direct exposure to violence.[7]

Emerging research in epigenetics further suggests that trauma may alter gene expression without changing DNA sequences, particularly in stress-regulation pathways. These epigenetic modifications may be transmitted to offspring, increasing vulnerability to anxiety, depression, and stress-related disorders.[8] **Intergenerational trauma thus illustrates how war becomes embedded in memory, family dynamics, and biological systems.**[9]

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[4] Shin, L. M., & Liberzon, I. (2010). The neurocircuitry of fear, stress, and anxiety disorders. Neuropsychopharmacology, 35.
[5] Yehuda, R., Daskalakis, N. P., Lehrner, A., Desarnaud, F., Bader, H. N., Makotkine, I., & Bierer, L. M. (2015). Influences of maternal and paternal PTSD on epigenetic regulation of the glucocorticoid receptor gene in Holocaust survivor offspring. American Journal of Psychiatry, 172(5).
[6] LeDoux, J. E. (2000). Emotion circuits in the brain. Annual Review of Neuroscience, 23, 155–184.
[7] Danieli, Y. (Ed.). (1998). International handbook of multigenerational legacies of trauma. Springer.
Yehuda, R., & Lehrner, A. (2018). Intergenerational transmission of trauma effects: Putative role of epigenetic mechanisms. World Psychiatry, 17(3), 243–257.
[8] Yehuda, R., Daskalakis, N. P., Lehrner, A., Desarnaud, F., Bader, H. N., Makotkine, I., & Bierer, L. M. (2015). Influences of maternal and paternal PTSD on epigenetic regulation of the glucocorticoid receptor gene in Holocaust survivor offspring. American Journal of Psychiatry, 172(5).
[9] LeDoux, J. E. (2000). Emotion circuits in the brain. Annual Review of Neuroscience, 23, 155–184.

Lived Experience and Intergenerational Transmission: Case Narrative

Elizabeth's Story: Cumulative Loss and Boundary Formation

Elizabeth's life reflects cumulative trauma across generations. Orphaned early, displaced, and later subjected to sexual violence and stigmatisation, she entered motherhood while still navigating her own unintegrated trauma. Her account reveals how unresolved grief, poverty, and lack of social protection contributed to maladaptive parenting patterns.

Importantly, Elizabeth identifies a turning point marked by self-awareness, boundary recognition, and deliberate healing of her "inner child." Her daughter's later understanding of her mother's struggles underscores how intergenerational trauma can shift toward intergenerational insight when narratives are shared and contextualised.

Elizabeth's reference to her grandmother, a woman shaped by multiple layers of violence (her husband married three other wives, for example), illustrates how trauma can be transmitted through modeled survival strategies such as emotional hardness and hyper-independence. These traits may protect in crisis yet hinder emotional intimacy across generations.

Elizabeth's later transformation highlights the possibility of repair. Through self-reflection, disclosure, and mutual acknowledgment of harm with her daughter, she disrupted the cycle of intergenerational trauma.

Elizabeth and Brooklyn: Reflection Analysis: Trauma, Parenting and Repair

Elizabeth's narrative illustrates how unprocessed trauma can distort early caregiving and identity formation. Having experienced parental loss, displacement, and sexual violence during adolescence, she entered motherhood without emotional or social support. Her early parenting was marked by emotional dysregulation, shame, and dissociation — patterns consistent with trauma-related impairment in affect regulation and attachment.

Crucially, Elizabeth's later transformation highlights the possibility of repair. Through self-reflection, disclosure, and mutual acknowledgment of harm with her daughter, she disrupted the cycle of intergenerational trauma. Their reconciliation demonstrates that trauma transmission is not inevitable, and relational repair can foster resilience and post-traumatic growth.

Neurobiological Consequences of Intergenerational Trauma During Pregnancy

When a pregnant woman has experienced trauma, particularly chronic, severe, or unresolved trauma, the effects can extend beyond her own psychological wellbeing and influence fetal neurodevelopment. Pregnancy is a critical period during which the maternal stress-response system and the developing fetal nervous system are closely interconnected. As a result, trauma-related neurobiological alterations in the mother can shape stress regulation, emotional processing, and vulnerability to mental health difficulties in the next generation.[10]

Neurobiological transmission of trauma occurs through epigenetics, which means changes in the gene expression throughout generations to come. These epigenetic modifications caused by maternal trauma can lead to permanent changes in the fetal brain development. Environmental factors such as maternal stress during pregnancy can lead to epigenetic changes that predispose their offspring to mental health conditions. Maternal unresolved trauma, poor socio-economic conditions can exacerbate the inherited trauma.

In Elizabeth's case, not only was the stigma affecting her, but her upbringing, the rape, and having a baby, in poor socioeconomic conditions, and being a teenager, losing her youth to looking after a fatherless baby. It was this combination that affected Brooklyn as she was growing up.

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Maternal Stress Systems and the Fetal Environment

Trauma exposure is strongly associated with dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis, the body's primary stress-response system. Individuals with trauma histories often exhibit altered cortisol production, either chronically elevated or blunted. During pregnancy, cortisol crosses the placenta and plays a central role in fetal brain development. While cortisol is necessary for maturation, excessive or poorly regulated exposure can disrupt the development of neural circuits involved in stress regulation and emotional control.

[10] LeDoux, J. E. (2000). Emotion circuits in the brain. Annual Review of Neuroscience, 23, 155–184.

When a pregnant woman experiences trauma-related hyperarousal, anxiety, or persistent fear, the intrauterine environment may signal danger rather than safety. The fetus adapts to this environment by calibrating its own stress-response systems accordingly. This adaptation may be protective in a threatening world, but in post-conflict or non-threatening environments, it can increase vulnerability to anxiety, hypervigilance, and emotional dysregulation later in life.[11]

Epigenetic Mechanisms and Gene Expression

One of the most significant findings in intergenerational trauma research involves epigenetic changes: modifications that affect gene expression without altering DNA sequences. Trauma exposure in mothers has been associated with epigenetic changes in genes related to stress regulation, particularly those involved in glucocorticoid receptor sensitivity. These changes can influence how efficiently stress hormones are regulated in offspring.

Importantly, epigenetic modifications may persist beyond infancy and shape lifelong patterns of stress responsivity. Children born to trauma-exposed mothers may show heightened physiological reactivity to stress, altered cortisol levels, and increased sensitivity to environmental threat. These biological patterns mirror those observed in trauma survivors, even in the absence of direct exposure to violence.[12]

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Postnatal Continuation of Neurobiological Risk

The intergenerational transmission of trauma does not end at birth. Maternal trauma may influence caregiving behaviors, emotional attunement, and attachment patterns. Neurobiological vulnerability established prenatally can be reinforced or mitigated depending on the postnatal environment. Sensitive caregiving, social support, and trauma-informed interventions can buffer stress responses and promote neural plasticity, while ongoing stress and stigma may amplify vulnerability.[13]

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[11] O'Donnell, K. J., & Meaney, M. J. (2017). Fetal origins of mental health: The developmental origins of health and disease hypothesis. American Journal of Psychiatry, 174(4).
[12] Yehuda, R., & Lehrner, A. (2018). Intergenerational transmission of trauma effects: Putative role of epigenetic mechanisms. World Psychiatry, 17(3), 243–257.
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Critically, these findings also highlight the potential for prevention and healing. Trauma-informed prenatal care, psychosocial support for trauma-exposed mothers, and early interventions can alter developmental trajectories and reduce the transmission of vulnerability across generations.[14]

Bosnia and Herzegovina: The War That Never Ended

Nearly three decades after the 1992-1995 conflict, survivors in Bosnia and Herzegovina continue to experience profound psychosocial consequences. Survivors of conflict-related sexual violence, torture, displacement, and families of the missing face persistent stigma, institutional exclusion, and fragmented reparations. Silence, often rooted in patriarchal and ethnopolitical norms, reinforces shame and discourages disclosure.

War Children: An Unrecognised Survivor Group

Individuals who experienced the war as children constitute a largely overlooked survivor population. Research shows elevated levels of anxiety, hypervigilance, unresolved grief, and disrupted educational trajectories among this group.[15] Their suffering is frequently minimised because of their age at the time, contributing to identity confusion and long-term psychosocial difficulties.

Individuals who experienced the war as children constitute a largely overlooked survivor population. Research shows elevated levels of anxiety, hypervigilance, unresolved grief, and disrupted educational trajectories among this group.

The Second Generation: Inherited Trauma

Children born after the war often inherit trauma indirectly through parental PTSD, emotional unavailability, overprotective or harsh parenting, and silence about the past. These dynamics occur within a broader sociopolitical environment marked by ethnically polarised narratives, reinforcing inherited grievances and obstructing reconciliation.[16]

[14] Buss, C., Entringer, S., Moog, N. K., Toepfer, P., Fair, D. A., Simhan, H. N., & Wadhwa, P. D. (2017). Intergenerational transmission of maternal childhood maltreatment exposure: Implications for fetal brain development. American Journal of Psychiatry, 174(4), 329–336.
[15] Mujanović, E. (2021). War childhood and post-war trauma in Bosnia and Herzegovina. Psychiatria Danubina, 33(Suppl. 4).
[16] Shin, L. M., & Liberzon, I. (2010). The neurocircuitry of fear, stress, and anxiety disorders. Neuropsychopharmacology, 35.

Lived Experience and Intergenerational Transmission: Case Narrative

Meris's Background Narrative

Meris was five and a half years old when the war began in Bosnia and Herzegovina (BiH). His early childhood was marked by constant fear and uncertainty, shaped by the realities of living in an active conflict zone. His mother, a medical doctor, provided care to war survivors, while his father was directly involved in detonating undetonated explosive devices, leaving the family in continual fear that he might not return home.

Meris grew up amid shelling, displacement, and pervasive threat, struggling to comprehend why violence was directed at people because of their name or religion. The war disrupted his education and sense of safety, and the experience of witnessing human cruelty at such a young age profoundly shaped his worldview, including his later decision not to have children. His family history of trauma extended further, as his grandmother had also survived multiple wars, reinforcing a multigenerational exposure to conflict and survival under extreme conditions.

Nearly three decades after the 1992-1995 conflict, survivors of wartime atrocities in Bosnia and Herzegovina, including survivors of CRSV, torture, forced displacement, and families of the missing, continue to live with the long-term consequences of trauma and stigma. While progress has been made in prosecuting war crimes and recognising survivors' rights, many still face social exclusion, economic marginalisation and limited access to reparations or psychosocial support. These conditions not only prolong individual suffering but also transmit trauma to subsequent generations, undermining social cohesion and trust in public institutions.

For many survivors, the war never truly ended. Survivors of CRSV often report fear of being blamed, shunned or considered "dishonoured," which discourages them from disclosing their experiences or seeking justice and medical care. Studies across BiH reveal that stigma is reinforced by silence within families and communities, rooted in patriarchal and ethnically-charged social norms.

Other victim groups, such as families of the missing, former detainees, or those displaced from their homes, also face social marginalisation and discrimination in employment or marriage. In many communities, narratives of guilt or collective blame further isolate survivors, leaving them to cope with trauma in silence.

Children born after the war often carry the invisible burdens of their parents' trauma. Empirical studies in BiH show that maternal war trauma is linked to higher rates of anxiety, depression, and behavioural difficulties in children. This transmission occurs through multiple channels. Parents who suffer from PTSD, depression, or substance abuse may exhibit withdrawal, overprotection or harshness, thereby disrupting the child's emotional development and sense of safety. Silence about the past, often intended to protect children, can leave them with fragmented identities and ambiguous feelings about belonging and trust.

At the collective level, polarised historical narratives in education and politics entrench mistrust between ethnic groups. Young people grow up in communities where schools, textbooks, and commemorations often reflect divided versions of the past, reinforcing inherited divisions and obstructing reconciliation.

Case Reflections: Meris

Meris's account illustrates how early exposure to existential threat shapes worldview, moral orientation, and life choices. Meris's narrative reveals a profound developmental shift shaped by early exposure to war, moral injury, and persistent stigma. Experiencing existential threat in early childhood fundamentally altered his perception of safety, human intent, and the value of life. The repeated fear of losing his father, combined with witnessing violence justified by identity and belonging, led Meris to conclude that the world was not a place into which he could ethically bring a child. This decision reflects not detachment or hopelessness, but a deeply moral response to a social environment perceived as unjust and dangerous.

Rather than withdrawing, Meris redirected this conviction into sustained advocacy. His lived experience of judgment, stigma, and institutional failure motivated a lifelong commitment to human rights, justice, and accountability for war crimes. Through this transformation, Meris exemplifies how trauma can reshape life choices while also catalysing ethical engagement: a refusal to reproduce cycles of harm paired with an active effort to confront them.

His trajectory underscores that intergenerational trauma may manifest not only through biological or familial transmission, but also through conscious decisions aimed at protecting future generations by transforming social and legal systems. His narrative emphasises hyper-awareness of mortality, moral responsibility, and the enduring effects of stigma. His reflections highlight the importance of acknowledgment, psychological support, and systemic justice in preventing trauma from becoming a "life sentence."

Lived Experience and Intergenerational Transmission: Case Narrative

Ajna's Background Narrative

Ajna grew up as a child born of war in Bosnia and Herzegovina, a reality she only fully understood during adolescence. Her early life was shaped by silence, stigma, and social exclusion within a deeply patriarchal post-conflict society. Her mother, a survivor of wartime sexual violence, faced discrimination as a single woman with a child, and Ajna herself was subjected to labeling, rejection, and shame within her community.

Throughout childhood, Ajna lived under the weight of secrecy intended to protect her, while simultaneously absorbing her mother's unresolved trauma. During adolescence, the cumulative effects of trauma, silence, and internalised stigma manifested in severe mental health struggles. Despite these challenges, Ajna later began to reclaim her narrative, and engage in advocacy as a way to confront injustice, break silence, and transform inherited trauma into agency.

Symbolic reparations, legal recognition, and access to education and psychosocial support are not merely benefits, but essential tools for restoring dignity and interrupting trauma transmission.

Reflection and Analysis: Ajna

Ajna's story illustrates how stigma and silence function as mechanisms of intergenerational trauma. The absence of open narrative within the family, combined with societal rejection, contributed to internalised shame and a fractured sense of self. Her early assumption of adult responsibilities reflects role reversal often observed in trauma-affected families, where children attempt to stabilise emotionally overwhelmed parents.

Ajna's later advocacy and insistence on recognition for children born of war demonstrate a shift from invisibility to agency. **Her reflections emphasise that symbolic reparations, legal recognition, and access to education and psychosocial support are not merely benefits, but essential tools for restoring dignity and interrupting trauma transmission.**

Lived Experience and Intergenerational Transmission: Case Narrative

Venesa's Background Narrative

Venesa was exposed to trauma both directly and indirectly from an early age, during the war in Kosovo. She witnessed her mother's rape at the age of five. Her mother is a survivor of wartime sexual violence and displacement. Her family lived under conditions of fear, silence, stigma and instability following the conflict. Venesa spent much of her childhood focused on protecting, and supporting her mother, while also trying to parent her younger siblings, limiting her own social development and sense of childhood safety.

As she grew older, the stress from trying to take on a parental role became overwhelming causing her to use maladaptive coping mechanisms. This unresolved trauma manifested in severe mental health struggles during her adolescence and into her adulthood which was accompanied by repeated hospitalisations, emergency room visits, and hospital day admissions. She was diagnosed with anorexia nervosa at the age of 14 in Canada and later was also diagnosed with bulimia nervosa that lasted 14 long years. Venesa describes growing up with a deep sense of responsibility for her mother's and siblings' wellbeing, while lacking the tools or support to address her own pain and trauma.

Reflection and Analysis: The "Flip"

The "Flip" represents a critical moment of cognitive and emotional reorientation in Venesa's life. Observing her mother's capacity to survive war, displacement, and stigma prompted Venesa to recognise her own capacity for agency and recovery. Rather than viewing trauma as an external, immutable force, she began to understand it as something that could be confronted internally.

This shift aligns with trauma theories emphasising self-efficacy and narrative integration as key components of recovery. Venesa's reflection underscores that while trauma may be inherited, it does not have to dictate life trajectories. Her story illustrates how intergenerational trauma can be transformed into intergenerational strength when survival is reframed not as silence, but as resilience coupled with self-awareness.

For Venesa, the “Flip” is about finally overcoming her chronic anorexia and bulimia by getting rid of her “demons” that she believes she created herself. Using her “Flip” to educate others, Venesa emphasises that **intergenerational trauma is not something to be overlooked, but rather something that must be addressed immediately after a child has experienced conflict. She stresses that this education should not be limited to educators, teachers, and psychologists, but must also extend to law enforcement, judicial experts, and public officials** in order to build a collective understanding of how to apply trauma-informed care and a child-sensitive approach regardless of age or gender.

Conclusion

Intergenerational trauma demonstrates that the impacts of war do not end when violence ceases. Legacy impacts are carried through neurobiology, family systems, and social structures. Without comprehensive, trauma-informed and survivor-centered policies, post-conflict societies risk transmitting suffering across generations.

Healing requires acknowledgment, justice, reparations, and sustained psychosocial support. Recognising all survivor groups, including children in war and children born of war, is essential for breaking cycles of trauma and building durable peace.

Taken together, the four cases — Elizabeth, Meris, Ajna, and Venesa — demonstrate how war-related trauma operates not as a discrete historical event, but as a multilevel, intergenerational process embedded in bodies, relationships, and social structures. Despite differences in geography, type of exposure, and life trajectories, all four narratives reveal common mechanisms through which trauma is transmitted, sustained, and, in some instances, transformed.

Multi-Level Consequences of Intergenerational Trauma

Individual level	Elevated prevalence of PTSD, depression, anxiety, and somatic symptoms.
Family level	Insecure attachment, emotional dysregulation, disrupted parenting.
Societal level	Distrust in institutions, weakened justice processes, reinforced polarisation.

At the individual level, each case reflects the enduring neuropsychological consequences of early or prolonged exposure to threat, loss, and injustice. Hypervigilance, emotional dysregulation, shame, and difficulties with identity formation recur across narratives, consistent with trauma-related alterations in stress-response systems. Whether exposure occurred directly in early childhood (as in Meris's case and Venesa's case), through adolescent sexual violence and displacement (as in Elizabeth's case, her daughter Brooklyn, and Ajna's case), or indirectly through parental trauma and silence (as in Venesa's case), the psychological imprint persisted well beyond the cessation of violence. These findings reinforce the understanding that trauma becomes biologically and psychologically embedded, shaping perception, behaviour, and health across the life course.

At the family level, the cases illustrate how unresolved trauma disrupts attachment and caregiving, often leading to role reversals (children taking care of parents), emotional unavailability, harsh or inconsistent parenting, and intergenerational misunderstanding. Elizabeth's experience as a young mother highlights how unprocessed trauma can be embodied within caregiving relationships, not as intentional harm, but as a consequence of unmet needs and the absence of social and institutional support. Meris and Venesa's narratives further show how children in trauma-affected families often assume premature emotional responsibility, internalise fear, or suppress their own needs to maintain family stability. These patterns underscore how trauma is transmitted relationally, even in the absence of explicit disclosure.

At the societal and structural level, all four cases reveal the central role of stigma, silence, and institutional failure in perpetuating trauma. Patriarchal norms, lack of accountability for perpetrators, inadequate reparations, and limited access to trauma-informed mental health services compound individual suffering and obstruct recovery. Silence, whether within families, communities, or state institutions, emerges as a powerful vector of intergenerational transmission and creation of fragmented identities. The experiences of Meris, Ajna, and Venesa, in particular, illustrate how children and second-generation survivors inherit not only trauma, but also polarised histories and moral burdens shaped by post-conflict political environments.

Importantly, these cases also demonstrate that intergenerational trauma is not deterministic. Moments of rupture, such as Elizabeth's reconciliation with her daughter, Meris's commitment to ethical action, Venesa's "Flip" toward self-agency, and Ajna's find for justice and accountability, highlight the possibility of transformation.

These turning points align with trauma research emphasising the role of narrative integration, acknowledgment, and relational repair in recovery. Healing, in these cases, did not occur through forgetting the past, but through confronting it within supportive, validating contexts.

Collectively, the four narratives affirm that addressing intergenerational trauma requires more than individual resilience. Sustainable healing depends on survivor-centred justice, recognition of all affected generations, trauma-informed mental health systems, and social environments that replace stigma with acknowledgment. Without these structural support systems, trauma risks becoming a legacy passed silently from one generation to the next. Even the deepest wounds of war can be transformed into foundations for dignity, connection, and change.

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