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Collective Trauma, Political Violence, and the Imperative for Integrated Mental Health Responses

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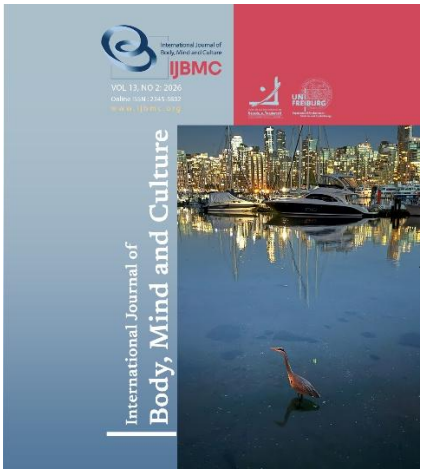

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ABSTRACT

Societies exposed to long-term and critical political violence, repression, and collective loss suffer not only immediate psychological distress but also enduring, multi-layered trauma that modifies individual subjectivity, family dynamics, and sociocultural meaning-making. In recent years, especially these days, Iran has witnessed a convergence of recurrent crises—including mass violence, loss of life, social fragmentation, economic insecurity, and perceived collapse of future orientation—that have placed unprecedented strain on the psychological resilience of its population. This editorial sheds light on some of the psychological, intergenerational, and psychosomatic consequences of such conditions, with particular attention to the reactivation of historical political traumas, as well as the risk of collective violence turned inward, and the emergence of suicide clusters in contexts of social defeat and hopelessness. Relying on international evidence, regional comparisons, and clinical observations, it supports a preliminary, multisystem mental health promotion aligned with global guidelines while remaining adaptable to Iran's sociocultural context. However, this concept paper draws on established trauma and mental health frameworks, psychosocial support, and the author's clinical observations; it does not present primary epidemiological data from Iran.

Keywords: Collective Trauma, Political Violence, Mental Health, Iran.

Collective Trauma and the Reactivation of Historical Wounds

Communal trauma goes beyond individual exposure to violence; it disrupts joint narratives, moral structures, and social trust (Alexander, 2004). In societies with incoherent historical stories, contemporary crises often reactivate unresolved traumas from personal and intergenerational past, producing what Volkan (2001) terms chosen trauma: a persistent psychological imprint transmitted across time.

Research on political violence demonstrates that descendants of traumatized populations may show elevated vulnerability to anxiety, depression, identity fragmentation, and moral injury, even in no direct exposure (Danieli, 2013; Yehuda et al., 2016). In Iran, there are no systematic surveys or qualitative studies in the field. However, as a psychotherapist and concept researcher through about thirty years of practice and research, I frequently and vastly encountered day by day chosen trauma phenomena similar to narratives of loss, silencing, and thwarted agency; transmitted through families, cultural memory, and collective silence, are being reawakened, intensifying present distress and complicating pathways to recovery. I have reported many of these cases in my recent Farsi book, "Body and all its times", and in a case study, "Abandoned bodies and lost gods" (Goli, 2023; Goli & Zanjani, 2026).

Intergenerational trauma is transmitted through parenting practices, emotional harmony, silence, hypervigilance, and implicit threat perception (Kellermann, 2001). Children and adolescents raised in chronically insecure environments frequently internalize helplessness or suppressed rage, later expressing themselves as psychosomatic symptoms, affect dysregulation, or self-directed aggression.

Furthermore, without adequate organizational support, entire professional communities become vulnerable to compassion fatigue, moral injury, and burnout, diminishing collective capacity for care (Figley, 1995). However, Vicarious trauma goes beyond caregivers and families to educators, journalists, and the general population who are repeatedly exposed to others' suffering.

Life-threatening caregiving and Hard Ethical Dilemmas

These days are the hardest days for caregivers in Iran. During the past two to three weeks of escalating crisis, my work as a clinician has unfolded alongside surgeons, ophthalmologists, emergency physicians, and nurses who were operating under extreme pressure while facing direct threats and persecution from military and security forces. Beyond exhausting workloads and daily exposure to severely injured and deceased patients, many were forced into painful and confusing ethical dilemmas—choosing between protecting their own safety and protecting the lives of those under their care, with many repeatedly placing patients' security above their own. Observing these times became tangible what Howard Barker, in his theory of the "Theatre of Catastrophe", argues: that catastrophe possesses a tragic, painful beauty because it removes the daily illusions and reveals, simultaneously, the most humane and the most brutal dimensions of human nature.

From External Violence to Internalized Aggression

A central finding in trauma psychology is that unexpressed rage and grief, when deprived of social acknowledgment or symbolic repair, may be turned inward (Freud, 1917; Van der Kolk, 2014). Many media and clinical reports from Iranian psychologists and psychiatrists, and among my recent practice, indicate increasing presentations of severe hopelessness, self-blame, moral injury, somatic distress free of clear medical etiology, and suicidal ideation and attempts framed as escape or silent protest. These patterns coincide with sociological and epidemiological evidence linking political repression, social defeat, and loss of dignity to increased suicide risk (Durkheim, 1897; Wilkinson & Pickett, 2010).

Suicide Clusters and Collective Despair

Evidence from Post-Authoritarian and Crisis-Affected Societies

Suicide clusters, as temporal or spatial aggregations of suicides, have been documented through many periods of political collapse, repression, or perceived collective failure. Some of the notable examples are:

- Post-Soviet states during the 1990s, where economic collapse and social disintegration coincided with dramatic rises in suicide rates (Brainerd, 2001).
- East Germany, following reunification, where identity loss and social displacement contributed to elevated suicide mortality (Clement et al., 2025).

- Greece during the austerity crisis, where suicide rates increased alongside economic despair and perceived erosion of dignity (Economou et al., 2016).
- Indigenous communities are subjected to historical and ongoing structural violence, where suicide clustering has been linked to unresolved collective trauma (Kirmayer et al., 2009).
- In countries affected by the Arab Spring, initial collective hope and narratives of dignity and agency were followed by political instability, repression, and unmet expectations, contributing to increased psychological distress and suicide risk (Rahmadi et al., 2025). Studies conducted after the Arab Spring report increased prevalence of depression, anxiety, and PTSD among populations exposed to political violence and repression (Charlson et al., 2019). In Egypt, clinical and national reports documented rising suicide attempts in the years following the 2011 uprising, often associated with economic despair and political disillusionment (Okasha et al., 2025; WHO, 2025). In Tunisia, suicide rates increased during periods of economic strain despite political transition, underscoring that political change alone does not mitigate psychological risk without parallel social and mental health support (Charfi et al., 2024). These acts functioned not only as individual expressions of despair but as symbolic protests against humiliation, structural violence, and blocked social mobility, illustrating the intersection of political trauma and self-destructive behavior (Lester, 2017; WHO, 2025). Analyses indicate mechanisms consistent with suicide clustering, including social identification, media amplification, and normalization of suicide as a response to injustice—paralleling findings in other post-authoritarian contexts (Niederkrotenthaler et al., 2010; WHO, 2025).

These patterns suggest that suicide clustering is not merely an individual psychopathological phenomenon but a social process embedded in shared narratives of defeat, humiliation, and hopelessness.

Mechanisms of Suicide Contagion

Research identifies several mechanisms underlying suicide clusters: social learning and identification, media amplification (Werther effect), normalization of suicide as a response to injustice, and erosion of protective social bonds. Conversely, responsible communication emphasizing coping and recovery (Papageno effect) has been shown to reduce suicide risk (Niederkrotenthaler et al., 2010; WHO, 2025).

The Necessity of an Integrated Mental Health and Psychosocial Response

Fragmented or exclusively individual-level interventions are insufficient in contexts of collective trauma. International consensus emphasizes multi-layered Mental Health and Psychosocial Support (MHPSS) systems addressing individual, family, community, and structural dimensions (Committee, 2006; WHO, 2025).

Mental Health and Psychosocial Response Framework

1. Core Principles

- Do no harm
- Safety and stabilization as first priorities
- Human rights and cultural humility
- Stepped care proportional to need
- Strengthening existing social and familial resources (Committee, 2006; WHO, 2025)

2. Universal and Community-Level Interventions

Universal interventions aim to reduce population-wide psychological harm during crises by strengthening protective factors, normalizing distress responses, and preventing escalation into severe mental health outcomes. These interventions are especially critical in contexts of prolonged conflict, displacement, social fragmentation, and mass trauma, where access to specialized care is limited, and stigma remains high.

2.1- Psychological First Aid (PFA)

Psychological First Aid (PFA) is internationally endorsed as a frontline, non-intrusive intervention for individuals and communities exposed to acute or chronic crises. Rather than focusing on trauma processing or symptom diagnosis, PFA prioritizes immediate human needs and psychological stabilization. Core principles include ensuring physical and emotional safety, promoting calm, fostering connectedness, instilling hope, and supporting self- and community-efficacy (Haw et al., 2013; WHO, 2025).

A key strength of PFA lies in its flexibility and cultural adaptability. It can be delivered by trained non-specialists, community leaders, teachers, healthcare workers, and volunteers, making it particularly suitable for low-resource and high-demand settings. Importantly,

PFA explicitly avoids forced emotional disclosure or premature trauma narration, practices that have been shown to increase distress and risk of re-traumatization when applied indiscriminately (Lewis et al., 2014).

Empirical evidence suggests that PFA contributes to reduced acute distress, increased engagement with social supports, and improved help-seeking behaviors, even though it is not designed as a standalone treatment for PTSD or depression (WHO, 2025). At a community level, widespread PFA implementation can counteract feelings of chaos, abandonment, and helplessness, thereby strengthening collective resilience.

2.2- Violence De-escalation and Emotional Regulation

In prolonged crises, unprocessed grief, fear, humiliation, and moral injury frequently manifest as irritability, aggression, interpersonal violence, or social polarization. Community-based violence de-escalation and emotional regulation interventions are therefore essential components of suicide and violence prevention strategies.

Psychoeducational programs that explain the neurobiology of stress—such as hyperarousal, sleep disruption, and threat-based cognition—help normalize emotional reactions and reduce self-blame (Miller & Rasmussen, 2010). Teaching practical grounding techniques (e.g., paced breathing, sensory orientation, muscle relaxation), emotion labeling, and distress tolerance skills empowers individuals to regain a sense of control during emotional surges.

At the collective level, facilitated dialogue spaces—when carefully moderated—can reduce dehumanization, challenge rigid "us vs. them" narratives, and restore social trust. WHO (2025) emphasizes that preventing violence in humanitarian settings requires addressing both individual emotional dysregulation and structural stressors such as injustice, uncertainty, and lack of agency.

2.3- Media and Communication Guidelines

Media reporting during crises plays a decisive role in shaping public emotional responses, risk perception, and help-seeking behavior. Extensive evidence demonstrates that sensationalized, repetitive, or romanticized reporting of suicide and violence increases the risk of imitation and contagion, particularly among vulnerable individuals (Hawton et al., 2020).

WHO media guidelines recommend avoiding explicit descriptions of methods, locations, or personal details; refraining from simplistic explanations; and eliminating language that portrays suicide as inevitable or heroic (WHO, 2025). Conversely, responsible reporting should emphasize recovery narratives, availability of psychosocial support, and the temporary nature of crises.

Beyond suicide prevention, clear, consistent, and empathetic public communication reduces anxiety, rumor proliferation, and mistrust. In crisis contexts, collaboration between mental health experts, journalists, and policymakers is essential to ensure that information dissemination supports psychological containment rather than collective panic.

3. Selective Interventions for At-Risk Groups

Selective interventions target subpopulations exposed to heightened risk due to cumulative stressors, prior trauma, social isolation, or structural vulnerability. These approaches bridge the gap between universal prevention and specialized clinical care.

3.1- Systematic Screening

Routine, context-sensitive screening is recommended in primary care, schools, shelters, and humanitarian services to identify individuals at elevated risk for suicide and severe psychological distress. Key constructs include hopelessness, suicidal ideation, internalized anger, moral injury, complicated grief, and perceived burdensomeness (Beck & Steer, 1989; Joiner et al., 2015).

Screening should not be a one-time event but an ongoing process, as risk fluctuates over time, particularly during prolonged crises. Ethical screening requires clear referral pathways, confidentiality safeguards, and trained personnel to respond appropriately to positive findings (Wood, 2025).

3.2- Gatekeeper Training

Gatekeeper training programs equip non-specialists—such as teachers, religious leaders, community volunteers, and healthcare workers—to recognize warning signs of suicide and severe distress, provide initial support, and facilitate timely referral. These programs have demonstrated effectiveness in improving knowledge, attitudes, and intervention confidence across diverse cultural settings (WHO, 2025; Rosenblum et al., 2025).

In contexts where mental health professionals are scarce, gatekeepers often represent the first and only point of contact. Their role is not to provide therapy but

to reduce isolation, challenge stigma, and act as a bridge to care.

3.3 Group-Based and Peer Support

Structured group interventions and peer-support models leverage shared experience as a therapeutic resource. Evidence indicates that such groups reduce loneliness, enhance meaning-making, and promote collective coping, particularly among displaced populations and survivors of mass trauma (Chowdhary & Sukriti, 2025).

Peer support also redistributes emotional labor within communities, preventing over-reliance on fragile clinical systems. When adequately supervised, peer-led initiatives can sustain long-term psychosocial support beyond the acute phase of crisis.

3.4- Therapeutic and Preventive Measures for Mental Health Professionals

In addition to interventions directed at affected populations, mental health protocols in crisis contexts must explicitly include structured support for healthcare professionals and therapists themselves. Longstanding approaches such as Balint groups, reflective practice groups, peer supervision, and regular clinical debriefings have demonstrated value in mitigating burnout, secondary traumatic stress, and professional isolation by providing a contained space for emotional processing and meaning-making in clinical work. These interventions remain essential first-line strategies, particularly in high-intensity settings where moral distress and cumulative exposure to suffering are pervasive.

Building on these foundations, during the COVID-19 pandemic a more comprehensive and transformative program for clinicians was developed with the support of the DAAD and the Department of Psychosomatic Medicine and Psychotherapy at the University of Freiburg, under the title Healers' Healing (Goli et al., 2021). This program conceptualizes clinician well-being not merely as stress reduction but as an ongoing ethical and professional practice, structured around seven interrelated domains of care: presence, reasoning, decision work, emotion work, relation work, moral work, and balance. The model integrates reflective, relational, and embodied dimensions of clinical work and has been incorporated into continuing medical education frameworks in Iran. In the context of current crises, this approach is increasingly recommended for mental health professionals as a scalable, ethically grounded framework to sustain clinical capacity, preserve professional integrity, and reduce the long-term psychological costs of caregiving under prolonged adversity.

4. Indicated Clinical Interventions

Indicated interventions are designed for individuals presenting with significant psychological symptoms, functional impairment, or high suicide risk. These interventions require professional expertise and ethical safeguards.

4.1- Trauma-Informed Therapy

Trauma-informed care recognizes the pervasive impact of trauma on cognition, affect, relationships, and meaning systems. Phased models emphasize safety and stabilization, affect regulation, and narrative integration, rather than immediate exposure-based techniques (Herman, 1992).

WHO (2025) cautions against premature trauma processing in unstable environments, where ongoing threat and resource scarcity may undermine treatment effectiveness. Meaning-making, restoration of agency, and strengthening relational safety are often more urgent therapeutic goals.

4.2- Family-Based Interventions

Families can function as either powerful protective systems or sources of additional stress. Family-based interventions aim to enhance communication, reduce blame, and support caregivers who may themselves be traumatized (Slone & Mann, 2016).

Supporting caregivers has downstream effects on children and adolescents, mitigating intergenerational transmission of trauma and maladaptive coping patterns.

4.3- Psychosomatic and Integrated Care

In many cultural contexts, psychological distress is primarily expressed through somatic symptoms such as pain, fatigue, gastrointestinal complaints, or cardiovascular dysregulation. Integrating mental health services into primary care improves detection, reduces stigma, and addresses the bidirectional relationship between mind and body (Dimsdale, 2008).

Neuroscientific research highlights how chronic trauma alters stress physiology, immune function, and pain perception, underscoring the need for integrated, biopsychosocial models of care (Van der Kolk, 2014).

4.4- Pharmacological Interventions

Pharmacotherapy may be indicated for severe depression, anxiety disorders, psychosis, or sleep disturbances, but should never be used in isolation. Evidence-based prescribing, regular monitoring, and integration with psychosocial interventions are essential to minimize risks and maximize benefits (WHO, 2025; Wood, 2025).

5. Suicide Postvention and Cluster Response

Postvention refers to interventions implemented after a suicide to support bereaved individuals and prevent further deaths. Immediate outreach, grief support, and monitoring of vulnerable peers are critical components (WHO, 2025).

Failure to address post-suicide dynamics increases the risk of suicide clusters, particularly in tightly connected communities. Public messaging must avoid romanticization, symbolic glorification, or political instrumentalization of suicide (Rosenblum et al., 2025) .

6. Protection of Mental Health Professionals

Mental health professionals working in crisis settings face elevated risk of burnout, secondary traumatic stress, and moral injury. Sustainable care systems require institutional recognition of clinicians' vulnerability, not just their resilience (Figley, 1995).

Protective measures include regular supervision, peer support, realistic caseloads, rest periods, and organizational cultures that legitimize emotional impact rather than pathologizing it (WHO, 2025).

Conclusion

The psychological consequences of prolonged crisis are neither transient nor confined to individuals. Without integrated, culturally informed, and system-level responses, societies risk the consolidation of intergenerational trauma, internalized violence, social fragmentation, and preventable loss of life. International evidence consistently demonstrates that mental health is not peripheral in times of crisis; it is foundational to social survival, ethical recovery, and long-term reconstruction.

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