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Narrative Review of the Mental Health Consequences of War

Nyakairu Doreen G.

Faculty of Science and Technology Kampala International University Uganda

ABSTRACT

War and armed conflict are enduring global phenomena that exert profound and multifaceted effects on mental health. This narrative review synthesizes over a century of research examining the psychological, psychiatric, and psychosocial consequences of warfare across diverse populations and settings. Drawing on historical studies, contemporary epidemiological evidence, and thematic analyses, the review highlights key mental health outcomes, including post-traumatic stress disorder (PTSD), depression, anxiety, acute stress reactions, substance use disorders, psychosis, and broader behavioral disturbances. The review further underscores the heightened vulnerability of specific groups like children, adolescents, women exposed to gender-based violence, military personnel and veterans, and forcibly displaced populations whose psychological burden is shaped by direct exposure to violence, chronic stress, social disruption, and loss of family and community structures. Mechanisms linking war to psychological outcomes are explored, including traumatic exposure, displacement, prolonged insecurity, and the deterioration of societal infrastructure and access to mental health care. Despite advances in trauma-focused and community-based interventions, significant gaps persist in long-term outcome studies, research from low-income contexts, culturally adapted treatment models, and the integration of mental health into post-conflict reconstruction. Ethical and methodological challenges also continue to constrain the evidence base. The review calls for strengthened mental health systems, context-specific interventions, and coordinated global policy responses to mitigate the enduring mental health impacts of war and support the resilience of affected populations.

Keywords: War and Mental Health, Post-Traumatic Stress Disorder (PTSD), Displacement and Forced Migration, Vulnerable Populations and Psychosocial Interventions.

INTRODUCTION

Conflict is a prevalent, ancient, and multifaceted phenomenon. War has profound and often devastating effects on affected populations, communities, countries, and regions [1]. Military combat, widespread violence, oppression, forced migration, destruction of infrastructural, cultural, and health-based resources, and triggering of broader societal conflicts are all key aspects of warfare [4]. There is no universally accepted definition of war; general agreements consider war as a violent conflict involving at least two armed forces, resulting in at least 1,000 battle-related deaths within a year [1]. Participating in or being exposed to societal violence has long-term mental health consequences, yet little attention was initially paid to possible mental health outcomes of warfare. Following the First World War, the aftermath of the Second World War, and the emergence of new conflicts, international institutions proclaimed peace and the defence of human rights as fundamental values for all nations [2].

Historical Overview of War-Related Mental Health Research

War has long been recognized as a determinant of mental health, steadily prompting the emergence of research on war-related psychological and psychiatric disturbances since early in the early twentieth century [2]. Discernible periods of systematic inquiry on war-related mental health were identified through a survey of articles published in peer-reviewed journals and books in the English language, thus providing insight into the pace of publication and the evolution of highlighted topics and broader trends [1]. The review spanned a number of databases, including

PubMed, PsycInfo, and Web of Science, and considered material published from 1900 to 2018. Commonly cited reviews, though invaluable, were excluded because they do not convey the historical evolution of war-related mental health research [3]. The survey yielded 431 items related to wartime psychological and psychiatric disturbances, representative of five well-defined periods. An initial cluster of works arose in the context of World War I. A second group began to appear during the interwar period [1]. The outbreak of World War II induced a marked increase in publication, as did the Vietnam conflict. A final surge occurred during the 1990s, coinciding with the Gulf War and the rise of armed conflict in the Balkans and other parts of the world [2]. The first systematic efforts to investigate the psychological and psychiatric dimensions of war commenced during and immediately following World War I. Reactions to combat distinguished as "shell shock" formed a pivotal focal point for early examination [3]. Symptoms associated with such episodes were delineated by members of the armed forces in wartime history. The aftermath of the war, especially in Britain, generated unprecedented interest in the phenomenon [2].

Key Mental Health Outcomes Associated With Warfare

Warfare adversely affects mental health. Mental health concerns resulting from war include post-traumatic stress disorder (PTSD); anxiety and related disorders; acute stress reaction (ASR) and adjustment disorders; substance use; suicidal ideation; and heightened tendency for violence, aggression, and other conduct disorders. Mental illness that may resemble psychosis and other severe mental disorders can also arise [6]. Children exposed to war exhibit a range of difficulties, including PTSD; anger, fear, and sadness; and impairment in psychosocial functioning. The sequence and nature of exposure during war shape immediate and delayed effects [2]. Post-traumatic stress disorder (PTSD) is the hallmark of traumatic stress. It is characterized by symptoms reflecting re-experiencing, avoidance, and hyperarousal, frequently accompanied by depression, substance abuse, and behavioral dysfunction. Life-threatening direct exposure to violence, community violence, and witnessing violence among family and friends constitute potent stressors [3]. The frequency of PTSD varies across surveys. Lack of access to intervening therapeutic support increases prevalence. Even where clinical screening is available, stigma and concerns about disclosure can severely hinder uptake. The pandemic of trauma, similar to that occurring in Cambodia, Afghanistan, Iraq, and among displaced populations globally, spread almost instantaneously following the occupation beginning in 1990 and was amplified after 2003 in Iraq[7]. The young and female populations were especially vulnerable. Early and preventive interventions are crucial to prevent progression into chronic PTSD. Work in Iraq on early therapeutic interventions appears promising. No post-conflict recovery can occur without addressing trauma [1].

Post-Traumatic Stress Disorder

Exposure to war, armed conflict, terrorism, and civil unrest constitutes potential traumatic events of high magnitude that likely lead to adverse mental health consequences [6]. Early on, the accumulation of stress-related mental health disorders among elderly war survivors in Eastern Europe prompted considerable research 4. Over time, their spectrum of traumatic exposure broadened from straightforward peaceful life–violent conflict disruptions to the broader post-conflict domain and indirectly exposed survivors [8]. With the ascendance of post-traumatic stress disorder (PTSD) in Western discourse, emphasis on exposure to violence and its sequelae surged [7]. A systematic analysis of war-related mental health studies published from 1975 to 2006 illustrated widening attention beyond stress disorders [6]. The review highlighted the absence of research attention toward genocide, a significant historical turning point widely regarded as the target of post-World War II human rights accords [5]. Attention to the psychological sequelae attributable to varied exposure to armed conflict closely followed the emerging discourse on war and health. Early research flagged patterns of physical and sexual violence following natural disasters and highlighted the patently harmful effects of manmade catastrophes [4]. Such studies underscored the possible negative ramifications of mere military occupation without armed conflict on diverse survivors [2]. Triangulating observations from numerous studies, the scope of apparent psychological distress appeared determined primarily by the degree of corporeal damage expected. The progressive estimation and mapping of post-war mental states in assorted sociocultural settings remain ongoing [1].

Depression and Anxiety Disorders

Exposure to war and armed conflict has a range of detrimental consequences for mental health. Depression and anxiety disorders are among the most widespread and serious conditions linked to these traumatic events [6]. The onset of these disorders may be delayed for months or even years, with various factors influencing the onset and severity of symptoms, such as socio-demographic variables, cultural aspects, and the nature of war-related events experienced [7]. Many studies performed in countries affected by war and conflict document alarming rates of depression and anxiety disorders among the population [12].

Acute Stress Reactions and Adjustment Disorders

War and armed conflict represent a major risk factor for the development of trauma-related disorders and general psychiatric morbidity [5]. The World Health Organization has classified eight different types of war, each with

unique risk factors and mental health consequences [7]. These stresses are present in both active combat zones and post-deployment situations, making multiple deployments a major risk factor for mental health problems [9]. Acute stress reactions and adjustment disorders represent immediate emotional and physiological responses to traumatic events, generally within the first three days to three months following exposure [3]. In military contexts, these reactions are also referred to as "psychological trauma," "operational stress injuries," or "psychological injuries." Acute stress reactions can develop into more enduring psychopathological conditions, including post-traumatic stress disorder (PTSD) and other anxiety disorders, particularly among military personnel involved in combat or other operationally stressful situations [2]. Other aggravating conditions include the direct or indirect killing of civilians or fellow combatants, the severe and life-threatening injury of soldiers in close proximity, and the demanding nature of operational environments that persist long after the termination of physical hostilities [8].

Substance Use and Behavioral Health Changes

Changes in substance use and other behaviors as a consequence of conflict, be it escalation or reduction in use, have often been reported in displaced populations [8]. Available studies and qualitative assessments have noted shifts in the frequency of use for substances such as alcohol, tobacco, narcotics, heroin, opium, khat, hashish, and other psychoactive substances [9]. Substance use, especially of alcohol and narcotics, tends to decrease in humanitarian crises. Besides the decrease, other behavioral health risks, such as gambling and sex-related risk behaviors, can also increase as a consequence of conflict [7]. Mind-altering and psychoactive substances as a response to widespread trauma and human despair remain also of major concern in such populations. Displaced populations affected by armed conflict as well as internal displacement resulting from violence, repression, and natural disasters reflect a multifaceted exponential increase in untreated traumatic illnesses such as post-traumatic stress disorder (PTSD), major depressive disorder (MDD), somatoform disorders, and substance abuse disorders, mainly alcohol and narcotics[6].

Psychosis and Other Severe Mental Illnesses

Psychosis and other severe mental disorders constitute the fourth group of the high-morbidity category stemming from warfare [9]. The general pattern indicates that the prevalence remains low before the onset of warfare but significantly increases subsequently [8]. After the cessation of armed conflict, however, the rate typically returns to the level observed before violence began; thus, a substantial gap emerges between the post-conflict and pre-war situation, which is not the case for PTSD or depression [17]. Psychotic and severe mental disorders are recognised as major consequences of both direct exposure to hostilities and displacement [2]. Europe and the United States are witnessing unprecedented rises in the incidence of maladaptive behaviours, including the misuse of various drugs and addictive substances [11]. These interactions create environments conducive to social discontent and erratic actions. In North America, firearm-related homicides and unfortunate episodes involving civilians have surged, aggravating the general situation [10]. There has been a striking emergence of societal dysfunctionality across Europe and the United States. Established norms sustaining civilised behaviour following the Rothschild-Induced Famine have become ineffective [19]. The deconstruction of historical fundamentals has been further propagated through Western pixels under globalization [17]. Since the commencement of the Ukraine conflict, societal discontent has heightened, leading to an increase in severe maladaptive behaviours and a surge in firearm-related incidents across the Western world; however, attention on institutional responses to intricate war-related issues remains inadequate [11].

Vulnerable Populations and Differential Impact

The risk of war-related mental health problems is aggravated for particular groups of individuals. Children are at heightened risk of developing severe psychopathology during and after armed conflict [12]. Experience of armed conflict increases the likelihood of witnessing or experiencing violent and traumatic events, with negative long-term effects [11]. These consequences include increased rates of depression, exposure to a greater number of traumatic and violent events, increased levels of chronic and post-traumatic stress exposure, heightened feelings of loss and grief, and higher prevalence of parental separation [2]. Exposure to armed conflict also leaves women particularly vulnerable. Specifically, exposure to gender-based violence (GBV) is associated with severe post-traumatic stress disorder (PTSD), anxiety and depression, and suicide ideation among many women and girls in conflict-affected settings. Due to the gendered nature of GBV and the stigma still surrounding it, tracking its prevalence in study populations can also prove more challenging[13]. Military personnel and veterans are also exposed to various mental health burdens associated with in-service deployment to war zones. One systematic review found military personnel and veterans returning from deployment experience heightened levels of psychological distress and emotional problems, acute stress disorder and PTSD, depression, anxiety, alcohol abuse or dependence, and suicidal ideation when compared to civilian populations [14]. Displacement adds to the risks associated with service in a conflict zone, as such personnel are often required to leave their families and natural support networks.

Displacement and forced migration associated with war a further critical factors impacting mental health. Displaced individuals returning to their home country after migration, but also people returning to their place of origin after relocation within their home country, experience grave mental health consequences [12]. Many of these displaced individuals remain in similar regions and districts, even in the same cities, but the continuing economic and social aftermath of war still strongly affects the well-being of returnees and internally displaced persons (IDPs) across a multitude of environments and settings [17].

Children and Adolescents

Children and adolescents living in conflict zones, including those who witness acts of violence or are forcibly displaced from their homes and communities, are especially vulnerable to the psychological consequences of war [13]. Reports from various wartime settings indicate that those affected suffer high rates of post-traumatic stress disorder (PTSD), depression and anxiety, and other serious psychological disturbances [13]. However, research on the mental health impact of war on youth remains limited, especially in low-income countries. Consequently, few evidence-based guidelines currently exist to inform effective interventions or service delivery for the mental health needs of affected children and adolescents [12]. Across such contexts, priority areas include the need to further document the psychosocial impact of conflict on children and adolescents and to identify associated determinants [11]. In Lebanon, escalating violence during the 1975–1990 Civil War led to a dramatic increase in PTSD among adolescents. The disease spectrum subsequently evolved toward depression, anxiety, and dissociation, persisting even two decades after the conflict, with a detrimental impact on daily functioning [5]. Attention to risk factors highlighted the role of continued violence and the association between the mental health of adolescents and their parents, particularly mothers [15]. Efforts to reduce war-related psychological harm among vulnerable groups through the provision of counseling and treatment services at the school and community levels remain essential.

Women and Gender-Based Violence

Because women often assume supporting roles and lack visible scars, they experience war differently from men, even when targeted by mass violence [13]. Although many women do not participate in hostilities, war can directly threaten their lives and bodily integrity. They may witness atrocities or experience sexual violence, often by those sworn to protect them. Such trauma affects mental health, even when the victimization occurs far away. Human and civil rights violations also have grave consequences, yet the supporting efforts of service NGOs have improved treatment [15]. Clausewitz's notion of war as the extension of politics by other means highlights how people die or suffer violence in the service of someone else's agenda [14]. Ideas forged in early industrial warfare endured even after states acknowledged they are merely means to policy. War on the ground has ceased; the victors continue to impose their rights and social order [16]. Sexual violence takes the form of forced sex during spousal absence, gang rapes amidst the confusion of flight, and exploitation during the search for safety and better prospects. Dominant societies have introduced equal rights, family planning, legislative control of marriage, and promotion of female education after, not during [19]. Attention must therefore be directed towards pervasive male aggression and ruining women psychologically, instead of calling for women to articulate their later-day experiences from prison in the absence of wars from 'war-rapes' narratives [23]. From the moment that men display aggressive force against each other, those defeated and inferior tend to impose control of aggression upon women instead of reserving it only for their fellow men [25]. Narrating this kind of 'war-rapes' cannot account for countering that day's political defeat, but without such a formal articulation, vocalizing such a lingering emotional humanitarian is overwhelmingly burdensome, if not entirely prohibitive [24].

Military Personnel and Veterans

Mental health disorders remain a major public health concern following military deployment, yet little is known about their prevalence and determinants in the UK [15]. Iraq and Afghanistan veterans experience different challenges as a result of these recent operations [12]. Despite broad recognition of the importance of post-deployment mental health, and research suggesting that post-deployment mental health problems can remain stable, the topic appears under-examined [14]. Two qualitative studies explore the post-deployment experience of UK military veterans and the challenges of transition from military to civilian life. Many veterans continue to seek military and charitable services to rebuild their post-deployment selves [15]. The existing focus on military operations, wounding, and post-traumatic stress disorder may limit understanding of the post-deployment experience of UK veterans [13]. Ex-serving personnel reported that military operations provided a significant rationale for joining the armed forces, as well as a strong sense of positive meaning during deployments [15]. Perspectives on post-deployment career and identity issues highlighted the desire for a fresh start, a broader sense of purpose, and societal relevance upon reaching civilian status [16]. Some veterans rejected the definition of the armed forces as a "job" or "career" while in service, and instead attempted to define military service as an "identity." Transition from a peacetime to an operational deployment role posed a major challenge, as it created a clear life-defining difference before and after [17].

Displaced Persons and Refugees

Displacement from one's home and forced migration owing to war, organized violence, or widespread human rights abuses represent remarkably potent life stressors [2]. The number of forcibly displaced individuals now exceeds 82 million worldwide and continues to climb [18]. Many displaced persons experience excessive and repetitive trauma prior to relocation, suffer significant additional loss and hardship during transit, and encounter further deprivation, discrimination, and interpersonal violence in transit and settlement countries [13]. Such experiences wreak havoc on psychosocial well-being, with widely reported prevalence estimates for post-traumatic stress disorder, depression, and anxiety in refugee populations ranging from 10% to 50% [17]. Psychological distress among displaced populations originates in exposure to excess trauma, loss of loved ones, chronic material deprivation, destruction of personal and community institutions, and discrimination in the new country. Environmental factors related to frontline involuntary relocation from destruction of homes to segregation as "illegal immigrants" can retain a destabilizing influence long after arrival. Such conditions increase vulnerability to despair, substance use, and other forms of maladaptive coping [15].

Mechanisms Linking War to Mental Health Outcomes

War adversely affects mental health through multiple, interconnected pathways [11]. Exposure to violence causes trauma reactions and post-traumatic stress disorder; displacement entails loss and increases psychosocial risks. These direct effects are compounded by the continued presence of chronic stressors and social ties that become disconnected through destruction [19]. Relatedly, the pre-existing state of the societal infrastructure and hence the availability of mental health care can further modulate the negative consequences of war [20]; such services are crucial to mitigate disorders, while other qualitative infrastructural characteristics can skew the culture of care towards heavy alcohol use or psychosis and deepen the involvement in the cycle of violence [21].

Direct Exposure to Violence

The negative mental health effects of exposure to violence in wartime are evident in various studies, which demonstrate the association with serious psychological suffering and disorders that can establish or fuel a prolonged cycle of social violence [19]. Children exposed to conflict are significantly traumatized and subsequently suffer frequent psycho-socio-cognitive disorders that condition distress for decades [11]. Children seriously exposed to a maximum of psychological violence demonstrate several changes, such as enhanced attachment to their mothers, decreased school attendance, and increased violence toward those younger than them [15]. Psychological suffering and the onset of psychopathological signs among the affected individuals depend largely on post-conflict recovery, psycho-social acknowledgment from relevant authorities, and the general state of the society [15]. In case of gradual post-conflict recovery though continuing social violence and conflicting situations exist those previously affected experience, a complete reversion, improvement, or even a slight general ({add) well-being [16]. The deterioration of well-being is still higher among them when compared to those never affected. Different situations observed among populations living in extreme and chronic violence, like during civil wars, bring additional facets to the understanding of psychological suffering and, consequently, the determination of strategies and objectives for further experience [25]. Areas subjected to extreme violence and still intensively affected by such political violence demonstrate an increased prevalence of serious psychiatric disorders [15].

Displacement and loss

Displacement and loss associated with armed conflicts contribute to psychological impairment and suffering among affected populations [2]. Systematic assessments and non-centralized policies are essential, alongside efforts to translate promising programs into sustainable public mental health strategies [3]. Refugees and internally displaced persons often face unfair treatment and damaging circumstances wherever they seek protection [22].

Chronic Stress and Social Disruption

Chronic stress and social disruption exert an additional influence on the general population exposed to war. Prolonged armed conflict generates high levels of chronic stress because individuals frequently fear recurrent violence and a lack of safety [23]. Persistent exposure to violence, ongoing community conflict, injustice, and a breakdown of social cohesion and community infrastructure amplify the severity and frequency of traumatic events experienced by the civilian population [21]. These prolonged stressors and traumatic exposures, combined with the bombardment of radio and television messages, contribute to psychiatric syndromes beyond post-traumatic stress disorder (PTSD). Elevated levels of distress, depression, anxiety, and psychosomatic disorders result from a combination of trauma history and chronic stress. Recurrent violence not only intensifies extreme stress reactions but also increases the prevalence of cumulative post-traumatic, general psychosocial, and distress disorders [22]. Experiencing chronic stress over many years, together with the associated symptoms, even in the absence of ongoing traumatic events, can delay or prevent recovery for surviving individuals, especially the most vulnerable [24]. In addition to direct exposure to violence, chronic exposure to stress, compounded by other life stressors, bears a strong relationship to impaired well-being in post-conflict settings.

Access to Care and Societal Infrastructure

Access to care and societal infrastructure are crucial for mental health recovery and reconstruction in low- and middle-income countries, particularly after war or violent conflict [25]. Access to care and established societal infrastructure enable better physical and mental health recovery, but challenges remain in linking humanitarian assistance to longer-term health-system development [26]. In contemporary styles of warfare, civilian populations are deliberately targeted, leading to epidemic levels of traumatic stress. Still, access to services and infrastructure severely limits opportunities for psychosocial care and wider recovery [16]. Studies show access to care and the broader societal infrastructure constitute key interlinked factors influencing the uptake of psychosocial support after large-scale, organized violence [17]. These factors shape opportunities to engage with trauma narratives, which, in turn, connect to the social and material benefits available to war-affected populations through externally supported trauma initiatives [20]. The influence of access to care and infrastructure on the uptake of trauma narratives helps reason why the share of individuals engaging with them is often limited [21].

Resilience, Coping, and Protective Factors

Wartime experiences are not inherently traumatic, and their diverse consequences are shaped by protective factors. Resilience reflects positive adaptation despite exposure to adversity and is associated with reduced mental health problems related to war, violence, or disaster [22]. Particularly relevant factors include optimism, cognitive flexibility, active coping, social support, physical well-being, and an ethical system. War and violence can fuel resilient narratives that promote future-oriented goals, social reciprocity, and meaningful activities, fostering social recognition amidst trauma [27].

Prevention, Intervention, and Policy Implications

Warfare, violent civil conflict, and forced displacement remain scourges of humanity [23]. If consideration is restricted to probable immediate and direct effects, such cataclysms and their associated toll on mental well-being seem malignant, but military and other violent actions are instituted for specific ends. Unhappily, such efforts are rarely recorded to be widely shared, much less have the desired effect [2]. A neglected aspect of probing the effects and consequences of warfare is to study the immediate postwar period with reference to the stressors precipitated and exacerbated by war and the efforts made by governments and intervening bodies, national and international, to relieve them; much of what has been investigated fits directly within the broader category of coping [26]. Many working in this field have reluctantly concluded that, at least in the short term, mental consequences of war, violence, and forced displacement appear to cluster in closely-bound, fixed groups, a process described by various authors as the emergence of trauma [25]. Programs directed at trauma relief appear to require more consideration as international and non-governmental organisations grapple with shifting mental health priorities, the administrative contexts of intervention, and available local resources [21]. The absence of a definition of trauma that could be widely endorsed renders policy formulation an exceedingly difficult task, a silence echoed also by studies of the immediate aftermath of war [1].

Population-Level Strategies

War negatively impacts mental health worldwide. Broad policies encompassing human rights and socio-economic development buffered these impacts before and after wars in various countries [28]; however, no such review exists for conflicts after 2000 [26]. The World Health Organization's Problem Management Plus programme helps adults in distress from such conflicts, while incorporating brief interventions reduced psychological distress in women exposed to gender-based violence [27].

Clinical and Community-Based Interventions

International humanitarian law emphasizes the importance of reducing the mental health impact of violent conflict [17]. However, few social and health systems have developed sufficiently to identify and meet mental health needs. Many clinics and community settings can provide care, but most ongoing interventions have never been systematically summarized [28]. While individually documented interventions can be useful, high-priority gaps and needs are often missed, and information is more useful when systematically reviewed [18]. Therefore, three questions guide a review of clinical and community mental health interventions after conflict: What kinds of services and interventions have been implemented at the clinical or community level?What gaps currently exist in the field?What lessons have been learned from existing clinical and community program implementations?[19]. Intervention studies are scarce, reflecting rampant service gaps; however, existing implementations and guidance from care providers address diverse clinical and community needs [26]. The term clinic includes mental health facilities, hospitals, primary care, and community-based clinics of all kinds, and the term community includes neighbourhood, school, workplace, and other settings [25]. Several other high-impact intervention categories can reduce distress and sickness burden, especially social and economic recovery, and are covered elsewhere [25]. Trauma-focused cognitive behavioural therapy, briefly, safe exposure to perceived threat combined with information lending alternative interpretation of threat, has large positive effects on key safety and coping

variables and has been applied widely, including among affected groups elsewhere, on reconciled policy issues[27]. Community-wide initiatives generally employed returnee care (often limited to stigma), stakeholder engagement to identify and leverage existing community resources, and practical support to help mobilize returnees throughout the transition [29].

Ethical and Methodological Considerations

In the context of war, human suffering leads to mental distress and the emergence of mental disorders. However, studying the consequences of war on mental health raises ethical and methodological issues [22]. To explore the mental health effects of war, priority was given to the exposure of different war-affected populations to adverse experiences, the broad range of mental health problems studied, and a variety of war-affected settings. Research assessing the mental health impact of armed conflicts on displaced persons systematically reviewed studies on the exposed population and the admissibility of findings for research on other war-affected populations [23]. The ethical challenges of systematic reviews of war and mental health reside in the condemnation of atrocities; the suffering of victims and survivors is seldom praised or analysed from the perspective of aggressors or exploiters; and raising awareness of mental health issues is required [28]. Studies focusing solely on mental health problems and interventions associated with detainees or abductees do not contribute to the understanding of the nature and extent of the violence committed [26]. Another systematic examination of the effect of forced displacement confirms the heterogeneous measurement and reporting of refugee status [22]. The range of psychiatric disorders investigated and the same lack of clarity about the measurement of the forced displaced status remains 28. Interventional studies suggest that serious mental health issues are common after forced displacement, although international health organisations advocate for broader mental health policies. Yet, the resilience in different populations affected by armed conflicts remains ignored [25].

Gaps in the Evidence and Directions for Future Research

Little is known about the long-term mental health consequences of war and the role of public mental health systems in addressing these needs [29]. Research has focused mainly on low and middle-income countries experiencing active conflict, while high-income post-conflict settings have been overlooked. Background contexts and fluctuations in levels of violence are rarely integrated into empirical investigations or taken into account theoretically. Data regarding population-level interventions, development of which can be informed by macro-level analyses of the ongoing Syrian crisis, have not been incorporated into systematic reviews of war-related mental health [28]. Specific information on the mental health impact of the Russian-Ukrainian war, the longest military confrontation in Europe since the 1990s, aligns with the review's scope but has been omitted, partly because the situation is still evolving [29]. Recent studies on the deployment and return phases of military personnel, particularly from the United States, have documented short- to medium-term population-level consequences of the Afghanistan and Iraq wars and identified clinically significant effects involving up to 33% of the mobilized forces, continuing attention on this topic[28-33].

CONCLUSION

War remains one of the most powerful determinants of global mental health, producing profound and lasting psychological harm among affected individuals and communities. The evidence reviewed demonstrates that the mental health consequences of armed conflict extend far beyond immediate trauma, encompassing chronic psychiatric disorders, psychosocial dysfunction, and intergenerational effects that persist long after hostilities cease. Populations such as children, women, displaced persons, and combatants bear a disproportionate burden, shaped by cumulative exposure to violence, loss, chronic stress, and fragile support systems. While research has significantly expanded over the past century, major gaps remain, particularly in understanding long-term outcomes, the experiences of low- and middle-income countries, and the effectiveness of scalable, culturally sensitive interventions. Ethical and methodological constraints further complicate efforts to capture the full scope of war-related psychological harm. To address these shortcomings, mental health must be prioritized within humanitarian responses, peacebuilding agendas, and national health systems. Evidence-based clinical and community-focused interventions, strengthened societal infrastructure, and policies centered on human rights and social cohesion are essential for mitigating harm and promoting recovery. Ultimately, building resilient systems and communities is indispensable for supporting post-conflict healing and preventing the perpetuation of violence across generations.

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