



The Public Health Impact of Armed Conflict on Mental Health

The aftermath of armed conflict extends far beyond the immediate physical casualties and destruction of infrastructure; it leaves a profound, often invisible, psychological toll on the surviving population. Historically and epidemiologically, exposure to war acts as a massive catalyst for public health crises, particularly concerning mental health. In the context of recent warfare affecting Iran, public health models and global epidemiological data strongly suggest that the prevalence of psychiatric disorders will experience a significant, sustained increase. Addressing this impending surge requires an understanding of the mechanisms of trauma, the specific disorders likely to emerge, the vulnerabilities of specific demographic groups, and the structural challenges of delivering care in a post-conflict environment (1,2).

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Mechanisms of Psychological Trauma in Conflict Zones

The rise in psychiatric morbidity following a war is driven by both direct and indirect stressors, which often compound one another. Direct stressors include exposure to violence, imminent threats to one's life, physical injury, and the sudden loss of family members or friends. These acute traumatic events trigger profound neurobiological stress responses.

However, the indirect or secondary stressors of war are often equally damaging to long-term mental health. These include forced displacement, the destruction of homes and communities, severe economic instability, unemployment, and the breakdown of social support networks. Furthermore, the disruption of basic services such as access to clean water, food, and routine medical care creates a pervasive environment of chronic insecurity and unpredictability. This combination of acute trauma and chronic daily stressors overwhelms normal coping mechanisms, leading to widespread psychological distress (1,2).

Prevalent psychiatric disorders

Based on global health data from previous conflict zones, several specific psychiatric conditions are expected to see a sharp rise in prevalence:

Post-Traumatic Stress Disorder (PTSD): PTSD is the most widely recognized consequence of war trauma. Individuals may experience intrusive memories, flashbacks, nightmares, and severe

anxiety. A post-conflict environment often contains numerous “triggers” (such as loud noises or ruined buildings) that perpetuate the condition, making recovery difficult without intervention (2).

Major depressive disorder (MDD): The profound sense of loss whether of loved ones, property, or one’s former way of life often manifests as severe depression. The economic devastation that follows war frequently leads to a sense of hopelessness and grief, driving up rates of clinical depression and, consequently, the risk of self-harm or suicide.

Anxiety disorders: Beyond PTSD, generalized anxiety and panic disorders increase sharply. The prolonged state of hypervigilance required to survive during a conflict is difficult to “turn off” once the acute danger has passed (2).

Substance use disorders: As individuals attempt to self-medicate their trauma, pain, and anxiety, public health systems typically record a rise in the abuse of alcohol, prescription medications, and illicit substances (1, 2).

Vulnerable sub-populations

While the entire population is affected, the psychiatric burden is not distributed equally. Certain demographic groups face heightened risks:

Children and adolescents: The psychological development of children is highly vulnerable to the toxic stress of war. Disruption of education, the loss of parents, and exposure to violence can lead to behavioral issues, severe anxiety, and developmental regression. The trauma experienced in childhood can permanently alter brain architecture, leading to lifelong psychiatric vulnerabilities (3, 4).

The elderly: Older adults often suffer from a lack of mobility during conflicts, making them highly vulnerable to isolation, lack of essential medications, and the loss of caregivers (5, 6).

First responders and healthcare workers: Medical personnel, rescue workers, and volunteers face relentless exposure to trauma, death, and suffering. This demographic is at an exceptionally high risk for burnout, compassion fatigue, secondary traumatic stress, and moral injury.

Displaced persons: Those who have been internally displaced face the highest levels of uncertainty. Living in temporary shelters or host

communities strips individuals of their autonomy and community ties, heavily exacerbating depressive and anxious symptoms.

Systemic healthcare challenges

Responding to this surge in psychiatric needs is heavily complicated by the realities of a post-conflict landscape. Warfare inevitably degrades a nation’s healthcare infrastructure. Hospitals and clinics may be damaged, and supply chains for essential psychotropic medications are often disrupted (2).

Furthermore, post-conflict zones frequently suffer from a “brain drain” of medical professionals, resulting in a severe shortage of psychiatrists, psychologists, and trained social workers. Even when resources are available, cultural stigma surrounding mental illness can prevent individuals from seeking help, as they may view psychological suffering as a personal weakness rather than a medical condition requiring treatment.

Strategic public health interventions

To mitigate the long-term psychiatric fallout, health ministries and international organizations typically implement a multi-layered approach to psychosocial support, guided by frameworks such as those provided by the World Health Organization (WHO).

Restoring basic services and security: The foundation of mental health recovery is the restoration of safety, shelter, and reliable access to food and water. Without these basic human needs, psychological interventions are largely ineffective.

Strengthening community and family supports: Interventions must focus on reuniting families, reopening schools, and facilitating community healing practices. Community-based support helps normalize the reactions to trauma and rebuilds the social fabric.

Integrating mental health into primary care: Given the shortage of psychiatric specialists, primary care physicians and general nurses must be trained to identify and manage common mental health conditions, such as depression and anxiety, ensuring broader access to basic pharmacological and psychological treatments (2).

Providing specialized clinical care: For those suffering from severe conditions—such as complex

PTSD, psychosis, or severe suicidality specialized psychiatric facilities and trauma-focused therapies (like Cognitive Behavioral Therapy) must be established and adequately funded (1, 2).

Conclusion

The expected increase in psychiatric disorders following warfare is a predictable public health crisis that requires a proactive, sustained, and well-resourced

response. The psychological wounds of conflict can persist for generations if left unaddressed. Rebuilding the mental health and psychosocial resilience of the population in Iran will require an integration of immediate humanitarian aid with long-term healthcare infrastructure development, ensuring that psychological recovery is prioritized alongside physical reconstruction.

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