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Navigating Mental Health Challenges in Conflict Zones: A Mixed Method Literature Review

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ABSTRACT

According to the World Mental Health Report (2022), 22% of the population living in conflict-afflicted areas have mental health disorders, including anxiety, depression, and Post-Traumatic Stress Disorder (PTSD). Mental health disorders are one of the most serious and underrepresented effects of surviving in conflict-afflicted areas. To investigate the prevalence of mental health disorders and potential risk factors that impact individuals residing in conflict regions and explore their lived experiences. A mixed-method literature review of the studies was conducted between January 2015 to August 2024. It combined substantial evidence from 15 quantitative (n=8) and qualitative (n=6) studies that were exposed to large-scale conflicts in the past ten years. The data was gathered through a range of databases (Google Scholar, Scopus, PubMed, (PsycINFO). Initially, 187 studies were identified, and 51 remained after screening. In total, 15 studies met the inclusion and exclusion criteria. The results suggested that individuals in conflicted areas have a high prevalence of severe mental health disorders like PTSD, anxiety, and depression. Moreover, some risk factors that contributed were persistent exposure to violence, loss of livelihood, and displacement. Consequently, religious and psychosocial coping mechanisms did provide some relief. However, these mechanisms dominated the treatment-seeking decisions and prevented individuals from opting for biomedical healthcare practices. Conclusion: This review highlighted the need for a multidisciplinary approach to curb these areas' growing mental health imbalance. In addition to being a humanitarian right and necessity, providing adequate mental health facilities is a vital component of rebuilding and recovering the affected communities.

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1. Introduction

According to the World Mental Health Report, 22% of the population living in conflict-afflicted areas have mental health disorders including anxiety, depression, and Post-Traumatic Stress Disorder (PTSD) (World Health Organization, 2022). PTSD is a psychological condition that refers to witnessing or exposure to traumatic or stressful situations. It comprises a chain of events or accumulated circumstances that could be natural, social (i.e. violence, confinement, assaults), psychological, war, and conflict (Adler, Svetlitzky, & Gutierrez, 2020). Anxiety refers to excessive fear, nervousness, and anxiousness about upcoming future and unexpected events (Lim et al., 2022). However, depression refers to the state of disperse and low emotions, excessive lethargic feelings (Kurapov et al., 2023). In the conflict zone, the common causes of these mental disorders were disputes among the armed forces, social problems, and displacement from one place to another. Additionally, the residents reported they were prone to

violence and traumatic experiences more frequently (Musisi & Kinyanda, 2020). However, these conflicts raised a significant public health challenge in the conflict or war zone, and as a result, the health care system deteriorated**.** Recently, the devasting impacts of war on mental health can be identified from conflicted regions such as Syria (Peconga & Høgh Thøgersen, 2020), Yemen (Islam et al., 2021), Gaza (Diab et al., 2023), Afghanistan (Naghavi et al., 2022), Ukraine (Roberts et al., 2019), and South Sudan (Metzler et al., 2023), etc.

Literature demonstrated that inadequate healthcare infrastructures and restricted eligibility for mental health services increased the burden of mental illness in conflicted and war zones. Particularly in cases where resources were provided, while people were frequently discouraged from seeking assistance due to cultural stigmas associated with psychological well-being and mental health issues (Carpiniello, 2023). Additionally, cognitive and psychological health problems were not just permanent, but, at the same time, they were persistent in residents because of the cyclical nature of violence and transference (Clark, 2021). This reflected that mental health problems were not just faced by one generation but were transferred to subsequent generations as well (Basheti, Ayasrah, & Al-Qudah, 2023). The purpose of conducting epidemiological/quantitative studies on mental health in conflicted and war zones is to shed light on the severity, prevalence, risk factors, and treatment deficiencies of disorders (i.e., PTSD, anxiety, and depression). However, qualitative studies allow the exploration of lived experiences, coping strategies, and care barriers (i.e., personal, cultural, and social) (Javanbakht et al., 2022; Scharpf et al., 2021). This review article employed the mixed-method literature review approach and included extensive research studies conducted from 2015 onwards. The studies consolidate the findings from conflict/war-afflicted regions like Gaza, Syria, Yemen, Afghanistan, Ukraine, and some regions of Africa (South Sudan) to present an in-depth perspective of the psychological challenges faced by the individuals as well as highlight key epidemiological data and lived experiences of those afflicted by conflict/war.

2. Methodology

The study utilized a mixed-method literature review to comprehensively study the epidemiological/quantitative and qualitative research findings in the conflict-afflicted zones regarding mental health disorders and their occurrence (Mayer et al., 2023). Quantitative literature delved deep into the prevalence rate and other contributing risk factors. The qualitative findings highlighted the lived experiences of the residents, physical, social, and cultural barriers in seeking mental health care, and their psychosocial coping mechanisms.
The inclusion and exclusion criteria for the literature selection are prespecified.

2.1. Inclusion Criteria

The inclusion criteria for the selected studies are given below:

1. Studies focused on refugees, Internally displaced Persons (IDPs), and migrant populations of conflicted/war zones
2. Mental health studies or interventions focused on specific mental health disorders (i.e., PTSD, anxiety, and depression)
3. The studies conducted within 10 years i-e between January 2015 to August 2024 to record the most relevant findings where only large-scale conflicts in the last 10 years were reported.
4. The studies published in English were included
5. Studies conducted in conflict/war-afflicted areas of Africa, Afghanistan, Gaza, the Middle East, South Sudan, Syria, Ukraine, and Yemen

2.2. Exclusion Criteria

The exclusion criteria for the current review are given below:

1. Studies focused on the population that were not residents of conflicted zones or had no psychological problems
2. Studies that assess other mental health disorders (other than PTSD, anxiety, and depression in particular)
3. The book chapters, conference-presented papers, thesis, commentaries, and editorials
4. Studies published in languages other than English

2.3. Search Strategy

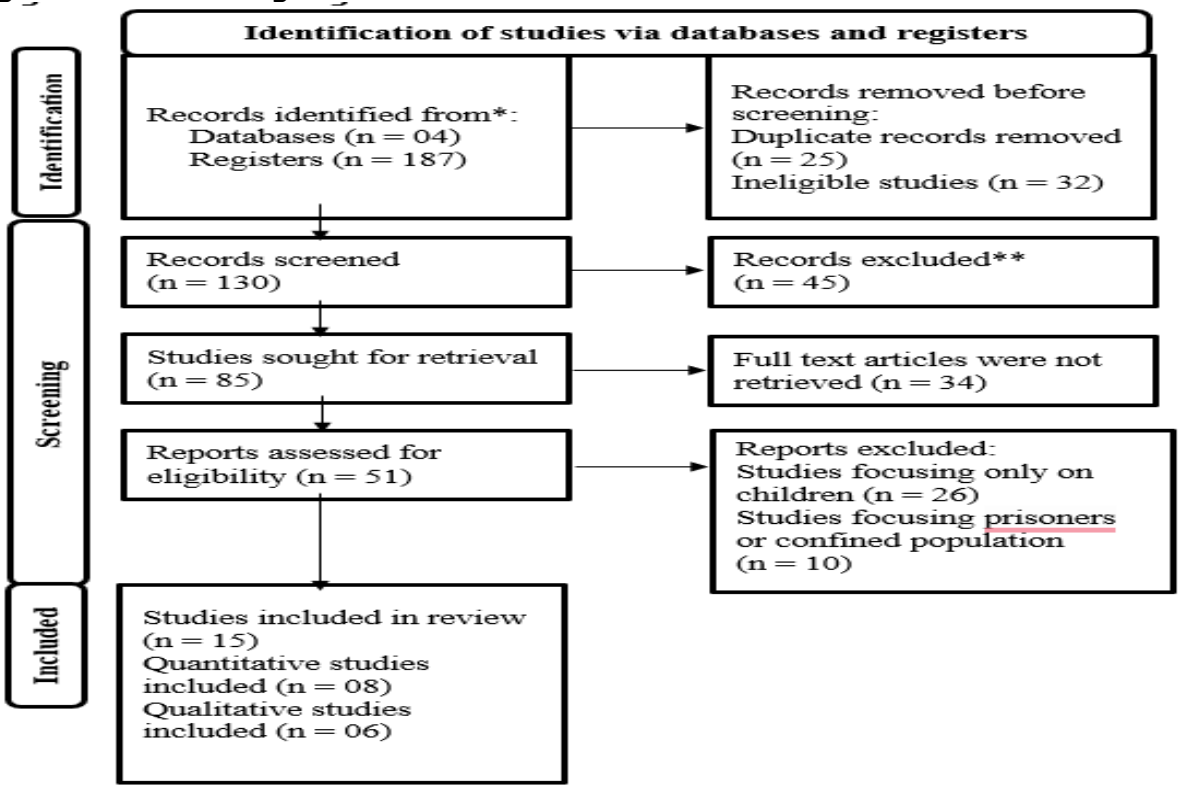
The data was gathered from the following sources: PubMed, Google Scholar, PsycINFO, and Scopus. The keywords used to identify the literature were *mental health*, *conflict zone*, *armed confinement*, *war areas*, *anxiety*, *depression*, *stigma*, *suicide ideation*, *suicide behavior*, *anxiety and depression*, *PTSD*, *mental health* *psychological problems*, *Gaza*, *Afghanistan*, *South Sudan*, *Syria*, *Africa*, *Yemen*, *Ukraine*. In addition, Boolean operators "AND" and "OR" were also used to search relevant literature. However, 187 articles were identified, and after the screening, 51 fulfilled the eligibility criteria, and 15 articles were shortlisted for the detailed analysis (see Figure. 1 below).

2.4. Data Extraction

All the studies were thoroughly skimmed, and an Excel sheet was formulated for data extraction. The spreadsheet contained the following information: authors, year, study locale, type of the study, sample size, study methods, study variables (e.g., disorders), and summary of the findings, limitations, and recommendations. After the first phase of data extraction, if any discrepancies were noted, they were resolved through discussion. The qualitative and quantitative data were reported in a separate table. Five authors independently worked on the literature selection. The review comprised quantitative and qualitative studies. The quantitative studies included were thoroughly studied, and key outcomes were extracted, i-e mental health prevalence, risk factors, and limitations based on treatment provision and treatment availability in the context of the conflict zones.

The qualitative literature was extracted through thematic analysis and highlighted residents' lived experiences and confounding concerns, The researchers familiarized themselves with the data by studying multiple articles and findings, taking notes of prominent patterns, and gaining preliminary insights. The relevant findings were clubbed and labeled under codes. After coding the repetitive patterns, similar codes were clubbed under themes and subthemes. The themes were further organized into broader categories based on recurring ideas and further refined through a literature review to ensure that they were backed up by previous studies. After final confirmation, themes were named accordingly, ensuring that the themes depicted the core meaning and coherence among codes. The studies were ethnographic, observations, or narrative accounts of the residents. Additionally, quantitative (i.e., prevalence and risk factors) and qualitative insights (i.e., lived experience, psychosocial coping mechanism, social and cultural barriers).

Figure 1: Prisma diagram of data included in the review



2.5. Ethical Considerations

Ethical considerations were followed when selecting the studies for the current review. Researchers tried hard to exclude any biases or subjectivity. Context-specific studies were included, and strict data extraction and security protocols were followed throughout the selection process. Moreover, cultural sensitivity and equity were also maintained when disseminating research findings.

3. Results

The current review highlighted the findings from secondary data. The studies incorporated in the review article are summed up in the table.

3.1. Quantitative Findings

3.1.1. Prevalence of Mental Health Disorders

According to the quantitative research findings, the majority of diagnosed mental health problems in conflict zones were anxiety, depression, and PTSD. These studies also regularly showed high rates of prevalence of mental health disorders in these areas (Johnson et al., 2022; Roberts et al., 2019; Schlaudt et al., 2020). These disorders were more common in conflict zones than in non-conflict areas because of both the indirect and direct impact of violence, discord, and uncertainty of life and security (Leshem & Halperin, 2020). A study conducted in Gaza revealed that populations exhibited symptoms of PTSD, anxiety, and depression, causing significant problems in the personal, societal, and daily lives of the residents (Abu El Noor, 2020; Veronese & Pepe, 2022). Additionally, there was a significant impact of gender, age, and living area on the perceptions and experiences of mental health disorders. Another study in Sudan revealed that 68% of the population had major depression symptoms (Awad et al., 2024). Similarly, the WHO World Mental Health Survey conducted in 24 countries reported that 41% of the population had anxiety and depression in conflict areas (Kessler et al., 2015).

In Syria, where civil war had uprooted millions, a study revealed that emotional distress was prevalent at 85%, 77% for anxiety, with 88% expressing depression symptoms (Alsamman, Dajani, & Al-Delaimy, 2024). Likewise, in Yemen, respondents experienced PTSD, depression, loss of sense of self, diminished self-esteem, growth and resilience (Islam et al., 2021). The studies showed the significant psychological impact of prolonged assault and displacement on civilian populations. The findings revealed that 98% experienced at least four traumatic events, 26.1% experienced 5-10 events, and 17.5% experienced more than ten events in the last 27 years (Khalaf Alkaisy et al., 2021).

Mental health disorders were worsened by ethnic warfare in South Sudan. One study suggested that over 20% of the population suffered from severe mental health conditions, with higher rates among refugees (i.e., forced to exile) and those who had been targeted with violence (Ahmead, Abu Turki, & Fawadleh, 2024; Bratti, 2015; Roberts et al., 2019). Another study using a mixed methods research design demonstrated that 40% of respondents experienced anxiety and depression. Regardless of the seriousness of these illnesses, only 10% sought competent mental health treatment, highlighting considerable barriers to getting care in regions of conflict (Blakeney, 2024).

3.2. Risk Factors for Mental Health Disorders

According to the previous literature, the following prevalent risk factors were identified in mental health in conflict zones.

3.2.1. Exposure to Violence

Immediate encounters with violence, whether by watching murders, experiencing bombs, or being physically assaulted, were the most potent indicators of mental health disorders. Children in Gaza who experienced airstrikes or the collapse of their houses were far more likely to display PTSD symptoms (Ahmead, Abu Turki, & Fawadleh, 2024). Another survey of the Ukrainian population demonstrated the prevalence of PTSD (32%), depression (22%), and anxiety (17%) (Roberts et al., 2019). Similarly, the Afghan population demonstrated that 70% of the population was suffering from PTSD, 70% from depression, and 39% had shown suicidal ideation/behavior (Naghavi et al., 2022). Another study from Gaza highlighted that any type of violence, such as witnessing, hearing, and experiencing trauma, impacted the mental health of the participants. Additionally, the literature stated that 85% of youth encountered violence once

in their life (Veronese & Pepe, 2022). Almost 47% of individuals were personal victims of trauma, 71% witnessed traumatic experiences, and 69% heard about the close ones who experienced the trauma. Similarly, research studies also highlighted that depression (55%), anxiety (37%), and distress symptoms (46%) were significantly higher among females as compared to males (Wagner et al., 2019). The research findings suggested that gender and age-specific strategies were needed and gave promising results.

3.2.2. Displacement and Loss of Livelihood

Displacement and loss of livelihoods tend to aggravate stress and alleviate the pessimistic thought pattern among young adults in the conflict zones. Research studies also depicted that age and gender significantly influenced vulnerability. Economic burdens were relieved for families, especially for females, when they lost their husbands and were displaced as well (Krampe, 2020). The forced displacement caused a collapse in social networks and an absence of money, both of which worsened stress and anxiety. In Yemen and Syria, refugees demonstrated higher levels of stress, depression, and PTSD as compared to the ones who remained in their own homes (Kreidie, Kreidie, & HayaAtassi, 2016). This indicated that migration also caused a significant amount of stress and psychological problems in refugees (Khalaf Alkaisy et al., 2021; Tomada & Getty, 2017).

3.2.3. Female Gender and Children

The literature indicated that women and children were more often affected by mental health disorders in conflict and war zones. Women usually bore additional responsibilities related to caregiving, experienced the loss of close relatives, and were at higher risk of sexual abuse (Awad et al., 2024; Bratti, 2015; Roberts et al., 2019). Another study from Palestine highlighted that gender and age group played an essential role in the consequences of traumatic experiences. Findings suggested that females reported comparatively high levels of anxiety, depression, and distress to their male counter-partners (Tol, Song, & Jordans, 2013). Other studies reported that females demonstrated four times elevated symptoms of mental health distress (Ellsberg et al., 2020; Kakaje et al., 2021). In Afghanistan, women were nearly twice as likely as men to develop PTSD (Bendavid et al., 2021). Meanwhile, children were especially vulnerable due to their developmental stages and lack of coping strategies. A study conducted on Palestinian youth revealed that young individuals were more prone to risk of traumatic experience as compared to older groups of society (Purgato et al., 2020). Students and young children stated that they felt lost, and threatened. As a result, their mental health deteriorated to a significant level (Cameron et al., 2021).

3.2.4. Duration of Conflict

The duration of experiencing conflict played a pivotal role in developing chronic mental health conditions. The more frequently someone was exposed to conflict, the more likely it was that they acquired severe psychological conditions (Bendavid et al., 2021; Tombak, 2024). The prolonged Israeli-Palestinian conflict in Gaza resulted in an estimated population in which mental health illnesses were normalized, with many generations experiencing psychological distress (Ahmead, Abu Turki, & Fawadleh, 2024; Khalaf Alkaisy et al., 2021; Veronese et al., 2021).

Another study highlighted that as the duration of violence exposure increased, people did not feel the urge to combat the situation, and they did nothing to overcome the problem (Hammad & Tribe, 2020). They felt more pessimistic, and feelings of remorse and aggression also led to low self-esteem and adverse health outcomes (Holt, 2020). Additionally, people started believing that no one would take a stand for them, and in this way, they felt disabled, and the feelings of hopelessness led them to feel frustrated and low well-being (Kakaje et al., 2022).

3.2.5. Mental Health Services and Access

Availability and access to mental health services in regions of conflict were sternly limited. Findings from Syria, Yemen, and Gaza based on quantitative research showed a significant shortage of psychologists, psychiatrists, and infrastructural resources (Basheti, Ayasrah, & Al-Qudah, 2023; Tombak, 2024). In Yemen, less than 1% of the national health budget was allocated to psychiatric care departments (Islam et al., 2021). Similarly, in Gaza, considering the high prevalence of mental health illnesses, just a few mental health clinics were present, and they were frequently swamped by demand (Veronese et al., 2021). It was noted that governmental policies significantly impacted access to mental health services in conflict zones.

The common reasons were inadequate funding and restricted prioritization, creating significant barriers to opting for mental health facilities. For example, in Syria and Yemen, very limited resources were allocated to mental health services, and in these regions, the only sources were NGOs and non-governmental authorities. However, developed countries focused on mental health services and collaborated with international agencies to alleviate the barriers or stigma related to mental health disorders (Alhariri, Mcnally, & Knuckey, 2021; Shoib et al., 2022). In South Sudan, the healthcare system was severely affected by violence, leading many people to depend on informal community support for psychological care or help. However, these networks were not enough to treat severe conditions like PTSD. It was concluded that stigma was a significant obstacle even when psychological care was available (Awad et al., 2024; Bunch et al., 2020). People avoided seeking treatment due to monophobia (such as fear of being alone) and the stigma attached to mental illness.

Table 1: Summary of Reviewed Articles (2015-2024)

Author(s) & Year	Region	Study Type	Mental Health Disorders Assessed	Key Findings
Quantitative Studies				
Naseer Abu-EI-Noor and Maysoon Abu-EI-Noor (2020)	Gaza	Quantitative	PTSD	PTSD led to detrimental health outcomes (i.e., psychological and physical), personal and social life
Tombak (2024)	Syrian Refugees	Quantitative	PTSD	Findings indicated that refugees and conflict zone residents were more easily affected by mental health disorders (such as PTSD, depression, and anxiety)
Roberts et al. (2017)	Ukrainian	Quantitative	PTSD, depression, and anxiety	Findings indicated that a significant increase in mental health issues was noted due to displacement.
Javanbakht et al., (2020)	Syrian and Iraqi refugees	Quantitative	PTSD, depression, and anxiety	PTSD, anxiety, and depression are more prevalent in the residents
Alkaisy et al., (2021)	Iraq	Quantitative	PTSD	Participants were exposed to traumatic experiences for significant years that impacted their routine life.
Naghavi et al., (2022)	Afghanistan	Quantitative	PTSD, Depression	Study findings revealed that PTSD and depression were prevalent in residents. Additionally, significant suicide ideation/ behavior was noted in participants.
Basheti et al., (2023)	Syrian Refugees	Quantitative	PTSD	Findings indicated that the population was suffering from PTSD.
Veronese et. al., (2022)	Gaza	Quantitative	PTSD, depression, and anxiety	Mental disorders were prevalent in conflicted zones, and there is an urgent need for scalable mental health intervention and persistent availability of resources
Qualitative studies				
Eid G. Abo Hamza et al., (2024)	Gaza	Qualitative	PTSD, depression	The trauma of witnessing warfare has led to an increased prevalence of PTSD and depression among children as well as adults.
Beuthin et al., (2023)	Syria	Qualitative	PTSD, depression, and anxiety	Findings demonstrated that cultural barriers impact care-seeking behavior
Zaid et al. (2024)	Yemen	Qualitative	PTSD, depression, and anxiety	Civil war and COVID-19, and lack of awareness regarding mental illnesses further exasperated the mental health conditions of Yemenis.
Musisi, & Kinyanda, (2020)	Africa	Qualitative	PTSD, depression, and anxiety	Findings highlighted that PTSD, anxiety, and depression are prevalent in conflict zones. Mainly, complex PTSD refers to

				the multiple experiences of trauma.
Afana et al., (2020)	Gaza	Qualitative	PTSD, depression, and anxiety	Loss of sense of self, positive growth, and resilience significantly diminished in the residents of conflict zones.
Al-Shatanawi et al., (2023)	Syria	Qualitative	Depression	The Yemeni people have no access to humanitarian assistance for mental illnesses.
Johnson et al. (2022)	South Sudan	Qualitative	PTSD	Elevated levels of PTSD were reported in the Population

3.3. Qualitative Findings

3.3.1. The Lived Experiences of Conflict-afflicted Populations

Qualitative studies highlighted the lived experiences of people surviving in a conflict-afflicted area. This played a crucial role in understanding the psychological impact it caused on individuals. The in-depth studies conducted in Gaza showed that with constant violence and airstrikes, trauma was a harsh and inevitable reality for many individuals, which perpetuated feelings of immense fear, hopelessness, and helplessness. Trauma, as defined in the Gazan context, was the loss of homes, loved ones, and homeland, and the social and economic hardships that were inflicted on the people through the blockade According to one Palestinian Refugee, "We have lost everything we once owned in this land, we have to grow up fast here as death is around the corner for us." The survivors still find hope amidst the crisis, as per one refugee, "We have lost our homes, but we are still hopeful that one-day things will settle down" (Ahmead, Abu Turki, & Fawadleh, 2024; G. Abo Hamza et al., 2019). Similar themes of fear, hopelessness, and helplessness were recorded in Syria and Yemen. According to one Syrian refugee, "Our biggest fear is not death itself but waiting for death to relieve us from our daily struggle" (Beuthin et al., 2023; McNatt et al., 2019). While in Yemen people expressed their misery of not having access to any mental health services. As per one refugee, "We don't have anyone to talk to; no matter how worse our situation gets, we must stay silent" (Zaid et al., 2024). In Afghanistan, the belief system of the community was the primary barrier that hindered people from acknowledging their mental illnesses explicitly. Spiritual healers were considered appropriate to treat mental health conditions instead of proper doctors. For many Afghanis, mental health is a rather private matter that does not require any external help, as per one Afghani Refugee, "I have extreme anxiety, but my family says that I should feel grateful to be alive, so I keep my suffering to myself" (Farahani et al., 2024).

3.2.2. Psychosocial Coping Mechanisms

The prolonged violence in Syria caused mass displacement and recurrent trauma, upsetting the social order and making grief, fear, and anxiety worse. Affected groups showed signs of anxiety disorder, PTSD, and depression; women and children were especially susceptible (Musisi & Kinyanda, 2020). Reliance on close-knit family structures—which frequently contracted because of displacement—and support systems seen in refugee camps were examples of coping strategies. Nonetheless, loneliness exacerbated this sense of helplessness, particularly for women and children. Many experienced emotions of identity loss and alienation from both their new environment and their own country (Al-Shatanawi et al., 2023).

In Yemen, severe psychosocial anguish was caused because of the continuing civil conflict and humanitarian crisis. The devastation of essential services like healthcare and education has exacerbated an omnipresent sense of insecurity. To deal with trauma, people frequently resorted to spiritual practices, conventional family structures, and community-based support networks. However, psychological suffering was made worse by the collapse of social order, and these support systems were brittle. Yemeni children suffered tough circumstances, with toxic stress impairing their emotional and cognitive growth. According to one individual, "Avoidance is bliss; the less I know, the more I am hopeful that things will be fine" (Zaid et al., 2024).

3.2.3. Social and Cultural Barriers

Stigma and societal attitudes toward mental illness often deterred people from seeking help. Studies in Afghanistan and Yemen found that cultural beliefs defining mental illness as a sign of weakness or curse contributed to low rates of medical care-seeking (Hamadeh et al., 2024). Access to mental health care in Afghanistan was severely restricted by traditional beliefs and gender restrictions, particularly for women. Because of traditional expectations of strength and endurance, women were typically discouraged from talking about personal difficulties,

including trauma or psychological anguish. Many suffered in silence as a result. Adding to the issue was the perception that emotional vulnerability was a sign of weakness among males. Many people lived in rural regions, where there were few professional treatments accessible and a widespread stigma around mental health. According to one Afghan refugee, "Lack of emotional strength is a sign of weakness; anyone who is weak makes this kind of excuse" (Farahani et al., 2024). Yemen's mental health crisis was made worse by a dearth of institutional mental health services infrastructure and awareness. Due to cultural perceptions of mental illness, people frequently turned to traditional healers rather than the severely underutilized official psychiatric facilities. The stigma and ignorance around mental health remained pervasive, and there was a notable dependency on community- or religious-based solutions that were not sufficient to address severe psychological illnesses. Furthermore, because women were frequently expected to put the needs of their families before their health, gender norms restricted the access that women had to mental health care. As per a Yemeni refugee, cultural beliefs are a deciding factor for looking at mental illnesses (Musisi & Kinyanda, 2020; Zaid et al., 2024).

In Gaza, societal disintegration, persistent conflict, and relocation had a significant negative impact on mental health. The neighborhood no longer felt secure due to ongoing threats to personal safety, forced relocation, and house demolition. According to studies conducted after several wars in the area, family member losses and forced separations caused a great sense of sadness and loneliness and disturbed people's desire for love and connection. In addition to experiencing a disturbed sense of normalcy and the loss of educational opportunities, children struggled with increased anxiety, sleep difficulties, and behavioral problems like bedwetting. According to a Palestinian living in a camp, "Most of the children in my camp have night tremors, as we don't have any access to any psychiatric facilities, we are only left with religious coping mechanisms of instilling hope that things will get better" (Afana et al., 2020). In South Sudan, people are influenced by cultural beliefs which often dictate their treatment-seeking decisions, instead of turning to healthcare professionals, people turn to religious figures and community leaders relying on healing practices that are a blend of religion and culture. There is a lot of mistrust among the people towards the healthcare professionals as well, due to the fear of bringing shame to family people tend to keep their mental health problems to themselves. As per a Sudanese refugee," We only trust our family, opening up to a doctor even is extremely difficult for us as the fear of being misunderstood is always there" (Mena & Hilhorst, 2022).

4. Discussion

The findings from the articles reviewed provide sufficient evidence of the mental health burden that individuals in conflicted territories face. Rates of mental disorders like depression, anxiety, and PTSD are prevalent across conflicted regions like Gaza, Syria, Yemen, Ukraine, South Sudan, and Afghanistan as compared to non-conflicted territories. The population suffering from mental health disorders is a direct result of years of trauma due to warfare. Several trends like exposure to violence, loss of livelihood, displacement of individuals, and duration of conflict emerged from the epidemiological data that suggested that these factors were the primary factors that drove mental health disorders in conflicted zones. In Gaza, due to the ongoing military strikes and overall violence exasperated PTSD and anxiety, especially among young adults, with the rates of PTSD reaching up to 38% among the overall population (G. Abo Hamza et al., 2019). In Syria and Yemen, where people had lived through protracted periods of political unrest and bloodshed, similar trends were apparent. The percentage of people in these areas with PTSD ranged from 30 to 40%, and a sizable portion also experienced anxiety and sadness (Hamadeh et al., 2024). The results of the current study confirm the hefty amount of data that supports the notion that mental health disorders are significantly triggered by the traumatic experiences that individuals in conflict are exposed to Al Ibraheem et al. (2017); Tomada and Getty (2017).

Secondly, the war/conflict revealed the gendered vulnerability of one gender as the prime affectees of the wars were mostly women and children. In a study conducted in Afghanistan on the prevalence of mental disorders, it was found that the probability of women suffering from PTSD was twice that of males (Bendavid et al., 2021). These findings confirm the findings of the research conducted in Gaza and South Sudan which concluded that the increased prevalence of mental health disorders in women was directly related to their lived experiences of sexual abuse, caregiving duties, loss of family members, and social isolation (Bunch et al., 2020; Veronese & Pepe, 2022). The children of conflicted areas like Syria and Gaza were especially vulnerable to

mental health disorders because of the intensity of the atrocities they were subjected to, such as the destruction of their houses and the killing of their loved ones (Bendavid et al., 2021; G. Abo Hamza et al., 2019). One of the important findings of the review was that getting mental health care in conflicted areas was significantly hampered. The locations that were conflict-afflicted lacked basic mental health care. In a study conducted in Yemen on mental health facilities, it was confirmed that for the millions of individuals subjected to violence, the area lacked sufficient mental health professionals and mental healthcare facilities (Islam et al., 2021). According to a study conducted in Gaza on the healthcare structure, it was found that the destruction of most of the health infrastructure and the presence of a strong blockade led to an increased risk of mental health illnesses (Abu El Noor, 2020). One of the main hurdles that restricted people from seeking mental health care was the social and cultural stigmas that promoted religious and cultural healing methods instead of biomedical treatment. The research studies conducted in Afghanistan and Yemen on the traditional healing methods revealed that mental or psychiatric illness was viewed as a spiritual torment and a sign of weak beliefs, which ultimately led to people altering their treatment-seeking decisions in favor of traditional healing methods (Abu El Noor, 2020; Farahani et al., 2024; Zaid et al., 2024). Violence-afflicted communities utilized psychosocial coping mechanisms to cope with the atrocities they were subjected to. In Syria and South Sudan, informal therapy mechanisms like religious rituals, informal talks with elders, and community support networks greatly improved mental health (Bunch et al., 2020; Musisi & Kinyanda, 2020).The findings of the current study aligned with the mounting global evidence confirming that although informal therapy mechanisms did provide some relief, they failed to address the complex nature of mental health issues that were related to trauma. In addition to traditional treatment options, biomedical treatment options should be put into practice (Alqahtani et al., 2024; Bratti, 2015).

Trauma affected several generations in places like Gaza, where the fighting has persisted for decades. Children, therefore, grow up in a perpetual state of anxiety and insecurity, which causes an intergenerational inheritance of mental health problems (Carpiniello, 2023). Children were prone to developing mental health problems significantly because they witnessed their elders and society suffering long-term mental and physical torture. Researchers reported that children who were born and brought up in the conflict zone had a high risk of developing anxiety, depression, and prolonged stress (Jayuphan et al., 2020; Wagner et al., 2019). Additionally, mental health problems can also be alleviated because of the confinement and conflict duration. Similarly, a study conducted in Gaza demonstrated that due to long-term violence and conflict mental health was diminished. However, the low levels of self-esteem and self-identity were noticed among residents (Abudayya et al., 2023; Diab et al., 2023). The findings confirmed that the burden on mental health was increased by the normalizing of trauma and the lack of sustainable treatments, depriving many of hope for a return to normality. Furthermore, because communities were frequently forced to migrate several times, the cyclical pattern of violence and displacement posed challenges to the implementation of sustainable mental health interventions (Bratti, 2015).

4.1. Limitations

Although this study offers an extensive examination of the epidemiology of mental health issues in conflict areas, it is essential to recognize that it has several limitations:

4.1.1. Data Gaps in Certain Regions

A good amount of recorded data from conflict zones like Gaza, Syria, Yemen, Sudan, and Ukraine research from other conflict regions, especially in sub-Saharan Africa and Southeast Asia, is conspicuously lacking. This regional imbalance constrains the findings' applicability to all conflict situations.

4.1.1 Methodological Variability

The evaluated studies exhibit significant variation in their methodological methods, specifically the diagnostic instruments employed for the evaluation of mental health illnesses. While some studies employ clinical diagnostic techniques that may not always be culturally appropriate, others rely on self-reported symptoms, which might result in under- or overreporting.

4.1.2 Cultural Sensitivity

Although qualitative research can provide insightful information about real-world experiences, it's possible that some cultural and religious influences on mental health in conflict areas are missed. To completely comprehend the social aspects of mental health, further research that is sensitive to cultural differences is required.

4.1.3 Language Barriers

Language barriers in reporting research are faced in regions like the Middle East, Central Asia, and Latin America. In these regions, studies are published in languages such as Arabic, Spanish, Russian, etc. This may hinder researchers from using multilingual findings. However, future studies can benefit from such research studies in gaining further insights from these conflicted territories.

4.2. Future Implications

Many prospective research avenues are suggested to solve the limitations and difficulties that currently exist in the field of mental health epidemiology in conflict zones:

4.2.1. Longitudinal Studies

More long-term research is needed to track mental health outcomes. Conflict-affected populations experience mental health changes over time. These studies would offer valuable information for better understanding of the Mental health shifts before, during, and after the conflict. The research might help in creating long-term treatment strategies.

4.2.2. Intervention-Based Research

Additional research is required to assess mental health treatment effectiveness. Conflict-affected communities need more studies on mental health interventions. Intervention studies should evaluate various community-based treatment strategies. Trauma-focused cognitive-behavioral therapy (CBT) is one approach to consider. Community-based interventions may provide significant mental health support. Professional interventions should be compared with community-driven strategies. These studies are crucial for improving mental health treatment outcomes.

4.2.3. Geographic Expansion

Underrepresented conflict regions like Sub-Saharan Africa, Southeast Asia, and Latin America should be included in future studies. Conducting research over larger areas improves overall data accuracy. Geographic diversity in studies helps uncover broader mental health trends.

4.2.4. Combining Mental Health Care with Humanitarian Aid

Humanitarian aid operations should take into account mental health. The existing humanitarian aid framework should inculcate mental services to the aid operations of these conflict areas.

4.2.5. Culturally sensitive interventions

Interventions that take into account the sensitive nature of cultural influence and social barriers need to be developed skillfully. This will allow more acceptance of mental health treatment.

5. Conclusion

Mental disorders in conflict-afflicted areas with high rates of PTSD, anxiety, and depression are a serious public health threat. The mental health crisis of these regions is exasperated by factors like the prolonged duration of the conflict, cultural stigma, human displacement, and the destruction of healthcare infrastructure. This review attempted to combine qualitative perceptions and quantitative epidemiological findings to address the debate surrounding the prevalence of mental health issues in conflict zones. Implementable solutions for mental health in conflict zones should be considered, including long-term resilience development and expanding digital services and community support. Additionally, mental healthcare provision should be incorporated in primary healthcare settings. Capacity building and trauma-focused therapy should be used to manage the unrest or chaotic situation. In the circumstances mentioned above, mental health providers and stakeholders can collaborate to

diminish the mental health burden among at-risk populations, develop resilience, and make recovery more adaptable. This review also highlighted the need for a multidisciplinary approach to curb these areas' growing mental health imbalance. In addition to being a humanitarian right and necessity, providing adequate mental health facilities is a vital component of rebuilding and recovering the affected communities.

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