UNIDIR

MANAGING EXITS
FROM ARMED CONFLICT

MEAC RESEARCH INTO ACTION

What Do We Know About Mental Health Support in War?

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October 2026

Background

About MEAC

UNIDIR's Managing Exits from Armed Conflict (MEAC) is a multi-year collaboration that examines why and how individuals exit armed groups and sustainably reintegrate into civilian life. Employing multi-method longitudinal studies that follow the trajectories of former armed group affiliates and their non-associate peers across six countries, MEAC seeks to inform evidence-based prevention and reintegration programming. The MEAC project benefits from generous support by the German Federal Foreign Office (GFFO) and is run in partnership with the International Organization for Migration (IOM); UNICEF; the UN Development Programme (UNDP); the UN Department of Peace Operations (DPO); the World Bank; the Secretariat of the Regional Strategy for Stabilization, Recovery and Resilience in the Lake Chad Basin; and United Nations University Centre for Policy Research (UNU-CPR).

About this Series

MEAC produces a series of short publications aimed at policymakers and practitioners to highlight key findings but recognizes that there is relevant research on the subject that may remain inaccessible to them. In an effort to make these studies, which are often highly technical and/or sit behind academic journal paywalls, accessible to decision-makers and to connect them to the evidence base MEAC is creating, UNIDIR has introduced this interview series. In this series, MEAC takes the role of an interlocutor, bridging the gap between academic research and practical application by presenting brief interviews with scholars on pertinent topics. What follows is a short, digestible dialogue around the main findings of a recent study and their policy and practical implications for those working to prevent and respond to political violence and armed conflict.

Citation: Stéfanie Fréel[1], Janne Punski-Hoogervorst[2], Chris Hoeboer[3], "What Do We Know About Mental Health Support in War?", *MEAC Research into Action,* UNIDIR, Geneva, 2026, https://doi.org/10.37559/MEAC/26/05.

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Overview

The scoping review "Mental health and psychosocial support interventions for populations affected by ongoing armed conflict: a scoping review"[1] summarizes existing evidence on mental health and psychosocial support (MHPSS) interventions for populations affected by ongoing armed conflict. Surveying the peer-reviewed literature, it outlines evidence gaps and proposed strategies to strengthen research and evaluation systems for MHPSS in these settings. A related position paper proposed recommendations for addressing critical gaps in support in scalable, culturally responsive ways.

The review examined research related to interventions implemented in active armed conflict settings and their associated mental health outcomes. Overall, the results were mixed, varying based on the population type and specific outcomes studied. Of the 47 papers included in the scoping review, 19 exclusively focused on children and adolescents, 14 exclusively on adults and 14 on both children/adolescents and adults. Many studies reported statistically significant positive outcomes in both adult civilians and ex-combatants with respect to decreased post-traumatic stress disorder, depression and anxiety symptomatology and improved psychosocial functioning, well-being and quality of life. Results were more mixed in children/adolescents and when specifically examining aggression, drug dependence and social/interpersonal skills in ex-combatants. Across all population groups, included studies examined both psychosocial and evidence-based psychotherapeutic interventions, though only 12 papers investigated specifically trauma-focused approaches to treatment.

Interview

1. ***What are the biggest challenges researchers and those implementing MHPSS programme assessments face when trying to measure mental health outcomes in conflict zones?***

Beyond ensuring that assessments do no harm and keeping investigators, providers, participants and communities alike safe, working in conflict zones also presents methodological hurdles to conducting impact assessments. Decisions surrounding outcome measurement tools affect *which* aspects of mental health are the focus of research and *how* these are evaluated and reported on. While not specific to active armed conflict settings, this may present challenges when attempting to draw meaningful conclusions concerning the impact of conflict-related adversity on individuals' mental health. The use of disparate diagnostic or screening tools in conflict settings may result in different mental health outcomes being reported across contexts, which are not necessarily due to the population or setting itself but rather to how mental health status is being measured. This heterogeneity also means that

disparate – and sometimes conflicting – findings may be reported within the same context or populations.

While not specific to conflict zones, another significant challenge facing researchers working in them is the cultural validity and appropriateness of mental health measures used, including whether these capture mental health constructs relevant to the local culture and aligned with communities' conceptualizations and expressions of mental (ill-)health. While psychological distress is characterized by physical ailments, spiritual or religious distress, or collective anguish in many cultures, the majority of tools used to measure mental health outcomes were developed in Western, individualistic cultures following a traditional biomedical model.

Finally, a significant challenge lies in the inherent need to adopt a reductionist approach when carrying out research in real-world contexts, whereby a tightly defined set of variables are used to effectively quantify cause-effect. While necessary, the multifaceted, complex dynamics affecting the lives of populations impacted by conflict may often be overly-simplified when controlling for potential confounding effects on the outcomes being assessed. This might include the historical and socio-cultural processes involved in generating – and maintaining conflict, institutionalized forms of oppression and discrimination, and the multidimensional experiences of adversity and hardship associated with experiences of war, displacement, migration and resettlement affecting both the dependent (effect) and independent (cause) variables being studied.

2. ***Most of the sources you reviewed are peer reviewed academic articles, suggesting that the evidence in question was collected by specialists and to a certain level of quality. There is likely a much bigger body of work in this space, but it may sit internal programme assessments or related grey literature. Can you speak a little about the utility of the latter, including specifically how programme assessments could be elevated to bolster the evidence base on MHPSS interventions in conflict settings?***

Peer-reviewed research helps quantify mental health burden, validate screening and assessment tools, evaluate interventions, and assess the generalizability of findings across populations and contexts. It also informs understanding of how mental health constructs vary across cultures and settings, guiding the development and implementation of culturally and contextually appropriate interventions in conflict settings.

In conjunction with existing peer-reviewed literature lies a wealth of knowledge derived from the design and implementation of MHPSS programming in conflict, and broader humanitarian, settings. Evidence captured in the grey literature can offer insights into approaches, programs and interventions applied "in action" in the real-world, with a relatively large number of individuals. These programs reflect the accrual of procedural and tacit knowledge by those working for local and global non-governmental organizations, multilateral or development

agencies across diverse settings, whereby "what works" is quickly and effectively replicated and what does not is removed or iterated upon. While this knowledge is rich, diverse and highly complementary to peer-reviewed research, it is rarely systematically captured or reported on.

This does not need to be the case, and a few modest actions could help elevate this knowledge. First, while academic databases offer repositories for peer-reviewed research, no structured equivalent currently exists for knowledge captured in the grey literature. Cataloguing non-academic findings into a common, searchable online database would greatly facilitate access to knowledge held by humanitarian actors working in the field and foster knowledge transfer between academic researchers and interdisciplinary practitioners. Second, a minimum set of common research standards could be created to support quality reporting of field-level programmatic findings (e.g., sample sizes, research design, participant recruitment, consenting and data analysis processes). Third, while increasing opportunities exist for academic researchers and humanitarian practitioners to collaborate, and as a result field level programs continue to be developed with limited consultation of the peer-reviewed literature and academic research still operates in a vacuum, divorced from on-the-ground realities. Efforts to integrate research and practice (e.g., creating in-house research units with practitioners, establishing networks supporting structured knowledge transfer) would go a long way in elevating the quality and relevance of both peer-reviewed and grey literature.

3. ***Many of the interventions covered by this study were initially developed in Western, Educated, Industrial, Rich, and Democratic (WEIRD) countries employed in peacetime (even if for those impacted by war exposure). Can you speak a little about the cultural relevance of some of these interventions and how they can be made more culturally relevant and better contextualized to meet the needs and realities of those in active conflict settings?***

Evidence-based psychological interventions developed in WEIRD settings by western providers to address the needs of local populations constitute a significant ongoing gap in the literature. While various treatment approaches developed in western contexts, such as cognitive behavioural therapy (CBT) and Narrative Exposure Therapy (NET), have demonstrated effectiveness against the biomedical outcomes used in assessment tools developed in WEIRD settings, across a variety of contexts and populations, our scoping review indicates that little information tends to be reported surrounding cultural and contextual adaptation processes.[4] That is to say while robust assessments suggest the relative universalism of the mechanisms underpinning these treatment modalities, there are questions about the sustainability of their impact over the medium- to long-term if western-based

[4] It should be noted that these omissions do not necessarily represent an absence of cultural adaptation but rather point towards ongoing gaps in systematic reporting of these processes in the existing literature.

approaches do not embed local cultural understandings and expressions of mental health and trauma.

A few steps can be undertaken to ensure interventions are more culturally relevant and more contextually attuned. Specific attention should be given to the conceptual paradigms used when assessing needs and designing interventions, ensuring that these are grounded in an understanding of local populations, context and culture. Specifically, frameworks seeking to empower individuals and communities to (re-)build their own psychological, social and cultural resources to heal may go a long way in reducing unintended harm and promoting recovery and fostering pathways to peace in conflict settings. Additionally, the adoption of multilevel frameworks examining the impact of conflict across individual, family, community and broader societal levels are needed. These frameworks would allow for a broader understanding of mental health outcomes across contexts, while accounting for the impact of structural factors, politico-historical processes and systemic power dynamics in maintaining cycles of conflict or mental ill-health. This may represent an important starting point within which to more comprehensively embed and tailor evidence-based interventions.

Moreover, validation of both standardised and culturally adapted clinical and psychosocial assessment tools and measures with populations in conflict could help both capture the broad array of trauma-related symptoms and psychosocial impairments and assess clinical worsening among affected populations. Similarly, the creation and application of a common cultural adaptation protocol across contexts may be useful in enhancing approaches to cultural adaptation and contextual attunement. Additionally, assessment tools and evidence-based interventions need to address cumulative, and often complex, conflict-related traumatic experiences to both improve mental health and psychosocial outcomes and address recurring cycles of violence. Finally, the meaningful involvement of people with relevant cultural and lived experience in the development and implementation of mental health interventions represents a prerequisite to ensuring cultural relevance, acceptability, and ownership.

4. ***In 2025, the world hit a grim milestone, there were 65 active conflicts – the highest number recorded since 1946 – with over two billion people affected. From the scoping review, did you draw any lessons about how to scale up interventions to reach a larger segment of the growing population of war affected peoples especially in light of dwindling humanitarian resources and access challenges?***

While the scoping review focused primarily on intervention outcomes, it also revealed important lessons learned for scale. First, in our scoping review, we noted that most interventions were delivered by local lay leaders (e.g., community and religious leaders), who can play an important role in the effective implementation and scaling of mental health interventions, helping overcome gaps in the availability of healthcare professionals and stigma surrounding seeking mental health support. This is relevant not only from a sustainability perspective but from a cultural and contextual attunement standpoint: engaging lay leaders, who are intrinsically embedded into the social and cultural fabric of implementation settings, means empowering local ownership of interventions, facilitating trust and rapport between participants and implementer(s), and supporting cultural competence and safety. Effectively partnering with lay leaders also must include through training and capacity strengthening underpinned by appropriate safeguards.

Second, while not novel, implementation in non-clinical and non-mental health settings (e.g., schools, sports activities, places of worship] can play an important role in increasing access to mental health interventions both by overcoming stigma associated with seeking care and facilitating easy access. This approach is directly aligned with the World Health Organization's ongoing efforts to promote mental health across all sectors.[5]

Third, balancing evidence-based psychotherapeutic principles with cultural and contextual attunement is central to ensuring intervention acceptability and scalability. In doing so, particular attention should be given to centering the voices of local communities, adopting culturally-grounded conceptualizations of mental health, and understanding both convergence and divergence in symptom manifestation across populations and cultures.

[5] World Health Organization, "WHO Launches New Guidance to Promote Mental Health across All Government Sectors," November 24, 2025.

5. ***Many studies focus on reductions in PTSD or depression, but outcomes like social functioning, relationships, and reintegration are also critical. How should researchers and practitioners broaden their understanding of "success" in MHPSS programmes?***

While MHPSS programming is intrinsically intersectoral in nature, traditionally clinical paradigms of mental health have been more systematically assessed than psychosocial metrics. This is in part because clinical outcomes are better quantified and easier to measure, and there is little consensus on which psychosocial constructs (e.g., social functioning, social cohesion) to measure and the relative absence of validated instruments to do so.

This presents a dilemma: the need to build stronger consensus surrounding psychosocial constructs, outcomes and associated measurement tools while seeking to broaden our definition of mental health by embracing a broader array of methodological approaches and theoretical frameworks used to define and measure it. This requires supporting the creation of interdisciplinary research teams, embedding practitioners in research processes – and researchers in practice, and developing methodological frameworks, designs and approaches that allow for the integration of a plurality of disciplinary viewpoints and outcome measurements. No easy feat! A move away from pathologization and strict clinical symptomatology measurement to approaches aimed at promoting mental health wellbeing and resilience building could further help promote contextual attunement and cultural relevance.

6. ***In the review, there are only a small number of studies focused on trauma-specific interventions. Why do you think trauma-focused care is still underrepresented in active conflict settings, and what are the implications of this gap?***

While widely accepted in MHPSS practice, trauma-informed approaches represent a relatively new construct. As is the case with any innovation or novel idea, the systematic integration of trauma-informed practices and approaches into MHPSS programming may require time for adoption.

On a more practical level, conventional trauma-focused interventions generally assume at least some degree of safety and stability which cannot be ensured under conditions of active armed conflict. For this reason, practitioners may be hesitant to undertake trauma-informed treatments. In addition, trauma-focused interventions typically require training, supervision, privacy and continuity of care, all of which may be difficult to provide in active armed conflict settings. Given time pressures and contextual demands, practitioners may be more likely to favour low-intensity, non-specialist interventions that may be more easily scalable to a larger number of individuals and communities in need. Practitioners may find assessing the appropriateness of trauma-focused treatments challenging when the boundaries between

acute psychological distress and more chronic trauma-related symptomatology or psychopathology are difficult to pinpoint amidst shifting conflict dynamics and ongoing violence.

7. *What are the most important implications of your findings for policymakers and practitioners as they design and resource mental health responses in active conflict settings today?*

Our review points to five key recommendations for policy and practice, which are expanded upon in a recent position paper we published. First, research on, and assessments of, MHPSS interventions in contexts of active armed conflict are complex but feasible provided the right conditions and safeguards are in place. This research needs to be highly contextualized and ideally carried out in partnership with local actors, grounded and driven by the needs of communities with effective measures to prevent the aggravation of conflict. For this reason, the inclusion of conflict-sensitive risk assessments should form part of minimum research standards put forward by international development and global mental health funders.

Second, one of the most effective routes to sustainable scaling of mental health interventions is the meaningful engagement of lay leaders. Task shifting within health and social workforce teams, and capacity building of lay community members supported by digital tools, represents an important means of overcoming challenges related to gaps in trained mental health human resources and mental health system financing. In this respect lay leaders, should be considered broadly – including peers, community and religious leaders, and more consistently be embedded in MHPSS programming activities.

Third, the implementation of MHPSS interventions in non-specialised mental healthcare settings (e.g., community centres, places of worship, schools), including the integration of evidence-based intervention components into existing, non- health- specific activities (e.g., education, spiritual practice) represents an important entry point to addressing stigma surrounding seeking and accessing treatment. For this reason, donors should consider how funding structures can best incentivize the effective operationalization of intersectoral programming on the ground and mental health streamlining across sectors. Such intersectoral approaches may also open new avenues for local ownership and sustainable MHPSS system strengthening when codeveloped through meaningful engagement of conflict-affected communities, grounded in reciprocal learning and implemented through a phased approach.

Fourth, a focus should be set on the validation of both standardised and culturally adapted clinical and psychosocial assessment tools and measures—with particular attention to transdiagnostic instruments, across contexts, populations and cultures—to both capture the broad array of trauma-related symptoms and psychosocial impairments and assess clinical worsening among conflict-affected populations. Actors such as the World Health Organization, in partnership with local professional associations, MHPSS practitioners and lived experience experts, could play a key role in harmonizing processes to broaden disease-specific

categorizations in diagnostic classification systems such as the International Classification of Diseases (ICD), develop and validate transdiagnostic instruments, and adopt a common set of cultural adaptation guidelines.

Finally, community-driven approaches to intervention development and implementation should be prioritized – both by global donors and implementing organizations in the field, grounded in the needs of local populations and informed by the contextual realities of conflict and cultural understandings of mental health. The integration of western evidence-based treatment components should be conducted within the cultural frame of reference relevant to local populations and communities rather than transposed across vastly disparate contexts.

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