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Silent Casualties: Depression and Moral Injury Among Healthcare Workers in Active and Post-Conflict Zones

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Abstract

This paper examines the psychological consequences of war on a group that is frequently overlooked in both academic research and public awareness: frontline healthcare workers. While existing literature on war and mental health has focused predominantly on soldiers and civilians, medical staff who serve in active conflict and post-conflict zones carry a distinct and underexplored psychological burden. This review focuses specifically on two outcomes: clinical depression and moral injury, both of which emerge repeatedly in the limited studies that do exist on this population. The findings reveal that healthcare workers in war zones suffer significant and lasting psychological harm, yet receive remarkably little institutional support or academic attention. They are neither recognised as victims of war nor protected as essential workers within it. This paper argues that this neglect is not only a humanitarian failure but a public health problem, since the mental collapse of medical staff directly affects the quality of care available to entire conflict-affected communities. Greater research attention, stronger policy frameworks, and dedicated psychological support systems are urgently needed for this invisible casualty of war.

Keywords: Depression, Moral Injury, Healthcare Workers, War, Armed Conflict, Post-Conflict, Mental Health, PTSD, Burnout, Frontline Medical Staff, Psychological Distress, Conflict Zones

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1. Introduction

War is one of the most destructive forces in human history, and its effects on public health extend well beyond the battlefield. While the casualties of combat receive widespread attention, there is a quieter group of people whose suffering tends to go unnoticed: the doctors, nurses, paramedics, and other healthcare workers who remain in conflict zones to provide medical care. These individuals are exposed to experiences that most people cannot imagine, including treating mass casualties, working without adequate medicine or equipment, facing personal physical danger, and making decisions about who receives care when resources simply do not allow for everyone to be treated.

It might be tempting to assume that medical training prepares people for such situations, but evidence increasingly suggests otherwise. The psychological toll of working in a war environment is severe and often long-lasting. Depression is one of the most commonly reported outcomes, but it is not the only one. A growing body of research has begun to pay attention to something called moral injury, which refers to the psychological damage that occurs when a person is forced to act against their own values, or when they are prevented from doing what they believe is right. For a nurse who watches a patient die because there are no supplies, or a doctor who must decide which wounded person to prioritise, the emotional aftermath is distinct from what soldier's experience after combat, and it requires its own understanding.

The inspiration for this paper grew from a creative writing project undertaken as part of a college initiative, in which the author was responsible for developing a character who was a medical staff member deployed into a war zone. The process of writing that character's experience brought into sharp focus something that is rarely discussed in public discourse: the psychological burden carried specifically by healthcare workers in conflict settings. Unlike soldiers, who are trained for combat, or civilians, who are recognised as victims of war, medical staff occupy a uniquely difficult middle ground. They are trained to handle blood, injury, and death in clinical settings, but war presents these realities on an entirely different scale and with an entirely different emotional weight. The repeated exposure to mass casualties, the inability to save everyone, and the collapse of normal medical infrastructure creates conditions for long lasting psychological harm that is distinct from anything experienced in peacetime medicine. Despite this, the existing body of literature on war

and mental health focuses overwhelmingly on soldiers and civilians. There are countless studies, books, and films exploring their experiences. Healthcare workers, by contrast, remain largely invisible in this conversation. This paper is an attempt to change that.

2. Literature Review

Most of what we know about the mental health effects of war comes from studies of soldiers and veterans (Mollica et al., 2004; Murthy & Lakshminarayana, 2006). Decades of research following conflicts in Vietnam, the Gulf, Afghanistan, and Iraq have produced a detailed picture of combat-related post-traumatic stress disorder, depression, and anxiety among military personnel. The National Vietnam Veterans' Readjustment Study (Kulka et al., 1990), which is frequently cited as a landmark in this field, found that nearly one in five participants had a lifetime history of PTSD, with depression and alcohol misuse appearing as common alongside conditions.

Research on civilian populations in conflict zones has also grown considerably (Charlson et al., 2019). A wide-ranging meta-analysis published in Frontiers in Psychiatry in 2022 (Lim et al., 2022), which drew on seventy studies published between 1982 and 2021, found that rates of depression in war-affected populations were around 38.7 percent during active conflict and fell to approximately 26.2 percent in post-conflict periods. These are significant numbers, and they paint a clear picture of the scale of mental health need in communities affected by armed conflict.

What is notably absent from most of this research, however, is sustained attention to healthcare workers as a distinct group. When medical staff appear in these studies at all, they tend to be included as part of a broader civilian category or treated as a minor subgroup. This is a serious gap, because the experience of a doctor or nurse in a war zone is qualitatively different from that of a civilian survivor or a combatant. Healthcare workers carry both the burden of personal exposure to violence and displacement, and the additional weight of professional responsibility for others, often without the institutional support that military personnel may receive.

A qualitative study published in 2024 (Legesse et al., 2024), which examined the lived experiences of healthcare workers at Ayder Comprehensive Specialized Hospital in Tigray, Ethiopia during the conflict there, offered some of the most direct testimony available on this subject. Participants described feeling helpless and deeply distressed by their inability to provide adequate care due to

supply shortages caused by the war. One healthcare worker described thinking about how they had reached what they called a kind of hell, feeling anxious and sad, and at times experiencing deep grief when they realised they could no longer treat patients who might otherwise have survived. These accounts reflect something that goes beyond ordinary occupational stress. The concept of moral injury becomes especially real when considering situations where healthcare workers possess the knowledge and skill to save a life, but lack the basic equipment to do so. Watching a patient die not because medicine failed, but because a war destroyed the supply chain, creates a wound that goes far deeper than grief. It is the psychological damage of knowing what could have been done, and being powerless to do it. This form of distress, rooted in professional helplessness rather than fear, is what distinguishes the experience of healthcare workers from that of other conflict-affected populations.

Writing published in the British Journal of Psychiatry in early 2025 (Invisible wounds, 2026) addressed the specific issue of vicarious trauma among psychiatrists and mental health clinicians working in conflict zones. The authors noted that in these settings, the line between the person providing care and the person receiving it often becomes unclear, because clinicians are frequently living through the same environment of fear and instability as their patients. The paper called for trauma-informed supervision and organisational safeguards as baseline requirements, while acknowledging that in most conflict settings, these do not exist.

A 2025 article based on the experiences of clinicians during the 2024 war in Lebanon (Atoui et al., 2025) added further texture to this picture. It described the clinical impossibility of treating patients with medications that take weeks to work in environments where follow-up care cannot be guaranteed, and noted that the mental health stigma common in many war-affected communities also affects healthcare workers themselves, making them reluctant to seek support even when they are clearly struggling.

3. Methodology

This paper is based on a narrative literature review. The goal of this approach is not to produce a statistical synthesis but rather to draw together findings from a range of study types, including quantitative surveys, qualitative interviews, clinical reflections, and large-scale meta-analyses, in

order to build a coherent picture of what is currently known about depression and moral injury in healthcare workers in conflict settings.

Searches were conducted across several academic databases, including PubMed, MEDLINE, ScienceDirect, Frontiers in Psychiatry, and the British Journal of Psychiatry. The search terms used included combinations of phrases such as depression among healthcare workers in war, moral injury in medical staff in conflict zones, mental health of frontline workers in armed conflict, burnout among doctors and nurses in war, and vicarious trauma among clinicians in humanitarian settings.

Studies were included if they focused on healthcare professionals as either a primary or identifiable subgroup, took place in an active conflict or post-conflict setting, and addressed psychological outcomes including depression, moral injury, burnout, or related forms of distress. The review focused on studies published in English between 2000 and 2025. Studies that focused exclusively on military combatants, veterans, or civilian populations without any identifiable healthcare worker subgroup were not included.

Because many of the relevant studies are qualitative or narrative in nature, a formal meta-analysis was not appropriate. Instead, themes were drawn out across the reviewed material and organised around four main areas: the types of psychological harm healthcare workers experience, the institutional and systemic factors that contribute to that harm, the specific nature and role of moral injury, and what interventions have been proposed or tested.

4. Results and Findings

4.1 Depression and Psychological Distress in Conflict-Zone Healthcare Workers

Perhaps the most devastating mental health outcome for healthcare workers in conflict zones is not fear, but guilt. Unlike soldiers who are trained to accept loss as part of combat, healthcare workers enter war zones with a fundamental professional mission: to save lives. When that mission becomes impossible, not because of any failure of skill or effort, but because the resources simply do not exist, the psychological consequence is a form of guilt that cuts to the core of who they are as professionals and as human beings. This guilt does not fade easily. The memory of a patient

who could not be saved, of a procedure that could not be performed, of a life that slipped away not because medicine failed but because war made medicine impossible, stays with healthcare workers long after the conflict ends. It becomes a wound that does not heal on its own. This is why depression in this population tends to be deep, persistent, and resistant to standard treatment approaches. It is not simply sadness. It is the weight of remembering, and the inability to forget.

A pattern that appeared across multiple studies was that depression in this population tends to coexist with continued professional functioning. Healthcare workers frequently continued to show up and treat patients even while experiencing significant psychological distress. Many attributed their difficulties to personal weakness rather than recognising them as a predictable response to genuinely extraordinary circumstances. This tendency to internalise suffering, combined with widespread cultural stigma around mental health in many conflict-affected regions, contributes to a situation where distress goes unaddressed for long periods.

4.2 Moral Injury as a Distinct Form of Harm

One of the most consistent themes across the reviewed literature is the importance of moral injury as a psychological outcome in this population. Moral injury is defined as the psychological damage that results from participating in, witnessing, or being unable to prevent events that violate a person's deeply held moral beliefs (Litz et al., 2009). It is different from PTSD in an important way: where PTSD is primarily rooted in fear and the experience of threat, moral injury is rooted in guilt, shame, and a sense that one has either done something wrong or failed to do what was right.

For healthcare workers in conflict zones, moral injury tends to arise from situations that are specific to their professional role. These include being forced to decide which patients receive treatment when there is not enough medicine or equipment for all of them, being unable to save someone whose life could have been saved in a properly resourced setting, and continuing to work within systems that they know are failing their patients. The 2024 Tigray study described this kind of distress in clear and human terms, with participants speaking about the grief they felt when they could not treat patients and the psychological weight of working in conditions of near-total institutional collapse.

What makes moral injury particularly important as a concept is that standard trauma therapies, including cognitive behavioural therapy and EMDR, are not well suited to addressing it. These approaches were developed primarily for fear-based trauma responses. Moral injury, by contrast, calls for approaches that engage with questions of guilt, professional identity, values, and meaning. Some research has pointed to compassion-focused therapies as a potentially useful direction, but this area remains underdeveloped, and almost no studies have looked at moral injury interventions specifically in the context of healthcare workers in conflict zones.

4.3 Institutional Gaps and the Absence of Support

Perhaps the most striking finding across the reviewed literature is the near-total absence of formal psychological support for healthcare workers in conflict settings. This stands in sharp contrast to the situation for military personnel in some countries. In the United States, for example, military mental health support has become increasingly integrated into deployment and post-deployment processes, with embedded behavioural health teams, structured screening, and dedicated services for veterans (Hoge et al., 2016). Research has shown that this kind of institutional support does make a measurable difference to mental health outcomes.

Civilian healthcare workers in conflict zones have no equivalent. International humanitarian organisations such as Medecins Sans Frontieres have developed some staff wellness frameworks, but implementation is inconsistent and the resources allocated to this area are limited. In the low- and middle-income countries where most of the world's armed conflicts take place, structured psychological support for medical staff is almost non-existent. Healthcare workers are deployed into some of the most psychologically demanding environments imaginable and then largely left to manage on their own.

5. Discussion

Taken together, the evidence reviewed in this paper reveals a population that carries a significant and underacknowledged psychological burden. Healthcare workers in conflict zones are not simply exposed to traumatic events in the way that soldiers or civilian survivors are. They also carry a professional identity that shapes how they interpret their own suffering, often in ways that

make it harder, rather than easier, to seek help. The combination of depression and moral injury creates a form of distress that existing frameworks are not well designed to address.

The comparison with military mental health systems is instructive. Countries that have invested in structured support for their armed forces have seen better outcomes. Translating a similar logic to civilian healthcare workers in conflict settings is not straightforward, but it is not impossible either. Telepsychiatry has shown some promise in conflict settings as a way of providing clinical supervision and support to health workers who have no access to local mental health services. Peer support networks, where healthcare workers are trained to recognise and respond to distress in their colleagues, offer another practical option that does not require significant infrastructure. Psychological first aid, properly adapted for professional caregivers rather than patients, is another approach that deserves further exploration.

It is also worth noting that protecting the mental health of healthcare workers is not separable from protecting the quality of care they provide. A doctor who is experiencing severe depression or moral injury is less able to make clear clinical decisions, less able to connect with patients, and less likely to remain in post for the duration of a crisis. The long-term sustainability of health system function in conflict-affected areas depends, in part, on ensuring that the people running those systems are supported well enough to keep going. Responsibility for the psychological welfare of healthcare workers in conflict zones cannot rest with any single body. These are individuals who made a conscious choice to enter some of the most dangerous environments on earth, not because they were ordered to as soldiers are, but because their professional values and human compassion compelled them. That choice deserves recognition at every level. Governments must legislate protections and fund mental health support for medical personnel deployed in conflict settings. Hospitals and healthcare institutions must create structured psychological care systems that follow workers before, during, and after their service in war zones. International organisations such as the WHO and the ICRC must treat the mental health of healthcare workers as a core humanitarian priority, not an afterthought. When a person gives everything, including risking their own life, to protect both civilians and soldiers alike, the least that society can offer in return is to protect their mind.

There is also a broader ethical dimension here. Healthcare workers who choose to remain in conflict zones, or who have no choice but to do so, are making an enormous contribution under conditions of extreme adversity. The least that the international health and humanitarian community can do is take their psychological welfare seriously, not as an afterthought, but as a core component of humanitarian response planning.

6. Overall Findings

The findings of this review point to a truth that is as simple as it is uncomfortable: the people who save lives during war are themselves being left behind. Healthcare workers enter conflict zones and give everything they have, their skills, their safety, and in many cases their mental health, to keep others alive. Yet when the war ends, they return to a world that has very little to offer them in return. The psychological problems they carry home, the depression, the moral injury, the guilt, the memories that cannot be erased, receive almost no formal recognition or structured support. They are not counted among the casualties of war, yet they are casualties in every meaningful sense of the word. This review finds that the neglect of healthcare workers in post-conflict mental health planning is not accidental. It reflects a broader failure to see these individuals as anything other than providers of care rather than people who need care themselves. That must change. The problems they face are real, they are serious, and they are lasting. Recognising that is the first and most important step toward doing something about it. With that in mind, the review points to five key conclusions:

> Healthcare workers in conflict zones experience depression and moral injury at rates that are significantly higher than baseline levels, driven by a combination of direct trauma exposure, professional helplessness, physical danger, and the near-total absence of institutional support.
>
> Moral injury is a central and distinct psychological outcome in this population. It is not adequately captured by existing PTSD frameworks and requires specific therapeutic approaches that engage with questions of guilt, professional identity, and values.

The research base for this topic remains very thin. Most conflict mental health studies either exclude healthcare workers entirely or treat them as a minor subgroup, which means the full scale of the problem is likely underestimated.

Institutional mental health support for healthcare workers in conflict settings is almost entirely absent, particularly in the low- and middle-income countries where most conflicts occur. This represents a significant and addressable policy failure.

The mental health of healthcare workers in war zones has direct and measurable consequences for the quality and sustainability of health system function in conflict-affected communities. It is, therefore, a public health issue as much as an occupational one.

7. Conclusion

Healthcare workers in conflict zones are among the most psychologically exposed people in the world, yet they are among the least studied and least supported. The evidence reviewed in this paper makes clear that depression and moral injury are significant, recurring, and largely unaddressed outcomes for medical staff operating in war and post-war settings. The way these conditions develop in healthcare workers is shaped by their professional identity and the particular ethical pressures of their role, and this makes their experience distinct from that of other conflict-affected populations.

Moving forward, there are several things that need to happen. Research needs to begin treating healthcare workers as a primary population of interest in conflict mental health studies rather than an incidental subgroup. Interventions that are specifically designed for this population, and that take moral injury seriously as a distinct form of harm, need to be developed and tested. And international bodies, including the World Health Organization, the International Committee of the Red Cross, and major humanitarian organisations, need to work with governments and health ministries to establish meaningful standards for the psychological protection of medical staff in conflict settings.

Healthcare workers who serve in war zones carry wounds that the world rarely sees. They walk into conflict not because they were commanded to, but because they chose to, driven by a

commitment to human life that does not pause for danger. Yet when the war ends, their trauma does not. The depression, the moral injury, the loss of colleagues, the memory of patients they could not save despite trying everything, these do not simply disappear. This paper ends with a simple but urgent hope: that these men and women are recognised for the extraordinary sacrifice they make. That governments take meaningful action to provide them with the psychological support they deserve. That the international community builds systems of care specifically designed for them. And perhaps most importantly, that we as a society understand the need to have doctors for doctors. Because those who spend their lives healing others deserve to be healed too.

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