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Final dissertation

Risk and protective factors for the development of Posttraumatic stress disorder among civilians exposed to war trauma

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Abstract

This dissertation aims to analyze the existing literature on risk and protective factors that can influence the development of posttraumatic stress disorder (PTSD) in civilians in the war context. Wars, which have always had a destructive impact on humanity, are increasingly attracting the attention of researchers to understand their influence on people's mental health and possible measures that can be used to help them cope with such devastating events.

Several studies showed that not all people who experienced a traumatic event will develop PTSD. Risk level is assumed to be connected with the type/severity of an event and its duration, and personal background such as socio-economic status, level of education, early experience, etc. Based on such observations possible recommendations and implications on how to help people deal with a traumatic event were suggested.

A literature review was conducted on articles reporting PTSD development and the factors that influence it. The literature search was performed using PubMed and Google Scholar search sources. To obtain potentially relevant studies, the following search terms were used: "post-traumatic stress disorder," "war," "prevalence," "risk factors," "protective factors," and "civilians."

The studies retrieved from the search were considered only if they met all requirements. Sociodemographic characteristics such as age, gender, and ethnicity were not used for research exclusion. The research papers selected were those exploring factors influencing PTSD development, particularly in war contexts among civilians. Only studies where participants met the DSM-5 criteria for PTSD diagnosis were included. Articles had to be published between the years 2015 and 2024 and had to be written in the English language to match inclusion criteria.

Risk and protective factors for the development of Posttraumatic stress disorder among civilians exposed to war trauma

Introduction

Nowadays, there are more than 110 ongoing armed conflicts in the world, including Russia's invasion of Ukraine and the Israeli-Palestinian conflict.

Any war violates basic human rights for life. During the conflict, people have to face constant stress, fear, threat anticipation, forced displacement, the death of loved ones, physical and sexual violence, lack of food, water, and medicine, absence of electricity and heat. Many mental problems, including post-traumatic stress disorder (PTSD), can result from these experiences.

PTSD has been defined as a mental disorder that can develop after a traumatic event, with symptoms lasting for at least 1 month. People with PTSD might re-experience the event through nightmares and flashbacks, have more negative thoughts, avoid situations that remind them of the event, and become more irritable. These symptoms cause intense distress or interferes with work or everyday life.

Not everyone experiencing traumatic events develops this disorder. Based on this observation, more and more researchers began to wonder what factors influence the development of PTSD and what can serve as protective factors.

This knowledge can be used to develop programs and preventive measures for working with people who have experienced or are experiencing traumatic events related to war.

The purpose of this dissertation is to review risk and protective factors for the development of PTSD and possible programs to build resilience to cope with traumatic events.

1. Clinical picture of Posttraumatic stress disorder

1.1 Diagnostic criteria of PTSD

In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA. 2013). PTSD is classified as a stress and trauma-related disorder. According to the DSM-5, post-traumatic stress disorder is a psychiatric disorder that might occur in people who have survived or witnessed a traumatic event or series of events. In DSM-5 traumatic event is defined as exposure to actual or threatened death, serious injury or sexual violence through direct experience or witnessing, learning about violent or accidental death of close ones, and repeated or extreme exposure to aversive details of traumatic event (O'Donnell et al, 2017). One of the specific characteristics of PTSD following war-related trauma is that people usually experience more than one traumatic event.

It is also important to mention that there is no constant threshold for each event and severity of PTSD since each person has its own sensitivity to the stressor, personal background, and experience that influence perception.

The diagnostic criteria for PTSD in the DSM-5 can be applied to adults, adolescents, and children older than 6 years. A diagnosis of PTSD requires the presence of symptoms from each of the mentioned further (see Table 1) categories for at least one month, causing significant distress or impairment in social, occupational, or other important areas of functioning (DSM-5; APA, 2013). If those symptoms are evident for a period shorter than 4 weeks, acute stress disorder is diagnosed.

There are two PTSD specifiers: with dissociative symptoms and with delayed expression. Dissociative symptoms include depersonalisation, that is persistent or recurrent experiences of feeling detached from one's cognition or body, and derealization, that is sensation of unreality of surroundings (Patel, 2020). PTSD with delayed expression is diagnosed if the complete diagnostic criteria are not met until at least 6 months after the traumatic event.

Traumatic events may result not only in PTSD but also in other comorbid disorders. Such comorbidities include depression, anxiety disorders, and substance use disorder.

Criterion	Description
A – Stressor criteria (one required)	A1: The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):
	Direct exposure
	Witnessing the trauma
	Learning that a relative or close friend was exposed to a trauma
	Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)
	A2: The person's response involved intense fear, helplessness or horror
B – Symptoms of re-experience (one required)	The traumatic event is persistently re-experienced, in the following way(s):
	Intrusive thoughts
	Nightmares
	Flashbacks
	Emotional distress after exposure to traumatic reminders
	Physical reactivity after exposure to traumatic reminders
C – Avoidance (one required)	Avoidance of trauma-related stimuli after the trauma, in the following way(s):
	Trauma-related thoughts or feelings
	Trauma-related reminders
D –Negative cognitions and mood (two required)	Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):
	Inability to recall key features of the trauma
	Overly negative thoughts and assumptions about oneself or the world
	Exaggerated blame of self or others for causing the trauma
	Negative affect
	Decreased interest in activities
	Feeling isolated
	Difficulty experiencing positive affect
E – Hyperarousal (two required)	Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):
	Irritability or aggression
	Risky or destructive behavior
	Hypervigilance
	Heightened startle reaction
	Difficulty concentrating
	Difficulty sleeping
F – Duration of symptoms (required)	Symptoms last for more than 1 month.
G – significant distress or impairment (required)	Symptoms create distress or functional impairment (e.g., social, occupational).
H - Exclusion criteria (required)	Symptoms are not due to medication, substance use, or other illness.

Table 1. DSM-5 diagnostic Criteria for PTSD.

1.2 History of the notion of posttraumatic symptoms among soldiers and civilians

Since the first tribes of people, our lives have always been filled with different human- and nature-caused traumatic events. Long before PTSD was introduced as a disorder by the

American Psychiatric Association in the DSM-III (1980), we could find PTSD-like symptom descriptions in the works of philosophers, poets, doctors, and researchers. The history of posttraumatic stress disorder can be traced back to ancient Roman and Greek times. For example, ancient Greek tragedies often depicted characters suffering from profound grief, shock, and behavioral changes following traumatic events like the destruction of their homes and loss of close ones as in Homer's "Iliad", where the character Achilles was depicted as experiencing symptoms akin to PTSD after the death of his friend Patroclus (Dils, 2024). At the time, these responses were viewed as a consequence of weak personality, and something that could be overcome with willpower.

Later, in the 17th century, military doctors were the first to attempt diagnosing and categorizing the display of acute combat reaction for which physician Johannes Hofer came up with the term "nostalgia" in his dissertation (Dils, 2024). This definition described a set of symptoms including depression, angst, and exhaustion. Since these symptoms were considered to be an outcome of a soldier's longing to go back home, and not a result of battlefield experience the name "nostalgia" was used.

During the American Civil War, many soldiers experienced "soldier's heart," characterized by rapid heartbeat and other cardiac conditions, chest pain, and anxiety (Friedman, 2024). Only much later it was acknowledged that such symptoms can be understood as manifestations of PTSD.

In the late 1800s, the increase of railway use caused more train accidents. After experiencing such traumatic events people showed psychological symptoms such as anxiety, nightmares, and hypervigilance. This was labelled "railway spine" and treated as a psychological condition arising from traumatic experiences.

During World War I, "shell shock" was introduced to the public knowledge concerning soldiers but also civilians who suffered from similar symptoms due to bombings and the loss of loved ones. Civilian populations displayed severe anxiety, nightmares, and other stress reactions following air raids and other wartime traumas. The concept of "shell shock" started to extend beyond military contexts, acknowledging that civilians could also experience profound psychological distress after traumatic events (Horowitz, 2018).

Post-World War II, the concept of "combat fatigue" in soldiers expanded to civilians who had endured different traumatic wartime experiences. Studies of Holocaust survivors, who had lived out extremely traumatic events, significantly advanced the understanding of the psychological outcomes of trauma (Saigh, 1999)

The Vietnam War was crucial in broadening the understanding of PTSD beyond military personnel. Anti-war protests, civil rights struggles, and the societal impact of the war itself led to an increased awareness of the impact of traumatic events among civilians. Studies on refugees and civilians displaced by war contributed to the growing body of knowledge (U.S. department of veteran affairs, 2023). The experiences of these individuals underscored the widespread nature of trauma and the need for comprehensive approaches to mental health.

Even though the first editions of DSM included a diagnosis named "gross stress reaction", which was to some extent similar to PTSD, it was assumed that the trauma could be of any severity, and it was only temporary (Horwitz, 2018). Thanks to the American Psychiatric Association's inclusion of PTSD in the DSM-III in 1980 PTSD was officially recognized as a disorder affecting both military and civilian populations. This formalization was based on extensive research, including studies of civilians who had experienced various traumas, such as natural disasters, accidents, and violent crimes. This recognition was crucial for developing standardized diagnostic criteria and effective treatment protocols that are currently used in clinical settings.

1.3 Epidemiology of PTSD in war-affected civilians

The likelihood of developing PTSD following a traumatic event depends on the complex interaction of several factors including the type and severity of the traumatic situation, cultural and individual characteristics, and others. According to the World Health Organization, the global prevalence of PTSD is identified to be approximately 3.6%. However, the figures can increase significantly if prevalence data are collected, for example, in a country that is currently experiencing armed conflict or other traumatic events, or if it is a developing country (Oakley, 2021).

Available studies show that human-caused disasters like terrorist attacks, wars, and sexual assaults have more detrimental psychological effects than natural disasters and are more strongly associated with the development of PTSD.

War exposure is one of the most traumatic events that can lead to the development of PTSD because of its multidimensional impact. Different studies report different prevalence estimates among war-affected civilians, from 12.9% - 26%, to 40%, for global data. However, the prevalence differs for different countries individually. For instance, during the Russian invasion of Ukraine, 12.9% of Ukrainians were estimated to be affected with PTSD (Zasiekina,

2023). Studies about the impact of war in Syria report that 36.9% of the general population suffered from PTSD (Latifeh, 2022).

Understanding the prevalence of PTSD can help identify high-risk groups and provide them with supportive programs, improve mental health services, refine and moderate diagnostic criteria of the disorder, and measure the effectiveness of treatment, etc. This data leads us to a further research questions: what are the factors that can increase the risk of PTSD development? What factors can buffer vulnerability to PTSD development?

2. Risk factors for PTSD in war-affected civilians

2.1 Pre-existing vulnerabilities for developing PTSD

As we mentioned earlier the impact of traumatic events can result in different responses among different people, since such impact is modulated by a variety of factors. Vulnerability factors, i.e., those factors that can increase the likelihood of developing PTSD, include sociodemographic variables such as sex, age, education, and socioeconomic status; personality characteristics such as cognitive and affective factors; neurobiological and genetic factors (Bomyea et al, 2012).

Sex

The majority of research studies conducted over the past years demonstrates that the female sex could be perceived as one of the pre-existing risk factors for PTSD development. There is evidence that women show higher levels of depression, anxiety, and PTSD and greater severity of symptoms compared to men (Stanisław Fel et al, 2022). Women and men are usually exposed to various traumatic events. Females are more likely to be victims of sexual violence, while males often face more combat-related trauma that has different psychological impact. However, this sex difference in PTSD prevalence is evident even when men and women experience the same type of trauma (Lehner et al, 2022).

In a research paper by Christiansen and Berke (2020), sex and gender emerged as factors that influence the development of PTSD in different ways through gender roles, genetic predisposition, and hormonal factors, and sensitized HPA axis, that put women at greater risk of developing PTSD compared to males (Moser et al., 2007).

There are some contradictory studies that did not find a significant associations between being female and developing PTSD (Brewin, 2000). It means that while sex is considered as a risk factor for PTSD development, the relationship is more complex and may be influenced by factors like trauma exposure, sociocultural context, and how trauma is experienced and reported by men vs. women.

Age

The search results indicate that the relationship between age and PTSD risk is complex and not fully clear. Factors like military service history, cultural context, and study design appear to influence the association between the age and PTSD development. Some studies showed that younger age is a risk-factor for PTSD dvelopment, explained by increased trauma

exposure and less developed coping strategies (Kongshøj, 2023). Meanwhile, other findings claimed that older population is more prone to develop PTSD. More studies are needed to understand its impact better.

Education

Different educational levels indirectly influence various factors such as economic resources, social status, social networks, and health behavior. Lower education levels and smaller cognitive capacity (i.e. skills involved in performing tasks associated with perception, learning, memory, understanding, awareness, reasoning, judgment, and language) (APA, 2018) have consistently been associated with a higher risk for PTSD. It could be explained by the lower ability of such people to use critical thinking to evaluate the situation. Additionally, there is a probability that such individuals have a limited number of coping strategies for dealing with stressful events. Education is closely linked to economic stability. Those with lower levels of education are often financially disadvantaged, which can worsen the stress and challenges faced during and after the traumatic event (Eshel, 2023).

Personality traits

High levels of neuroticism, lower extraversion and agreeableness, adherence to masculine ideals and gender role-related stress, and cognitive biases (systematic errors in thinking that occur when people process and interpret information in their surroundings, influencing their decisions and judgments such as confirmation bias) play an important role in how people cope with traumatic events that, as a result, can result in PTSD development. In a meta-analytic study by Cyniak-Cieciura et al (2021), the analysis of 19 studies has shown that personal traits, such as neuroticism, have a positive relation with PTSD development.

Level of intelligence

Studies have been consistently demonstrating that lower intelligence level before trauma exposure also predicts PTSD development. One of the possible explanations could be similar to the one that we mentioned earlier - higher intelligence is associated with greater abilities to use executive functions and effective problem-solving strategies to cope with traumatic events. (Bomyea, 2012)

Previous traumatic experience

Individuals with a history of trauma seem to be less resilient to the psychological impact of war. People who have experienced previous trauma may become more sensitive to subsequent stressors. The sensitization of the neural substrate of the stress response would

lower the threshold of such response when faced with new traumatic events. For example, people who suddenly lost their loved ones because of COVID-19 during the pandemic and immediately after were exposed to the war would be more likely to develop PTSD. Additionally, prior trauma can strengthen emotional reactions to new trauma making it more difficult for individuals to process and cope with the additional stress. This sensitization can transform normal stress reactions into pathological responses, making individuals more susceptible to PTSD following new traumatic experiences.

Also, people who have a previous history of depression, acute stress disorder, dissociation, etc, are more sensitive towards traumatic stressors and are more likely to develop PTSD.

Early childhood experiences

Adverse events during childhood significantly increase vulnerability to trauma-related disorders later in life. The impact of adverse experiences during this developmental period can lead to lasting psychological effects, increased sensitivity to stress, and difficulties in emotional regulation, that contribute to a heightened risk of PTSD later in life.

Additionally, it is well-known that interaction with a consistent, emotionally available caregiver during infancy is crucial to social, emotional, and cognitive development. The lack of this interaction may lead to an inability to engage in effective emotion regulation when emotionally threatened, to consider the emotional states of others and themselves, or to maintain relationships that provide emotional comfort, when necessary, that are crucial for coping with a traumatic event.

2.2 Risk factors for developing PTSD associated with war exposure

For civilians, one of the most important risk factors for the onset of PTSD is exposure to shelling/explosions/destruction, human rights violations, being wounded or injured, witnessing death, being tortured or being taken captive, and being sexually abused.

Such events present a direct threat to an individual that may evoke intense feelings of fear and helplessness. Continual exposure to danger and its unpredictability can lead to a chronic hyperarousal that is one of the main PTSD symptoms. Furthermore, the destruction caused by these violent acts often results in the loss of homes, infrastructure, and community resources. This results not only in disruption of one's life but also in a pervasive sense of insecurity and loss.

Witnessing the death of others, especially loved ones or community members, is an intensely traumatic experience. The shock, grief, and horror of such events are proved to play an important role in PTSD progression. Stanisław Fel (2020) highlighted that unexpected death of close people is the most frequently reported traumatic experience in epidemiological studies worldwide.

Human rights violations such as forced displacement, and the denial of basic freedoms, destroy an individual's sense of trust and safety that subsequently leads to the development of different mental disorders. In this case, place of residence is another predictor of PTSD in war-affected civilians. The severity of symptoms was the highest among people who live in currently occupied areas, followed by lower scores in previously occupied but presently liberated areas, followed by the lowest scores in the areas that were not occupied during the war (Karatzias, 2023). These results could be explained by the fact that in occupied territories people experience hundreds of war crimes, such as sexual assaults, tortures, and a variety of freedom-restrictions.

Furthermore, in a study by Gulnaz Anjum et al (2023) higher prevalence rates of PTSD were reported among refugees displaced in cultures like their own or outside. Refugees are more likely to be exposed to intentional trauma, threatening circumstances, and stigmatizing cultural beliefs that restrict their access to employment, housing, education, and health care. Larysa Zasiekina et al (2023) linked the elevated PCL-5 (i.e. 20-item self-report measure of the DSM-5 symptoms of PTSD) scores in displaced individuals to high levels of distress related to feelings of loss and often separation from the family.

Another significant risk factor in developing PTSD is the disruption of an individual's normal activity. Civilians who lost their jobs and/or interrupted their education were more likely to have stress-related disorders associated with feelings of hopelessness, helplessness, desperation, and loss of financial security.

Additionally, lack of social support has been identified as a risk factor for PTSD development. Social support plays an important role in an individual’s well-being and self-efficacy. If this part of human life is absent it causes feelings of loneliness and weakness and can influence cognitive and emotional processing of traumatic events, making it harder to process.

Lastly, limited access to some facilities like medical institutions, lack of water, gas, electricity, and food may further exacerbate symptoms.

3. Protective factors for PTSD in war-affected civilians

3.1 Protective factors against the development of PTSD in war-affected civilians

The American Psychological Association (2018) defined protective factors as "a clearly defined behavior or constitutional (e.g., genetic), psychological, environmental, or other characteristic that is associated with a decreased probability that a particular disease or disorder will develop in an individual, that reduces the severity of an existing pathological condition, or that mitigates the effects of stress generally." Different studies showed that social support and higher levels of education and socioeconomic status can serve as protective factors against developing PTSD.

When faced with potentially traumatic events, most individuals normally do not remain passive but try to implement cognitive, affective, and behavioral strategies to deal with the challenge.

One of the first protective factors that is worth mentioning is well-being. Well-being is a state of joy and satisfaction with one's physical, psychological, and social life, the experience of positive emotions such as happiness and contentment as well as the development of one's potential, having some control over one's life, having a sense of purpose, and experiencing positive relationships. It has been observed that a higher level of well-being in people who have experienced war-exposure is negatively associated with PTSD manifestation (Long, 2022).

The notion of well-being can be parsed into different components that can be analysed separately. Social support is viewed as a form of emotional, informational, and practical assistance from close ones, specialists, and government. Social support helps defend individuals from the negative effect of trauma exposure by strengthening coping abilities, reducing negative effects of the trauma, and weakening harmful physiological stress responses. (Wang, 2021). This stress-buffering effect helps prevent PTSD development. Lack of social support leads to the feeling of isolation and loneliness.

When individuals believe in a hopeful future, they are more likely to connect with others, share their experiences, and seek help. Social interaction not only provides emotional support but also strengthens community bonds, creating a supportive environment where individuals feel understood and validated (Gallagher, 2020).

Personal characteristics and skills play a significant role in buffering the risk of developing PTSD. For instance, the ability to cope with stress and trauma effectively is a

critical determinant of whether an individual will develop PTSD after experiencing war-related trauma. Coping skills are defined as strategies and techniques that individuals use to manage stress, emotions, and adverse circumstances.

Several studies identified hope as a powerful cognitive-motivational characteristic that encourages persistence toward goals despite obstacles and influences planning and problem-solving. In a study by Gallagher et al (2020) greater hope was associated with lower levels of PTSD. Some researchers explain this result by the fact that people with higher rates of hope tend to focus more on their success by preserving their past difficulties and experiencing more satisfaction from goal achievement than those with low levels. Additionally, even though trauma can disrupt the perception of control over someone's life in different fields, hopeful individuals report stronger control over their objectives. (Long, 2022)

Furthermore, as mentioned in the previous chapters, levels of education, income, and current occupation also serve as protective factors. People with higher levels of education and cognitive abilities are more resilient toward traumatic stress. They can appraise the event, possible harm, scenarios, and solutions in a more rational and critical way that would lead to more effective problem-solving and coping strategies.

Civilians with higher income levels have been found to be more confident, rate themselves as more secure, and have access to more resources.

Moreover, people who managed to keep their "normal life" (i.e., having a place to live in, having access to food and water, medical and educational institutions, having a job, working at a place that would satisfy needs and interests, continuing education) or managed to rebuild one were less likely to develop stress-related disorders (Eshel, 2023).

Also, it is important to mention that early access to psychological help, including counselling and therapy, can mitigate the impact of trauma.

3.2 Resilience building strategies against PTSD

Resilience is the process and outcome of successful adaptation to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands (APA, 2018). The resilience cycle (Figure 2) highlights continuous interactions among a complex array of biological (e.g., genetic, epigenetic), psychological (e.g., cognitive, emotional), and environmental (e.g., social,

economic, and cultural) factors that affect how an individual responds to a particular stressful experience (Ord, 2020).

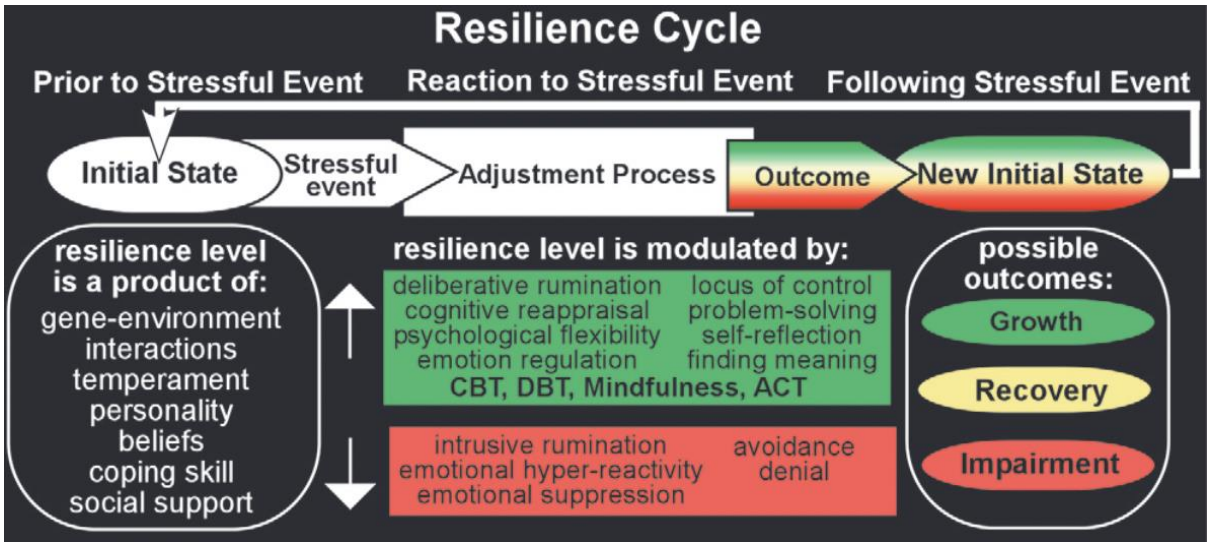

Figure 2. Resilience cycle (Ord; 2020)

Effective characteristics and skills for coping with traumatic stress can be developed in different ways. Resilient individuals maintain an adaptive level of physiological and psychological functioning when challenged by stressful/traumatic events. Higher resilience is associated with greater emotion regulation capacity, which buffers against PTSD development. Greater levels of positive expectancies, such as hope, optimism, and self-efficacy, positively affect resilience connected to traumatic stress. These characteristics and skills can be strengthened through psychotherapy or self-guided strategies. From a psychological perspective, interventions that promote cognitive flexibility and emotional regulation have the potential to strengthen resilience.

Cognitive-behavioral therapy has been proven to be one of the most effective for PTSD treatment. This approach is most useful to facilitate resilience (Ord, 2020). The main idea is to identify and challenge negative and rigid thought patterns rather than to solve a certain problem or achieve some outcome. Working on a way of thinking about, and appraisal of, a traumatic event would help develop adequate coping mechanisms to prevent PTSD development.

Another approach is Acceptance and Commitment Therapy. ACT is a transdiagnostic therapy that primarily aims to enhance psychological flexibility as a tool to adaptation and psychological well-being. During ACT sessions people learn to accept their emotions and feelings that occurred in response to a certain situation and try to make necessary changes in

their behavior. Recent systematic reviews and meta-analyses of randomized controlled trials involving mindfulness-based interventions such as ACT, mindfulness-based stress reduction, and mindfulness-based cognitive therapy, have reported beneficial effects on a wide range of behavioral health outcomes, including anxiety, depression, fatigue, stress, quality of life, and post-traumatic growth in adults who have experienced different traumatic events (Ord, 2020).

Mindfulness-based interventions have also been shown to decrease the use of maladaptive coping strategies while dealing with trauma. Practicing mindfulness helps individuals stay present and manage anxiety connected to the trauma by focusing on the present moment rather than ruminating on past events. Additionally, techniques such as deep breathing, progressive muscle relaxation, and guided imagery have been shown to reduce physical symptoms of stress and promote emotional stability.

Dialectical-behavior therapy (DBT) may also be a useful therapeutic approach to facilitate emotion regulation, because it incorporates mindfulness, emphasizes the role of difficulties in emotion regulation, and focuses on the development of emotion-regulation skills.

Overall, meta-analyses and systematic reviews indicate that psychosocial interventions based on the principles of cognitive-behavioral therapy and mindfulness tend to have the most substantial effect sizes in promoting resilience and psychological growth after adverse events.

Relationships with family, friends, and community members provide emotional support and practical assistance which are crucial for recovery and resilience. Different forms of social interactions would be beneficial for civilians who have experienced war. People who are involved in cultural, recreational, educational, volunteering, and working activities have more sources of social support and can cope with stressful events more effectively. Participation in groups with others who have experienced similar traumas can provide understanding, validation, and mutual support. In addition, engaging in community service or helping others can create a sense of purpose and belonging, enhancing resilience. Involvement in everyday activities such as going to work/school, being able to rest and do what a person likes, etc, can evoke a sense of normalcy and provide emotional relief (Committee on the Assessment of Ongoing Efforts in the Treatment of Posttraumatic Stress Disorder, 2014).

People who survived traumatic events such as war should engage in self-caring behavior through adequate sleep, nutritious eating, physical activity, and avoiding excessive substance use. This activity will support both physical and emotional well-being.

Even though nowadays the amount of different intervention programs for people who have experienced traumatic events has grown, there is still a lot of work to accomplish. One of

the main problems is a societal awareness about and stigmatization of PTSD. There are still some people who perceive PTSD as a “disorder of the weak”. Learning about stress reactions and coping mechanisms through educational programs can empower individuals to manage their symptoms effectively. Additionally, easier access to professional psychological help and mental health services such as crisis counselling, psychotherapies, etc, can provide structured support and strategies for building resilience.

Conclusions

PTSD development is influenced by individual characteristics, and social and financial factors.

Among war-affected civilians, risk factors such as lack of social support, previous mental health issues, and maladaptive coping strategies can increase vulnerability to PTSD. On the other hand, resilience and protective factors such as strong individual coping skills, social support, level of education, and income can significantly reduce these risks. Understanding these factors is crucial for developing effective supportive programs and interventions.

Working on resilience using psychological, social, and personal growth strategies is crucial for the ability to cope with trauma and protect oneself from PTSD development. Interventions based on cognitive-behavioral therapy, mindfulness, and acceptance and commitment therapy have shown promising results in nurturing psychological flexibility and helping with recovery. Moreover, fostering positive expectancies such as hope, optimism, and self-efficacy can play an important role in building resilience and improving coping skills in stressful contexts.

In conclusion, a comprehensive approach that addresses both risk and protective factors is necessary to support the mental health of war-affected civilians. By promoting resilience and providing targeted interventions, it is possible to reduce the incidence of PTSD and help individuals recover from the devastating impacts of war. Understanding and leveraging these factors can lead to more effective support systems and better outcomes for those affected by the traumas of conflict.

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