VIPSIG NEWSLETTER

SUMMER 2026

Clinicians' mental health in conflict zones

We are grateful for your contribution: Top picture, **Dr Mostafa Shalaby**; second row right, **Dr Peter Hughes**; second row left, **Dr Pardis Mostajabi**; third row right, **Dr Joseph El-Khoury**; third row middle, **Dr Mustafa Alachkar**; third row left, **Dr Yasser Saeed Khan**.

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Reflections from the Editorial Board

Dear VIPSIG colleagues and readers,

It gives us great pleasure to share this emotive and very special edition of the VIPSIG newsletter. It is based on our webinar on 26th March 2026 regarding clinicians' mental health in conflict zones. It brings together accounts from our speakers and our very own chair. In a world in turmoil, the newsletter is poignant and timely.

From my end, I will share a few memories. I was in Doha with colleagues on 15 April 2026. While we were having a post-lunch cup of tea, everyone's mobiles pinged at the same time. I came to know that their usual annual leave had been suspended since the Middle East conflict. For a few hours, we had lunch, chatted and interacted as if nothing had changed. Suddenly, an email reminded us that the conflict was real. Into the normal flow of life lay uncertainty and tension. Another picture that stuck with me was from a friend working in Iraqi Kurdistan. While she was speaking to her husband, stuck in the UK with travel restrictions, a drone flew in the sky, framed by her window. A speck in the screenshot of their WhatsApp call. Again, a reminder that things are not quite right! And finally, I was reminded by a text from a colleague in Dubai: 'It's tough here at the moment. Sleepless nights. Home schooling. Staff panicking and functioning on low battery. Missile alerts all day. So it's real. And growing uncertainty for jobs etc.'

This edition will touch you with both sadness and hope. It will impress you with the bravery of our colleagues, both in conflict zones and those who live with the worry of relatives in war-torn countries. We hope this edition will serve as a reminder of the fragility of our times and what we have to be grateful for when things settle. There is reason to be grateful for life's uneventful, predictable routines, though sometimes boring or mundane.

Professor Nandini Chakraborty
Consultant Psychiatrist in early intervention in psychosis at Leicester Partnership NHS Trust
VIPSIG Newsletter Editor &
Dean of the Royal College of Psychiatrists

I worked as a humanitarian in the Rohingya crisis in Bangladesh. For the first time, I felt privileged for what I've got; my parents gave me a good life. And, I am grateful for that. I heard stories that seemed like they were from movies, but for many displaced people, it was reality. I stopped comparing my life to others' after that. It gave me perspective and made me realise that there are many differences between humans, but the core human characteristics aren't too different.

I'm glad I got to be a humanitarian. On the one hand, I could actively contribute; on the other, I've learned things about life I wouldn't have learned otherwise. I extend my heartfelt gratitude to all clinicians - doctors, nurses and other health professionals who dedicated their skills, compassion and commitment to humanitarian work.

Dr Shamiya Nazir
Core Psychiatry Trainee at Betsi Cadwaladr University Health Board (BCUHB) North Wales
& VIPSIG co-editor

Professor Nandini Chakraborty

Dr Shamiya Nazir

Lessons in Humanity: Reflections from a Psychiatric Mission to Syria

My recent visit to Syria was initially driven by a desire to contribute—to offer clinical support, share knowledge, and better understand the realities of mental healthcare delivery in a conflict-affected setting. On a more personal level, my decision to embark on this mission came when I was seeking deeper meaning in life, a sense of purpose. Like many clinicians, there are periods where practice demands, combined with broader life challenges, prompt reflection on meaning and direction. This mission became, in part, a response to that search.

What I did not anticipate, however, was the extent to which this experience would reshape my perspective as both a clinician and a human being.
Working alongside local psychiatric teams, I witnessed a system operating under immense constraint—limited resources, high patient volumes, and ongoing societal challenges. Yet, despite these pressures, the quality of care was defined not by what was lacking, but by what was profoundly present: compassion, patience, and a deep sense of responsibility for patients.

One of the most striking observations was the nature of therapeutic relationships. In contrast to the often time-pressured environment many of us experience in the NHS, clinicians and nursing staff in Syria demonstrated remarkable commitment to engaging patients on a human level. For instance, I observed numerous instances where, rather than resorting quickly to intramuscular medication in cases of agitation or refusal, staff would sit with patients for extended periods—sometimes well beyond what would be considered feasible in our own settings—gently encouraging adherence through conversation, reassurance, and trust-building. This approach was not only humane but, in many cases, highly effective.

Equally impactful was the cohesion within multidisciplinary teams. The relationship between doctors and nursing staff appeared less hierarchical and more collaborative, fostering a shared sense of purpose. This dynamic translated into consistent and compassionate care, even in the face of systemic adversity.

Beyond direct clinical work, this visit opened doors to meaningful future collaborations. One key area identified was electroconvulsive therapy (ECT). I found that despite having an ECT machine, there was a need for structured training and guidance to optimise its safe and effective use. Following our return, we have initiated plans for remote teaching and supervision. This was to support local teams in developing confidence and competence in delivering ECT treatments. This ongoing collaboration represents a small but significant step towards sustainable capacity-building at a local/national level.

Personally, the experience prompted deep reflection. Practising in the UK, it is easy to become accustomed to systems, protocols, and resources which, while not without their challenges, provide a level of structure and support. In Syria, stripped of many of these layers, the essence of psychiatry became more visible—human connection, presence, and empathy as the core tools of our profession. This journey has undoubtedly influenced my clinical practice. I find myself more attuned to cultural and contextual dimensions of mental illness. I am more patient in my interactions and more reflective about the balance between efficiency and empathy. It has also reinforced the importance of humility—recognising that innovation and excellence in care are not solely the product of well-resourced systems, but can thrive even in the most challenging environments. Perhaps most importantly, this mission served as a reminder of why many of us chose psychiatry in the first place. Beyond diagnoses, risk assessments, and treatment plans lies a fundamental human connection. In Syria, that connection was not an adjunct to care—it was care.

As we continue to navigate the demands of modern psychiatric practice, there is much we can learn from our colleagues working in different contexts. Their resilience, creativity, and unwavering commitment to patients offer valuable lessons—not only in global mental health, but in rediscovering the core values of our profession.

Dr Mostafa Shalaby
Consultant Psychiatrist at West London NHS Trust &
VIPSIG Chair

Clinicians’ Mental Health in Conflict Zones

The reality behind the professional role

When we talk about conflict in the clinical or policy spaces, we usually focus on the people affected and rightly so. What is rarely discussed is the position of the clinicians who work in those same settings. They have to keep services running, see patients, and make decisions often while living in the same instability.

In some parts of the Middle East and in other areas affected by conflict, my colleagues describe a simple but difficult reality. Work goes on no matter what happens outside the hospital or clinic. There may be insecurity, disrupted routines, concerns about family safety and uncertainty about the future. The clinicians’ responsibilities do not stop. Over time, all of these pressures add up. It is not usually one event that causes the problem. It is more often a gradual wearing down, noticed in hindsight rather than at the time.

Living and working in crisis

One of the main things about conflict areas is that clinicians are often part of the same group of people who are affected as much as their patients. They are not standing outside the crisis; they are right in the middle of it. The overlap between their professional and personal lives changes their work style. My colleagues often talk about feeling always on alert and as if there is no clear difference between their work life and their home life. They may have trouble sleeping or concentrating. They may feel emotionally drained. Some talk about going into a " mode" in which they just focus on getting through each day without thinking about how they are really doing. There is also the weight of hearing about traumatic events over and over. Hearing these stories is part of the job in any health setting. In conflict zones, these stories are often shared by patients who go through the same things as clinicians. This shared reality can make it more difficult for clinicians to keep their distance.

The strain of choices

Along with emotional fatigue, there is often another kind of pressure that quietly builds over time. Clinicians working in conflict-affected areas often have to make decisions with limited resources, disrupted services or no pathways to refer patients to other services. This can lead to situations in which clinicians feel unable to provide the standard of care they normally expect. Over time, the gap between what they want to do and what they can actually do can be really tough to deal with. It is not always discussed openly. It is a common feeling. For some clinicians, this can lead to burnout or emotional withdrawal from parts of their job. For others, it means they just keep going because there is no choice, even when it takes a big emotional toll.

Working with children, families and communities

The impact of conflict on children and young people adds another layer of complexity. Clinicians often see anxiety, sleep disturbances, behavioural changes, withdrawal and trauma-related symptoms. Typically, these symptoms are part of a picture of distress, displacement or loss in the family. Clinicians are often supporting parents and caregivers at the same time, many of whom are dealing with their own emotional strain. This can create an environment where distress is shared between many family members and where managing anxiety becomes a central part of the work. Many children and adolescents are deeply affected by the news they see in the media, even when they are not physically in the conflict zone and have concerns about their relatives. Clinicians in these settings often see a mix of anxiety, guilt, anger and confusion that can be challenging to separate from developmental challenges.

What clinicians find helpful

Despite these challenges, clinicians consistently say that what helps them is often quite simple, although not always available. My colleagues talk about the value of speaking with peers who understand the context. Informal conversations after clinical encounters or brief moments to debrief during the workday can make a big difference. When they exist, structured supervision and reflective practices are highly valued. Leadership recognition is equally important.

Acknowledging that staff are working under pressure without expecting them to downplay or normalise their experiences can help. In some settings, even small gestures of recognition can be meaningful. The absence of these supports can contribute to feelings of isolation in prolonged crises where there is little chance of recovery or time away from the environment.

Learning and professional connection

A recent webinar organised by the Royal College of Psychiatrists Middle East International Division in collaboration with VIPSIG and the Iranian Diaspora Association in Psychiatry brought together clinicians working across different systems to reflect on these issues.

Although the contexts were different, there were common themes. Clinicians described exhaustion, emotional strain and pressure, but a continued commitment to patients and services despite difficult circumstances. What stood out was the sense that these experiences are widely shared, even if not always openly discussed. There was also an emphasis on professional connections. In situations where local resources are stretched, international collaboration and peer support networks can provide a sense of solidarity and shared understanding.

Conclusion

Clinicians working in conflict zones are often described as resilient. While resilience is certainly present, it is part of the picture. Many clinicians work under pressure with limited opportunities to step back and recover.
Supporting clinicians is not separate from caring for patients. The two are closely linked. When clinicians are adequately supported, in small and practical ways, it has a direct impact on the quality and stability of care provided.

In conflict settings, this becomes more significant. The well-being of clinicians is not a consideration. It is central to sustain healthcare systems under strain. Clinicians' mental health in conflict zones needs to be addressed systematically.

Dr Yasser Saeed Khan
Hamad Medical Corporation, Consultant Psychiatrist
Royal College of Psychiatrists, Chair, Middle Eastern Division.
Qatar University College of Medicine, Clinical Associate Professor

Clinicians' Mental Health in Conflict Zones
Maintaining Sanity and Inner Peace in a Crazy and Violent World

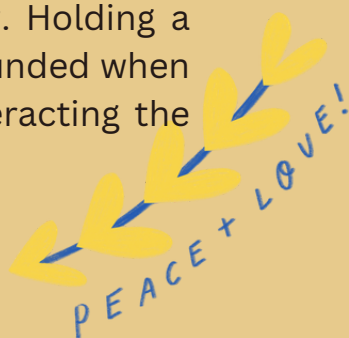
Most, if not all of us, become healthcare professionals because we want to help people. Whether 'true altruism' exists or not, clinicians are, by nature, driven into the profession to alleviate others' suffering and assist them to live better lives. A small proportion of clinicians take this commitment to helping others further, sometimes putting themselves in harm's way to be there for others. Working clinically in war zones is an excellent example of clinicians leaving a peaceful, comfortable life to be in a place most people are desperate to leave. Some of these clinicians may be motivated by novelty seeking, 'the adrenaline rush' and adventure. Others choose to work in war zones to make a difference to the lives of the people they work with or derive a sense of meaning from their own existence. For example, when treating individual patients in an NHS clinic no longer feels fulfilling enough.

Some clinicians, and these may be the majority, are so moved by the injustices inherent in war that they feel it is their moral duty 'to be there' and do what they can, being aware of the privilege they have of possessing skills desperately needed in these situations. This kind of work is, however, not without cost. The emotional impact on clinicians working in war zones has been widely described, both in the literature and in the individual testimonies of doctors, nurses and other healthcare professionals. No matter how resilient or experienced the clinician is, they are always affected by what they see in war zones and by being in touch with some of the most painful forms of human suffering. 'PTSD', compassion fatigue and secondary traumatisation are relevant but possibly over-simplistic terms that are often used to describe the mental health burden on clinicians working in war zones. Changes to one's fundamental beliefs and values, such as losing faith in the goodness of humanity or the value of medical training, etc., and other such existential effects, may more meaningfully reflect what happened to clinicians working in war zones who may describe their experience as having changed them forever.

A strong desire to help and a ‘high level of altruism’ are not enough to protect clinicians from the painful effects of this work. Neither is a solid commitment to the cause. Surrounding oneself with people who share the same values of justice and human rights is crucial. Conversely, having to explain or justify oneself to others can be an unhelpful distraction that may move the clinician away from their rightful desire to stand by the oppressed against the oppressor. Needing support is not a weakness. Reaching out for help from friends, family, or even professionals is a sign that one is self-aware enough to notice that they might not be doing well and that ‘compulsive caregiving’ is not good for anyone.

My own experience of working in Gaza during the ongoing Israeli genocide in 2025 helped me see myself with more humility than before I travelled to Gaza. I learnt to manage my expectations, from myself, so that my desire to alleviate the suffering of everyone and take away their pain became a strong commitment to ‘being with’, sharing their pain and bearing witness to the injustices and the dehumanisation that they were/are being subjected to by the Israeli Army. This shift in expectations helped me bear the pain of myself. Maintaining contact with friends and family ‘back home’ meant a lot to me. It kept me in touch with ‘some normality’ when everything around me was abnormal. What was also immensely helpful was a weekly space that a senior colleague kindly offered on the phone. This was an hour-long conversation, which I spent mostly crying. I needed it.

The impact of war on many aspects of our identity as human beings is profound: our thoughts, our belief systems, and our emotions. War is also damaging to the five senses through which we connect with the world beyond our bodies. Listening to the birds in the morning became a pleasant antidote to the sounds of explosions setting off every few minutes and drones hovering constantly overhead. Watching the sunset from the rooftop of my guesthouse in Khan Yunis became a ritual I looked forward to every day. This was after a long day of listening to painful stories of suffering and despair. Having a little spoonful of Biscoff spread was a delightful moment during the day, as was drinking my yerba mate after work! Listening to music before bed was my way of soothing myself to sleep, with a few drops of lavender essential oil on my pillow. Holding a ‘crystal worry stone’ in my hand was also my way of staying grounded when the bombing was too close. These were all my ways of counteracting the damaging effects of war and genocide on my senses.



Lastly, and perhaps most importantly, observing, with respect and humility, Gazans' resilience, humanity and great love for life إذا ما استطعنا إليها سبيلا - "we love life if we can find a way to it", to quote the Palestinian poet Mahmoud Darwish, was always my strongest source of support and what kept me going. Noticing the many examples of compassion, care and pure humanity between Gazans helped me appreciate how privileged I was to be among them. At some of the most difficult times in Gaza, and when the world felt so ugly and hypocritical and human life so cheap, it was thinking of Gazans, their connection to their land and to each other, and their bravery in the face of genocide, that helped me maintain my conviction that, to quote Mahmoud Darwish again, على هذه الأرض ما يستحق الحياة - "there is on this earth what makes life worth living". It made it all feel worth it.

Dr Mustafa Alachkar
Consultant psychiatrist and medical psychotherapist

Supporting Diaspora Communities During Conflict: Reflections on Trauma, Connection, and Hope

I was a child during the Iran–Iraq War. One evening, my family gathered for dinner. The table was set, and we were just about to serve food when the sirens began. There was fear and chaos, but my father quickly took control. Everyone was given a role. My job was to take a torch downstairs to the basement. We sat there listening to explosions nearby until one particularly loud blast was followed by the sound of shattering glass. When we returned upstairs, the windows were broken, and glass covered the dining table. I remember looking at the table and thinking: We will not be able to eat now. Then I looked at my mother. She was trying to hold back her tears, but when she saw how frightened I was, she smiled and said, “At least the food has not been served yet — it is all still safe in the oven.” And then we continued. Years later, as a psychiatrist, I understand that moment differently. Trauma often lives inside sensory memories: the sound of glass breaking, a siren, the feeling of waiting. But equally significant is what protects us in those moments. It was not in the absence of fear; it was in the presence of calm, contained adults who restored a sense of continuity and safety.

More recently, as conflict and unrest escalated again in Iran, I found myself reflecting on these memories not only personally, but professionally and collectively — particularly in relation to the Iranian diaspora. One of the striking features of trauma within diaspora communities is that it often unfolds remotely, yet intimately. Physical distance does not lessen emotional proximity. Many people live their lives in the UK while simultaneously remaining psychologically connected to unfolding events through family members, news updates, disrupted communication, and uncertainty. In recent months, individuals within the Iranian diaspora have experienced a period of silence and shock, followed by helplessness, anxiety, irritability, and emotional exhaustion. There was constant news checking and repeated attempts to contact loved ones. Internet disruptions and communication blackouts amplified the distress even further. For many, the day has become organised around waiting for a single phone call. I recognise this in myself. I would wait throughout the day to hear from my mother in Iran. The timing of those calls depended entirely on when communication became possible.

Until that call came, there was a persistent undercurrent of anxiety. Once I heard her voice and knew she was safe, my day could begin. The impact extended beyond adults. I noticed my nine-year-old son searching online for information about Iran's air force — quietly trying to understand a situation that felt frightening and uncertain. It was a reminder that children absorb far more than we realise, even from a distance. At the same time, we celebrated the Persian New Year, Nowruz — traditionally a celebration of renewal, connection, and hope. Yet for many people this year, there was little desire to celebrate. There was guilt associated with joy while loved ones remained at risk. Families described emotional withdrawal and difficulty engaging in rituals that normally bring comfort and continuity.

From a clinical perspective, these experiences remind us that not all trauma presents itself in conventional ways. Diaspora communities may experience chronic anticipatory anxiety, ambiguous loss, sleep disturbances, emotional numbing, or somatic symptoms without necessarily identifying themselves as traumatised. Many live not in the aftermath of trauma, but in an ongoing state of uncertainty and vigilance. In such contexts, support often begins not with intervention, but with acknowledgement. One of the most meaningful aspects of this recent period was the response from colleagues and professional networks. The Royal College of Psychiatrists issued messages of support and organised an emergency response meeting that recognised the emotional impact these events were having on clinicians and diaspora communities. That acknowledgement matters deeply. Feeling seen and understood is itself protective.

What also stood out was the role of human connection. Colleagues who I hadn't spoken to for years reached out to see if I was alright. Even some patients expressed concern. There were moments during the ward rounds when I mentioned that I might need to take an urgent call from my family abroad. Patients gently reassured me that I should answer if needed. These interactions reminded me that care is not always one-directional. In times of crisis, our shared humanity often becomes more visible. The experience also reinforced the importance of community networks. Informal support systems — messages, phone calls, checking in on one another — are not secondary to coping; they are often central to it.

Iran is a country with a rich cultural and historical heritage, but also a society that has endured decades of war, political upheaval, sanctions, and uncertainty. These experiences leave traces across generations, shaping both vulnerability and resilience.

In Persian literature, there is the mythical bird, the Ghoghnoos, often compared to the phoenix — a creature associated with endurance, destruction, and renewal. I have thought about that image often recently. Not because resilience means remaining untouched by suffering, but because people continue despite uncertainty. They continue caring for one another, continuing rituals where possible, continuing to work, parent, connect, and hope. Perhaps hope during conflict is rarely dramatic. More often, it is quiet.
It is waiting for the phone call.
It is checking on a colleague.
It is sitting together after the glass has shattered, and continuing the meal.
And perhaps that is what we hold on to — not certainty, but connection, even in the most uncertain of times.

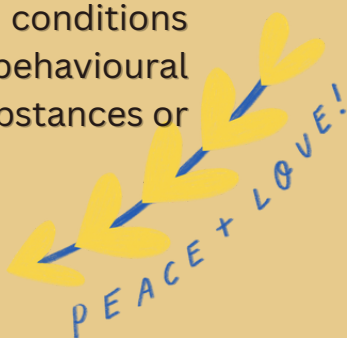
Dr Pardis Mostajabi
Chair, Iranian Diaspora Association in Psychiatry (IDAP)

Clinicians' Mental Health in Conflict Zones and Humanitarian Emergencies

Before discussing clinicians' mental health in conflict zones and humanitarian emergencies, it is important to reflect on the undeniable stress experienced by mental health clinicians residing in the UK. Nevertheless, being involved in conflict zones and in humanitarian emergencies is different because of the intensity of experience. People working in these areas suffer the same adversity as everyone else in the community. They may experience homelessness, grief, and uncertainty about the future. In Afghanistan, women workers arrived at my workplace in tears after yet another restriction on their rights. My colleague working in Gaza during the war told me that every day she would come to her workplace and find that at least one of her colleagues had suffered a bereavement or some loss of some kind. What's fascinating is their resilience!

There are now more pockets of emergency than ever before, and fewer and fewer resources. This increases the needs of beneficiaries and the stress on mental health workers. Research by the Antares Foundation found that 30% of international aid workers show symptoms of PTSD, and rates of depression and anxiety are 2-3 times higher than in the general population. Local staff, who often cannot leave the crisis zone, carry an even heavier burden. They may be survivors themselves while also providing care for others. My own experiences come from a position of privilege, as I can leave the situation in a secure environment and with security guards present. That isn't the experience of local mental health workers.

International emergency response in mental health now includes, quite rightly, self-care and those employed in mental health. This is in the Inter-Agency Standing Committee guidelines. The Psychological First Aid Toolkit has many sections on self-care for mental health workers, as well as empowering others to look after themselves. There are new toolkits that can be very helpful for self-care, such as Doing What Matters in Times of Stress. This is useful for both beneficiaries and mental health workers. There are clear signs of burnout in mental health staff. Depression, anxiety, and hopelessness are common. Grief is a common thing. Despite this, life goes on, and people have to attend to their day-to-day duties. Stress conditions are common and lead to many physical, emotional, and behavioural problems. There can be maladaptive coping methods, such as substances or alcohol, or excessive work.



From my own experience, I would like to share a few examples. Nothing prepared me for the stress of the 2010 Haiti earthquake. I will not go into the details, but those memories linger with me to this day. I saw people broken by what they saw. Some people just couldn't take it anymore and needed to be removed. To help others, one must have good mental health. In our group, everyone had burnout or a breakdown at some point, including me. We found our way of dealing with stress. During the Ebola crisis, making a mistake with a needle is a potentially lethal mistake. As a result of prolonged stress, people perform poorly at work and make mistakes. One of the areas I have focused on during my humanitarian service is supporting staff who make mistakes. This could be as simple as taking time off and addressing problems. Over the past 15 years, there has been significant progress in care for workers in humanitarian emergencies. Many organisations have counsellors as essential members of their teams. For myself, on a few missions in dangerous places, I had mandatory psychological assessments before and after deployment. This actually helped, especially in adjusting back to a world without imminent danger.

Over the years, I have learned several strategies for reducing stress. First, mandatory rest periods. In an emergency, there is always a tendency to want to work all hours. We stopped doing this, although it was extremely difficult, but it helped us. Secondly, we supported mental health workers and others through sessions on Psychological First Aid and basic self-care. Thirdly, other aspects of maintaining a healthy mental health are ensuring that people have clear roles in their jobs. This includes supervision and, most importantly of all, a regular salary. In some places, I learned that it wasn't just the mental health of the staff that needed to be discussed, but their children as well. Sometimes I've seen children not managing well, with behavioural problems clearly attributable to humanitarian emergencies.

Humanitarian workers' mental health is of paramount importance. A clear job description, being valued and respected, and receiving time off are critical. It is important to ensure that not only the employees, but also their families and children are safe.

Dr Peter Hughes
Consultant Psychiatrist & Founding Member of VIPSIG

Care in Conflicts: The Elephant in the Field

Conflict imposes particular cruelty on healthcare workers. It not only puts them in danger but also compels them to remain in that danger. They need to set aside their own fear and grief to attend to others, and they often do it repeatedly without adequate rest, resources, or recognition. The clinician in a conflict zone occupies an almost paradoxical position: They are simultaneously among the most essential people on the ground and among the least likely to receive support for their own psychological needs. This extends to mental health professionals, even when not deployed on the frontline. Harm in modern warfare is insidious, unpredictable and less impacted by physical proximity.

Personally, mass armed conflict has been at the forefront of my existence since inception. I was born at the height of the infamous Lebanese civil war and witnessed the impact of political violence and constant instability. The irony is that my adult life seems to have gone full circle with the latest ‘war in the Middle East'. Over the years, I have worked with asylum seekers in the UK, Syrian refugees in Lebanon, and again with the victims of the Beirut explosion in 2020. I found myself in Dubai again, where I relocated 5 years ago, asking at the clinic, ‘So how did the war affect you?' I am now convinced that this context is unavoidable, but also that traditional training frameworks are not equipped to address it.

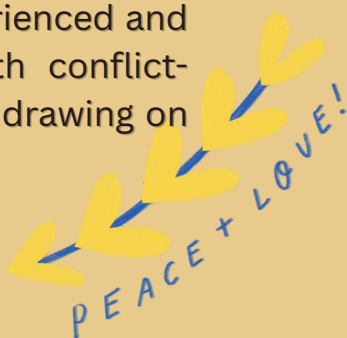
The Middle East has historically and in recent years been one of the most obvious illustrations of this reality. We could highlight all the conflicts that have shaped this narrative, but we risk falling into the trap of comparing scale and context. In all cases, what has emerged is not simply a story of courage, but one of accumulated, unaddressed psychological injuries. Field surveys conducted in conflict-affected regions across the globe have consistently documented rates of post-traumatic stress disorder (PTSD), depression, and burnout among healthcare workers that far exceed those seen in civil practice. Yet disclosure remains rare, and when it happens, it leads to hardly any action. Stigma, long a barrier to help-seeking in general populations, is compounded in conflict settings by professional culture, by the internalised belief that the clinician must endure what the patient endures, and sometimes by the very real logistical impossibility of accessing support.

What distinguishes the mental health burden of clinicians in conflict zones from that of other trauma-exposed groups is not simply the intensity or duration of exposure, but its compound and morally laden nature. These are professionals trained to save lives who are forced to make triage decisions under bombardment, who work without anaesthesia, who watch patients die from injuries that would have been survivable in peacetime. This is the terrain of moral injury, a construct that has gained considerable traction in military psychiatry. However, it remains overlooked for civilian clinicians at war. Moral injury arises not from fear alone, but from the violation of deeply held professional and ethical commitments. It manifests as guilt, shame, spiritual distress, and a corroding sense of professional identity. This is not adequately captured by diagnostic frameworks alone. The psychiatric community has a responsibility to respond to this reality with seriousness from a clinical and advocacy perspective.

Several principles can guide this effort. Psychological injury in conflict-exposed clinicians is frequently invisible, both to those who bear it and to the system nominally responsible for their welfare. Routine, structured psychological assessment, not as a punitive measure, but as a standard of institutional care, should be integrated into humanitarian health responses. Organisations such as the WHO and Médecins Sans Frontières have developed frameworks for this; the challenge lies in implementation within health systems that are themselves collapsing.

Peer support is not a luxury. In environments where specialist mental health input is scarce, trained peer support structures offer a pragmatic and culturally acceptable first line of response. Psychological first aid delivered by peers has strong evidence. In the Arab world specifically, where the therapeutic relationship is often shaped by trust built through shared community and professional identity, peers and senior colleagues may serve as more effective first points of contact than external consultants unfamiliar with the local context.

Western trauma frameworks, including PTSD, may be insufficient or, in some cases, alienating when applied without adaptation to Middle Eastern clinical contexts. Concepts of collective suffering, religious meaning-making, family honour, and community cohesion all shape how distress is experienced and expressed. Psychiatrists and psychologists working in or with conflict-affected regions must engage genuinely with these frameworks, drawing on local expertise.



Mental health sequelae in clinicians do not resolve when the guns fall silent. Many practitioners carry the weight of what they witnessed for years or decades, often without adequate follow-up. Diaspora clinicians, including many who have relocated to the Gulf states, Europe, or North America, may present in Western consulting rooms or as colleagues working side-by-side. They may carry all the baggage of war, displacement and nostalgia. The Royal College and its international networks are well placed to support the development of long-term follow-up pathways for this population.

The mental health of clinicians in conflict zones cannot be meaningfully addressed without addressing the conditions that generate that distress. Attacks on healthcare facilities, which the UN has documented regularly across several countries, are violations of international humanitarian law. The psychiatric profession should align itself unambiguously with calls for the protection of health workers and healthcare infrastructure. Our credibility as advocates for mental health depends, in part, on our willingness to name and shame the structural violence that produces the conditions we are asked to treat.

Clinicians working in the most dangerous places on earth deserve more than admiration. They deserve our focused professional attention, advocacy, and commitment to building systems that treat their suffering as an urgent clinical and ethical concern. Bearing witness to trauma is part of what they do. It should also be part of what we do for them.

Joseph El-Khoury, MD, MSc, FRCPsych
Consultant Psychiatrist
Dubai, UAE

VIPSIG is running a volunteering survey.

We are aware that many of our members are engaged in fantastic work in the UK and abroad. We hear stories about this work at all the events we run. We are keen to learn more about it and showcase it in an effective way. Our hope is that other members will take inspiration from the work already being undertaken to further their own volunteering ambitions, as it fits with their personal and professional expertise and interests. By better understanding the work that is already being done, VIPSIG hopes to enhance our ability to organise, inspire and promote volunteer work at home and abroad.

We know that this work is tremendously diverse in the form it takes. Some will join a large NGO and be part of a multinational effort, and some will be ad-hoc groups of interested colleagues. We also know that our colleagues vary in their commitment level. Some will contribute small pieces of work occasionally and some will commit full time. All of this work is valued and we would like to hear about it.

We would be very grateful if you could fill in this short survey, which should take less the 5 minutes to complete.

Dr Lachlan Fotheringham and the VIPSIG executive committee

THANK YOU SO MUCH!