Psychosocial Protection in Humanitarian Crises

A proactive response to emotional and traumatic stress

By Fernanda Menna Barreto Krum
& Nonviolent Peaceforce

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Contact
Huibert Oldenhuis
Global Head of Programming
holdenhuis@nonviolentpeaceforce.org



Assessment during a brutally cold winter marked by targeted attacks on civilian infrastructure and weaponization of weather. Kherson, Ukraine, January 2026. Photo: Nonviolent Peaceforce

Mental Health and Psychosocial Support (MHPSS) and Unarmed Civilian Protection (UCP)



NP staff and partners at a six-day Veterans Retreat. Ukraine, November 2025. Photo: Nonviolent Peaceforce

Introduction

The physical safety and mental health of people experiencing violence are deeply intertwined. Conflict and violence generate high levels of psychological distress due to direct threats to safety and human rights. Affected communities are experiencing a persistent range of stressors with short and long-term consequences. Cases abound of unaddressed trauma fueling cycles of violence or reducing capacities for civic engagement and self-protection. Effective protection efforts need to integrate responses to these mental health challenges to be sustainable, effective, and ethical. Though the mental health and wellbeing of populations affected by violence have always been concerns in humanitarian crises, this has only been recognised as a core protection issue within the last decade.

"I became afraid to help others, thinking, "This is what I get for being kind," reflects a youth who was detained over two years in Myanmar after helping a friend. That friend had asked for his company to go through a checkpoint in Mandalay region but was secretly carrying drugs. Through volunteering for an emergency response after the 2025 earthquake, the formerly detained youth regained trust in his community members through engaging in unarmed civilian protection (UCP) that combined civic engagement with peer-to-peer early psychosocial and support interventions. A recent study on safety and mental wellbeing in Myanmar reveals that one in seven youth live in near-constant fear for their personal safety, while four in ten feel unsafe walking alone at night

"Everything broke in my head and soul. And my body. You are alive, but you don't feel alive" reflects Serhii Dovbysh, of the impact of the Ukrainian war on his already pre-existing mental health issues. With lost limbs and dealing with depression, post-traumatic stress disorder symptoms such as nightmares, or panic attacks and anxiety, veterans of war continue to face major risks and challenges to reintegrate into life, as do their families. Tensions between couples and families have exacerbated, intimate partner violence has increased. The broader violence of the war has put a strain on interpersonal relationships and community resilience. In Ukraine and elsewhere, responses that recognise and address the interlinkages between violence and psychosocial health are essential to creating the conditions for sustainable peace – individually and relationally.

The impacts of violence on mental health

Over 100 million people around the world are in ongoing need of protection support in the context of humanitarian crises, and all face major life events and changes that have an immense impact on people's mental health. The World Health Organization (WHO) estimates that one in five [22.1%] conflict affected populations will develop a mental health disorder.

Across the countries where Nonviolent Peaceforce (NP) is currently active, traumatic stress is pervasive. For instance, a 2017 study in South Sudan showed 41% of participants displayed PTSD symptoms, a trend consistent across ethnicities. Similarly, research in 2023 indicated that 47% of those displaced by conflict from Khartoum experienced PTSD. After the 2021 military coup in Myanmar, a survey of 7,720 adults highlighted that approximately 60% suffered from anxiety and depression. Likewise, a 2022-23 study in Ukraine unveiled a marked rise in PTSD and moral injury among civilians, with greater severity of PTSD symptoms observed among women, the elderly, those who were forcibly displaced or from areas under Russian occupation. While these insights represent a limited sample, they reflect the widespread experience of trauma within conflict-affected communities.

While not everyone develops an acute mental health condition because of experiencing violent conflict, many suffer from less severe but remarkable (and lately, compounded) psychological distress. Human rights violations and constant threats to safety, forced displacement, and separation from family and community have direct and individual impacts, but are also experienced collectively. Violent conflict disrupts entire cultures and societies, and the negative psychosocial impacts of mass violations can obstruct social cohesion, fracture a sense of morality and ethical considerations, and ultimately fuel new cycles of violence.

The case for integrating protection, peacebuilding, and MHPSS

Amidst the compounding adversities described above, it is imperative that civilian protection responses integrate the psychosocial protection aspect of human safety. While many actors in the humanitarian and peacebuilding sectors are stepping up their efforts to provide or facilitate mental health and psychosocial support (MHPSS), it is still largely viewed as a post-incident service of healing for survivors of violence. This ignores its potential to be applied as a protection strategy. In a world where violent conflicts and wars stretch out without end in sight, it is all too easy for exhausted or traumatised frontline protection actors to retreat or give up. In the worst cases, trauma and stress fuel feelings of revenge or lead people to make poor decisions about their own security or that of their teammates. The integration of MHPSS into protection and peacebuilding efforts, therefore, is not merely a duty of care but also a security management tool and a strategy for violence prevention.

Several evidence-based studies (described below) of integrated programmes show that cycles of violence can indeed be more effectively interrupted if we address the conflict-induced mental health challenges within these communities, as these challenges typically amplify the risk of adverse social patterns (i.e. substance misuse, gender-based violence, and organised criminality).

For example, a PhD study examining part of a three-year (2017–2021) multisectoral initiative in northern Uganda found that the programme—aimed at conflict mitigation and reconciliation by addressing unattended past conflict-related trauma and economic hardships—led to a significant decrease in SGBV, tribal disputes, and land conflicts among participants. A research paper on integrating MHPSS in reconciliation and violence prevention among Rwandan and Tajikistanis communities in 2023, showed that the most effective peacebuilding approaches are the ones which provide holistic responses to the complex interplay of cycles of violence. In Rwanda it led to enhanced trust and solidarity, increased quality of interactions across social divides, improved attitudes towards peaceful conflict resolution, and a stronger sense of a shared identity among community members. In Tajikistani families, there was a decrease in violence against women and girls that improved the family unit wellbeing and enhanced inclusion and social cohesion at the local level. These examples show that mental health and psychosocial support should not merely be regarded as a matter of post-incident care for survivors, but as a method for preventing violence and protecting civilians from violence. We call this psychosocial protection.

Unarmed Civilian Protection as a pathway for psychosocial protection

Over the past few years Nonviolent Peaceforce (NP) has integrated MHPSS into the practice of Unarmed Civilian Protection (UCP). One of the foundations of mental health and psychosocial wellbeing is the sense of security that comes from living in a safe and supportive environment. This aligns with the practice of UCP, which is rooted in interconnection, relationships, and being responsive to local needs. As an approach, UCP considers both the mental state and psychosocial wellbeing of people as integral to their security and that the path to healing is reconnection with oneself and with others, through safe and trustworthy relationships. Additionally, UCP supports communities in engaging directly (or indirectly) with perpetrators of violence, which often empowers people, reduces fear, and creates opportunities for individual and collective healing.

When direct protection and psychosocial support are integrated and applied at the frontlines of active conflict and war, the gap between traumatic events and response efforts is narrowed, thus reducing opportunities for untreated trauma to fuel cycles of violence. The physical accompaniments by UCP actors of civilian populations across insecure areas are inevitably imbued with a sense of care and psychosocial support, even if their primary focus lies on ensuring the physical safety of these civilians. By strengthening the ability of UCP actors to recognise and stabilise traumatic stress, they are better positioned to build relations and engage in conversations about safety and security threats. Likewise, the visible protective presence of UCP actors, patrolling insecure areas day and night builds trust that allows affected communities to become more open to traumatic stress relief efforts.

Ultimately, when psychosocial protection is integrated into peacebuilding and civilian protection processes to improve the wellbeing of individuals, families and communities, then communities will be enabled to interrupt cycles of violence and regain agency. This contributes to structural transformation and social cohesion, strengthening resilience, and supporting societies to recover and relate better to themselves and others. Moreover, when perpetrators of violence (often people who have been hurt deeply) are included in these healing processes, it is less likely that cycles of violence are perpetuated.

NP's peer welfare programme: Psychosocial protection in practice

NP's integration of psychosocial protection is based on a peer-to-peer approach built for non-specialised personnel. It is applied by trained unarmed civilians through a task-shifting strategy based on evidence-based, low-intensity and early psychological interventions for psychosocial support. Those are primarily Eye Movement Desensitisation and Reprocessing (EMDR) and Sensorimotor Psychotherapy-based interventions for stress management and reduction, somatic management, neuro-regulation and stabilisation practices. It is called the Peer Welfare Programme (PWP), and it has been implemented since early 2024, notably in Ukraine and Myanmar.



NP partners and volunteers incorporate EMDR-based grounding technique into emotionally intense meetings. Kherson, Ukraine, February 2025. Photo: Dr. Sofiia Vecherok

EMDR is an evidence-based therapy derived from the natural coping mechanism of the mind to heal itself, which occurs during sleep, particularly during the rapid eye movement (REM) sleep stage. It was developed in 1987 by Francine Shapiro, whose research demonstrated dramatic improvements in the mental health and wellbeing of trauma survivors through EMDR interventions. Her work, and related research studies, including Randomised Control Trials (RCTs), demonstrate that EMDR early interventions (EEI) protocols used within three months of a traumatic event consistently reduces post-traumatic stress symptoms with outcomes maintained at follow-up, suggesting that it can prevent the exacerbation of such symptoms. Additionally, it aims to prevent the development of a full Post-Traumatic Stress Disorder (PTSD) or other severe mental conditions such as depression. Since then, EMDR has evolved further with adaptations of the standard protocol to various mental health problems, approaches to specific populations such as children, adolescents and people with intellectual disabilities, and is among the psychotherapies recommended by the World Health Organization (WHO).

Sensorimotor Psychotherapy (PS) is an evidence-informed therapy that integrates elements that are evidence-based like mindfulness, neurobiological informed treatments for trauma, and attachment theory. The approach was developed in the early 1980s by Pat Odgen, who worked with clients who had experienced trauma and noticing that traditional verbal therapy did not fully address how the trauma was stored in the body and manifested in physiological symptoms. Her research found PS approaches - such as the window of toleralce, learning to regulate nervous system activation, and adressing somatic symptoms with somatic practices - helped improve conditions for her severely and chronically PTSD patients. Like in EMDR and many other contemporaneous trauma approaches, the idea is that the body's innate intelligence is a natural source for coping with adversity. From the understanding that many symptoms of people affected by traumatic events are somatically based, this approach integrates sensorimotor processing with cognitive and emotional processing in the treatment of trauma. One RTC study showed that a body-orientated group therapy adapted from the Sensorimotor Psychotherapy was valuable for the survivors of childhood trauma to help them develop body awareness, self-soothing skills, and decrease anxiety symptoms.

NP's Peer Welfare Programme has increasingly been adopted by frontline workers and local partners in Ukraine and applied through a proactive psychosocial protection emergency response in Myanmar.

In Ukraine 30 local frontline partners' organisations have participated in NP's Peer Welfare Programme through experiencing EMDR and Sensorimotor Psychotherapy-based early interventions. Besides learning core low intensity practices based on those two therapy models, the PWP also provides theoretical scientific content on peer support, stress signs and management, and identifying traumatic stress and PTSD symptoms. They have created and established their own peer circles with the support of national NP trained peers. Between October 2025 and January 2026, 388 individuals have taken part in Peer Welfare interventions among the 5 regions where NP works in partnership with local Civil Society and Non-governmental Organisations and other community members.

Ukraine Case Study 1: Peer Circles among frontline workers

Since trained NP staff started introducing the peer welfare to frontline workers and community members throughout the region of Mykolaiv, in south Ukraine, two peer circles were established in October 2025 among the partner organisations staff. Those circles consist in in-person and on-line meetings where they alternate between theory and practice of the peer-to-peer based early interventions built for non-specialised personnel. They deepen their knowledge and practice on psychological first aid, and expand their learning about stress management, grounding and nervous-system techniques, as well as how acute and traumatic stress processes happen and present themselves.

This experiential-learning supports psychosocially their own team and prepare them better to support the communities they serve through psychosocial protection skills. They are proactively participating in the design of the meetings, and the gradual facilitation handover is also applied. This participatory and continuing practice approach increases feeling of ownership and commitment, creating the suitable atmosphere for a peer circle to be established.

In their real-life application, frontline workers reported using the grouping practice in acute stress circumstances. When one of their mothers became extremely distressed during an air raid alert. According to her words, "she calmed down visibly and was able to sit through the alarm period without panicking anymore". Others began to integrate the practices into their professional roles, like facilitating a peer-to-peer stress management protocol with a client during a psychosocial session. Frontline workers also use parts of the stress reduction technique in daily activities, like breathing and physical grounding while driving, to reduce anxiety and stress and support regaining control and reducing risky reactions on the road.

They feel more comfortable in giving and receiving support and are finding their ways in creating additional elements of psychosocial protection. To support strengthening their connection with their positive cognitions from the stress management practice, they are setting affirmations as phone wallpapers, creating small collages, writing supportive phrases and keeping them in their wallet or placing them in visible places. Some participants are becoming open to seek psychotherapy as well. All those elements show the positive preliminary impact that peer circles among frontline workers can achieve, to their own wellbeing and the wellbeing of the communities they serve, establishing a multiplier effect of the psychosocial protection layer of duty of care.



Mykolaiv, Ukraine, 2025. Photo: Nonviolent Peaceforce

Ukraine Case Study 2: Peer Tea Sessions for Psychosocial Protection

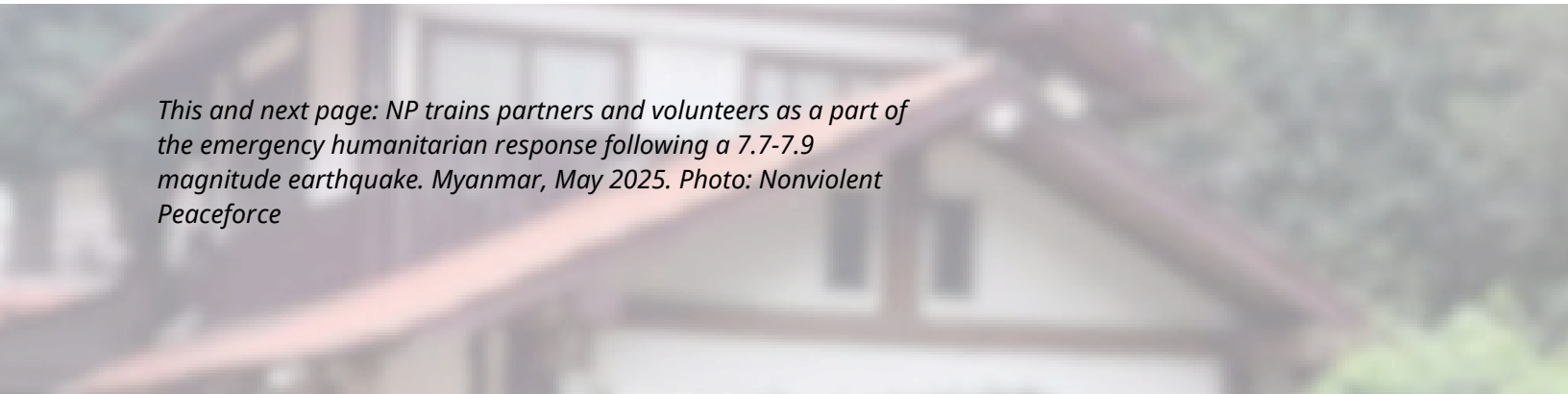
An elder woman living on the formerly occupied and currently frontline region in eastern Ukraine requested support from NP Donetsk team, as she was reacting very distressed to the daily explosions and loud noises. Crying for no reason, chest pain and constant worry about her children were among her traumatic stress symptoms. In addition to that, her husband showed even more severe symptoms, such as a constant depressed mood.

NP team responded to the request by providing psychosocial protection through early intervention practices for stress reduction and grounding as a start. She showed visible improvement of all her symptoms and reported feeling much better. During the second session, she requested to learn the method, so she could support her husband at home. NP staff taught her the practice and provided her with the script to follow for learning how to guide her husband through it.

After a session or two, her husband also started responding positively to the practice, which contributed directly to her strength and confidence on supporting people dealing with distress. As a strong and active member of her community and among her peers, she holds weekly tea meetings at her house and so she started using the peer welfare grounding practice during those meetings.

Now she is known in the community as the “free psychologist” to whom people come if they feel distressed where they can have tea, talk and ground themselves and practice to enhance their sense of psychosocial safety amid constant threats.

In Myanmar, NP applied a proactive psychosocial protection emergency response to the 2025 earthquake in two community regions in the country. Forty civilian volunteers were trained in UCP and early psychosocial protection interventions to deliver community-based listening sessions to 2019 participants. Besides the direct impact on survivors, this intervention has established a confident group of peers that is part of community mechanisms for psychosocial civilian-led protection and early warning early response.



This and next page: NP trains partners and volunteers as a part of the emergency humanitarian response following a 7.7-7.9 magnitude earthquake. Myanmar, May 2025. Photo: Nonviolent Peaceforce

Myanmar Case Study: I am committed to supporting those who have lost their loved ones.

“As a manager at a pharmacy counter, I dedicate my free time to helping those in need and have been involved in charitable organizations. I was involved in different social groups as a volunteer. Through this training, I have learned invaluable lessons about what to do and what to avoid, especially on Do-No-Harm. More than anything, I’ve gained renewed strength and a fresh perspective on life. I want to share my story.

For over seven months, I lived with overwhelming emotional trauma, crying day and night. The second day of this training marked exactly seven months since my husband's passing.
I and my husband, we had a small argument, and I sulked for about three days. Despite his efforts to console me, I couldn’t let go of my resentment. One day, he came to pick me up, and I told him I wasn’t ready to return yet. He gently said, “You’re the one in charge at this department. It’s okay to leave early sometimes. Let’s have dinner together.” But I stubbornly refused, saying I still couldn’t go. He responded softly, “Fine, I’ll never come to pick you up again.”

Shortly after, I received an unknown call. The caller said, “Ko Maung” was in a car accident,” then the line went dead. “Ko Maung” was what close friends called him. At first, I thought it was a prank or a joke. But an uneasy feeling soon took over. I tried calling him back, but his phone was unreachable. When I called again, a hospital staff member answered and told me he was in the ICU. They advised me to come immediately if I was a family member.
I rushed to the hospital. By the time I arrived, he was unconscious. I had gone to pick him
up, but tragically, he would never come to pick me up again.

I blamed myself endlessly, living with guilt and trauma that kept me awake every night. The **Safe Place exercise** and **EMDR therapy** from this training helped me immensely. Yet, it was during the last night, when we listened to a gentle melody and engaged in **peer support** that I finally felt a flicker of strength. I am deeply grateful to the facilitator and all the participants.

I came to this training seeking peace and relief, but instead, I received a **second chance** and a **new life**. The earthquake has taken many loved ones, often without a chance to say goodbye. The pain is almost unbearable. Now, I am determined to help others in similar despair. I believe I can do more than I ever thought possible. **I am ready to stand with those who have lost loved ones**. Thank you to all the participants and donors of this training. May God bless you all.”



Earthquake response. Myanmar, May 2025.
Photo: Nonviolent Peaceforce

Ensuring Do No Harm in scaling out psychosocial protection

The question of Do No Harm has played an important role in the design and piloting of NP's Peer Welfare Programme and in its efforts to scale out psychosocial protection more broadly.

Do no harm is a cross-cutting, overarching guiding principle that must be considered during all stages of the integration of MHPSS into civilian protection programming.
As a fundamental ethical principle, Do No Harm imposes the obligation to certify that the redistribution of tasks from mental health specialists to paraprofessionals, community volunteers or non-specialised personnel does not cause physical, psychological and emotional harm.

NP, through its Peer Welfare Programme initiative, ensures that its personnel are introduced to trauma sensitivity and essentials of MHPSS, such as psychological first aid. Trained peers receive holistic and technical systematic supervision to conduct low-intensity interventions (brief and structured, focusing on practical skills rather than past exploration to treat mild-to-moderate symptom-focused mental conditions). NP staff learn the practices through intensive experiential-learning, training and peer-to-peer approach by first applying them among themselves to cultivate self-awareness and self-care while developing their psychosocial skills.

This approach aims also to increase community-based mental health, promote awareness and decrease stigma and discrimination, and provide affordable interventions while expanding the capacity to deliver evidence-based mental health care and addressing ethical concerns within these treatments. Furthermore, it is based on a cross-sector collaboration, where civilians are trained as non-specialised support. This allows local actors to scale up psychosocial support and early interventions to fill the gap of specialised mental health services and build long-term resources.

Conclusion

Working together to ensure that psychosocial protection is prioritised, resourced, and actioned through humanitarian and peacebuilding programmes is an urgent task. Communities continue to request this support, and many organisations and donors are seeking to find pathways to provide for these needs. The way psychosocial protection is integrated into UCP approaches is one example of this in action, with the evidence demonstrating the tangible impact this approach can have across different violent contexts. The threat and experience of psychological and physical harm are fundamentally interlinked – so making sure we work together, programme across thematic and programmatic silos, and recognise and support safety of communities holistically is essential.

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