BMJ Global Health

Mental health of Ukrainian children and youth during the Russian-Ukrainian war: a scoping review

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To cite: Silwal S, Westerlund M, Osokina O, *et al*. Mental health of Ukrainian children and youth during the Russian-Ukrainian war: a scoping review. *BMJ Glob Health* 2026;**11**:e020506. doi:10.1136/bmjgh-2025-020506

Handling editor Luca Nelli

► Additional supplemental material is published online only. To view, please visit the journal online (https://doi.org/10.1136/bmjgh-2025-020506).

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Received 9 May 2025
Accepted 3 February 2026

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ABSTRACT

Introduction On 24 February 2022, Russia launched a full-scale invasion of Ukraine, escalating the conflict that began in April 2014 with the invasion and occupation of parts of Eastern Ukraine and Crimea by Russian forces. We conducted a scoping review of studies examining mental health problems of children and youth from the beginning of the war in 2014 until 2024. Additionally, we examined traumatic events, resilience, risk and protective factors of mental health.

Methods We searched PubMed and PsycINFO for articles published in English and Open Ukrainian Citation Index and Ukrainian Scientific Periodical for articles published in Ukrainian. We reviewed quantitative and qualitative articles, focusing on children and adolescents aged 0–19 years. The review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) and the protocol was registered with the Open Science Framework.

Results 37 articles (20 English, 17 Ukrainian) met the inclusion criteria. Most studies were cross-sectional in design or quantitative and focused on children and youth residing in Ukraine. The mental health outcomes were diverse, with prevalence rates varying across studies. Among the included studies on mental health, few studies assessed resilience among war-exposed adolescents. Forced displacement, exposure to war-related events and separation from parents were associated with mental health problems. Protective factors included perceived social support, living in a familiar environment and problem-focused coping skills.

Conclusion Methodologically comparable studies, including prospective and mixed-methods studies, are needed to further advance our understanding of the long-term psychological effects of war and explore their perceptions and experiences of wartime adversities.

Protocol registration Open Science Framework (https://osf.io/cuhgd/).

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ The Russian-Ukrainian war has severely affected children and adolescents' mental health; however, literature on their mental health after exposure to the local war in 2014 to the 2022 full-scale has not been reviewed.

WHAT THIS STUDY ADDS

⇒ This scoping review provides crucial insights into war-related experiences and mental health problems among Ukrainian children and youth. Most studies are cross-sectional or quantitative, focus on those living in Ukraine and reveal a wide range of mental health outcomes across studies. Forced displacement, exposure to war-related events and parental separation are common risk factors, while protective factors include perceived social support and problem-focused coping.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ The evidence underscores the profound mental health impact of war on Ukrainian young people, yet long-term consequences remain unexplored. More longitudinal and mixed-methods studies are needed.

INTRODUCTION

On 24 February 2022, Russia launched a full-scale invasion of Ukraine, escalating the conflict that began in April 2014 with the invasion and occupation of parts of Eastern Ukraine and Crimea by Russian forces. By February 2025, over 12 654 civilians had been killed, including 673 children, since the beginning of the full-scale invasion.[1] Furthermore, 6 million Ukrainians have sought refuge in Europe, 3.7 million are internally displaced and 2.9 million people live near front lines where humanitarian access is severely limited.[2] Amid the ongoing conflict, Ukrainian children and adolescents face war atrocities including direct violence and forced separations from family members, contributing to significant mental health challenges and psychosocial needs.[3]

Children and youth are among the most vulnerable groups when there is an armed conflict.[4–6] Apart from the obvious threats to physical health, war also poses significant psychological strain and suffering on young

people.[7 8] Minors face numerous stressors during armed conflicts, including direct hostilities as well as displacement, family violence, separation from or death of caregivers,[4] sexual exploitation, malnutrition, substance use[9] and harsher parenting.[10] Children and youth show a broad spectrum of externalising and internalising symptoms in response to war experiences,[11] including sleep problems, trauma-related play, psychosomatic reactions, separation anxiety, conduct problems,[12] post-traumatic stress disorder (PTSD), depression, anxiety disorders and attention deficit hyperactivity disorder.[4] There can also be psychosocial consequences, such as low educational attainment, poverty and discrimination.[9]

To our knowledge, the literature on the mental health of children and youth exposed to the Russian-Ukrainian war, spanning from the local war in 2014 to the full-scale invasion beginning in 2022, has not previously been systematically reviewed. Therefore, we conducted a scoping review of studies examining mental health of children and youth from the beginning of the Russian-Ukrainian war in 2014 until 2024. Additionally, we examined traumatic events, resilience and risk and protective factors of mental health. A comprehensive review can provide crucial insights into the scope and nature of mental health problems in war-exposed children and adolescents.

METHODS

Search strategy and selection criteria

We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR)[13] and the protocol was registered on the Open Science Framework on 24 April 2024 (https://osf.io/cuhgd/). We searched PubMed and PsycINFO for articles published in English between February 2014 and 7 May 2024. For additional information, we searched for articles published in Ukrainian in two databases: Open Ukrainian Citation Index and Ukrainian Scientific Periodicals. We also screened reference lists of eligible articles and existing reviews on the impact of the Russian-Ukrainian war on mental health of children and youth. Eligible studies were peer-reviewed articles that met the following inclusion criteria: (a) included a sample of children and youth of 0–19,[14] with a flexibility of ±2 years (studies with participants above this age range were included if results were reported separately); (b) considered symptoms of mental health problems or psychiatric diagnoses, including trauma-related and stressor-related disorders (post-traumatic stress disorder and post-traumatic stress symptoms), mood (affective) disorders such as depression, anxiety disorders and anxiety symptoms, obsessive-compulsive disorder, internalising and externalising behaviour problems, self-harm and self-injury, suicidal ideation and suicide attempts, substance use (including alcohol, smoking, cannabis and vaping), attachment-related problems, attention-deficit/hyperactivity disorder, conduct problems, adjustment problems, oppositional behaviour problems, sleep problems, loneliness and eating problems; (c) studies reporting mental health effects of the Russian-Ukrainian war since 2014, (d) were both quantitative observational studies such as cross-sectional, case-control, cohort studies, longitudinal or ecological studies and qualitative studies, (e) were published in English and Ukrainian languages. Studies reporting conference abstracts, case series or case reports were excluded. The syntax is provided in online supplemental table S1. For studies published in English, two reviewers (KA, SS) independently screened the titles and abstracts. Full texts were reviewed for final eligibility and in cases of disagreement, final decisions were made after discussing with senior researchers (MW and AOP). For studies published in Ukrainian, two reviewers (OO, BI) screened articles and disagreements were resolved through discussions. Then, KA, SS and OO extracted key information (ie, author, year, study design, sample size, age, data source, trauma exposure measurement, outcome measures, main findings and other findings). Next, we conducted a narrative synthesis from the included studies.

In this review, we used 'early phase of war' to refer to studies addressing the Russian invasion of Eastern Ukraine from February 2014 to February 2022 and 'full-scale war' for studies conducted since February 2022 full-scale Russian invasion until 7 May 2024.

Quality assessment

For studies published in English, four authors (KA, SS, MW and AOP), first independently and then in pairs, scored and compared each study according to the Quality Assessment with Diverse Studies (QuADS),[15] a tool that assesses quality that can be applied to methodologically diverse studies and that includes 13 areas rated on a scale from 0 ('low quality') to 3 ('high quality') with the option of 'not applicable.' The total score ranges from 0 to 39. A percentage of the total score was calculated for each study, where 39 represented 100%. Following Goagose and colleagues,[16] this percentage was used to sort the studies into three categories: Category 1 (> 50%), Category 2 (50–75%) and Category 3 (> 75%). Total scores for each of the 13 areas were calculated to identify the strengths and weaknesses of the quality of the studies. The 13 areas are indicated in the footnote of online supplemental table S2.

Patient and public involvement

This research was done without patient and public involvement.

RESULTS

Characteristics of the included studies

In the database search for studies published in English, we identified 434 citations and removed 42 duplicates (see flowchart in figure 1). After screening the titles and abstracts of the remaining 392 citations based on the inclusion and exclusion criteria, an additional 355 studies

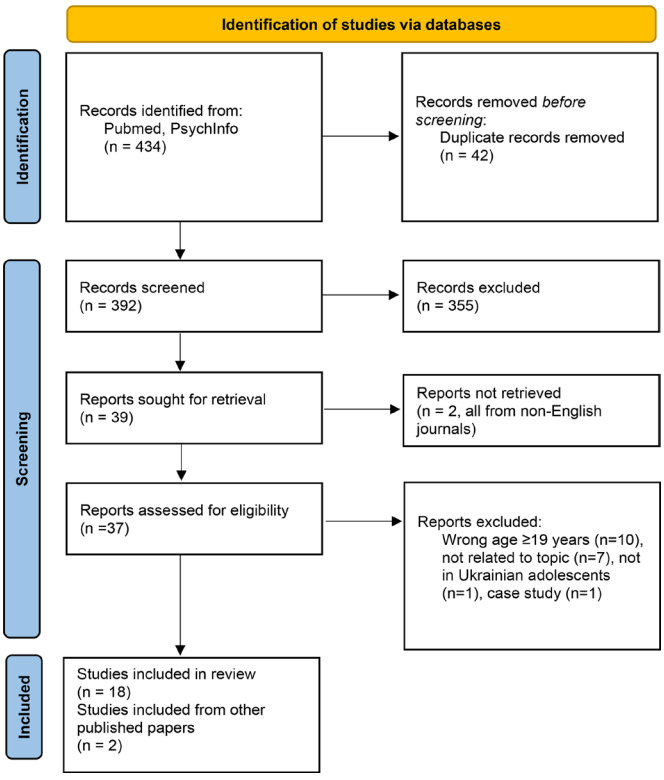

Figure 1 Flow diagram of the study selection process for articles published in English.

were excluded. Out of 37 full-texts reviewed, 19 studies were excluded for the following reasons: mean age group ≥19 years (n=10), not related to the topic (n=7), not focused on Ukrainian adolescents (n=1) and case study (n=1). We included three studies with an age range of 19±2 years.[17–19] We identified two additional articles from the reference lists of eligible articles. For Ukrainian articles, an initial search identified 34 articles, with 17 articles meeting the inclusion criteria. The reasons for exclusion were reviews and age ≥19 years. In total, this scoping review included 20 articles published in English, with 26 006 participants with age range from 1.5 to 21 years, and 17 articles published in Ukrainian involving 2315 participants aged 1–18 years. Two studies[20 21] used the same samples as another two studies,[22 23] respectively.

Study design

Among 20 articles published in English, 17 were quantitative, one study used a mixed-methods approach and two were qualitative. Of the 17 quantitative studies, 16 were cross-sectional and one was longitudinal (table 1). 13 of the 20 studies focused on children and youth in Ukraine,[18–30] three on those in Ukraine and abroad[17 31 32] and four on Ukrainian children and youth in Poland (n=2),[33 34] Germany (n=1)[35] and Israel (n=1).[36] The samples varied from population-based (n=14) to clinical (n=3) or refugee (n=3). Mental health was reported by the children and youth in 13 studies, by the caregivers in five studies and by both in two studies.

As shown in table 1, four studies were conducted during the early phase of war[22–24 27] and 16 studies during the full-scale war.[17–21 25 26 28–36] The studies were published between 2020 and 2024, with a rapid increase of studies published during the full-scale war (see figure 2).

We explicitly included articles in Ukrainian to enhance evidence on the mental health effects of the war on children and youth. The Ukrainian-language articles were not indexed in scientific databases; as such, the results from these studies are summarised in a separate section. Of the 17 studies published in Ukrainian, seven had mixed-methods designs,[37–43] six were quantitative[44–49] and four were qualitative[50–53] (online supplemental table S3). Most studies were cross-sectional (n=14) and three were quasi-experimental. Sixteen studies were focused on children and youth living in Ukraine, while one study was on those abroad.[45] Samples varied from general population (n=2),[39 48] school-based (n=3),[45 47 49] internally displaced (n=4),[38 44 52 53] internally displaced in camps (n=2),[40 50] summer camps (n=1),[41] military families (n=1)[37] and clinical (n=2).[42 43] A key methodological difference was that the Ukrainian studies commonly used interviews, whereas studies published in English often relied on self-reports. Furthermore, Ukraine studies more frequently focused on local populations, used local assessment tools and projective methods. Informants were children and youth (n = 8),[41–43 45 46 48 49 52] parent only (n=1)[37] or both (n = 5).[38–40 50 53] Some studies examined children in occupied territories[41] and military families.[37 41] Three studies reported the effects of war through drawings.[44 47 51] The studies were published between 2014 and 2024, five studies were conducted during the early phase of war[42–44 50 51] and twelve studies during the full-scale war.[37 39–41 45–49 52 53]

Quality assessment

Of the 20 articles published in English language, six studies were classified into Category 3, eleven studies into Category 2 and three into Category 1 (online supplemental table S2). The area of the QuADS tool with the highest score was 2. Statement of research aim/s followed by 4. The study design is appropriate to address the stated research aim/s (online supplemental table S2). Most studies received a score of 3 (high quality) in study design (area 4), although most used convenient samples. Given the restraints of conducting research in the context of war and recruiting representative samples, we considered convenience samples and cross-sectional designs appropriate as long as they were properly tailored to address the study aims. All but three studies scored '0' on area '12. Evidence that research stakeholders have been considered in research design or conduct'.

Mental health problems (Studies published in English)

Among the 20 studies published in English, most were quantitative studies (n=18) and used validated standardised tools to assess mental health problems.[27] The most common symptoms of mental health problems examined

Table 1 Summary of the quantitative studies published in English

Author	Study design	Study population	Sample size Age range (years)	Informant	Measures	Prevalence of mental and psychosocial problems	Quality category*
Quantitative studies—early phase of war							
Martsenkovskyi *et al*[27]	L	Clinical sample in Ukraine	n=149 15–17	Interview: children and parent	K-SADS-PL, CAPS-CA, CDRS-R	32.9% with PTSD developed depression vs 8.5% without PTSD (RR 3.8 (95% CI 1.7 to 8.8). 24.1% had non-suicidal self-harming behaviour and 18.1% had suicidal thoughts.	3
Burlaka *et al*[24]	CS	Students in Ukraine	n=2763 10–17	Self-report: adolescents	UIBS, YSR, APQ	1.8% (n=28) of girls and 3.4% (n=41) of boys met a borderline cut-off for conduct disorder and, among them, 6.1% (n=73) boys and 3.7% (n=57) of girls were in clinical range.	2
Osokina *et al*[22]	CS	Students in Ukraine	n=2766 11–17	Self-report: adolescents	HTQ, GAD-7, PHQ-9	Point prevalence in war-torn region compared with non-war region: PTSD (5.3% vs 1.2%), moderately severe or severe depression (7.5% vs 2.9%), severe anxiety (4.4% vs 1.5%).	3
Sourander *et al*[23]	CS	Students in Ukraine	n=2752 11–17	Self-report: adolescents	Self-harm, suicidal ideation, suicide attempts: single item	Any suicidality or self-harm was 31.7% in war-torn region vs 18.6% in the non-war region (aOR 1.9, 95% CI 1.6 to 2.4). Girls in a war-torn region had higher suicide attempts, suicidal ideation and self-harm behaviour than girls in the non-war region. Boys reported more suicidal ideation.	3
Quantitative studies—full-scale war							
Karamushka *et al*[17]	CS	Youth and adults in Ukraine and abroad	n=344 Age: <20	Self-report: youth, online	BBC-SWB	Psychological well-being scores M 3.6 (SD=0.8), were at the average level compared with other age groups, 21–30, 31–40 and >50 years but higher than the 41–50 year age group.	1
Catani *et al*[35]	CS	Refugees in Germany	n=42 M (SD)=16.4 (0.7)	Self-report: adolescents in schools	GAD-7, PHQ-9, PC-PTSD-5, RHS-15	Of all four mental health domains (general emotional distress, PTSS, depressive and anxious symptoms), 21.4% exceeded cut-off scores in all screening tools.	2
Palace *et al*[19]	CS	Students in Ukraine	n=223 M (SD)=18.4 (2.1)	Self-report: students, online	BDS, War Events Questionnaire	NA	2
Urbański et al[34]	CS	Refugees in Poland	n=284 M (SD)=12.0 (1.8)	Self-report: adolescents	CDI 2, STAI-C, JSR, CYRM-R	NA	2

Continued

Table 1 Continued

Author	Study design	Study population	Sample size Age range (years)	Informant	Measures	Prevalence of mental and psychosocial problems	Quality category*
Bean *et al*[33]	CS	Clinical sample in Poland	n=19 2–19	Interview: caregivers and children	CBCL, YSR 11–18	Children report: 11.1% have internalising problems, 22.2% externalising problems and 11.1% in total problems clinical range. Parent report: 15.8% of participants have internalising problems, 10.5% externalising problems and 10.5% in total.	1
Goto *et al*[31]	CS	Students in Ukraine and abroad	n=8096 Age: ≥15	Self-report: adolescents, online	CATS, PHQ-9, GAD-7, CRAFFT 2.1, SCOFF	Ukraine: 35.0% psychological trauma, 6.9% severe depression, 5.9% severe anxiety, 20.5% substance use and 29.5% eating disorders. Abroad: 43.6% psychological trauma, 11.4% severe depression, 8.0% severe anxiety, 17.4% substance use and 36.5% eating disorders.	3
Halchenko *et al*[25]	CS	Students in Ukraine	n=1022 10–20	Self-report: adolescents, online	CD-RISC-10	Boys, internally displaced and children demonstrated higher levels of resilience.	2
Kapel Lev-Ari *et al*[36]	CS	Refugees in Israel	n=59, 15–18	Caregiver report	YCPC, CBCL	Three children (5.3%) had clinical PTSD, 29.8% internalising problems, 19.3% externalising problems, anxiety was 17.5% and depression 12.3%.	2
Three-Item Loneliness Scale et al[20]	CS	Children in Ukraine	n=1238 M (SD)=9.9 (3.9)	Caregiver report, online	CATS, GAD-7, PHQ-9, TILS, AUDIT-10, ITQ	Among children aged 3–6 years (n=302), 17.5% met DSM-5 criteria for PTSD, children aged 7–17 years (n=936), 12.6% had PTSD. Of all children, 13.8% experienced PTSD.	2
McElroy *et al*[21]	CS	Children in Ukraine	n=1238 M (SD)=9.9 (3.9)	Caregiver report, online	PSC-17	Internalising symptoms increased since start of the war M 1.1 (SD=1.4) and externalising symptoms M 0.8 (SD=1.4) and attention problems M 1.1 (SD=1.4). 35.9% of parents reported children worried a lot since the beginning of the war.	2
Nabochenko *et al*[32]	CS	Children with SEN in Ukraine and abroad	n=466 6–10	Caregiver report, online	Self-developed questions	Children experienced restlessness (40.1%), anxiety (38.6%), fear (26.6%), depressed mood (1.5%), sleep problems (11.2%), withdrawn (3.6%) and indifferent (2.8%).	1
Pfeiffer *et al*[28]	CS	Clinical sample in Ukraine	n=200 Age range: 4–21	Interview: adolescents	CATS-2	68.7% (n=123) fulfilled DSM-5 PTSD criteria, 31% (n=56) ICD-11 PTSD and 21% (n=38) ICD-11 CPTSD.	3

Continued

Table 1 Continued

Author	Study design	Study population	Sample size Age range (years)	Informant	Measures	Prevalence of mental and psychosocial problems	Quality category*
Redican *et al*[29]	CS	Students in Ukraine	n=499 3–6 n=1505 7–17	Caregiver report, online	CATS	PTSD for preschool sample was 15.4% (n=77) and for child and adolescent sample was 14.4% (n=217).	2

*Quality appraisal was scored using Quality Assessment with Diverse Studies and scores categorised into three categories: Category 1 (> 50%), Category 2 (50–75%) and Category 3 (> 75%).
aOR, adjusted odds ratio; APQ, Alabama Parenting Questionnaire; AUDIT-10, Alcohol Use Disorders Identification Test; BBC-SWB, BBC Subjective Well-being scale; BDS, Brief Depression Scale; CAPS-CA, Clinician-Administered PTSD Scale for Children and Adolescents; CATS-2, Child and Adolescent Trauma Screen; CBCL, Child Behavioural Checklist; CDI 2, Children's Depression Inventory; CD-RISC-10, Connor–Davidson Resilience Scale; CDRS-R, Children's Depression Rating Scale-Revised; CRAFFT 2.1, Car, Relax, Alone, Forget, Friends, Trouble; CS, cross-sectional; CYRM-R, Child and Youth Resilience Measure-Revised; GAD-7, General Anxiety Disorder; HTQ, Harvard Trauma Questionnaire; ICD-11, International Classification of Diseases 11th Revision; ITQ, International Trauma Questionnaire; JSR, Jak Sobie Radzisz; K-SADS-PL, Kiddie-Schedule for Affective Disorders and Schizophrenia-Present and Lifetime version; L, longitudinal; M, mean; NA, not available; PC-PTSD-5, PrimaryCare PTSD Screen for DSM-5; PHQ-9, Patient Health Questionnaire; PSC-17, Paediatric Symptom Checklist; PTSD, post-traumatic stress disorder; PTSS, Post-traumatic Stress Symptoms; RHS-15, Refugee Health Screener-15; RR, relativerisk; SCOFF, screening for eating disorders; SEN, special educational needs; STAI-C, State–Trait Anxiety Inventory, Child Version; TILS, Three-Item Loneliness Scale; UIBS, University of Illinois Bully Scale; YCPC, Young Child PTSD Checklist; YSR, Youth Self-Report.

Figure 2 Number of publications from 2014 to 2024.

were PTSD, externalising and internalising problems. The prevalence rates varied widely across studies, partly driven by the use of different instruments, different time periods of data collection and different informants (ie, self and caregiver-report) to measure the same problems, which limited the possibility to make comparisons. Depression and anxiety were commonly measured using self-reported Patient Health Questionnaire-9 or Generalised Anxiety Disorder-7 in three studies[22 31 35] and via caregiver report in one study.[20] PTSD was assessed using the Child and Adolescent Trauma Screen in two studies.[20 29] Emotional and behavioural problems were measured using the Youth Self-Report in two studies[24 34] and Child Behaviour Checklist in two studies.[33 36] Additionally, various scales were used in individual studies such as Brief Depression Scales,[19] Clinical-Administered PTSD Scale for Children and Adolescents,[27] Connor-Davidson Resilience Scale,[27] Child and Youth Resilience Measure-Revised,[34] War Events Questionnaire,[19] Refugee Health Screener[35] and Young Child PTSD Checklist,[36] etc. In studies conducted during the early phase of war, children and youth living in a war-affected region reported symptoms of PTSD, anxiety and depression, self-harm and suicidal behaviours.[22 23] One longitudinal study on children and youth with PTSD for 12 months reported that 32.9% developed depression after 1 year compared with 8.5% without PTSD, 24.1% experienced non-suicidal self-harm behaviour and 18.1% reported suicidal ideation.[27]

In a study conducted during the full-scale war, in a clinical sample, the prevalence of children and youth meeting criteria for PTSD as per the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) and International Classification of Diseases 11th Revision was as high as 68.7% and 31.3%, respectively.[28] Two studies reported internalising and externalising problems both at the clinical[33] and the population level.[21] In three studies, adolescents reported peritraumatic dissociative experiences, anxiety related to the Russian use of nuclear, chemical or biological weapons and death anxiety,[19] withdrawal and sleep problems.[21 32]

In the following sections, we describe traumatic events, resilience, risk and protective factors identified among the 20 studies published in English.

Traumatic events (studies published in English)

Among the 20 studies published in English, 10 studies reported on traumatic events experienced by children and youth. One of the most significant contextual changes to civilian life during war is relocation and forced migration. In one study conducted in the early phase of the war, 12.2% of children and youth residing in a region more directly affected by the war reported forced separation from parents or family members, compared with 0.8% in safer regions of Ukraine.[22] Another study found that in 2023, during the full-scale war, around one-fifth of young people had been separated from parents,[31 32] and 5.8% had lost a loved one.[32] Other studies documented that adolescents exposed to the early phase of war frequently witnessed different types of violence such as homes being destroyed (37.2%), civilians being killed or injured (30.3%) and armed attacks (60.2%),[22] and 53.7% reported seeing familiar people being killed or injured.[27]

In studies conducted during the full-scale war, caregivers reported that 49.7% of children aged 3–6 years, 53.8%–57.1% of children and adolescents[20 21 36] and 49.7% of respondents were directly exposed to war.[31] Violence was reported by individuals residing both inside and outside Ukraine during full-scale war: 42.9% of preschool children (3–6 years) had witnessed violent attacks, community violence (33.3%) or family violence (38.1%), based on caregiver report.[28] Additionally, some studies reported a few instances of sexual violence/abuse.[28 36] Other forms of violence included physical assaults against 1.5–18 year-olds by family and non-family members,[36] and children with special educational needs were also subjected to violence and peer bullying.[32]

Goto and colleagues[31] found that 28.5% of Ukrainian children and youth had experienced displacement since 2022, while Halchenko and colleagues[25] found that 21.1% of the respondents had been relocated within Ukraine or abroad within the first 2 months of the full-scale war, particularly from areas with active hostilities. Another study found that about 40.0% of children with special educational needs were relocated within Ukraine in 2023.[32] Feelings of safety were higher in safer areas of Ukraine, with 55.6% of a sample of students and younger pupils reporting feeling safe.

Resilience

Among the 20 studies published in English, three studies included measures for resilience. In one study, resilience was higher among boys than among girls and higher among those internally displaced than among those relocated abroad.[25] These children reported higher resilience compared with teachers and parents.[25] In another study, higher levels of resilience, including personal or caregiver resilience, were associated with less depressive symptoms among refugees in Poland.[34] Similarly, lower resilience was negatively associated with peritraumatic dissociative experiences, PTSD and depression in youth living in Ukraine.[19]

Risk and protective factors of mental health problems

While war undoubtedly increases psychological strain, several factors were identified as being associated with mental health problems (table 2). Regarding sex differences, four studies reported girls experiencing higher levels of emotional distress, PTSD, depression and anxiety, suicidal ideation and suicide attempt than boys.[19 23 27 35] In one study, conduct problems were more prevalent among boys than girls.[24] Four studies found no significant differences between boys and girls in trauma-specific assessment scores.[20 28 29 36] Notably, boys exhibited higher levels of resilience than girls.[25] The association between a child's age and mental health outcomes was inconsistent. Depressive symptoms[34] and internalising problems were more prevalent in older children,[21] while younger children more often experienced attention-related problems.[21]

In two studies, living in war-affected areas increased the risks of PTSD, anxiety or depressive symptoms and suicidality or self-harm compared with adolescents living in regions not directly affected by the war during the early phase of war.[22 23] In a study conducted during the full-scale war, the prevalence of depression or anxiety, substance use disorder, eating disorders and psychological trauma was high not only in the war-affected regions but also abroad.[31] Among Ukrainian refugees, 17.5% experienced anxiety and 12.3% had depressive symptoms.[36] Refugees generally reported more symptoms than peers in Ukraine,[31] though one study found no significant differences in trauma exposures, PTSD or complex PTSD between adolescents in Ukraine and those abroad.[28]

Forced relocation posed additional psychological burden, with displaced adolescents having experienced increased depression, anxiety and PTSD symptoms.[22] War-related experiences such as being a victim of violence and forced separation from parents were associated with increased risks for PTSD,[22] and loss of a loved one was associated with depressive and anxiety symptoms.[34] In two studies, experiencing non-violent war events, including loss of social support networks, seeking safer places and extended time at checkpoints increased risks for PTSD, anxiety, depression and suicidality or self-harm.[22 23] Based on caregiver reports, exposure to any war event increased the risk of internalising problems[21] and adversely affected all mental health domains assessed.[31] One study found a dose-response relationship between war trauma exposure and suicidality or self-harm.[23]

A few studies examined pre-existing mental health conditions. A child's prior emotional and behavioural problems, parental PTSD or complex PTSD, parental depressive and anxiety symptoms were associated with higher risks for paediatric PTSD, externalising and attentional problems.[20 21] Previous internalising problems

Table 2 Risk and protective factors explored in the studies published in English

Author	Risk	Protective
Quantitative studies—early phase of war		
Martsenkovskyi *et al*[27]	Depression: PTSD, being female, school non-attending, exposure to secondary traumatic events	Depression: treatment with Trauma-Focused Cognitive Behavioural Therapy
Burlaka *et al*[24]	Conduct disorder: poor parental supervision, inconsistent discipline, corporal punishment, being male, higher bullying perpetration	Conduct disorder: parental involvement
Osokina *et al*[22]	PTSD, depression, anxiety: living in a war-torn region, exposure to direct violent and non-violent war events	NA
Sourander *et al*[23]	Any suicidality or self-harm: living in a war-torn region, being female, having PTSD, depression or anxiety, war trauma exposure (3–4 or ≥5)	NA
Quantitative studies—full-scale war		
Catani *et al*[35]	Global mental health scores (emotional distress, PTSD, anxiety, depression): being female	NA
Palace *et al*[19]	Peritraumatic dissociative experiences: being female, perceived social support, loneliness PTSD: being female, loneliness Depression: being female, loneliness Anxiety about Russian use of nuclear weapons: expected military support from the west, loneliness Anxiety about Russian use of chemical weapons: expected military support from the west, loneliness Anxiety about Russian use of biological weapons: loneliness Death anxiety: expected military support from the west, loneliness Resilience: perceived social support, expected military support from the west	Peritraumatic dissociative experiences: high resilience PTSD: high resilience Depression: high resilience
Urbański *et al*[34]	Depression: being female, older age, emotional-oriented coping, loss of a loved one, Anxiety: higher levels of emotional-oriented coping, loss of loved ones	Depression: personal resilience, caregiver/relational resilience, support-seeking coping Anxiety: problem-solving, support-seeking coping
Catani *et al*[35]	Global mental health scores (emotional distress, PTSD, anxiety, depression): being female	NA
Goto *et al*[31]	Moderate or severe depression, moderate or severe anxiety, psychological trauma, substance use disorder, eating disorders: War exposure	NA
Halchenko *et al*[25]	Resilience: forced relocation, negative emotional profile Depression, anxiety: age (students vs pupils)	Resilience: remaining in Ukraine vs abroad, positive emotional profile, perceived safety, being male
Kapel Lev-Ari *et al*[36]	PTSD symptoms: internalising problems	NA
Martsenkovskyi *et al*[20]	PTSD: delay in milestone development, forced migration, having a parent affiliated with the emergency services or army, parental PTSD/CPTSD, mean changes in parental anxiety or depression, child having prior emotional and behavioural problems	PTSD: remaining in a familiar environment
McElroy *et al*[21]	Internalising problems: older age of the child, child exposure to war trauma, parental depression and anxiety. Externalising problems: child with prior emotional and behavioural problems, living in a single-parent household, parental exposure to war trauma, parental depression. Attention problems: child with prior emotional and/or behavioural problems, parental exposure to trauma, parental depression and anxiety, residing in West Ukraine	Internalising problems: higher parental education level, Attention problems: higher parental education level, residing in North Ukraine, older age of child
Redican *et al*[29]	PTSD: delays in milestone development, prior psychological or pharmacological support	NA
Qualitative studies - Full-scale war		
Author, year	Risk	Protective

Continued

Table 2 Continued

Author	Risk	Protective
Lopatovska *et al*[26]	NA	Media religiosity: positive content markers with less emphasis on anger, painful feelings, less focus on the past and thoughts about death, more focus on religious coping (prayer, faith)
Kostruba *et al*[18]	Traumatic memories	Schools, language skills, cultural similarities, cultural identity, sense of belonging
Thompson *et al*[30]	Resilience: traumatic experiences	Resilience: external support (eg, families, communities and continuous schooling) and internal skills (eg, social competence, problem-solving and critical consciousness)

Note: Karamushka *et al*[17], Bean *et al*[33] (2024), Nabochenko *et al*[32] and Pfeiffer *et al*[28] did not report risk and protective factors.
CPTSD, Complex PTSD; NA, not available; PTSD, post-traumatic stress disorder.

were associated with higher PTSD symptoms in refugees.[36] Other factors influencing the mental health of children were family structure, socio-economic status and parenting practices. Living in a single-parent household was associated with high externalising problems, and low parental education or socio-economic status was linked with high internalising and attention problems.[21] Poor parental supervision, inconsistent discipline and corporal punishment were identified as risk factors for conduct disorder, while inadequate parental involvement increased risks for both conduct disorder and bullying.[24] Two studies documented how loneliness, peritraumatic experiences and low social support increased the risks for depression and PTSD.[19 27] A cross-sectional study found that prior psychological or pharmacological interventions were associated with higher PTSD symptoms,[29] while a longitudinal study found that trauma-focused cognitive behavioural therapy (CBT) reduced the risk of depression in those with PTSD.[27] Another study identified developmental delays positively associated with paediatric PTSD[20] and post-traumatic stress scores,[29] emotion-oriented coping was associated with more depressive and anxiety symptoms. In contrast, problem-solving and support-seeking coping strategies were associated with reduced anxiety symptoms.[34] Perceived safety and positive emotional profile were associated with higher resilience,[25] which was inversely related to depressive symptoms in adolescents.[34]

Qualitative studies

A mixed-methods study[30] and two qualitative studies[18 26] examined the psychological and social impact of the war on Ukrainian adolescents, shedding light on potential risk and protective factors for mental health (online supplemental table S3). During the full-scale war, students practising religion via digital technologies were inclined to use positive content markers (ie, shifting away from anger, distressing emotions, decreasing reflection on the past events, emphasis on religious coping strategies), whereas adolescents with low levels of media religiosity were more prone to describe their experiences with an emphasis on anger, physical and emotional pain.[18] Lopatovska and colleagues categorised adolescents relying on coping strategies into three levels of resilience support: individual, family and community.[26] Coping was increased by a variety of internal skills, including social interaction skills, ability to problem solve, critical consciousness and a sense of purpose in planning. In addition, families and communities, social interaction with friends and continuous schooling were identified as protective factors. This study also showed that information and communication technology was considered useful for maintaining social connections and being distracted from trauma or stress. Internally displaced adolescents found it easier to settle in new regions that they found culturally and linguistically similar to their own region, and schools served as an additional stabilising factor.[30] Being reminded of traumatic memories was one of the negative effects that adolescents associated with internal displacement.

Studies published in Ukrainian

To further investigate the mental health impact of war, we examined articles published in Ukrainian (online supplemental table S4). The sample size of the studies varied, with one study including 1000 participants,[40] eight studies including fewer than 100 participants and four lacking sample size data.[44 47 51 52] PTSD was assessed by Child Impact of Events Scale-8 in two studies,[38 46] and anxiety by Hospital Anxiety and Depression Scale in two studies.[45 48] Three studies used projective drawings.[44 47 51] Children and youth reported wartime traumatic stressors, PTSD, depression, anxiety, panic disorder and suicidal behaviour. Trauma exposure was particularly high among children with parents at the frontline or who lived in occupied areas.[41] Adolescents reported war-related experiences such as forced separation from families, death of relatives and property damage.[39 40] Displaced children often displayed nightmares and withdrawal[40 50] as well as aggressive behaviour.[38] Children and youth living abroad reported higher levels of depression and low resilience compared with their peers living in Ukraine.[45] Drawings by internally displaced children reflected destruction due to war, lost homes and pets, memories of pre-war life[44] and social withdrawal.[47] Despite the deterioration

of children's mental health since the beginning of war, few sought psychological support.[40] However, those who received CBT showed reductions in PTSD symptoms, depression and anxiety.[53]

DISCUSSION

Our scoping review included 37 studies examining the mental health of Ukrainian children and youth, 20 in English and 17 in Ukrainian, from the start of the local Russian invasion of Eastern Ukraine in 2014 through the 2022 full-scale war. Including studies published not only in English but also in Ukrainian allowed us to add unique insights into the cultural context. In addition to the prevalence of mental health problems, we extracted information on traumatic experiences as well as risk and protective factors for mental health problems. Both quantitative and qualitative studies were included to deepen our understanding of young people's experiences and resilience factors that help them cope with adversity. Most studies were cross-sectional and were conducted with children and youth residing in Ukraine. The increase in studies since the full-scale war in 2022 underscores the heightened attention this conflict has received in recent years.

Human responses to severe adversities, such as armed conflicts, are commonly described as 'normal reactions to abnormal situations' and would ideally be viewed along a continuum ranging from expected distress to clinically significant reactions. Investigating these reactions merely through a medical lens is insufficient,[54] but the number of identified studies going beyond the clinical realm was scarce, which limited a more nuanced examination of children and youth's experiences in this review. In the included studies, children and youth reported a wide range of mental health outcomes with prevalence rates that fluctuated across studies. The variation was likely due to differences in methodology, assessment tools, informants, population and timing of assessments. For instance, evidence shows that caregivers may underreport or overreport symptoms of mental health problems compared with children and youth.[55 56] Although this posed challenges for cross-study comparisons, it could be concluded that mental health problem prevalence rates were generally higher during the full-scale war than during its earlier stages. This could possibly be explained by the cumulative and prolonged exposure to war and its consequences.

Resilience serves as a protective factor against mental health problems when people are faced with adversity.[57] In the present review, higher levels of children and adolescent's personal resilience and caregiver's resilience were associated with fewer depressive symptoms.[34] Moreover, children reported higher levels of resilience compared with teachers and parents.[25] Strong support systems are an important factor in rebuilding resilience,[58] and it is plausible that well-supported children may not bear the brunt of war to a greater extent than those without strong support. A further important supportive factor was found to be religious beliefs, with a qualitative study showing that young people taking part in digital religious practices placed more emphasis on positive content and religious coping during the full-scale war.[18] Similarly, mental health professionals in Ukraine have also shown resilience while working under the intensely stressful conditions of the ongoing war.[59]

Regarding demographic factors, differences in the prevalence of symptoms of mental health problems were observed by biological sex and age. Consistent with existing literature,[60] girls were more likely than boys to experience suicidal thoughts, attempt suicide and engage in self-harm. Boys showed a higher prevalence of conduct disorders.[24] The association between age and symptoms of mental health problems was mixed. Generally, age showed a positive association with internalising and externalising problems,[21 34] while younger children were more prone to attention problems.[21] However, some studies conducted during the full-scale war found no age differences in PTSD, internalising or externalising problems.[36] As expected, living in a war-torn region of Ukraine was associated with moderate to severe symptoms of mental health problems, including suicidality and self-harm.[22 23] These associations were observed during both the early phase and full-scale war, underscoring the harmful impact that the proximity to war events has on mental health.

Among the risk factors explored, exposure to traumatic events, internal displacement and forced migration were common factors associated with mental health problems.[20 22] Approximately one-fourth to one-half of the children and youth reported direct or indirect exposure to war-related events at any time during the war.[20 22 23 27 28 31 32 35 36 39 40] Exposure to war events and witnessing violence or killings increased the risk for symptoms of mental health problems, with an even higher risk among those directly victimised[22] and those with greater exposure to war-related events.[23] Such cumulative exposure to traumatic events may intensify the impact of trauma on adolescents' mental health and overwhelm their coping abilities.[61]

Around one-fifth of the children and youth had experienced displacement, whether internal or external.[25 31 32 39] Forced relocation to another country during the war was linked to increased risks of symptoms of mental health problems.[31] Similarly, internal displacement was associated with higher levels of resilience compared with relocation abroad,[25] suggesting that living within a familiar sociocultural context may help buffer against psychological distress.

Around one-fifth of the children and youth reported being separated from parents or family members.[25 31 32] The loss of a loved one and forced separation from family members often disrupts crucial relationships and sources of attachment,[62] likely compounded by the uncertainty of when, or if, they will be reunited with their parental figures. In usual conditions, children experience their

caretakers as a secure base from which they can explore the world, and a loss of this attachment figure subsequently disrupts the child's sense of safety.[62] The loss of and separation from a parent was linked to psychological problems in this review,[22] consistent with findings from previous studies,[63] suggesting that the impact of parent-offspring separation on war-affected children and youth's mental health is likely significant. Indeed, studies on the mental health of unaccompanied, asylum-seeking children and adolescents have shown a high prevalence of depression, PTSD and anxiety disorders.[33 36 64]

Relatedly, a child's sense of safety and psychological adjustment is profoundly influenced by the quality of their support network.[65] Parenting practices can serve as either risk or protective factors in the context of war. Our findings indicate that negative parenting practices or lacking parental involvement were linked to conduct problems and bullying risk.[24] These findings align with a recent mixed-methods systematic review and meta-analysis, which examined the impact of war and conflict on caregiving behaviours in different war regions.[10] The review found that caregivers in highly dangerous, war-affected regions displayed more harshness and hostility and less parental warmth, whereas parents living in regions experiencing threats but no direct conflict exhibited more warmth and overprotection.[10] Furthermore, child maladjustment to war was partially mediated by decreased warmth and increased harshness among caregivers who were more exposed to armed conflict,[10] underscoring the critical role of parental support in helping children cope with environmental adversity.

Finally, we also identified various coping mechanisms that influenced mental health outcomes. For instance, emotion-focused coping strategies, which involve managing emotional responses rather than addressing the source of stress,[66] were found to increase depressive symptoms among Ukrainian refugees.[34] This aligns with previous studies showing that emotion-focused coping is often associated with poorer mental health outcomes.[61 67 68] In contrast, problem-solving strategies that focus on actively addressing challenges have been linked to reduced mental health issues.[69]

Several important limitations need to be considered when interpreting the findings. Through our quality assessment, we evaluated the robustness of the empirical support for the described findings. Conducting longitudinal, representative studies in the context of war presents significant challenges. Consequently, most studies included in this review were cross-sectional, with varying sample sizes. The assessment tools were heterogeneous, limiting our ability to draw firm conclusions across studies and generalisability. Most studies were quantitative in nature and used existing scales for psychopathological symptoms, which may have limited us from developing a more comprehensive understanding about the range of mental health reactions children and adolescents experience in war contexts. Additionally, many studies lacked culturally adapted translation measures, affecting cultural relevance of the findings. As per the constraints of the scoping review, this review does not provide evidence-based recommendations for policy-making or clinical implications, but rather maps the existing literature and identifies gaps in the research.

In summary, as the first review focusing on children and youth mental health in the context of the Russian-Ukrainian war, our findings provide a comprehensive understanding of the empirical evidence on mental health effects of Ukrainian children and adolescents affected by the Russian invasion and may guide future efforts aimed at informing the development of targeted interventions. Most studies primarily focused on the mental health consequences of war. This underscores the critical need for further research exploring mechanisms through which children and adolescents build resilience in the face of adversity. Our review identified forced displacement, exposure to war-related events and parental separation as key risk factors for mental health problems. In contrast, protective factors included perceived social support, residing in familiar environments and employing problem-focused coping strategies.

To better understand the long-term impact of the ongoing conflict, methodologically comparable and prospective studies are needed. These should aim to explore the trajectories of mental health problems over time and uncover the underlying mechanisms driving these outcomes. Additionally, mixed-methods research would be crucial to fully capture human perceptions and experiences during war. Collectively, such studies could help develop interventions to leverage individual, family and community resources to address these challenges. This research line is particularly urgent in a world facing unprecedented violations against children in armed conflicts.[70]

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Funding Sanju Silwal received funding from the Juho Vainio foundation. Kaisa Ahramo received funding from the Sigrid Jusélius Foundation. Ana Ortin Peralta

received funding from the National Institute of Mental Health (1R01MH137702) and the INVEST Fellowship Programme.

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting or dissemination plans of this research.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement All data relevant to the study are included in the article or uploaded as supplementary information.

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