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Psychological Issues among Adults Following the 2025 Indo-Pakistan Conflict: The Mediating Role of Social Support

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ABSTRACT

Armed conflict is one of the more psychologically damaging experiences a civilian population can go through, and it commonly leaves depression, anxiety, stress, and disrupted sleep in its wake. The 2025 escalation of the Indo-Pakistan conflict created a sustained climate of fear and uncertainty for Pakistani civilians, but until now no one had actually measured its psychological effects using validated instruments. We set out to do that here, examining how common conflict-related psychological distress was among Pakistani adults and, more specifically, whether perceived social support helps explain the link between that distress and depression and anxiety. Data came from 302 adults (M age = 24.98 years, SD = 4.00; 66.6% female) recruited through purposive sampling from communities in the Bahawalpur district of Punjab. Participants completed the Depression Anxiety Stress Scale-21 (DASS-21) along with three scales built for this study, a Conflict-Related Psychological Distress Scale, a Sleep Disturbance Scale, and a Social Support Scale (all $\alpha \geq .96$). Depression, anxiety, stress, and sleep disturbance all came out at moderate levels, while conflict-related distress was somewhat higher (M = 3.11, SD = 0.86), sitting above the scale's midpoint. Conflict-related distress correlated positively with every distress outcome we measured (r = .50–.61, $p < .001$), and social support correlated negatively with all of them (r = $-.42$ to $-.50$, $p < .001$). Using Baron and Kenny's (1986) regression-based approach, we found that social support partially mediated the relationship between conflict-related distress and both depression and anxiety, accounting for roughly 22% of the total effect on depression. Gender and education level did not significantly affect any of the outcomes. Together, these findings mark the 2025 conflict as a genuine collective psychological stressor for Pakistani civilians and point to social support as something that can actually be acted on to reduce conflict-related psychological harm, with clear implications for both clinical practice and mental health policy.



Introduction

Few experiences damage civilian mental health as reliably as armed conflict. Living through war, or through the drawn-out threat of it, has repeatedly been linked to depression, anxiety, posttraumatic stress, disrupted sleep, and a general erosion of day-to-day functioning (Galea et al., 2002; Steel et al., 2009), and the knock-on effects reach well beyond the individual, weakening social stability, economic productivity, and community life more broadly (Murthy & Lakshminarayana, 2006). South Asia has suffered widespread instability for decades. India and Pakistan have locked horns in a structural rivalry since the partition in 1947. The development of nuclear weapons in both countries in 1998 worsened the rivalry (Ganguly, 2002). In 2025, the situation was further aggravated by military engagement along the Line of Control, cross-border strikes, and almost continuous coverage by both countries' media. The result for the Pakistani public, especially for those already struggling with a fragile mental health system, was an increased vulnerability and continuous threats.

Despite the newness of this particular conflict in Pakistan, the mental health impact of warfare is a well-trodden research area. Out of the various studies looking into the effects of violence and warfare on the mental health of the general Pakistani public, the study by Mumford and colleagues (1996) is most relevant. It looked at the prevalence of psychiatric disorders in the conflict-affected area of Rawalpindi and found it to be significantly higher than in most areas of the West. The worsening of conflict and of the economic situation in a country leads to a situation of destitution and paralysis. Disorders and disruptions caused by these different but interrelating phenomena affect mental health at the population level. The study by Kawachi and Berkman (2001) illustrates the significance of social networks in the mental health of a collectivistic and integrated society.

The World Health Organization (2001) has stated that armed conflict is the most significant stressor of mental health in general population. The mental health stress caused by armed conflict tends to affect low- and middle-income countries the most. Depression, anxiety, and stress appear to be the most chronic conditions reported in this literature. Steel et al. (2009) aggregated 161 studies from 40 nations and reported incidence rates that were much higher than those of the non-conflict population, and Norris et al. (2002), from their review of 102 studies of victims of disasters and conflicts, reported similar findings. Distress and posttraumatic symptoms were repeated participants and were mainly influenced by the intensity of exposure, the loss of resources, and the amount of available social support. One of the key points of this literature is that you do not need to be directly involved in violent acts to be impacted by them. Galea et al. (2002) found that even residents of Manhattan who were indirectly exposed to the events of 9/11 via television and the vicarious experience of threat and fear, rather than through physical presence of the attacks, reported clinically significant levels of depression and posttraumatic symptoms. Most of the participants of this study, the 2025 Conflict, directly experienced it through the media and the collective feeling of threat posed by the conflict. Therefore, Galea et al. (2002) is a good point of departure. A biological dimension is provided by McEwen's (1998) allostatic load model. Continuous threat in the absence of a single traumatic event will cause the body's stress-response to become less effective and the body will suffer the consequences in the form of depression, anxiety, and insomnia.

This literature tends to underemphasize sleep. Harvey et al. (2003) claimed insomnia, as well as other sleep disorders like waking during the night, nightmares, and unrefreshing sleep, affect between 70% and 91% of people with PTSD. Meanwhile, Neylan et al. (1998) reported sleep disturbance as the most popular symptom of Vietnamese veterans long after their combat. Various mechanisms can account for the observed phenomenon. Hyperarousal keeps the body too activated

to fall asleep, nightmares fragment whatever sleep the person gets, and the post-trauma rumination interferes with a sleep onset (Harvey et al., 2003; Mysliwiec et al., 2013). The long-term consequences of sleep disturbance and its discomfort level are beyond what most people think. Insomnia is not only a distress symptom; it is a precursor of a deeper level of distress, as a meta-analysis of longitudinal studies conducted by Baglioni et al. (2011) indicated that insomnia doubles the risk of depression.

Social support is one area in literature that balances social defense mechanisms. One of the more popular explanations coming from Cohen and Wills' (1985) stress-buffering model is that social support can reduce social defense mechanisms in two ways. People in supportive networks are more likely to perceive a potential stressor or threat as less stressful, or if a person socializes a stress response, support is likely to help that individual's response faster. There is a good amount of support from biology for each of the statements. Heinrichs et al. (2003) combined social support and the presence of oxytocin and showed a blunting of the cortisol response to stress in lab settings. Uchino (2006) examined the links between lower depression-related inflammatory markers and social support, and the same may also be said in conflict situations. Ai et al. (2005) found that Bosnian refugees who had social support from religious communities were more successful regarding coping, and noted Llabre and Hadi's (2009) work with Kuwaiti children who had lower depression and PTSD related stress following the Gulf War in relation to social support. Lastly, Ehlers et al. (2000) stated that of the social support measurements he examined, perceived social support was the most important with regards to former political prisoners coping post-incarceration. Overall, social support in Pakistan slightly differs from the rest of the literature coming from the West due to differing social support frameworks. The biraderi kinship system strengthens family ties across patrilineal families (Korson, 2015). Religious life based in the mosque builds community and provides coping resources that have been shown to contribute to resilience in Muslim populations (Koenig et al., 2001; Pargament, 1997).

The literature on gender is more fragmented. Most evidence suggests that women suffer more than men from the psychological consequences of conflict, including depression and anxiety (Breslau et al., 1998; Tolin & Foa, 2006). But this is not a fixed rule. Scholte et al. (2004), working with Afghan adults, found that the apparent gender gap mostly disappeared once they controlled for the type of exposure people had actually experienced—suggesting it may be less about vulnerability and more about who ends up exposed to what. Education is, if anything, even less predictable: more schooling could plausibly help (more resources, better coping skills, easier access to information; McLeod & Kessler, 1990) or hurt (more media consumption, more sophisticated and perhaps more anxious threat appraisal), and the literature does not clearly favor one direction over the other.

A few gaps in this literature motivated the present study. No one has yet documented the psychological toll of the 2025 escalation on Pakistani civilians using validated instruments the event is recent, but the data gap is real. Social support is well established as a protective factor in general (Cohen & Wills, 1985; Uchino, 2006), but whether it actually functions as a statistical mediator, rather than just a correlate of the link between conflict distress and psychological symptoms has not been tested in this population, and that distinction matters: a mediator points toward a mechanism you can intervene on, not just a variable that happens to move together with distress. It is also unclear whether this conflict's psychological burden fell evenly across gender and education groups, information that would matter quite a bit for anyone trying to target limited mental health resources. And sleep, despite its well-documented two-way relationship with psychological distress (Baglioni et al., 2011; Harvey et al., 2003), has barely been studied in Pakistani conflict contexts at all.

The study draws upon both Lazarus and Folkman's (1984) stress and coping theory and Cohen and Wills' (1985) stress-buffering model. According to stress and coping theory, not all distressing events are perceived as stressful in the same way. Rather, the appraisal process of an event determines how stressful an event is perceived to be. In this process, the level of perceived event-related threat is taken into consideration, as is the capacity and availability of social support to assist in coping with the threat. Social support is a resource normally drawn upon. In the context of this study, Cohen and Wills' (1985) stress-buffering model explains the erosion of perceived social support due to conflict distress and the influence of diminished social support on depression and anxiety. Thus, the model predicts that the direct relationship between conflict distress and depression and anxiety would be weaker in the presence of social support. From these frameworks, five hypotheses followed. H1: psychological distress would be substantially prevalent, with a sizeable share of participants in the moderate-to-severe range. H2: women would report significantly more distress than men. H3: sleep disturbance would be elevated and would correlate positively with conflict-related distress. H4: social support would significantly mediate the relationship between conflict-related distress and both depression and anxiety. H5: demographic variables would significantly differentiate the severity of psychological distress.

Method

Research Design

This study adopted a cross-sectional, quantitative survey design, which is common in the field of conflict psychology for research conducted during or in close time proximity to the event of interest (Creswell, 2014; Steel et al., 2009). Alone, a cross-sectional design cannot demonstrate causation, and we do not assume it is. However, cross-sectional designs, when implemented with regression techniques based on a particular theory (e.g., Baron and Kenny, 1986), can provide sufficient directional control on analyses to justify a potential causal claim. Therefore, this is the claim we make in this study.

Participants and Setting

The participants for this study comprised 302 adult civilians from the residential communities in the Bahawalpur district of Punjab comprising Mubarakpur, Ahmadpur East, Yazman, Hasilpur, Khairpur Tamewali, Dera Nawab Sahib. These communities are populated and have been directly impacted by the psychological climate of the 2025 conflict. Participants had to be Pakistani nationals, aged 18 and above and lived in the affected communities along the conflict, and were able to respond to the survey in English or Urdu. Participants with severe, clinically diagnosed, mental disorders were not included in the sample. Among the 302 working participants, 201 (66.6%) of the sample were female and 101 (33.4%) were male, with a mean age of 24.98 years ($SD = 4.00$, range = 18–41). Less than half of the sample had a postgraduate degree (44.7%), 32.8% were undergraduates, 13.6% completed education at intermediate and 8.9% were PhD degree holders. The largest occupational group in the sample were students (37.7%), followed by government employees (11.6%), homemakers (11.6%), employees in the private sector (11.3%), teachers (9.6%), the unemployed (9.6%) and psychologists (8.6%). The participants were single (57.3%) and had no children (59.9%).

Sampling Procedure

To avoid recruiting participants along a single route, we used multiple channels to identify participants, including purposeful sampling, community networks, door-to-door distribution of the questionnaires, social network referrals, and local clinical psychologists. Statistical analyses we

intended to perform justified our sample size; a sample size of 84 achieves an 80% power to detect a correlation of $r = .30$, and the Baron and Kenny (1986) method of mediation analysis estimates a sample size of 200 for an adequate power to detect a small-to-medium sized effect (Fritz & MacKinnon, 2007). The study was conducted during the conflict for a period of 6 weeks. Of the 320 questionnaires, 302 were returned, giving a 94.4% response rate.

Instruments

DASS-21

The DASS-21 (Lovibond & Lovibond, 1995) consists of 21 items that form three seven-item subscales for depression, anxiety, and stress. The past week was the reference period for the DASS-21. The standard DASS-21 scoring was the 0-3 scale; however, we used a 1-5 Likert scale for all items. This permitted all the questionnaires to have the same response format. The severity cutoffs were adjusted to accommodate this response format. The scale has been well validated for various populations (Antony et al., 1998; Henry & Crawford, 2005) and has been validated on Pakistani samples (Waseem & Raza, 2021). The overall scale showed excellent reliability, and the subscales showed good reliability: $\alpha = .974$; depression $\alpha = .977$; anxiety $\alpha = .972$; stress $\alpha = .977$.

Conflict-Related Psychological Distress Scale

Because no existing instrument captures distress tied specifically to this conflict, we developed a six-item scale for the purpose, covering conflict-related anger and irritability, fear about the future, emotional avoidance, social detachment, mood instability, and helplessness. Items were rated from 1 (Never) to 5 (Always), and reliability was excellent ($\alpha = .968$).

Sleep Disturbance Scale

A five-item scale, also developed for this study, covered difficulty falling asleep, waking during the night, conflict-related nightmares, waking unrefreshed, and daytime fatigue linked to poor sleep. Items were rated 1–5, and reliability was excellent ($\alpha = .972$).

Social Support Scale

A five-item scale assessed how much support participants felt they had from family, friends, community members or neighbors, and religious or spiritual sources, plus one item on how effective they felt that support was at reducing their distress; items were rated from 1 (Strongly Disagree) to 5 (Strongly Agree). We built the item set deliberately around Pakistan's own support ecology, biraderi kinship networks and mosque-based community ties in particular rather than importing a Western support scale wholesale. Reliability was excellent ($\alpha = .959$).

Demographic Questionnaire

A short questionnaire captured age, gender, education level, occupation, marital status, and whether the participant had children.

Procedure

After receiving institutional ethical approval, we collected written informed consent and administered paper questionnaire packets, demographics, DASS-21, the Conflict-Related Psychological Distress Scale, the Sleep Disturbance Scale, and the Social Support Scale, through the recruitment channels described above. Completing the packet took most participants somewhere between 15 and 25 minutes. Ten percent of the data were double-entered to check for entry errors, and missing responses (about 3.6% of the total) were handled through multivariate

normal imputation (Schafer & Graham, 2002); we also re-ran the key analyses on the non-imputed data as a sensitivity check, and the results held.

Ethical Considerations

The research adhered to the American Psychological Association's (APA) 2017 ethical standards and the principles enshrined in the Declaration of Helsinki. Each participant provided their informed consent in writing and participated in the study voluntarily. Participants also had the right to withdraw from the study at any time and for any reason. Participants were assured that their responses would remain anonymous and confidential. A few participants demonstrated some degree of distress during the survey, and these participants were provided with an informal supportive discussion immediately, along with a referral to external professional psychological services, including the student counseling services at the university.

Data Analysis Plan

IBM SPSS Statistics (Version 26) was used to conduct all analyses. Before running any of the statistical tests, univariate outliers ($|z| > 3.29$) were screened. Then, tests for normality of distribution were conducted. The internal consistency was measured using Cronbach's alpha. A score of .70 or above (Nunnally & Bernstein, 1994) was considered acceptable. The DASS-21 scores were also grouped in the standard severity bands, Normal, Mild, Moderate, Severe, and Extremely Severe. To measure the strength of the relationship of the psychological variables assessed, Pearson correlations were used. The following conventions (small effect .10, moderate effect .30, large effect .50) were used to assess the strength of the relationships (Cohen, 1988). Independent-samples *t* tests were used to assess gender differences. Cohen's *d* was used. One-way ANOVA was used to assess differences based on level of education (η^2). For the main hypothesis, mediation was assessed using Baron and Kenny's (1986) four-step regression: Path *c* measured the total effect of conflict distress on the outcome, Path *a* measured the effect of conflict distress on social support, and the effect of both conflict distress and social support on the outcome was estimated by Paths *b* and *c'*. The indirect effect was assessed by the product $a \times b$. The alpha level of significance was set at .05 for all analyses.

Results

Before addressing the hypothesis tests, it is important to briefly describe the sample. The majority of the participants were women (66.6%), had an average age of 24.98 years ($SD = 4.00$) with an age range of 18-41, and were highly educated (77.5% at least an undergraduate degree). The participants also tended to be singles (57.3%). The sample was primarily young and university-related. However, while the majority of the sample was students, the addition of teachers, government workers, housewives, and psychologists, through community and professional recruitment efforts, ensured that the sample was not entirely a student sample.

Descriptive Statistics and Reliability

On the DASS-21, participants reported moderate depression ($M = 2.73$, $SD = 0.93$), anxiety ($M = 2.52$, $SD = 0.88$), and stress ($M = 2.87$, $SD = 0.90$). What stands out more is conflict-related distress, which came out higher than any of the DASS-21 subscales ($M = 3.11$, $SD = 0.86$), clearly above the scale midpoint, and a hint that the purpose-built conflict measure was picking up something the generic depression and anxiety items were not fully capturing. Social support was moderately high ($M = 3.40$, $SD = 0.86$), and sleep disturbance sat in the moderate range ($M = 2.60$, $SD = 0.93$). Skewness (-0.17 to 0.20) and kurtosis (-0.53 to -0.19) were both well within

acceptable limits for parametric analysis, and every scale showed excellent reliability ($\alpha = .959-.977$; Table 1).

Table 1: Descriptive Statistics and Reliability for Psychological Scale Variables (N = 302)

Variable	M	SD	Min–Max	Skew	Kurt	α
Depression (DASS-21)	2.73	0.93	1.00–5.00	0.04	-0.39	.977
Anxiety (DASS-21)	2.52	0.88	1.00–5.00	0.20	-0.19	.972
Stress (DASS-21)	2.87	0.90	1.00–5.00	0.14	-0.53	.977
DASS-21 Total	2.70	0.79	1.00–4.95	0.17	-0.24	.974
Conflict-Related Distress	3.11	0.86	1.00–5.00	-0.17	-0.27	.968
Sleep Disturbance	2.60	0.93	1.00–5.00	0.10	-0.31	.972
Social Support	3.40	0.86	1.00–5.00	-0.05	-0.47	.959

Note. All scales scored 1–5 (Likert). M = mean; SD = standard deviation; Skew = skewness; Kurt = kurtosis; α = Cronbach's alpha. Severity-band analysis using standard DASS-21 cutoffs indicated that a substantial proportion of participants fell in the moderate-to-severe range for depression and anxiety.

Correlational Analysis

Table 2 shows the full correlation matrix; every coefficient in it was significant at $p < .001$. Conflict-related distress correlated positively with depression ($r = .557$), anxiety ($r = .497$), stress ($r = .538$), DASS-21 total ($r = .610$), and sleep disturbance ($r = .559$), a fairly strong and consistent pattern that supports Hypothesis 1. Social support ran the other way, correlating negatively with every distress variable ($r = -.416$ to $-.502$), exactly as its theorized protective role would predict. The three DASS-21 subscales were very strongly correlated with one another ($r = .613-.881$), which makes sense given that they are meant to capture related facets of a broader negative-affect construct rather than fully independent constructs. The correlation between sleep disturbance and conflict-related distress ($r = .559$) was also strong enough on its own to support Hypothesis 3.

Table 2: Pearson Correlation Matrix of Psychological Variables (N = 302)

Variable	1	2	3	4	5	6
1. Depression	—	.648	.642	.881	.557	-.465
2. Anxiety		—	.613	.863	.497	-.429
3. Stress			—	.865	.538	-.416
4. DASS-21 Total				—	.610	-.502
5. Conflict Distress					—	-.468
6. Sleep Disturbance / 7. Social Support (row 6 shown; col 6 = Social Support)						—

Note. Column 6 = Social Support; all correlations with Social Support are negative, reflecting its protective buffering role. All coefficients significant at $p < .001$ (two-tailed).

Gender Differences

A somewhat surprising picture emerged for gender. Independent-samples *t* tests found no statistically significant differences between men and women on any psychological variable: depression, $t(300) = -0.238$, $p = .812$, $d = -0.03$; anxiety, $t(300) = -1.104$, $p = .271$, $d = -0.14$; social support, $t(300) = 0.198$, $p = .843$, $d = 0.02$; conflict-related distress, $t(300) = -0.875$, $p = .382$, $d = -0.11$ (Table 3). Every effect size fell in the negligible-to-small range ($|d| < .20$), and on this basis Hypothesis 2 was not supported.

Table 3: Independent-Samples *t*-Test Results for Gender Differences in Psychological Variables ($N = 302$)

Variable	Male M (SD)	Female M (SD)	<i>t</i> (300)	<i>p</i>	Cohen's <i>d</i>
Depression	2.71 (0.89)	2.73 (0.95)	-0.238	.812	-0.03
Anxiety	2.44 (0.85)	2.55 (0.90)	-1.104	.271	-0.14
Social Support	3.42 (0.89)	3.40 (0.85)	0.198	.843	0.02
Conflict-Related Distress	3.05 (0.84)	3.14 (0.87)	-0.875	.382	-0.11

Note. Male $n = 101$; Female $n = 201$. All p values $> .05$ (non-significant). Cohen's d : .20 = small, .50 = medium, .80 = large (Cohen, 1988).

Education-Level Differences

A one-way ANOVA compared four education groups, intermediate, undergraduate, postgraduate, and PhD on the same four variables. None of the main effects reached significance: depression, $F(3, 298) = 1.30$, $p = .276$, $\eta^2 = .013$; anxiety, $F(3, 298) = 1.10$, $p = .349$, $\eta^2 = .011$; conflict-related distress, $F(3, 298) = 0.80$, $p = .493$, $\eta^2 = .008$; social support, $F(3, 298) = 1.06$, $p = .367$, $\eta^2 = .011$ (Table 4). Every η^2 fell well below what would be considered even a small effect, so Hypothesis 5 was not supported for education level.

Table 4: One-Way ANOVA Results for Education-Level Differences in Psychological Variables ($N = 302$)

Variable	SS Between	df	SS Within	df	F	<i>p</i>	η^2
Depression	3.336	3	255.629	298	1.296	.276	.013
Anxiety	2.571	3	231.762	298	1.102	.349	.011
Conflict-Related Distress	1.773	3	219.187	298	0.804	.493	.008
Social Support	2.358	3	221.281	298	1.059	.367	.011

Note. Education groups: Intermediate, Undergraduate, Postgraduate, PhD. Critical $F(3, 298) \approx 2.63$ at $\alpha = .05$; all obtained F -values fall below this threshold.

Mediation Analysis: Social Support as Mediator

This is where the study's central question was tested, using Baron and Kenny's (1986) four-step procedure with conflict-related distress as the predictor, social support as the proposed mediator,

and depression and anxiety as outcomes. The first step just establishes that there is a total effect to explain: conflict distress significantly predicted depression (Path c), $\beta = .557$, $B = 0.603$, $SE = 0.052$, $t(300) = 11.61$, $p < .001$, $R^2 = .310$. The second step asks whether the predictor affects the mediator, and it does, conflict distress significantly and negatively predicted social support (Path a), $\beta = -.468$, $B = -0.470$, $SE = 0.051$, $t(300) = -9.16$, $p < .001$, $R^2 = .219$, meaning that people under more conflict-related distress reported feeling less supported. The real test comes in the third step, where conflict distress and social support were entered together as predictors of depression. Both stayed significant: conflict distress (now Path c'), $\beta = .434$, $B = 0.470$, $t(299) = 8.32$, $p < .001$, and social support (Path b), $\beta = -.262$, $B = -0.282$, $t(299) = -5.02$, $p < .001$, with the combined model explaining more variance than either predictor alone ($R^2 = .364$). The standardized coefficient for conflict distress dropped from $\beta = .557$ to $\beta = .434$ once social support was in the model, and because it stayed significant rather than disappearing, this is partial rather than full mediation. Multiplying the two paths ($a \times b = -0.470 \times -0.282$) gives an indirect effect of 0.133, which works out to roughly 22.1% of the total effect of conflict distress on depression running through social support. A parallel model for anxiety told the same story: conflict distress, $\beta = .379$, $t(299) = 6.91$, $p < .001$; social support, $\beta = -.252$, $t(299) = -4.59$, $p < .001$; $R^2 = .296$. Taken together, these results supported Hypothesis 4, social support partially mediates the relationship between conflict-related distress and both depression and anxiety (Table 5).

Table 5: Mediation Regression Analysis: Social Support as Mediator of the Conflict Distress–Depression/Anxiety Relationship ($N = 302$)

Model / Predictor	B	SE	β	t	p
Model 1 (Path c): Depression ~ Conflict Distress, $R^2 = .310$					
Conflict Distress	0.603	0.052	.557	11.61	<.001
Model 2 (Path a): Social Support ~ Conflict Distress, $R^2 = .219$					
Conflict Distress	-0.470	0.051	-.468	-9.16	<.001
Model 3 (Paths b, c'): Depression ~ Conflict Distress + Social Support, $R^2 = .364$					
Conflict Distress (c')	0.470	0.057	.434	8.32	<.001
Social Support (b)	-0.282	0.056	-.262	-5.02	<.001
Model 4: Anxiety ~ Conflict Distress + Social Support, $R^2 = .296$					
Conflict Distress	0.390	0.057	.379	6.91	<.001
Social Support	-0.258	0.056	-.252	-4.59	<.001

Note. Indirect effect ($a \times b$) = 0.133, representing 22.1% of the total effect of conflict distress on depression. Partial mediation confirmed for both depression and anxiety.

Discussion

This study set out to document the psychological toll of the 2025 Indo-Pakistan conflict on Pakistani adults and to test whether social support helps explain why some people were hit harder than others. Five hypotheses were on the table; three held up, and two did not.

Prevalence and Severity of Psychological Issues

Hypothesis 1 was largely supported. Distress levels were moderately to highly reported by participants. Furthermore, conflict-related distress stood out as the highest distress variable in the dataset ($M = 3.11$). The findings are consistent with existing literature and show that conflict-related situations even when participants are exposed to conflict indirectly through various forms of media as well as community induced conflict and direct conflict, still has a detrimental impact on the psychological wellbeing of individuals (Galea et al., 2002; Norris et al., 2002). It was particularly interesting that participants reported higher levels of conflict-related distress compared to the DASS-21 sub-scales. The DASS-21 sub-scales reported levels of (2.51-2.87). The reason conflict-related distress was so high could have been that our measure of conflict-related distress was capturing something that the DASS sub-scales of depression and anxiety were not. This was conflict-related anger, fear, and detachment. This is related to what Shoeb et al. (2007) proposed. The levels of social support were at a relatively good standard ($M = 3.40$) and negatively correlated with measures of distress. This is what Cohen and Wills (1985) suggested and is also evident in the studies carried out with the Afghan (Scholte et al. 2004), and Kuwaiti (Llabre & Hadi, 2009) populations and older Pakistani studies that show that socioeconomic and security-related distress impact the psychiatric wellbeing of individuals (Mumford et al., 1996).

Sleep Disturbance

Support for hypothesis 3 was found. Sleep disturbance ($M = 2.60$) was found to be higher than expected for otherwise healthy young adults. Given the strong association between sleep disturbance and conflict-related distress ($r = .559$), it is fair to conclude that disturbance was not due to general background sleep disturbance. The implications of this finding are significant. Baglioni et al. (2011) conducted a longitudinal study and found that a single episode of insomnia doubles the likelihood of developing major depression in the future. The symptoms of sleep disturbance, therefore, may be more serious than the symptoms of sleep disturbance as a passive symptom of bigger issues. This suggests that the treatment of sleep is a valid and reasonable outcome goal for this population, and the treatment of Insomnia using Cognitive Behavioural Therapy, sleep hygiene, or relaxation training, should be offered prior to the resolution of psychological symptoms of distress, as it is highly unlikely that sleep disturbance will resolve as a result of the other emotional symptoms of distress dissipating.

Gender and Education-Level Differences

The data show that hypothesis 2 was not supported. Across all measured variables, including depression, anxiety, and conflict distress, the psychological profiles of men and women were found to be essentially the same (all $p > .27$, $|d| < .14$), and therefore it is not appropriate to assert that women are more psychologically vulnerable as a result of exposure to conflict. A few things could explain this. Most participants in this sample were exposed to the conflict indirectly, through media and shared community anxiety, rather than through direct violence with a gendered pattern of victimization, and Scholte et al. (2004) found something similar with Afghan adults: once you control for the type of exposure people actually had, the apparent gender gap mostly evaporates. It is also possible that the relatively narrow educational range of this sample, or the fact that mosque-based communal coping is available to men and women alike in Pakistani society, flattened out differences that might show up elsewhere. Hypothesis 5 fared no better for education level (all $F < 1.30$, $p > .27$): distress was spread fairly evenly across intermediate, undergraduate, postgraduate, and PhD groups. If anything, this is a useful finding for planning purposes, it suggests that mental health outreach after this conflict should be broad rather than narrowly targeted at any one educational tier, and it is a reminder that even highly educated people, including the psychologists in our own sample, are not somehow immune to conflict-related distress.

Mediating Role of Social Support

This is probably the most important finding in the study, and the one with the clearest practical payoff. Social support did not simply track alongside lower distress; it partially explained the relationship between conflict distress and both depression and anxiety, which is a meaningfully stronger claim. Path a ($\beta = -.468$) shows that conflict-related distress, the anger, fear, avoidance, detachment, and helplessness described earlier, actively wears down how supported people feel, probably through some mix of withdrawing socially, straining relationships through irritability, and simply being too preoccupied with the conflict to notice or use the support that is available. Path b ($\beta = -.262$) then shows that social support, once you control for conflict distress, still independently predicts lower depression, consistent with the main-effects side of Cohen and Wills' (1985) model. When both paths were accounted for, the direct effect of conflict distress on depression dropped from $\beta = .557$ to $\beta = .434$, a real drop, but not to zero, which is why we describe this as partial rather than full mediation; something else besides eroded social support is also carrying part of the effect. Roughly 22.1% of the total effect on depression runs through the social support pathway, which is not a small number, it implies that interventions aimed squarely at rebuilding people's support networks could plausibly chip away at close to a fifth of the psychological damage attributable to conflict distress, and the fact that anxiety showed the same pattern suggests this mechanism is not specific to depression but operates on distress more generally. This is consistent with earlier findings where social support constitutes a real mediating mechanism, rather than a passive correlate, in conflict situations. Ai et al. (2005) described a similar situation, with religious community support for the Bosnian refugees, while Ehlers et al. (2000) identified perceived social support as a strong predictor for the poor coping of former political prisoners. Here, the cultural channel through which social support is expressed is possibly more relevant. Particularly, kinship relationships (biraderi) and mosque networks included in this study give a degree of detail for this study specific to Pakistan, which a more general Western social support scale would be unlikely to capture.

Clinical and Policy Implications

What does this mean in practice? Doctors may find that distress levels warrant screening and community outreach, since potential patients often do not seek help. In Pakistan, where there is a lot of stigma, and potential patients have little access to services, self-referral is almost nonexistent. Since social support is an active mechanism, social support is deserving of a routine place in clinical assessment, and the strengthening of social support via family therapy, peer support groups, community activities, and counseling can be considered a therapeutic goal. Support from the sleep community is a mechanism that is deserving of social support. Sleep is a therapeutic goal, and sleep community support is a potential mechanism to achieve this goal. While this burden showed up in a relatively well-educated, non-clinical sample that was not vulnerable in any way, it indicates the real population burden and likely ranges from low- to zero-resourced communities. This burden alone supports the integration of psychosocial support into community preparedness plans. The community-based training of healthcare workers to provide psychosocial support, the development of school-based mental health programs, and the community-based mental health programs developed and promoted by the WHO, are evidence-based strategies that should be employed.

Limitations and Future Directions

There are a few limitations that should be addressed. This is a cross-sectional study. Even with good behavior from the numbers, the mediation model cannot eliminate reverse causation. For

example, it is possible that higher levels of depression erode the perception of social support. This could only be determined by a longitudinal study with measurements before, during, and after the conflict. Unfortunately, there are many issues with the sample population. It skews young, educated, and female and is drawn from one district in Punjab. Because of these issues, we do not want to generalize to older, less educated, rural populations, those who live closer to the border, and those who have had direct exposure to combat. Stratified sampling would be an improvement to this work. Everything was self-reported, which leads to social desirability bias and common method variance. The variance is especially problematic for a mediation model, as it can create artificial strength in the paths. It is also important to note that the Conflict-Related Psychological Distress and Sleep Disturbances scales were excellent for this study. However, these scales have not been subjected to independent validation, so that work should be done.

The Baron and Kenny (1986) method is considered a manageable entry point, but in general, for a majority of applications, it is acknowledged to be less rigorous than more contemporary bootstrapped approaches. The logical next step to this analysis would be to apply Hayes's (2013) PROCESS macro, incorporating religious coping, appraisal style, resilience, and economic security as candidate mediators, and importantly, to consider the Indian civilian population exposed to the same conflict as a comparative sample in order to determine the extent to which the findings are context dependent (specific to Pakistan) versus context independent (general).

Conclusion

Overall, this study demonstrates that the 2025 Indo-Pakistani conflict had a significant psychological impact on adult, civilian Pakistanis. The evidence suggests that this impact was felt in the form of moderate to severe depression, anxiety, stress, and sleep disruption. This evidence was also reflected in the respondents' conflict-related distress. However, none of these findings represents the complete picture. This study firmly establishes social support as an explanatory factor for lower distress. Social support, in the context of this study, is significant in that it explains how conflict-related distress is converted to depression and anxiety. Social support explains approximately 20% of the total effect on depression. This is a mechanism and a significant finding, especially when compared to the existing literature. Gender and educational attainment did not significantly impact the outcomes, which indicates that the psychological burden of the conflict was relatively evenly distributed. This suggests the need for community-based, conflict-focused social and policy interventions; dedicated, community-level, psychosocial support services focusing on sleep and social support; and a shift in pathological focus to psychosocial support and mental health from physical health and security.

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