5 Healing and restoring war-affected families: Family violence prevention, psychosocial recovery and restorative mobility

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Introduction

War affects children and caregivers not only through direct exposure to bombardment, displacement, injury, bereavement and deprivation but also by reshaping the emotional and relational systems that ordinarily protect children and sustain family life. Armed conflict disrupts routines, impairs caregiving, fragments social support, narrows developmental opportunities and alters the everyday environment in which children learn trust, security and emotional regulation. Research on children affected by armed conflict has consistently shown that psychological outcomes are shaped not only by exposure to organised violence, but also by the wider social ecology surrounding the child, especially caregivers, family functioning and community support systems (Betancourt & Khan, 2008; Bürgin et al., 2022).

Accordingly, healing in war-affected settings cannot be defined narrowly as the treatment of PTSD, depression, anxiety or grief in isolated individuals. War damages family life as a system: it undermines parental emotional availability, intensifies relational strain, destabilises family roles, disrupts attachment and restricts the conditions under which children can develop safely. A meaningful recovery framework must therefore move beyond symptom reduction and address the restoration of family functioning itself, including safety, caregiving stability, non-violent relationships, routine, developmental opportunity and the possibility of shared life beyond survival (Betancourt & Khan, 2008; World Health Organization, 2025a, 2025b).

A further argument advanced here is that, in Gaza, war should not be understood only as repeated exposure to violent events, but as a prolonged ecol-

ogy of siege in which recovery is repeatedly interrupted. Under such conditions, war-related harm may acquire an intergenerational character, not only because one generation remembers war, but because multiple generations are socialised into chronic uncertainty, restricted movement, fragmented family life, blocked educational and professional futures and diminished opportunities for play, travel, leisure, study, treatment and family reunion. This interpretation is consistent with evidence showing that children's prolonged exposure to war-related toxic stress in the Middle East carries serious developmental and mental health consequences and that these effects are shaped by caregiving, social ecology and repeated exposure rather than by single events alone (Bürgin et al., 2022; El-Khodary & Samara, 2019a, 2020; Procter, 2024; Samara, Hammuda, et al., 2020).

A central argument of this chapter is that psychosocial recovery in war-affected families depends on two inseparable processes. The first is the prevention and reduction of family violence, including harsh discipline, coercive control, emotional intimidation, inter-parental aggression and child maltreatment. The second is the restoration of positive shared family life, including play, leisure, recreation, cultural participation, safe mobility and meaningful shared experiences through which family members can reconnect outside the script of fear. These should not be treated as separate policy fields. A family in which fear remains normalised within the home cannot recover well; yet a family that receives only crisis stabilisation without any return of shared positive life, may remain trapped in emergency functioning (Catani, 2009; Catani et al., 2008; Jepson et al. 2019; Lehto et al., 2009; Miyakawa & Oguchi, 2022; Saile et al., 2014; Sriskandarajah et al., 2015).

This broader view is also supported by children's rights and humanitarian frameworks. Article 31 of the Convention on the Rights of the Child recognises children's rights to rest, leisure, play, recreation and participation in cultural life, while UNICEF's humanitarian child protection guidance places psychosocial support and protection at the centre of emergency response rather than treating them as optional additions (UNICEF, 2019a, 2026b). The implication is that the restoration of play, safe movement, shared experience and meaningful family time should be understood as part of psychosocial recovery itself rather than a luxury postponed until after "real" recovery has occurred.

This shift is theoretically important because it moves recovery from a narrow clinical endpoint to a broader developmental and relational process. This broader conception matters because, in protracted war settings such as Gaza, healing involves more than reducing PTSD or distress. It also requires restoring the conditions for caregiving, developmental exploration and shared family life under chronic blockade, displacement and cumulative

trauma (Aqtam, 2025; El-Khodary & Samara, 2019a, 2020, 2022; Procter, 2024; Samara, Hammuda, et al., 2020; World Health Organization, 2025a, 2025b).

The chapter develops a conceptual and applied account of healing that moves from survival to restoration. It first clarifies what restoration means in war-affected family systems. It then examines why family violence prevention must be central to psychosocial recovery, before outlining a multilayered family-centred intervention system involving parenting support, schools, community organisations, non-specialist providers and long-term monitoring. A later section develops the tourism, leisure, and restorative-mobility dimension with particular reference to Gaza. The chapter concludes by presenting the proposed Siege-Intergenerational Restoration and Mobility (SIRM) model, which integrates psychological repair, parenting reintegration, family violence prevention, developmental reopening, ecological rebuilding and restorative mobility within a single recovery framework.

From survival to restoration

In acute war and displacement settings, survival dominates humanitarian action. Families need food, water, shelter, medicine and physical protection. Yet survival alone does not restore family life. A child may survive bombardment and still remain embedded in chronic fear, unstable caregiving, harsh discipline, educational disruption, emotional disconnection and the absence of ordinary developmental opportunities. A caregiver may survive physically while remaining psychologically overwhelmed, grieving, emotionally unavailable, ashamed or highly reactive. For this reason, restoration is not merely a secondary stage after safety has been achieved. It is part of what meaningful safety requires, because families cannot recover well if they remain trapped in purely emergency forms of life (United Nations Office for the Coordination of Humanitarian Affairs (OCHA), 2026b; WHO Eastern Mediterranean Regional Office, 2026; World Health Organization, 2025a, 2025b).

This distinction can be sharpened further. In protracted conflict settings, survival and restoration should not be treated as sequential phases, as though families first survive and only later begin to heal. In Gaza, repeated escalations, blockade, displacement, institutional collapse and mobility restrictions mean that families are often required to attempt restoration under continuing threat. The practical implication is that psychosocial recovery must be embedded within humanitarian response itself rather than postponed until a fully stable post-war period emerges. This aligns with WHO's position that support in emergencies must be layered, scalable and embedded within disrupted daily life rather than reserved only for specialist treatment at a later stage (World Health Organization, 2015, 2025a, 2025b).

Restoration can be understood across five interrelated domains. The first is psychological restoration, which includes trauma processing, grief support, reduction of distress and restoration of emotional regulation. The second is relational restoration, involving attachment repair, trust-building, communication, emotional attunement and reduction of family violence. The third is developmental restoration, involving access to education, play, peer relations and age-appropriate opportunities for exploration and competence. The fourth is ecological restoration, involving the rebuilding or replacement of wider systems that support families, such as clinics, schools, community spaces, and social support networks. The fifth is experiential restoration, meaning the reintroduction of positive shared experiences through play, outings, visits, community events, contact with nature, cultural participation, and, where possible, restorative forms of family mobility. This layered understanding is consistent with multilevel and social-ecological approaches to children affected by war and forced displacement (Betancourt & Khan, 2008; Bürgin et al., 2022).

Experiential restoration and restorative mobility are important because war compresses family life into survival roles. Safe, meaningful and chosen shared experiences, including play, outings, visits, cultural participation and contact with wider social worlds, can help widen life again beyond fear and loss and support children's developmental recovery (Jepson et al., 2019; Lehto et al., 2009; Miyakawa & Oguchi, 2022; Office of the High Commissioner for Human Rights, 1989; OCHA, 2026a, 2026b; World Health Organization, 2025a).

The Gaza Strip as a context of cumulative trauma and deprived family mobility

The Gaza Strip offers a particularly important case through which to understand family restoration because it concentrates several mutually reinforcing forms of harm: repeated military violence, blockade, prolonged movement restrictions, infrastructural devastation, family separation and cumulative trauma. OCHA explicitly states that restrictions on the movement of people and goods to and from Gaza have undermined living conditions for years, that many restrictions intensified after the 2007 blockade and that they intensified again after October 2023 (OCHA, 2016, 2022, 2026a). This is not merely background context; it is part of the causal architecture through which family life is destabilised and recovery is repeatedly obstructed.

WHO emergency reporting likewise situates Gaza within a severe and prolonged health emergency. The EMRO emergency situation reports document repeated damage to health facilities, massive strain on the health system, interruptions to medical evacuation, and the fragility of attempts at ceasefire

or humanitarian access. These reports also highlight that the crisis is not over even in periods labelled as "ceasefire," as continued casualties, displacement, and disruption persist. The cumulative effect is that families are forced to live in a state of chronic emergency, where recovery is repeatedly interrupted by renewed danger, scarcity, or forced movement (WHO Eastern Mediterranean Regional Office, 2026). This matters because it shifts the discussion away from a simple event-response model of trauma toward a model in which harm is continually reproduced by the wider ecology of siege.

Recent literature on Gaza's mental health burden reinforces this picture. Current research describes severe psychosocial distress, pervasive trauma and grief, and an urgent need for scalable interventions, while also indicating that children's lives are shaped not simply by discrete war events but by prolonged exposure to toxic stress and developmental disruption. Taha et al. (2024) described a severe mental health crisis among children in Gaza and called for urgent action. Aqtam (2025) reviewed the mental health and psychosocial impact of the war in Gaza, highlighting pervasive trauma, grief and the urgent need for scalable psychosocial interventions. UNICEF has also emphasised the destruction of childhood in Gaza and the need for psychosocial support that addresses fear, instability and interrupted futures (UNICEF, 2025, 2026b). These sources suggest that children in Gaza are not simply "war-exposed"; they are growing up in an environment where the developmental conditions of childhood have been systematically constricted. Research further shows that cumulative exposure to violence is associated with mental health and behavioural difficulties among Palestinian children and adolescents, that exposure and PTSD are socially patterned, and that structured school-based intervention remains possible even in heavily affected settings (El-Khodary & Samara, 2019a, 2019b, 2020, 2022; El-Khodary et al., 2020; Samara, Hammuda, et al., 2020)

Taken together, these studies help shift the discussion from an event-based model of trauma to a cumulative, ecological, and intervention-relevant model of war-affected child development. This context is especially relevant to the theme of tourism, leisure, and family life because Gaza is not only a site of organised violence, but also a site of profound mobility deprivation. In many societies, family well-being is supported by the possibility of getting away from daily stress through local outings, visiting relatives, going to the seaside or countryside, joining communal events, taking school trips or travelling for leisure, worship, or reunion. These experiences do not merely entertain. They provide families with opportunities for bonding, emotional decompression, role flexibility and the making of positive memories (Jepson et al., 2019; Lehto et al., 2009). In Gaza, however, movement has long been heavily restricted and, in wartime, becomes even more dangerous, humiliating and coercive.

Families move to flee bombardment, search for food or seek shelter. They do not move freely to restore themselves. This replaces restorative mobility with survival mobility. That distinction is important because it shows that mobility in Gaza is not merely restricted in a logistical sense; it is transformed in psychological and relational meaning.

An intergenerational perspective is essential here. In Gaza, some older adults have lived through displacement linked to 1948, occupation after 1967, the First Intifada, the Second Intifada, repeated wars, long-term blockade, and the most recent devastation since October 2023. Adults who were once children under earlier periods of violence are now parents or grandparents. As a result, siege is not experienced by one age group at one historical moment; it is lived across overlapping generations, each inheriting not only memories of danger but altered expectations about movement, education, aspiration, family reunion and the future itself. In such settings, intergenerational harm is transmitted not only through recollection, but through parental distress, altered parenting, chronic anticipatory fear, repeated disruption of routines and the normalisation of constrained horizons (Aqtam, 2025; Sangalang & Vang, 2017; Tarabay & Golm, 2024). This suggests that the effects of siege are not confined to immediate symptoms, but also reshape the temporal horizon within which families imagine what life can be.

The deprivation of tourism and family mobility in Gaza should therefore be understood as part of the psychosocial architecture of suffering. Families are not merely losing vacations in a narrow consumer sense. They are losing access to respite, recreation, visits, outings, festivals, exploration and temporary relief from chronic stress. For children, this means loss of positive developmental experiences linked to play, movement, curiosity, and positive memory. For caregivers, it means loss of one avenue through which family strain and emotional overload might otherwise be moderated. The inability to 'get away' is not trivial in war. It is one of the ways in which war narrows life until survival displaces almost every other dimension of living and weakens the conditions under which recovery might otherwise begin.

Family violence prevention as a core part of recovery

Family violence prevention must therefore be central to any serious framework for healing war-affected families. Conflict is often discussed as though violence exists only outside the home, yet evidence shows that war trauma can intensify violence within family systems. Catani (2009) reviewed the relationship between war trauma and family violence and argued that organised violence and violence in the home are closely linked. Catani et al. (2008) found in

Sri Lanka that family violence, war, and natural disaster exposure combined to influence children's mental health. Saile et al. (2014) documented war-related contributions to family violence against children in Northern Uganda, while Sriskandarajah et al. (2015) identified predictors of violence against children in Tamil families in northern Sri Lanka. Together, these studies suggest that organised violence and family violence may accumulate rather than operate independently, becoming part of the same ecology of harm.

The mechanisms are increasingly clear. Chronic fear, grief, humiliation, overcrowding, displacement, hunger, unemployment and loss of social status increase caregiver strain and reduce emotional regulation within the household. Trauma-related irritability, hyperarousal, emotional numbing, shame, helplessness and dysphoria may intensify harsh discipline, coercive control, inter-parental aggression or emotional withdrawal. Children may therefore be exposed to organised violence outside the home and encounter fear reproduced inside it. In such cases, the family is both a protective system and a site through which war continues to be lived in everyday relational life.

This account is also consistent with Christie et al. (2019), whose systematic review shows that parental post-traumatic stress can alter parenting quality and child relational experience, thereby reinforcing the need to treat caregiver trauma and family violence prevention as part of the same recovery ecology.

The relevance of this argument is reinforced by evidence from Palestinian contexts showing that war exposure, emotional dysregulation, and caregiving processes are closely interconnected. El-Khodary and Samara (2019a) found that trait emotional intelligence, prosocial behaviour, parental support, and parental psychological control were significantly associated with PTSD and depression following exposure to war-traumatic events. This is theoretically important because it suggests that children's outcomes are shaped not only by what they have experienced externally, but also by the relational and emotional environment in which those experiences are processed. In practice, this means that family violence prevention cannot be treated as peripheral to trauma recovery; it is one of the mechanisms through which trauma is either amplified or interrupted within the family system (Samara, Hammuda, et al., 2020).

This is especially important because children's recovery depends not only on what happens outside the home, but on whether the home remains emotionally bearable and relationally safe. A child cannot meaningfully recover from war trauma if the home remains frightening, coercive, or unpredictable. Likewise, caregivers cannot be expected to regain emotionally available parenting without support for their own trauma, grief, shame and stress regulation. Family violence prevention must therefore be embedded within psychosocial response through screening, psychoeducation about non-violent

caregiving, support for caregiver regulation, referral pathways and interventions that address the emotional climate of the family. UNICEF's child protection in humanitarian action framework explicitly states that emergencies heighten risks of violence, exploitation, abuse, neglect, and separation and that child protection must be embedded in humanitarian action rather than treated as an afterthought (UNICEF, 2026b).

A further implication is that psychosocial recovery and family violence prevention should not be institutionally separated, because that division reproduces a false distinction between symptom treatment and relational safety. If mental health services focus only on symptoms while protection services focus only on acute safety, families may fall through the gap between them. By contrast, integrated models can address trauma, caregiving, protection and family functioning together, providing the foundation for the multi-layered family-centred intervention system outlined in the next section.

A multi-layered family-centred intervention system

Because war affects families across multiple levels, recovery must also be multi-layered. No single clinic, therapy model or sector can carry the entire burden in contexts where needs are massive, infrastructure is damaged and access is repeatedly interrupted. A family-centred psychosocial system therefore needs to operate simultaneously across counselling centres and clinics, schools and educational settings, and social or community organisations. This is consistent with social-ecological and needs-oriented approaches to war-affected children, which emphasise that recovery depends on linked supports across family, school, community, and service systems (Betancourt & Khan, 2008; Bürgin et al., 2022; Jordans et al., 2016; World Health Organization, 2015, 2025a, 2025b).

A family-sensitive intervention logic is especially important in protracted conflict because children rarely recover in isolation from their caregiving context. Effective intervention therefore requires not only symptom-focused treatment, but relational repair, parenting support, caregiver regulation, and the strengthening of the wider caregiving ecology. These three settings should be understood not as isolated service points but as interacting components of a wider family restoration system. Counselling services reduce symptoms, assess risk, and support grief work. Schools restore routine, peer contact, observation, cognitive engagement, and future orientation.

Community organisations rebuild belonging, social support, practical resilience, and cultural continuity. Together, they support not only the treatment of disorder, but the reconstruction of a family's emotional, developmental, social, and cultural world. This broader intervention logic is also supported

by evidence syntheses showing that MHPSS programmes in humanitarian settings are most effective when they are context-sensitive, embedded and connected to everyday social environments rather than narrowly clinical in design (Arega, 2023; Bangpan et al., 2024; Jordans et al., 2016).

Counselling centres and clinics: psychological repair within the family context

Within a multi-layered family-centred intervention system, specialist and semi-specialist clinical care remains essential for children and caregivers with severe trauma symptoms, complicated grief, depression, anxiety, dissociation, substantial behavioural disturbance or marked impairment. Narrative Exposure Therapy has been widely used in war-affected and refugee populations because it helps organise fragmented traumatic memories into a coherent autobiographical narrative. Dixius and Möhler (2021) concluded that NET is feasible and promising for children and adolescents in war settings. KIDNET and related narrative exposure approaches illustrate how structured trauma-focused intervention can remain clinically meaningful in highly disrupted conflict settings, although they should be understood as one component of a broader care system rather than stand-alone solutions (Dixius & Möhler, 2021; Fazel et al., 2020; Jordans et al., 2016; Neuner et al., 2008).

Yet clinical work in war settings should not be purely individualistic. Even when a child is the identified patient, assessment should include caregiving stability, family bereavement, family violence risk, displacement stressors and caregiver mental health. Bürgin et al. (2022) emphasise multilevel, needs-oriented, and trauma-informed support for war-affected children, which supports assessment beyond the individual child and into the caregiving ecology. In practice, this means understanding the family context in which symptoms occur. Engaging caregivers in treatment can improve co-regulation, strengthen attachment repair and reduce harmful misreadings of trauma-related behaviours. A child's aggression, regression, sleep disturbance or withdrawal may otherwise be interpreted by an exhausted caregiver as stubbornness rather than as trauma. This broader approach is also consistent with evidence showing that parenting and caregiver functioning help shape how war exposure affects children's adjustment, and that parental post-traumatic stress can alter parenting quality and child relational experience (Betancourt & Khan, 2008; Christie et al., 2019; Eltanamly et al., 2021).

Clinical care should therefore aim at both symptom reduction and relational de-escalation. If therapy occurs in a home environment that remains frightening or coercive, gains may be limited. Helping caregivers regulate grief, fear, shame and anger may reduce frightening interactions and create conditions in which children's therapy can be more effective. Clinics and counselling cen-

tres should therefore be understood not only as sites of individual symptom treatment, but also as settings for relational assessment, caregiver support, risk identification and referral into wider family and community systems of care (Betancourt & Khan, 2008; Bürgin et al., 2022; Jordans et al., 2016). The mhGAP Humanitarian Intervention Guide remains especially relevant because it was designed for crisis settings where scalable, adaptable care is needed beyond conventional specialist models and where specialist and non-specialist care must often be linked rather than separated (World Health Organization, 2015). In this sense, the function of counselling centres and clinics in war settings is not only to treat disorder, but to help create the psychological and relational conditions under which family recovery becomes more possible.

Parenting reintegration

Parenting is one of the central mechanisms through which children either regain safety or continue to live in dysregulation. Under bombardment, displacement, hunger, uncertainty and repeated grief, caregivers are still expected to soothe, structure, protect, guide and emotionally contain their children. Yet war-related stress often undermines those capacities. Eltanamly et al. (2021) showed that parenting helps explain part of the relationship between war exposure and child adjustment and described how and why parenting changes under war conditions. El-Khani et al. (2016) likewise identified danger, instability, inconsistency and caregiver guilt as major pressures on parenting in refugee and displacement contexts. This is theoretically important because it shows that parenting is not simply another variable affected by war, but one of the main pathways through which war-related stress is either transmitted to children or buffered within family life (Betancourt & Khan, 2008; Samara, Hammuda, et al., 2020).

Parenting reintegration therefore, requires more than advice on discipline. It involves helping caregivers recover enough emotional regulation, confidence and support to resume nurturing and containing roles. This includes psychoeducation about trauma responses, support for grief and stress regulation, non-violent discipline, restoration of routines where possible and repair of emotional ruptures. Parenting support groups can reduce isolation and normalise distress. Family-based therapy can improve communication and co-regulation. Low-literacy or highly practical parenting resources may be crucial in displaced populations. Material support also matters: caregivers struggling to secure food, warmth, medicine or safe sleep may find it extremely difficult to sustain emotional patience and responsiveness. Parenting reintegration is therefore both psychological and material. It is also relational and ecological, because caregiving improves not only through insight

or advice, but through reductions in stress load, greater practical stability and stronger support around the family (Betancourt & Khan, 2008; El-Khani et al., 2016; UNICEF, 2022).

Parenting repair also occurs through shared positive family experiences. Parents and children reconnect not only through trauma-focused discussion but through safe, ordinary activities such as play, meals, storytelling, visits, rituals and time outdoors, which can help restore emotional connection and a more ordinary family life. In war settings, even small forms of shared activity may help re-establish emotional connection and support the wider restoration of safer, more ordinary family life (Jepson et al., 2019; Lehto et al., 2009; Miyakawa & Oguchi, 2022; UNICEF, 2026b).

Schools as stabilising and restorative environments

Schools often provide one of the few semi-structured environments still available to children in conflict-affected settings. Even where formal schooling is disrupted, educational settings can restore routine, peer contact, adult oversight and a sense that time continues beyond crisis. School-based psychosocial support may include group interventions, psychoeducation, arts and narrative activities, trauma-sensitive pedagogy, and teacher training in recognising trauma responses. These functions matter not only for distress reduction but also for rebuilding developmental continuity, because armed conflict strips children of predictability, social participation, and future orientation (Bangpan et al., 2024; Bürgin et al., 2022; El-Khodary & Samara, 2019b).

This is particularly important in Gaza because school-based responses may be among the few scalable platforms capable of reaching large numbers of war-affected children. El-Khodary and Samara (2019b) found that a school-based intervention was effective in reducing PTSD symptoms after war-related trauma, supporting the argument that schools are not merely educational institutions but potential sites of psychological stabilisation, relational repair and developmental reopening. This is especially valuable where specialist services are scarce, disrupted or inaccessible (Ataullahjan et al., 2020; Samara, Hammuda, et al., 2020).

The importance of school ecology is further underscored by Samara et al. (2020), whose work on refugee children in the UK showed that psychosocial wellbeing is shaped not only by prior adversity, but also by peer relations, bullying, belonging, and school-based social experience. Although the UK context differs from Gaza, the theoretical implication is transferable: educational environments matter not only for academic continuity, but for protection, adjustment, and relational recovery.

Schools can also function as spaces of re-humanisation by restoring routine, connectedness, hope, expression and belonging. School-based intervention,

peer contact, outings, arts, play, sport, storytelling and contact with nature can provide small but meaningful forms of developmental continuity and relief, even when broader tourism is impossible (Allen & Boyle, 2018; Frasco et al., 2025; Hamilton et al., 2016; Jepson et al., 2019; Moody-Pugh et al., 2025; Morison et al., 2022; Nijhof et al., 2018; Rose et al., 2019; Tillmann et al., 2018; Tol et al., 2014). Article 31 of the Convention on the Rights of the Child reinforces the view that play, recreation, leisure and cultural participation are central to children's development, not peripheral luxuries (Glos, 2025; Office of the High Commissioner for Human Rights, 1989).

Social and community organisations: rebuilding belonging and shared life

War fractures not only households but also the wider social networks that sustain family life. Community organisations can therefore play a major role in recovery by providing psychosocial support, parenting groups, family activities, youth programmes, legal assistance, material aid and culturally grounded care. UNICEF's child protection and community-based MHPSS guidance emphasises the importance of community-level and systems-level responses for children exposed to violence, displacement and separation, while broader humanitarian MHPSS reviews likewise support multi-layered, community-embedded approaches rather than relying only on individual clinical intervention (Arega, 2023; Jordans et al., 2016; UNICEF, 2019a, 2019b).

Community organisations are especially valuable because they can help restore positive collective life, not only coordinate emergency response. Storytelling circles, memorial practices, religious gatherings, community meals, children's activities, family days and locally organised cultural events can help families reconnect for reasons other than immediate survival. Jepson et al. (2019) found that local community festivals and events can facilitate familial bonding, belonging, memorable shared experiences and quality-of-life benefits. In war or post-war settings, such community-based activities may therefore become locally adapted forms of restorative leisure, especially where formal tourism is inaccessible or politically constrained.

The aim is not to commercialise recovery, but to strengthen connectedness beyond fear by creating shared, meaningful, identity-affirming experiences that interrupt the dominance of trauma and allow relationship-building in a different emotional register. This broader emphasis on connectedness, belonging and collective participation is also consistent with wider literature showing that social connectedness and local community belonging are associated with better mental health and wellbeing for children, adolescents, and families (Blum et al., 2022; Hamilton et al., 2016).

Tourism, leisure, and restorative mobility in war and in Gaza

Tourism, leisure and restorative mobility matter because shared movement and leisure can support family bonding, communication, stress regulation and positive memory-making. In war settings, however, these ordinary forms of family life are disrupted, and their loss should be understood not as a superficial lifestyle issue but as the erosion of an everyday relational context that supports psychosocial recovery (Ataullahjan et al., 2020; Bangpan et al., 2024; Jepson et al., 2019; Lehto et al., 2009; Miyakawa & Oguchi, 2022; UNICEF, 2026b; World Health Organization, 2025a, 2025b).

In Gaza, long-standing movement restrictions and the intensified constraints following October 2023 mean that mobility is predominantly coercive rather than chosen: families move to flee attack, search for aid or reach shelter, not to rest, reconnect or experience shared pleasure (UNICEF, 2026a; OCHA, 2022, 2026a, 2026b, 2026c; World Health Organization, 2026).

Restorative mobility can be understood as safe, meaningful and chosen movement that helps children and caregivers reconnect with one another, with community life and with experiences beyond immediate survival, including visits, school trips, cultural and religious gatherings, time in nature and movement for education or care (Hermosilla et al., 2019; Jepson et al., 2019; UNICEF, 2026b).

This has practical implications for intervention. In acute conflict, it may be ethically difficult to discuss tourism in conventional market terms. A more defensible focus is the restoration of safe and dignified forms of family-supportive mobility and recreation: local supervised outings where feasible, structured family days, temporary learning and play spaces, school excursions, child-friendly spaces, cultural events and protected routes for medical and educational movement. Evidence syntheses suggest that mental health and psychosocial support for children in humanitarian settings must be carefully tailored to context and that child-friendly spaces can provide at least modest protective and psychosocial benefits for younger children when well designed. OCHA's reporting on Gaza, including temporary learning spaces and the distribution of recreational and early-childhood kits, also indicates that recreation and developmental continuity are already being treated in practice as part of humanitarian response rather than as optional extras (Bangpan et al., 2024; Hermosilla et al., 2019; OCHA, 2026b).

There is also a specifically developmental reason to take this seriously in Gaza. Recent research suggests that war has distorted children's play, pushed it toward violent and survival themes and reduced ordinary opportunities for

childhood activity (Aqtam, 2025; Bdier et al., 2025; Taha et al., 2024). Seen in this light, safe play, leisure, and restorative mobility are not decorative additions to recovery. They are part of preserving developmental continuity, relational repair, and hope in a setting where blockade and war have narrowed everyday life to survival.

Resilience, non-specialist providers, and long-term recovery

Resilience in war-affected families should not be reduced to stoicism or treated as a fixed individual trait. Research on children affected by armed conflict instead emphasises protective processes located within the child's social ecology, including attachment relationships, caregiver well-being, family resources and wider social support networks. In this sense, resilience is better understood as a dynamic process than as a rare quality possessed only by exceptional children (Betancourt & Khan, 2008; Masten & Barnes, 2018).

An important extension of this argument is that resilience may be strengthened not only by reducing harm, but also by restoring positive shared experience. A child who attends a family-centred community event, joins a school excursion, visits relatives, spends time outdoors with a caregiver or participates in a culturally meaningful family activity may be engaging in resilience-building in ways that complement formal therapy. Shared positive experiences, including family-centred community activities and safe routine, may strengthen resilience by supporting bonding, communication and parental wellbeing, even when formal leisure travel is impossible (Lehto et al., 2009; Miyakawa & Oguchi, 2022).

Because specialist mental health professionals are often scarce in protracted emergencies, non-specialist provision and task-sharing are central to scalable care. WHO's mhGAP Humanitarian Intervention Guide was specifically developed to provide first-line management recommendations for non-specialist health-care providers in humanitarian emergencies where access to specialists is limited. Research on supervision in humanitarian MHPSS further shows that regular, supportive supervision is important both for intervention quality and for protecting staff well-being, especially in low-resource or high-stress settings (Perera et al., 2021; World Health Organization, 2015).

Technology should also be recognised as part of the recovery infrastructure, especially where movement is restricted or services are disrupted. Evidence from conflict-affected settings indicates that eHealth and tele-mental-health can help extend care across geographic and access barriers, although feasibility depends heavily on communications infrastructure, privacy and suit-

ability for particular patient groups. In addition, WHO's guided Step-by-Step intervention for displaced Syrians in Lebanon showed that digitally delivered support with non-specialist helpers reduced depression and improved functioning, anxiety, post-traumatic stress and well-being among participants who had adequate digital access. At the same time, WHO reports that, in the occupied Palestinian territory in 2026, displacement, damaged infrastructure, and access restrictions continue to undermine care, underscoring that although technology can extend support, reduce isolation, broaden the reach of specialist and non-specialist services, sustain educational and scholarly connections, and help maintain family and professional ties across borders, it cannot substitute for safety, functioning systems or freedom of movement (Bowsher et al., 2021; Cuijpers et al., 2022; Ibragimov et al., 2022; World Health Organization, 2026).

Long-term recovery also requires monitoring and sustained investment. Longitudinal evidence from post-conflict Sierra Leone shows that caregiver and child mental health remain linked over time and that family acceptance and community stigma matter for outcomes. Recent evidence syntheses also show that, although the MHPSS evidence base in humanitarian settings is growing, findings across modalities remain mixed and strongly shaped by context. This suggests that evaluation in war-affected families should look beyond short-term symptom change to include caregiving quality, family functioning, developmental opportunity and social reintegration, rather than relying on symptom reduction alone (Bangpan et al., 2024; Betancourt & Khan, 2008; World Health Organization, 2025a, 2025b).

A proposed Siege–Intergenerational Restoration and Mobility (SIRM) model

A more theoretically precise way to integrate the chapter's argument is through a proposed Siege-Intergenerational Restoration and Mobility (SIRM) model. The model begins from the premise that, in protracted war settings such as Gaza, harm is generated not only through direct exposure to traumatic events but also through a recursive ecology of siege-related disruption. Repeated bombardment, blockade, displacement, institutional breakdown, material deprivation and severe movement restrictions interact to generate chronic toxic stress, destabilise caregiving, compress family roles into survival functions, disrupt education and play and narrow children's developmental environments and future horizons (Ataullahjan et al., 2020; Betancourt & Khan, 2008; Procter, 2024; Samara, Hammuda, et al., 2020; World Health Organization, 2025a, 2025b).

Within the SIRM model, intergenerational harm is transmitted through at least five linked pathways. First, war and siege affect parents and caregivers through grief, fear, traumatic stress, depression, exhaustion and hopelessness, all of which can reduce emotional availability and regulatory capacity (Aqtam, 2025; Ataullahjan et al., 2020; Betancourt & Khan, 2008; El-Khodary & Samara, 2019a, 2020; Procter, 2024). Second, these pressures may alter parenting and family interaction through harshness, inconsistency, emotional withdrawal, reduced attunement and greater risk of conflict within already overburdened households; more broadly, parenting quality and warmth are known to shape how strongly war exposure affects children's mental health and functioning (Hazer & Gredebäck, 2023; SIPRI, 2022). Third, repeated interruption to schooling, play, peer relations and routine constrains developmental opportunity, and removes key protective environments that ordinarily support psychosocial adjustment (Bdier et al., 2025; Bessell & O'Sullivan, 2026; Glos, 2025). Fourth, blocked mobility limits access not only to safety, but also to family reunion, health care, education, cultural life and professional participation, thereby converting movement from a developmental and relational resource into a field of restriction and coercion (Procter, 2024; OCHA, 2026a). Fifth, prolonged siege may contract what families can realistically imagine for the future, normalising interruption, enclosure, uncertainty and suspended life trajectories across generations (Aqtam, 2025; World Health Organization, 2026).

The SIRM model therefore proposes that recovery requires coordinated restoration across five linked domains. The first is psychological restoration, including trauma care, emotional regulation, grief support and mental health and psychosocial support. The second is relational restoration, including parenting reintegration, caregiver support and prevention of family violence. The third is developmental restoration, through the reopening of education, play, peer life and age-appropriate exploration. The fourth is ecological restoration, through rebuilding the institutions and social protections on which family functioning depends, including schools, clinics, community organisations and child-protection systems. The fifth is mobility and connection restoration, including safe local movement, family visits, cultural participation, educational and medical travel and opportunities for positive shared family experience. This emphasis is consistent with humanitarian child-protection and mental-health frameworks, which stress that children's recovery depends not only on symptom reduction but also on safe relationships, supportive systems and restored everyday environments (UNICEF, 2026b; World Health Organization, 2025a, 2025b).

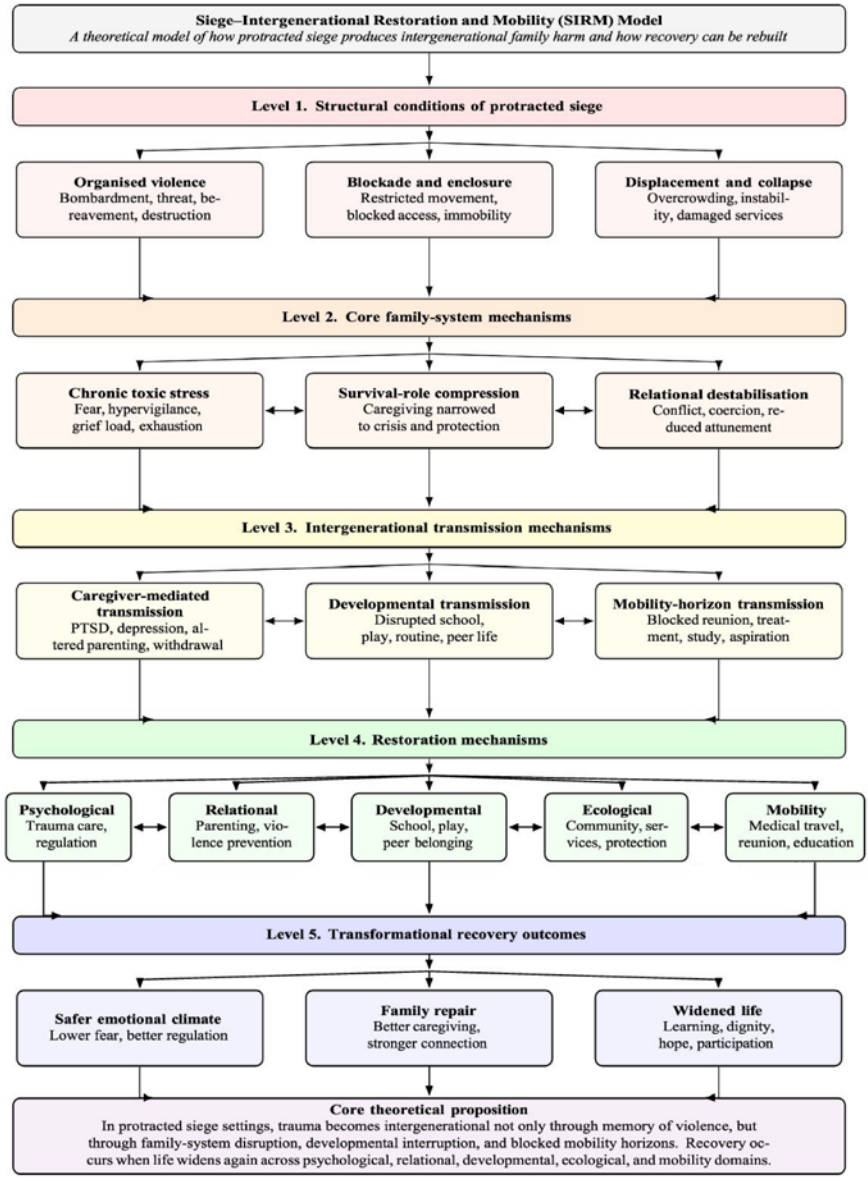

Figure 5.1: The Siege–Intergenerational Restoration and Mobility (SIRM) model. The model proposes that protracted siege generates intergenerational family harm through structural violence, blockade, displacement, and institutional breakdown. These forces operate through chronic toxic stress, caregiving strain, relational destabilisation, developmental disruption and blocked mobility. Recovery is conceptualised as coordinated restoration across psychological, relational, developmental, ecological and mobility domains.

The value of the SIRM model is that it explicitly brings together bodies of scholarship that are often treated separately: parenting and family violence, child development, humanitarian child protection, family leisure and mobility restriction. In doing so, it foregrounds a point that is often insufficiently theorised in conflict research: families recover when the wider conditions of ordinary family life begin to reopen (Ataullahjan et al., 2020; Betancourt & Khan, 2008; Lehto et al., 2009; Miyakawa & Oguchi, 2022; Samara, Hammuda, et al., 2020; UNICEF, 2026b; World Health Organization, 2025b). Relative to the earlier SDFD framework, which explains how war and siege generate family disintegration, the SIRM model shifts the emphasis from pathways of harm to coordinated pathways of restoration.

Practical implications for policy and intervention

Several practical implications follow from this integrated account of healing and restoration. First, psychosocial support in war settings should be family-centred, cross-sectoral and scalable. Recovery infrastructures should link health, education, child protection, social welfare and community organisations, while also equipping non-specialist providers such as teachers, social workers, community health workers, religious leaders, lay facilitators and NGO staff to contribute through psychological first aid, psychoeducation, supportive listening, case identification, referral, parenting support and safe child and family spaces (Bangpan et al., 2024; El-Khodary & Samara, 2019b; Hermosilla et al., 2019; UNICEF, 2018, 2019a, 2022, 2024a, 2024b; World Health Organization, 2015). Family violence prevention should therefore be built into humanitarian mental health, child protection, education and social protection responses, and shared routines, safe play, peer contact and family-supportive community activities should be treated as part of recovery architecture rather than optional extras (Backhaus et al., 2025; Bhatt, 2017; Jordans et al., 2016). Digital and hybrid systems can extend support where services are fragmented, but they should be understood as extensions of care rather than substitutes for safety, functioning institutions or freedom of movement (Bowsher et al., 2021; Humayun et al., 2025; Ibragimov et al., 2022).

Second, long-term recovery strategies should monitor more than symptom change alone. The current evidence base suggests that some MHPSS approaches can help in humanitarian settings, but effects vary by modality and context, and important outcomes are often under-measured (Bangpan et al., 2024). This strengthens the case for evaluating whether caregiving stability, family functioning, exposure to violence, developmental access, educational re-engagement and opportunities for shared positive life are actually returning over time. In Gaza specifically, recovery planning should also address mobility justice and reconnection pathways. WHO's 2026 appeal

states that displacement, damaged infrastructure and access restrictions continue to undermine care in the occupied Palestinian territory, UNICEF reports that more than 1 million children require psychosocial support and hundreds of thousands need access to education and OCHA documents that restrictions have disrupted medical evacuations, returns from abroad, and humanitarian movement coordination (UNICEF, 2026a; OCHA, 2026b, 2026c; World Health Organization, 2026). Taken together, these sources support a broader policy view in which recovery must include protected routes and practical mechanisms for medical care, education, family reunification and professional connection, rather than treating mobility as a peripheral issue.

Third, donors, universities, international organisations and community institutions should invest in sustained, ring-fenced recovery infrastructures rather than short emergency cycles alone. This includes support for caregiver and parenting programmes, community-based family support, school-linked MHPSS, training and supervision for non-specialists, remote and hybrid supervision where appropriate, and opportunities for educational and scholarly continuity for Gazan students, academics and professionals. It includes scholarship pathways, research fellowships, visiting or remote scholar schemes, protected academic partnerships and carefully designed opportunities for humanitarian, educational, clinical, cultural and collaborative engagement with Gaza when safe and feasible (UNICEF, 2026a, 2026b; OCHA, 2026a, 2026b, 2026c; World Health Organization, 2026).

Most importantly, practitioners and policymakers should recognise that healing war-affected families requires rebuilding the conditions under which families can experience connection rather than only crisis management. Emergency stabilisation is indispensable, but by itself it does not restore ordinary family life. Recovery becomes more plausible when children and caregivers can again learn, play, move, meet others, access support and imagine a future beyond immediate survival. Across the humanitarian MHPSS, child protection, parenting, education, and conflict-health literatures, the consistent message is that recovery also requires restoration of the relational, developmental, and social conditions that make family life liveable again (Bangpan et al., 2024; UNICEF, 2022, 2024b; World Health Organization, 2025a, 2025b).

Conclusion

Healing war-affected families requires more than helping them endure suffering. It requires rebuilding the conditions under which family life can once again become protective: safety, trust, caregiving stability, non-violent relationships, play, routine, cultural continuity, meaningful time together and access to supportive community structures. This is consistent with work on

children affected by armed conflict, which shows that recovery depends not only on reducing exposure to harm but also on restoring the protective processes embedded in children's social ecologies, including caregiving relationships, family support and wider community systems (Ataullahjan et al., 2020; Betancourt & Khan, 2008; UNICEF, 2026a, 2026b; World Health Organization, 2025b).

Family violence prevention is central because children are unlikely to recover fully in homes that remain frightening or unstable. In protracted siege settings such as Gaza, recovery requires more than symptom reduction. It requires interrupting cycles of toxic stress, fractured caregiving, blocked development and restricted movement so that parents can reconnect with their children, children can play and learn, violence within the home is reduced, schools and communities can reopen developmental possibility and families can move, reunite, heal and imagine a future together (Ataullahjan et al., 2020; Betancourt & Khan, 2008; Samara, Hammuda, et al., 2020; UNICEF, 2024a, 2026a, 2026b; OCHA, 2026a; World Health Organization, 2025a, 2025b, 2026).

As a proposed integrative framework, the SIRM model makes this argument explicit by suggesting that psychosocial recovery in siege contexts is simultaneously psychological, relational, developmental, ecological, and mobility-based. Its main contribution is to show that family recovery should be understood not simply as the reduction of symptoms, but as the gradual restoration of the relational, institutional, and movement conditions that allow family life to become protective again.

References

Allen, K.-A., & Boyle, C. (2018). *Pathways to Belonging: Contemporary Research in School Belonging. (1st ed.)*: Brill.

Aqtam, I. (2025). A narrative review of mental health and psychosocial impact of the war in Gaza. *Eastern Mediterranean Health Journal, 31*(2), 89-96. doi:10.26719/2025.31.2.89

Arega, N. T. (2023). Mental health and psychosocial support interventions for children affected by armed conflict in low-and middle-income countries: a systematic review. *Child Youth Care Forum*, 1-26. doi:10.1007/s10566-023-09741-0

Ataullahjan, A., Samara, M., Betancourt, T. S., & Bhutta, Z. A. (2020). Mitigating toxic stress in children affected by conflict and displacement. *British Medical Journal, 371*, m2876. doi:10.1136/bmj.m2876

Backhaus, S., Blackwell, A., & Gardner, F. (2025). The effectiveness of parenting interventions in reducing violence against children in humanitarian settings in low- and middle-income countries: A systematic review and meta-analysis. *Child Abuse and Neglect, 162*(Pt 2), 106850. doi:10.1016/j.chiabu.2024.106850

Bangpan, M., Felix, L., Soliman, F., D'Souza, P., Jieman, A.-T., & Dickson, K. (2024). The impact of mental health and psychosocial support programmes on children and young people's mental health in the context of humanitarian emergencies in low-and middle-income countries: A systematic review and meta-analysis. *Cambridge Prisms: Global Mental Health, 11*, e21. doi:10.1017/gmh.2024.17

Bdier, D., Hamamra, B., & Mahamid, F. (2025). From laughter to survival: The effect of war on children's play in Gaza. *Children and Youth Services Review, 178*, 108526. doi:https://doi.org/10.1016/j.childyouth.2025.108526

Bessell, S., & O'Sullivan, C. (2026). The failure to protect the rights and needs of children in Gaza. *Frontiers in Public Health, 13*. doi:10.3389/fpubh. 2025.1708975

Betancourt, T. S., & Khan, K. T. (2008). The mental health of children affected by armed conflict: Protective processes and pathways to resilience. *International Review of Psychiatry, 20*(3), 317-328. doi:10.1080/09540260802090363

Bhatt, P. (2017). *Caregiver psychosocial wellbeing and family violence: A scoping review of factors that affect the wellbeing of children in humanitarian crisis.* https://resourcecentre.savethechildren.net/document/caregiver-psychosocial-wellbeing-and-family-violence-scoping-review-factors-affect-wellbeing

Blum, R. W., Lai, J., Martinez, M., & Jessee, C. (2022). Adolescent connectedness: cornerstone for health and wellbeing. *British Medical Journal, 379*, e069213. doi:10.1136/bmj-2021-069213

Bowsher, G., El Achi, N., Augustin, K., Meagher, K., Ekzayez, A., Roberts, B., & Patel, P. (2021). eHealth for service delivery in conflict: a narrative review of the application of eHealth technologies in contemporary conflict settings. *Health Policy Planning, 36*(6), 974-981. doi:10.1093/heapol/czab042

Bürgin, D., Anagnostopoulos, D., Vitiello, B., Sukale, T., Schmid, M., & Fegert, J. M. (2022). Impact of war and forced displacement on children's mental health-multilevel, needs-oriented, and trauma-informed approaches. *European Child and Adolescent Psychiatry, 31*(6), 845-853. doi:10.1007/s00787-022-01974-z

Catani, C. (2009). Krieg im Zuhause – ein Überblick zum Zusammenhang zwischen Kriegstraumatisierung und familiärer Gewalt. *Verhaltenstherapie, 20*(1), 19-27. doi:10.1159/000261994

Catani, C., Jacob, N., Schauer, E., Kohila, M., & Neuner, F. (2008). Family violence, war, and natural disasters: A study of the effect of extreme stress on children's mental health in Sri Lanka. *BMC Psychiatry, 8*(1), 33. doi:10.1186/1471-244X-8-33

Christie, H., Hamilton-Giachritsis, C., Alves-Costa, F., Tomlinson, M., & Halligan, S. L. (2019). The impact of parental posttraumatic stress disorder on parenting: a systematic review. *European Journal of Psychotraumatology, 10*(1), 1550345. doi :10.1080/20008198.2018.1550345

Cuijpers, P., Heim, E., Abi Ramia, J., Burchert, S., Carswell, K., Cornelisz, I., . . . El Chammay, R. (2022). Effects of a WHO-guided digital health intervention for depression in Syrian refugees in Lebanon: A randomized controlled trial. *PLoS Med, 19*(6), e1004025. doi:10.1371/journal.pmed.1004025

Dixius, A., & Möhler, E. (2021). Feasibility and effectiveness of a new short-term psychotherapy concept for adolescents with emotional dysregulation. *Frontiers in Psychiatry, 11*. doi:10.3389/fpsyt.2020.585250

El-Khani, A., Ulph, F., Peters, S., & Calam, R. (2016). Syria: The challenges of parenting in refugee situations of immediate displacement. *Intervention: Journal of Mental Health and Psychosocial Support in Conflict Affected Areas, 14*(2), 99-113. doi:10.1097/WTF.0000000000000118

El-Khodary, B., & Samara, M. (2019a). The mediating role of trait emotional intelligence, prosocial behaviour, parental support and parental psychological control on the relationship between war trauma, and PTSD and depression. *Journal of Research in Personality, 81*, 246-256. doi.org/10.1016/j.jrp.2019.06.004

El-Khodary, B., & Samara, M. (2019b). Effectiveness of a school-based intervention on the students' mental health after exposure to war-related trauma. *Front Psychiatry, 10*, 1031. doi:10.3389/fpsyt.2019.01031

El-Khodary, B., & Samara, M. (2020). The relationship between multiple exposures to violence and war trauma, and mental health and behavioural problems among Palestinian children and adolescents. *European Child & Adolescent Psychiatry, 29*(5), 719-731. doi:10.1007/s00787-019-01376-8

El-Khodary, B., & Samara, M. (2022). *The effect of displacement on mental health amongst children who are exposed to war trauma: Comparative study.* Paper presented at the International Society for the Study of Behavioural Development (ISSBD), Rhodes, Greece.

El-Khodary, B., Samara, M., & Askew, C. (2020). Traumatic events and PTSD among Palestinian children and adolescents: the effect of demographic and socioeconomic factors. *Frontiers in Psychiatry, 11*. doi:10.3389/fpsyt.2020.00004

Eltanamly, H., Leijten, P., Jak, S., & Overbeek, G. (2021). Parenting in times of war: a meta-analysis and qualitative synthesis of war exposure, parenting, and child adjustment. *Trauma, Violence, & Abuse, 22*(1), 147-160. doi:10.1177/1524838019833001

Fazel, M., Stratford, H. J., Rowsell, E., Chan, C., Griffiths, H., & Robjant, K. (2020). Five applications of narrative exposure therapy for children and adolescents presenting with post-traumatic stress disorders. *Frontiers in Psychiatry, 11*. doi:10.3389/fpsyt.2020.00019

Frasco, E., Sherr, L., Dedios Sanguineti, M. C., Vera San Juan, N., & Burgess, R. (2025). The impact of creative arts-based interventions for mental health in conflict-affected contexts: A systematic narrative review. *SSM - Mental Health, 7*, 100419. doi.org/10.1016/j.ssmmh.2025.100419

Glos, A. (2025). Children's right to play in times of war. *Bioethics, 39*(1), 26-40. doi.org/10.1111/bioe.13232

Hamilton, A., Foster, C., & Richards, J. (2016). A systematic review of the mental health impacts of sport and physical activity programmes for adolescents in post-conflict settings. *Journal of Sport for Development, 4*, 44-59.

Hazer, L., & Gredebäck, G. (2023). The effects of war, displacement, and trauma on child development. *Humanities and Social Sciences Communications, 10*(1), 909. doi:10.1057/s41599-023-02438-8

Hermosilla, S., Metzler, J., Savage, K., Musa, M., & Ager, A. (2019). Child friendly spaces impact across five humanitarian settings: a meta-analysis. *BMC Public Health, 19*(1), 576. doi:10.1186/s12889-019-6939-2

Humayun, A., Najmussaqib, A., & Muneeb, N. u. A. (2025). Supervision-based evaluation of primary healthcare workers' performance after mhGAP-HIG training in Pakistan. *SSM - Mental Health, 7*, 100451. doi.org/10.1016/j.ssmmh.2025.100451

Ibragimov, K., Palma, M., Keane, G., Ousley, J., Crowe, M., Carreño, C., Casas, G., Mills, C., Llosa, A. & , M. S. F. Mental Working Health Group (2022). Shifting to tele-mental health in humanitarian and crisis settings: an evaluation of Médecins Sans Frontières experience during the COVID-19 pandemic. *Conflict and Health, 16*(1), 6. doi:10.1186/s13031-022-00437-1

Jepson, A., Stadler, R., & Spencer, N. (2019). Making positive family memories together and improving quality-of-life through thick sociality and bonding at local community festivals and events. *Tourism Management, 75*, 34-50. doi.org/10.1016/j.tourman.2019.05.001

Jordans, M. J., Pigott, H., & Tol, W. A. (2016). Interventions for children affected by armed conflict: a systematic review of mental health and psychosocial support in low- and middle-income countries. *Current Psychiatry Reports, 18*(1), 9. doi:10.1007/s11920-015-0648-z

Lehto, X. Y., Choi, S., Lin, Y.-C., & MacDermid, S. M. (2009). Vacation and family functioning. *Annals of Tourism Research, 36*(3), 459-479. doi.org/10.1016/j.annals.2009.04.003

Masten, A. S., & Barnes, A. J. (2018). Resilience in children: Developmental perspectives. *Children (Basel), 5*(7). doi:10.3390/children5070098

Miyakawa, E., & Oguchi, T. (2022). Family tourism improves parents' well-being and children's generic skills. *Tourism Management, 88*, 104403. doi:https://doi.org/10.1016/j.tourman.2021.104403

Moody-Pugh, J., Renshaw, K., & Parson, J. (2025). Exploring play-based interventions with war-affected children: A scoping review. *The Arts in Psychotherapy, 95*, 102337. doi.org/10.1016/j.aip.2025.102337

Morison, L., Simonds, L., & Stewart, S. F. (2022). Effectiveness of creative arts-based interventions for treating children and adolescents exposed to traumatic events: a systematic review of the quantitative evidence and meta-analysis. *Arts Health, 14*(3), 237-262. doi:10.1080/17533015.2021.2009529

Neuner, F., Catani, C., Ruf, M., Schauer, E., Schauer, M., & Elbert, T. (2008). Narrative exposure therapy for the treatment of traumatized children and adolescents (KidNET): From neurocognitive theory to field intervention. *Child and Adolescent Psychiatric Clinics of North America, 17*(3), 641-664. doi.org/10.1016/j.chc.2008.03.001

Nijhof, S. L., Vinkers, C. H., van Geelen, S. M., Duijff, S. N., Achterberg, E. J. M., van der Net, J., . . . Lesscher, H. M. B. (2018). Healthy play, better coping: The importance of play for the development of children in health and disease. *Neuroscience Biobehavioural Review, 95*, 421-429. doi:10.1016/j.neubiorev.2018.09.024

Office of the High Commissioner for Human Rights. (1989). *Convention on the Rights of the Child*. www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child

Perera, C., McBride, K. A., Travers, Á., Tingsted Blum, P., Wiedemann, N., Dinesen, C., . . . Vallières, F. (2021). Towards an integrated model for supervision for mental health and psychosocial support in humanitarian emergencies: A qualitative study. *PLoS One, 16*(10), e0256077. doi:10.1371/journal.pone.0256077

Procter, C. (2024). Coerced migration: mobility under siege in Gaza. *Journal of Ethnic and Migration Studies, 50*(10), 2359-2383. doi:10.1080/1369183X.2024.2312229

Rose, J., McGuire-Snieckus, R., Gilbert, L., & McInnes, K. (2019). Attachment aware schools: the impact of a targeted and collaborative intervention. *Pastoral Care in Education, 37*(2), 162-184. doi:10.1080/02643944.2019.1625429

Saile, R., Ertl, V., Neuner, F., & Catani, C. (2014). Does war contribute to family violence against children? Findings from a two-generational multi-informant study in Northern Uganda. *Child Abuse & Neglect, 38*(1), 135-146. doi.org/10.1016/j.chiabu.2013.10.007

Samara, M., El Asam, A., Khadaroo, A., & Hammuda, S. (2020). Examining the psychological well-being of refugee children and the role of friendship and bullying. *British Journal of Educational Psychology, 90*(2), 301-329. doi.org/10.1111/bjep.12282

Samara, M., Hammuda, S., Vostanis, P., El-Khodary, B., & Al-Dewik, N. (2020). Children's prolonged exposure to the toxic stress of war trauma in the Middle East. *British Medical Journal, 371*, m3155. doi:10.1136/bmj.m3155

Sangalang, C. C., & Vang, C. (2017). Intergenerational trauma in refugee families: A systematic review. *Journal of Immigrant and Minority Health, 19*(3), 745-754. doi:10.1007/s10903-016-0499-7

SIPRI. (2022). *Child development and resilience in war, conflict and displacement.* Stockholm International Peace Research Institute. www.sipri.org/commentary/topical-backgrounder/2022/child-development-and-resilience-war-conflict-and-displacement

Sriskandarajah, V., Neuner, F., & Catani, C. (2015). Predictors of violence against children in Tamil families in northern Sri Lanka. *Social Science & Medicine, 146*, 257-265. doi.org/10.1016/j.socscimed.2015.10.010

Taha, A. M., Sabet, C., Nada, S. A., Abuzerr, S., & Nguyen, D. (2024). Addressing the mental health crisis among children in Gaza. *The Lancet Psychiatry, 11*(4), 249-250. doi:10.1016/S2215-0366(24)00036-1

Tarabay, J., & Golm, D. (2024). The transmission of intergenerational trauma and protective factors in survivors of the Lebanese civil war and their adult offspring. *International Journal of Intercultural Relations, 99*, 101952. doi.org/10.1016/j.ijintrel.2024.101952

Tillmann, S., Tobin, D., Avison, W., & Gilliland, J. (2018). Mental health benefits of interactions with nature in children and teenagers: a systematic review. *Journal of Epidemiological Community Health, 72*(10), 958-966. doi:10.1136/jech-2018-210436

Tol, W. A., Komproe, I. H., Jordans, M. J., Ndayisaba, A., Ntamutumba, P., Sipsma, H., . . . de Jong, J. T. (2014). School-based mental health intervention

for children in war-affected Burundi: a cluster randomized trial. *BMC Medicine, 12*, 56. doi:10.1186/1741-7015-12-56

UNICEF. (2018). *Community-based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families.* United Nations Children's Fund. www.mhpss.net/toolkit/children-and-families-mhpss-resource-collection/resource/community-based-mental-health-and-psychosocial-support-in-humanitarian-settings

UNICEF. (2019a). *Community-based mental health and psychosocial support operational guidelines*. www.unicef.org/reports/community-based-mental-health-and-psychosocial-support-guidelines-2019

UNICEF. (2019b). *Community-based mental health and psychosocial support operational guidelines*. www.unicef.org/media/96671/file/CPHA-Advocacy-Brief-2021.pdf

UNICEF. (2022). *Global multisectoral operational framework for mental health and psychosocial support of children, adolescents and caregivers across settings.* United Nations Children's Fund. www.unicef.org/media/109086/file/Global%20multisectorial%20operational%20framework.pdf

UNICEF. (2024a). *Protecting children's mental health in emergency settings. UNICEF Europe and Central Asia.* www.unicef.org/eca/stories/protecting-childrens-mental-health-emergency-settings

UNICEF. (2024b). *Integrating mental health and psychosocial support into education in emergencies using the Minimum Service Package: Technical brief.* United Nations Children's Fund. www.unicef.org/media/159916/file/MHPSS%20in%20EiE%20Technical% 20Brief.pdf

UNICEF. (2025). *We close our eyes and imagine what we want to become*. /www.unicef.org/stories/we-close-our-eyes-and-imagine-what-we-want-become

UNICEF. (2026a). *State of Palestine 2026 HAC Appeal - Revision 1.* United Nations Children's Fund. www.unicef.org/media/179101/file/2026-HAC-State-of-Palestine-Revision1.pdf

UNICEF. (2026b). *Child Protection in Humanitarian Action Brief.* United Nations Children's Fund. www.unicef.org/documents/child-protection-humanitarian-action-brief-0

United Nations Office for the Coordination of Humanitarian Affairs (OCHA). (2016). *The Gaza Strip: The humanitarian impact of the blockade.* www.ochaopt.org/content/gaza-strip-humanitarian-impact-blockade-november-2016

United Nations Office for the Coordination of Humanitarian Affairs (OCHA). (2022). *The Gaza Strip: The humanitarian impact of 15 years of the blockade*. www.ochaopt.org/content/gaza-strip-humanitarian-impact-15-years-blockade-june-2022

United Nations Office for the Coordination of Humanitarian Affairs (OCHA). (2026a). *Gaza crossings: Movement of people and goods*. www.ochaopt.org/data/crossings

United Nations Office for the Coordination of Humanitarian Affairs (OCHA). (2026b). *Humanitarian Situation Report*. www.ochaopt.org/content/opt-humanitarian-response-6-march-2026

United Nations Office for the Coordination of Humanitarian Affairs (OCHA). (2026c). *Humanitarian Situation Update: Gaza Strip*. www.ochaopt.org/content/humanitarian-situation-update-357-gaza-strip

WHO Eastern Mediterranean Regional Office. (2026). *Gaza hostilities emergency situation reports*. www.emro.who.int/opt/information-resources/emergency-situation-reports.html

World Health Organization. (2015). *mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies*. www.who.int/publications/i/item/9789241548922

World Health Organization. (2025a). *Mental health in emergencies*. www.who.int/news-room/fact-sheets/detail/mental-health-in-emergencies

World Health Organization. (2025b). *Mental health in emergencies: A lifeline, not a luxury*. www.who.int/news-room/commentaries/detail/mental-health-in-emergencies--a-lifeline--not-a-luxury?utm

World Health Organization. (2026). *occupied Palestinian territory: WHO Health Emergency Appeal 2026*. www.who.int/publications/m/item/occupied-palestinian-territory-who-health-emergency-appeal-2026