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PERSPECTIVES

Holistic care for children's mental health in protracted conflict: A trauma-informed nursing perspective

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Abstract
For children growing up in protracted conflict, violence is rarely a series of isolated events; instability becomes woven into the fabric of their daily lives. Such conditions heighten the risk of mental health problems and disrupt emotional, social, and cognitive development. However, addressable as these challenges may seem, clinical services alone are rarely sufficient when children's distress is rooted in chronic insecurity, displacement, and loss. Consequently, a more integrated and holistic response is required. This perspective article explores the role of trauma-informed care in supporting the mental health of children in protracted conflicts, drawing on Palestine as an illustrative case study. Holistic care goes further than symptom management by addressing the interconnected biological, psychosocial, and spiritual dimensions of children's well-being. Trauma-informed care provides the relational foundation for this approach, emphasizing safety, trust, collaboration, and empowerment within paediatric nursing practice. Although child mental health services in conflict-affected settings often rely on screening, short-term counselling, and referral networks, their impact is frequently constrained by limited access, fragmented care, stigma, and cultural barriers. A holistic orientation addresses these gaps by strengthening family and community support, integrating age-appropriate non-pharmacological interventions, and preserving children's safety, hope, and meaning. Nurses are positioned to operationalize this framework through therapeutic relationships, early identification of distress, and continuous support. This article advocates for child mental health services that are more humane, responsive, and sustainable in various situations.

Keywords: Child mental health, holistic nursing care, pediatric nursing, protracted conflict, trauma-informed care

Children's mental health in the middle of conflict

Children are among those most affected when conflict persists over years rather than unfolding as a short-lived crisis (Kadir et al., 2025). Prolonged exposure does more than simply disrupt routines; over time, it reshapes the child's entire developmental environment (Bunyatova, 2025). Indeed, essential capacities for emotional regulation, attachment security, cognitive integration, and the formation of basic trust are still emerging during childhood. Studies indicates that when these processes occur in insecure environments, vulnerability tends to accumulate rather than diminish over time (Haer & Brown, 2025; Sharma et al., 2025). Repeated exposure to threats has been associated with anxiety and depressive symptoms in school-aged children (Harphoush et al., 2025). In line with this, cumulative stress exposure increases the probability of post-traumatic stress reactions (Scharpf et al., 2024). Unlike acute disasters that are temporally bounded, protracted conflict embeds uncertainty into children's daily life. For instance, children may witness violence, experience displacement, lose family members, and endure prolonged school interruption. Exposure to long-term instability across multiple regions has been associated with higher prevalence rates of anxiety and depression among children (Chen et al., 2025). Sleep disturbances and concentration difficulties are also reported in conflict-affected pediatric populations (Ferrara et al., 2025). Post-traumatic stress symptoms have persisted even after hostilities subsided, suggesting that chronic exposure may alter developmental trajectories (Gómez-Restrepo et al., 2023). Psychological effects do not remain confined within the child. They unfold within families and communities that are themselves under strain. When caregivers face displacement, financial instability, or unresolved trauma, children's emotional regulation often becomes more fragile (Williamson & Murphy, 2025). Also, community-level disruption, of schools, health services, and social networks, further compounds distress (Pember & Pettit, 2025). As a consequence,

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understanding children's mental health in such contexts requires attention from the healthcare professionals and organizations such as United Nations International Children's Emergency Fund (UNICEF). Recent global estimates indicate that millions of children currently reside in conflict-affected regions (United Nations Children's Fund, 2024).

Although Palestine is often cited as a longstanding example of protracted conflict, comparable patterns are evident elsewhere. In Ukraine, ongoing war has been associated with increased emotional distress, displacement-related anxiety, and educational disruption among children (Naeem et al., 2025). Border tensions between Thailand and Cambodia have likewise generated psychosocial insecurity among children living in the areas (Nou, 2024). Across Ukraine and the Thailand–Cambodia border regions, children's distress reflects exposure to discrete violent incidents, the normalization of disrupted schooling, repeated displacement alerts, and fluctuating access to health services. This pattern parallels conditions observed in Palestine, where instability becomes embedded in everyday developmental contexts. Palestine remains an illustrative context because many children there have lived their entire lives amid movement restrictions, intermittent violence, and social fragmentation (Arvisais et al., 2026). This article, however, does not position Palestine as an isolated case. It functions instead as a reflective lens through which broader nursing responses to prolonged conflict may be reconsidered.

Much of the literature on child mental health in war settings prioritizes trauma-focused psychological interventions designed for discrete events. Such approaches demonstrate effectiveness in reducing acute post-traumatic symptoms (Arega, 2023). Yet they may not fully capture the persistent, evolving stress characteristic of protracted conflict environments. Indeed, children in these settings are not simply processing past events as they must navigate instability. Consequently, this distinction holds vital practical implications for nursing practice. Nurses maintain a sustained presence across key community touchpoints including primary care clinics, educational institutions, and outreach initiatives. This structural continuity enables them to observe incremental changes in child behavior and emotional regulation that might otherwise go undetected. Thus, in settings marked by limited or fragmented specialist mental health coverage, nurses often represent the most reliable anchor for trauma-informed relational care. Feasibility, however, cannot be taken for granted. In conflict environments, severe workforce shortages, infrastructure fragility, and ongoing security risks tightly constrain clinical implementation. In light of these operational limits, nursing contributions must be explicitly aligned with realities. Rather than relying on resource-intensive protocols, interventions can center on reinforcing caregiver–child attachment dynamics. Therefore, this perspective advances a nursing framework that understands pediatric distress as relational, developmental, and context-bound.

Conceptual foundation of the holistic trauma-informed nursing framework

The bio–psycho–social–spiritual perspective conceptualizes development as an ongoing interaction among physiological regulation, emotional processes, attachment relationships, and existential (Tassos et al., 2025). Contemporary pediatric and family nursing scholarship continues to affirm multidimensional assessment as foundational to child health practice (Sheehan et al., 2025). Within this comprehensive diagnostic approach, trauma-informed care (TIC) has emerged as an essential framework for addressing cumulative psychological stress. TIC has evolved as a practice stance grounded in safety, relational trust, collaboration, and avoidance of adaptive stress responses (Qin et al., 2025). Systematic reviews in humanitarian settings confirm that trauma-focused cognitive behavioral therapy (TF-CBT) are implemented and demonstrate effectiveness in reducing acute post-traumatic stress symptoms among children (Arega, 2023; Thielemann et al., 2022). However, much of this literature lacks a focus on the specific mental health consequences experienced by children in environments affected by ongoing armed conflict. Most trauma-informed pediatric frameworks were originally designed in response to discrete adverse events, such as abuse, natural disasters, or isolated episodes of violence. Consequently, the core clinical objective centers on recovery from a past incident. Evidence shows significant reductions in post-traumatic symptoms disorder (PTSD) severity following structured trauma-focused psychological interventions (Douglas et al., 2025). Protracted conflict disrupts the traditional linear progression from trauma to recovery. In these settings, childhood development unfolds not in the aftermath of violence, but within its continuous and recurrent presence.

Recent research demonstrates that chronic exposure to political violence recalibrates stress physiology, executive functioning, and emotional regulation over time (Arvisais et al., 2026). Studies in Gaza and the West Bank also indicate cumulative exposure is associated with sustained autonomic arousal, sleep disturbance, and altered cognitive control processes (Arvisais et al., 2026; Hamamra et al., 2025). The facts above call for models that account for taking into consideration of trauma among children. Holistic nursing provides multidimensional assessment. However, without

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an explicit trauma lens, it may underestimate how sustained threat alters physiological arousal, attachment behavior, and meaning-making across development. Trauma-informed care models foreground safety and relational ethics, yet it does not map how biological, psychological, social, and spiritual domains intersect under health systems (Goldstein et al., 2024). The present framework was constructed to address this conceptual gap. Its contribution lies in proposing new domains of care and reconfiguring holistic dimensions through a trauma-informed orientation **(Figure 1)**. The framework reconceptualizes nursing care as sustained developmental accompaniment for children growing up amid ongoing conflict. The model positions the child's mental health and developmental trajectory at the center of care. The innermost circle contains four interrelated domains; biological, psychological, social, and spiritual, treated as concrete fields of nursing engagement rather than abstract categories. These domains are encircled by trauma-informed relational principles. The outer layer represents the protracted conflict environment that shapes and constrains every interaction. The conceptual framework presented in the figure was developed independently by the authors and is not adapted from any single previously published conceptual model or figure. The model was constructed through theoretical synthesis by integrating the bio–psycho–social–spiritual perspective, trauma-informed care principles, and ecological perspectives on child development. These theoretical foundations are now explicitly acknowledged in the revised manuscript with appropriate citations. The framework lies in introducing the Protracted Conflict Environment as the overarching contextual layer and Sustained Nursing Presence as the nursing mechanism linking family, school, community, and healthcare settings.

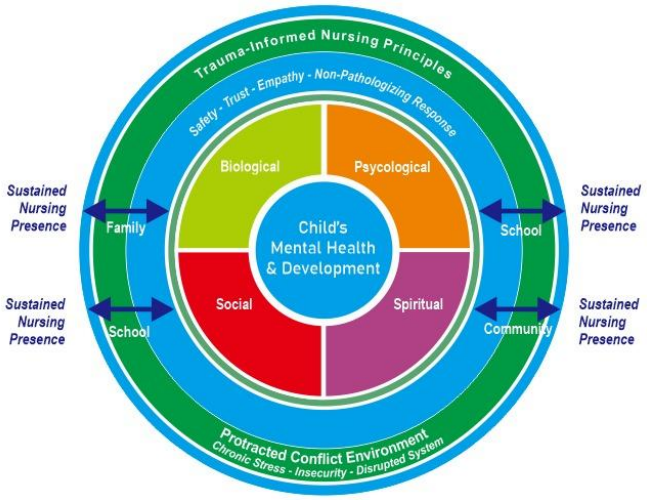

Figure 1. Child's mental health & development model (Produced by the authors).

Biological dimension

Chronic insecurity manifests in physiological patterns, as children experience fragmented sleep, recurrent headaches, abdominal pain, appetite fluctuations, or sustained autonomic arousal. To counter these physiological disruptions, nurses must support regular sleep routines where possible, monitor hydration and nutrition during displacement, and guide caregivers in recognizing stress-related bodily signs. So, biological stabilization—even at a modest level—creates the necessary baseline for emotional regulation to become attainable.

Psychological dimension

Under persistent threat, emotional expression may appear as irritability, withdrawal, regression, exaggerated startle responses, or repetitive play centered on themes of danger (Douglas et al., 2025). Within this framework, such behaviors are approached first as adaptive efforts to manage conditions. Nurses may facilitate drawing, storytelling, or brief reflective dialogue that allows children to organize fragmented experiences into narrative form (Arega, 2023). The focus is less on diagnostic categorization and more on promoting coherence. Over time, these interventions can support continuity of identity development.

Social dimension

Prolonged conflict often disrupts schooling, peer relationships, and family networks. Furthermore, social disconnection can intensify distress even when immediate violence subsides (Pearson et al., 2025). Hence, nurses working in schools or community clinics may collaborate with educators to support reintegration, encourage peer-group activities that rebuild confidence, and assist caregivers in maintaining relational boundaries at home (Agatha et al., 2025).

Spiritual dimension

Sustained crisis prompts deeper engagement with questions of meaning, hope, and safety. Across numerous households, coping is anchored in religious belief, cultural tradition, or relational solidarity (Elzamzamy et al., 2024). The framework conceptualizes spirituality as the human search for connection and purpose. For instance, nurses create

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space for children to articulate fear, uncertainty, or hope without imposing interpretation. Faith-informed nursing traditions have integrated spiritual compassion and ethical as foundational elements of care.

Surrounding these four domains are the core principles of trauma-informed care: safety, trust, empathy, transparency, and collaboration. These principles are not mechanical steps, but relational habits that define every clinical interaction. Simple actions bring these principles to life, turning the clinical environment itself into a powerful tool for healing. The outermost layer of the framework represents the protracted conflict environment. Insecurity, damaged infrastructure, interrupted referral systems, and workforce shortages are not peripheral variables; they define the terrain of practice. The model therefore emphasizes feasible, low-resource, relationship-centered interventions rather than specialist-dependent programs that may be unrealistic in unstable contexts. Bidirectional arrows depicted in the figure signify sustained nursing presence across family homes, schools, temporary shelters, and health facilities. In many conflict-affected settings, nurses remain among the few professionals maintaining continuous contact with children over time.

Approaches to child mental health care and its challenges

In pediatric context, mental health care follows a pathway that begins with screening. The process initiatives may be introduced in schools or primary care settings. When concerns are identified, psychosocial support is offered as a first-line response (Maximous et al., 2025). Referral to specialized mental health providers is then recommended for children whose symptoms persist or intensify (Ganga et al., 2024). Therapy effectiveness, however, depends on stable institutional arrangements, sufficient staffing, and functioning referral mechanisms. During the conflict, health facilities in several regions remain limited in number and capacity (Al Bakri et al., 2025). Moreover, the distribution of trained mental health professionals is concentrated in urban centers, leaving rural or marginalized communities (Roach et a., 2025). Even where services exist, stigma continues to discourage families from disclosing emotional concerns or seeking help. When discussions about emotional wellbeing are embedded in familiar relationships, families may perceive less stigma than when referred to specialist mental health services. In settings marked by protracted armed conflict, these challenges intensify as ongoing insecurity disrupts outreach programs and severely restricts health worker mobility. Referral chains—already inherently fragile—are further disrupted by infrastructural damage, leaving patient records fragmented and continuity of care compromised by population displacement. Under such circumstances, comprehensive screening programs followed by specialist referral are difficult to sustain. Nurses must adapt by offering supportive conversations, stabilizing routines where possible, and connecting families with whatever community resources remain accessible (Innab et al., 2025). These tensions are well-documented in regions such as Palestine as children's psychological needs are influenced by individual temperament and exposure to violence (Zedan, 2025). This requires a sustained nursing approach focused on building trust and addressing the social conditions shaping children's growth and coping.

Holistic care and the role of nurses in children's mental health

Holistic care positions the child as a developing person whose wellbeing emerges from the interaction of biological, psychological, social, and spiritual dimensions (Tjale & Bruce, 2007). In contexts of prolonged conflict, each dimension may be strained in distinct yet overlapping ways. Therefore, nurses operating in active war zones need to grasp these multidimensional factors to provide appropriate clinical interventions. Children exposed to chronic insecurity display persistent hyperarousal, particularly when threat is unpredictable and recurring. Repeated displacement has been associated with sleep disturbances, including difficulty initiating and maintaining sleep (Hamamra et al., 2025). Forced migration and abrupt separation from caregivers often give rise to sustained separation anxiety (Figueiredo & Corradini, 2026). From this standpoint, trauma-informed care functions as the operational face of holistic nursing. Trauma-informed frameworks urge clinicians to interpret behavioral shifts in light of prior adversity (Çınar et al., 2023). Implementation, however, is rarely straightforward. In conflict-affected settings, nurses may conduct assessments in minimum resource. Under such circumstances, standardized screening tools are not consistently feasible. Observational assessment becomes indispensable. Therefore, a short nursing visit in a temporary shelter may be the only window available for supportive intervention.

In relation to caregivers, their psychological wellbeing has a measurable influence on children's emotional regulation capacity (Chow et al., 2024). When caregivers experience distress, their capacity to provide a co-regulating environment is compromised, which can heighten a child's autonomic arousal and behavioral dysregulation. Accordingly, trauma-informed nursing interventions must prioritize stabilizing the caregiver's mental state to safeguard pediatric psychological resilience in conflict zones. Moreover, economic hardship and unresolved trauma in

displacement contexts can constrain parental responsiveness. In unstable regions, community-grounded approaches may prove more sustainable than models dependent on continuous specialist referral. The spiritual dimension often becomes more visible during crisis. Spiritual care in war zones acts as a vital coping mechanism and a bridge to mental health support. Studies show that many individuals in conflict areas rely on faith leaders before seeking conventional psychiatric care, making integrated bio-psycho-social-spiritual interventions essential for treating trauma and moral injury (Vivalya et al., 2025). Holistic care in protracted conflict zones is far from an abstract ideal; rather, it is operationalized within constrained spaces. Nevertheless, when pediatric distress is framed as a relational and context-bound response, the trajectory of nursing practice shifts. In this framework, perceived safety, relational continuity, and contextual meaning emerge as primary anchors that sustain therapeutic effectiveness even within highly volatile environments.

Conclusion

Children growing up in conflict-affected areas face mental health challenges. Symptoms such as hypervigilance, withdrawal, regression, and emotional volatility are not isolated pathologies, but rather adaptive responses to unstable environments. Any nursing approach in these settings must therefore ground itself in these concrete psychological realities. In practice, nurses often operate with limited privacy, disrupted referral networks, and scarce mental health specialists. Under such constraints, what remains feasible are focused, relational interventions: brief supportive encounters, caregiver guidance on trauma-related behaviors, simple play-based activities in shelters or schools, and efforts to restore daily routines that rebuild predictability. In due course, these modest yet consistent actions can reduce stigma, enhance caregiver understanding, and help children regain safety. However, sustaining this critical role requires structural support. Nurses in conflict zones face prolonged stress themselves; without peer supervision and organizational backing, maintaining continuous, empathetic care becomes nearly impossible. Future work should examine how holistic nursing frameworks can be operationalized under severe resource limitations. Doing so will ensure that clinical recommendations remain strictly grounded in the lived realities of children in conflict.

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AI statements

The authors confirm that this manuscript was independently conceptualized, analyzed, and written by the team. Grammarly was used solely for language editing and grammatical refinement.

Author's declaration

This article is an original scholarly perspective that reflects the authors' critical engagement with contemporary issues in children's mental health within contexts of protracted conflict. The conceptual arguments presented are grounded in interdisciplinary literature on pediatric nursing, holistic care, and trauma-informed practice. All interpretations, reflections, and conceptual contributions expressed in this manuscript are the sole responsibility of the authors and were developed independently, without influence from any institutional, political, or funding entities.

Availability of data and materials

This is a perspective article and does not involve the collection or analysis of empirical data. All sources cited are derived from publicly available reports, policy documents, and peer-reviewed academic literature accessible through recognized databases.

Competing interests

The authors declare that there are no competing interests associated with this publication.

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Publishers and journal's note

This article is important as it addresses the essential role of nurses in conflict settings. As ongoing conflicts in several countries continue to impact children's mental health, this perspective is particularly urgent. The Editor-in-Chief extends sincere gratitude to the authors for providing such an in-depth, comprehensive, and highly practical discussion.

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Authors' insight

Key points

- Children living in situations of protracted conflict experience mental health challenges that are cumulative, collective, and embedded.
- Holistic nursing care offers a comprehensive framework for understanding and supporting children's mental health in complex and chronic stress contexts.
- Nurses work in hospitals, homes, schools, and communities, allowing them to offer long-term support to families affected by conflict.

Emerging nursing avenues

- In what ways can nursing-led, non-pharmacological interventions be adapted and sustained within conflict-affected and resource-limited settings?
- How can nurses collaborate with families, schools, and community to create protective psychosocial environments for children living under chronic stress?
- What institutional policies and support systems are needed to ensure the sustainability of relational and humane care in protracted conflict contexts?

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