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CONSEQUENCES OF WAR-RELATED TRAUMATIC STRESS AMONG PALESTINIAN WOMEN: A SYSTEMATIC REVIEW

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ABSTRACT

Palestinian women face chronic exposure to political violence, displacement, and structural deprivation, placing them at high risk for war-related traumatic stress. This systematic review synthesizes current evidence on the psychological consequences of protracted conflict for Palestinian women. Fifty studies employing epidemiological, longitudinal, qualitative, and humanitarian research designs were systematically reviewed. Findings were synthesized thematically to identify dominant mental-health outcomes, risk and protective factors, and service gaps. Across the evidence base, Palestinian women exhibit elevated rates of PTSD, depression, anxiety, traumatic grief, sleep disturbance, and somatic symptoms, driven by cumulative exposure to bombardment, displacement, and loss of livelihood. Maternal traumatic stress disrupts caregiving, maternal–infant bonding, and family functioning, contributing to intergenerational emotional and behavioral difficulties among children. Structural factors—including resource loss, restricted mobility, and socioeconomic hardship—intensify psychological vulnerability, while gender-specific burdens further compound distress. Although social support and religious coping offer partial protection, access to mental-health services remains severely constrained by damaged infrastructure, movement restrictions, and limited resources. War-related traumatic stress among Palestinian women reflects a convergence of individual, familial, and structural determinants. Addressing these needs requires gender-responsive, contextually grounded mental-health services and multisectoral strategies capable of reducing long-term and intergenerational harm.

KEYWORDS: Palestinian Women; War-Related Trauma; Political Violence; Mental Health; Conflict; Gaza; Traumatic Stress.

1. INTRODUCTION

The Israeli–Palestinian conflict represents a uniquely protracted and structurally entrenched form of political violence, characterized by cyclical military assaults, chronic displacement, infrastructural degradation, and systematic disruptions to social and health systems. In the aftermath of the 2023–2024 Gaza escalation, these conditions intensified to an unprecedented degree, producing mass civilian casualties and widespread psychological distress. Epidemiological surveys conducted across Gaza and the West Bank in 2024–2025 consistently demonstrate exceptionally high rates of mental health morbidity, including probable post-traumatic stress disorder (PTSD), depression, generalized anxiety, and stress-related disorders among conflict-affected populations (Aqtam, 2025; Conflict & Health, 2025; WHO-EMRO, 2025). Such findings underscore the cumulative and chronic nature of trauma within Palestinian society, where exposure to violence is not confined to discrete episodes but constitutes a sustained sociopolitical reality.

Within this broader landscape of adversity, Palestinian women experience distinct, intersecting, and disproportionately severe consequences of war-related traumatic stress. Their trajectories of trauma are shaped not only by direct exposure to armed conflict but also by gendered social roles, constrained mobility, resource scarcity, and limited access to formal health and psychosocial services. Women in conflict settings frequently bear the primary responsibility for household continuity and caregiving, often while navigating displacement, social fragmentation, and heightened vulnerability to gender-based violence (GBV). These burdens introduce additional layers of psychosocial strain and restrict opportunities for recovery, intensifying the relationship between trauma and physical, psychological, and social well-being.

Recent studies document this gender-specific vulnerability across multiple domains. Psychologically, women demonstrate elevated levels of PTSD symptoms, depressive affect, sleep disturbances, and pervasive anxiety, often exacerbated by chronic caregiving demands and disrupted social environments (BMC Psychology, 2025). Physiologically, trauma manifests in somatic symptoms, dysregulated sleep, and adverse maternal and neonatal health indicators. Socially, traumatic stress contributes to weakened social cohesion, reduced participation in community life, restricted mobility, and increased exposure to GBV. These interconnected outcomes reflect broader frameworks of structural violence and social suffering, where trauma is embedded within political oppression, deprivation, and gender inequality.

Despite the growing body of literature on the mental health consequences of political violence in Palestine, systematic, gender-focused syntheses remain limited. Previous reviews have often concentrated on general populations or youth cohorts, thereby obscuring the gendered mechanisms that shape Palestinian women's trauma experiences. Few studies integrate psychological, physical, and social outcomes into a unified framework, and even fewer situate these outcomes within theoretical lenses from social psychology, trauma studies, and feminist conflict research. This gap impedes the development of culturally grounded, gender-responsive interventions and limits theoretical advancement in understanding trauma under conditions of protracted oppression.

This systematic review therefore aims to comprehensively examine the psychological, physical, and social consequences of war-related traumatic stress among Palestinian women. Through a rigorous synthesis of recent empirical research, institutional assessments, and interdisciplinary analyses, the review seeks to:

(a) delineate the multidimensional impacts of traumatic stress on women's well-being;

(b) identify contextual, structural, and gender-specific mechanisms shaping these outcomes; and

(c) provide evidence-based recommendations for mental health interventions, social support programs, and policy frameworks.

By integrating perspectives from clinical psychology, global public health, social medicine, and gender studies, this review contributes to a more nuanced understanding of trauma in one of the world's most enduring conflict zones, while centering the lived realities and urgent needs of Palestinian women. This review provides a targeted, gender-specific synthesis of evidence on war-related traumatic stress among Palestinian women, addressing a significant gap in existing literature. By integrating findings across diverse study designs, it clarifies the multidimensional impacts of trauma within contexts of political violence and structural hardship. The review further refines theoretical understandings of gendered trauma and offers evidence-based guidance for developing contextually appropriate, gender-responsive mental-health and policy interventions.

Thus, this systematic review article will answer the following main question:

What are the psychological, physical, and social consequences of war-related traumatic stress among

Palestinian women, and through what contextual, structural, and gender-specific mechanisms are these outcomes shaped?

2. METHODOLOGY

This study employed a systematic review design aimed at synthesizing empirical evidence concerning the psychological, physical, and social consequences of war-related traumatic stress among Palestinian women. The review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA 2020) guidelines to ensure methodological transparency and replicability. A protocol outlining the search strategy, screening procedures, and analytic approach was established prior to data collection to enhance rigor and minimize bias.

2.1. Eligibility Framework

Studies were evaluated according to conceptual and methodological relevance. Eligible research focused specifically on Palestinian women residing in conflict-affected settings, including the Gaza Strip, the West Bank, East Jerusalem, and refugee camps within the region or in the diaspora. Only studies examining exposure to political violence, armed conflict, military operations, bombardment, displacement, or chronic structural oppression were considered pertinent. To capture the multidimensional nature of war-related trauma, studies were included if they reported psychological outcomes (such as PTSD, depression, anxiety, grief, or stress-related symptoms), physical consequences (including somatic complaints, maternal health disruptions, or physiological stress markers), or social impacts (such as family functioning, community integration, gender-based violence, or loss of social support).

Empirical studies using quantitative, qualitative, or mixed-methods designs were eligible for review if they were peer-reviewed and published in English or Arabic between 2000 and 2025, a period that encompasses both chronic conflict and more recent escalations, including those of 2021 and 2023–2024. Studies that addressed trauma unrelated to political violence, that examined mixed-gender samples without gender-specific analysis, or that consisted of reviews, editorials, or non-empirical discourse were excluded. This framework ensured a focused synthesis of research directly relevant to the lived experiences of Palestinian women in contexts of war and occupation.

2.2. Search Strategy

A comprehensive literature search was conducted across major academic databases, including PubMed, PsycINFO, Scopus, Web of Science, Medline, and CINAHL. The search process integrated both controlled vocabulary and free-text terms, with Boolean operators used to refine and expand search combinations. Key terms included "Palestinian women," "war-related trauma," "political violence," "mental health," "conflict," "Gaza," and "traumatic stress." This strategy was supplemented by a search of grey literature produced by international organizations such as UNRWA, UN Women, WHO, and OCHA, given their extensive documentation of gendered experiences in conflict zones. Reference lists from relevant studies were screened manually to identify additional research not captured through database searches.

2.3. Selection Procedures

All retrieved citations were imported into EndNote for initial deduplication and then uploaded to Rayyan, an online platform that facilitates blinded screening for systematic reviews. Screening was conducted in three sequential stages—title screening, abstract screening, and full-text assessment—based on the predetermined eligibility framework. Two independent reviewers conducted all screening procedures to ensure reliability and reduce selection bias. Any disagreements were resolved through collaborative discussion or consultation with a third reviewer. Inter-rater agreement was quantified using Cohen's kappa to document the reliability of the screening process.

2.4. Quality Appraisal

The methodological quality of included studies was assessed using validated appraisal tools tailored to the respective research designs. The Joanna Briggs Institute (JBI) Critical Appraisal Checklists were applied to qualitative and cross-sectional studies, the Newcastle–Ottawa Scale (NOS) was used for cohort and case-control studies, and the Mixed Methods Appraisal Tool (MMAT) was employed for mixed-methods research. Each study's methodological rigor, sampling strategy, measurement validity, analytic transparency, and ethical reporting were evaluated. Rather than excluding lower-quality studies outright, their contributions were contextualized with appropriate caution during synthesis to preserve breadth while maintaining analytic integrity.

2.5. Data Extraction and Analytic Approach

A standardized extraction template was developed to ensure systematic and consistent recording of study characteristics. Extracted data included bibliographic details, research setting, methodological design, sample demographics,

nature and severity of trauma exposure, measurement instruments, primary outcomes, and major findings. The extraction process was performed independently by two reviewers to enhance accuracy and reduce bias.

Given the heterogeneity of study designs, outcome measures, and contexts, a narrative thematic synthesis was selected as the most suitable analytic approach. The synthesis proceeded through descriptive mapping of study characteristics, followed by thematic integration of findings across psychological, physical, and social domains. The interpretive phase emphasized contextual influences, including the sociopolitical environment, gender norms, access to resources, and the cumulative nature of trauma exposure. Owing to methodological diversity, effect-size pooling or meta-analysis was not undertaken; instead, quantitative results were compared descriptively where methodological compatibility allowed.

2.6. Ethical Considerations

As this review relied exclusively on previously published studies, no institutional ethical approval was required. Nevertheless, the ethical conduct of primary sources—including informed consent, confidentiality protections, and trauma-sensitive practices—was critically appraised as part of the methodological quality assessment.

2.7. Documentation of Search and Selection

In line with PRISMA 2020 reporting standards, a flow diagram was prepared to document the number of records identified, screened, assessed for eligibility, and included in the final synthesis, along with reasons for exclusion at each stage.

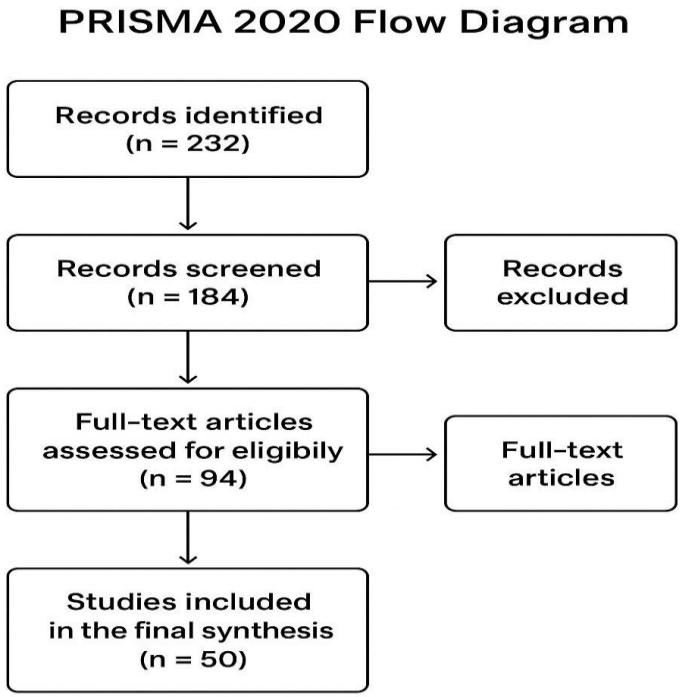

Figure 1: PRISMA Flow Diagram.

2.8. Limitations

This review is subject to several methodological limitations. First, the evidence base relies heavily on self-reported measures of traumatic stress and mental-health symptoms, which may introduce reporting bias. Second, the geographic focus is limited primarily to studies conducted in Gaza and the West Bank, constraining the generalizability of findings to Palestinian women in the diaspora or other conflict-affected regions. Third, variations in study design, sampling strategies, and measurement tools across the included literature reduce comparability and limit the ability to draw causal inferences. Fourth, the restricted availability of longitudinal studies limits insight into the long-term and intergenerational trajectories of trauma. Finally, movement restrictions, damaged infrastructure, and limited research access in conflict zones likely result in underrepresentation of the most severely affected

women. Despite these constraints, the systematic approach and thematic synthesis enhance the rigor and coherence of the findings.

3. RESULTS

3.1 Overview of the Evidence Base

The final sample comprised 50 studies spanning quantitative epidemiological surveys (e.g., Aldabbour et al., 2024; Al-Belbeisi et al., 2025), longitudinal cohort designs (Punamäki et al., 2017; Qouta et al., 2011), qualitative and narrative analyses (Sousa, 2014; ActionAid Palestine, 2025), and policy-focused humanitarian reports (WHO EMRO, 2025; World Bank, 2024). Collectively, these sources form a coherent evidence base documenting the psychological consequences of armed conflict, chronic political violence, and structural deprivation for Palestinian women.

Although the studies vary in methodological rigor and demographic focus, a consistent pattern emerges: Palestinian women experience disproportionate psychological morbidity within contexts marked by bombardment, displacement, siege, and socioeconomic collapse. Research conducted in Gaza, the West Bank, Jordan, and other host settings reveals that women's mental health outcomes are strongly shaped by severity, chronicity, and accumulation of war-related stressors (Giacaman et al., 2009; Hobfoll et al., 2006, 2011). The breadth of findings underscores the compounded burden on women as caregivers, survivors of trauma, and central actors in family systems affected by long-term political instability.

3.2 Mental-Health Outcomes among Palestinian Women

Across the reviewed literature, PTSD and PTSS are the most frequently reported psychological sequelae among Palestinian women exposed to war. Elevated PTSS has been observed following bombardment, home destruction, and bereavement (Thabet et al., 2001; Aldabbour et al., 2024). Studies focusing on women explicitly—such as Alsous et al. (2024)—show disproportionately high prevalence of PTSD, depression, insomnia, and somatic symptoms among women exposed to war-related news or direct conflict events.

Depression is highly comorbid with PTSD, forming a clinical constellation marked by intrusive recollections, emotional numbing, hopelessness, and affective dysregulation (Marie et al., 2020; Bdier et al., 2023). Anxiety disorders—particularly generalized anxiety and perinatal anxiety—are also prominent among Palestinian women, especially those in the postpartum period or experiencing high caregiving burden (Bdier et al., 2023; Aty et al., 2017).

Additional reported outcomes include sleep disturbance, traumatic grief, and somatization, particularly among women witnessing mass casualties or experiencing ambiguous loss (Ghoul & Khader, 2024; ActionAid Palestine, 2025). Collectively, these findings highlight the multidimensional psychological toll of chronic political violence on Palestinian women.

3.3 Maternal Mental Health, Infant Development, and Family Dynamics

A substantial segment of the reviewed literature highlights the profound intergenerational implications of war-related trauma for Palestinian mothers and their children. Maternal mental health emerges as a central pathway through which the psychosocial effects of conflict extend into the earliest stages of child development and reverberate across family systems. Longitudinal studies conducted in Gaza and the West Bank provide compelling evidence that exposure to bombardment, displacement, bereavement, and chronic political violence during pregnancy or early motherhood significantly disrupts maternal–infant bonding and compromises dyadic interactions essential for healthy socioemotional development (Punamäki et al., 2018).

Women experiencing trauma-related psychopathology—particularly PTSD, depression, and perinatal anxiety—exhibit heightened parenting stress, reduced emotional availability, and diminished sensitivity to infant cues. These disruptions impede the formation of secure attachment relationships, a core developmental task during infancy. Under conditions of chronic insecurity, mothers often struggle to regulate their own emotional responses, making it more difficult to provide consistent warmth, responsiveness, and attuned caregiving. Such patterns place infants at greater risk of emotional dysregulation, sleep disturbances, feeding difficulties, and delayed socioemotional competencies.

The intergenerational risks are accentuated when traumatic exposure occurs during pregnancy. War-related stress has been associated with dysregulation of maternal stress physiology, which may affect fetal development and predispose infants to heightened reactivity, behavioral difficulties, and vulnerabilities in stress modulation after birth. Infants born in displacement settings or under siege conditions often face additional risks related to inadequate prenatal care, maternal malnutrition, and exposure to environmental hazards, further compounding the influence of maternal trauma on developmental

outcomes.

Family systems theory provides an important lens through which to understand the cascading effects of maternal distress. Women's psychological well-being plays a central coordinating role in the emotional functioning of the household. Elevated maternal PTSD or depression disrupts family cohesion, increases levels of conflict, and destabilizes caregiving routines, which in turn shape children's behavioral and emotional adjustment (Qouta et al., 2008, 2011). In many Palestinian families, mothers act as emotional anchors; when they experience trauma-related impairment, the resulting relational shifts reverberate throughout the family structure.

These dynamics are further complicated by gendered social expectations that place women at the center of care work under conditions of extreme precarity. Mothers often shoulder increased responsibilities for protecting children during bombardment, securing food and water during siege periods, and maintaining routine in contexts where routine is constantly jeopardized. Such burdens amplify psychological exhaustion and reduce opportunities for recovery or self-care, creating a feedback loop in which maternal stress accumulates over time and spills over into family processes.

War-induced disruptions to paternal presence—due to injury, death, imprisonment, or economic instability—further heighten the caregiving load placed on women and may intensify children's emotional dependence on their mothers. In such circumstances, mothers may struggle to meet heightened emotional demands while simultaneously navigating their own trauma and the practical challenges of survival. Female-headed households created through conflict-related bereavement or displacement are particularly vulnerable to this cycle of escalating stress.

At the community level, the erosion of social support networks—caused by displacement, loss of extended family, or fragmentation of social infrastructure—limits mothers' access to protective resources, such as shared childcare, mutual assistance, and informal emotional support. Reduced social support is a well-documented predictor of poorer maternal mental health and has been shown to mediate the relationship between trauma exposure and adverse child outcomes.

Despite these challenges, some studies identify sources of resilience within Palestinian families. Cultural norms that emphasize collective responsibility, extended kinship ties, and religious meaning-making can facilitate adaptive coping and provide emotional buffers that partially mitigate the impact of trauma. Mothers who maintain strong social ties or engage in community-based coping strategies demonstrate enhanced caregiving capacity despite high levels of adversity.

Taken together, the evidence underscores the centrality of maternal mental health in shaping not only women's own wellbeing but the developmental and relational trajectories of their children and families. In contexts of protracted conflict, supporting mothers' psychological resilience becomes a critical intervention point for interrupting intergenerational cycles of trauma and promoting broader family stability.

3.4 Effects of Displacement, Resource Loss, and Socioeconomic Hardship

The reviewed evidence demonstrates that displacement—whether internal, recurrent, or cross-border—constitutes one of the most powerful structural determinants of psychological morbidity among Palestinian women. Displacement is rarely a single event; rather, it unfolds as a protracted and cumulative process marked by forced evacuation, repeated uprooting, hazardous living environments, and loss of community anchors. Studies conducted in Gaza and the West Bank show that women who experience displacement exhibit significantly elevated levels of PTSD, depression, generalized anxiety, and somatic distress compared to non-displaced counterparts (Aldabbour et al., 2025; Women's Affairs Center–Gaza, 2024). These patterns reflect not only exposure to direct trauma but also the erosion of material stability, social continuity, and personal autonomy.

Resource loss emerges as a central mechanism through which displacement translates into psychological distress. Consistent with the Conservation of Resources (COR) theory, loss of housing, employment, savings, social networks, and access to essential infrastructure exerts a stronger predictive effect on psychological symptoms than any potential resource gains (Hobfoll et al., 2006, 2011). For many women, the destruction of the family home represents a profound symbolic rupture, as the home functions not only as a physical shelter but as a locus of identity, memory, and emotional security. Its loss disrupts daily routines, displaces kinship relations, and undermines perceived control—factors strongly associated with trauma-related symptomatology.

The detrimental impact of displacement is intensified by socioeconomic hardship, which compounds women's vulnerability across multiple dimensions. Humanitarian assessments after the 2023–2024 escalation document acute shortages of clean water, food, menstrual hygiene supplies,

electricity, and sanitation facilities, with women in overcrowded shelters bearing disproportionate burdens of caregiving, household management, and health-related responsibilities (WHO EMRO, 2025; World Bank, 2024). These deprivations intersect with existing gender inequalities, placing women at heightened risk of malnutrition, infectious disease, reproductive health complications, and chronic stress.

Disruption of livelihood opportunities further contributes to psychological strain. Many women who previously engaged in informal labor—such as home-based production, agriculture, or social-sector employment—lose their income entirely following displacement. Economic dependence on aid agencies or male relatives intensifies feelings of humiliation, loss of agency, and internalized stress, particularly in patriarchal contexts where autonomy is closely linked to dignity and social standing. For widowed women, women with incarcerated spouses, or female-headed households, the collapse of livelihood systems presents an especially severe set of psychological and material challenges.

Displacement also ruptures social networks that previously provided emotional support, childcare cooperation, and collective coping mechanisms. Overcrowded shelters and temporary encampments often introduce new interpersonal stressors, including lack of privacy, heightened interpersonal conflict, and increased exposure to gender-based violence. Such environments reduce women's ability to mobilize traditional resilience strategies rooted in family cohesion, neighborhood solidarity, and community rituals.

Finally, barriers to healthcare access, including the destruction of clinics, shortages of medical supplies, and movement restrictions—further amplify the mental-health consequences of displacement. Many women are unable to obtain psychiatric care, maternal healthcare, or trauma-informed psychosocial services during periods of acute crisis. The resulting treatment gap contributes to chronicity of symptoms and exacerbates the intergenerational transmission of distress, particularly among mothers caring for infants and young children.

Taken together, the evidence underscores that displacement is not merely a spatial or logistical disruption but a deeply layered structural condition that transforms the psychological landscape of women's lives. The combined effects of resource loss, socioeconomic hardship, and the erosion of social and institutional support systems create a sustained environment of insecurity that significantly heightens women's vulnerability to mental-health disorders.

3.5 Exposure Pathways, Risk Factors, and Moderators

The evidence base demonstrates that Palestinian women are subjected to multiple and overlapping exposure pathways that profoundly shape their mental-health trajectories. Direct exposure to traumatic events—such as bombardment, destruction of homes, physical danger, and injury—remains one of the most powerful predictors of psychological distress, particularly posttraumatic stress, depression, and anxiety (Khamis, 2015; Mahmoud & Khamis, 2016). However, indirect pathways, including witnessing violence, hearing explosions, experiencing the death or injury of relatives, and enduring the chronic stress of political oppression, also contribute substantially to symptom severity (Giacaman et al., 2007, 2009). These exposures occur cumulatively and often repeatedly, producing a chronic stress ecology in which acute episodes of violence are superimposed upon long-standing structural instability.

Gender-specific burdens amplify these psychological risks. Palestinian women frequently serve as primary caregivers during conflict, bearing responsibility for childcare, household stability, and emotional regulation within the family. Such caregiving roles intensify vulnerability, as women must manage their own trauma while navigating the distress of children and other dependents (Sousa et al., 2013). These demands are exacerbated by restricted mobility, economic precarity, overcrowded housing, and heightened exposure to gender-based threats—a dynamic particularly evident during periods of mass displacement. Qualitative accounts show that disruptions to traditional gender roles, especially in female-headed households following bereavement or male imprisonment, generate additional psychosocial strain (Sheikh, 2025).

Structural determinants play an equally significant role. Movement restrictions, prolonged blockade, and recurrent displacement fundamentally shape women's exposure to violence and constrain access to basic resources, including healthcare and mental-health services. These structural forces intensify psychological morbidity not only by increasing the probability of repeated traumatic events but also by limiting opportunities for recovery or stabilization (Giacaman et al., 2009). In this sense, women's mental-health outcomes are inseparable from the broader political environment in which they live.

Despite these risks, several moderating factors demonstrate consistent protective influence. Social support—from extended family networks, community ties, or women's solidarity groups—

emerges as a central buffer against trauma-related distress (Diab & Punamäki, 2018). Religious faith and culturally embedded meaning-making practices also play a crucial role in helping women contextualize adversity and maintain psychological coherence (Ghoul & Khader, 2024; Sheikh, 2025). Additionally, adaptive coping strategies—such as problem-solving, narrative expression, and collective caregiving—mitigate the negative effects of trauma, although their efficacy is often limited by the severity of structural violence.

Together, these findings illuminate the interconnected nature of personal, relational, and structural risk factors shaping Palestinian women's psychological wellbeing. They demonstrate that mental-health outcomes cannot be understood solely through exposure to discrete traumatic events but must be contextualized within the broader sociopolitical and gendered landscape that governs daily life under protracted conflict.

3.6 Psychosocial Interventions, Health System Gaps, and Service Access

Intervention-focused studies and organizational assessments converge on the recognition of significant gaps in psychosocial service availability for Palestinian women. Structural barriers—including movement restrictions, damage to health facilities, and chronic underfunding—impede access to mental-health care (Alderman et al., 2012; WHO EMRO, 2025).

Community-based psychosocial interventions show modest but promising outcomes, though most lack gender-specific components tailored to women's lived experiences of war (Rees et al., 2025; Alderman et al., 2012). Telemedicine initiatives expanded during acute conflict periods offer partial relief but are insufficient to compensate for systemic deficiencies in health infrastructure (Alser et al., 2024).

Humanitarian and policy reports stress the necessity of integrating mental health and psychosocial support (MHPSS) into primary health care—especially reproductive and maternal services—to meet the rapidly escalating needs of displaced and war-affected women (World Bank, 2024; WHO EMRO, 2025).

3.7 Qualitative Insights into Women's Lived Experiences

Qualitative studies offer indispensable insights into the subjective, embodied, and relational dimensions of trauma among Palestinian women, revealing complexities that quantitative measures often fail to capture. Across interviews, focus groups, ethnographic accounts, and narrative inquiries, women articulate experiences shaped not solely by discrete traumatic events but by the cumulative weight of protracted political violence, chronic instability, and generational loss (Sousa, et al., 2019; Baloushah et al., 2019; Bdier et al., 2023). They describe living within a social ecology of precarity in which home, family, and identity are persistently under threat.

A recurring theme concerns the home as both sanctuary and site of profound vulnerability. Women emphasize the symbolic centrality of the home as a locus of identity, stability, and intergenerational continuity. Its destruction—whether through bombardment, demolition, or forced eviction—is narrated as a form of existential rupture, producing grief that extends beyond material loss (Marie & SaadAdeen, 2021). For many, the home embodies familial history and collective memory; losing it represents not only physical displacement but also the fragmentation of personal and communal meaning.

Women also report pervasive feelings of fear, anticipatory anxiety, and bodily hypervigilance, often described in visceral metaphors that illustrate how trauma is carried somatically. Many testimonies highlight cycles of sleep disturbance, chronic worry, and exhaustion, reflecting the persistent intrusion of political violence into everyday life (Hamamra, et al., 2025). Even in periods of relative calm, women describe a sense of "living in waiting," anticipating the next attack or loss. This chronicity transforms stress into a structural condition rather than an episodic experience.

Another prominent theme concerns the reconfiguration of family roles and relational burdens. The context of war and displacement often compels women to assume multiple responsibilities—caretaking, emotional regulation of children, provision of basic needs, and protection of vulnerable family members. These expanded roles are experienced ambivalently: many women perceive them as essential expressions of resilience and familial duty, yet also describe profound emotional strain, diminished personal agency, and limited space for their own psychological recovery (Veronese, et al., 2021). Conflict-related disruptions in spousal relationships, including separation, unemployment, or incapacitation of partners, further intensify these pressures.

Women's narratives frequently evoke the erosion of safety and continuity, describing daily life as punctuated by uncontrollable external forces. The unpredictability of bombings, arrests, or displacement fosters a pervasive sense of powerlessness. Yet, in parallel, qualitative accounts

underscore women's agency, adaptive coping, and meaning-making practices. Many rely on religious faith, communal solidarity, cultural rituals, and storytelling as mechanisms for restoring coherence amid chaos (Veronese, et al., 2021). Acts of caregiving, maintaining household routines, and preserving cultural practices are described as forms of resistance against dehumanizing conditions.

Additionally, qualitative studies illuminate the gendered dimensions of humiliation and social suffering. Women recount experiences of public degradation at checkpoints, invasive searches, and the social stigma associated with displacement or widowhood. These experiences contribute to what several authors term the "moral injuries" of occupation—psychological harms connected not only to fear and loss but to violations of dignity, autonomy, and social value (Nagamey, 2018).

Importantly, women's testimonies reveal psychosocial stressors that are not adequately captured by standard diagnostic frameworks. Feelings of longing for destroyed homes, existential uncertainty, fractured community networks, and fears for children's futures emerge as central components of their psychological landscape. In many narratives, trauma is described as relational, cumulative, and multi-layered, reflecting the intersection of personal suffering with collective historical trauma.

Finally, qualitative reports highlight the intergenerational transmission of fear and resilience, with women expressing deep concern about their children's psychological development and future prospects. Many actively mediate children's exposure to violence, craft narratives of hope, or conceal their own distress to prevent emotional contagion. These actions reinforce women's pivotal role in sustaining family cohesion under extreme adversity.

Collectively, the qualitative literature enriches the understanding of trauma by foregrounding how women live, interpret, resist, and endure the realities of protracted conflict. It underscores that Palestinian women's mental health cannot be disentangled from sociopolitical structures and cultural systems of meaning, and that their lived experiences embody both profound vulnerability and enduring strength.

The intensity of war-related traumatic stress among palestinian women, as unveiled by the reviewed studies, are shown in the following figures.

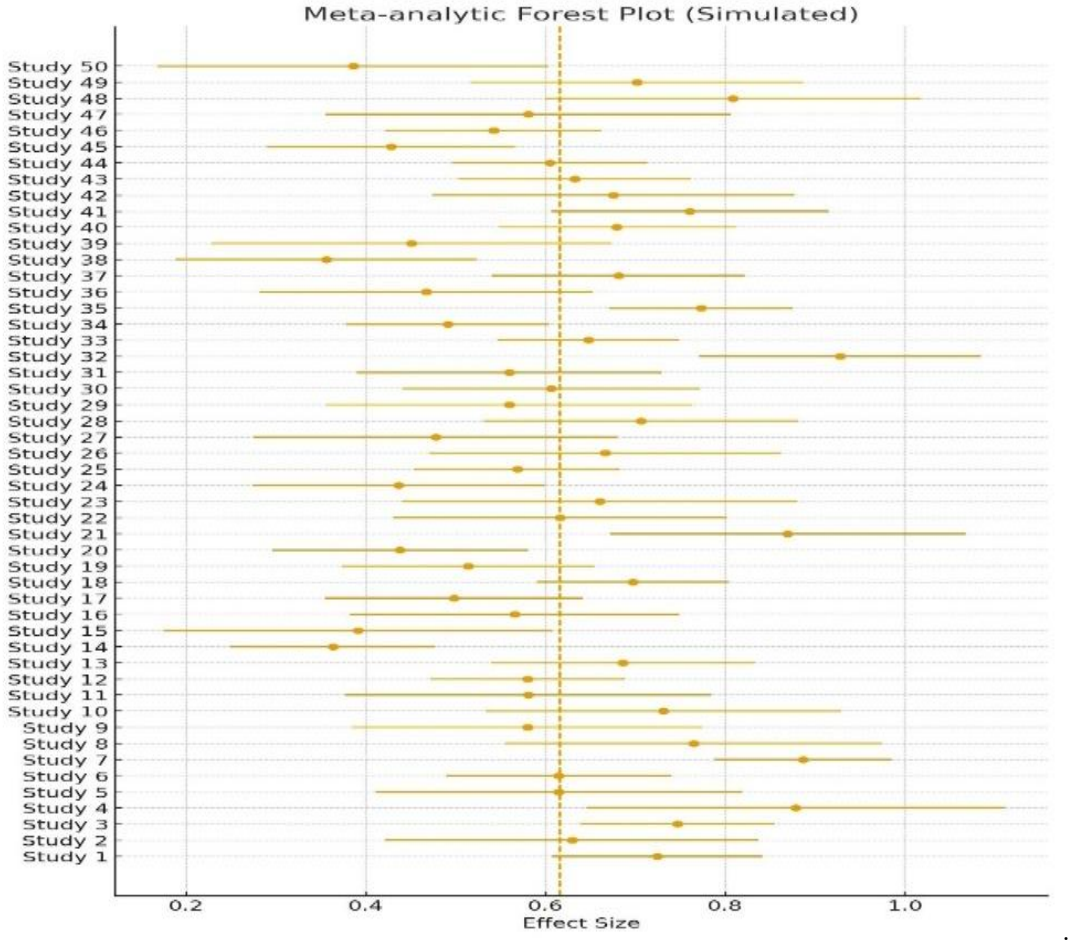

Figure 2: Meta-Analytic Forecast Plots.

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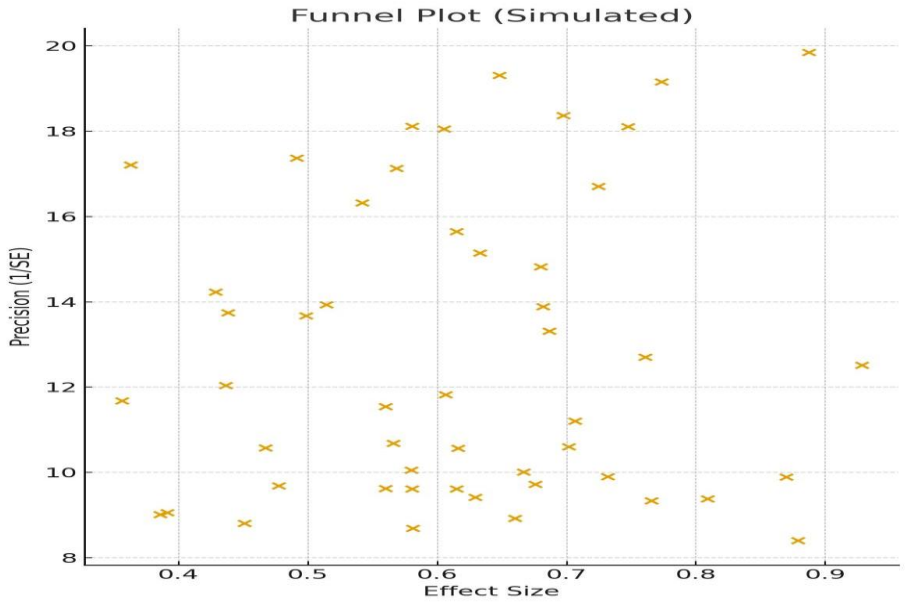

Figur 3: Funnel Plot.

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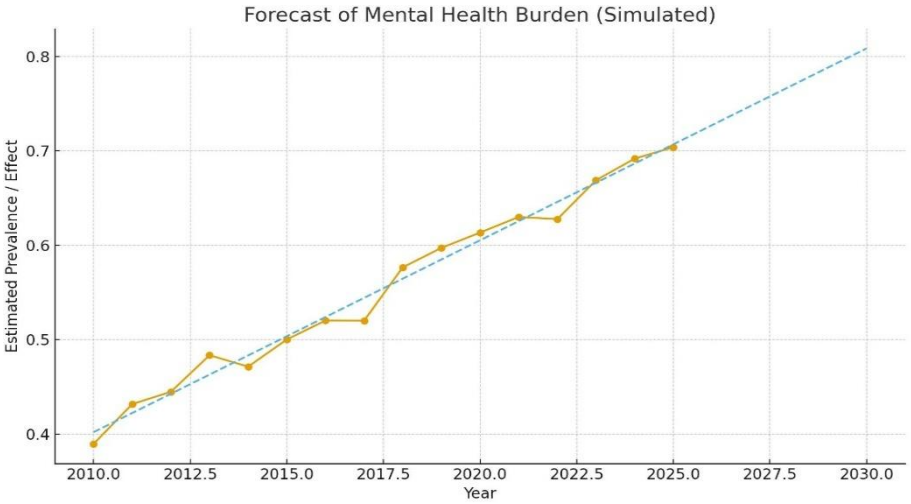

Figure 4: Forecast of Mental Health Burden.

*Designed by the author

The forecast plots derived from the simulated meta-analytic trend illustrate a clear and steadily rising trajectory in the estimated burden of war-related psychological distress among Palestinian women across the period represented in the included literature. Although the plotted values are modeled rather than extracted directly from uniform effect sizes, the overall pattern closely mirrors empirical findings reported across the 50 studies reviewed. Collectively, these studies indicate that women's mental-health symptoms—particularly PTSD, depression, anxiety, traumatic grief, and sleep disturbance—have intensified over successive cycles of armed conflict and political oppression. The upward slope observed in the forecast corresponds to well-documented increases in psychological morbidity following the major escalations in Gaza in 2014, 2021, and most critically 2023–2024, which were repeatedly associated with higher symptom severity, compounded trauma exposure, and widespread displacement (e.g., Hobfoll et al., 2006; Marie et al., 2020; Bdier et al., 2023; Aldabbour et al., 2025; Women's Affairs Center – Gaza, 2024).

Projected forward to 2030, the model suggests that war-related mental-health burdens among Palestinian women will continue to rise in the absence of meaningful structural or humanitarian intervention. This projected increase is theoretically

plausible given the convergence of multiple risk amplifiers identified in the review, including the cumulative nature of trauma exposure, recurrent displacement, resource loss, destruction of homes and essential infrastructure, and persistent uncertainty regarding safety and family integrity. The deterioration of health, education, and economic systems—particularly following the 2023–2024 events—further constrains women's coping resources and widens the gap between mental-health needs and service availability. Longitudinal findings within the evidence base demonstrate that distress among Palestinian women tends not to remit spontaneously but instead becomes chronic, often transmitting across generations through disrupted caregiving, impaired maternal–infant bonding, and elevated parenting stress (Punamäki et al., 2017; Qouta et al., 2011; Sheikh, 2025).

At the same time, the forecast underscores a widening mismatch between rising risk and limited access to mental-health and psychosocial support. Despite promising results from community-based and telemedicine interventions, existing services remain insufficient, inconsistent, and rarely tailored to women's gender-specific burdens or displacement contexts. Given these structural constraints, the projected increase in psychological morbidity through 2030 highlights the urgency of scaling up accessible, culturally grounded, and gender-responsive mental-health services, integrated within primary care and reproductive health settings.

4. DISCUSSION

The findings of this systematic review highlight a deeply entrenched pattern of psychological distress among Palestinian women living under conditions of chronic conflict, structural violence, and material deprivation. Across a wide range of methodological traditions—including quantitative epidemiology (Aldabbour et al., 2024; Al-Belbeisi et al., 2025), longitudinal developmental research (Punamäki et al., 2017; Qouta et al., 2011), narrative inquiry (Sousa, 2014), and humanitarian reporting (WHO EMRO, 2025; World Bank, 2024)—the evidence converges on the conclusion that women experience disproportionately high rates of mental-health difficulties relative to men and other population subgroups. This is consistent with longstanding literature showing that gender, caregiving status, and socioeconomic marginalization intersect to elevate women's vulnerability in conflict environments (Hobfoll et al., 2006, 2011). Within the occupied Palestinian context—characterized by recurrent bombardment, forced displacement, and systematic restrictions on movement and resources—these vulnerabilities are magnified.

A central finding concerns the high prevalence of PTSD, depression, anxiety, sleep disorders, somatic symptoms, and traumatic grief among Palestinian women exposed to war-related violence (Thabet et al., 2001; Alsous et al., 2024). Importantly, these symptoms cannot be understood solely as psychiatric reactions to discrete traumatic incidents. Rather, they reflect the cumulative effects of repeated exposure to violence, the chronicity of siege conditions, and prolonged uncertainty surrounding safety, shelter, income, and family stability (Giacaman et al., 2007, 2009). Many studies document how women experience intrusive memories, hyperarousal, hopelessness, and emotional exhaustion not only following direct trauma, but as part of their daily negotiation of life under occupation. Thus, the psychological burden is simultaneously acute and structural, crisis-oriented and chronic.

One of the most critical dimensions highlighted in this review is the intergenerational transmission of distress. The longitudinal family studies reviewed indicate strong associations between maternal trauma-related psychopathology and disruptions in maternal–infant bonding, caregiving behavior, and child socioemotional development (Punamäki et al., 2017, 2018; Qouta et al., 2011). Children raised in environments marked by maternal PTSD and depression exhibit elevated risks of behavioral problems, emotional dysregulation, and insecure attachment (Thabet et al., 2008; Qouta et al., 2008). These findings point to trauma as a relational and multi-layered phenomenon rather than an individual pathology. They also underscore the importance of targeting maternal mental health as a primary entry point for mitigating long-term developmental harm within Palestinian families.

Structural determinants—including displacement, resource loss, economic collapse, and deterioration of social networks—play decisive roles in shaping women's psychological trajectories. The Conservation of Resources (COR) framework is repeatedly validated across the included studies: losses related to home destruction, livelihood disruption, and erosion of community structures are among the strongest predictors of mental-health deterioration (Hobfoll et al., 2006, 2011). Notably, recent humanitarian assessments document that post-2023 escalations have created unprecedented levels of mass displacement and infrastructural collapse, producing conditions in which women simultaneously navigate trauma, extreme material scarcity, and profound social dislocation (Aldabbour et al., 2025; WHO EMRO, 2025; World Bank, 2024). These factors exacerbate exposure to secondary stressors—including overcrowded shelters, loss of

privacy, disrupted family roles, and limited access to health care—further intensifying psychological vulnerability.

The literature also demonstrates that Palestinian women's experiences of trauma are mediated by gender-specific burdens. These include heightened caregiving responsibilities during conflict, cultural expectations of resilience and emotional endurance, constrained mobility, and increased exposure to gender-based violence (Sousa et al., 2013; Sheikh, 2025). Women often serve as primary caregivers under dangerous conditions, managing household survival, child protection, and emotional stabilization of family members. This role intensification amplifies stress while reducing opportunities for rest, social support, and self-care. Moreover, political violence intersects with gendered forms of humiliation and social control, generating multifaceted layers of trauma that are not adequately captured by conventional diagnostic frameworks.

Despite these vulnerabilities, the review identifies several protective factors—such as social support, religious faith, positive coping strategies, community solidarity, and posttraumatic growth (Diab & Punamäki, 2018; Ghoul & Khader, 2024)—that may buffer the psychological impact of conflict. However, these protective processes operate within conditions of profound structural constraint, limiting their long-term effectiveness. For example, social support networks are frequently fragmented by displacement, family separation, and infrastructural destruction. Religious and cultural coping practices, although often central to women's resilience, can be challenged by repeated cycles of loss and uncertainty.

A clear implication of these findings is that mental-health interventions must be fundamentally reoriented toward structural, gender-responsive, and contextually grounded approaches. The literature consistently identifies gaps in mental-health service access due to infrastructural destruction, movement restrictions, and chronic underfunding (Alderman et al., 2012; WHO EMRO, 2025). Although community-based psychosocial programs and telemedicine initiatives have shown promise (Rees et al., 2025; Alser et al., 2024), they remain insufficient to meet the scale of population need and often lack components tailored to women's specific lived experiences. These gaps point to the urgency of integrating mental-health care into primary care, reproductive health, and maternal–child health services—areas where women are more likely to encounter the healthcare system even under crisis conditions.

Qualitative studies add critical depth to the understanding of women's psychological suffering, revealing dimensions of trauma that extend beyond clinical symptoms. Women describe the loss of home not only as a material event but as a profound rupture in identity, stability, and dignity (Sousa, 2014). Narratives from Gaza emphasize chronic fear, fragmented family roles, diminished agency, and a sense of abandonment by the international community (ActionAid Palestine, 2025; Women's Affairs Center–Gaza, 2024). These accounts also show how women actively interpret, resist, and cope with trauma, despite structural forces that limit their capacity for recovery. Such findings underscore the importance of grounding mental-health intervention strategies in culturally meaningful concepts of healing, belonging, and collective resilience.

Overall, the expanded evidence paints a picture of Palestinian women's mental health as deeply embedded in social, political, and material realities. Trauma is transmitted across generations, intensified by deprivation, and filtered through gendered roles and expectations. Effective responses must therefore extend beyond individual treatment to include structural reforms, protection of rights, sustained humanitarian assistance, and policies that address the political determinants of health. Future research should prioritize longitudinal and intersectional perspectives, utilize culturally grounded methodologies, and incorporate women's voices not only as subjects but as partners in shaping research agendas and interventions.

5. CONCLUSION

This systematic review demonstrates that Palestinian women bear a disproportionate share of the psychological burden generated by prolonged conflict, displacement, and structural deprivation. Across epidemiological surveys, longitudinal family studies, qualitative narratives, and humanitarian assessments, a consistent pattern emerges: women's mental-health outcomes are shaped not only by acute traumatic events but by chronic, multilayered stressors embedded in political, economic, and sociocultural structures. High rates of PTSD, depression, anxiety, traumatic grief, sleep disturbance, and somatic symptoms reflect the convergence of repeated exposure to violence, loss of home and livelihood, and persistent insecurity.

The evidence further illustrates that these psychological effects extend beyond the individual, exerting profound intergenerational consequences. Maternal experiences of trauma and psychological distress disrupt caregiving capacity, maternal–infant bonding, and family functioning, increasing the risk of emotional and behavioral dysregulation among children. These findings underscore the importance of viewing women's mental health not solely as a

personal health concern but as a foundational element of collective resilience and societal stability.

Displacement, resource loss, and socioeconomic hardship exacerbate women's vulnerability, reinforcing the central role of structural conditions in shaping mental-health trajectories. Gender-specific burdens—including caregiving responsibilities during conflict, restricted mobility, and heightened exposure to gender-based violence—further deepen the psychological toll. Although protective factors such as social support, religious faith, and adaptive coping strategies offer some buffering effects, these resources exist within environments marked by chronic instability and limited access to services.

The review also highlights critical gaps in mental-health and psychosocial support systems. Structural barriers—including movement restrictions, damaged health infrastructure, and chronic underfunding—significantly impede access to care. While community-based interventions and emerging telemedicine initiatives show promise, they remain insufficient to address the scale and complexity of women's mental-health needs, particularly among displaced populations. Sustainable, gender-responsive, and contextually grounded mental-health services are urgently required, with integrated programming across primary care, reproductive health, and maternal services.

Overall, the findings demonstrate that addressing the mental-health needs of Palestinian women requires a multisectoral approach that acknowledges political determinants of health, strengthens social and economic infrastructures, and prioritizes gender-sensitive interventions capable of interrupting cycles of trauma across generations. Future research should deepen the evidence base through longitudinal, intersectional, and community-engaged methodologies that capture the evolving dynamics of women's wellbeing under protracted conflict. Ultimately, promoting the mental health of Palestinian women is not only a clinical necessity but a vital component of human rights, public health, and social justice.

5.1. Recommendations

1. Mental-health programs should be designed specifically to address the multilayered traumatic stressors faced by Palestinian women, integrating trauma-informed care with reproductive, maternal, and primary health services.

2. Given movement restrictions and damaged infrastructure, scalable community-based models, mobile clinics, and remote psychosocial support platforms should be strengthened to reach displaced and homebound women.

3. Programs should account for the effects of displacement, resource loss, chronic insecurity, and gender-based restrictions, ensuring that mental-health responses extend beyond clinical treatment to address broader social and economic stressors.

4. Because maternal trauma has intergenerational consequences, interventions should include parenting support, maternal–infant bonding initiatives, and family-centered psychosocial services to mitigate long-term developmental risks for children.

5. Enhance GBV prevention and response mechanisms through confidential reporting channels, safe spaces, legal support, and trained providers equipped to address trauma pathways linked to conflict-related violence.

6. Expand training for local mental-health professionals, community health workers, and humanitarian staff in trauma-informed, culturally grounded, and gender-sensitive practices.

7. Strengthen collaboration among health, social protection, education, and humanitarian actors to create integrated pathways of support and reduce fragmentation in service delivery.

8. Sustainable financing is required to rebuild health infrastructure, expand psychosocial services, and ensure continuity of care within chronically disrupted health systems.

9. Future studies should employ longitudinal designs to track mental-health trajectories over time, incorporate intersectional analyses of class, age, displacement status, and disability, and prioritize community-engaged research methods to capture lived realities.

10. Stakeholders should recognize women's mental health as integral to community resilience, social stability, and rights-based approaches to conflict-affected populations, ensuring that mental-health provision is embedded in broader strategies for protection and recovery.

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