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Psychological Trauma, Collective Anxiety, and the Erosion of Everyday Normalcy in Border Conflict Zones

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Abstract

Populations living along active or intermittently active international borders and lines of control experience a distinctive psychological burden that differs, in intensity and character, from the trauma documented among combatants or among civilians in interior conflict zones. This paper synthesises epidemiological, sociological, and political-psychological literature to examine three interlinked phenomena: individual psychological trauma arising from repeated exposure to shelling, cross-border firing, and military escalation; collective anxiety as a socially transmitted and reinforced emotional state; and the progressive erosion of "everyday normalcy" — the routines, livelihoods, and assumptions of continuity that underwrite ordinary civilian life. Drawing on regional case literature from the India–Pakistan Line of Control and International Border in Jammu and Kashmir, the Gaza-envelope communities of southern Israel, conflict-affected districts of sub-Saharan Africa, and comparative data from Ukraine and the wider Middle East and North Africa (MENA) region, the paper constructs a conceptual framework linking chronic threat exposure to individual psychopathology, socially shared threat perception, and the deterioration of ontological security. Prevalence estimates compiled from the literature show markedly elevated rates of post-traumatic stress disorder (PTSD), depression, and anxiety among border-proximate populations relative to non-border populations in the same countries, alongside quantifiable disruption of education, agriculture, and household income. The paper argues that "normalcy" in border conflict zones is not merely absent but actively renegotiated — residents construct a provisional, defensive version of ordinary life that is itself a symptom of chronic insecurity. The paper closes with a discussion of resilience factors, methodological limitations of the existing evidence base, and policy implications for mental health infrastructure, livelihood support, and conflict-sensitive governance in border regions.

Keywords: *psychological trauma; collective anxiety; border conflict; ontological security; PTSD; civilian mental health; Line of Control; Gaza envelope; everyday life; community resilience*

1. Introduction

Border regions occupy a peculiar position in the study of armed conflict. They are neither fully "war zones" in the conventional sense of active combat between organised forces, nor are they places of settled peace. Instead, many international borders and lines of control exist in a condition that scholars increasingly describe as *low-intensity, persistent confrontation* —

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punctuated by ceasefire violations, artillery exchange, and sudden escalation, interspersed with long stretches of tense but functioning civilian life [16]. It is precisely this oscillation between calm and crisis that makes border communities psychologically distinct from both frontline combat zones and peaceful interiors: residents are neither permitted the adaptive closure that follows a discrete traumatic event, nor granted the security that would allow trauma responses to resolve.

Globally, the scale of civilian exposure to this condition is substantial and, according to recent humanitarian reporting, worsening. UNICEF estimates that more than 473 million children — nearly one in five children worldwide — now live in conflict-affected areas, a proportion that has roughly doubled since the 1990s [2]. Save the Children places the broader figure, including adults fleeing or living amid conflict, above 520 million [3]. The World Health Organization, in figures relayed by the United Nations, estimates that more than one in five people living in conflict-affected settings suffers from a diagnosable mental health condition, compared with much lower baseline rates in stable populations [4]. These are not merely statistics of injury or death; they describe a population living, working, raising children, and attempting to sustain ordinary routines under conditions that psychologists increasingly recognise as productive of both individual trauma and a distinct, socially shared form of anxiety [5].

The present paper is concerned specifically with border conflict zones — the strips of territory adjoining contested or militarised international boundaries — as a distinct sub-category of conflict-affected space. Unlike populations in the interior of a war-torn state, border residents typically continue to reside in functioning towns and villages, send children to school, cultivate land, and participate in local economies, even as their immediate environment carries an ever-present possibility of shelling, infiltration, or evacuation. This paper argues that this combination of ongoing functional life and chronic latent threat produces a psychological and social condition that cannot be adequately captured by trauma models developed for single catastrophic events. It requires, instead, an integrated framework that draws on (a) clinical trauma psychology, (b) the sociological concept of collective trauma, and (c) the concept of ontological security — the sense of continuity and order that underwrites a stable experience of everyday life [38,39].

The paper is structured as follows. Section 2 reviews the relevant literature across three theoretical strands: individual trauma in conflict-exposed civilian populations, collective trauma and collective anxiety, and ontological security/everyday-life disruption. Section 3 proposes an integrated conceptual framework. Section 4 outlines the narrative-synthesis methodology used to compile this review. Section 5 presents comparative prevalence data in tabular and graphical form. Section 6 offers deep regional case analyses of the Kashmir Line of Control, the Gaza-envelope towns of southern Israel, conflict zones of sub-Saharan Africa, and comparative material from Ukraine and the Arab region. Section 7 discusses the findings from multiple disciplinary perspectives — psychological, sociological, political-geographic, economic, and gendered. Section 8 examines resilience and protective factors. Section 9 discusses policy implications, Section 10 notes limitations, and Section 11 concludes.

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2. Literature Review

2.1 Individual Psychological Trauma in Conflict-Affected Civilian Populations

The clinical literature on trauma among conflict-exposed civilians is now extensive, though heavily weighted toward refugee and displaced populations rather than residents who remain in place near active borders. A 2024 systematic review and meta-analysis synthesising 57 eligible studies drawn from an initial pool of over 38,500 articles estimated the pooled prevalence of PTSD and depressive symptoms among civilians residing in armed conflict-affected regions to be substantially elevated relative to general population baselines, with women and children again identified as disproportionately affected [5]. A parallel review of systematic reviews conducted by Carpiniello, synthesising fifteen reviews and meta-analyses in adult populations and seven in children and adolescents, found that prevalence rates of anxiety, depression, and PTSD were two- to three-fold higher among people exposed to armed conflict compared with unexposed populations, with women and children carrying the greatest burden [3,10].

More recent meta-analytic work focused on sub-Saharan Africa has quantified this burden with greater regional specificity. A landmark systematic review of 181 surveys covering more than 81,000 refugees and conflict-exposed civilians across 40 countries reported an unadjusted weighted PTSD prevalence of 30.6% [12]. WHO-supported modelling separately estimated that 22.1% of adults in conflict-affected settings live with a mental disorder at any given time, spanning depression, anxiety, PTSD, and more severe psychiatric conditions, with a global model suggesting that between 316 and 354 million adult war survivors worldwide currently live with PTSD or major depression [12]. These figures situate border and conflict-zone populations among the most psychiatrically burdened civilian groups documented in contemporary epidemiology.

A cross-sectional, person-centred analysis of a population-based sample from the eastern Democratic Republic of Congo found that patterns of trauma exposure — rather than exposure per se — differentiated risk of psychopathology, suggesting that cumulative and compounded exposure (for instance, combining displacement, sexual violence, and loss of family members) produces qualitatively different mental health outcomes than singular exposure types [13]. This finding is corroborated by sex-differentiated research: a quantitative review of 25 years of trauma research found consistent sex differences in trauma exposure type and subsequent PTSD risk, with women disproportionately exposed to sexual violence-related trauma and men disproportionately exposed to combat- and injury-related trauma, each carrying distinct risk profiles [16]. A widely cited JAMA study similarly found that exposure to torture and other traumatic events was strongly and consistently associated with adverse mental health outcomes among populations exposed to mass conflict and displacement across multiple national contexts [11].

Cultural framing further complicates the clinical picture. A systematic review of qualitative literature on trauma-related cultural concepts of distress from the Middle East, North Africa, and sub-Saharan Africa found that psychological distress is frequently expressed and interpreted through somatic and culturally specific idioms rather than through the diagnostic

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categories of Western psychiatry — for example, physical pain among Mozambican refugees has been documented as an embodied response to underlying social and identity-related disruption rather than as a purely somatic complaint [14]. This literature cautions against uncritical application of standardised instruments (such as the PTSD Checklist or the Generalized Anxiety Disorder-7 scale) across cultural contexts without complementary qualitative or ethnographic validation.

Service-delivery literature reinforces the severity of unmet need. A review of psychiatric care in conflict zones across the Arab region found that domestic and sexual violence remain under-researched relative to other trauma types, that regional mental healthcare systems remain structurally underdeveloped, and that international relief agencies — while providing valuable short-term intervention — typically withdraw once funding cycles end, leaving host governments unable to sustain continuity of care [15]. A recent scoping review of displaced populations similarly concluded that daily survival routinely overshadows emotional recovery, so that psychological wounds accumulate silently even where death and injury rates are not the primary indicator of harm [10].

2.2 Collective Trauma and Collective Anxiety

Where clinical psychology addresses the individual, sociological and social-psychological literature addresses the *shared* dimension of trauma. Hirschberger's influential formulation defines collective trauma as a cataclysmic event that "shatters the basic fabric of society" [6], extending earlier sociological work by Erikson, who characterised collective trauma as a blow to the tissue of social life that damages the bonds attaching people to one another and undermines the prevailing sense of communality [7]. Crucially, both formulations emphasise that collective trauma is not simply the aggregation of many individual traumas; it is a distinct social phenomenon that reshapes shared narratives, cultural identity, and the assumptive worldview of an entire community [6,7].

This distinction matters directly for border conflict zones, where the relevant "event" is frequently not a single catastrophe but a *recurring condition*. Community-level psychological literature identifies several consistent consequences of sustained collective trauma: social fragmentation, characterised by increased distrust, community polarisation, and stigmatisation of affected subgroups; disruption of cultural and identity narratives, producing disorientation, collective grief, and, in some contexts, collective guilt or shame; and long-lasting economic and social disruption across education, employment, and healthcare systems that compounds and prolongs emotional distress [6]. Community resilience frameworks, drawing on disaster and community psychology, argue that collective trauma should be approached not merely as a deficit to be treated clinically but as a social-dynamic process in which the affected community itself — rather than external agencies alone — must become the principal agent of recovery through cooperative, locally owned initiatives [19].

Clinical models of "collective healing," most notably the community-based treatment framework developed from work with Holocaust survivors, post-war Kosovo, the Liberian civil wars, and post-9/11 Lower Manhattan, argue that trauma-informed intervention in conflict-affected communities must be culturally and contextually adapted rather than imported

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wholesale from individual-focused Western psychotherapy [21]. This body of work is directly relevant to border communities, where trauma is neither a single historical event (as with a terrorist attack) nor a fully resolved past (as with a completed war), but an ongoing, recursive condition that resists conventional "post"-traumatic framing altogether.

Collective anxiety, distinct from collective trauma but closely related to it, refers to the socially transmitted and reinforced experience of anticipatory threat — the shared expectation that harm may recur, even during periods of relative calm. This has been documented directly in South Asian border reporting: residents describe fear, confusion, panic, and stress as recurring emotional states that are collectively recognised and discussed within border communities, independent of any single triggering incident [9]. Journalistic and psychiatric accounts converge on the observation that such anxiety is not confined to individuals directly affected by a specific shelling incident but circulates through the community as a shared expectation, reinforced by air-raid drills, mock evacuation exercises, and recurring media coverage of escalation [22].

2.3 Ontological Security and the Structure of Everyday Life

The third theoretical strand draws on sociology and international relations rather than clinical psychology. Anthony Giddens's concept of ontological security describes a stable mental state derived from a sense of continuity and order in one's life, sustained through routine, trust, and the ability to give coherent meaning to one's experiences [38]. Giddens argues that in ordinary circumstances, people are able to set aside existential questions about safety and meaning precisely because daily routines proceed predictably; it is only in what he terms "critical situations" — moments when routine breaks down — that these underlying anxieties resurface [43]. Ronald Laing's earlier psychoanalytic formulation, from which Giddens draws, describes ontological security as a "firm core" that allows an individual to experience their own being as continuous, real, and differentiated from a chaotic external world [44].

International relations scholars have extended this framework from individuals to states and, more recently, to communities living under conditions of chronic geopolitical threat. Kinnvall and Mitzen argue that ontological security functions as a conceptual lens for understanding how actors — whether individuals, communities, or states — manage anxiety through the maintenance of cognitive consistency and biographical continuity, particularly in environments "shaken with the dislocations" of instability [9,42]. Crucially for the present paper, this literature suggests that anxiety management under conditions of chronic threat does not necessarily produce the "chaos" that Giddens's original model implies; instead, individuals and communities frequently develop defence mechanisms — denial, routinisation, and normalisation — that allow them to sustain a functional sense of ordinary life even while the objective threat persists [39]. This insight is central to understanding border conflict zones, where residents do not simply live in a state of unremitting panic but actively construct and maintain a provisional, adapted version of normal life around the threat.

This theoretical move — from "trauma disrupts normalcy" to "normalcy is actively reconstructed around chronic threat" — provides the conceptual bridge between the clinical trauma literature (Section 2.1) and the collective trauma literature (Section 2.2). It also aligns

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with direct empirical reporting from border zones: Indian government analyses of border security note explicitly that "the normalization of conflict conditions affects mental health and long-term community stability," implying that normalisation itself — while adaptive in the short term — functions as a mechanism of chronic psychological strain rather than genuine resolution [16].

2.4 Border Zones as a Distinct Analytical Category

A small but growing literature treats border zones as analytically distinct from both "war zones" and "peaceful" territory. Ethnographic work on the Kargil borderland in the Indian Himalaya documents how repeated wars, cross-border shelling, and geopolitical tension have driven forced migration and village abandonment even in the absence of a currently active war, situating this as a form of slow, protracted displacement distinct from the acute displacement typically studied in refugee literature [25]. This work explicitly frames "border anxiety" as a driver of what it terms the "unmaking of home" — the erosion not just of physical safety but of the meaning and security historically invested in place and dwelling [25].

Comparable dynamics have been documented in the borderlands of sub-Saharan Africa, where farmers and pastoralists face compounding risks from resource conflict, climatic shocks, and weak infrastructure, producing chronic livelihood insecurity that is frequently treated as a purely economic phenomenon but that United Nations Development Programme research increasingly recognises as entangled with psychosocial vulnerability and community resilience [33]. Taken together, this literature supports treating border conflict zones as a coherent, comparative analytical category rather than as a simple subset of "conflict zones" in general.

3. Conceptual Framework

Synthesising the three literatures reviewed above, this paper proposes a four-stage framework (illustrated above) linking chronic border exposure to the erosion of everyday normalcy:

- **Chronic border exposure** — repeated, unpredictable exposure to shelling, cross-border firing, infiltration threats, and military mobilisation, punctuated by ceasefires that do not eliminate the underlying threat structure [16,18].
- **Individual trauma response** — the clinical sequelae of chronic exposure, including PTSD, generalised anxiety, depressive symptoms, sleep disturbance, and somatic complaints, often without full remission between episodes of acute threat [5,10,12].
- **Collective anxiety** — the socially transmitted amplification of individual threat perception into a shared community disposition, reinforced through collective memory, local narrative, media coverage, and periodic civil-defence activity such as evacuation drills [6,7,9,22].
- **Erosion of everyday normalcy** — the cumulative disruption of routine, livelihood, education, and ontological security, producing a reconstructed, defensive form of "normal life" that is itself a chronic-stress adaptation rather than a return to pre-conflict baseline functioning [16,25,38,42].

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The framework includes an explicit feedback loop: the normalisation of conflict conditions — itself a coping mechanism — can paradoxically sustain and prolong exposure by reducing collective and political pressure for de-escalation or infrastructure investment, a dynamic noted directly in Indian border-security literature [16]. Resilience and coping resources — social support networks, community cohesion, livelihood diversification, and, where available, mental health infrastructure — function as a moderating variable across all four stages, attenuating but rarely eliminating the psychological burden [19,21,34,35].

4. Methodology

This paper employs a narrative-synthesis methodology, appropriate for a topic that spans clinical epidemiology, sociology, political psychology, and area-studies literature that cannot be adequately integrated through a single-discipline systematic review protocol. Sources were identified through targeted search of peer-reviewed journals (including *Frontiers in Psychology*, the *International Journal of Environmental Research and Public Health*, *Scientific Reports*, *JAMA*, *Psychological Bulletin*, and *Intervention: Journal of Mental Health and Psychosocial Support in Conflict-Affected Areas*), grey literature from humanitarian and multilateral organisations (UNICEF, Save the Children, WHO/UN News, UNDP), regional policy literature (Carnegie Endowment for International Peace, Carnegie India), and long-form investigative journalism providing ethnographic depth unavailable in quantitative studies (*The Caravan*, *Al Jazeera*). Priority was given to systematic reviews and meta-analyses where available, supplemented by primary empirical studies and qualitative/ethnographic accounts where quantitative synthesis was unavailable for a given region (notably the Kashmir Line of Control and the Gaza-envelope towns of southern Israel, where much of the available evidence derives from targeted surveys conducted by trauma-focused non-governmental organisations rather than peer-reviewed meta-analyses).

Given the heterogeneity of measurement instruments (PHQ-9, GAD-7, PTSD Checklist, locally administered surveys by organisations such as Médecins Sans Frontières and NATAL), this paper does not attempt formal meta-analytic pooling of prevalence estimates across regions. Instead, prevalence figures are presented comparatively in Section 5, with explicit acknowledgement of measurement heterogeneity as a limitation (Section 10).

5. Comparative Findings: Prevalence, Disruption, and Regional Variation

5.1 Prevalence data

The chart above compiles selected, directly comparable prevalence figures drawn from the literature reviewed. Several patterns are evident. First, prevalence of trauma-related symptoms among populations proximate to active borders consistently exceeds both national baselines and the already-elevated rates found among general conflict-affected populations. In Jammu and Kashmir, the border districts of Kupwara and Baramulla recorded depression prevalence of 58% and 51% respectively in a 2015 Médecins Sans Frontières study, compared with 28–38% in non-border districts of the same region [18,19] — meaning that mere geographic proximity to the Line of Control, independent of any single incident, is associated with substantially elevated psychiatric morbidity. Second, child populations are disproportionately

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affected everywhere data exists: in Sderot, southern Israel, a 2007 NATAL-affiliated study found that 30% of adults but fully 75% of children aged 4–18 met criteria for post-traumatic stress symptoms, with subsequent studies reporting PTSD rates among children three to four times the national Israeli average even during non-escalation periods [28–32].

Table 1 below summarises indicative prevalence and impact data compiled across the reviewed literature.

Region / Population	Indicator	Reported figure	Source
Sub-Saharan Africa, conflict-exposed civilians (pooled, 40 countries)	PTSD prevalence	30.6% (95% CI 26.3–35.2%)	[12]
Global conflict-affected adults (WHO modelling)	Any mental disorder	22.1%	[12]
Global war survivors (adults)	PTSD and/or major depression	316–354 million persons	[12]
Kupwara district, J&K (LoC-proximate)	Depression prevalence	58%	[18,19]
Baramulla district, J&K (LoC-proximate)	Depression prevalence	51%	[18,19]
Non-border districts, J&K (Ganderbal, Srinagar, Anantnag, Pulwama)	Depression prevalence	28–38%	[18,19]
LoC border villages, J&K	PTSD prevalence	15%	[20]
Uri sector residents, J&K	Conflict-related trauma	93% of adults surveyed	[21]
Sderot, southern Israel, adults (2007)	PTSD diagnosis	28%	[34]
Sderot, southern Israel, children 4–18 (2007)	Any PTSD symptom	75%	[32]
Sderot, southern Israel, children 12–14 (2008)	PTSD symptoms	86%	[33]
Sderot, southern Israel, children (2015, Pat-Horenczyk study)	PTSD/anxiety symptoms	40% (vs. 7–10% national baseline)	[31]
Azad Jammu & Kashmir schools near LoC	Population reporting psychological effect of shelling	41–47%	[26]
Samre Woreda, Tigray, Ethiopia (conflict-affected farmers)	Household income loss	97% of respondents	[36]

Note: figures derive from studies using differing instruments, sample frames, and time periods (2007–2026); they are presented for descriptive comparison rather than formal meta-analytic pooling. See Section 10 for methodological caveats.

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5.2 Everyday-life and livelihood disruption

Beyond clinical prevalence, the literature documents extensive disruption of the material infrastructure of daily life. **Table 2** summarises the principal thematic domains of "erosion of everyday normalcy" identified across the reviewed literature, along with representative manifestations.

Domain	Representative manifestation	Source
Education	School enrolment decline, teacher and student stress, damaged infrastructure near the Line of Control	[15,26]
Livelihood / agriculture	Destruction of farms and livestock, 97% household income loss in conflict-affected Ethiopian district	[36], [58]
Housing and settlement	Village abandonment and forced migration despite absence of active war, e.g. Kargil borderland	[25]
Sleep and daily routine	Residents near the LoC reporting inability to sleep, families relocating sleeping arrangements away from exterior walls	[21,37]
Social trust and cohesion	Distrust, community fragmentation, and stigma following repeated collective trauma exposure	[6]
Access to healthcare	Absence of mental health infrastructure in border districts; residents reporting no knowledge of available services	[21]
Economic informal coping	Households selling assets, reducing agricultural investment, liquidating goods for short-term relief	[61]

5.3 Interpreting the pattern

Two interpretive observations follow from this comparative data. First, the gap between border-proximate and non-border populations *within the same country* (as in the Kashmir data) is arguably more analytically significant than cross-national comparisons, because it holds constant many confounding factors — national mental health infrastructure, cultural context, overall socioeconomic development — while isolating proximity to active conflict as the primary variable of interest [18,19,20]. Second, the consistently higher rates among children across every regional case examined (Kashmir, Sderot, and the broader sub-Saharan African literature) suggest that developmental exposure to chronic border conflict may produce durable psychological vulnerability extending well beyond the acute exposure period, a concern amplified by UNICEF's finding that global grave violations against children reached record levels in 2023–2025 even as awareness of child-specific mental health needs has increased [2,55].

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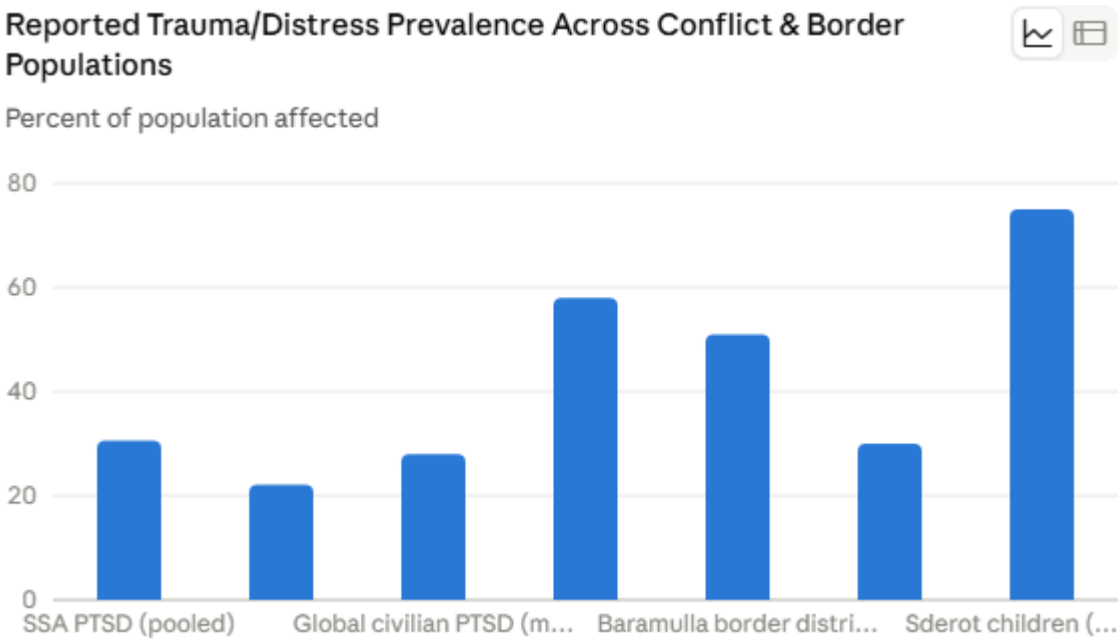

Reported Trauma/Distress Prevalence Across Conflict & Border Populations

Category	Prevalence (%)
SSA PTSD (pooled)	30.6
WHO conflict-zone mental disorder	22.1
Global civilian PTSD (meta-analysis midpoint)	28
Kupwara border district (depression)	58
Baramulla border district (depression)	51
Sderot adults (PTSD, 2007)	30
Sderot children (any PTSD symptom, 2007)	75

6. Regional Case Analyses

6.1 The India–Pakistan Line of Control and International Border

The Line of Control (LoC) dividing Indian- and Pakistani-administered Kashmir, together with the adjoining International Border, represents one of the most extensively documented border-conflict psychological contexts globally, owing in part to the region's decades-long history of intermittent ceasefire violations. Field reporting from villages along the LoC describes cross-border firing and shelling as having become, in the words of residents interviewed by *The Caravan*, "part and parcel of life" rather than an exceptional event [21]. This normalisation is itself analytically significant: it exemplifies the ontological-security adaptation described in Section 2.3, whereby chronic threat is absorbed into the structure of daily expectation rather than remaining a discrete, bounded crisis.

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Quantitatively, the 2015 Médecins Sans Frontières study remains the most frequently cited source, documenting depression prevalence of 51–58% in border-proximate districts against 28–38% in non-border districts of the same Indian state [18,19]. A subsequent 2023 cross-sectional study of 300 youth aged 18–25 across International Border and Line of Control villages in Jammu and Rajouri districts found elevated perceived stress and anxiety, with an associated PTSD prevalence of approximately 15% — lower than the MSF depression figures but consistent with the broader pattern of elevated psychiatric morbidity in border-proximate youth populations [20]. Qualitative interviews with children aged 10–14 in border villages documented a persistent sense of anxiety and unpredictability, alongside recurring themes of family separation and fear of displacement [20].

The Carnegie Endowment's 2023 policy analysis synthesises these findings into an explicit policy argument: that the 2021 India–Pakistan ceasefire renewal created a rare "interval of peace" that should be used deliberately to build mental health infrastructure in border districts, given the chronic and largely unaddressed backlog of psychiatric morbidity accumulated over two decades of intermittent conflict [9]. This argument is reinforced by direct testimony collected by Al Jazeera from residents of Pakistan-administered Kashmir during the 2019 India–Pakistan tension following the Pulwama attack, in which residents described being trapped, physically and psychologically, in what one report termed a "web of fever-pitch tensions between nuclear-armed neighbours" [17]. Reporting from the same period documented that since 2019, at least 60 civilians had been killed and more than 280 wounded in shelling on the Pakistani side of the LoC alone, with residents describing living "fearing he could be killed any moment" even while going about ordinary agricultural work [18].

More recent developments confirm the persistence of this dynamic: following the April 2025 Pahalgam terror attack, renewed India–Pakistan tension prompted government-organised civilian preparedness drills across 244 Indian districts, with mental health professionals publicly advising strategies for managing the population-wide anxiety generated by air-raid drills and continuous distressing news coverage [22]. This episode illustrates that the psychological burden documented in earlier academic literature is not a historical artefact but a recurring, contemporary feature of the region's conflict dynamics.

6.2 The Gaza-Envelope Towns of Southern Israel

The Israeli town of Sderot, located less than a mile from the Gaza Strip, provides one of the most intensively studied examples of chronic rocket-exposure trauma anywhere in the world. Since 2001, more than 10,000 rockets have been fired toward the town [37], producing what NATAL (the Israel Trauma Center for Victims of Terror and War) and independent pollsters have documented as a population-wide psychiatric crisis rather than an incident-specific one. A 2007 NATAL study found that 28% of adults and 30% of children met full diagnostic criteria for PTSD, with 1,117 new trauma-victim case files opened at the Sderot Mental Health Center within a single year [34]. The same period saw reports that up to 94% of Sderot's children displayed at least one PTSD-related symptom, including hypervigilance, nightmares, bed-wetting, and regression to earlier developmental behaviours [34].

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Subsequent studies documented a consistent, if fluctuating, pattern: a 2008 poll found that 86% of children aged 12–14 exhibited PTSD symptoms, with academic performance affected for roughly one-third of high-school students [33]; a comparison study using residents of the socioeconomically similar but non-targeted town of Ofakim as a control group found that Sderot residents were three times more likely to seek support from a family doctor or spiritual counsellor than their Ofakim counterparts, evidence of a measurable population-level coping response distinct from formal psychiatric treatment [28,36]. A 2015 study led by Prof. Ruth Pat-Horenczyk found that 40% of Sderot children displayed symptoms of anxiety, fear, and PTSD, a rate three to four times the national Israeli average even outside periods of acute military escalation, alongside symptoms including separation anxiety, developmental regression, and new-onset fears [31]. Notably, the same research also documented adaptive, collective coping: community-organised play and recreational activity for children was identified as a significant protective mechanism against the psychological toll of sustained rocket exposure [31] — direct empirical support for the resilience-moderator component of the conceptual framework proposed in Section 3.

A longitudinal three-wave study of 1,052 individuals aged 18–40 residing in Israeli conflict zones, tracking symptoms from February through May 2024, documented sustained elevated anxiety, depression, and PTSD symptoms across the study period, reinforcing that acute escalation produces psychiatric effects that persist well beyond the immediate triggering events [8]. This finding parallels historical research on the September 11 attacks, which similarly found nationwide elevated PTSD symptoms and chronic worry persisting across the decade following the attacks among highly exposed populations [8], underscoring that both border-conflict and terrorism-related trauma follow a similarly protracted psychological trajectory rather than resolving quickly after acute threat subsides.

6.3 Sub-Saharan Africa: Compounded Trauma and Livelihood Collapse

Border and internal conflict zones across sub-Saharan Africa present a distinct pattern in which psychological trauma is compounded by severe and often simultaneous economic collapse. The person-centred analysis of trauma exposure patterns in the eastern Democratic Republic of Congo found that specific *combinations* of traumatic exposure — rather than exposure to any single traumatic event type — were the strongest predictors of subsequent psychopathology, a finding with direct relevance for border zones where residents frequently experience multiple, overlapping stressors (shelling, displacement, livelihood loss, and family separation) simultaneously rather than sequentially [13].

Economic literature from the region reinforces this compounding dynamic. A 2025 study of livelihood challenges in the conflict-affected Samre Woreda district of Tigray, Ethiopia, found that nearly 97% of surveyed households reported substantial income losses attributable to conflict, alongside destruction of physical assets, restricted access to land, and breakdown of social networks — with the study explicitly noting that men in affected households experienced "role dislocation and trauma" distinct from the economic marginalisation disproportionately affecting women in the same communities [36]. A parallel 2026 assessment of Sudan's conflict-affected agricultural sector found that smallholder farmers facing overlapping conflict, economic instability, and climate shocks resorted to reactive coping strategies — selling

household goods, reducing agricultural investment, and liquidating assets — that provided short-term relief but systematically undermined long-term recovery capacity [37]. This literature collectively demonstrates that in resource-poor conflict settings, the erosion of everyday normalcy operates simultaneously through psychological and material-economic channels, each reinforcing the other.

Notably, UNDP-sponsored research on borderland farmers and pastoralists across the continent has begun to shift emphasis away from a purely deficit-based narrative of conflict and deprivation toward documenting the specific coping strategies, sources of resilience, and everyday adaptive practices that allow borderland communities to sustain functioning social and economic life despite chronic risk [33]. This shift mirrors the broader theoretical move, discussed in Section 2.3, from viewing chronic-threat populations solely as trauma victims toward recognising the active, ongoing reconstruction of normalcy as itself a subject worthy of empirical study.

6.4 Comparative Notes: Ukraine and the Wider Middle East and North Africa Region

Although outside the primary regional focus of this paper, evidence from Ukraine's conflict-affected border oblasts and from the wider MENA region offers useful comparative context. UNICEF reporting highlights the case of a fourteen-year-old girl in the Ukrainian town of Novotoshkivske who must plan her walks in advance to avoid unexploded ordnance scattered through her town — an illustration, at the level of individual lived experience, of how border-proximate conflict disrupts even the most mundane elements of daily movement and routine [53]. More broadly, UN figures indicate that more than one in five people living in conflict-affected areas globally suffers from a diagnosable mental health condition, a finding that prompted direct WHO calls for increased and sustained investment in regional mental health services [4].

In the MENA region, the qualitative literature on culturally specific expressions of trauma-related distress — for instance, somatic complaints understood locally as embodied responses to social and identity disruption — cautions against directly transplanting the trauma frameworks developed in the Kashmir or Israeli contexts without adaptation to local idioms of distress [14]. This comparative material reinforces a central argument of this paper: while the *structural* dynamics of chronic border exposure, individual trauma, collective anxiety, and eroded normalcy appear to recur across highly diverse geographic and cultural settings, the specific expression, interpretation, and social response to that trauma is substantially shaped by local cultural, religious, and political context.

7. Multi-Perspective Discussion

7.1 The psychological/clinical perspective

From a strictly clinical standpoint, the evidence compiled here supports the conclusion that chronic border exposure functions as a distinct trauma category requiring its own diagnostic and therapeutic consideration, rather than being subsumed under standard single-incident PTSD models developed largely from research on veterans, assault survivors, and disaster

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victims. The persistence of elevated symptomatology even during ceasefire periods — as documented in both the Kashmir and Sderot case studies — suggests that conventional PTSD criteria, which presume a discrete index trauma followed by a recovery trajectory, may inadequately capture the psychological experience of populations for whom the "traumatic event" is an ongoing structural condition rather than a bounded occurrence [5,31,34]. This supports calls within the clinical literature for greater use of complex trauma and continuous-traumatic-stress frameworks in border-conflict contexts, alongside standard PTSD and depression measures [10,14].

7.2 The sociological/collective-trauma perspective

From a sociological standpoint, the Hirschberger and Erikson frameworks direct attention away from individual diagnosis and toward the social fabric itself [6,7]. The consistent finding, across every regional case reviewed, that border communities develop shared narratives, informal support networks, and collectively recognised coping rituals (spiritual counselling, community play activities for children, informal mutual aid) suggests that collective trauma in border zones produces not only fragmentation but also — counterintuitively — forms of intensified local solidarity, even as broader social trust in state protection and infrastructure may erode [21,28,31]. This dual movement, toward both fragmentation and localised solidarity, is consistent with community resilience literature emphasising that trauma-affected communities frequently become, of necessity, their own primary agents of psychosocial recovery [19].

7.3 The political-geographic and international-relations perspective

Ontological security theory offers a distinctive contribution largely absent from clinical accounts: it reframes the "normalisation" of conflict — often treated in clinical literature simply as a maladaptive coping mechanism — as a rational, if costly, strategy for preserving a coherent sense of self and continuity under conditions where the underlying geopolitical threat cannot be resolved by the individual or the local community [38,42,43]. This perspective also illuminates the state-level dynamics underlying border conflict: as Kinnvall and Mitzen note, states themselves may become invested in the continuation of long-running rivalries because such rivalries provide a stable, if adversarial, source of national identity and purpose — a dynamic with direct bearing on why border conflicts such as the Kashmir dispute have proven so durable despite periodic ceasefire agreements [42]. From this perspective, the psychological burden borne by border civilians is, in part, a structural by-product of state-level ontological security dynamics operating at a scale far beyond any individual community's capacity to resolve.

7.4 The economic perspective

Economic literature reframes "erosion of everyday normalcy" in more material terms: the destruction of physical assets, restricted market access, and breakdown of agricultural investment documented in Ethiopia and Sudan demonstrate that chronic border conflict produces measurable, quantifiable economic contraction alongside psychological harm [36,37]. Importantly, the psychosocial support literature reviewed in Section 2.1 suggests these

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two channels are not independent: an action-research study of Syrian farmers found that livelihood support programmes integrated with psychosocial support produced significantly greater improvements in well-being than either livelihood or psychosocial support delivered alone, indicating that interventions addressing only the economic or only the psychological dimension of border-conflict harm are likely to under-perform relative to integrated approaches [59]. This finding has direct implications for the design of humanitarian and development interventions in border regions (see Section 9).

7.5 The gendered perspective

Across every regional case reviewed, gender emerges as a significant differentiating variable, though its direction and mechanism vary by context. In sub-Saharan Africa, women in conflict-affected households face compounded marginalisation through unequal access to land, credit, and protective services, while men more frequently experience what one study terms "role dislocation and trauma" tied to disrupted breadwinner and protector identities [36]. Globally, meta-analytic evidence consistently finds women at higher risk of depression and PTSD in conflict-affected populations, generally attributed to disproportionate exposure to sexual violence, caregiving burden, and economic precarity, while men show distinct exposure and risk profiles tied to combat-adjacent trauma and, in border contexts, direct exposure to shelling while engaged in outdoor agricultural or occupational activity [3,8,16]. These findings caution against gender-neutral intervention design and support calls in the literature for gender-differentiated mental health and livelihood programming in border-conflict settings [15,36].

7.6 The child-development perspective

The consistency with which children register the highest prevalence rates across every region examined — 75% of Sderot children showing PTSD symptoms in 2007 [32], 86% among 12–14 year-olds in 2008 [33], and elevated rates persisting into 2015 despite periods of relative calm [31] — represents perhaps the most striking pattern in the comparative evidence. UNICEF's finding that the global proportion of children living in conflict-affected areas has approximately doubled since the 1990s, alongside record levels of grave violations against children in 2023–2024, situates the regional case findings within a broader global trend of intensifying, rather than diminishing, child exposure to chronic conflict conditions [2,54,56]. Save the Children's estimate that more than 24 million conflict-affected children currently require mental health support, against a backdrop of chronically underfunded psychosocial service provision, underscores a substantial and apparently widening gap between documented need and available intervention capacity [55].

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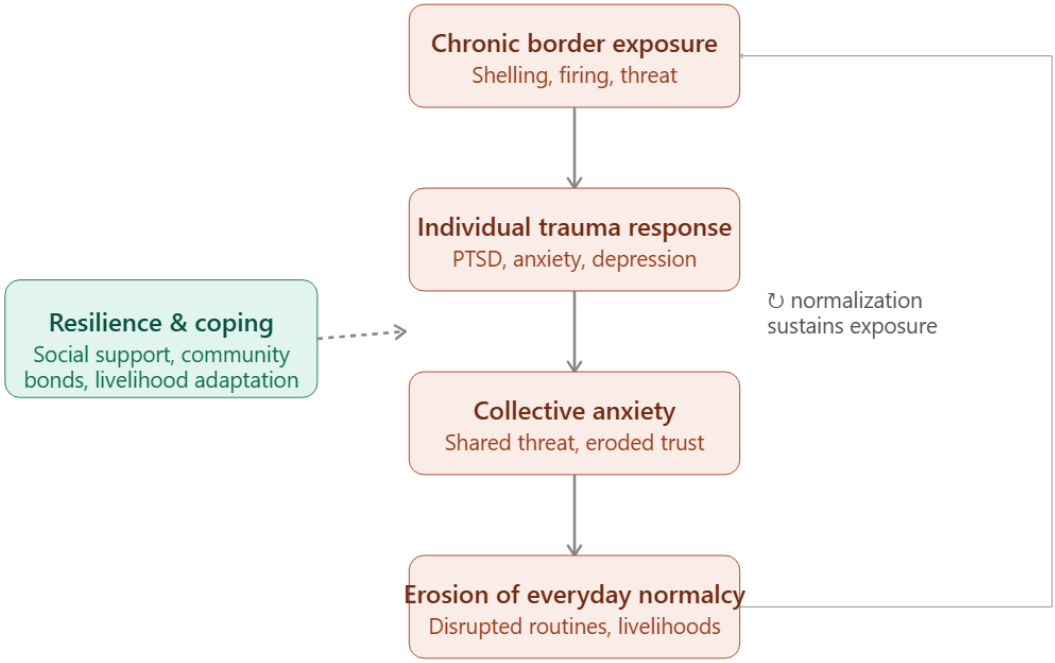

8. Resilience, Coping, and Protective Factors

Despite the consistently severe prevalence data reviewed above, the literature also documents a range of protective and adaptive mechanisms that meaningfully moderate — without eliminating — the psychological burden of chronic border exposure.

Community-organised recreational and social activity. The Sderot literature specifically identifies structured play and recreational activity for children as an important buffering mechanism against chronic rocket-exposure anxiety, allowing children a bounded, socially sanctioned space in which ordinary developmental activity can continue despite the surrounding threat environment [31].

Informal social and spiritual support networks. Comparative research contrasting Sderot with the control town of Ofakim found that rocket-exposed residents were three times more likely to seek support from family doctors and spiritual counsellors, indicating that informal support infrastructure — rather than formal psychiatric treatment, which remains scarce in most border regions — functions as the primary coping resource for the majority of affected residents [28,36].

Integrated livelihood and psychosocial programming. The Syrian farmer psychosocial-support study found that combining livelihood assistance with structured psychosocial support produced measurably larger improvements in well-being across emotional, social, economic, and skills-based dimensions than livelihood assistance alone, with particularly pronounced benefit for beneficiaries with disabilities [59]. This finding, while drawn from an internally

displaced population rather than a border-resident population specifically, offers a transferable model for border-zone intervention design.

Household-level resilience factors in economic shock absorption. Research on smallholder farmers facing conflict-related land and livelihood shocks in sub-Saharan Africa identifies household assets, off-farm income diversification, access to social safety nets, and education level as significant resilience factors mitigating the negative economic effects of conflict shocks, suggesting that pre-existing socioeconomic resources substantially shape a household's capacity to absorb both the economic and, indirectly, the psychological impact of chronic border conflict [60,62].

Collective narrative and cultural meaning-making. At the community level, collective trauma literature emphasises that communities able to construct and sustain coherent shared narratives about their experience — rather than experiencing narrative rupture or historical erasure — demonstrate greater long-term psychosocial stability, a finding with direct relevance to border communities whose experience is often marginalised or under-documented relative to combatant-focused conflict narratives [6,21].

Collectively, these findings suggest that resilience in border conflict zones is neither purely individual nor purely structural, but emerges from the interaction of community-level social infrastructure, household economic resources, and — where available — professionally delivered, culturally adapted psychosocial support.

9. Policy and Practice Implications

Several policy implications follow directly from the evidence reviewed.

First, the marked within-country disparity between border-proximate and non-border populations documented in Kashmir — a 20-to-30 percentage-point gap in depression prevalence between border and interior districts of the same state [18,19] — indicates that national mental health resource allocation should be explicitly weighted by geographic proximity to active conflict lines, rather than allocated purely on the basis of overall population or general socioeconomic indicators. The Carnegie Endowment's explicit recommendation to use periods of ceasefire as windows for building border-district mental health infrastructure represents a concrete, actionable articulation of this principle [9].

Second, the demonstrated superiority of integrated livelihood-and-psychosocial programming over stand-alone livelihood assistance [59] suggests that humanitarian and development actors operating in border conflict zones should default to integrated intervention design rather than treating economic and psychological support as separable programme streams.

Third, the disproportionate and consistent impact on children documented across every regional case suggests that school-based psychosocial support — delivered through existing education infrastructure rather than requiring the construction of parallel specialist mental health systems — represents a comparatively cost-effective channel for reaching the most severely affected population subgroup, particularly given that damaged school infrastructure

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and declining enrolment near the Line of Control have already been separately documented as needing urgent policy attention [15,26].

Fourth, given the finding that international relief interventions in the Arab region tend to be short-term and dependent on external funding cycles that leave local systems unable to sustain continuity of care once funding ends [15], policy design in border conflict zones should prioritise building sustainable local and regional service capacity — training local health workers, embedding services within existing government health infrastructure — over externally delivered, time-limited programming.

Finally, given the state-level ontological security dynamics identified in the international relations literature [42], purely local or humanitarian interventions, while necessary, are unlikely to be sufficient to resolve the underlying condition; sustained diplomatic engagement aimed at durable de-escalation remains the only mechanism capable of addressing the root cause of chronic border-conflict psychological burden, a point implicit in the consistent finding that psychiatric morbidity in border populations tracks closely with periods of heightened political tension and improves, though does not fully resolve, during sustained ceasefire periods [9,22].

10. Limitations

This paper is subject to several important limitations. First, as a narrative synthesis rather than a formal systematic review or meta-analysis, the selection of sources, while extensive, is not exhaustive and may be subject to selection bias favouring more widely reported or English-language-accessible studies. Second, the prevalence data compiled in Section 5 derive from studies employing markedly different diagnostic instruments, sampling frames, and time periods spanning nearly two decades (roughly 2007–2026); these figures should therefore be interpreted as indicative of broad regional patterns rather than as directly comparable point estimates suitable for formal meta-analytic pooling. Third, much of the most granular border-specific data — particularly from the Kashmir Line of Control and the Gaza-envelope towns — derives from surveys conducted by advocacy-oriented or trauma-focused non-governmental organisations (Médecins Sans Frontières, NATAL) rather than from independently peer-reviewed academic studies, which may introduce methodological and framing biases not fully assessable from available published summaries. Fourth, this paper's regional focus, while deliberately comparative, cannot claim global representativeness; border conflict dynamics in, for example, the Korean Demilitarized Zone, the Democratic Republic of Congo–Rwanda border, or the U.S.–Mexico border present distinct political, economic, and psychosocial configurations not directly addressed here. Finally, the conceptual framework proposed in Section 3, while grounded in the reviewed literature, has not itself been empirically tested through primary data collection within this paper and should be understood as a synthesising heuristic for future empirical research rather than a validated causal model.

11. Conclusion

This paper has argued that populations living along active or intermittently active international borders experience a psychological and social condition that is analytically distinct from both

single-incident trauma and from the trauma documented in the interior of active war zones. Chronic, unpredictable exposure to shelling and cross-border violence produces individual psychiatric morbidity at rates substantially exceeding both national and broader conflict-zone baselines, with border-proximate populations in Kashmir showing depression prevalence up to 30 percentage points higher than non-border populations in the same state, and children in Israel's Gaza-envelope towns showing PTSD symptom rates as high as three to four times the national average even during periods of relative calm. This individual trauma is compounded, rather than simply aggregated, at the community level into a form of collective anxiety that reshapes shared narratives, social trust, and collective identity. Crucially, this paper has argued that the resulting "erosion of everyday normalcy" is not merely a negative absence — the loss of ordinary life — but an active, adaptive reconstruction of a provisional, defensive version of normal life around chronic, unresolved threat. This reconstructed normalcy, while representing a genuine and often admirable form of community resilience, simultaneously functions as a mechanism that can obscure the true scale of accumulated psychological harm from policymakers, donors, and even from affected populations themselves. Addressing this condition adequately will require mental health and livelihood interventions integrated at the community level, sustained rather than time-limited international support, and, ultimately, diplomatic and political resolution of the underlying border disputes that no local or humanitarian intervention can substitute for.

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