

Play-Based Interventions for Children's Mental Health and Psychosocial Well-being

Evidence from Conflict and Crisis-Affected Settings



Children outside a school in Zambo, Malawi.
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Children affected by armed conflict, displacement, and other humanitarian crises face elevated risk of mental health and psychosocial difficulties, often with limited access to clinical care. Play-based psychosocial support (PSS) interventions—programs that use structured or facilitated play, creative arts, sport, movement, and expressive activities to promote mental health—are a common response because they can be delivered by non-specialist staff in non-clinical, resource-constrained settings where trained mental health professionals are scarce. This review synthesizes evidence from 31 studies on the effectiveness of these interventions, published between 2001 and 2025 (see Methodology and Scope for further detail on sources and inclusion criteria).

The evidence shows that play-based programs usually improve children's general well-being and social connection. Effects on clinical symptoms such as post-traumatic stress disorder (PTSD), depression, and anxiety are far less consistent. Harm is also documented in two forms. In some programs, participants did worse on average than children who did not receive the program. In others, the program looked successful on average, but that average masked harm to specific children within it, helping most children while leaving some worse off than before. The evidence on when and why harm occurs is thin, and this review treats that as a reason for caution.

Key Takeaways

- PSS interventions most reliably improve children's quality of life, sense of belonging, and psychosocial functioning.
- Effects on PTSD, depression, anxiety, and externalizing behaviors are frequently null, often modest where positive effects appear, and occasionally negative.
- Most programs combine play with psycho-education, group activities, structured facilitation, and are delivered in child-friendly and safe spaces. The evidence cannot separate play's contribution from everything else happening in the program.

Photo Credit: Name / Organization

Impact of Play-based Programs in Children's Mental Health and Psychosocial Well-Being

Evidence suggests play-based interventions can improve well-being, quality of life, psychosocial functioning, and social connection

Evidence suggests that play-based programs can improve children's general well-being, quality of life, psychosocial functioning, and social connection. For example, the TeamUp program in Uganda improved emotional and psychosocial well-being and social connectedness relative to a comparison group (Bleile et al., 2024; see case study below). Of the studies included in this evidence review, 12 directly measured these outcomes. Eight of the 12 (about two-thirds) found the program had a positive effect, while the others found no clear change or found that the effects differed across groups. In practice, these outcomes describe how a child is doing day to day: mood, sense of belonging and safety, quality of friendships, and engagement in school and family life, rather than a clinical diagnosis.

Recent studies across Uganda, the Palestinian territories, and other conflict-affected and refugee-serving settings have found similar improvements across a range of program models, from movement-based group activities to structured classroom curricula that include drama, movement, and cooperative games. While the outcomes and effects vary across studies, positive results have been reported in areas such as emotional well-being, health-related quality of life, social connectedness, resilience, and relational capacities.

Case Study TeamUp in Uganda

Research: Evaluating a Movement-Based Mental Health Promotion Intervention for Refugee Children in Uganda: A Quasi-Experimental Study (Bleile et al., 2024)

Location: Bidibidi refugee settlement, Uganda | 549 children, ages 10–15 | Quasi-experimental

What was the program? Children participated in 45–60 minute sessions twice a week for six weeks, using group games, dance, movement, songs, breathing exercises, and body-awareness activities. Ten community facilitators delivered the sessions after five days of training.

What improved? Compared with children who did not participate, children in TeamUp showed small improvements in emotional and psychosocial well-being, traumatic stress, quality of life, physical health, social connection, attitudes toward school, and sense of agency.

What did not improve? There were no clear improvements in depressive symptoms, irritability, bullying, friendships, or body awareness.

Did all children benefit? Results were less positive for girls and children with higher levels of depressive symptoms. Children who did not participate experienced a decline in emotional and psychosocial well-being during the same period.

Girls playing peekaboo outdoors.
Credit: Riccardo Mayer / Shutterstock.



Despite these gains, evidence suggests play-based PSS has limited direct effects on clinical PTSD, depression, and anxiety

The evidence on clinical outcomes is far less consistent. Clinical outcomes refer to diagnosable symptoms measured on standardized scales, primarily PTSD, depression, and anxiety, as distinct from the broader well-being outcomes above. Among the primary studies in this review that estimated these effects directly, only about a third of clinical-outcome measurements (9 of 25, across PTSD, depression, and anxiety) found a positive effect; most found no significant effect. Two meta-analyses reinforce this pattern at a larger scale: A meta-analysis of 60 studies found inconsistent, sometimes counterproductive, effects specifically for psychosocial programs built around creative and expressive activities (Bangpan et al., 2024), and an individual participant data meta-analysis of psychosocial interventions for conflict-affected children generally found essentially no effect on depression and anxiety (Purgato et al., 2018), suggesting the ceiling on clinical-outcome improvement is not specific to play-based approaches.

Case Study: School-based Intervention in Indonesia

Research: School-Based Mental Health Intervention for Children Affected by Political Violence in Indonesia: A Cluster Randomized Trial (Tol et al., 2008)

Location: Poso district, Central Sulawesi, Indonesia | 495 children, mean age 9.9 years | Cluster randomized evaluation

What was the program? Children participated in 15 school-based sessions over five weeks, combining trauma-processing activities, cooperative play, and creative and expressive activities. Locally trained paraprofessionals delivered the sessions.

What improved? Compared with children on a waitlist, children who participated showed larger improvements in PTSD symptoms and hope. Six months later, PTSD symptoms had decreased by 49.5 percent among children who received the program, compared with 27.5 percent among children on the waitlist.

What did not improve? The program did not lead to clear improvements in depressive symptoms, anxiety, daily functioning, or trauma-related experiences.

Did all children benefit? The study did not examine whether the effects differed for different groups of children. Importantly, children on the waitlist also improved over time, although their improvement in PTSD symptoms was about half as large as that of children who received the program.



Programs built around social connection and agency tend to outperform generic activity-based designs

Where studies have tested why play-based programs work, the evidence points less to the activity itself and more to two underlying mechanisms: social connection and a sense of agency. For example, a mediation analysis of the TeamUp program found that social connectedness explained 15 percent of the variance in well-being gains at five-month follow-up (Jordans et al., 2024). A systematic review of mediation analyses across four school-based randomized evaluations found that improvements in peer relations and the learning environment partially mediated mental health and well-being outcomes, while improvements in individual emotional regulation and coping skills—the outcomes most curricula explicitly target—did not mediate outcomes at all (Bosqui et al., 2022).

Play-based PSS takes many forms, and the evidence directly comparing one design feature against another is limited. The patterns below should be read as suggestive, not as established causal guidance.

What The Evidence Favors

- **Cooperative games:** Activities that require children to work toward a shared goal are more consistently linked to social-connection gains than individual or competitive formats.
- **Movement-based coordination activities:** Non-verbal, movement-based formats such as TeamUp appear effective across linguistic and cultural groups without requiring disclosure of personal experience.
- **Drama and storytelling built around shared narrative:** Group-based dramatization and storytelling, framed around collective rather than individual experience, support group identity without requiring individual trauma disclosure.

Where The Evidence Counsels Caution

- **Competitive sport without an explicit psychosocial framing:** The one randomized evaluation in this evidence base with a clear net-negative effect was a competitive league where peace-building content was not consistently delivered in practice.
- **Individual expression disconnected from a relational context:** Solitary drawing or journaling, without facilitation or peer connection, is not supported by the mechanisms (social connection, agency) that drive outcomes elsewhere in this evidence base.
- **Trauma re-enactment without a clinical capacity to contain:** Asking children to dramatize or narrate traumatic experience carries a documented risk of destabilizing rather than helping (see the Wessells framework below).

Case Study: Huggy Puppy intervention in Israel and Bangladesh

Research: Young Children's Reactions to War-Related Stress: A Survey and Assessment of an Innovative Intervention and Evaluation of an Innovative Intervention for Traumatized Children from a Low Resourced Country (Sadeh et al., 2008; Deeba & Rapee, 2015)

Location: Israel | 292 children (191 intervention, 101 comparison) | Bangladesh replication with children in institutional shelter care who had experienced severe trauma

What was the program? Children received a stuffed toy and were encouraged to comfort it when it was sad or frightened. In Bangladesh, an enhanced version also guided children to say positive statements about themselves, others, and the future while caring for the toy.

What improved? Compared with children on a waitlist, children who participated showed larger improvements in PTSD symptoms and hope. Six months later, PTSD symptoms had decreased by 49.5 percent among children who received the program, compared with 27.5 percent among children on the waitlist.

What did not improve? The program did not lead to clear improvements in depressive symptoms, anxiety, daily functioning, or trauma-related experiences.

Did all children benefit? The study did not examine whether the effects differed for different groups of children. Importantly, children on the waitlist also improved over time, although their improvement in PTSD symptoms was about half as large as that of children who received the program.

The risk of creating harm

Play-based programs can also cause harm

For example, a randomized evaluation of a competitive, community-based football league in Gulu, Uganda, found that boys assigned to the league showed significantly worse mental health than boys on a waitlist, with depression-like symptoms increasing by an effect size of 0.67 sd and anxiety-like symptoms by 0.63 sd in the Acholi Psychosocial Assessment Instrument; the waitlist group's mental health improved over the same period (Richards et al., 2014). The league was not simply football: it paired football with a formal peace-building curriculum, delivered by coaches trained in both, and awarded trophy points across football results, on-field behavior, peace-building activities, and community service. Despite this design, the authors report that most coaches and participants emphasized football performance in practice, and they explain the harm to boys as most likely mediated by emotional stressors associated with competition, a risk they suggest was heightened because armed conflict had been the boys' only previous reference point for physical contest. A mediation analysis of the same Indonesia evaluation referenced above found that the program significantly increased children's play-based social support relative to a waitlist comparison, but that increases in play social support were associated with smaller reductions in PTSD symptoms, not larger ones (Tol et al., 2010). Tol and co-authors (2010) argue that for children with more severe PTSD symptoms at the start of the intervention specifically, engaging in play-based social support may have been functioning as a way of avoiding the kind of direct trauma processing that supports recovery, rather than aiding it.

Case Study: Competitive Football League

Research: Physical Fitness and Mental Health Impact of a Sport-for-Development Intervention in a Post-Conflict Setting: Randomised Controlled Trial Nested within an Observational Study of Adolescents in Gulu, Uganda (Richards et al., 2014)

Location: Gulu, Uganda | 1,462 students | Randomized evaluation nested within an observational study

What was the program? Students took part in a voluntary, competitive community football league over 11 weeks. Thirty-two volunteer coaches delivered the program after two weeks of training in coaching and peace-building.

What improved? The program did not lead to improvements in physical fitness or mental health. In contrast, the waitlist comparison group showed improvements in mental health over the same period.

What did not improve? Depression-like symptoms and anxiety-like symptoms worsened among students in the intervention group, with standardized effect sizes of 0.67 and 0.63, respectively. These represent moderate-sized differences between the intervention and comparison groups.

Did all children benefit? The negative effect was observed across the entire intervention group of boys, rather than being limited to a particular subgroup.

Children playing soccer in Taouloukoul, Morocco.
Credit: Dziurek / Shutterstock.



This risk is not confined to programs with a negative effect on average

For example, a randomized evaluation of communities in northern Sri Lanka found no clear effects on PTSD, depression, or anxiety overall. However, girls who participated in the program showed smaller reductions in PTSD symptoms than girls who were waiting to receive it, suggesting that the program may have had a negative effect for girls even though there was no overall effect (Tol et al., 2012). The Indonesia study provides another example. Although the program had a positive effect on PTSD symptoms overall, children who started with more severe symptoms actually had worse outcomes after taking part in the program.

More broadly, several studies show that the same program can affect different groups of children in different ways. The pattern varies across settings: gender was linked to different outcomes in the Indonesia and Sri Lanka studies, while household composition and displacement status affected results in Burundi (Tol et al., 2014). A study in Nepal also found different effects by gender and age, even though there was no clear effect for the group as a whole (Jordans et al., 2010). Not all of these differences indicate harm—sometimes a program simply helps some children more than others. Together, however, these findings show that a positive result overall can hide very different experiences among individual children. Most studies and program monitoring systems are not designed to identify these differences at the level of individual children. Similarly, research with Syrian refugee children in Lebanon identified seven different groups of children with distinct patterns of psychological well-being, linked to factors such as gender, exposure to conflict, and school experiences (Aber et al., 2024). This suggests that children affected by conflict are not a single, uniform group, and that the same program may not work equally well for all children.

Case Study: School and Group-based Mental Health Intervention in Sri Lanka

Research: Outcomes and Moderators of a Preventive School-Based Mental Health Intervention for Children Affected by War in Sri Lanka: A Cluster Randomized Trial (Tol et al., 2012)

Location: Northern Sri Lanka | 399 communities | Cluster randomized evaluation

What was the program? Children participated in 15 school-based sessions combining cognitive behavioral techniques with drama, drawing, and cooperative games. Trained paraprofessionals delivered the sessions.

What improved? The program led to a significant reduction in conduct problems, particularly among younger children.

What did not improve? There was no clear overall effect on PTSD, depression, or anxiety for the full group of children.

Did all children benefit? Younger children showed greater improvements in conduct problems. However, girls did not benefit in the same way: girls who received the program had smaller reductions in PTSD symptoms than girls in the waitlist comparison group.

What does this tell us? The overall results were mostly neutral, but the findings suggest that the program affected different groups of children differently. In particular, the negative result for girls was hidden by the lack of an overall effect.



This risk is not unique to play-based programs.

Wessells (2017) argues that most humanitarian psychosocial programming for children, despite good intentions, has unintended consequences, and identifies five categories of harm.¹ All five warrant ongoing attention, but one is especially relevant here: picking open children's psychological wounds, since expressive and narrative activities can destabilize rather than heal when they prompt children to revisit traumatic experiences without adequate support. Wessells (2017) also argues against treating conflict-affected children as one homogeneous group, calling instead for approaches tailored to age, vulnerability, and gender, and stresses the need to build on protective factors available in the context and create local ownership.

Girl blowing soap bubbles outdoors. Credit: Riccardo Mayer / Shutterstock.



¹ Wessells (2017) identifies that the main sources of unintended harm in MHPSS and peacebuilding support for children affected by conflict are: (1) discrimination by choosing the specific areas, age groups, gender, ethnic groups where humanitarian programs are delivered resulting in specific groups not receiving support; (2) reaching orphanages first, and focusing the efforts on improving the quality of those spaces, rather than working with the living family members, further separates children from their families; (3) raising expectations creating frustration and abandonment; (4) dependency on external organization or support rather than building on local resources and enhancing local capacities, undermines the sense of agency and collective self-efficacy, and leaves them at risk of not being able to provide long-term wellbeing; and (5) picking open children's psychological wounds.

Areas for Further Research and Action

While evidence on PSS interventions is growing, the range of impacts in these types of interventions and several open questions limit what this evidence base can currently support. Future research could seek to address three specific questions that would strengthen the evidence base for this type of intervention. First, there is a need to understand what the long-term effects of play-based PSS are. Only the TeamUp follow-up study (Jordans et al., 2024) provides evidence of sustainability beyond the immediate post-intervention period. Second, most evaluated programs combine several components, and the evidence cannot yet separate play's specific contribution from the rest of the program. More clear evidence on how play interacts with other program elements, including psycho-education and trauma-focused cognitive behavioral therapy, would strengthen the case for play-based interventions. Lastly, almost all evidence is for school-age children; early childhood in humanitarian settings remains an evidence gap.

Play-based PSS has an uncertain evidence base, faces many open questions, and carries a real risk of harm. Closing these gaps requires more than academic research: it requires program monitoring and learning built into delivery itself. Programs need the capacity to detect early signs that a child is not benefiting or is being harmed, before it is too late. They need to respond to differences across children by design, building in enough specificity to see who is not responding and enough flexibility to act on it. And they need to adjust in real time, adapting activities and escalating concerns as they are observed, which in turn requires building local capacity to do this work, not simply collecting data.

Conclusion

Play-based programming has the potential to bring real benefits to conflict-affected children, most reliably for their general well-being and social connection. This evidence should not be read as a license to treat PSS as a magic bullet: its effects on clinical outcomes are inconsistent, harm is documented though not yet well understood, and the same program can help most children while leaving some behind. The most responsible use of this evidence is not confidence, but attentiveness to who is and is not benefiting, and to the possibility of harm, as programs are delivered.

Methodology and Scope

This review draws on a structured screening of 53 papers examining mental health and psychosocial interventions for children affected by conflict, displacement, or other humanitarian crises, coded across variables including conflict or humanitarian context, low- or middle-income country status, study design, comparison group presence, sample size, and outcome domain (PTSD, depression, anxiety, externalizing behavior, social-emotional learning, well-being and quality of life, functional impairment, and psychological distress).

Of the 53 papers screened, 31 met inclusion criteria requiring a play-based, arts-based, or closely related recreational or expressive component and child-focused outcome measurement; one of these, Aber et al. (2024), is a descriptive profiling study included for context rather than as a test of a play-based intervention. Papers were excluded for reasons including absence of a comparison group or non-conflict-affected populations. The included evidence spans randomized evaluations, quasi-experimental evaluations, systematic reviews, and meta-analyses published between 2001 and 2025, across conflict and humanitarian settings in Uganda, Sri Lanka, Burundi, Indonesia, Nepal, Bangladesh, Lebanon, Jordan, Israel, the Palestinian territories, and other low- and middle-income and refugee-serving contexts. One additional conceptual source outside the formal screening, Wessells (2017), is also cited to provide a broader framework for understanding programmatic risk of harm. These findings were also complemented by an interview with Michael Wessells, an expert in the field, whose reflections informed the discussion of programmatic risk of harm below.

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***This brief is not an exhaustive review of all the rigorous evidence on this topic.**

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