

Psychosocial and mental health interventions for children and adolescents in conflict: A systematic mapping review

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Abstract

With nearly one in six children globally living in conflict zones, evidence-based mental health and psychosocial support (MHPSS) is crucial. This systematic mapping review with narrative synthesis followed the PRISMA 2020 guidelines to synthesize fifty-six studies examining in-country interventions for conflict-affected youth under 25 from 1990 to 2025. The studies were mostly conducted in the global South and utilized various methods, including Teaching Recovery Techniques, trauma-focused cognitive behavioural therapy, and school-based programmes.

The findings were mixed. While twenty-five studies reported positive outcomes regarding post-traumatic stress symptoms (PTSS), anxiety and social functioning, the effects often diminished over time, and long-term data (>6 months) remains scarce. The review identified three critical success factors: multilayered stepped-care models, task-sharing with trained lay workers, and family engagement. To be effective, cultural adaptation and age-appropriate tailoring were essential; efforts in this regard ranged from play-based interventions for younger children to structured therapies for adolescents.

The evidence base is limited by methodological heterogeneity and short follow-up periods. To bridge the research–practice gap, future efforts must prioritize longitudinal evaluations and stronger collaboration between researchers and humanitarian actors to ensure that interventions effectively mitigate the long-term impacts of conflict.

Keywords: armed conflict, conflict, systematic mapping review, intervention, mental health, children and youth.

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Introduction

Mental health and psychosocial support (MHPSS) programmes are essential to humanitarian aid, including those focused on the psychological well-being and social functioning of children, adolescents and youth affected by conflict. This review systematically synthesizes the current literature to identify and evaluate the efficacy, design and implementation challenges of MHPSS interventions for young people in conflict and post-conflict settings. The supplementary materials for this review are available at: <https://osf.io/9et73>.

Children in conflicts

The global situation for humanitarian aid is increasingly defined by the severe impact of armed conflict on civilians, with children, adolescents and youth being

particularly affected. According to UNICEF,¹ over 473 million children are living in conflict zones, representing nearly one in six children worldwide. Living in such areas is often severely damaging to individuals and communities. UNICEF's executive director highlighted the year 2024 as one of the most challenging years on record due to the unprecedented number of children affected and the severe impact on their lives.²

Children in conflict zones experience international law violations and violence directly and indirectly. They are confronted with loss of family members, friends and familiar support structures, as well as injuries and the loss of, or lack of access to, essential services such as health care and education. In addition, children in conflict areas are exposed to profound immediate and lasting trauma. The origins of such trauma and stress range from direct warfare exposure to the effects of challenges in caregiving associated with adults' emotional distress. This often results in mental disorders such as post-traumatic stress disorder (PTSD) or more general post-traumatic stress symptoms (PTSS), as well as anxiety and depression.³ For children who are internally displaced or forced to migrate, the trauma stemming from exposure to conflict-related violence is compounded by the loss of their home, parents and relatives, identity, and social networks – losses that are themselves significant sources of trauma directly linked to the conflict, and that often lead to a heightened risk of chronic stress and anxiety.⁴ The omnipresent exposure to violence and loss can fundamentally alter a child's cognitive, emotional and social development.⁵

The Uppsala Conflict Data Program (UCDP) – which uses a different typology than international humanitarian law's terminology when it comes to conflict classification – categorizes conflicts into three groups:⁶ State-based armed conflict (both inter-State and intra-State), non-State armed conflict and one-sided violence. State-based armed conflict involves the use of armed forces by at least two parties, one of which is the government of a State. An inter-State conflict involves two or more States, and an intra-State conflict occurs between a State government and an organized, non-State opposition within the State's territory. Non-State armed

1 UNICEF, “‘Not the New Normal’ – 2024 ‘One of the Worst Years in UNICEF’s History’ for Children in Conflict”, 28 December 2024, available at: <https://www.unicef.org/press-releases/not-new-normal-2024-one-worst-years-unicefs-history-children-conflict> (all internet references were accessed in May 2026).

2 *Ibid.*

3 Rochelle L. Frounfelker *et al.*, “Living through War: Mental Health of Children and Youth in Conflict-Affected Areas”, *International Review of the Red Cross*, Vol. 101, No. 911, 2019; Kenneth E. Miller and Mark J. D. Jordans, “Determinants of Children’s Mental Health in War-Torn Settings: Translating Research Into Action”, *Current Psychiatry Reports*, Vol. 18, No. 6, 2016.

4 Kenneth E. Miller and Andrew Rasmussen, “War Exposure, Daily Stressors, and Mental Health in Conflict and Post-Conflict Settings: Bridging the Divide between Trauma-Focused and Psychosocial Frameworks”, *Social Science and Medicine*, Vol. 70, No. 1, 2010.

5 Bessel A. van der Kolk, *The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma*, Penguin Books, New York, 2015.

6 UCDP, “UCDP Definitions”, Uppsala University, 2024, available at: www.uu.se/en/department/peace-and-conflict-research/research/ucdp/ucdp-definitions; Magnus Öberg, “Mapping Global Violence: The Uppsala Conflict Data Program”, *One Earth*, Vol. 8, No. 9, 2025.

conflicts involve the use of armed force between two organized, non-State groups that is persistent and results in battle-related deaths (e.g., drug cartels). One-sided violence refers to the use of armed force by a State government or an organized non-State group against unarmed civilians, often targeting specific groups based on identity.⁷ This article will refer to the UCDP's classification, without this implying that the contexts referred to constitute armed conflicts to which international humanitarian law would be applicable.

The situation of children affected by conflict is a core humanitarian issue which may also amount to a serious violation of their fundamental children's and human rights as established by international law, in particular but not limited to the United Nations Convention on the Rights of the Child (CRC).⁸ Given that these laws are readily violated in conflicts, the question emerges: if conflict and harm is unavoidable, how can children be assisted in recovering from trauma and to prevent or mitigate (mental) health problems from arising?

The role of mental health and psychosocial support in conflicts

In response to the growing number of conflicts and humanitarian crises occurring around the world, MHPSS has emerged as a critical component that is relevant not only to acute humanitarian aid but also to the broader humanitarian-development-peace nexus, including development, peacebuilding and transitional justice efforts, as described by, for example, the German Federal Ministry for Economic Cooperation and Development.⁹ The Inter-Agency Standing Committee (IASC) defines MHPSS as a layered system of care that promotes psychological well-being, reduces distress and prevents long-term mental health problems.¹⁰ It integrates four levels of support: (1) basic services and security to meet essential needs, (2) community and family support, (3) non-specialized care by trained workers, and (4) specialized clinical services.¹¹ This multi-tiered approach combines community-led initiatives with formal health systems to strengthen resilience and recovery.

The base of the pyramid focuses on integrating mental health and psychosocial considerations into basic services and security. This includes ensuring that the provision of food, shelter, water and sanitation is carried out in a way that is dignified, culturally sensitive and safe. Tier 2 builds upon this foundation by strengthening existing community and family support; this involves community-led initiatives, activation of social networks, and support for positive coping mechanisms and communal healing practices. This is followed by the provision

7 UCDP, above note 6; M. Öberg, above note 6.

8 Convention on the Rights of the Child, 1577 UNTS 3, 20 November 1989 (entered into force 2 September 1990).

9 Federal Ministry for Economic Cooperation and Development in Germany, *The Humanitarian-Development-Peace Nexus in Practice – a Literature Review*, Berlin, May 2021.

10 IASC, *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, Geneva, 2007.

11 *Ibid.*

of focused, non-specialized support to individuals and families, often delivered by trained front-line workers who are not necessarily mental health specialists. Key interventions at this level include psychological first aid, stress management programmes, and structured psychosocial activities in settings like schools or other child-friendly spaces. Finally, the top of the pyramid consists of specialized clinical services for individuals with severe mental health conditions. This is a crucial, though less prevalent, level of care provided by qualified mental health professionals such as psychiatrists and psychologists. The IASC model stresses that these four tiers are not sequential steps but rather are complementary services that should be provided simultaneously to meet the diverse and dynamic needs of a population in crisis.

Aim and scope of review

While numerous studies have documented the devastating impacts of conflict on children's lives and well-being, a significant evidence gap exists with regard to what MHPSS interventions work best in what specific context. Existing literature is often fragmented, with studies varying widely in methodology, context and focus. There is a particular lack of robust evidence on the effectiveness of non-specialized, community-based MHPSS interventions, which are the most widely implemented in humanitarian settings.

The primary aim of the present systematic mapping review is twofold: to synthesize the scientific literature on the documented impacts of conflict on the well-being of children, adolescents and youth, and to likewise synthesize the literature on state-of-the-art approaches to addressing these challenges. The review focuses specifically on studies examining MHPSS interventions targeting children, adolescents and youth affected by conflict. A core objective is to critically assess the methodological quality of the evidence beyond simply synthesizing findings; such comprehensive, up-to-date review is urgently needed to inform evidence-based, scalable MHPSS intervention practices and policies, strengthen MHPSS provision for children, adolescents and young people in ongoing conflicts, and inform further discussions, research and development of MHPSS responses benefiting children and young people in conflict zones.

Methodology

This systematic mapping review with narrative synthesis was conducted following the PRISMA 2020 guidelines.¹² Given the heterogeneity of populations, interventions, outcomes and study designs, a mapping approach was chosen to synthesize what types of interventions exist, how they have been studied and where gaps remain. In multiple phases, the relevant literature addressing MHPSS interventions

12 Matthew J. Page *et al.*, "The PRISMA 2020 Statement: An Updated Guideline for Reporting Systematic Reviews", *BMJ*, Vol. 372, 2021.

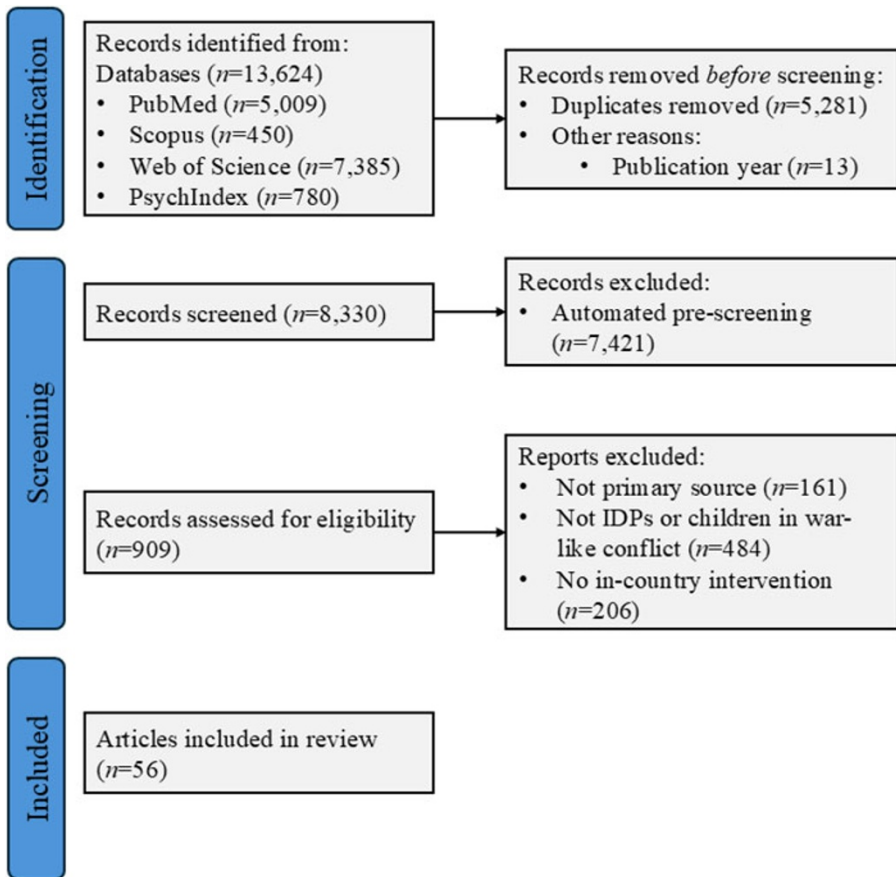


Figure 1. PRISMA flow diagram.

for children, adolescents and youth affected by conflict was identified, screened and analyzed. The process of this systematic mapping review followed a “funnel” structure, beginning with broad searches in databases using key terms (see the supplementary materials) and progressively narrowing down the results based on set criteria to arrive at a collection of relevant studies. Figure 1 describes these steps in more detail.

Prior to the identification of relevant articles, criteria were defined related to population, intervention focus, setting, language, and publication characteristics. The population of interest for this review comprised children, adolescents and youth, defined as individuals under 25, consistent with the United Nations (UN) definition of youth, which traces back to the International Youth Year in 1985.¹³ This

¹³ See UNGA Res. 36/28, 13 November 1981; *International Youth Year: Participation, Development, Peace: Report of the Secretary-General*, UN Doc. A/36/215, 19 June 1981.

definition has been in use by the UN ever since, and current UN statistics are also based on it. While the target population was individuals under 25, two studies were retained where participants slightly exceeded this threshold (up to age 30) because the majority of the study sample fell within the defined age range. The population included specifically internally displaced people (IDPs) and individuals residing in conflict zones; however, parents, caretakers and other stakeholders who are in contact with children and young people in conflict zones were also included.

The intervention focus was narrowed down to MHPSS, including trauma-related interventions, social support, and community-based mental health programmes. The articles included in the review are peer-reviewed primary studies, published after 1990 and in English. Another inclusion criterion was that the studies reported on in-country interventions, meaning those delivered within the country where the conflict occurred or was ongoing. This also includes populations displaced to safer areas within the country, who continue to face the consequences of conflict exposure as well as additional displacement-related stressors. Both active conflict and post-conflict settings were considered. Exclusion criteria were interventions delivered outside the conflict-affected country or region (e.g., resettlement countries) and reviews or meta-analysis.

Four databases were searched: PubMed ($n=5,009$), Scopus ($n=450$), Web of Science ($n=7,385$) and PsychIndex ($n=780$). The searches were conducted using Boolean strings with similar key terms but specified for each database. The first string included the population, the second narrowed down the context, the next included MHPSS terms, and lastly the age was specified to receive relevant outcomes in the database. The search strategy combined four main concept blocks. The population block included terms such as “child”, “adolescent”, “young adult”, “refugee” and “internally displaced people”, while the context block covered exposures related to armed conflict, war, forced migration, violence, abduction, kidnapping, threat and resilience. The outcome block focused on MHPSS, mental health, psychosocial support, trauma, community-based interventions and social support, and finally, a youth filter was applied with terms such as “adolescent”, “young adult”, “youth”, “young people”, “under 25”, and “under 18”. As an example, the PubMed search string was: (child*[tiab] OR adolescent*[tiab] OR “young adult”[tiab] OR refugee*[tiab] OR “internally displaced people”[tiab] OR “internal displacement”[tiab]) AND (armed conflict[tiab] OR war[tiab] OR frontline[tiab] OR “forced migration”[tiab] OR abduction[tiab] OR kidnapping[tiab] OR threat[tiab] OR violence[tiab] OR resilience[tiab]) AND (MHPSS[tiab] OR “mental health”[tiab] OR “social support”[tiab] OR trauma[tiab] OR “community based intervention”[tiab]) AND (adolescent*[tiab] OR “young adult”[tiab] OR youth[tiab] OR “under 25”[tiab] OR “under 18”[tiab]). Strings were adapted for Scopus, Web of Science and PsychIndex. Full search strings for each database are provided in the supplementary materials.

The initial number of search results across all databases was 13,624. These were imported into Zotero reference management software, and its duplication detection feature was used to merge identical records. Afterwards, 8,343 articles remained. Thirteen records were excluded because they were published before

1990. The next step included an automated pre-screening based on a custom Python script, developed using Cursor (an AI-assisted coding environment), to perform keyword-based filtering of titles and abstracts. The script matched titles and abstracts against the same concept blocks used in the database searches (population, context, MHPSS and age terms) and flagged records that did not contain sufficient keyword overlap for exclusion. Importantly, this step served only as a pre-screening aid; all flagged exclusions and retained records were subsequently verified manually by the researchers. The script is accessible in the supplementary materials.

After the automated exclusion, 3,182 records were left. A manual screening of titles and abstracts was then conducted, and it narrowed down the results to 1,179. From these, 748 articles were selected for the full-text screening, which then further narrowed the number down to 264 eligible studies that aligned with our focus on children, adolescents and youth in conflict zones. Lastly, studies were assessed for alignment with the criterion of in-country implementation. This resulted in a final sample of fifty-six studies that met all inclusion requirements. Throughout the screening process, one author led the identification and extraction of studies, while all co-authors independently double-checked each study before final inclusion. Disagreements were resolved through consensus discussion. References of all included studies were also screened to identify additional relevant papers.

For data extraction, an Excel spreadsheet was developed to systematically extract key information from each study. Extracted data included population demographics, conflict type and setting, the type, duration and delivery method of the MHPSS intervention, study design and methods, mental health or psychosocial outcome measured, and key findings and limitations. Intervention duration was categorized as short (up to four weeks), medium (four to eight weeks) or long (more than eight weeks).

Methodological quality was assessed using the Mixed Methods Appraisal Tool (MMAT, version 2018).¹⁴ The fifty-six included studies comprised randomized controlled trials ($n=16$), non-randomized studies ($n=7$), quantitative descriptive studies ($n=24$), qualitative studies ($n=8$), and one mixed-methods study. All studies met both screening criteria (S1 and S2). Across the category-specific quality criteria (Q1–Q5), the majority of ratings were positive. Where criteria could not be fully verified based on the available reporting, most commonly with regard to representativeness of the sample (Q2) and the control of potential influencing variables (Q4), ratings of “can’t tell” were assigned. In these cases, the assessment gave the benefit of the doubt to the authors, assuming sound research practices where reporting was limited rather than absent. “No” ratings were rare and concentrated on Q4, reflecting the scarcity of blinding of outcome assessors, as well as limited long-term follow-up beyond six months. Detailed MMAT ratings for each study are provided in the supplementary materials.

14 Quan Nha Hong *et al.*, “The Mixed Methods Appraisal Tool (MMAT) Version 2018 for Information Professionals and Researchers”, *Education for Information*, Vol. 34, No. 4, 2018.

Results

The following sections provide an overview of the findings from the fifty-six included studies, summarizing study characteristics, geographic and conflict contexts, intervention types, and measured outcomes. Results are organized to first provide an overview of included studies, followed by impacts on MHPSS, reported outcomes, and effectiveness. For an overview of all studies, see [Table 1](#).

Study context and demographics

The publication year of the included studies ranges from 2000 to 2024, with a peak between 2015 and 2022. Studies are geographically diverse, but with a focus on the global South (>80%); for an overview, see [Figure 2](#). The geographic distribution concentrates in South Asia ($n \sim 12$, predominantly India) and the Middle East and North Africa region ($n \sim 20$, predominantly Palestine and Israel). Additionally, research was conducted in sub-Saharan Africa, including Sierra Leone, Uganda and the Democratic Republic of the Congo, as well as East and Southeast Europe ($n \sim 5$, Ukraine and Bosnia). Other countries chosen for research were Afghanistan, Colombia, South Africa, Indonesia and Brazil, along with some multi-country settings.

Across the studies included, most interventions are conducted in state-based conflicts as defined by the UCDP. As indicated above, the UCDP uses a typology which is different from international humanitarian law for the purposes of conflict classification and for determining whether that body of rules applies. Specifically, thirty-three studies took place in internationalized intra-State conflicts, fifteen in intra-State conflicts, and four in inter-State conflicts, as visualized by [Figure 3](#). One study addresses non-State violence, and three do not specify the conflict type. In connection with this, (internal) forced displacement as well as host-refugee integration is a recurring topic in the included studies.

The sample sizes (participants in interventions) are not normally distributed and range from ten to 29,292. The median is 190 participants. Eleven studies have fewer than fifty participants, fifteen studies have between fifty and 199 participants, and twenty-three studies include 200 or more participants. Larger samples are more common in school-based trials, while smaller are more prevalent in pilot psychosocial programmes. The age of intervention participants ranges from early childhood (2–7, $n=3$) to early adulthood (>20, $n=13$). Most studies focus on school-aged children and adolescents (6–18, $n=36$), and some include mixed-age groups spanning children, adolescents and adults, or are not specified ($n=9$). For an overview, see [Figures 4, 5 and 6](#).

Key impacts on well-being and mental health

The impact of conflict on child, adolescent and youth well-being that is emphasized in the studies can be categorized into four key areas: physical health impacts,

Table 1. *Structural overview of the incorporated studies*

First author, year	Target group	Age	N	Conflict	Type of conflict	Conflict duration	Intervention type	Location	Duration	Provider	Onset	Unit
Betancourt <i>et al.</i> (2014)	War-affected youth	15–24	436	Sierra Leone	Intra-State	1991–2002	Focused psychological support	Community, family	Long	Lay health workers	After	Group
Malla <i>et al.</i> (2019)	Lay health worker training	14–20	40	Kashmir	Internationalized intra-State	1947–ongoing	Focused psychological support, skills-building	Online, community	Long	Community and NGO	Before, during, after	Indiv, group
Luttenberger <i>et al.</i> (2024)	Forcibly displaced adolescents	14–18	233	Syria	Internationalized intra-State	2011–ongoing	Skills-building, recreational activities	Community	Medium	Community and NGO	During, after	Group
Karibwende <i>et al.</i> (2022)	Orphaned and abandoned children	6–15	72	Rwanda	Intra-State	1990–1994	Focused psychological support	Group sessions, SOS children's village	Long	Mental health professionals	After	Group
Berger <i>et al.</i> (2016)	Students	8–12	200	Israel	Internationalized intra-State	1947–ongoing	Skills-building, social and emotional learning	School	Long	Educational staff	After	Group
Ahmadi <i>et al.</i> (2024)	Female adolescents	12–18	63	Afghanistan	Internationalized intra-State	1979–ongoing	Specialized clinical care	Group sessions	Short	Trained facilitators	After	Group

First author, year	Target group	Age	N	Conflict	Type of conflict	Conflict duration	Intervention type	Location	Duration	Provider	Onset	Unit
Macisaac <i>et al.</i> (2021)	Adolescents and young adults in life transition	16–22	156	N.A.	N.A.	N.A.	Skills- building, self-help	Online	Medium	Researchers and technical	After	Indiv
Ramachandran <i>et al.</i> (2019)	Internally displaced people	0–18	2203	Ukraine	Inter-State	2014– ongoing	Assessment/ screening tool	Community	Short	Researchers and technical	During	Indiv
Murray <i>et al.</i> (2018)	Conflict- affected youth in refugee camps	7–18	37	Somalia	Internationalized intra-State	1991– ongoing	Focused psycho- logical support	Refugee camp	Medium	Community and NGO	During	Indiv, family
Clacherty (2021)	Children with war experience	7–16	120	South Africa	Intra-State	1948–1994	Skills- building, creative expression	SCPS retreat house	Long	Paraprofessionals	After	Group
Diab <i>et al.</i> (2014)	Children	10–13	428	Palestine	Internationalized intra-State	1947– ongoing	Focused psycho- logical support	School	Medium	Mental health professionals	After	Group
Barron <i>et al.</i> (2017)	School counsellors	25–60	10	Palestine	Internationalized intra-State	1947– ongoing	Capacity- building for providers	Government, online, community	Long	Supervisors and peers	During	Group
Scharpf <i>et al.</i> (2024)	War- affected youth	11–25	268	Congo	Internationalized intra-State	1996– ongoing	Family and caregiver support	Community	Not reported	Researchers	During	Indiv
Mels <i>et al.</i> (2015)	War- affected youth	13–21	952	Congo	Internationalized intra-State	1996– ongoing	Skills- building	Community	Not reported	Researchers and technical	During, after	Indiv
Continued												

TABLE 1.
Continued

First author, year	Target group	Age	N	Conflict	Type of conflict	Conflict duration	Intervention type	Location	Duration	Provider	Onset	Unit
Amone-P'Olak (2007)	(Formerly) abducted adolescents	12–20	134	Uganda	Intra-State	1971–2006	Skills-building	Community	Not reported	Researchers and administrators	During, after	Indiv
Khamis (2015)	War-affected youth	9–16	205	Palestine	Internationalized intra-State	1947–ongoing	Focused psychological support	Community	Not reported	Researchers and technical	During	Indiv
McBain <i>et al.</i> (2016)	War-affected youth	15–24	436	Sierra Leone	Intra-State	1991–2002	Focused psychological support	Community, school	Long	Lay health workers	After	Group
Veronese and Pepe (2020)	Primary school children in refugee camps	6–11	1215	Palestine	Internationalized intra-State	1947–ongoing	Assessment/school tool	Refugee camp	Not reported	Researchers	After	Indiv
Pineros-Leano <i>et al.</i> (2024)	Conflict-affected youth	18–28	28	Colombia	Intra-State	1965–ongoing	Focused psychological support	Community	Medium	Researchers and technical	After, during	Group
Müller <i>et al.</i> (2023)	Language mediators working with minor refugees	19–87	129	N.A.	N.A.	N.A.	Capacity-building for providers	Online	Short	Researchers and technical	During, after	Group
Karam <i>et al.</i> (2008)	Students	6–18	2500	Lebanon	Internationalized intra-State	1975–ongoing	Focused psychological support	Community, school	Short	Educational staff	After	Group
Diab <i>et al.</i> (2015)	War-affected youth	10–13	482	Palestine	Internationalized intra-State	1947–ongoing	Focused psychological support	School	Medium	Paraprofessionals	After	Group

First author, year	Target group	Age	N	Conflict	Type of conflict	Conflict duration	Intervention type	Location	Duration	Provider	Onset	Unit
Hewitt-Ramirez <i>et al.</i> (2020)	Children, adolescents, adults	0–60	964	Colombia	Intra-State	1965–ongoing	Basic psychosocial support, community-based care	Community	Long	Lay health workers	During	Group
Slone and Shoshani (2008)	Conflict-affected youth	12–15	181	Israel	Internationalized intra-State	1947–ongoing	Basic psychosocial support, social and emotional learning	School	Medium	Educational staff	During	Group
Najm <i>et al.</i> (2023)	Children and adolescents; health-care, education and NGO staff; parents	Not reported		Afghanistan	Internationalized intra-State	1979–ongoing	Specialized clinical care	Community	Not reported	Community and NGO	During, after	Indiv, group
Jordans <i>et al.</i> (2010)	Conflict-affected youth	11–14	325	Nepal	Intra-State	1996–2006	Focused psychological support, social and emotional learning	School	Medium	Paraprofessionals	After	Group
Barron and Abdullah (2012)	Conflict-affected youth	7–17	24	Palestine	Internationalized intra-State	1947–ongoing	Focused psychological support	School	Medium	Paraprofessionals	After	Group
Getanda and Vostanis (2023)	Conflict-affected adolescents	14–17	54	Kenya	Intra-State	1990–ongoing	Focused psychological support, creative expression	Community, school	Short	Paraprofessionals	During	Group

Continued

TABLE 1.
Continued

First author, year	Target group	Age	N	Conflict	Type of conflict	Conflict duration	Intervention type	Location	Duration	Provider	Onset	Unit
Thabet <i>et al.</i> (2005)	War-affected youth	9–15	111	Palestine	Internationalized intra-State	1947–ongoing	Psychological first aid, creative expression, toy-assisted therapy	School, refugee camp	Medium	Mental health professionals	During	Group
McMullen <i>et al.</i> (2013)	War-affected boys (incl. former child soldiers)	13–17	50	Congo	Internationalized intra-State	1996–ongoing	Focused psychological support	Community, school	Long	Researchers and technical		Group, indiv
D'Andrea <i>et al.</i> (2024)	Conflict-affected children	8–12	287	Palestine	Internationalized intra-State	1947–ongoing	Focused psychological support, skills-building	Community	Long	Community and NGO	During	Group
McBain <i>et al.</i> (2015)	War-affected youth	15–24	436	Sierra Leone	Intra-State	1991–2002	Focused psychological support	Community	Long	Paraprofessionals	After	Group
Qouta <i>et al.</i> (2012)	War-affected youth	10–13	482	Palestine	Internationalized intra-State	1947–ongoing	Focused psychological support	School	Medium	Mental health professionals	After	Group

First author, year	Target group	Age	N	Conflict	Type of conflict	Conflict duration	Intervention type	Location	Duration	Provider	Onset	Unit
Cohen <i>et al.</i> (2014)	Mothers, infants	Not reported	70	Israel	Internationalized intra-State	1947–ongoing	Basic psychosocial support, recreational activities, toy-assisted therapy	Community	Long	Mental health professionals	During	Group
Tol <i>et al.</i> (2010)	Conflict-affected children	8–13	403	Indonesia	Intra-State	1990–ongoing	Focused psychological support	School	Medium	Paraprofessionals	After	Group
Barron <i>et al.</i> (2021)	Conflict-affected children	8–14	30	Brazil	Non-State conflict	1980–ongoing	Focused psychological support	Community	Medium	Community and NGO	During	Group
Jordans <i>et al.</i> (2011)	Conflict-affected children in low-income countries	Not reported	29,292	Burundi, Indonesia, Sri Lanka, Sudan	Intra-State	1955–ongoing	Multilayered MHPSS (basic to specialized)	School, community	Long	Lay health workers	During, after	Group
Wieling <i>et al.</i> (2017)	Mothers with children	6–12	14	Uganda	Intra-State	1971–2006	Family and caregiver support	Community	Medium	Community and NGO	After	Group
Barron <i>et al.</i> (2016)	Adolescents	11–15	154	Palestine	Internationalized intra-State	1947–ongoing	Focused psychological support	Community	Medium	Paraprofessionals	During	Group

Continued

TABLE 1.
Continued

First author, year	Target group	Age	N	Conflict	Type of conflict	Conflict duration	Intervention type	Location	Duration	Provider	Onset	Unit
Sakat and Schiff (2021)	High-school students	14–18	2,992	Israel	Internationalized intra-State	1947–ongoing	Religion	Community	Long	Community	Before, during, after	Indiv
Giordano <i>et al.</i> (2024)	War-affected youth	18–22	15	Ukraine	Inter-State	2014–ongoing	Skills-building, social and emotional learning	Community, online	Long	Researchers	During	Group
Tol <i>et al.</i> (2015)	War-affected youth	8–17	329	Burundi	Intra-State	1993–ongoing	Basic psychosocial support	School	Medium	Paraprofessionals	After	Group
Shaar (2013)	Adolescents with sensory impairments	10–20	232	Lebanon	Internationalized intra-State	1975–ongoing	Assessment/sci tool	School, community	Not applicable	Researchers	After	Indiv
Taverne and Nicholls (2025)	Trauma-affected adolescents	Not reported	Not reported	Not reported	Not reported	Not reported	Creative expression, recreational activities	School	Not reported	Mental health professionals		

First author, year	Target group	Age	N	Conflict	Type of conflict	Conflict duration	Intervention type	Location	Duration	Provider	Onset	Unit
Lange-Nielsen <i>et al.</i> (2012)	Conflict-affected youth	12–17	124	Palestine	Internationalized intra-State	1947–ongoing	Focused psychological support, creative expression	Community	Short	Mental health professionals	During	Group
Diab <i>et al.</i> (2018)	Conflict-affected children	10–13	303	Palestine	Internationalized intra-State	1947–ongoing	Multi-level protective factors	School, community	Long	Community	Before, during, after	Indiv
Veronese <i>et al.</i> (2020)	Children in refugee camps	7–13	29	Palestine	Internationalized Intra-State	1947–ongoing	Participatory assessment/research method	Community, refugee camp		Researchers and technical	During	Indiv
Miller <i>et al.</i> (2020)	Parents	10–70	72	Palestine	Internationalized intra-State	1947–ongoing	Family and caregiver support	Community	Medium	Community and NGO	During	Group
Malla <i>et al.</i> (2019)	Conflict-affected youth	14–30	262	Kashmir	Internationalized intra-State	1947–ongoing	Focused psychological support	Community	Long	Lay health workers	During, after	Indiv, family
Continued												

TABLE 1.
Continued

First author, year	Target group	Age	N	Conflict	Type of conflict	Conflict duration	Intervention type	Location	Duration	Provider	Onset	Unit
Dekel and Solomon (2016)	Adolescents	12–15	2.858	Lebanon	Internationalized intra-State	2006–ongoing	Family and caregiver support	Community	Not applicable	Community	After	Indiv, family
Hillis <i>et al.</i> (2024)	Caregivers	Not reported	577	Ukraine	Inter-state	2014–ongoing	Family and caregiver support	Community, online	Long	Mixed	During	Group
Raknes and Chorna (2024)	War-affected adolescents	13–17	10	Ukraine	Inter-State	2014–ongoing	Skills-building, social and emotional learning	Community	Long	Community and NGO	During	Group
Newnham <i>et al.</i> (2015)	War-affected youth	15–24	32	Sierra Leone	Intra-State	1991–2002	Focused psychological support	Community	Long	Lay health workers	After	Group
Layne <i>et al.</i> (2001)	War-affected youth	15–19	55	Bosnia	Internationalized intra-State	1992–1995	Focused psychological support	School	Long	Trained facilitators	After	Group
Veronese <i>et al.</i> (2017)	Primary school children in refugee camps	6–11	200	Palestine	Internationalized intra-State	1947–ongoing	Psychological first aid, skills-building	School	Not applicable	Community	During	Indiv, group
Sadeh <i>et al.</i> (2008)	War-affected children	2–7	74	Lebanon	Internationalized intra-State	2006–ongoing	Basic psychosocial support, toy-assisted therapy	Family	Short	Mixed	During, after	Indiv

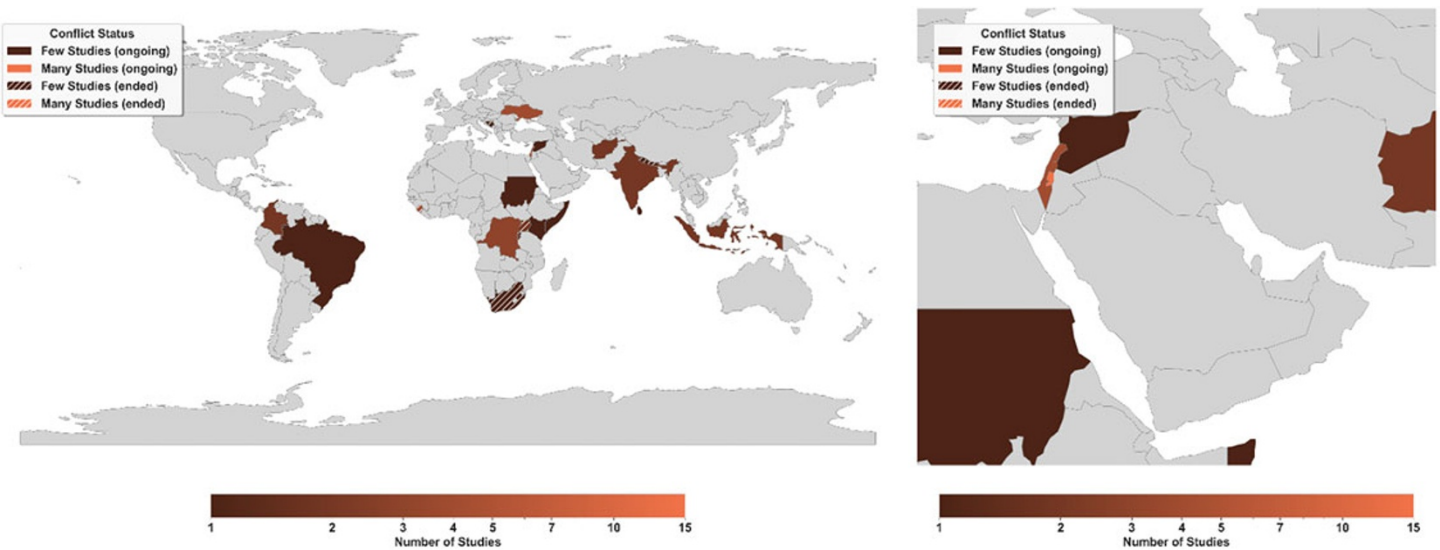


Figure 2. Distribution of conflicts by country. Left: global distribution. Right: zoomed in on most studied region.

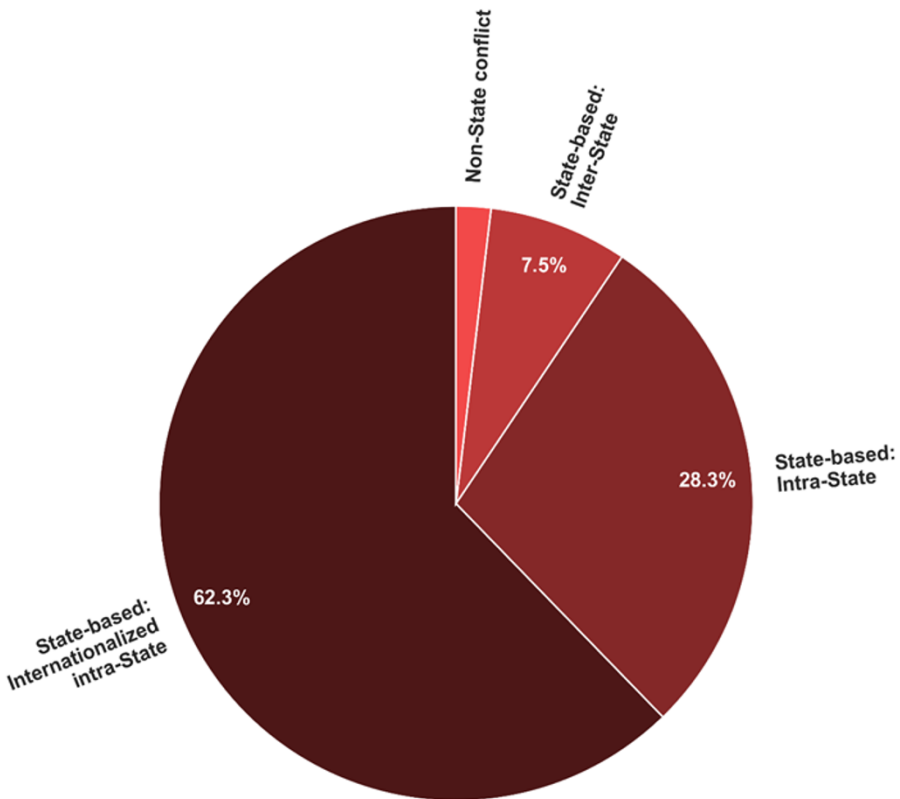


Figure 3. Types of conflicts covered by the included studies.

mental health impacts, social and relational impacts, and educational and developmental impacts. Only a few studies directly assess physical health; one study reports an injury during an intervention which had an impact on the physical health of a participant (ankle fracture during a bouldering (climbing) intervention). Mental health impacts are emphasized in the studies, and a high baseline prevalence of PTSS can be identified, as well as common comorbidities such as anxiety, depression, and somatic symptoms. Regarding the social and relational impacts, the review of the studies shows that a breakdown in peer, family and community networks can be identified, for example due to mistrust between groups in inter-group conflict zones. In addition, stigma and prejudice are mentioned in connection to studies in school environments and in the context of displacement. Lastly, studies with school-based approaches highlight that exposure to conflict is linked to concentration difficulties and reduced educational progression rates. These changes were identified through classroom engagement scores before and after the intervention.

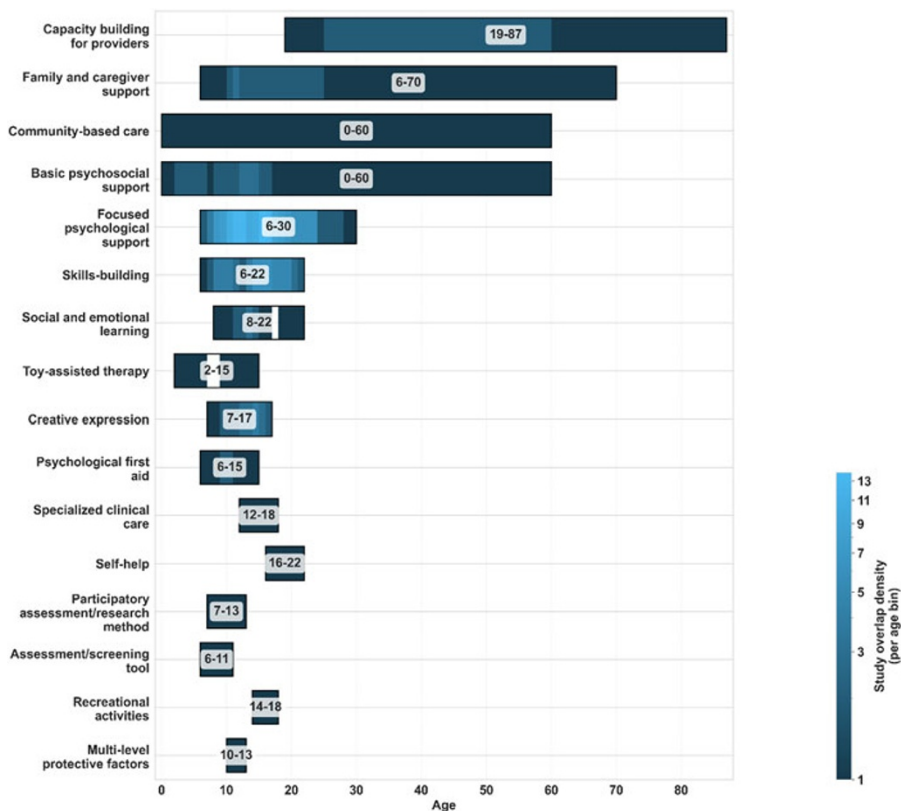


Figure 4. Age range spans by intervention type.

Intervention type and design variety

The intervention types are characterized by a strong methodological variety. Forty-six unique intervention labels are used in the studies, and only Teaching Recovery Techniques (TRT) psychosocial intervention ($n=4$), the Youth Readiness Intervention (YRI) ($n=3$) and coping strategies ($n=2$) are recurring intervention types. Additionally, cultural tailoring is common in effective programmes. The programmes are either based on psychosocial (school-based, group therapy, arts, sport-based), clinical (trauma-focused cognitive behavioural therapy (TF-CBT), trauma recovery techniques, narrative therapy), family/community (parenting programmes, community resilience training), tech-based (app-based resilience, online support) or mixed-model interventions (combing education, mental health, and children’s, adolescents’ and youth’s environment). The approaches also vary greatly (thirty-five unique approaches), but they can be generalized into broader categories such as community (e.g., local professionals), children’s, adolescents’ and youth’s direct environment (e.g., teachers, family), and external professionals. In some studies,

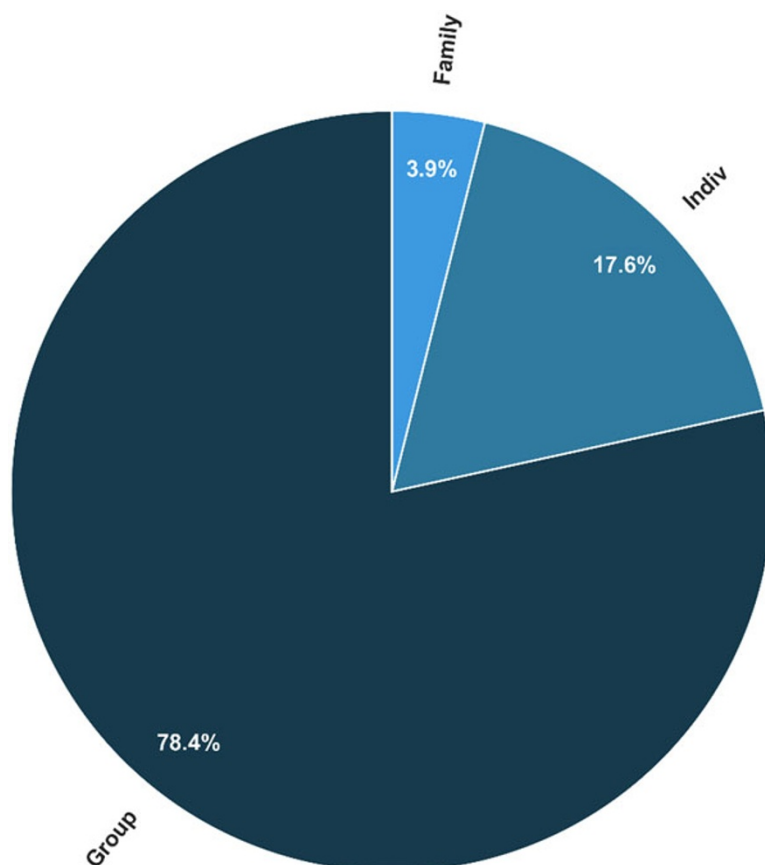


Figure 5. Individual versus group interventions.

diverse agents deliver services and interventions to children, adolescents and youth, allowing a mix of local and external involvement through a clinical psychologist or researchers. This is primarily seen in the TRT interventions, the YRI or the JoyPop App. Nineteen studies also include trained local professionals and therefore appear repeatedly; nevertheless, delivery settings and facilitator training are highly heterogeneous. As with the intervention types, the study designs show variation, although a pattern can be identified as randomized controlled trials ($n=15$) are mostly applied in CBT and psychosocial trials, while qualitative approaches ($n=6$) are primarily used in community programmes.

Measured outcomes

The measured outcomes can be separated into psychological outcomes, social outcomes, behavioural outcomes and overall intervention effectiveness (i.e., whether the intervention achieved its intended objectives and produced measurable

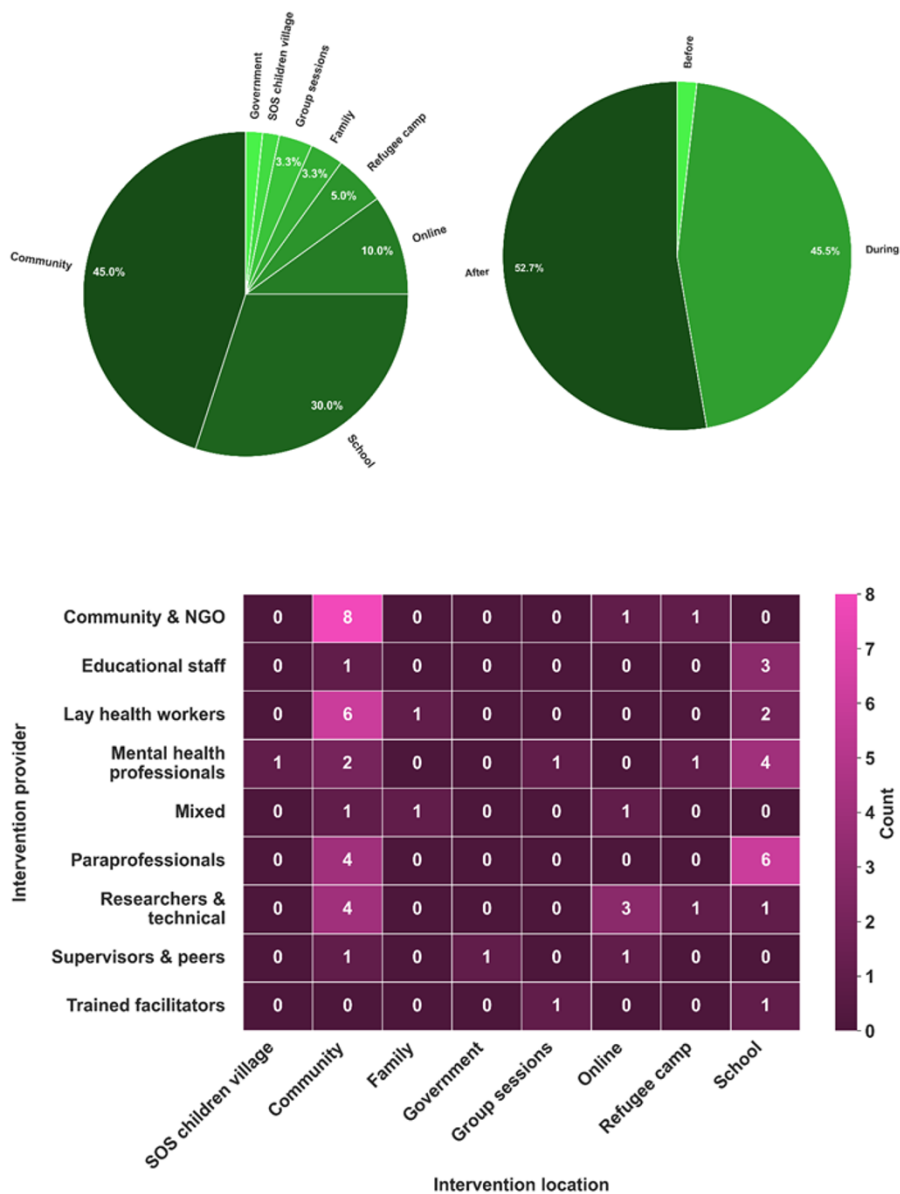


Figure 6. Intervention locations; intervention timing relative to conflict; provider type versus location matrix.

improvements, assessed from both a programme evaluation and psychological research perspective).

Twenty-nine studies target psychological outcomes, and while most programmes address PTSS, the follow-up sustainability is mixed, mentioning no

significant improvement in the case of writing therapy but improved mood regulation with app-based tools. However, a reduction in PTSS, depression, anxiety and distress, along with improved emotion regulation, coping and resilience, is identified by studies mentioning psychological outcomes. Some 60–70% of studies record reduced rates of anxiety, with the most significant reductions being found in randomized controlled trials (effect sizes medium to large). Some interventions mention these successes in the short term but not at follow-up, and others only for specific symptoms, while still others show no significant change (e.g., depressive symptoms remain unchanged despite PTSS improvement). Effects were either measured during or immediately after the intervention; only nine studies measure effects after ≥ 6 months, and no study assesses effects one year after the intervention. Most studies are evaluated shortly after the end of the testing period. The studies evaluating psychological outcomes use a variety of validated measures, including CPSS,¹⁵ UCLA PTSD RI,¹⁶ SCARED,¹⁷ Kessler K-6,¹⁸ WEMWBS,¹⁹ DERS,²⁰ WHODAS II²¹ and WHOQOL-100;²² however, the same measure is rarely used for multiple studies and in some cases a scale is adjusted to fit the needs of the intervention participants or environment (e.g. shortened, culturally adapted, translated).

Thirteen studies address social outcomes that are mainly measured in community-driven interventions. These outcomes range from increased prosocial behaviour and improved peer/family relations to better communication, improved community cohesion and reduced prejudice. The implementation of community-led programmes has been demonstrated to have a positive impact on collective resilience, even in the context of ongoing conflict. Social outcomes are assessed at the individual, family and community levels. While psychological outcomes are primarily measured by standard clinical scales and context-adapted measures, studies use self-reports or reports from teachers or caregivers to assess social outcomes.

Seven studies measure outcomes regarding the intervention participants' behaviour. Indicators for this were school attendance, aggression, violent involvement, and activity participation; however, the definition and scope of these terms differ, especially for violence and aggression. Some studies assess level of

15 Child Post-Traumatic Stress Symptom Scale: a self-report or clinician-administered tool for assessing the frequency and severity of PTSD symptoms in children and adolescents.

16 University of California, Los Angeles Post-Traumatic Stress Disorder Reaction Index: a scale used to assess PTSD symptoms in children and adolescents based on *Diagnostic and Statistical Manual* criteria.

17 Screen for Child Anxiety Related Emotional Disorders: a self-report and parent-report questionnaire used to screen for five common anxiety disorders in children.

18 Kessler Psychological Distress Scale (K-6): a short screening instrument used to measure non-specific psychological distress (e.g., anxiety and depressive symptoms) in the general population.

19 Warwick-Edinburgh Mental Well-Being Scale: a scale designed to measure positive mental well-being (e.g., feeling good and functioning well).

20 Difficulties in Emotion Regulation Scale: a self-report questionnaire designed to assess multiple facets of emotion dysregulation.

21 World Health Organization Disability Assessment Schedule 2.0: a generic assessment tool for measuring health and disability across cultures.

22 World Health Organization Quality of Life 100: a comprehensive assessment of quality of life across multiple domains (e.g., physical, psychological, social).

Table 2. Outcome domains assessed across the fifty-six included studies

Outcome domain	Number of studies
PTSS/trauma	30
Depression	17
Social/prosocial functioning	17
Behavioural outcomes	11
Resilience/coping	11
Family/parenting	10
Functional impairment	10
Anxiety	9
General psychological distress	8
Well-being/quality of life	7
Emotion regulation	6
Qualitative only (<i>no standardized measures</i>)	10

aggression as an individual behavioural tendency and use standardized self-report scales such as Strengths and Difficulties Questionnaires to measure anger expression and frequency of aggressive behaviour, thereby focusing on internal processes and aggressive acts such as hitting or shouting. Others emphasize more socially situated definitions, involving social conflict behaviours within the peer, school or community environment; examples of these behaviours may include domestic violence, bullying and interpersonal violence.

Table 2 provides an overview of the outcome domains assessed across the fifty-six studies. PTSS and trauma-related symptoms were the most frequently measured ($n=30$), followed by depression ($n=17$), social and prosocial functioning ($n=17$), and behavioural outcomes ($n=11$). Resilience and coping ($n=11$), family and parenting outcomes ($n=10$), and functional impairment ($n=10$) were moderately represented. Anxiety ($n=9$), general psychological distress ($n=8$), well-being and quality of life ($n=7$), and emotion regulation ($n=6$) were less commonly assessed. Ten studies relied exclusively on qualitative methods without standardized outcome measures.

Overall effectiveness

The effectiveness of interventions can be divided into four categories. Studies were classified as “positive” when the authors reported that the intervention had a beneficial effect on their assessed outcome variables; “mixed” when improvements were observed on some outcomes but not others, or when effects were not sustained at

follow-up; “null/negative” when no measurable benefits were found or adverse effects were reported; and “not reported” when outcome information was insufficient to determine effectiveness. This qualitative approach was adopted because the heterogeneity of study designs, outcome variables and assessment methods precluded a meaningful quantitative comparison. Across the fifty-six studies, twenty-five report positive effects on children’s, adolescents’ and youth’s symptoms and/or functioning. Eleven studies show mixed effects, with improvements on some outcomes while others are unchanged or not sustained at follow-up. Two studies report null or negative findings, meaning that they either failed to show measurable benefits or produced (short-term) setbacks for participants. One of these studies, for example, documented no psychological gain and noted a temporary increase in depression symptoms right after a session. It is important to note that temporary increases in distress can be a recognized occurrence during therapeutic interventions, particularly those involving trauma-related content, and do not necessarily indicate harm. In eighteen studies, outcome information is not reported or cannot be determined from the available data.

To summarize the findings, the studies cluster around internationalized intra-State conflicts ($n=33$) and school-age samples ($n=36$), with primarily moderate to high numbers of participants. Methodological heterogeneity is evident, with forty-six intervention labels. Psychological symptoms dominate measurement ($n=29$) while social outcomes, behaviour and well-being are comparatively under-measured.

Discussion

Across diverse conflict settings, MHPSS interventions for children, adolescents and youth are most promising when delivered as part of multilayered systems that integrate universal school/community activities, targeted group programmes, and indicated counselling with referral pathways. Consistent but typically modest improvements are observed in PTSS, emotion regulation, functioning, and peer relations, with effects often attenuating over time without reinforcement. Programmes adapted to local context and delivered by trained teachers, lay workers or non-governmental organization (NGO) staff are feasible and scalable in low-resource and protracted-conflict environments. Evidence demonstrates that lay health workers can be effectively trained in less than four months, with interventions successfully reaching large populations with low dropout rates. In addition, cultural adaptation processes involving community members result in high acceptability and effectiveness even in protracted conflicts.²³

23 Mark J. D. Jordans *et al.*, “Practice-Driven Evaluation of a Multi-Layered Psychosocial Care Package for Children in Areas of Armed Conflict”, *Community Mental Health Journal*, Vol. 47, No. 3, 2011; Ashok Malla *et al.*, “A Model of Mental Health Care Involving Trained Lay Health Workers for Treatment of Major Mental Disorders among Youth in a Conflict-Ridden, Low-Middle Income Environment, Part I: Adaptation and Implementation”, *Canadian Journal of Psychiatry*, Vol. 64, No. 9, 2019; Ashok Malla *et al.*,

What works for children, adolescents and youth in conflict settings

Effective MHPSS interventions for children, adolescents and youth in conflict-affected settings share several core characteristics.

Based on the reviewed literature, a promising and scalable framework is a multilayered, stepped-care model that provides a continuum of support.²⁴ Such a model typically begins with community or school-based psycho-education; this is followed by more targeted group interventions and care, with the option of more intensive services for those with greater needs.

Group programmes delivered in school or community settings are particularly effective, yielding short-term benefits in reducing PTSS and improving social functioning and resilience.²⁵ Task-sharing, which involves trained teachers and lay workers delivering interventions under supervision, is a critical component of this success. This approach makes care feasible and effective in low- and middle-income countries and fragile contexts.²⁶

Furthermore, the inclusion of family and caregiver components significantly amplifies the impact of these interventions. Supporting caregiver well-being and parenting skills can reduce family violence and likely help sustain improvements over time.²⁷ Alongside core skills training, adjunctive approaches such as structured physical activity, arts, or narrative therapy can enhance engagement and promote well-being;²⁸ digital and hybrid support have also demonstrated their feasibility and have the potential to improve emotion regulation and access to care, as long as they

“Testing the Effectiveness of Implementing a Model of Mental Healthcare Involving Trained Lay Health Workers in Treating Major Mental Disorders among Youth in a Conflict-Ridden, Low-Middle Income Environment, Part II: Results”, *Canadian Journal of Psychiatry*, Vol. 64, No. 9, 2019.

24 M. J. D. Jordans *et al.*, above note 23.

25 Samir R. Qouta, Esa Palosaari, Marwan Diab and Raija-Leena Punamäki, “Intervention Effectiveness among War-Affected Children: A Cluster Randomized Controlled Trial on Improving Mental Health”, *Journal of Traumatic Stress*, Vol. 25, No. 3, 2012; Mark J. D. Jordans *et al.*, “Evaluation of a Classroom-Based Psychosocial Intervention in Conflict-Affected Nepal: A Cluster Randomized Controlled Trial”, *Journal of Child Psychology and Psychiatry and Allied Disciplines*, Vol. 51, No. 7, 2010; Elie G. Karam *et al.*, “Effectiveness and Specificity of a Classroom-Based Group Intervention in Children and Adolescents Exposed to War in Lebanon”, *World Psychiatry*, Vol. 7, No. 2, 2008.

26 A. Malla *et al.*, “A Model of Mental Health Care”, above note 23; A. Malla *et al.*, “Testing the Effectiveness”, above note 23; Laura K. Murray *et al.*, “An Evaluation of a Common Elements Treatment Approach for Youth in Somali Refugee Camps”, *Global Mental Health*, Vol. 5, 2018.

27 Susan Hillis *et al.*, “The Effectiveness of Hope Groups, a Mental Health, Parenting Support, and Violence Prevention Program for Families Affected by the War in Ukraine: Findings from a Pre-Post Study”, *Journal of Migration and Health*, Vol. 10, 2024; Kenneth E. Miller *et al.*, “Strengthening Parenting in Conflict-Affected Communities: Development of the Caregiver Support Intervention”, *Global Mental Health*, Vol. 7, 2020; Florian Scharpf, Roos Haer and Tobias Hecker, “Close Relationships with Caregivers as [a] Protective Factor for the Mental Health and Functioning of War-Affected Congolese Youth”, *Conflict and Health*, Vol. 18, No. 1, 2024.

28 Katharina Luttenberger *et al.*, “A Psychosocial Boulderling Intervention Improves the Well-Being of Young Refugees and Adolescents from the Host Community in Lebanon: Results from a Pragmatic Controlled Trial”, *Conflict and Health*, Vol. 18, No. 56, 2024; Glynis Clacherty, “Artbooks as Witness of Everyday Resistance: Using Art with Displaced Children Living in Johannesburg, South Africa”, *Global Studies of Childhood*, Vol. 11, No. 1, 2021.

are implemented with strong safeguarding and inclusion measures.²⁹ Relating these findings to the IASC multilayered model of care, structured physical activity, arts-based activities and psycho-education correspond to Tiers 1–2 (basic services and community support), group-based programmes such as TRT and classroom coping skills align with Tier 3 (focused non-specialized support), and evidence-based therapies such as TF-CBT and the YRI represent Tier 4 (specialized clinical services). Distinguishing between these levels is important, as the evidence base, required training and specific needs of the target populations differ across tiers.

Age-, culture- and trauma-informed fit

Successful interventions in conflict settings are not “one-size-fits-all”. According to the literature, effectiveness is dependent on tailoring programmes to be age-appropriate, culturally sensitive and trauma-informed.

For children in the early stages of development, interventions are most effective when they focus on dyadic play, attachment, and symbolic tools. These approaches reduce stress, strengthen the bond between caregivers and children, and provide a foundation for emotional resilience in conflict settings.³⁰ For older children, classroom-based coping skills and prosocial routines have shown to be both implementable and effective. Programmes such as Cognitive Behavioural Intervention for Trauma in Schools have been shown to reduce PTSS and improve social skills in the short term, and are therefore a crucial intervention with regard to MHPSS.³¹ Programmes for adolescents and young adults also need to be tailored to their age, and the review has shown that for these age groups, more structured, evidence-based therapies like CBT, TF-CBT and the YRI are effective. These interventions reduce PTSS and improve emotion regulation and overall functioning.³² The studies reviewed indicate that CBT interventions use systematic sessions to help young people identify and change harmful emotional responses, behaviours and thought patterns while teaching them practical coping strategies for daily challenges.³³ TF-CBT builds on these approaches by addressing trauma specifically

29 Solfrid Raknes and Tetiana Chorna, “The Helping Hand in Ukraine: Feasibility and Potential Impact”, *Pilot and Feasibility Studies*, Vol. 10, No. 1, 2024.

30 Esther Cohen, Ruth Pat-Horenczyk and Dafna Haar-Shamir, “Making Room for Play: An Innovative Intervention for Toddlers and Families under Rocket Fire”, *Clinical Social Work Journal*, Vol. 42, No. 4, 2014; Avi Sadeh, Shai Hen-Gal and Liat Tikotzky, “Young Children’s Reactions to War-Related Stress: A Survey and Assessment of an Innovative Intervention”, *Pediatrics*, Vol. 121, No. 1, 2008.

31 M. J. D. Jordans *et al.*, above note 25; Wietse A. Tol *et al.*, “Mediators and Moderators of a Psychosocial Intervention for Children Affected by Political Violence”, *Journal of Consulting and Clinical Psychology*, Vol. 78, No. 6, 2010; S. R. Qouta *et al.*, above note 25.

32 Elizabeth A. Newnham *et al.*, “The Youth Readiness Intervention for War-Affected Youth”, *Journal of Adolescent Health*, Vol. 56, No. 6, 2015; Elijah Mirona Getanda and Panos Vostanis, “Feasibility Evaluation of Psychosocial Intervention for Internally Displaced Youth in Kenya”, *Journal of Mental Health*, Vol. 31, No. 6, 2023.

33 Vivian Khamis, “Coping with War Trauma and Psychological Distress among School-Age Palestinian Children”, *American Journal of Orthopsychiatry*, Vol. 85, No. 1, 2015.

through educational components that help youth understand trauma reactions;³⁴ it establishes safe environments where participants can build confidence and uses group formats that allow youth to learn from their peers as they practice new problem-solving and coping skills together.³⁵ The YRI is delivered in group settings, typically consisting of 10–12 sessions, and integrates family and community involvement.³⁶ Studies show that the YRI helps youth develop better emotional regulation abilities, improve their relationships with others and gain the skills needed for participation in school and work.³⁷ To maintain these benefits long-term, however, booster sessions are often necessary since the positive effects decrease after a short period of time (e.g., six months for YRI outcomes).³⁸

At the core of effective interventions are trauma-informed principles. These principles include creating a sense of safety, establishing stability and taking a phased approach to skill-building that minimizes the risk of re-traumatization. Protocols such as TF-CBT are based on these principles to ensure that they are effective and safe for participants.³⁹

Along with age, interventions should be tailored to new contexts because structuring them for specific settings improves their acceptability and effectiveness. Cultural norms can influence the success of an intervention, as demonstrated by a study in which acceptance and commitment therapy is shown to be more effective than TF-CBT for a group of Afghan girls.⁴⁰ This suggests that interventions must align with local values and practices.⁴¹

Contextual influences and heterogeneity

Beyond individual factors, effects were shaped in similar ways by setting, timing, delivery platform and family systems. In the Middle East, school-based group interventions are common, but the timing of these interventions is sensitive: immediate post-escalation delivery sometimes produces null or transiently adverse

34 S. R. Qouta *et al.*, above note 25.

35 John McMullen, Paul O'Callaghan, Ciaran Shannon, Alastair Black and John Eakin, "Group Trauma-Focused Cognitive-Behavioural Therapy with Former Child Soldiers and Other War-Affected Boys in the DR Congo: A Randomised Controlled Trial", *Journal of Child Psychology and Psychiatry*, Vol. 54, No. 11, 2013.

36 E. A. Newnham *et al.*, above note 32.

37 Maria Pinerós-Leano *et al.*, "Cultural Adaptation of an Evidence-Based Intervention to Address Mental Health among Youth Affected by Armed Conflict in Colombia: An Application of the ADAPT-ITT Approach and FRAME-IS Reporting Protocols", *Global Mental Health*, Vol. 11, 2024.

38 Theresa S. Betancourt *et al.*, "A Behavioral Intervention for War-Affected Youth in Sierra Leone: A Randomized Controlled Trial", *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 53, No. 12, 2014.

39 J. McMullen *et al.*, above note 35; Ian Barron, Ghassan Abdallah and Unni Heltne, "Randomized Control Trial of Teaching Recovery Techniques in Rural Occupied Palestine: Effect on Adolescent Dissociation", *Journal of Aggression Maltreatment and Trauma*, Vol. 25, No. 9, 2016.

40 Sayed Jafar Ahmadi, Azadeh Tavoli, Zeinab Musavi and Justin Dainer-Best, "Acceptance and Commitment Therapy Versus Trauma-Focused Cognitive Behavior Therapy: A Comparative Study of the Effects on the Posttraumatic Stress Symptoms of Female Afghan Adolescents", *American Psychologist*, Vol. 79, No. 9, 2024.

41 M. Pinerós-Leano *et al.*, above note 37.

outcomes. Research by Karam *et al.*⁴² in Lebanon emphasizes that an immediate, daily, classroom-based intervention had no significant long-term effect, and had adverse effects on some participants; similarly, the TRT delivered immediately after the 2008 Israel–Hamas war showed only modest overall effectiveness and was associated with a temporary increase in psychological distress.⁴³ In contrast, interventions delivered with a delay of a few months, such as a later TRT delivery, showed more positive outcomes.⁴⁴ This suggests that practitioners should exercise caution with regard to immediate intensive trauma-processing interventions and instead focus first on stabilization and safety, allowing children's natural coping mechanisms to stabilize before structured emotional processing is introduced. Importantly, this does not preclude early trauma-informed or skills-based interventions, which can be safely delivered alongside stabilization efforts.⁴⁵

In sub-Saharan Africa, trials emphasized task-sharing and functional outcomes. TF-CBT reduces PTSS and psychosocial distress among adolescents in the Democratic Republic of the Congo, and the YRI shows educational and functional gains, though durability varies.⁴⁶ In South Asia, lay health worker models are feasible and effective in protracted conflicts. The fit of the modality matters, underscoring the importance of cultural and gender-sensitive therapeutic approaches.⁴⁷ In Ukraine, studies demonstrate the feasibility of caregiver and youth groups, which improve caregiver mental health and reduce family violence. This indicates the importance of family-level mechanisms when the threat is sustained.⁴⁸ Several studies report stronger benefits for girls and younger cohorts at the individual level, which is consistent with the need for age- and gender-tailored interventions.⁴⁹

Disability status alters exposure patterns, but not PTSS prevalence. For example, adolescents with sensory impairments in Lebanon have lower sensory exposure to trauma but similar PTSS rates to those without such impairments, pointing to the importance of inclusive access and support.⁵⁰

Family and community systems are found to consistently moderate outcomes. Close and supportive relationships with caregivers are associated with lower

42 E. G. Karam *et al.*, above note 25.

43 S.R. Qouta *et al.*, above note 25.

44 Marwan Diab, Raija-Leena Punamäki, Esa Palosaari and Samir R. Qouta, "Can Psychosocial Intervention Improve Peer and Sibling Relations among War-Affected Children? Impact and Mediating Analyses in a Randomized Controlled Trial", *Social Development*, Vol. 23, No. 2, 2014.

45 E. G. Karam *et al.*, above note 25; Ida Ingridstatter Lange-Nielsen *et al.*, "Short-Term Effects of a Writing Intervention among Adolescents in Gaza", *Journal of Loss and Trauma*, Vol. 17, No. 5, 2012.

46 J. McMullen *et al.*, above note 35; Ryan K. McBain *et al.*, "Improving Outcomes for Caregivers through Treatment of Young People Affected by War: A Randomized Controlled Trial in Sierra Leone", *Bulletin of the World Health Organization*, Vol. 93, No. 12, 2015.

47 A. Malla *et al.*, "A Model of Mental Health Care", above note 23; A. Malla *et al.*, "Testing the Effectiveness", above note 23; S. J. Ahmadi *et al.*, above note 40.

48 S. Hillis *et al.*, above note 27; S. Raknes and T. Chorna, above note 29.

49 W. A. Tol *et al.*, above note 31.

50 Khuzama Hijal Shaar, "Severe War Trauma and Post-Traumatic Stress Disorder in Adolescents with Sensory Impairments: A Cross-Sectional Study", *Health Psychology Research*, Vol. 1, No. 2, 2013.

PTSS and better functioning, while caregiver and parenting programmes have been shown to enhance and sustain improvements in children.⁵¹ School and peer contexts are also influential: teacher-delivered programmes can reduce symptoms, though attitudinal outcomes may be vulnerable to social desirability, which underscores the importance of multi-informant measurement.⁵² Finally, heterogeneity in conflict intensity, displacement, and family functioning contribute to preventive or treatment effects. This implies that delivery should be more tailored (e.g., stepped care or reassignment for non-responders) in routine practice.⁵³ Notably, while roughly a third of studies described referral pathways for participants requiring more intensive support, systematic adverse event monitoring was rarely reported. Where safeguards were mentioned, they typically involved supervision of facilitators and protocols for referring participants with severe symptoms. This underscores the need for standardized safeguarding and adverse event reporting in future MHPSS research in conflict settings.

Implications for practice and research

The findings provide significant implications for future mental health programmes for children, adolescents, and youth in conflict settings. They involve multilayered, adaptable approaches that emphasize accessibility, cultural relevance and long-term sustainability. Based on the review of the study sample, the following recommendations have been identified:

1. Programmes and interventions should consider a stepped-care model that links psycho-education at community or school level with more targeted, evidence-based interventions for those in need. These interventions, such as TF-CBT, should be delivered by task-sharing with trained non-specialists, like teachers, NGO staff and lay health workers, who are supervised by specialists. This approach expands the reach of care significantly and creates a ripple effect.
2. Interventions must be tailored to the specific needs of different age groups – for example, they should use play-based and dyadic caregiver–child work for early childhood, focus on classroom and prosocial routines for older children, and apply CBT for adolescents and young adults. Programmes should also culturally adapt their content, adjusting language, focus and pacing, and should incorporate the close environment of the child, such as by improving family well-being and reducing children's exposure to domestic violence and dysfunction.

51 F. Scharpf, R. Haer and T. Hecker, above note 27; K. E. Miller *et al.*, above note 27.

52 Rony Berger, Marc Gelkopf, Yotam Heineberg and Philip Zimbardo, "A School-Based Intervention for Reducing Posttraumatic Symptomatology and Intolerance during Political Violence", *Journal of Educational Psychology*, Vol. 108, No. 6, 2016.

53 W. A. Tol *et al.*, above note 31.

3. Practitioners should thoughtfully integrate safe and culturally appropriate practices and adjustments into their programmes to enhance reach and effectiveness. This can include incorporating physical activities, such as bouldering interventions or art-based therapies, as supplementary interventions. Furthermore, secure digital platforms can be utilized to extend services, for example by offering remote support; it should be noted, however, that access to digital services is inconsistent between conflict regions, limiting comprehensive application. Additionally, it is non-negotiable that any use of technology must be paired with robust data privacy safeguards to protect sensitive information and build trust within the community.

Although the existing research has made valuable contributions in high-pressure environments, the quality of the evidence base is constrained by important methodological considerations that influence the certainty and generalizability of its findings. Specifically, the evidence base would be strengthened by more long-term follow-up, as current studies often lack the data required to assess the durability of effects and the need for future booster strategies. Furthermore, studies would benefit from more consistent reporting of essential implementation data (e.g., training, supervision, fidelity) to facilitate confident scale-up. The reliability of findings is also influenced by the possibility of allegiance and expectancy bias introduced when researchers are involved in both the delivery and evaluation of an intervention; this is a common challenge inherent to resource-constrained settings. Finally, increased attention to standardized adverse event reporting is needed to fully evaluate the safety profile of these programmes and ensure that ethical standards are consistently met.

Future research should prioritize longitudinal follow-up to assess the durability and effectiveness of treatments and interventions, especially in settings with ongoing or re-escalating conflict, with follow-up periods of 12–24 months. To optimize intervention design, studies should move beyond simple efficacy comparisons and instead use, for example, factorial or SMART (Sequential, Multiple Assignment, Randomized Trial) designs. Through this, multilayered MHPSS interventions can be optimized and used for diverse children, adolescents and youth in dynamic conflict settings, since factorial designs tell us which inputs and combinations matter, and SMART designs tell us how to adapt over time, and for whom.

Research–practice gap

In MHPSS, the rapid and dynamic nature of real-world service delivery differs greatly from the pace of scientific research, resulting in a notable gap between what front-line workers do and the scientific evidence. This disconnect is amplified by the volatility and dynamics of conflict, which create significant challenges for research implementation, often forcing front-line helpers to adjust programmes rapidly in response to immediate security situations, population displacement, and constantly evolving needs.

Although multilayered MHPSS programmes are being implemented on a large scale across communities and schools, with reported uptake and perceived benefits, the supporting evidence does not meet scientific standards. Studies with control groups and long-term outcome data are rarely available.⁵⁴ This operational reality makes it necessary to fundamentally shift toward greater collaboration between researchers and fieldworkers – particularly civil society and humanitarian actors that are often at the forefront of providing MHPSS to children, adolescents and youth in conflict settings.

In addition to the previously mentioned limitations of scientific practices, many frequently used approaches are evaluated using pragmatic pre-post designs without control groups. Although this methodology reflects the ethical considerations and operational difficulties inherent in conflict settings, it ultimately restricts the strength of causal inference.⁵⁵ In addition, while task-sharing models (using non-specialists to give care) are practical and effective in real-world settings, the research studies rarely mentioned the necessary quality checks; these include independent checks of results, fidelity checks, and analysis of who benefits most (moderator analyses). It is essential to include these quality checks when managing programme quality and tailoring delivery to scale up the programme.⁵⁶ Furthermore, front-line staff typically prioritize outcomes related to functional well-being, school participation, and safety, while in contrast, much research relies on self-report symptom scales, which often have limited cross-cultural validation and incorporate few multi-informant or functional endpoints.⁵⁷ This means that studies often overlook objective feedback from parents and teachers, failing to measure real-life improvements in daily behaviour and social engagement. Lastly, essential economic evidence necessary for informing policy and scaling up remains scarce, with few exceptions.⁵⁸ In addition, the observation that frequent, unplanned adjustments to programme timing and maintenance (often due to factors such as fluctuating funding or sudden security crises) co-occur with a fading of positive effects at follow-up highlights a crucial knowledge gap. Rather than accepting this decline, researchers and practitioners should collaborate to experimentally evaluate planned sustainability strategies, such as scheduled booster sessions, in order to identify the most effective and scalable methods for sustaining long-term programme benefits in conflict settings.⁵⁹

In order to close the gap between implementation and evidence, there must be urgent collaboration between MHPSS providers and scientists in conflict areas,

54 M. J. D. Jordans *et al.*, above note 23.

55 S. Hillis *et al.*, above note 27; S. Raknes and T. Chorna, above note 29.

56 A. Malla *et al.*, “A Model of Mental Health Care”, above note 23; A. Malla *et al.*, “Testing the Effectiveness”, above note 23.

57 M. J. D. Jordans *et al.*, above note 25; Guido Veronese and Alessandro Pepe, “Cross-Cultural Adaptation, Psychometric Properties and Factor Structure of the Multidimensional Student Life Satisfaction Scale (MSLSS): A Study with Palestinian Children Living in Refugee Camps”, *Current Psychology*, Vol. 39, No. 5, 2020.

58 R. K. McBain *et al.*, above note 46.

59 T. S. Betancourt *et al.*, above note 38; E.G. Karam *et al.*, above note 25.

most often civil society and humanitarian organizations. Due to instability and rapid changes in conflict settings, future efforts must move away from inflexible, traditional research designs. Prioritizing hybrid effectiveness–implementation studies, which evaluate a programme’s impact and the real-world factors affecting its delivery simultaneously, is essential. This means incorporating independent assessments, practical functional outcomes, clear documentation of adaptations, cost reporting, and robust designs that specifically assess timing and maintenance within the fluid operational realities of large-scale service delivery. This approach ensures that research informs practice at the speed required by humanitarian work and vice versa.

Limitations

This review’s findings are subject to several limitations. The review is based exclusively on English-language studies, which means it likely omits relevant research published in other languages, especially of the studied locations.

The heterogeneity of interventions, comparators and outcomes across the included studies restricted the ability to make direct and solid comparisons. Additionally, incomplete reporting on, for example, adaptations and adverse events limited the capacity to draw definitive conclusions about the implementation of these interventions. Furthermore, several included studies originate from the same conflict contexts and, in some cases, from overlapping research programmes (e.g., Betancourt, McBain, and Newnham in Sierra Leone, and Diab and Qouta in Palestine). While these studies examine different outcome variables and measures, their shared samples and settings mean that certain conflicts and populations are disproportionately represented in the evidence base while others remain under-explored. This uneven coverage should be considered when interpreting the breadth of the findings, and future research should aim to address these gaps by expanding investigations across a wider range of conflict settings.

Conclusion

This systematic mapping review shows that children and adolescents exposed to conflict experience severe and complex disruptions to their psychological, social and developmental well-being. The evidence strongly supports the short-term effectiveness of multilayered MHPSS systems that integrate universal and community- and school-based activities with more targeted therapeutic and clinical services. Interventions implemented through task-sharing, in which trained teachers, lay workers and NGO staff deliver structured psychosocial care under specialist supervision, have been shown to be feasible and scalable in contexts of ongoing conflict and limited resources. Family and caregiver engagement consistently enhances and sustains the benefits of interventions, emphasizing the central role of the child’s immediate environment in recovery and increased resilience.

The review further emphasizes that meaningful engagement and effectiveness require culturally adapted, age-appropriate and trauma-informed approaches.

Dyadic and play-based interventions promote secure attachment and emotional regulation for younger children, while structured, evidence-based therapies such as TF-CBT and the YRI are most beneficial for adolescents and young adults.

Despite frequently evidenced moderate to large short-term improvements in symptoms of post-traumatic stress, anxiety, and emotional functioning, few studies have assessed outcomes beyond six months, and evidence of sustained long-term benefits is limited. The ability to draw definitive conclusions about overall programme effectiveness is restricted by methodological heterogeneity, inconsistent outcome reporting and the scarcity of follow-up data. Furthermore, there is a significant gap between scientific research and field implementation. Real-world MHPSS programmes evolve rapidly in response to shifting conflict dynamics and children's, adolescents' and youth's needs, and academic research lags behind in evaluating these adaptive practices. The current literature primarily reflects interventions such as CBT and the YRI, but in the field there has been a growing interest in body-oriented methods (e.g., yoga-based approaches), which show preliminary promise.⁶⁰ This trend is currently under-represented in the systematic evidence base, and closing this divide will require hybrid effectiveness–implementation studies that assess intervention impact and contextual delivery factors simultaneously. These studies must be supported by transparent reporting on fidelity, cost and sustainability.

Ultimately, the findings affirm that protecting the mental health of children, adolescents and youth in conflict settings demands coordinated, scalable and contextually grounded approaches that combine psychosocial care with education, family support and community resilience-building. Strengthening collaboration among civil society and humanitarian actors, researchers and policy-makers can help MHPSS transition to an evidence-based and ethically responsible framework that mitigates the long-term psychological impact of conflict on future generations.

⁶⁰ Bessel A. van der Kolk *et al.*, “Yoga as an Adjunctive Treatment for Posttraumatic Stress Disorder: A Randomized Controlled Trial”, *Journal of Clinical Psychiatry*, Vol. 75, No. 6, 2014.