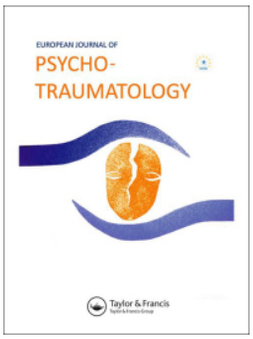

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The relation between post-migration stressors and trauma treatment outcomes: a scoping review

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REVIEW ARTICLE

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The relation between post-migration stressors and trauma treatment outcomes: a scoping review

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ABSTRACT

Background: People seeking refuge and asylum must often endure diverse adversities before, during, and after migration, making them more susceptible to develop psychological problems. The effect of post-migration stressors on responsiveness to psychological treatment is unclear.

Objectives: To: (1) evaluate the scope of the literature on the relation between post-migration stressors (e.g. struggles related to legal status in the context of resettlement) and outcomes of interventions targeting PTSD and comorbid conditions, in adult refugees and asylum seekers; (2) identify conceptual and methodological limitations of the literature; and (3) present limitations and recommendations for future research.

Methods: This review follows the guidelines of PRISMA-ScR for Scoping Reviews, and the Population, Concept, and Context (PCC) framework for identifying concepts pertaining to the review question and the search strategy.

Results: From 1,151 studies found through PsycINFO, PubMed, Web of Science Select, and review of sources, we assessed the 14 studies that fulfilled our criteria and found various post-migration barriers and facilitators of treatment success. Obtaining a more secure immigration status, reported in four studies, was the most emphasized factor associated with clinical improvement. Although the quality of the studies was overall high, there were frequent study limitations including small sample sizes and inconsistent post-stressor measures.

Conclusion: Recommendations for future research include more robust methodologies, including mixed and longitudinal designs, and consistently using valid tools to assess post-migration stressors. The studies provide evidence for the effectiveness of psychological treatment in reducing symptoms of distress, despite being implemented in the context of post-migration stress. Post-migration stressors, although they may hamper treatment results, are not an indication to withhold treatment but a sign that additional services may be needed, but uniform and consistent evaluation of post-migration stressors should be implemented.

La relación entre estresores post migración y los resultados del tratamiento del trauma: una revisión de alcance

Antecedentes: Las personas que buscan refugio y asilo con frecuencia deben soportar diversas adversidades antes, durante y después de la migración, lo que las hace más susceptibles a desarrollar problemas psicológicos. El efecto de los estresores post migratorios sobre la respuesta al tratamiento psicológico no es claro.

Objetivos: (1) evaluar el alcance de la literatura sobre la relación entre estresores post-migratorios (por ej., dificultades relacionadas con la situación legal en el contexto del reasentamiento) y los resultados de las intervenciones dirigidas al TEPT y las condiciones comórbidas, en adultos refugiados y solicitantes de asilo; (2) identificar las limitaciones conceptuales y metodológicas de la literatura; y (3) presentar las limitaciones y recomendaciones para investigaciones futuras.

Métodos: Esta revisión sigue los lineamientos de PRISMA-ScR para las Revisiones de Alcance y el marco de Población, Concepto y Contexto (PCC) para identificar conceptos relacionados a la pregunta de revisión y la estrategia de búsqueda.

Resultados: De 1.151 estudios encontrados a través de PsycINFO, PubMed, Web of Science Select y la revisión de fuentes, evaluamos los 14 estudios que cumplieron con nuestros criterios y encontramos diversas barreras post migración y facilitadores del éxito del tratamiento. Obtener un estatus de inmigración más seguro, reportado en cuatro estudios, fue el factor más destacado asociado con la mejoría clínica. Si bien la calidad de los estudios fue en general alta, hubo limitaciones frecuentes incluyendo el tamaño pequeño de las muestras e inconsistencia de las mediciones post estresores.

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KEYWORDS
Post-migration stress; refugees; asylum seekers; psychotherapy; psychosocial interventions; posttraumatic stress disorder; scoping review

PALABRAS CLAVE
Estrés postmigratorio; refugiados; solicitantes de asilo; psicoterapia; intervenciones psicosociales; trastorno de estrés postraumático; revisión de alcance

HIGHLIGHTS

- This scoping review evaluated the relation between adults' post-migration stressors and outcomes of interventions targeting PTSD and comorbid conditions.
- Obtaining a more secure immigration status was the most emphasized post-migration factor associated with clinical improvement.
- Most research evaluating the effect of post-migration stressors on treatment outcome have had various methodological limitations.
- There is no evidence that ongoing resettlement stressors are an indication for refraining from treatment.

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Conclusión: Las recomendaciones para investigaciones futuras incluyen metodologías más robustas, que incorporen diseños mixtos y longitudinales y la utilización sistemática de instrumentos válidos para evaluar los estresores post migración. Los estudios proveen evidencia para la eficacia del tratamiento psicológico para reducir los síntomas de angustia, a pesar de implementarse en el contexto de estrés post migración. Si bien los estresores post migración pueden alterar los resultados del tratamiento, no son una indicación para suspenderlo, sino una señal de que podrían necesitarse servicios adicionales, pero deberían implementarse evaluaciones uniformes y consistentes de los estresores post migratorios.

1. Introduction

We present a scoping review of research on the relation between post-migration stressors and outcomes of psychological interventions for PTSD symptomatology among adults seeking refuge and asylum. We first define the population surveyed in the articles reviewed, list various pre-, peri- and post-migration traumas and stressors, and review the literature on the mental health of forced-displaced people and the treatments used with them.

At the beginning of 2024, the number of forcibly displaced people worldwide exceeded 117 million (UNHCR Global Trends, 2024). Violence, armed conflicts, and human rights violations are some of the factors forcing populations to leave their homes and communities. Additional hardships, particularly post-migration stressors, may arise in the context of resettlement, adding to prior potentially traumatizing experiences (PTEs). People displaced within their countries of origin account for about 60% of the displaced populations. Of those who have crossed international borders, 67% reside in countries neighbouring their home country and close to three out of four people seeking international protection do so in low- and middle-income countries (UNHCR Global Trends, 2024).

The term *refugee* implies that someone has crossed a border as a result of war, violence, conflict, torture, or a well-founded fear of persecution connected to race, nationality, religion, political views, or equivalent (UNHCR, 1967). Seeking asylum is a human right (United Nations [UN], n.d.) and a*sylum seekers* request international protection from persecution or human rights violations but have yet to acquire refugee or permanent legal status (Amnesty International, n.d.). We discuss below common experiences of people seeking refuge.

1.1. Pre-, peri-, and post-migration stressors and their evaluation

1.1.1. Pre-migration stressors

It takes a lot for a person or family to leave their home. There are many pre-migratory factors that make people take this step, including human rights violations, armed conflict, and physical violence. As would be expected, refugees are more likely to have had PTEs than the general population (Li et al., 2016) and more PTEs predict psychological disorders like depression, anxiety, and PTSD (Adams & Boscarino, 2006). A frequently reported PTE is sexualized and sexual violence, which places women at greater risk (Tolin & Foa, 2006; UNHCR, 2003).

1.1.2. Peri-migration stressors

To exercise the right to seek asylum in another country many people are forced to undergo perilous journeys. There is a risk of encountering additional PTEs during the flight, such as human trafficking, sexual violence, forced labour, and detention (UNHCR, 2021). According to the Convention and Protocol Relating to the Status of Refugees, states are prohibited from penalizing illegal entries or stays of refugees and expelling refugees to countries where they fear a threat to life or human rights (UNHCR, 1967). Nevertheless, this is not always a reality because of hostile and restrictive migration policies.

1.1.3. Post-migration stressors

Post-migration stressors are challenges or barriers that refugees and asylum seekers confront in the context of integration and resettlement. They include uncertainty about legal status and one's rights; poor living or working conditions; loss of financial, social, and professional status; cultural shock; being dependent on others and having problems communicating one's needs; not knowing how to access necessary services; difficulty finding suitable accommodation; dissatisfaction with the employment situation; having to acquire new skills; racism and exclusion; social isolation; and possible deportation (Cardeña et al., 2025; Silove et al., 1997; UNHCR, 2024). These stressors relate to mental ill health (even after pre-migration factors are controlled for) and health-related quality of life (Carswell et al., 2011; Gleeson et al., 2020; Jannesari et al., 2020; Li et al., 2016; Miller & Rasmussen, 2010; Schick et al., 2016; Solberg et al., 2020). Several studies with similar definitions and measurements conceptualize the challenges refugees face post-migration. Instruments to assess stressors include the Post-migration Living Difficulties Checklist (PMLDC), which measures the asylum-process and

related problems such as separation from family and limited access to work opportunities and healthcare (Silove et al., 1997) and the Refugee Post-Migration Stress Scale (RPMS), with seven domains such as perceived discrimination, social strain, family conflict, and others, which correlate with depression, anxiety, and PTSD scores, and negatively with mental well-being (Malm et al., 2020). A new measure assesses common posttraumatic symptoms as well as posttraumatic stressors such as emotional distress, anger, concerns about family/friends in other countries, concerns about family/friends in country of resettlement, adjustment/resettlement/practical difficulties, and impairment (Cardeña et al., 2025).

1.2. Mental health among resettled refugees

Mental health is a human right and does not only include the absence of mental illness but the ability to handle life stressors and contribute to one's community. Mental ill health is more common among refugees and asylum seekers than in other groups of migrants, such as labour migrants and general populations in host countries (Blackmore et al., 2020; Bogic et al., 2015; Heeren et al., 2014; Nickerson et al., 2017; Steel et al., 2009). In one study, the association between resident status and mental health outcomes persisted even when controlling for social desirability, post-migration resources, and previous traumatic events (Heeren et al., 2014; Shawyer et al., 2017). Asylum seekers and refugees have similar levels of past trauma, anxiety, depression, and post-traumatic stress, but asylum seekers score higher on post-migration stressors, particularly those related to insecure residency status and legal rights (Silove et al., 1998).

Even though most literature focuses on PTSD symptomatology, other common symptoms among people seeking refuge and asylum include dissociation, depression, and anxiety. Past traumatic experiences and post-migration stressors predict higher rates of mental disorders, and these elevated rates persist over time (Blackmore et al., 2020; Bogic et al., 2015) and impact affected individuals and their families (Sangalang & Vang, 2017).

1.3. Treatment of mental Ill health in refugees and asylum seekers

Although refugees have more mental health disorders than host country populations, they are less likely to receive treatment and support (Legido-Quigley et al., 2019), and there are few guidelines for their treatment. Current recommended psychological interventions for the prevention and treatment of PTSD in general population adults include trauma-focused cognitive–behavioural therapies (TF-CBT) (American Psychological Association, 2017; National Institute for Health and Care Excellence [NICE], 2018). Pharmacological interventions are not recommended unless the patient prefers drug treatment or has not responded to other treatments (NICE, 2018). Trauma-focused psychological therapies have been effective in refugees and asylum seekers (Nosè et al., 2017; Turrini et al., 2019), even in the presence of multiple traumas, complex PTSD, and war and torture trauma (Thompson et al., 2018), but a recent meta-analysis found a reversion back to baseline at 3-to-6 month follow ups (Daniel et al., 2024).

Some treatments presuppose that the patient is treated in the context of safety, which might be the case for veterans and others for whom many PTSD treatments were developed, but this raises the question of the efficacy of psychological treatments for PTSD in the context of ongoing adversity such as post-migration stressors. For instance, the goal of stability in a phase-model of treatment presupposes basic safety. A phased treatment consists of an initial stabilizing phase focusing on safety, coping skills training, and symptom reduction; a second focuses on the processing of previous trauma; and a third on social reconnection and reintegration (e.g. Cardeña et al., 2009; Cloitre et al., 2012). Furthermore, a critique of trauma-focused treatment is that exposure elements may be psychologically overwhelming for patients living under unsafe circumstances (Ventevogel et al., 2015). Thus, clinicians might unnecessarily avoid or delay treatment until traumatized individuals are in a safe context (cf. Ter Heide et al., 2016), but withholding treatment even in precarious situations is questionable.

Recent studies suggest that the requirement of a stabilization phase, which is seldom possible for refugees and asylum seekers, lacks evidence (Ter Heide et al., 2016; Tribe et al., 2019). Furthermore, it is not justified to delay or deny these patients healthcare or support (De Jongh et al., 2016; Gušić et al., 2019; Ter Heide et al., 2016; Thompson et al., 2018; Tribe et al., 2019; Turrini et al., 2024). Recovering from PTSD may improve resilience, cognitive capacity, and energy levels (Turrini et al., 2024).

Although it is not possible to completely differentiate between the psychiatric and the social (Gušić et al., 2019), clinicians also ought to be attentive to the structural and political context surrounding their clients. Interdisciplinary approaches are emerging. Miller and Rasmussen (2010) propose an integrative, sequenced approach model where treatment is offered but preceded by, or combined with, addressing particularly impactful stressors. UNHCR, International Organization for Migration (IOM), and The Mental Health & Psychosocial Support Network (MHPSS.net) present ways to address psychological, social, and cultural aspects of well-being (Ventevogel et al., 2015). The International Society for Traumatic Stress Studies mentions the importance of contextual

factors (e.g. family background and daily stressors) when working with refugees and asylum seekers (Nickerson et al., 2017).

1.4. The current study

To our knowledge, no review has examined the relation between treatment for posttraumatic conditions and ongoing post-migration stressors for refugees and asylum seekers, though there have been requests to address this gap in the literature (Li et al., 2016; Malm, 2021; Nickerson et al., 2017; Stammel et al., 2017; Yim et al., 2023). This scoping review evaluates the relation between post-migration stressors and the psychological treatment of refugees and asylum seekers.

2. Methods

This review follows the guidelines of PRISMA-ScR, Preferred Reporting Items for Systematic Reviews, and Meta-Analyses extension for Scoping Reviews (Tricco et al., 2018). It is still an emerging approach used to scope out the size and nature of the state of the literature, clarify concepts, examine how research is conducted, and highlight gaps in the existing research or preceding systematic reviews (Munn et al., 2018). We also chose this framework for its appropriateness when exploring a heterogeneous field relating to different academic disciplines (Arksey & O'Malley, 2005; Levac et al., 2010). Scoping reviews require systematic and transparent methods when synthesizing knowledge and usually do not contain statistical analyses or systematic methodological appraisals of the sources (Tricco et al., 2018).

This review used the Population, Concept, and Context (PCC) framework for identifying concepts pertaining to the review question and the search strategy (Pollock et al., 2023; Tricco et al., 2018) and focused on adult refugees and asylum seekers (population) undergoing treatment for traumatic experiences of war, torture, or persecution (concept) in a post-migration setting (context). Although depression, anxiety, and other comorbidities are frequent in the population, treatment for PTSD symptomatology was a criterion when selecting studies. It was used as a marker because of the concern of initiating PTSD treatment with individuals in unstable living conditions, rooted in the idea of the need for stabilization before implementing exposure components to mitigate the risk of heightened distress. However, because of the mapping nature of a scoping review, related mental health and treatment concepts found within the scope were explored.

The objectives of the study were to:

(1) Map and explore the current scope of literature to evaluate the relation between post-migration stressors in adult refugees and asylum seekers and posttraumatic symptomatology in the context of treatment outcome.
(2) Evaluate the quality and risk of bias of the publications to identify conceptual and methodological limitations.
(3) Present limitations and recommendations for future research.

2.1. Information sources and literature search

A review protocol was registered on the Open Science Framework on the 6th of July, 2023, https://osf.io/sdu7j/. The electronic databases PsycInfo, PubMed, and Web of Science Select were screened independently by the two authors, without date or language filters. Based on consultations with clinicians and researchers working in the field of trauma and previous reviews and readings of reports on the subject (e.g. Ennis et al., 2021; Gleeson et al., 2020; Malm et al., 2020; O'Brien & Charura, 2022; Yim et al., 2023), search terms were selected and individually searched for relevance, before being added to the complete query. The final search strategies are presented in Appendix A. After arriving independently to a list of potential articles to include, the authors communicated to reach a consensus on which were relevant.

2.2. Eligibility criteria

Studies had to: (1) target adult refugees or asylum seekers with traumatic experiences of war, torture, or flight, undergoing psychological treatment for posttraumatic related symptoms, (2) assess interventions aimed at reducing PTSD-related symptomatology (including depression, anxiety, dissociation, and sleep disturbance), (3) occur in a context of post-migration or post-resettlement, where post-migration stressors were assessed, and (4) be peer-reviewed. Studies were excluded if they were systematic reviews, meta-analyses, preliminary data, or grey literature since only empirical studies were considered in this review.

The final combinations of search terms were run in the databases PsycInfo, PubMed, and Web of Science Select. Titles and abstracts were screened and selected if they fulfilled the inclusion criteria. Additional records were found through bibliographies of eligible or otherwise topically relevant articles. The selection of sources of evidence is presented in Figure 1.

2.3. Data charting process and data items

See Table 1 for the following items extracted from the selected articles: (1) *Authors, year, and country of study*, (2) *Study design,* (3) *Aims,* (4) *Sample,* (5) *Intervention type, duration, and agent,* (6) *Post-migration stress measure,* (7) *Definition of relation between*

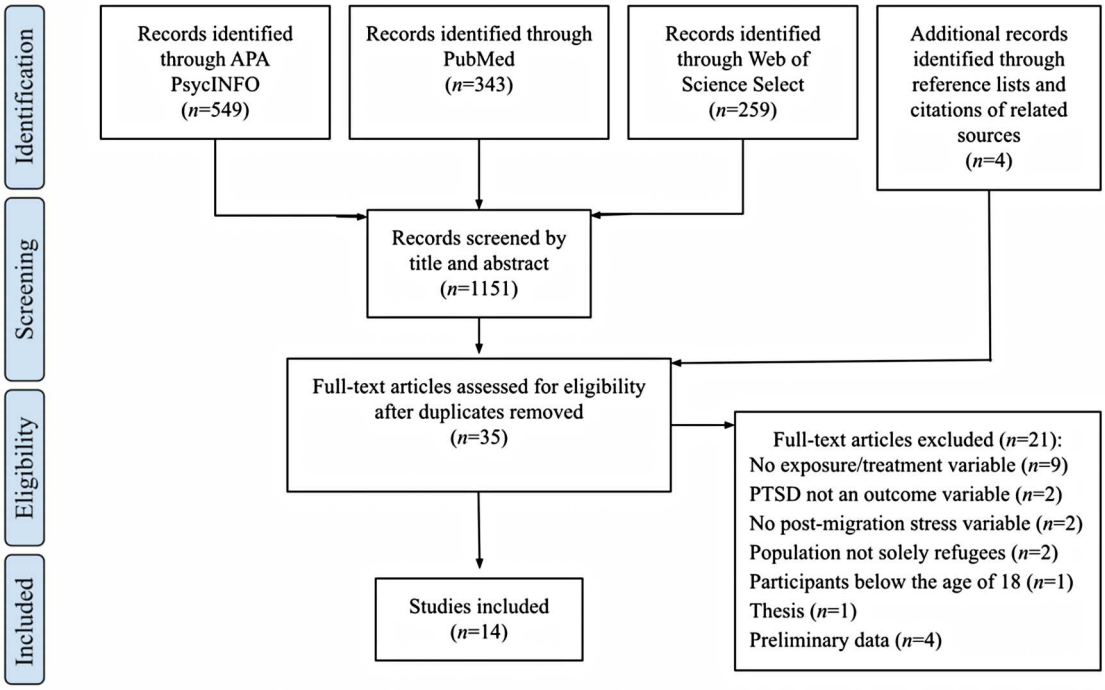

Figure 1. Selection of Articles.

intervention and post-migration stressors, (8) *Mental health measure*, and (9) *Main findings*.

2.4. Critical appraisal of individual sources of evidence

Prior to inclusion, the risk of bias was assessed using the Joanna Briggs Institute's Critical Appraisal Tools (Joanna Briggs Institute, n.d.). The evaluation tool was chosen based on its applicable range (Ma et al., 2020). We used the checklist for Analytical Cross-Sectional Studies to assess the compiled data. The presence of each criterion was rated as 'yes,' 'no,' 'unclear,' or 'not applicable'. Each study was judged for low (<4) or high (>4) quality. The assessment can be found in Table 2.

Because this scoping review evaluated results from existing primary research, institutional ethics approval was not required. We used transparency in the execution of the search strategy, eligibility criteria, interpreting, and charting processes, in line with recommended methods (Suri, 2020). To anchor the review in ongoing practice and perspectives of healthcare providers impacted by the research, knowledge users were consulted in formulating the review question and scope. They were clinicians and researchers at the Red Cross treatment and competence centres in Uppsala.

2.5. Synthesis of results

We used a narrative synthesis method to summarize, explore, and map the charted data. This approach is appropriate when there is heterogeneity in the studies' methods, participants, and data (Lucas et al., 2007; Peters et al., 2020). The synthesis adheres to the Guidance on the Conduct of Narrative Synthesis for Systematic Reviews (Popay et al., 2006). Studies were thematically grouped by categories of post-migration stressors acting as barriers or facilitators to the implementation or successfulness of treatment outcomes.

3. Results

Thirty-five studies potentially meeting the inclusion criteria were identified, after excluding articles unrelated to the review's topic, as judged from their titles or abstracts. After full-text screening, several studies did not meet inclusion because they lacked a clear psychological treatment, had no measure of post-migration stressors, and so on. Some records were excluded based on features like including non-refugees, adolescents, or being a thesis or preliminary data. At the end, 14 studies fulfilled all the study's criteria. A PRISMA flowchart outlining the selection process is presented in Figure 1.

3.1. Characteristics of sources of evidence

Table 1 below presents information regarding authors, year and country of study, study design, aim(s), sample (size, legal status, country of origin if stated, and mean age), intervention type, duration and agent, post-migration stress measure, definition of relation between intervention and post-migration stressors, mental health measures, and main findings.

3.2. Critical appraisal

3.3. Synthesis of results

3.3.1. Overview of studies

As shown in Table 1, most studies were conducted in Denmark, the United States, and the Netherlands, and

Table 1. Characteristics and results of sources of evidence.

Study	Study design	Aims	Sample	Intervention type, duration and agent	Post-migration stress measure	Relation between intervention and post-migration stressors	Mental health measure	Main findings
Bruhn et al., 2018; Denmark	Longitudinal	To assess frequency and types of post-migration stressors considered to interfere with the treatment of refugees for trauma-related mental distress.	Refugees ($n = 140$ initial, 116 completers), multinational	Multidisciplinary treatment (CBT and medical doctor meetings); 6 months; medical doctors, psychologists, and interpreters, and social counsellor pre-treatment	Clinician-rated postmigration stressors interfering with treatment (PMS-IT) (accommodation, work/finances, family, and residency permit), developed for study	Post-migration stressors' *interference* with treatment.	HTQ; GAF-F; GAF-S	Post-migration stressors impacted 39% of sessions. Stressors related to work, finances, and family were the most important. Stressors interfering were most common among males, those living alone, Middle East origin, and low baseline GAF-F.
Djelantik et al., 2020; The Netherlands	Naturalistic pre and post study design	To study reductions in PTSD and PCBD (grief) symptoms and explore the presence of post-migration stressors and their associations with symptom change and non-completion in a traumatic grief-focused treatment for refugees.	Asylum seekers and refugees ($n = 81$, 57 completers), multinational, M(age) = 42	DPT-TG (including BEP-TG), group and individual; one year; psychologists and psychiatrists	Qualitative analysis of the patient files for stressors (but not for symptoms) (Li et al., 2016)	Post-migration stressors *associations* with symptom change and non-completion in treatment.	TGI-SR; CAPS-5	Medium effect size significant reductions in PCBD and PTSD were found. Ongoing conflict in the country of origin was associated with smaller PTSD symptom reductions, and the total number of post-migration stressors was linked to smaller PCBD symptom reductions. Asylum seekers who received a negative status decision were more likely to be non-completers.
Drožđek et al., 2013; The Netherlands	Longitudinal	To examine legal status and other resettlement stressors' influence on outcomes of a trauma-focused group PTSD treatment within a day-treatment setting.	Asylum seekers and refugees ($n = 66$), Iran, Afghanistan, M(age) = 38.3	Group psychotherapy and non-verbal (psychomotor, art, and music) therapy, and medication; one year; therapists and interpreters	Interview with semi-structured self-constructed questionnaire (legal status, living arrangements, housing, family left behind, work, and fluency in Dutch). Questions about losses and life changes.	Legal statuses' and other resettlement stressors' *influence* on outcomes of treatment	HTQ; HSCL-25	Obtaining refugee status improves outcomes of group therapy for PTSD. Asylum seekers may benefit from group treatment regardless of unstable living conditions.
Graef-Calliess et al., 2023; Germany	Naturalistic multi-center, cross-sectional	To investigate whether PMLD and perceived discrimination predict mental health at the beginning of treatment and treatment effects within the refuKey project among asylum seekers and refugees	Asylum seekers and refugees ($n = 541$ initial, 95 completers), multinational, M(age) = 32,67	refuKey (multi-sessions treatments) in a stepped-care setting; clinical staff and interpreters	17 item PMLDC (Silove et al., 1997) (general adaptational stressors, family concerns, refugee determination process, health, welfare and asylum problems, and social and cultural isolation)	The *relation* between post-migration stressors and mental health in treatment-seeking asylum seekers and refugees	WEMWBS; HSCL-25; SCL-90; HTQ; WHOQoL-BREF	Mental health improved after treatment. PMLD and perceived discrimination predicted all mental health outcomes before but not after treatment. Perceived discrimination only correlated significantly with quality-of-life and traumatization.
Haagen et al., 2016; The Netherlands	Prospective longitudinal multilevel modelling design, analyzing data from a RCT	To identify response predictors of PTSD treatment for adult refugees	Refugees and asylum seekers ($n = 72$, 58 completers), multinational, M(age) = 41.5	EMDR or stabilization therapy; nine or 12 sessions; trained clinicians and interpreters	Lack of refugee status, and comorbid depression, demographics, trauma-related and treatment-related variables analyzed as potential predictors of PTSD treatment outcome	Whether factors such as lack of refugee status, and interpreter presence during therapy were *potential predictors* of PTSD treatment outcome.	CAPS; HSCL-25;	Refugee patients with PTSD and severe comorbid depression benefit less from PTSD-focused treatment. The findings emphasize the need to adapt treatments for PTSD and severe depression in traumatized refugees and to explore whether initially targeting depressive symptoms could enhance the effectiveness of PTSD treatment.

Kashyap et al., 2019; United States	Naturalistic longitudinal	To investigate factors associated with reduced psychological distress at an interdisciplinary clinic for survivors of torture addressing post-migration stressors.	Survivors of torture seeking asylum (n = 323), multinational, M(age) = 37.5	Interdisciplinary treatment (including psychological, legal and social services encounters); 6 months; information on service providers not available to researchers	Psychosocial treatment targets (presence of stable housing, employment and chronic pain, and clients' perception of having emotional support and organizational support).	*Relationships* between pre-, post-migration factors, and changes in depression and PTSD symptom levels	Parts of HTQ; PHQ-9	Symptoms of depression and PTSD decreased post-treatment. Higher amounts of pre-migration traumas, female gender, and change to a more secure visa status were associated with reduced distress. Accessing many social services and not reporting chronic pain was associated with PTSD reduction. Stable housing and employment significantly moderated the relation between lower chronic pain and reduced PTSD.
Knefel et al., 2022; Austria	Single-center RCT	To investigate the success of an adapted version of Problem Management Plus (aPM+).	Afghan refugees and asylum seekers (n = 88), Afghanistan, M(age) = 34.3	Brief transdiagnostic psychological intervention including a session on coping with PMLDs (adapted Problem Management Plus, aPM+) through anger regulation or self-efficacy, patients randomly allocated either to aPM + in addition to treatment as usual (aPM+/TAU) or TAU alone; 6 weeks; clinical psychologists and interpreters	26 item PMLDC (Silove et al., 1997), expanded to cover broader range of stressors and adapted to Austrian refugees	The interventions *association* with reducing distress by PMLDs and symptoms of PTSD, DSO, self-identified problems, and improved quality of life	RHS-15 (at baseline);HTQ; GHQ-28; ITQ; WHOQoL-BREF; PSYCHLOPS; IPL-12	PMLD-related distress and general health problems were reduced in the aPM + group in the short-term. The two groups differed on outcomes of physical health, PMLD distress, and PTSD symptoms. Interpretations were limited by the high drop-out rate.
Raghavan et al., 2013; United States	Longitudinal – one sample	To examine individual components of an interdisciplinary approach and their relation to symptom reduction.	Refugee survivors of torture (n = 172), multinational, M(age) = 36.9	Interdisciplinary approach (individual and group psychotherapy, medical treatment, and social, legal, and educational counselling); 6 months; psychologists and/or supervised trainees, psychiatrists, interpreters, experienced staff, and volunteers	Nonclinical variables assessed through interviews (immigration status, employment, and income)	*Correlates* of symptom reduction and immigration status, employment, and income variables	BSI; HTQ	45% of the treated patients experienced improvement in symptoms of PTSD, depression, anxiety, or somatization within the first six months of entering the treatment. Gaining secure immigration status was the strongest correlate of clinical improvement. Psychotherapy and educational sessions predicted improvement in symptoms beyond adjusting to a more secure immigration status.
Schick et al., 2018; Switzerland	Longitudinal cross-sectional	To examine interactions between changes in PTSD, depression, and anxiety symptoms and change in PMLD in traumatized refugees and asylum seekers receiving treatment.	Refugees and asylum seekers (n = 71), multinational, M(age) = 46	A variety of manualized trauma specific as well as non-manualized unspecific psychotherapeutic interventions and medication, individually adapted to patients' needs. All participants were offered social counselling addressing PMLD; The assessment at the 3-year follow-up was supervised by a clinical psychologist or a masters-level student of clinical psychology.	17-item PMLD (Silove et al., 1997), adapted to the Swiss context (loneliness, boredom or isolation, worries about family back home, being unable to return to home country in an emergency, difficulty learning German, separation from family, difficulties with employment, communication difficulties, fearful of being sent back to country of origin, difficulties getting financial assistance, etc.).	*Association* between change in PTSD, depression, and anxiety symptoms, and PMLD post-treatment.	HTQ; PDS; HSCL-25	At follow-up, patients showed a significant decrease in PTSD and depression/anxiety symptoms, as well as in more than half of the PMLD scores. Reduction in PMLD predicted changes over time in depression/anxiety, but not in PTSD. Depression/anxiety, but not PTSD, predicted changes in PMLD outcomes.

(*Continued*)

Table 1. Continued.

Study	Study design	Aims	Sample	Intervention type, duration and agent	Post-migration stress measure	Relation between intervention and post-migration stressors	Mental health measure	Main findings
Schock et al., 2016; Germany	Longitudinal	To explore the symptom course throughout treatment for patients with PTSD, after either experiencing or not experiencing a subsequent critical life event.	Refugees seeking asylum ($n = 94$, of whom 23 had experienced a subsequent stressful event or trauma), multinational, M(age) = 36	Multimodal treatment including psychotherapy, medical interventions, and support related to prior traumatic experiences; standardized symptom assessments were conducted at the beginning of treatment and after 6- and 12 months during treatment; therapists; social workers, and interpreters.	'List of Life Events' based on post-migration stressors (Silove et al., 1998) and clinical expert interviews, including an open category and eight events: rejection of asylum application and impending deportation, interview, war in the home country, physical abuse, serious illness, death or serious illness of relatives, verbal threats, and travel to the homeland.	*Impact* of new stressful or traumatic life events on pre-existing PTSD, depression, and anxiety symptoms throughout treatment.	PTS; PDS; HSCL-25	New stressful life events, in addition to traumatic events, increased posttraumatic, anxious, and depressive symptoms in the first 6 months after the events, with no differential symptom exacerbations between the two event types. Stressful life events, with insecurity about residency status being the most frequently mentioned, were associated with an increase in PTSD avoidance symptoms.
Sonne et al., 2016; Denmark	Longitudinal – one sample	To examine possible psychosocial predictors of treatment outcomes.	Trauma affected refugees ($n = 195$), multinational	Multidisciplinary treatment (pharmacological treatment, psychoeducation, manualized cognitive therapy, and social counselling); 6–7 months; psychiatrists, medical doctors, psychologists, and social counsellors.	CTP Predictor Index developed for study (motivation, upbringing, previous relevant treatment carried out without measurable effect, chronic pain, chronicity of mental condition, understanding of the concept of therapy, receptiveness to treatment, reflectivity, motivation for participation, cognitive resources, social relations, etc.)	The *relations* between treatment outcomes and scores of the CTP Predictor Index	HTQ; HSCL-25; HAM-D + A; SDS; WHO-5; SCL-90; VAS; GAF	The total score of the CTP Predictor Index (of psychosocial resources potentially predicting treatment outcome) correlated significantly with outcomes on most of the mental health scales, with modest correlations. The only item significantly correlated with PTSD symptoms was employment status. Integration and education were significantly related to depression and anxiety symptoms with the association being negative for education.
Sonne et al., 2021; Denmark	Longitudinal, on data pooled from two consecutive RCTs	To identify possible predictors of treatment outcomes regularly assessed in clinics, for refugees with PTSD.	Trauma-exposed refugees (n = 321), multinational, M(age) = 43.4	Bio-psycho-social treatment programme (offered a combination of pharmacotherapy, psychoeducation, psychotherapy and social counselling); 6–7 months, longer for some patients due to practical circumstances; psychiatrists, psychologists, and social counsellors.	Possible predictors of treatment outcomes regularly assessed in clinics, including sociodemographics, refugee status, time since arrival, living alone or not, occupational status, and adhering to Muslim faith.	What factors *predict* treatment outcomes?	HTQ; HSCL-25; HAM-D + A;	High baseline scores and high level of functioning were associated with improvements on all ratings. Full time occupation, young age, short time in host country, and status as family reunified (compared to refugee) were associated with improvement on at least one outcome measure. Being Muslim had an inverse correlation with symptom improvement.

Van Wyk et al., 2012; Australia	Longitudinal naturalistic	To examine the impact of therapeutic interventions for refugees from Burma on mental health within a naturalistic setting.	Refugees ($n = 70$ initial, 62 pre and post), Burma, M(age) = 34.13	Combination of therapeutic interventions (conducted with the aim of facilitating adjustment); 6.9 months on average; therapists with professional backgrounds in psychology, social work, and counselling, interpreters	PMLDC (Silove et al., 1997), 7 categories adapted to Australian context.	Strength of *relation* between initial symptom score, final symptom score, PMLD, and trauma experiences	HTQ; HSCL-37	The patients' symptoms of posttraumatic stress disorder, anxiety, depression, and somatization decreased significantly. Pre-intervention symptoms predicted symptoms post- intervention for posttraumatic stress, anxiety, and somatization. Number of traumas experienced, the number of contacts with the service agency, and PMLD were not related to any of the mental health outcomes.
Whitsett & Sherman, 2017; United States	Naturalistic observational	To examine whether the resettlement factors housing, language fluency, and employment status predict integrative mental health intervention outcomes.	Asylum-seeking survivors of torture ($n = 105$), multinational, M(age) = 34.8	Integrative group and individual psychotherapy (supportive, psychoeducational, CBT, interpersonal and exposure techniques), and case management services; slightly more than a year; clinical psychologists, licensed clinical social workers, and interpreters	Resettlement variables assessed through semi-structured interviews (housing, language fluency, and employment status)	Whether resettlement factors *predict* intervention outcomes	HTQ; HSCL-25; HURIDOCS Events Standard Formats Second Edition	Patients experienced significant improvements in depression, anxiety, and trauma symptoms, although symptoms remained near or above clinical thresholds. Stable, uncrowded housing conditions significantly predicted lower depression, anxiety, and trauma symptoms at follow-up.

Abbreviations: GAF-F: *Global Assessment of Functioning, function*; PTSD: posttraumatic stress disorder; PCBD: persistent complex bereavement disorder; PMLD: *Post-migration Living Difficulties;* CTP Predictor Index: *Competence Centre for Transcultural Psychiatry Predictor Index*; CBT: *cognitive behavioral therapy*; PMS-IT: *postmigration stressors interfering with treatment*; HTQ: *Harvard Trauma Questionnaire*; GAF-F: *Global Assessment of Functioning, function*; GAF-S: *Global Assessment of Functioning – Symptom Scale*; DPT-TG: *day patient treatment for traumatic grief*; BEP-TG: *brief eclectic psychotherapy for traumatic grief*; TGI-SR: *Traumatic Grief Inventory-Self Report*; CAPS-5: *Clinician-Administered PTSD Scale 5*; HSCL-25: *Hopkins Symptom Checklist-25*; PMLDC: *Post-migration Living Difficulties Checklist*; WEMWBS: *Warwick Edinburgh Mental Well Being Scale*; SCL-90-R: *Symptom Checklist 90-R*; WHOQoL-BREF: *WHO Quality-of-Life-BREF*; EMDR: *eye movement desensitization and* reprocessing; PHQ-9: *Patient Health Questionnaire-9*; RCT: *Randomized Controlled Trial*; aPM+: *adapted Problem Management Plus*; RHS-15: *Refugee Health Screener*; GHQ-28: *General Health Questionnaire 28*; ITQ: *International Trauma Questionnaire*; PSYCHLOPS: The Psychological Outcome Profiles; IPL-12: *Immigrant Integration Index*; BSI: *Brief Symptom Inventory*; PDS: *Posttraumatic Diagnostic Scale*; PTS: *posttraumatic stress symptoms*; CTP Predictor Index: *Competence Centre for Transcultural Psychiatry Predictor Index*; HAM-D + A: *Hamilton Depression and Anxiety Ratings Scales*; SDS: *Sheehan Disability Scale*; WHO-5: *WHO-5 Well-being Index*; SCL-90: *the somatisation scale of the Symptoms Checklist-90*; VAS: *visual analogue scales*; HSCL-37: *Hopkins Symptom Checklist-37*

Table 2. Critical appraisal within sources of evidence.

Publication	1.	2.	3.	4.	5.	6.	7.	8.	Met
Bruhn et al., 2018	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	8/8
Djelantik et al., 2020	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	8/8
Drožđek et al., 2013	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	8/8
Graef-Calliess et al., 2023	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	7/8
Haagen et al., 2016	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	8/8
Kashyap et al., 2019	Yes	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	7/8
Knefel et al., 2022	Yes	Yes	Yes	Yes	Yes	Yes	yes	Yes	8/8
Raghavan et al., 2013	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	8/8
Schick et al., 2018	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	8/8
Schock et al., 2016	Unclear	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/8
Sonne et al., 2016	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	8/8
Sonne et al., 2021	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	8/8
Van Wyk et al., 2012	Unclear	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/8
Whitsett & Sherman, 2017	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	8/8

1: Were the criteria for inclusion in the sample clearly defined? 2: Were the study participants and the setting described in detail? 3: Was the exposure measured in a valid and reliable way? 4: Were objective, standard criteria used for measurement of the symptomatology? 5: Were confounding factors identified? 6: Were strategies to deal with confounding factors stated? 7: Were the outcomes measured in a valid and reliable way? 8: Was appropriate statistical analysis used?

then Germany, Australia, Austria, and Switzerland. A few studies targeted specific populations in terms of country of origin: Iran, Afghanistan, and Burma, whereas most included regions or continents (or countries within these) such as the Middle East, Africa, Asia, Europe, and the Americas. Study sample sizes ranged from 323 to 66. The studies were conducted in specialized healthcare and the treatment providers were psychologists, non-specified therapists/clinical staff, social workers/counsellors, and medical doctors (in psychiatry and other specialties); in most studies interpreters were available as needed. Only one study (Kashyap et al., 2019) lacked information about the service providers. However, it was partly based on a previous study by Raghavan et al. (2013), carried out in the same clinic and involving several health professionals, therefore it is likely that similar types of clinicians were involved in it. Four studies used group interventions, either on their own or alongside individual sessions. Stated treatment duration ranged from six weeks to slightly over a year. Most of the administered treatments explicitly targeted psychosocial, including post-migration, stressors in addition to PTSD and other diagnoses. Most studies used existing definitions or diagnostic criteria to assess diagnostic treatment outcomes. Because of the lack of generic measures of postmigration stressors, the indices and assessments used varied among the studies. Studies had high overall quality and no studies were of low quality.

3.3.2. Domains

Compiled data of included studies was thematically divided into categories relevant to the review's objective. Aspects related to post-migration stress clustered into nine domains: *Legal status, housing, work/education, finances, language, family, discrimination and social/cultural isolation, worries about healthcare access*, and *refugee determination processes*.

Definitions of post-migration stressors were not always described within the samples. Nonetheless, measured stressors related to: (a) *family*, as in living arrangements and family concerns (10 studies); (b) *legal status* (8 studies); (c) *housing* (8 studies); (d) *finances* (4 studies); (e) *refugee determination processes* and related stressors such as interviews with immigration officials or conflict in the country of origin (4 studies); (f) *discrimination and social/cultural isolation* (2 studies); (g) *work/education* (7 studies); (h) *learning a new language* (6 studies); (i) *worries about healthcare access* (2 studies); and (j) *receptiveness to treatment* (1 study). One study mentioned *organizational support* which might have overlapped with other domains and was thus not included in any domain. Another described new *traumatic events* (such as watching videos of violence in the home country involving friends and family members) and stressful life events, but only the latter were categorized into domains.

3.3.3. Barriers to treatment success

Several potential barriers to treatment success were assessed (see Table 3). One was the number of post-migration stressors experienced (Djelantik et al., 2020; Sonne et al., 2016). Unemployment correlated with less reduction in PTSD symptoms (Sonne et al., 2016). Work, finances, and family concerns interfered with treatment outcomes (Bruhn et al., 2018). In one study, ongoing conflict in the country of origin was associated with lower symptom reduction (Djelantik et al., 2020). Poor integration and higher levels of education correlated negatively with improvement in anxiety and depression items (Sonne et al., 2016). Individual differences in PTSD treatment effects were partly attributed to the presence and severity of comorbid depression in one study (Haagen et al., 2016). Experiencing stressful life events, most of which were related to insecure residency status, was associated with increased PTSD avoidance symptoms (Schock et al., 2016). A study found stressors to be more common among males, those living alone and those with Middle East origin (Bruhn et al., 2018); another study found that being Muslim correlated

Table 3. Barriers versus facilitators of treatment success.

Barriers	Facilitators
Negative asylum decision (Djelantik et al., 2020; Schock et al., 2016)	Secure immigration status (Drožđek et al., 2013; Kashyap et al., 2019; Raghavan et al., 2013; Schick et al., 2018*)
Unemployment, financial/work issues (Bruhn et al., 2018; Sonne et al., 2016;); higher education (Sonne et al., 2016*)	Full-time occupation (Sonne et al., 2021)
Ongoing conflict in origin land (Djelantik et al., 2020) and stress related to family (Bruhn et al., 2018)	Reunified family (Sonne et al., 2021)
Poor integration (Sonne et al., 2016*) and living alone (Bruhn et al., 2018)	Stable, uncrowded housing (Whitsett & Sherman, 2017)
Symptom comorbidity (Haagen et al., 2016)	Access to social services (Kashyap et al., 2019)
# of post-migration stressors (Djelantik et al., 2020; Sonne et al., 2016)	

*Correlate with changes in anxiety and depression symptoms, but not PTSD.

negatively with symptom improvement (Sonne et al., 2021). Asylum seekers who received a negative decision were more likely to be non-completers (Djelantik et al., 2020).

3.3.4. Facilitators of treatment success

The most frequently reported facilitator of clinical improvement was obtaining a more secure immigration status (Drožđek et al., 2013; Kashyap et al., 2019; Raghavan et al., 2013; Schick et al., 2018). Schick et al. (2018) found this correlation for symptoms of depression and anxiety, but not PTSD. Sonne et al. (2021) found that full-time occupation, short time in the host country, and status as family reunified were associated with symptom reduction. Stable, uncrowded housing predicted improvements in anxiety, depression, and trauma symptoms (Whitsett & Sherman, 2017). Accessing many social services (Kashyap et al., 2019) was associated with PTSD reduction (see Table 3).

Higher pre-migration traumas (among torture survivors; Kashyap et al., 2019) and high baseline scores were associated with improvements in several ratings (Sonne et al., 2021). Being female (Kashyap et al., 2019) and younger (Sonne et al., 2021) related to reduced distress. Schick et al. (2018) reported that changes in depression and anxiety predicted changes in PMLD outcomes, and reduction in PMLD predicted changes in depression and anxiety. In an RCT (Knefel et al., 2022), both PMLD-related distress and general health problems decreased more in the treatment than in the control group.

3.4. Limitations and recommendations

Various limitations were mentioned in the studies themselves. Sample limitations were acknowledged in 12 studies, including low sample sizes, non-generalizability to broader population, missing values, and attrition. Measurement problems were likewise mentioned in 12 studies, of which those related to assessment instruments were the most frequently mentioned. Another limitation was subjective scoring methods through observer ratings or self-reports, which might influence estimates of effect sizes and reliability. Other limitations related to the statistical and psychometric methods applied.

Ten articles mentioned methodological limitations, including low internal validity because of study design, lack of a comparison group, use of secondary data, limited length of intervention or follow-up time, and limited analyses and coding methods. Eight studies discussed limitations in controlling for confounds, which generally referred to restricted numbers of demographic or resettlement variables, or strategies to deal with them.

Various studies recommended more frequent or long-term follow-ups, combining qualitative and quantitative methods, and/or using RCTs, and one study (Van Wyk et al., 2012) suggested examining services across agencies and considering the cultural assumptions of Western modes of mental health practices. Various studies also called for a standardization of post-migration stress measures, to account for as many factors as possible.

4. Discussion

4.1. Summary of findings

Fourteen studies fulfilled this study's criteria, with samples ranging from 66 to 323. We found and evaluated the effect of nine domains of post-migration stressors on trauma treatment outcomes: legal status, housing, work/education, finances, language, family, discrimination and social/cultural isolation, worries about healthcare access, and refugee determination processes. The number of post-migration stressors correlates negatively with treatment outcome (Djelantik et al., 2020; Sonne et al., 2016). and there was also evidence for specific stressors being barriers to treatment, as well as for some variables relating to improved outcome.

4.2. Barriers and facilitators to treatment outcome

4.2.1. Legal status and asylum decision

Legal status was the challenge to successful treatment implementation most often mentioned, although some articles did not report on legal status or used

the term 'refugees' inclusively, regardless of the recognition of the asylum seeker's claim. Several articles displayed the participants' asylum status in demographics as secure versus insecure, or temporary/permanent versus pending/rejected. In a study, attrition was higher in asylum seekers who received a negative status decision, making it a potential barrier to treatment success (Djelantik et al., 2020), whereas in another all participants had permanent visas or citizenships (Bruhn et al., 2018). Notably, patients granted a permanent refugee status showed more symptom reduction than those whose legal status was unchanged, including those who already had a permanent refugee status. Even after obtaining a refugee status and starting to rebuild their lives in new contexts, new post-migration stressors may arise (e.g. Drožđek et al., 2013). For instance, asylum seekers and refugees are often expected to quickly integrate into the host country, particularly by learning a new language and becoming financially self-sufficient, aspects that may be more difficult for mature individuals.

4.2.2. Unemployment, financial, work problems

One study reported that unemployment correlated with less reduction in PTSD symptoms (Sonne et al., 2016) and another that work, finances, and family concerns interfered with treatment outcomes (Bruhn et al., 2018). It is easy to see how financial problems and unemployment limit the options of refugees and asylum seekers and impact self-esteem negatively.

4.2.3. Poor integration/higher education levels

In one study (Sonne et al., 2016), both factors correlated negatively with changes in PTSD and depression symptoms. Poor integration is a factor that may severely restrict the options of refugees and asylum seekers. A higher level of education was associated with lower symptom reduction maybe because loss of status and identity in refugees with high educational levels may decrease integration possibilities (Sonne et al., 2016). Higher education, particularly if not recognized in the new country and/or not leading to employment, will accentuate the loss of a previous professional identity and respect.

4.2.4. Symptom comorbidity

Comorbid depression was related to a lower impact of PTSD treatment in a study (Haagen et al., 2016), which is a common finding in the treatment of comorbid symptomatology.

4.2.5. Ongoing danger/stressful life events

Ongoing conflict and danger in the land of origin can interfere with processing traumatic memories in treatment, emotionally and practically (Ennis et al., 2021; Yim et al., 2023). Stressful life events, but not new traumatic events, were associated with an increase in avoidance symptoms in Schock et al. (2016). The authors suggest that critical life events – such as the most frequently reported stressor in this study, the rejection of an asylum claim – may lead to feelings of social invalidation and helplessness and a reactivation of PTSD symptoms.

4.2.6. Communication limitations

A potential post-migration stressor involves difficulties in communication with authorities, support centres, and others. Most studies mentioned the help of interpreters without examining their impact through follow-ups (Bailey et al., 2020; Mälarstig et al., 2021). The lack of reporting potential problems raised by the use of translators has been mentioned previously (Jacobsen & Landau, 2003) and even though most studies occurred in naturalistic settings, the clinical reality is that healthcare services many times fail to provide patients with interpreters or therapists who speak their mother tongue (Mälarstig et al., 2021). This is an area that needs systematic evaluation.

4.2.7. Demographics

According to one study, being a woman predicted better treatment outcome (Kashyap et al., 2019), perhaps because women may express more psychological distress among asylum seekers and refugees, making improvements more detectable. Sonne et al. (2021) found that adherence to the Muslim faith was a negative predictor of treatment outcomes of anxiety and depression, perhaps because of a failure to provide patients with culturally appropriate healthcare and/or the possible negative influence of discrimination against Islam or Muslims impacting mental health.

4.3. Effectiveness of treatment

Despite being implemented in the context of post-migration stressors, evidence for the effectiveness of psychological treatment in reducing symptoms of distress was acknowledged by all studies. This review found symptom reductions using various treatments, where many of the post-migration stressors evaluated did not correlate with symptom change. Thus, to reject trauma-focus in therapy, or therapy at all, based on an assumption of the need for complete stability before starting therapy will leave people unnecessarily untreated for uncertain, and in many cases long, periods of time.

Symptom reduction was generally the single measure of whether the treatment was successful, but some authors mentioned the importance of even minor improvements in overall health and functioning for the patient group, generally highly symptomatic. The association of high baseline scores with symptom improvements (Kashyap et al., 2019; Sonne

et al., 2021) speaks for this as not only a challenging but also gratifying group to treat. Besides PTSD-related symptomatology, most studies examined multiple measures, including depression and anxiety. These improved after treatment, especially controlling for post-migration stressors. Furthermore, many studies had treatment targets and goals over and above symptom reduction, including quality of life, reduced post-migration stress, and enhanced protective factors (Dangmann et al., 2021; WHO, 2022).

The fact that an RCT (Knefel et al., 2022), adopting a transdiagnostic approach, including a session on coping with PMLDs, showed higher reductions in PMLD-related distress and general health problems in the treatment group supports a transdiagnostic approach. In addition to that RCT, most studies applied psychosocial approaches involving sessions with social counsellors, explicitly or indirectly addressing post-migration stressors. To manage these stressors, counsellors worked to strengthen patients' social networks and assist in applying for jobs, education, activities, and legal assistance. One study showed that 39% of medical/psychological treatment sessions were impacted by PMLDs (Bruhn et al., 2018). Accessing more social services correlated with PTSD reduction in another study (Kashyap et al., 2019), indicating the potential importance and value of addressing resettlement stressors alongside clinical treatment. Djelantik et al. (2020), speculated that the group setting may have offered participants support that enhanced their coping skills and management of resettlement stressors.

4.4. Limitations of the studies

4.4.1. Methodological limitations

Most studies mentioned methodological problems, some of which may be difficult to overcome (e.g. conducting RCT), but others may be solvable. Low sample sizes and attrition problems were mentioned in some studies, and more longitudinal designs should be implemented to assess the effect of changes in post-migration stressors across time. Another problem was the lack of clarity and comparability of the measures of post-migration stressors used. As mentioned in a previous review (Yim et al., 2023), the measurements used differ even when using the same instrument. Although several of the studies cited Silove et al. (1997), the PMLD categories had been adapted to the specific contexts based on what the studies deemed appropriate for the group and the context.

4.4.2. Inconsistent findings

Although specific post-migration stressors acted as potential barriers or facilitators in some studies, the same stressors showed no association with treatment outcomes in others. For instance, Van Wyk et al. (2012) and Haagen et al. (2016) found no association between the studies' selected PMLD and mental health outcomes, whereas Graef-Calliess et al. (2023) found that PMLD and perceived discrimination predicted mental health outcomes before treatment only. Note that Haagen et al. (2016) measured refugee status pre-treatment and, therefore, could not account for the potential impact of changes in refugee status throughout treatment, exemplifying the need for longitudinal studies. Furthermore, some of the barriers and facilitators of treatment success come from one or a few studies. This may be because of non-generalizability of findings but also because of the lack of a common measure of post-migration stressors.

4.4.3. Limited generalizability

Because of the sparseness of studies, our review could not compare groups of displaced people in terms of place of origin, ethnicity, reason for asylum, or religion, or draw firm conclusions about differences in resettlement conditions, and only two studies assessed discrimination (Graef-Calliess et al., 2023; Schick et al., 2018). Thus, any generalizations are limited, and we cannot determine potential interactions such as certain groups differing in their post-migration stressors. Even though they found relatively weak correlations between discrimination and treatment outcomes, Graef-Calliess et al. (2023) acknowledged that differences, visible ones in particular, such as language, skin colour, and cultural/traditional or religious, affect how much racism people experience in the labour market and other contexts. There might also be an under-reporting of discrimination, even in its more pronounced forms. For instance, anti-immigrant hate crimes are often under-reported, either because the targeted individual does not recognize the victimization as a crime or fears the consequences of involving the police; even when reported, police may fail to identify the crime as bias-driven due to language barriers or lack of training (Shively et al., 2013). Hate-crimes are often preceded by toxic language or hate speech (Arcila Calderón et al., 2024) and minorities, refugees, and other marginalized groups are increasingly stigmatized in public discourse for political gain (United Nations [UN], 2019).

Overall, few firm conclusions can be drawn given the inconsistent results and a lack of information on the studies' PMLD categories. The Joanna Briggs Institute's (JBI) critical appraisal of studies suggests that they would reach moderately high quality for this field (cf. Jacobsen & Landau, 2003), but there is room for improvement. Only one study was an RCT, but several articles used data from existing RCTs. It is noteworthy that several studies used self-constructed or adapted measurement instruments, making comparisons between studies somewhat arbitrary.

Adopting consistent measures of psychological health and migration stressors will allow a more precise elucidation of if/how different stressors may affect treatment outcome. There is also a need for more accessible interventions, such as community-based treatments, social support, problem management, and psychosocial interventions provided by trained helpers without health-professional background (Sijbrandij et al., 2017; Ventevogel et al., 2015).

Because many of the studies which took confounders into account found associations between demographic variables and symptom outcomes, other variables might be important as well, and difficulties in controlling relevant demographic or resettlement moderators was a commonly mentioned limitation. Many authors discussed the issue of resettlement variables being dependent on political legislation and thus uncontrolled by researchers.

The examined clinical settings do not make justice to the overall challenges of attaining healthcare faced by many refugees, particularly asylum seekers, due to their limited legal rights in host countries. Much of the research was conducted by or largely refers to human rights organizations working to protect the rights of refugees and other marginalized groups. A dual imperative in research on refugees is to meet high academic standards and, at the same time, influence policymakers (Jacobsen & Landau, 2003). Although the perspective of systems working closely with and for the targeted group is essential and central, these results might not cover the daily struggles in accessing healthcare.

Some studies reviewed discussed cultural sensitivity and the limitations of not considering patients' perspectives in the study design or assuming the diagnostic system to be universal, even though diagnostic manuals were developed in Western middle-class contexts and service providers in resettlement contexts may lack contextual understanding of patients' experiences. A more nuanced and culturally sensitive understanding of diagnoses and treatments of mental health conditions, with respect to representativeness is needed (Hinton & Lewis-Fernández, 2011; Lau & Rodgers, 2021; O'Brien & Charura, 2022) and might help bridge the gap between mental health care and resettlement services as well as prevent drop-out (Mbamba et al., 2022).

4.5. Limitations of this review

Our study and its implications are limited by various factors. First, it is a review with a small and fairly heterogenous set of studies. Second, there was an element of subjectivity in the inductive synthesis process of extracting objective-driven categories and domains. Third, no grey literature was searched for. Fourth, more databases might have been searched, although the ones used are comprehensive and likely the most important ones for the topic. Finally, we limited ourselves to samples of adult refugees and asylum seekers, partly due to the scarce research on children. Nonetheless, over half of the world's refugees are children (UNHCR, n.d.) and post-migration stressors may impact them even more than they do adults. Trauma and other stressors during childhood are particularly detrimental and a predictor of various mental and physical health conditions later in life (WHO, 2022).

5. Conclusions and implications

The inconsistent ways of assessing post-migration stressors point to the need for a more unified approach. Based on this study's mapping there is no commonly used instrument, with various studies using ad-hoc questions/items. The thematic categorization in this review corresponds well with these existing post-migration stress measurements, but even though many mentioned stressors were common in this literature sample, concepts were not culturally made equivalent, to make sure, that they refer to the same phenomena. The robustness of relations, limits of theoretical concepts, and development of new theories, moderators, and intervening variables could be explored by analyzing intervention effects across social groups and political and environmental contexts (Popay et al., 2006).

Given the high attrition within the studied population, an emerging area to explore is the implementation of short-term, intensive trauma treatment programmes. Ongoing (Röda Korsets Högskola, 2024) and recent studies with promising results (Van Woudenberg et al., 2018) treat PTSD in this population within a short time frame. A substantially abbreviated duration of therapy could help retention.

One of the treatment's goals may be to distinguish post-migration stressors that migrants might be able to do something about from more intractable ones. Thus, for instance, linguistic difficulties or obtaining appropriate housing are within the scope of what social services may help with. Others, like systemic discrimination or loss of earlier professional status may require learning ways of coping and achieving a new, harmonious self-definition.

In conclusion, the central findings identified in this scoping review largely align with and confirm results from previous research, but in the context of a comprehensive scoping review. The review supports the evidence for a relation between post-migration stressors and treatment outcomes, and points out to barriers and facilitators of treatment outcome, which need to be evaluated systematically across populations and contexts. Individuals' hesitation to seek healthcare due to a perceived or actual threat of deportation ought to be explored as well. Current interventions

with promising results should also be further examined and culturally adapted as needed. Answers to how we can treat and prevent suffering and mental health problems related to pre- peri- and post-migration do not seem to be merely of psychological nature but also a matter of systemic and political transformations. Taking care of forced migrants will require interventions at various levels, including psychological, political, social, and cultural.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Data availability statement

Data sharing is not applicable to this article as no new data were created or analyzed.

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