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The relation between post-migration stressors and trauma treatment outcomes for people seeking refuge and asylum: A scoping review

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Abstract

Experiences of people seeking refuge and asylum are characterized by diverse adversities before, during, and after migration, making these individuals more susceptible to developing mental ill health. This scoping review intended to map and explore the relation between post-migration stressors (such as struggles related to legal status, finances, housing, and discrimination in the context of resettlement) and outcomes of interventions targeting PTSD and comorbid conditions, in adult refugees and asylum seekers. The literature review further aimed to assess the quality of selected studies and compile limitations and recommendations for future research presented within the scope. Twelve studies published between 2011 and 2023 were reviewed. Obtaining a more secure immigration status was the most emphasized factor associated with clinical improvements. Frequently mentioned limitations within the scope were small sample sizes and inconsistencies in exposure and outcome measures. Recommendations for future research included more robust methodologies and study designs and developing and using a standard index assessing post-migration stressors. Despite being implemented in the context of post-migration stress, the included studies provided evidence for the effectiveness of psychological treatment in reducing symptoms of distress for the participants. In accordance with previous research, the results suggested that ongoing resettlement stressors, possibly impeding treatment results, are not an indication for refraining from offering treatment but rather a sign that additional services are needed.

Keywords: Post-migration stress, Refugees, Asylum seekers, Psychotherapy, Psychosocial interventions, Posttraumatic Stress Disorder, Scoping review

Sammanfattning

Upplevelser hos människor som söker asyl eller flyktingstatus präglas av olika prövningar och svåra upplevelser innan, under och efter migrationen, vilket gör dessa individer mer mottagliga för att utveckla psykisk ohälsa. Denna scoping review syftade till att kartlägga och utforska relationen mellan postmigrationsstressorer (såsom utmaningar relaterade till legal status, ekonomi, boendesituation, och diskriminering i den nya levnadskontexten) och utfall av interventioner som avser behandla PTSD och komorbida tillstånd, hos vuxna flyktingar och asylsökande. Litteraturöversikten ämnade även bedöma kvaliteten hos de utvalda studierna samt sammanställa begränsningar och rekommendationer för framtida forskning som presenterades i litteraturen. Tolv studier publicerade mellan 2011 och 2023 granskades. Att erhålla en mer stabil status gällande asyl eller uppehållstillstånd, var den mest betonade faktorn kopplat till förbättrade behandlingsutfall. Begränsningar som nämndes ofta i studierna var små urvalsstorlekar och inkonsekvent användning av exponerings- och utfallsmått. Rekommendationer för framtida forskning inkluderade mer robusta metodologier och forskningsdesigner samt utvecklingen och implementeringen av ett standardiserat mätinstrument för postmigrationsstressorer. Trots att de psykologiska behandlingarna implementerades i en kontext av postmigrationsstress, visade de inkluderade studiernas resultat att det psykiska lidandet generellt minskade hos deltagarna under behandlingen. I linje med tidigare forskning så föreslog resultaten att pågående postmigrationsstressorer, som potentiellt hämmar behandlingsresultat, inte är en indikator för att avstå behandling utan snarare ett tecken på att ytterligare insatser krävs.

Nyckelord: Postmigrationsstress, Flyktingar, Asylsökande, Psykoterapi, Psykosocial behandling, Posttraumatiskt stressyndrom, Scoping review

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The relation between post-migration stressors and trauma treatment outcomes for people seeking refuge and asylum: A scoping review

In 2022 the number of forcibly displaced people worldwide exceeded 100 million. There is a considerable increase compared to a decade ago when the number was 42.7 million (United Nations High Commissioner for Refugees [UNHCR], 2022a). Violence, armed conflicts, human rights violations, and persecution are some of the factors forcing populations to leave their homes and communities. Emerging evidence shows that new hardships, particularly post-migration stressors, are likely to arise in the context of resettlement, adding to prior potentially traumatic experiences. This thesis is a scoping review of recent research on the effect of post-migration stressors for adults seeking refuge and asylum on psychological interventions for PTSD symptomatology among forced migrants. People displaced within their countries of origin account for about 60% of the displaced populations. Of those who have crossed international borders, 70% reside in countries neighboring their home country (UNHCR, 2022b). Three out of four people seeking international protection do so in low- and middle-income countries (UNHCR, 2022b). Less than 10% of the world's refugees reside in the EU (European Commission, 2022b). In 2022, there were roughly 26 million refugees and almost 5 million asylum seekers worldwide (2022b). The term refugee implies that someone has crossed a national 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). Asylum seekers seek international protection from persecution or human rights violations but have yet to acquire refugee or permanent legal status (Amnesty International, n.d). Seeking asylum is a human right (United Nations [UN], n.d.).

The lottery of birth determines a migrant's accessibility to a safe haven. Accessing visa or visa-free arrangements depends upon the applicant's national passport, and countries from which many people flee generally rank the lowest on entry freedom to other nations (Henley & Partners, 2023; McAuliffe & Triandafyllidou, 2021). Without the required documentation, migration options are scarce. A common but dangerous irregular route is across the Mediterranean Sea, on which over 20 000 deaths have been recorded since 2014 (Missing Migrants project, 2023). Further unequal migration conditions were shown when the EU recently activated a Temporary Protection Directive providing Ukrainians fleeing the invasion and war with temporary protection and access to residence permits, education, and

the labor market (European Commission, 2022a). While this initiative was a logical response of solidarity to an ongoing crisis, it has not been offered to forcibly displaced groups from previous and other ongoing humanitarian emergencies to the same extent. For several years, many European countries have implemented significantly more restrictive immigration legislation to reduce the number of asylum applications to their respective countries. Disagreements exist within the EU about who is eligible to ask for and acquire protection in different member countries. Some of the most recent agreements within the EU Council include an increased focus on the deportation of rejected asylum seekers, detention at borders, and using resources to pay countries outside of Europe to receive refugees (Amnesty International, 2023). A lot of the urgent work for refugees today is done through humanitarian agencies and rescue organizations. It is important to note that while they are vital and necessary while waiting for political solutions, they cannot replace them (UN, 2021). The overall outcomes of the EU's migration policies remain to be seen.

Pre-, peri- and post-migration

It takes a lot for a person or a family to be ready to leave their home. There are many pre-migratory factors making people take this step; some involve human rights violations, armed conflict, or political violence. Refugees are more likely to have experienced potentially traumatic events, PTEs, than the general population (Li et al., 2016). A higher number of PTEs predict psychological disorders like depression, anxiety, and PTSD (Adams & Boscarino, 2006). There are frequent reports of torture despite the UN Convention against torture and other cruel, inhuman, or degrading treatment or punishment (Amnesty International, 2014; Office of the United Nations High Commissioner for Human Rights, 1984; Steel et al., 2009). Another frequently reported PTE is sexual and sexualized violence, which women are more at risk of being exposed to (Tolin & Foa, 2006; UNHCR, 1995).

In order to exercise the right to seek asylum in another country and in the hope of finding safety for their families, many people are forced to undergo perilous journeys. There is a risk of encountering further PTEs during the flight, such as human trafficking, sexual violence, forced labor, 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 due to political changes to more hostile and restricted migration policies and narratives.

In the resettlement context, living conditions for refugees, particularly asylum seekers, can differ severely from the local population. From, historically, explaining refugee mental health mainly through experiences of pre-migration trauma, there is now evidence of the association between post-migration stressors and mental ill health (even after pre-migration factors are accounted for), as well as for 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 these challenges refugees face post migration. One instrument for assessing the construct is the Post-migration Living Difficulties Checklist (PMLDC). It includes items referred to the asylum-process and related problems such as separation from family and limited access to work opportunities and healthcare (Silove et al., 1997), stressors that have been evaluated in various contexts depending on study aims. Another tool is the Refugee Post-Migration Stress Scale (RPMS). It divides the stress into seven domains: perceived discrimination, lack of host country-specific competencies, material, and economic strain, loss of home country, family and home country concerns, social strain, and family conflict, all of which significantly correlated with depression, anxiety and PTSD scores, and negatively correlated with mental wellbeing scores (Malm et al., 2020). In this review, the term post-migration stressors will be used as a collective noun for the socioeconomic and legal challenges refugees and asylum seekers are forced to confront in the context of, and what can be expected to be connected to, resettlement.

Mental health and mental ill health in resettled refugees

Mental health, one of several factors of an individual's overall well-being, is a human right. It does not only include the absence of mental illness but the ability to handle life stressors and contribute to one's community. Education access, job opportunities, safe neighborhoods, community cohesion, and social inclusion are some protective factors that can strengthen resilience and mental health (World Health Organization [WHO], 2022). These social determinants of health can affect health outcomes more than healthcare and lifestyle choices in some cases, indicating that feeling better is about more than implementing medical or psychological treatment (WHO, n.d.).

Higher levels of mental ill health are seen in refugees and asylees compared to other groups of migrants and general populations in host countries (Blackmore et al., 2020; Bogic et al., 2015; Nickerson et al., 2017; Steel et al., 2009). One of the disorders overrepresented in

refugees is posttraumatic stress disorder (PTSD). The diagnosis requires direct or indirect exposure to or threatened death, sexual violence, or serious injury, followed by symptoms of intrusion, avoidance, and negative changes in thoughts, mood, arousal, and reactivity (American Psychiatric Association, 2013). Even though most literature focuses on PTSD, other highly prevalent diagnoses among people seeking refuge and asylum are dissociation, depression, and anxiety disorders. Past traumatic experiences and post-migration stressors cumulatively predict higher rates of mental disorders. These elevated rates seem to persist over time (Blackmore et al., 2020; Bogic et al., 2015) and seriously impact not only affected individuals but also their families (Sangalang & Vang, 2017).

Treatment of mental ill health in refugees and asylum seekers

Recommendations for treatment

Although refugees experience elevated risks of mental health disorders compared to host country populations, they are less likely to receive treatment and support (Legido-Quigley et al., 2019). Furthermore, there are few guidelines on treatment methods for PTSD in refugees and asylum seekers specifically. Current recommended psychological interventions for the prevention and treatment of PTSD in general population adults include trauma-focused cognitive-behavioral therapies (TF-CBT) such as cognitive processing therapy (CPT), prolonged exposure (PE), and narrative exposure therapy (NET) (American Psychological Association, 2017; National Institute for Health and Care Excellence [NICE], 2018). Another recommended method is Eye Movement Desensitization and Reprocessing (EMDR). Pharmacological interventions are not recommended unless the patient prefers drug treatment or has not responded to other treatments (NICE, 2018). Although research lags, trauma-focused psychological therapies have been proven effective in refugees and asylum seekers (Turrini et al., 2019; Nosè et al., 2017), even in the presence of multiple trauma, complex PTSD and trauma of war and torture (Thompson et al., 2018).

Treatment of mental ill health in the context of ongoing post-migration stress

Many psychological treatments presuppose that the patient is treated in the context of safety, which might be the case for veterans and other groups for whom many PTSD treatments were developed. This has raised the question of the feasibility of starting psychological treatments for PTSD and other diagnoses in the context of ongoing adversity, such as post-migration stressors, which is more often the case than not for resettled refugees and asylum seekers. The stability requirement for starting the therapy is closely related to the

treatment phases. A phased treatment can consist of an initial stabilizing phase focusing on safety, a feeling of control, and symptom reduction, a remembrance phase where traumatic memories are processed, followed by a third phase of reconnection and reintegration of control outside of therapy. This deviation from trauma-focused treatment builds on the idea that exposure elements may be psychologically overwhelming for patients living under unsafe circumstances and has initially been applied to treating complex PTSD (Herman, 1992; Ventevogel et al., 2015). 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). More importantly, there seems to be a clinical consensus that 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., 2019). Conversely, recovering from PTSD may improve resilience, cognitive capacity, and energy levels, making daily emotional and practical challenges more manageable (Turrini, 2019).

Another way of dividing approaches to understanding and addressing mental health needs is trauma-focused and psychosocial. There are conflicting views on how stressful social and material conditions mediate the effects of previous war exposure and, consequently, at what stage trauma treatment is appropriate to implement. Miller and Rasmussen examine this split and propose an integrative, sequenced approach model where treatment is offered but preceded by, or combined with, addressing particularly impactful stressors, which may reduce the need for treatment in some individuals (2010).

Further adapted treatments for refugees

Consistent in previous research is the impossibility of differentiating between the psychiatric and the social (Gušić et al., 2019). As with all patients, clinicians ought to be attentive to the structural and political context surrounding them. Interdisciplinary approaches are emerging. 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 with interventions ranging from therapy to counseling, social support, and community-based activities (Ventevogel et al., 2015). In a briefing paper conducted by the International Society for Traumatic Stress Studies, the importance of contextual factors (i.e., school, family background, daily stressors, and culture) when working with refugees and asylum seekers is addressed (Nickerson et al., 2017). Moreover, cultural

and language barriers can affect trust-building with the clinician. A prerequisite for healthcare to work is therapists speaking the patient's language or, when not possible, access to an interpreter (Bailey et al., 2020; Mälarstig et al., 2021). Lack of information on how to access care and fear of arrest or deportation are only a few barriers to refugees' usage of mental health services (Legido-Quigley et al., 2019). Restrictive legislation denying or restraining refugees' and asylum seekers' care not only pose barriers for these patients but also actualize ethical dilemmas for healthcare workers and other support providers in frequent countries of resettlement (Holmes et al., 2021; Kramer et al., 2018).

Summary

In sum, refugees and asylum seekers are at higher risk of developing mental ill health than local populations in resettlement countries. This is linked to experiences of pre-migration traumatic events, harrowing conditions during flight, and post-migration stressors. To support recovery for refugees and reduce the consequences of post-migration stressors, measures must be taken by mental health services and society as a whole. There is discordance on when and if trauma treatment is appropriate for refugees with post-migration stress (Miller & Rasmussen, 2010). Researching the health conditions of forcibly displaced individuals poses distinct challenges due to the complex nature of post-migration stressors and their interconnected sociological measures. The substantial healthcare needs and lack of consistent measures (Yim et al., 2023), however, make it not only clinically interesting to investigate and further evaluate these constructs but also politically relevant and urgent.

One of the largest refugee populations in modern times originates from Syria, a displacement crisis that started in 2011. Many other regions of the world have since seen severe increases in humanitarian emergencies and conflicts arising or escalating, forcing people to flee their homes (UNHCR, 2022a). In an attempt to map how the wide-ranging consequences faced by individuals forced to flee and resettle can be understood and addressed, I conducted a literature review using a filter of twelve years to cover these recent events.

Several previous systematic reviews have looked at the relation between mental health interventions and post-migration difficulties, some of which have targeted studies undertaken in settings of ongoing threat (Ennis et al., 2021; Yim et al., 2023). These reviews stress the importance of daily stressors' impact on the treatment outcomes and feasibility but propose that treatment is effective in these populations and should not be withheld. To my knowledge,

no literature review has examined the relation between PTSD treatment and ongoing post-migration stressors for refugees and asylum seekers specifically, though previous sources have requested future research 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), which is what the current study aims to do.

Scoping review

The first framework for scoping reviews was published by Arksey and O'Malley (2005), and it has since been further developed (Levac et al., 2010; Peters et al., 2020). This review will follow 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 current state of literature, clarify concepts, examine how research is conducted, and highlight gaps in the existing research or preceding systematic reviews (Munn et al., 2018). The methodological framework is also chosen 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 conducting the knowledge synthesis but usually do not contain statistical analyses or methodological appraisals of included sources, unlike systematic reviews (Tricco et al., 2018).

This review uses the PCC framework recommended by JBI for identifying concepts pertaining to the review question and the search strategy. The PCC framework describes the population, concept, and context used to conceptualize the review's objectives (Pollock et al., 2023; Tricco et al., 2018). As outlined above, this thesis is concerned with adult refugees and asylum seekers (population) undergoing treatment for traumatic experiences of war, torture, or persecution (concept) in a post-migration setting (context). Even though depression, anxiety, and other comorbidities are frequent in the population, PTSD treatment was a central criterion when selecting studies. It was used as a marker due to the concern of initiating PTSD treatment with individuals under unstable living conditions. This assumption is rooted in the idea of the need for stabilization prior to implementing exposure components to mitigate the risk of heightened distress or re-traumatization. However, due to the mapping nature of a scoping review, various mental health and treatment concepts found within the scope were explored.

Objectives

The aim of this thesis is to conduct a scoping review of recent research with findings about the relation between psychological interventions for PTSD and post-migration stressors in adult refugees and asylum seekers. The research question is: What is the current state of knowledge on the success of psychological interventions for individuals with experiences of traumatic events (war, torture, or persecution) seeking refuge and asylum, taking into consideration post-migration stressors? The objectives are to:

1. Map and explore the current scope of literature on the relation between psychological interventions for PTSD and post-migration stressors in adult refugees and asylum seekers
2. Evaluate the quality and risk of bias of the selected publications to identify conceptual and methodological limitations
3. Compile limitations and recommendations for future research presented within the existing scope

Methods

Protocol and registration

A scoping review framework was chosen due to its applicability when conducting a broad overview relating to various fields, including psychology (Tricco et al., 2018), within the framework of a student thesis (Forsberg & Wengström, 2016). Following the guidelines of PRISMA-ScR for scoping reviews, a protocol was developed in consultation with my supervisor E.C. The protocol was registered on the Open Science Framework on the 6th of July 2023 https://osf.io/sdu7j/.

Information sources and literature search

The electronic databases PsycInfo and PubMed were screened for applicable literature from January 2011 to June 2023. 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. L.I., a librarian with extensive experience working at the Social Sciences Faculty Library at Lund University, assisted in developing the search strategy. The final search strategies are presented in Appendix A.

Eligibility criteria

Publications were selected based on their evidence and relevance for this scoping review's Population, Concept, and Context (see Appendix A). For inclusion, studies were required to meet all ten categories of criteria: 1) published between 2011 and 2023, 2) targeting adult refugees or asylum seekers with traumatic experiences of war, torture, or flight, undergoing treatment for PTSD, 3) assessing interventions aimed at reducing symptoms of PTSD (possibly among other issues), 4) in a context of post-migration or post-resettlement, where post-migration stressors (e.g., perceived discrimination, lack of host country-specific competences, material and, economic strain, loss of home country, family and home country concerns, social strain, and family conflicts) could be assessed, 5) written in English, Italian, Spanish or Swedish 6) peer-reviewed, and 7) linked full text with references and abstracts available. Studies were excluded if they were: 8) systematic reviews, meta-analyses, preliminary data, or gray literature since only empirical studies were considered in this scoping review, 9) studying ongoing threat in terms of participants residing in conflict-affected or unsafe areas with a real and substantial risk of re-exposure to a DSM criterion A event or equivalent, or 10) theses with difficult to access text.

Selection of sources of evidence

The final combinations of search terms were run in the databases PsycInfo and PubMed. Titles and abstracts were screened and then selected if covering all terms of interest. Additional records were found through bibliographies of eligible or otherwise topically relevant articles. Duplicates were thereafter manually removed. A full-text screening was conducted by A.M. and discussed with E.C. before the final selection. See Figure 1. for a PRISMA flow diagram outlining the selection process.

Data charting process

An initial data charting form was developed independently by A.M. and revised after consultation with E.C. It was continuously refined in later review stages to contribute to the synthesis of results. The final form is presented in Appendix B.

Data items

See Appendix B, as well as Table 1, for a table of the following items extracted from the selected articles: 1) *Study/Authors, year, and country of study*), 2) *Aim(s)*, 3) *Sample* (size, legal status, country of origin if stated, and mean age), 4) *Main findings*, 5) *Study design*, 6)

Intervention type, duration, and agent, 7) *Post-migration stress measure*, 8) *Definition of relation between intervention and post-migration stressors*, and 9) *Mental health measure*.

Critical appraisal of individual sources of evidence

Prior to inclusion, the risk of bias was assessed by a single reviewer using 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). The checklist for Analytical Cross-Sectional Studies was used to assess all 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 assessor's appraisals and ratings were discussed with supervisor E.C. and, after that, revised. The final assessment can be found in Table 2.

Ethical considerations

Since this scoping review aimed to review results from existing primary research, institutional ethics approval was not required. Even though systematic and other types of literature reviews use publicly accessible material, their results may influence further research, policies, and practice. Macro ethical considerations, i.e., how research findings may affect the studied population and influence the discourse of the research field, are essential for this study and will be discussed.

The four general principles of biomedical ethics are *autonomy*, *non-maleficence*, *beneficence*, and *justice*. Non-maleficence, beneficence, and justice relate to the potential costs and benefits of concerned stakeholders. This study aims to benefit the studied group and their access to appropriate care. Related ethical considerations regard the results' potentially unfavorable implications for healthcare recommendations or future funding (Beauchamp & Childress, 2019; Jacobsen & Landau, 2003). The sociopolitical terms refugee and asylum seeker have implications for the groups' legal statuses and accompanying conditions, but they do not reflect people's diverse experiences (American Psychological Association, 2019; Amnesty International, n.d.). When claiming a group as different from the general population in terms of being particularly vulnerable, for instance, there is a risk of portraying individuals in a pathologizing or stereotypical way (Jacobsen & Landau, 2003).

As a scoping reviewer, I intended to use audience-appropriate transparency in the execution of the search strategy, eligibility criteria, interpreting, and charting processes and use internationally recommended methods (Suri, 2019). Even though existing guidelines for conducting a literature review and assessing articles have been used, there is a risk of

selection bias in favor of specific treatments or research methods, especially since there will be only one student writing the paper (Forsberg & Wengström, 2016).

To anchor the review in ongoing practice and views of healthcare providers impacted by the research, knowledge users were continuously consulted in addition to the supervisor (Pollock et al., 2023). The knowledge users in the current review process were clinicians and researchers at the Red Cross treatment center Uppsala and the competence center, respectively, for rehabilitation of torture and war trauma.

Synthesis of results

A narrative synthesis method was used to summarize, explore and map the charted data. This approach is appropriate when there is heterogeneity in the studies' methods, participants, and data (Peters et al., 2020; Lucas et al., 2007). The synthesis adhered 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. The evidence was then summarized and applied to the aims and objectives of the current study.

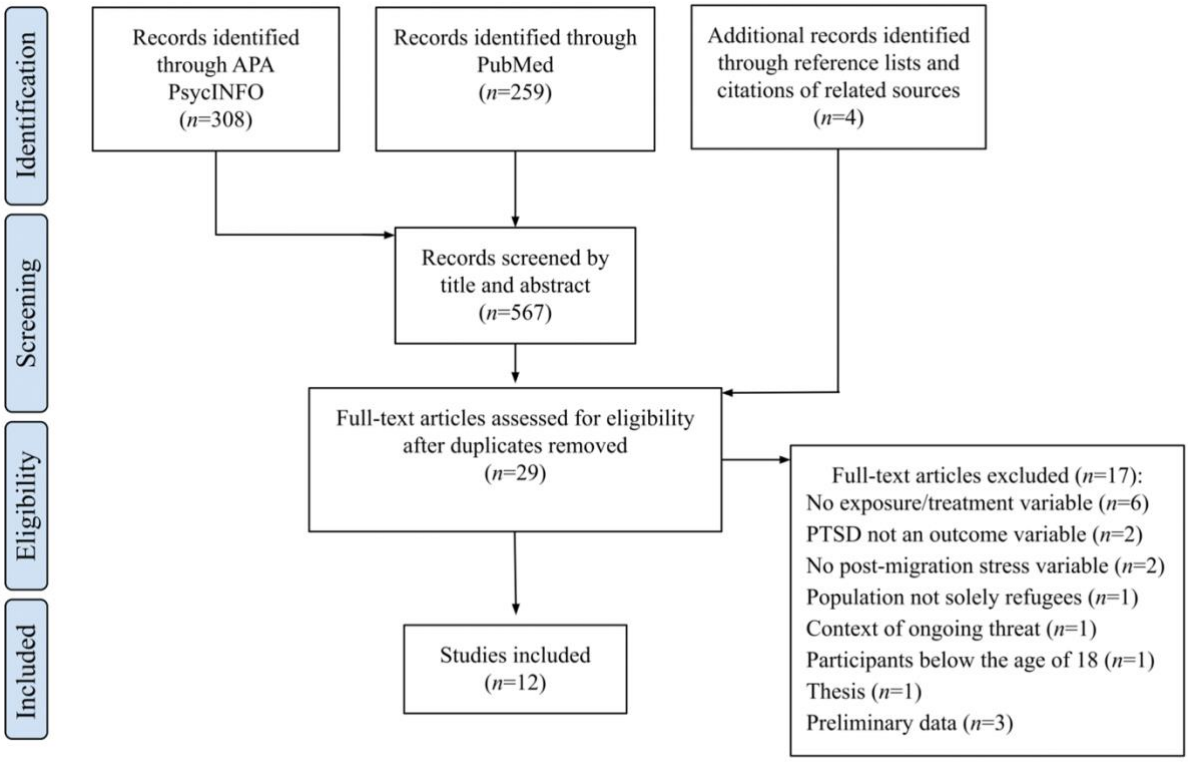
Results

Selection of sources of evidence

Using the search strategy in Appendix A, 29 studies potentially meeting the inclusion criteria were identified. After the full-text screening, several studies did not meet inclusion: treatment (in terms of exposure), post-migration stress, or PTSD outcomes. Some records were excluded based on features like including non-refugees, adolescents, contexts of ongoing threat, or being a thesis or preliminary data. A PRISMA flowchart outlining the selection process is presented in *Figure 1*.

Figure 1.

Selection of articles.



Characteristics of sources of evidence

Table 1 below presents information regarding authors and year of study, aim(s), sample, and main findings.

Table 1.

Characteristics of sources of evidence

Study	Aims	Sample	Main findings
Bruhn et al., 2018	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	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	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	Medium effect size significant reductions in PCBD and PTSD were found. Patients experienced an average of three different post-migration stressors during treatment. 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. Undocumented asylum seekers were more likely to be non-completers.
Drožđek et al., 2013	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	Legal status helps outcomes of group therapy for PTSD. Asylum seekers may benefit from group treatment regardless of unstable living conditions.
Graef-Calliess et al., 2023	To investigate whether PMLD and perceived discrimination predict mental health at the beginning of treatment and	Asylum seekers and refugees (*n*=541 initial, 95	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

	treatment effects within the refuKey project among asylum seekers and refugees	completers), multinational, *M*(age)=32,67	quality-of-life and traumatization.
Kashyap et al. 2019	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	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	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	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	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	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	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	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.
Sonne et al., 2016	To examine possible psychosocial predictors of treatment outcomes.	Trauma affected refugees (*n*=195), multinational	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. A number of single items correlated significantly with changes in depression and anxiety symptoms.
Sonne et al., 2021	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	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	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	The patients' symptoms of post-traumatic stress disorder, anxiety, depression, and somatization decreased significantly. Pre-intervention symptoms predicted symptoms post- intervention for post-traumatic 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	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	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*

Critical appraisal

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	Unclear	Yes	7/8
Djelantik et al., 2020	Yes	Yes	Yes	Yes	Yes	Unclear	Unclear	Yes	6/8

Drožđek et al., 2013	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	7/8
Graef-Calliess et al., 2023	Yes	Yes	Yes	Yes	Yes	No	Unclear	Yes	6/8
Kashyap et al. 2019	Yes	No	Unclear	Yes	Yes	Yes	Unclear	Yes	5/8
Knefel et al., 2022	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	7/8
Raghavan et al., 2013	Yes	Yes	No	Yes	Yes	Yes	Unclear	Yes	6/8
Schick et al., 2018	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	6/8
Sonne et al., 2016	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	7/8
Sonne et al., 2021	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	7/8
Van Wyk et al., 2012	Unclear	Yes	No	No	Yes	Yes	Yes	Yes	5/8
Whitsett & Sherman, 2017	Yes	Yes	Unclear	Yes	Unclear	Unclear	Unclear	Yes	4/8

*Study compared therapies
1: *Were the criteria for inclusion in the sample clearly defined?*; 2: *Were the study subjects 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 condition?*; 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?*

Results of individual sources of evidence

The studies were evaluated individually. The information relating to the review question and objectives are collated in table 3 below.

Table 3.

Results of individual sources of evidence

Authors, year and country of study	**Study design**	**Intervention type, duration and agent**	**Post-migration stress measure**	**Definition of relation between intervention and post-migration stressors**	**Mental health measure**
Bruhn et al., 2018; Denmark	Longitudinal	Multidisciplinary treatment (CBT and medical doctor meetings); 6 months; medical doctors, psychologists, and interpreters, and social counselor pre-treatment	Clinician-rated PMS-IT (accommodation, work/finances, family, and residency permit), developed for study	Post-migration stressors *interference* with treatment.	HTQ; GAF-F; GAF-S
Djelantik et al., 2020; the Netherlands	Naturalistic pre and post study design	DPT-TG (including BEP-TG); one year; psychologists and psychiatrists	Qualitative analysis of the patient files for stressors (but not for symptoms)	Post-migration stressors *associations* with symptom change and non-completion in treatment.	TGI-SR; CAPS-5
Drožđek et al., 2013; The Netherlands	Longitudinal	Group psychotherapy and non-verbal therapy; one year; therapists and interpreters	Interview with semi-structured questionnaire (legal status, living arrangements, housing, family left behind, work, and fluency in the Dutch language). Additional questions were asked about major losses and life changes.	Legal statuses' and other resettlement stressors' *influence* on outcomes of treatment	HTQ; HSCL-25

Graef-Calliess et al., 2022; Germany	Naturalistic multi-center, cross-sectional	refuKey (clustered into psychosocial support and different treatments) in a stepped-care setting; clinical staff and interpreters	17 item PMLDC (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
Kashyap et al. 2019; United States	Naturalistic longitudinal	Interdisciplinary treatment (including mental health, 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	HTQ; PHQ-9
Knefel et al., 2022; Austria	RCT	Brief transdiagnostic psychological intervention that includes a session on coping with PMLDs 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, 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
Raghavan et al., 2013; United States	Longitudinal - one sample	Interdisciplinary approach (individual and group psychotherapy, medical treatment, and social, legal, and educational counseling); 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
Schick et al., 2018; Switzerland	Longitudinal cross-sectional	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 counseling 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, 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, being fearful of being sent back to country of origin in the future, difficulties obtaining financial assistance, difficulties obtaining appropriate accommodation, not enough money to buy food, pay the rent or buy necessary clothes, discrimination, worries about not getting access to treatment for health problems, difficulties in interviews with immigration officials, not being recognized as a refugee, conflicts with social workers/other authorities, and ethnic conflicts).	*Association* between change in PTSD, depression, and anxiety symptoms, and PMLD post-treatment.	HTQ; PDS; HSCL-25
Sonne et al., 2016; Denmark	Longitudinal - one sample	Multidisciplinary treatment (pharmacological treatment, psychoeducation, manualized cognitive therapy, and social counseling); 6-7 months; psychiatrists, medical doctors,	CTP Predictor Index (motivation, upbringing, previous relevant treatment carried out without measurable effect, chronic pain, chronicity of mental condition, understanding of the concept of therapy, receptiveness/acceptability to psychological treatment, reflectivity, motivation for active	The *relations* between treatment outcomes and scores of the CTP Predictor Index	HTQ; HSCL-25; HAM-D+A; SDS; WHO-5; SCL-90;

		psychologists, and social counselors.	participation, cognitive resources, social relations, education, dwelling, and employment status), developed for study		VAS; GAF
Sonne et al., 2021; Denmark	Longitudinal, on data pooled from two consecutive RCTs	Bio-psycho-social treatment program (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 counselors.	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;
Van Wyk et al., 2012; Australia	Longitudinal naturalistic	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, 7 categories, Australian context.	Strength of *relation* between initial symptom score, final symptom score, PMLD, and trauma experiences	HTQ; HSCL-37
Whitsett & Sherman, 2017; United States	Naturalistic observational	Integrative group and individual psychotherapy (supportive, psychoeducational, CBT, interpersonal and exposure techniques), and case management services (aimed at enhancing language skills, gaining stable employment, healthcare, and housing); slightly more than a year; clinical psychologists, licensed clinical social workers, and interpreters	Resettlement variables (housing, language fluency, and employment status)	Whether resettlement factors *predict* intervention outcomes	HTQ; HSCL-25; HURIDOCS Events Standard Formats Second Edition

Abbreviations: CBT: *cognitive behavioural 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*; 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*; 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*

Synthesis of results

Overview of studies

As presented in table 3, the largest proportion of selected studies were conducted in Denmark and the United States, followed by the Netherlands. The remaining study settings were Australia, Germany, and Switzerland. Some studies targeted specific populations in terms of country of origin: Drožđek et al. (2013) included Iranian and Afghan participants,

Knefel et al. (2022) studied Afghan refugees and asylum seekers, and Van Wyk et al. (2012) participants were refugees from Burma. In the remaining studies, mentioned regions or continents (or countries within these) were the Middle East (Bruhn et al., 2018; Djelantik et al., 2020; Graef-Calliess et al., 2023; Djelantik et al., 2020; Sonne et al., 2021; Whitsett & Sherman, 2017), Africa (Raghavan et al., 2013; Graef-Calliess et al., 2023; Djelantik et al., 2020; Kashyap et al., 2019; Whitsett & Sherman, 2017), Asia (Raghavan et al., 2013; Djelantik et al., 2020; Kashyap et al., 2019), Europe (Raghavan et al., 2013; Djelantik et al., 2020; Sonne et al., 2021), and the Americas (Raghavan et al., 2013). Populations were not specified by area of origin in Sonne et al. (2016) or Schick et al. (2018).

Study sample sizes ranged from 323 (Kashyap et al., 2019) to 66 (Drožđek et al., 2013). One study consisted of 541 participants, of which only 95 were assessed for the prediction of the treatment effect by PMLD (Graef-Calliess et al., 2023). The treatment providers mentioned were psychologists or clinical psychologists, non-specified therapists/clinical staff, social counselors, psychiatrists, and medical doctors. Due to the use of archival clinical data, information on service providers was unavailable to the researchers in Kashyap et al. (2019). In most studies, it was expressively stated that interpreters were available if needed. Stated treatment durations ranged from six weeks (Knefel et al., 2022) to slightly over a year (Whitsett & Sherman, 2017). The majority of the administered treatments explicitly targeted psychosocial, including post-migratory, stressors in addition to PTSD and other diagnoses (Djelantik et al., 2020; Graef-Calliess et al., 2023; Kashyap et al., 2019; Knefel et al., 2022; Raghavan et al., 2013; Schick et al., 2018; Van Wyk et al., 2012; Whitsett & Sherman, 2017).

The review author assessed the quality of included studies based on the JBI's predesigned criteria. According to them, studies showed high overall quality and no studies were of low quality. Nonetheless, the most frequently unmet criteria within this sample of studies were issues with measurements of exposures and outcomes. Most studies used existing definitions or diagnostic criteria to assess diagnostic treatment outcomes. However, due to the lack of generic measures of postmigration stressors, studies using self- or service provider assessments or indices developed for or adapted to their particular research were appraised as "unclear" on the question "Were outcomes measured in a valid and reliable way?". Additional limitations were raised by study authors and are presented under *limitations*.

Domains

Compiled data of included studies was thematically divided into categories relevant to examining the review's objective to map research on the relation between psychological interventions for refugees and asylum seekers and post-migration stressors within and across studies. Reported aspects related to post-migratory stress, which fell into the categories of acting as barriers or facilitators to the implementation or success of treatment outcomes are clustered into ten domains: *Legal status, housing, work/education, finances, language, family, discrimination and isolation, chronic pain, worries about healthcare access*, and *refugee determination processes.*

Post-migration stressors related to *legal status* were assessed in eight studies (Bruhn et al., 2018; Djelantik et al., 2020; Drožđek et al., 2013; Graef-Calliess et al., 2023; Raghavan et al., 2013; Schick et al., 2018; Sonne et al., 2021), as was *housing* (Bruhn et al., 2018; Djelantik et al., 2020; Drožđek et al., 2013; Graef-Calliess et al., 2023; Kashyap et al., 2019; Schick et al., 2018; Sonne et al., 2016; Whitsett & Sherman, 2017). *Work/education* was identified in seven studies (Bruhn et al., 2018; Drožđek et al., 2013; Kashyap et al., 2019; Raghavan et al., 2013; Sonne et al., 2016; Sonne et al., 2021; Whitsett & Sherman, 2017). *Finances* were examined by four authors (Bruhn et al., 2018; Graef-Calliess et al., 2023; Raghavan et al., 2013; Schick et al., 2018). Post-migration stressors related to *language*, such as fluency or difficulties in learning host language (Drožđek et al., 2013; Graef-Calliess et al., 2023;), were assessed in five studies (Djelantik et al., 2020; Drožđek et al., 2013; Graef-Calliess et al., 2023; Schick et al., 2018; Whitsett & Sherman, 2017). *Family*, as in living arrangements, family concerns, and social support, was encountered in nine studies (Bruhn et al., 2018; Djelantik et al., 2020; Drožđek et al., 2013; Graef-Calliess et al., 2023; Kashyap et al., 2019; Schick et al., 2018; Sonne et al., 2016; Sonne et al., 2021; Whitsett & Sherman, 2017). Two studies (Graef-Calliess et al., 2023; Schick et al., 2018) assessed *discrimination and isolation*, under which conflicts with own/other groups in the host country were also grouped. Two studies assessed *chronic pain* (Kashyap et al., 2019; Sonne et al., 2016) and *worries about healthcare access* (Graef-Calliess et al., 2023; Schick et al., 2018). *Refugee determination processes* and related stressors such as interviews with immigration officials, fear of being sent back to their country of origin, not being recognized as a refugee, conflicts with social workers/authorities (Graef-Calliess et al., 2023; Schick et al., 2018), or conflict in the country of origin (Djelantik et al., 2020) was examined in three sources. Receptiveness to

treatment (Sonne et al., 2016) and organizational support (Kashyap et al., 2019) were other mentioned aspects, but they were not grouped into any domains.

Overall, definitions of post-migration stressors were scarcely described within the samples. Knefel et al. (2022) and Van Wyk et al. (2012) did not provide details of what stressors their, country-adapted, 26-item PMLD, and 7-category PMLDC assessed and were therefore not included in the thematic analysis.

Barriers to treatment success

Several potential barriers to treatment success were presented in the studies' results. One mentioned barrier was the number of post-migration stressors experienced (Djelantik et al., 2020; Sonne et al., 2016). Unemployment correlated with a poorer reduction in PTSD symptoms (Sonne et al., 2016). Also, in Bruhn et al. (2018), work and finances interfered with treatment outcomes, as did family concerns (Bruhn et al., 2018). In another 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 had negative correlations to changes in PTSD and depression in one article (Sonne et al., 2016). One study found stressors to be the most common among males, those living alone and those with Middle East origin (Bruhn et al., 2018), and one study found that being Muslim had an inverse correlation with symptom improvement (Sonne et al., 2021). Undocumented asylum seekers were more likely to be non-completers (Djelantik et al., 2020).

Facilitators to treatment success

The most frequently reported facilitator correlating with clinical improvement was gaining a more secure immigration status (Drožđek et al., 2013; Kashyap et al., 2019; Raghavan et al., 2013). Sonne et al. (2021) found that full-time occupation, young age, short time in the host country, and status as family reunified (compared to refugee) were associated with symptom reduction. Stable, uncrowded housing predicted improvements in anxiety, depression, and trauma symptoms, according to one study (Whitsett & Sherman, 2017). Not reporting chronic pain was associated with PTSD (Kashyap et al., 2019) and depression (Sonne et al., 2016) reduction. Stable housing and employment significantly moderated the relation between lower chronic pain and reduced PTSD (Kashyap et al., 2019). Accessing many social services (Kashyap et al., 2019) was another factor associated with PTSD reduction. Higher pre-migration traumas (Kashyap et al., 2019) and high baseline scores were associated with improvements in several ratings (Sonne et al., 2021). Female gender (Kashyap

et al., 2019) and young age (Sonne et al., 2021) were also associated with 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 were reduced for the treatment group, compared to the control group.

Presented limitations and recommendations for future research

Limitations

Measurements

Measurements problems were a limitation in 11 studies. Assessment instruments were the most frequently mentioned limitation (Bruhn et al., 2018; Drožđek et al., 2013; Kashyap et al., 2019; Knefel et al., 2022; Raghavan et al., 2013; Sonne et al., 2016; Sonne et al., 2021; Van Wyk et al., 2012; Whitsett & Sherman, 2017). Another limitation was subjective scoring methods through observer ratings (Bruhn et al., 2018; Sonne et al., 2016; Whitsett & Sherman, 2017) or self-reports (Graef-Calliess et al., 2023; Schick et al., 2018; Sonne et al., 2021; Whitsett & Sherman, 2017), which might influence estimates of effect sizes and reliability. Further limitations related to the statistical (Kashyap et al., 2019; Knefel et al., 2022; Sonne et al., 2016; Sonne et al., 2021) and psychometric (Sonne et al., 2016) methods applied.

Methods

Eight articles mentioned methodological limitations. One limitation was internal validity due to study design (Djelantik et al., 2020; Drožđek et al., 2013; Graef-Calliess et al., 2022; Raghavan et al., 2013; Whitsett & Sherman, 2017). Other reported limitations were use of secondary data (Djelantik et al., 2020; Kashyap et al., 2019), limited length of intervention (Van Wyk et al., 2012), or follow-up time (Kashyap et al., 2019; Knefel et al., 2022), and potentially limited analyses (Knefel et al., 2022) or coding methods (Van Wyk et al., 2012).

Samples

Sample limitations were acknowledged in 10 studies. The majority of authors mentioned deficient sample sizes (Bruhn et al., 2018; Djelantik et al., 2020; Drožđek et al., 2013; Graef-Calliess et al., 2023; Knefel et al., 2022; Schick et al., 2018; Sonne et al., 2021; Van Wyk et al., 2012; Whitsett & Sherman, 2017). Apart from sample size, other reported limitations were non-generalizability to broader population (Bruhn et al., 2018; Drožđek et

al., 2013; Graef-Calliess et al., 2023; Knefel et al., 2022; Schick et al., 2018; Van Wyk et al., 2012), missing values (Van Wyk et al., 2012), and attrition (Whitsett & Sherman, 2017).

Confounds

Six studies discussed limitations in controlling for confounds (Bruhn et al., 2018; Drožđek et al., 2013; Kashyap et al., 2019; Sonne et al., 2021; Whitsett & Sherman, 2017; Whitsett & Sherman, 2017), which generally referred to restricted numbers of demographic or resettlement variables, or strategies to deal with them.

Reflexivity

Another limitation relating to the previously outlined is reflexivity. The term "reflexivity" was generally not explicitly mentioned, but concepts related to it included not adopting a patient's perspective (Bruhn et al., 2018), or questioning the notion of universality, for instance of diagnostic concepts, potentially missing cultural differences (Drožđek et al., 2013; Raghavan et al., 2013; Schick et al., 2018; Whitsett & Sherman, 2017).

Recommendations

Samples

Three studies explicitly stated the need for more extensive samples in future studies (Djelantik et al., 2020; Drožđek et al., 2013; Graef-Calliess et al., 2022; Sonne et al., 2021).

Methods

Three authors proposed more frequent or long-term follow-ups (Drožđek et al., 2013; Kashyap et al., 2019; Knefel et al., 2022). Proposed study designs were longitudinal studies (Drožđek et al., 2013; Sonne et al., 2021) combining qualitative and quantitative methods (Drožđek et al., 2013) or controlled study designs including a control group (Djelantik et al., 2020). Another study called for a focus on reducing drop-out rates (Knefel et al., 2022). One study suggested strengthening a causal explanation of post-migration stressors' interaction with treatment outcomes by studying refugees originating from the same country and resettling in countries with different immigration policies (Drožđek et al., 2013). Another article suggested examining services across agencies and bringing cultural assumptions of Western modes of mental health practices to light (Van Wyk et al., 2012).

Measurements

Six studies brought up elaboration of a more standardized post-migration stress measurement (Djelantik et al., 2020; Drožđek et al., 2013; Schick et al., 2018; Van Wyk et al., 2012; Whitsett & Sherman, 2017) accounting for as many factors as possible (Kashyap et al.,

2019). The development of measures to be used by a broader range of personnel (Bruhn et al., 2018) and the assessment of inter-rater and intra-rater reliability (Van Wyk et al., 2012) were proposed. A content-oriented approach was suggested instead of counting the number of traumatic events (Kashyap et al., 2019) or service visits (Raghavan et al., 2013). More detailed information on provided psychological interventions is further requested (Kashyap et al., 2019).

Aims

Regarding aims, three studies wanted to continue to elucidate the association between one or several post-migration stressors and treatment effect (Djelantik et al., 2020; Schick et al., 2018; Sonne et al., 2016) and what composite measures might predict responsiveness to various treatment modalities (Schick et al., 2018; Sonne et al., 2021). Other proposed aims were to examine the complex relation between social support from a spouse and mental health and the impact of life events on mental health before and upon legal recognition (Drožđek et al., 2013). One study wanted to expand on the research question by adding psychoticism and somatization variables (Graef-Calliess et al., 2022). Another proposed future research to account for the impact of gender identity on change in distress (Kashyap et al., 2019), to disentangle chronic pain from other PTSD symptoms (Kashyap et al., 2019) and explore to what extent subgroups of refugees and asylum seekers are affected differently by discrimination (Graef-Calliess et al., 2022). Furthermore, the authors suggested investigating psychosocial interventions for addressing complex and long-lasting symptomatology (Sonne et al., 2021) or helpers without health-professional backgrounds to provide patients within post-conflict areas with mental health support (Schick et al., 2018). Sonne et al. (2021) mentioned newer interventions, such as neurofeedback for trauma-affected refugees, for future investigation. Lastly, the scope's authors wish replications to verify attained findings (Djelantik et al., 2020; Drožđek et al., 2013; Knefel et al., 2022; Schick et al., 2018; Sonne et al., 2021).

Discussion

Summary of evidence

The objectives of this thesis were to explore existing knowledge on the relation between psychological interventions for PTSD and post-migration stressors in adult refugees and asylum seekers, evaluate the risk of bias and identify methodological limitations of

included studies, and summarize stated limitations and recommendations for future research. The twelve articles comprising the scoping review both resemble and differ from each other. This section aims to discuss conclusions drawn from the research while critically reflecting upon the literature process and findings.

Despite being implemented in the context of post-migration stress, evidence for the effectiveness of psychological treatment in reducing symptoms of distress was acknowledged by all included studies in various ways. All identified concepts relating to post-migration stressors were compiled and divided into ten categories relating to their implications for treatment in refugees.

Legal status was the most emphasized challenge to successful treatment implementation in this review. Notably, patients who were granted a permanent refugee status showed more symptom reduction than patients whose legal status was unchanged, including those who already had a permanent refugee status. Some authors' (Drožđek et al., 2013) interpretation of this was that after obtaining a refugee status and starting to rebuild their lives in new contexts, new post-migratory stressors might arise. They further speculated why asylum seekers did not have lower symptom success than refugees, despite their higher stress load. They also discussed the group treatment setting's possible provision of a sense of support and safety, advancing resilience, and coping skills in these patients. In another study, attrition was higher in undocumented asylum seekers, making it a potential barrier to treatment success (Djelantik et al., 2020).

A higher level of education was associated with lower symptom reduction (Sonne et al., 2016). The authors reasoned about the loss of status and identity in refugees with high educational levels as a possible explanation for fewer symptom improvements. This partly relates to their other finding of poor integration as a barrier to symptom improvement. However, they mentioned that an association between education and lower symptom reduction had also been shown in other populations, suggesting other explanations.

According to two studies comparing females and males, being a woman seemed to predict better treatment outcomes (Bruhn et al., 2018; Kashyap et al., 2019). These studies explained that one reason for this could be that women generally show more psychological distress among asylum seekers and refugees, making the improvement more detectable.

Sonne et al., 2021 found that adherence to the Muslim faith was a negative predictor of treatment outcomes of anxiety and depression. The lower treatment success rates for

Muslims were discussed as a failure within the clinic to provide patients with the proper healthcare, despite their emphasis on the implications of cultural and religious beliefs for treatment. The authors stated that they need to modify the treatment to make it receptive to the needs of Muslim patients. Furthermore, although they did not account for discrimination as a post-migration stressor, they discussed the possible negative influence of discrimination on these patients, referring to negative public statements by people and sectors against Islam or Muslims, potentially impacting mental ill health. Generally, discrimination was discussed more in recent studies, suggesting that it is an emerging theme within the field. As with legal status, discrimination outside of therapy is a variable difficult to modify.

This 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). 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 color, and cultural/traditional or religious dress and attire, may affect what extent people experience discrimination and racism, e.g., in the labor market. They also bring up the possibility of answers being biased due to social desirability or that people do not recognize all situations in which they are discriminated against due to a lack of insight into possibly discriminating structures of society. Discrimination is generally defined as treating another group unequally even after controlling for other relevant variables, such as level of education and work experience. In an extensive mapping of discrimination and white privilege in the Swedish labor market, Wolgast and Nourali Wolgast (2021) instead argued that accumulated discriminating processes, e.g., in the school system, can create a difference at the group level, such as a lower educational level leading to lower recruitability, which is thereafter viewed as justified in the process of "dynamic discrimination". In other words, discrimination might be rooted in societal and institutional structures in addition to individual ones. Although their study focused on people subjected to racism in general, the findings are likely to have implications for refugees and asylum seekers. How different types of discrimination affect this population could be an area of further inquiry.

Most studies mentioned the help of interpreters without examining the quality or effect of this through follow-ups, despite potentially impacting trust-building (Bailey et al., 2020;

Mälarstig et al., 2021). The lack of reporting potential problems or facilitators raised by the use of translators has been mentioned in previous literature (Jabcobsen & Landau, 2003). Even though most studies occurred in naturalistic settings, the clinical reality is that healthcare services often fail to provide patients with interpreters or therapists who speak their mother tongue (Mälarstig et al., 2021). It is even a right that has been questioned. For instance, together with other refugee critical propositions, the leading parties in Sweden recently suggested that translation, despite being a prerequisite for assisting healthcare, shall be paid by the client (Sverigedemokraterna et al., 2022). As a basic but questioned right, lack of interpreters could be categorized as a post-migration stressor.

Ongoing danger, as examined in previous research (Ennis et al., 2021; Yim et al., 2023), might, in some cases, interfere with processing traumatic memories in treatment, emotionally and practically, but even in these contexts, treatment has shown to be feasible and effective. This review found similar results, showing symptom reductions through various treatments, where many of the post-migration stressors accounted for did not correlate with symptom change. However, the stressors inspected within this thesis are not necessarily of the exact acute nature as in previous reviews. 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 untreated for uncertain, and in many cases long, periods of time. Although symptom reduction is generally the single measure of whether the treatment was successful, the investigated studies point to the importance of even minor improvements in overall health and functioning for the patient group, generally highly symptomatic. Besides, the association of high baseline scores with symptom improvements (Kashyap et al., 2019; Sonne et al., 2021) could speak for this as not only a challenging but also gratifying group to treat, as there is a great opportunity for symptom relief. The results further raise the question of what treatment may be better and for what outcomes. While PTSD was an inclusion criterion for articles in this study, most studies examined multiple measures, including depression and anxiety. These additional measures showed improvement after treatment, especially when testing for post-migration stressors, which are not directly connected to PTSD. Furthermore, many studies had treatment targets and goals over and above symptom reduction, including measures like quality of life, reduced post-migration stress, or enhanced protective factors (Dangmann, 2021; WHO, 2022).

The undeniably complex nature of the research question is one aspect affecting the robustness of the results. Some studies relied mainly on dichotomized outcome measures, whereas others used continuous Likert scales. The differing study designs, and conceptualizations of central concepts, or lack thereof, are further likely to have increased the heterogeneity of results. 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) found no association between PMLD and mental health outcomes, whereas Graef-Calliess et al. (2023) found PMLD and perceived discrimination to predict mental health outcomes before treatment only. However, few conclusions can be drawn from this due to a lack of information on the study's PMLD categories. As claimed in a previous review on the field (Yim et al., 2023), the measurements used differed. Many interventions partly evaluated post-migratory stressors, while some did not explicitly do so, making it difficult to discern what elements reduced/increased mental ill health and post-migration stressors, respectively. However, the fact that the RCT (Knefel et al., 2022), adopting a transdiagnostic approach including a session on coping with PMLDs, showed significantly higher reductions in PMLD-related distress and general health problems in the treatment group compared to the control points to incipient evidence of this transdiagnostic psychological treatment being feasible and helpful in reducing distress and post-migration stressors for refugees and asylum seekers. No causal relationships can be established, though, and results should be interpreted in the light of various limitations.

The selected literature comprised few countries of research. Additionally, authors reappeared within the scope. The RCTs comprising the results of Sonne et al. (2016), Sonne et al. (2021), and Bruhn et al. (2018) overlap in time and clinical setting, as well as Raghavan et al. (2013) and Kashyap et al. (2019) targeting the same clinic. This concentration of authorship could indicate that perspectives are excluded but could also reflect the limited number of active researchers conducting research in this emerging field.

The overall results reflect a clinical reality within which politics and healthcare work independently rather than cooperatively. Beauchamp and Childress even argue, "Unless the world's economic systems are radically revised, and economic resources are abundantly available, this conception of human right that applies globally will remain a utopian ideal that is unlikely to be fully realized" (2019). As a result of the distressing experiences that come with being a refugee on the one hand and an increasingly hostile political climate towards the

population on the other hand, there is a considerable gap between the treatment needs and delivery reality for this patient group. Still, these studies' participants can only be potentially generalized to individuals receiving treatment. 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 or other marginalized groups. 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. Furthermore, a dual imperative in research on refugees has been described in which researchers aspire to meet high academic standards and, at the same time, influence policymakers (Jacobsen & Landau, 2003). There could be cases, Jacobsen and Landau argue, where the endeavor of producing necessary evidence for a disadvantaged patient group makes the researchers seek specific evidence or employ accessible methodologies. However, contexts of refugee studies, ranging from refugee camps to therapy settings, makes stronger study designs such as RCTs difficult to implement.

The JBI critical appraisal of the included studies indicated that the selected studies reached relatively high quality for this field (Jacobsen & Landau, 2003), but there is room for improvement. The naturalistic settings partly impeded methodological transparency. Only one study was an RCT, although several articles used data from existing RCTs. Noteworthy, several studies used self-constructed or adapted measurement instruments, making comparisons between studies somewhat arbitrary. This inconsistency could explain why exposure and outcome measures were frequently deemed unfulfilled or unclear.

This scoping review further aimed to map stated limitations and recommendations within the scope. Measurement weaknesses were mentioned in 11 out of 12 studies and most often referred to instruments of assessment being non-standardized and thus possibly inadequate or incomparable to other studies. Several studies acknowledged subjective rating scales as a weakness, perhaps impairing reliability. Suggestions on how to address this weakness included clinician-administered diagnostic interviews and carrying out more foundational research. Studies could improve construct validity and develop a composite index of post-migration stressors while recognizing the impossibility of removing subjectivity from social science research entirely.

Study sample size has been another recurring limitation in the field to date, compounded by attrition and missing values, affecting generalizability. Even the more extensive sample-sized studies presented this problem. Consequently, greater sample sizes were a common suggestion for future research, for instance, to increase statistical power in outlining relations between variables. Study designs, including usage of archival data or limited length or number of interventions or follow-ups, were another limitation mentioned, so future longitudinal, non-naturalistic studies with control groups and careful follow-ups were recommended.

Accounting for confounders could be argued to have been implemented in these studies regarding the objectives of assessing factors predicting treatment outcomes. Since 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 for enough or reliable demographic or resettlement moderators was a commonly mentioned limitation in the literature. Many authors discussed the issue of resettlement variables being dependent on political legislation and thus uncontrollable by researchers. As mentioned in the synthesis of results, counteracting endeavors could be to map and work around post-migration stressors.

Some studies discussed cultural sensitivity and the limitations of not considering patients' perspectives in the study design or assuming the diagnostic system to be universal. This relates to diagnostic manuals being developed in Western middle-class contexts and service providers in resettlement contexts lacking contextual understanding of patients' experiences. Globally, there are differentiating mental health concepts and ways of healing from trauma (Van der Kolk, 2021a). In an interview, the researcher and psychiatrist Bessel van der Kolk describes Western culture as disembodied, connecting it to a post-alcoholic culture, where unpleasant or threatening emotions and somatic symptoms are repressed (Van der Kolk, 2021b). Somatization, in particular, was a variable Graef-Calliess et al. (2022) asked for further research. 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).

There was agreement in the included studies that more research is needed to further examine their similar objectives of assessing the success of psychological interventions for refugees and asylum seekers in the context of post-migration stressors and replicating their findings.

Limitations

A single researcher (A.M.) conducted this scoping review. All analyses were thus performed by one reviewer although verified by a second reviewer (E.C.). There is a potential lack of transparency, and a natural element of subjectivity, in the inductive synthesis process of extracting objective-driven categories and domains, affecting the approach's reproducibility. Even though measures have been taken to ensure that the evidence has been appropriately interpreted, the author has limited research experience, and there is an undeniable risk of human errors (Forsberg & Wengström, 2016). Additionally, it was the student researcher's first time using the PRISMA-ScR framework and assessing methodological quality with the JBI appraisal tool. Although the appraisal instrument provided the assessor with straightforward and comprehensible questions, it simultaneously allowed varied interpretations.

Another area for improvement is the breadth of literature. No gray literature was located, and disciplines other than clinically psychological might be necessary, especially due to many post-migratory factors' political and sociological nature. Only two databases and bibliographies of selected studies were searched.

Threats to construct validity include the definitions of various interventions and participants' legal statuses. There is yet no standard definition of post-migration stressors or living difficulties, giving rise to difficulties in comparing the studies. Conforming to previous literature on forced migration (Jacobsen & Landau, 2003), the articles' methodologies were considered a limitation. The fact that more robust methods and measurements could have yielded different results should be considered.

At the protocol stage, the researcher intended to avoid contacting study authors due to unavailable full-text. Nevertheless, the authors of Graef-Calliess et al. (2023) were contacted, and the full-text study was shared with the current researcher. No other studies were deemed to be excluded solely on the criterion of unavailable full-text, making this deviation from the protocol of minor significance for the result.

In research, representations of the individuals being analyzed are constructed by researchers and inevitably implicated in societal power dynamics. The Critical Methodologies Collective describes constructing representations as an inherently political endeavor, regardless of the aims and outcomes (The Critical Methodologies Collective, 2021). A related aspect is reflexivity. The single author is a student in an academic field (in which a thesis production can be regarded as an academic goal), holding Swedish citizenship without own experiences of migration or discrimination due to prejudice on ethnicity, race, or religion (on the other hand, the second reviewer is an immigrant, who has experienced discrimination in different contexts, and has ample experience in research of trauma evaluation and treatment). Regardless of carefully executed research, these favorable conditions will influence the lens through which the researcher has analyzed the data. Few studies examined a refugee perspective, although several proposed this as important. In line with previous suggestions (Nickerson et al., 2017; The Critical Methodologies Collective, 2021), a research-informing practice should consider the voices and experiences of patients through community participatory designs.

Notwithstanding, limited operationalizations, conceptual understandings, and the inherent failure of researchers in depicting their studied populations' subjective experiences ought not to be in the way of working for improvements in living conditions for people seeking refuge and asylum experiencing mental ill health.

Recommendations for future research

The purpose of scoping reviews is not to produce recommendations for decision-making but rather to compile data on a subject, identify appropriate parameters for future studies and reviews (Forsberg & Wengström, 2016), and, in this review, present recommendations for future research.

It seems feasible to perform a systematic review on a more condensed research question or studies with less heterogeneity regarding study design, methods, interventions, and settings, to enable studies' comparability and generalizability. For instance, the many ways of assessing post-migration stressors point to the need for a more united approach. There have been attempts to develop tools for this, including the Post-migration Living Difficulties Checklist (PMLDC) (Silove et al., 1997) and the more recent refugee post-migration stress scale, RPMS (Malm et al., 2020) but based on this study's mapping there is yet no generic and commonly used instrument for this outcome. The thematic categorization in this review

corresponds well with these two existing post-migration stress measurements. Even though many mentioned stressors matched over studies in this literature sample, concepts were not culturally made equivalent, to make sure, that they refer to the same phenomena. Further research is needed to validate existing instruments, also to different populations and settings.

For future studies to test 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 various social groups and political and environmental contexts (Popay et al., 2006).

Given the high attrition within the studied population, the included articles argued for addressing post-migration stressors as a mediator of treatment completion. Another emerging area to explore could be implementing intensive trauma treatment programs. Ongoing studies (Röda Korsets Högskola, 2021), and recent studies with promising results (Van Woudenberg et al., 2018), are looking at the possibility of treating PTSD in this population delivered in a shorter time frame. The substantially abbreviated duration of therapy could help retention, increasing the chances of alleviating the patient's suffering and impairments caused by trauma.

This review limited itself to evidence on adult refugees, partly due to the scarce amount of evidence on children. Over half of the world's refugees are children (UNHCR, n.d.), and post-migration stressors are likely to impact them. Trauma and other stressors during childhood are particularly detrimental and a predictor of various mental and physical health conditions later in life (WHO, 2022). Therefore, more research on how treatment can be applied to child and adolescent refugee populations is needed.

Conclusions

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 results support earlier findings of the effectiveness of psychosocial interventions for reducing mental ill health in refugees and asylum seekers and a relation between post-migration stressors and treatment outcomes, wherein there can be mutually detrimental and beneficial interactions. An overall main finding pertaining to all objectives is the need for conceptual clarity in refugee and asylum seekers' health research. The results indicate that type of residency permit predicts treatment success, which accentuates the importance of clearly outlining and exploring the implications of holding different legal statuses. Moreover,

there are opportunities to conduct research in, for this population, the less “advantageous” settings of host countries. One such setting could be primary care, where service providers will not go outside of their medical or therapeutic duties to make up for an absence of interventions by other legal or social authorities, compared to many psychosocial interventions examined in this review. Individuals' states of 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, however, also be further examined and psychosocially and culturally adapted. In future research, variables and their connections should be constructed carefully, ideally providing comprehensive and common measurements. The fact that several included studies geographically adapted existing instruments to assess post-migration stressors could be considered a strength. However, it also makes the results of various studies not fully comparable. Combined with a lack of integrating patient perspectives, all relevant post-migration stressors might not have been captured.

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 as much a matter of systematic and political transformations. One can conclude that counteracting challenging living conditions and hostile policies is likely to have a beneficial effect for clients and society at large.

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Appendices

Appendix A.

Search strategy

PCC

Population	Adult patients with refugee/asylum seeker status
Concept	Psychological/psychosocial interventions aimed at treating PTSD symptoms
Context	Setting of ongoing post-migration stressors but not ongoing threat (i.e. risk of traumatic events such as violence or persecution)

Database: APA **PsycInfo**, Date: 07/05 2023

S#: 1
Refugee*
OR asylum seeker*
OR forcibly displaced*
OR displaced person
OR displaced people
OR immigrant*
OR forced migrant*
OR torture*

S#: 2
Posttraumatic stress disorder
OR ptsd
OR trauma*
OR torture*
OR depress*
OR anxi*

S#: 3
Treat*
OR intervention*
OR therap*
OR psychotherap*
OR counsel*

S#: 4
S2 AND S3

S#: 5
Post-migra*
OR postmigra*
OR exile-related stress*
OR ongoing stress*

OR continuous stress*
OR resettle*
OR asylum process*
OR legal status

S#: 6
S1 AND S4 AND S5
Linked full text
Peer reviewed
References Available
Language English
Publication year 2011-2023
Age Adulthood (18 yrs & older)

Database: APA **PubMed**, Date: 07/05 2023

S#: 1
Refugee*
OR asylum seeker*
OR forcibly displaced*
OR displaced person*
OR displaced people
OR immigrant*
OR forced migrant*
OR torture*

S#: 2
Posttraumatic stress disorder
OR ptsd
OR trauma*
OR torture*
OR depress*
OR anxi*

S#: 3
Treat*
OR intervention*
OR therap*
OR psychotherap*
OR counsel*

S#: 4
S2 AND S3

S#: 5
Post-migra*
OR postmigra*
OR exile-related stress*

OR ongoing stress*
OR continuous stress*
OR resettle*
OR asylum process*
OR legal status

S#: 6
S1 AND S4 AND S5
Full text
Language English
Publication year 2011-2023
Age Adult (19+ years)

Appendix B.

PRISMA-ScR

Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	0
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	0
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	6-7
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	8
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	8
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	9
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	9
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	42-44
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	9
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	10
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	11
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe	10

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
		the methods used and how this information was used in any data synthesis (if appropriate).	
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	11
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	11-12
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	12-13
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	13-14
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	14-16
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	16-22
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	22-29
Limitations	20	Discuss the limitations of the scoping review process.	29-30
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	31-32
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	32

JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.

* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.

† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).

‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.

§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).

From: Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMAScR): Checklist and Explanation. Ann Intern Med. 2018;169:467–473. doi: 10.7326/M18-0850.