



## Brief CBT-based psychological interventions to improve mental health outcomes in refugee populations: a systematic review and meta-analysis

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### ABSTRACT

**Background:** Refugees, asylum seekers, and internally displaced people experience a high burden of mental health problems owing to their experiencing traumas and stressful events.

**Objective:** To summarise the available evidence and analyse the efficacy of brief psychological interventions (< 3 months) on improving mental health outcomes, including depression, anxiety, and post-traumatic stress disorder (PTSD)-related symptoms in refugees.

**Method:** We searched Medline, EMBASE, PsycINFO, CINAHL, and Global Index Medicus from inception to 19 December 2023. We included controlled studies using any cognitive behavioural therapy (CBT) or CBT-based therapies delivered over a short time (< 3 months), which reported mental health outcomes pre-and post-intervention. We conducted meta-analyses using random effects to derive pooled summary statistics. The quality of the evidence was assessed with the Cochrane Risk of Bias (RoB2) and ROBINS-I tools. This study is registered on the Open Science Framework, DOI [10.17605/OSF.IO/9CXU4](https://doi.org/10.17605/OSF.IO/9CXU4).

**Results:** 34 eligible studies across 37 publications were retrieved for analysis, and 33 studies with 4479 participants were included in the meta-analysis. There was an overall improvement in immediate mental health outcomes for all three domains, with analysis of 13 studies on anxiety outcomes (SMD  $-1.12$ , 95% CI  $-1.72$  to  $-0.52$ ), 20 studies on depression (SMD  $-1.04$ , 95% CI  $-1.97$  to  $-0.11$ ), and 24 studies on PTSD (SMD  $-0.82$ , 95% CI  $-1.20$  to  $-0.45$ ). At 3 to 6-month follow-up, however, analysis of mental health outcomes shows no significant change from baseline, with a SMD of  $0.24$  (95% CI  $-0.94$  to  $1.42$ ) across 4 studies,  $-0.73$  (95% CI  $-2.14$  to  $0.68$ ) across 9 studies, and  $0.29$  (95% CI  $-0.94$  to  $1.53$ ) across 12 studies for anxiety, depression, and PTSD respectively.

**Conclusion:** Low-quality evidence shows brief psychological interventions have a positive immediate effect on refugees and internally displaced people's mental well-being. However, these effects do not persist in the short-term follow up. Heterogeneity was high, even among subgroups, impacting our findings' generalisability.

### Intervenciones psicológicas breves para mejorar los resultados de salud mental en poblaciones de refugiados: una revisión sistemática

**Antecedentes:** Los refugiados, los solicitantes de asilo y las personas desplazadas internamente experimentan una gran carga de problemas de salud mental debido a la experiencia de traumas y eventos estresantes.

**Objetivo:** Resumir la evidencia disponible y analizar la eficacia de las intervenciones psicológicas breves (<3 meses) para mejorar los resultados de salud mental, incluidos los síntomas relacionados con la depresión, ansiedad y trastorno de estrés postraumático (TEPT) en refugiados.

**Método:** Realizamos búsquedas en Medline, EMBASE, PsycINFO, CINAHL y Global Index Medicus desde el inicio hasta el 19 de diciembre de 2023. Incluimos estudios controlados que utilizaban cualquier terapia cognitivo-conductual (TCC) o terapias basadas en TCC administradas durante un período corto (<3 meses), que informaban resultados de salud mental pre y post-intervención. Realizamos metanálisis utilizando efectos aleatorios para derivar estadísticas de resumen agrupadas. La calidad de la evidencia se evaluó con las herramientas Cochrane Risk of Bias (RoB2) y ROBINS-I. Este estudio está registrado en Open Science Framework, DOI [10.17605/OSF.IO/9CXU4](https://doi.org/10.17605/OSF.IO/9CXU4).

**Resultados:** Se recuperaron 34 estudios elegibles para el análisis en 37 publicaciones, y se incluyeron 33 estudios con 4.479 participantes en el metanálisis. Hubo una mejoría general en los resultados inmediatos de salud mental para los tres dominios, con análisis de 13 estudios sobre resultados de ansiedad (SMD  $-1,12$ , IC del 95%:  $-1,72$  a  $-0,52$ ), 20 estudios

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### PALABRAS CLAVE

Refugiados; solicitantes de asilo; personas desplazadas internamente; TCC; intervención psicológica breve; ansiedad; depresión; TEPT; revisión sistemática; metaanálisis

### HIGHLIGHTS

- We analysed the evidence on the use of brief CBT-based psychological interventions to improve mental health outcomes in forcibly displaced persons.
- These interventions had a positive effect on anxiety, depression and PTSD, though there was high heterogeneity between studies.
- Positive effects on mental health disappeared at long-term follow-up.

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sobre depresión (SMD  $-1,04$ , IC del 95%:  $-1,97$  a  $-0,11$ ) y 24 estudios sobre TEPT (SMD  $-0,82$ , IC del 95%:  $-1,20$  a  $-0,45$ ). Sin embargo, en el seguimiento de 3 a 6 meses, el análisis de los resultados de salud mental no muestra cambios significativos desde el basal, con una SMD de  $0,24$  (IC del 95%:  $-0,94$  a  $1,42$ ) en 4 estudios,  $-0,73$  (IC del 95%:  $-2,14$  a  $0,68$ ) en 9 estudios y  $0,29$  (IC del 95%:  $-0,94$  a  $1,53$ ) en 12 estudios para ansiedad, depresión y TEPT respectivamente.

**Conclusión:** La evidencia de baja calidad muestra que las intervenciones psicológicas breves tienen un efecto inmediato positivo en el bienestar mental de los refugiados y las personas desplazadas internamente. Sin embargo, estos efectos no persisten en el seguimiento a corto plazo. La heterogeneidad fue alta, incluso entre los subgrupos, lo que afecta la generalización de nuestros hallazgos.

## 1. Introduction

The population of refugees, asylum seekers, and internally displaced people has grown to 110 million in 2023 (Global Appeal, 2023). The traumatic issues that force people to leave their homes, including persecution, violence, and human rights violations, have profound impacts on mental health (Hargreaves, 2002; Jolof et al., 2022; Jud et al., 2020). They are then likely to experience additional stressful events during migration and resettlement in a new location (Benjeddi et al., 2023; Jolof et al., 2022; Oldroyd et al., 2022). As a result, forcibly displaced people have a markedly high prevalence of mental illness (Blackmore et al., 2020; Fazel et al., 2005; Gwynn et al., 2008; Hamrah et al., 2021); one meta-analysis of refugee and asylum-seeker populations found a prevalence of 31% for PTSD, 31.5% for depression, and 11% for anxiety, which appear to persist for many years after resettlement (Blackmore et al., 2020). Therefore, there is an urgent need for mental health care in the forcibly displaced population.

Psychosocial interventions have the potential to mitigate mental health symptoms among forcibly displaced persons. However, psychosocial interventions are often challenging to implement due to limited resources in host countries, with 75% of forcibly displaced people hosted by low- and middle-income countries (LMICs) (Global Trends, 2023). The scarcity of mental health specialists in LMICs, compared to high income countries, complicates the delivery of psychosocial interventions (Rathod et al., 2017). Furthermore, lengthy psychosocial interventions can be challenging for forcibly displaced persons to attend due to competing priorities, such as child care responsibilities and employment opportunities (DeSa et al., 2022; Kyrillos et al., 2023), as well as short-term living situations. Forcibly displaced persons are often housed in transient living situations for indeterminate periods of time. For example, the duration of the initial detention of asylum seekers upon their arrival in a new country (Asylum Information Database | European Council on Refugees and Exiles 2018) can vary widely; in Germany, the average period is 20 days (Duration of detention, 2024), while in Greece, there is an initial

50-day duration for asylum detention, extendable up to legal maximum of 18 months (Duration of detention, 2024). Additionally, forcibly displaced persons experience highly variable durations in refugee camps; for instance, an average of 71 days in Moria refugee camp (van de Wiel et al., 2021) and around 2 years in a Ugandan settlement (Goninon et al., 2021).

A possible way to handle these challenges is brief psychological interventions, where a restricted number of sessions are delivered over a short-term period. These brief psychological interventions are potentially more suitable for the low-resource, transient situations that forcibly displaced persons are often found in. Many brief psychological interventions are based on cognitive behavioural therapy (CBT) and narrative exposure therapy (NET), which is a specific type of CBT. CBT and NET have been shown to be effective in relieving symptoms of PTSD, depression, and anxiety in refugee populations (Cowling & Anderson, 2023; Turrini et al., 2019). CBT is a structured, goal-orientated form of therapy that aims to identify and modify harmful patterns of thinking and behaviour (Chand et al., 2023). NET is short-term, trauma-focused CBT whereby therapist and patient work to create a timeline of the patient's life, rebuilding the autobiographical memory, allowing for the reduction of anxiety (Schauer et al., 2005).

Furthermore, there has recently been an emergence in scalable, transdiagnostic interventions which are less resource intensive as they can be delivered by trained lay workers rather than mental health specialists. Examples include the low-intensity, transdiagnostic interventions developed by the World Health Organisation (WHO), such as Problem Management Plus (PM+) and Self-Help Plus (SH+). PM+ uses aspects of CBT to improve one's management of practical problems and associated mental health issues (Dawson et al., 2015). SH+ is a guided self-help programme delivered through a pre-recorded audio course, based on Acceptance and Commitment Therapy (ACT) (Epping-Jordan et al., 2016). ACT contains elements of CBT and aims to promote greater psychological flexibility, allowing individuals to cope better with psychological difficulties.

In 2020, a Cochrane scoping review (Uphoff et al., 2020) found a gap in the evidence on mental health interventions for refugees, asylum seekers, and internally displaced persons. There have been several recent systematic reviews looking at psychological interventions for refugees and asylum seekers. Two focus only on low-intensity, transdiagnostic interventions (Schäfer, Thomas, et al., 2023; Schäfer et al., 2023); one on psychological interventions in children (Thabet et al., 2023); and one on psychosocial interventions for PTSD only in low- and middle-income countries (Dowllah & Melville, 2023). There is still a gap in the evidence requiring an up-to-date systematic review which focuses on the effect of brief CBT-based interventions on mental health symptoms. Furthermore, it is necessary to assess potentially moderating factors, such as who the interventions are delivered by. Finally, given the recent research released on long-term follow-up (Bryant et al., 2022b; Jordans et al., 2023; Turrini et al., 2022), there is a need to determine if any effects on mental health symptoms are long-lasting.

To address the gap in the research, we aimed to synthesise the body of evidence on short-term CBT-based interventions that were delivered in less than 3 months. The timing reflects the transient nature of housing situations for many forcibly displaced persons and the limited resources for their mental health provision.

## 2. Methods

This systematic review adheres to standards outlined by Cochrane Collaboration (Cochrane Handbook for Systematic Reviews of Interventions, n.d.) and is reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA Page et al., 2021). Differences between the preregistration of this review (preregistration-ID: 10.17605/OSF.IO/9CXU4) and the final review are presented in the Supplementary Material (SM1).

### 2.1. Search strategy

We developed the search strategy based on previous studies (Turrini et al., 2019; Uphoff et al., 2020) and consulted an information specialist to assess the search keywords and give recommendations for the final search strategy.

We searched databases from inception, with the search last updated on December 19, 2023. We searched five databases: Ovid Medline, Ovid EMBASE, Ovid PsycINFO, CINAHL, and Global Index Medicus. Further searches on Google Scholar and the ICTRP (International Clinical Trials Registry Platform) were conducted to ensure all relevant comprehensiveness of the search strategy.

Full search strategies are presented in SM2. We also screened the reference lists of included studies and related systematic reviews for inclusion.

### 2.2. Selection criteri

We included controlled trials using any CBT (or CBT-based therapies) delivered over a short period of time, as defined by the study, or as interventions that took place in a time frame of up to 3 months, reporting mental health outcomes pre-and post-intervention. Both randomised and non-randomised trials were included so as not to exclude relevant research where randomisation was not feasible due to lack of resources. The control group included waitlist control, care as usual, enhanced care as usual, no-treatment monitoring group, or meditation-relaxation techniques, provided there was no use of psychological or pharmacological interventions. We excluded observational studies and feasibility trials without a control group, case reports, case series and reviews of internet-delivered CBT interventions. Studies not published in English were also part of our exclusion criteria due to the language skill set of the authors; however, there were no reports excluded for this reason during the screening progress.

We used 3 months as the specific time limit because studies which describe their interventions as 'brief' generally take place within this timeframe (Bryant et al., 2022a; Knefel et al., 2020; Shepardson et al., 2018). We focussed on CBT-based interventions, as these interventions are feasible and generalisable in forcibly displaced persons and have evidence to support their use (Lawton & Spencer, 2021; Nosè et al., 2017; Turrini et al., 2019).

The review aimed to:

- (1) demonstrate if these interventions are efficacious in improving a range of mental health symptoms, particularly PTSD, anxiety, or depression,
- (2) assess if improvements can be sustained in the long term; and
- (3) identify factors that influence the effectiveness of the psychological interventions.

### 2.3. Study selection

All abstracts and full texts retrieved from our search strategy were screened in duplicate by three authors (ND, LX, EED), and any discrepancies were resolved by discussion with a third author.

### 2.4. Data extraction

Three investigators extracted data in duplicate by two of three authors (ND, LX, EED) using a standardised

data collection template on Microsoft Excel with predefined data fields, including study characteristics, participant demographics, primary and secondary outcome measures, and drop-out rate. Any discrepancies were resolved by discussion with the third author.

Where the total length of the intervention or primary data on mental health measures pre- and post-intervention was not reported, we contacted corresponding authors via email to request additional information.

### 2.5. Quality appraisal

Three authors (ND, LX, EED) independently evaluated the risk of bias using the Cochrane Risk of Bias (RoB 2) tool (Uphoff et al., 2020) for randomised trials and the ROBINS-I tool for non-randomised studies (Schäfer, Thomas, et al., 2023). Any conflicts in the duplicated data were resolved by discussion with the third reviewer. We examined publication bias using visual inspections of funnel plots (Sterne & Harbord, 2004) and Egger's test.

### 2.6. Data synthesis

As our primary outcome measure is the change in mental health outcomes as measured within 3 months of the intervention, the means for pre- and post-intervention measures were pooled, along with their standard deviations (SDs) and number of participants per study. We conducted the primary analysis according to the intent-to-treat principle, to minimise potential biases associated with non-random attrition. We estimated standardised mean differences of anxiety, depression, and PTSD measures using Cohen's *d* statistic, then converted to Hedge's *g* to correct for small sample size ( $n < 20$ ). Summary statistics for all trials were computed and displayed as forest plots using R version 4.3.2, using the meta package. We performed a random-effects meta-analysis for brief CBT-based psychological interventions in treating anxiety and depression and for brief CBT-based psychological interventions in treating PTSD.

We investigated the long-term effect of brief CBT-based interventions on mental health outcomes by using a random-effects meta-analysis. The stratification of long-term follow-up periods into 3–6 months and 7–12 months intervals was determined after the initial data collection.

Post-hoc subgroup analyses were performed due to high heterogeneity in the primary outcome measures, grouping studies by the type of mental health assessment tools used, intervention type, population type, personnel conducting the intervention, sample size ( $>100$  or  $<100$ ), and whether the setting was in a low or high-income country.

Finally, we performed sensitivity analysis by removing studies with a moderate and high risk of bias to assess the robustness of the outcome.

## 3. Results

### 3.1. Search outcomes

The search strategy yielded 4784 hits. After de-duplication and full-text screening, 34 studies (32 unique trials) were identified. Screening the reference lists of the identified studies yielded three further studies (Orang et al., 2022; Spaaij et al., 2022; Ehntholt et al., 2005), which were included in the subsequent analysis (Figure 1).

### 3.2. Study characteristics

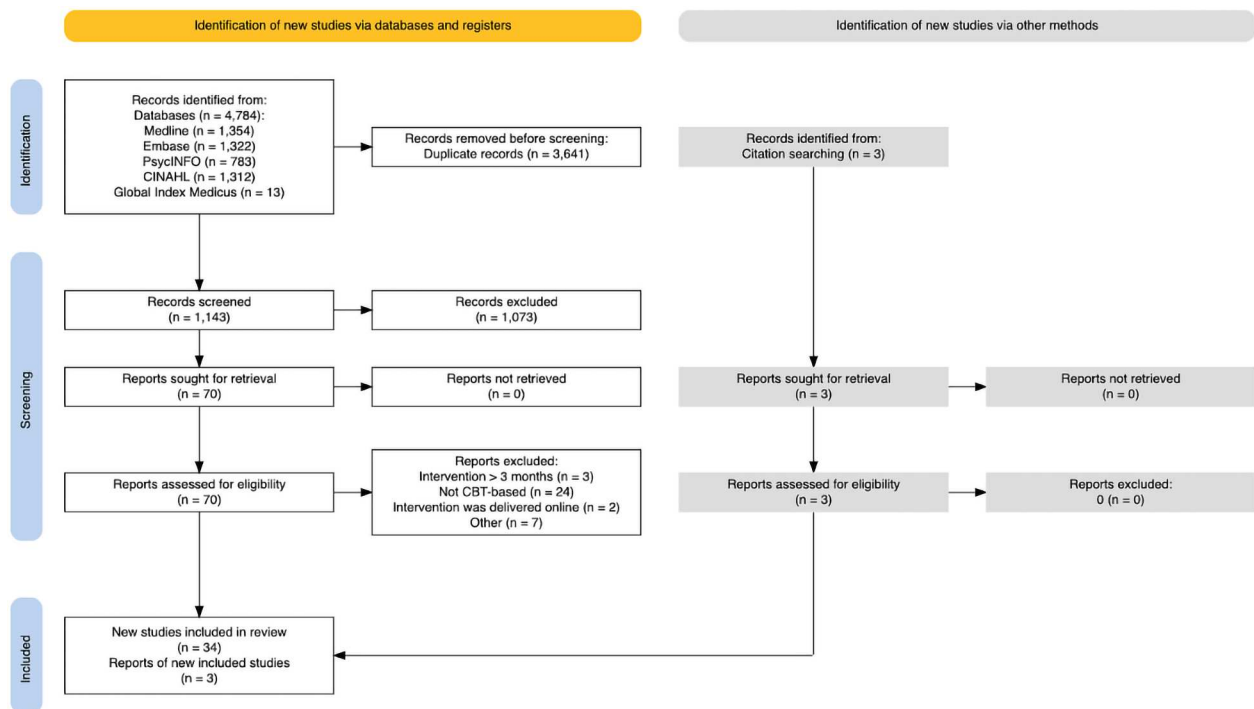
Tables 1 and 2 report the characteristics of the 37 included studies and their extracted outcomes. Of these studies, 28 were carried out in adults, and the remaining nine were conducted in child and adolescent populations. Most studies were performed in Germany (6 studies), followed by Uganda (5 studies), then Jordan, Turkey, and the USA (3 studies each). Only two trials involved internally displaced persons; the rest were conducted on refugees and/or asylum seekers. Most studies were RCTs ( $n = 31$ , 83.8%).

Commonly used intervention programmes included the WHO interventions Problem Management Plus (PM+; 5 studies) and Self-Help Plus (SH+; 3 studies) in adult samples; other interventions more generally employed the principles of Cognitive Behavioural Therapy (CBT; 7 studies) as well as Narrative Exposure Therapy (NET; 7 studies). In children/adolescents, Early Adolescent Skills for Emotions (EASE; 3 studies) and Narrative Exposure Therapy for Traumatized Children and Adolescents (KIDNET; 2 studies) were employed (see Table 1).

### 3.3. Quality appraisal

Overall, analysis of the 31 RCTs found that 8 (26%) studies were reported as 'low risk', 15 (48%) had 'some concern', and 8 (26%) had 'high risk'. The main areas of concern for the RCTs were missing outcome data and measurement of the outcome, where the psychological assessment tools used were not validated or even shown to be inconsistent. Analysis of the six remaining non-randomised studies using the ROBINS-I tool revealed methodological biases; four studies were reported as 'serious risk' and two were judged 'moderate risk' (SM 3). The main flaws in the non-randomised trials were due to confounding, missing data, and measurement of outcomes.

The funnel plots of anxiety and PTSD outcomes were visually symmetrical (SM 4); Egger's test for a



**Figure 1.** PRISMA flowchart of the study selection process.

regression intercept gave  $p$ -values of .63 and .07, respectively, indicating no evidence of publication bias. The funnel plot of depression outcomes showed asymmetry of effect sizes (Egger's test  $p = .12$ ), suggesting possible publication bias. A search of the WHO's ICTRP (International Clinical Trials Registry Platform) did not show any unpublished studies.

### 3.4. Effectiveness of psychosocial outcomes

Figure 2 shows that brief psychological interventions were effective in decreasing anxiety symptoms (13 studies, 1183 participants) relative to the controls (SMD  $-1.12$ , 95% CI  $-1.72$  to  $-0.52$ ,  $I^2 = 95\%$ ). Figure 3 shows that brief psychological interventions relative to control yielded SMD  $-1.04$ , (95% CI  $-1.97$  to  $-0.11$ ,  $I^2 = 99\%$ ) for depression (20 studies, 3855 participants) and Figure 4 shows the effectiveness for PTSD (24 studies, 3770 participants), with a SMD of  $-0.82$  ( $-1.20$  to  $-0.45$ ,  $I^2 = 93\%$ ).

#### 3.4.1. Intervention method

Four RCTs [Eskici et al., 2023; Shaw et al., 2019; Hinton et al., 2004, 2005] investigated the effectiveness of culturally adapted CBT (CA-CBT) sessions on anxiety; there was no significant effect (SMD  $-1.46$ , 95% CI  $-3.17$  to  $0.25$ ,  $I^2 = 83\%$ ).

For PM+, the three RCTs (Spaaij et al., 2002; Knefel et al., 2022; De Graaff et al., 2020) utilising this intervention did not demonstrate a significant effect on anxiety (SMD  $-0.40$ , 95% CI  $-1.50$  to  $0.69$ ,  $I^2 = 66\%$ ). These same three studies using PM+ also found this intervention to have no significant effect

on depression (SMD  $-0.41$ , 95% CI  $-1.17$  to  $0.34$ ,  $I^2 = 48\%$ ). However, the four RCTs [De Graaff et al., 2020; Spaaij et al., 2022; Knefel et al., 2022; Acarturk et al., 2022] using PM+ showed a significant effect on PTSD (SMD  $-0.34$ , 95% CI  $-0.50$  to  $-0.17$ ,  $I^2 = 0\%$ ) (SM 5.1).

Three RCTs [Bryant et al., 2022b; Fine et al., 2021; Jordans et al., 2023] investigated the effectiveness of EASE as an intervention on PTSD outcomes. The results indicated that there was no significant effect on PTSD (SMD  $-0.19$ , 95% CI  $-2.32$  to  $1.95$ ,  $I^2 = 98\%$ ).

Three RCTs [Acarturk et al., 2022; Purgato et al., 2021; Tol et al., 2020] investigated the effectiveness of SH+ on PTSD. The results indicated that there was no significant effect on PTSD (SMD  $-0.25$ , 95% CI  $-1.18$  to  $0.67$ ,  $I^2 = 96\%$ ).

The remaining intervention types or outcomes not mentioned had too few studies ( $n < 3$ ) included in meta-analysis to be examined.

#### 3.4.2. Intervention type (group vs individual)

We did not find any difference between interventions conducted in a group setting versus individually on anxiety, depression, and PTSD outcomes (SM 5.2).

#### 3.4.3. Intervention providers

We also examined the effectiveness of interventions conducted by trained lay persons (those in the local community or even peer refugees) versus professionals with a background in clinical psychology or psychiatry (Figure 5). Effect sizes were comparable across lay and trained providers for anxiety

**Table 1.** Characteristics of included studies.

Study	Study type	Country	Population	Intervention/control	Number of participants (males)	Age †	Outcome measures extracted	Total length of intervention (average)	Average number of sessions	Treatment provider	Time elapsed since arriving in country (months)	Maximum follow-up period (months)
De Graaff et al. (2020)	RCT	Netherlands	Syrian refugees	PM+/CAU	206 (127)	36.4 ± 11.7 (18-69)	Depression (HSCCL-25), anxiety (HSCCL-25), PTSD (PCL-5)	5 weeks	5	Trained peer refugees	42.22 (1-97)	3
Eskici et al. (2023)	RCT	Turkey	Female Syrian refugees	CA-CBT/TAU	23 (0)	35.1 ± 8.3	Depression (HSCCL-25), PTSD (HTQ)	7 weeks	7	Trained facilitators from local community	NR	-
Jordans et al. (2023)	RCT	Lebanon	Syrian refugee adolescents	EASE/ETAU	198 (101)	11.8 ± 1.3 (10-14)	Depression (PHQ-A), PTSD (CRIES-13)	7 weeks	7	Trained facilitators from local community	NR	12
Acarturk et al. (2022)	RCT	Turkey	Syrian refugees	gPM+/ECAU	46 (15)	38.0 ± 10.9	Depression (HSCCL-25), anxiety (HSCCL-25), PTSD (PCL-5)	5 weeks	5	Trained peer refugees	NR	3
Acarturk et al. (2022)	RCT	Turkey	Syrian refugees	SH+/ECAU	322 (116)	31.2 ± 8.9	Depression (PHQ-9), PTSD (PCL-5)	5 weeks	5	Trained peer refugees	54.53 ± 41.44	6
Bryant et al. (2022a)	RCT	Jordan	Syrian refugees	gPM+/EUC	410 (110)	40.0 ± 7.0	Depression (HSCCL-25), anxiety (HSCCL-25), PTSD (PCL-5)	5 weeks	5	Trained peer refugees	70.7 ± 20 (12-108)	12
Bryant et al. (2022b)	RCT	Jordan	Adolescent Syrian refugees	EASE/EUC	471 (238)	11.6 ± 1.3 (10-14)	Depression (PHQ-A), PTSD (CRIES-13)	7 weeks	7	Trained facilitators from local community	NR	12
Knefel et al. (2022)	RCT	Austria	Afghan refugees	aPM+/TAU	51 (26)	34.3 ± 13.6	Depression (GHQ), anxiety (GHQ), PTSD (ITQ)	6 weeks	6	Clinical psychologists	NR	-
Orang et al. (2022)	RCT	Germany	Refugees of various nationalities	VBC/WLC	103 (63)	30.6 ± 8.1 (18-62)	Depression (PHQ-9), anxiety (GAD-7), PTSD (PCL-5)	4 weeks (2-7 weeks)	4 (2-7)	Trained migrant counsellors (mostly refugees)	34.3 ± 20.5 (1-480)	3
Spaaji et al. (2022)	Pilot RCT	Switzerland	Syrian refugees	PM+/ETAU	59 (29)	39.9 ± 9.9	Depression (HSCCL-25), anxiety (HSCCL-25), PTSD (PCL-5)	5 weeks	5	Trained peer refugees	40.3 ± 25.6	3
Aizik-Reebs et al. (2021)	RCT	Israel	Eritrean asylum seekers	MBTR-R/WLC	158 (85)	31.8 ± 5.21 (20-48)	Depression (PHQ-9), anxiety (Beck Anxiety Inventory), PTSD (HTQ)	9 weeks	9	Clinical psychologists	NR	1.25
Fine et al. (2021)	Cluster RCT	Tanzania	Adolescent Burundian refugees	EASE/ETAU	82 (37)	12.3 ± 1.5 (10-14)	PTSD (CPSS)	7 weeks	7	Trained peer adult refugees	NR	-
Foka et al. (2021)	CCT	Greece	Child refugees of various nationalities	SFJ/WLC	72 (25)	10.8 ± 2.0 (7-14)	Depression (CES-DC)	6 days	6	Trained facilitator	NR	-
Goninon et al. (2021)	CCT	Uganda	Congolese refugees	EMPOWER	98 (45)	33.4 ± 11.7 (18-80)	PTSD (SPTSS)	2 weeks	9	Trained facilitator	20.4 ± 24	1.5
Purgato et al. (2021)	RCT	Western European countries	Refugees of various nationalities	SH+/ETAU	459 (325)	32.6 ± 10.2	Depression (PHQ-9), PTSD (PCL-5)	5 weeks	5	Trained peer refugees	NR	12

Alsheikh (2020)	RCT	Jordan	Female Syrian refugees	Group counselling/no counselling	40 (0)	NR	PTSD (PCL-5)	6 weeks	10	Clinical psychologist	NR	-
Jeon et al. (2020)	CCT	South Korea	North Korean refugees	CBT/simple relaxation	38 (3)	38.1 (20-60)	Depression (CES-D), anxiety (STAI-S), PTSD (IES-R)	8 weeks	8	Clinical psychologist and psychiatrist	NR	-
Kananian et al. (2020)	RCT	Germany	Male Afghan and Iranian refugees	CA-CBT+/WLC/ ECAU	24 (24)	21.9 ± 3.4	PTSD (PCL-5)	6 weeks	12	Trained facilitator	21.8 ± 3.7	12
Tol et al. (2020)	Cluster RCT	Uganda	Female South Sudanese refugees	SH+/ECAU	694 (0)	30.9 ± 10.9	Depression (PHQ-9), PTSD (PCL-C)	5 weeks	5	Trained facilitators	NR	3
Shaw et al. (2019)	RCT	Malaysia	Female Afghan refugees	CA-CBT/WLC	29 (0)	31.9 ± 9.9	Depression (HSC-25), anxiety (HSC-25), PTSD (HTQ)	8 weeks	8	Trained facilitators from local community	21.6	3
Pfeiffer et al. (2018)	RCT	Germany	Child and adolescent refugees of various nationalities	Mein Weg/UC	99 (92)	17 ± 0.95	Depression (PHQ-8), PTSD (CATS-S)	6 weeks	6	Trained social workers	12.7 ± 4.54	-
Ooi et al. (2016)	Cluster RCT	Australia	Child and adolescent refugees of various nationalities	TRT/WLC	82 (29)	12.6 ± 1.7(10-17)	Depression (DSRS), PTSD (CRIES-13)	8 weeks	8	Trained graduate psychology students	28.1 ± 21.4	3
Bolton et al. (2014)	RCT	Thailand	Burmese refugees	CETA/WLC	347 (130)	35.5 ± 12.1 (18-85)	Depression (HSC-25), anxiety (HSC-25), PTSD (HTQ)	10 weeks (7-12 weeks)	9.7 (7-13)	Trained peer refugees	66.5 ± 57.2 (0-420)	4
Hijazi et al. (2014)	RCT	USA	Iraqi refugees	Brief NET/WLC	63 (28)	48.2 ± 8.9	Depression (Beck-II), PTSD (HTQ)	3 weeks	3	Doctoral clinical psychology students	27.6 ± 27.6	4
Stenmark et al. (2013)	RCT	Norway	Refugees of various nationalities	NET/TAU	81 (56)	35.3 ± 11.0	Depression (HAM-D), PTSD (CAPS)	10 weeks	10	Mental health professionals	56 ± 50.6	6
Adenauer et al. (2011)	RCT	Germany	Refugees of various nationalities	NET/WLC	34 (19)	33.5 ± 9.9	PTSD (CAPS)	6-12 weeks	12	Clinical psychologists	-	4
Ertl et al. (2011)	RCT	Uganda	Former Ugandan child soldiers in IDP camps	NET/WLC	57 (29)	18.4 ± 3.6	Depression (MINI), PTSD (CAPS)	3 weeks	8	Trained facilitators from local community	-	12
Sonderregger et al. (2011)	CCT	Uganda	Ugandan IDPs	EMPOWER/WLC	202 (82)	29.1 ± 12.6	Depression (APAI Two Tam, Kumu, Par), anxiety (APAI Ma Lwor)	2 weeks	9	Trained facilitators from local community	NR	3
Neuner et al. (2010)	RCT	Germany	Refugees of various nationalities	NET/TAU	32 (22)	31.4 ± 7.6 (8-14)	Depression (HSC-25), PTSD (PDS)	4 weeks (2.5-8.5 weeks)	8.79 ± 3.77	Clinical psychologists	55.6 ± 42.7	6
Ruf et al. (2010)	RCT	Germany	Child refugees of various nationalities	KIDNET/WLC	26 (14)	11.5 ± 3.1 (7-16)	PTSD (UPID)	8 weeks	8	Clinical psychologists	37.3 ± 46.9	12
Catani et al. (2009)	RCT	Sri Lanka	Child IDPs	KIDNET/MED-RELAX	31 (17)	12 ± 2 (8-14)	PTSD (UPID)	2 weeks	6	Local counsellor	NR	6
Neuner et al. (2008)	RCT	Uganda	Rwandan and Somali refugees	NET/MG	166 (83)	34.8 ± 12.8	PTSD (PDS)	3 weeks	6	Trained lay counsellors	NR	8
Ehnholt et al. (2005)	CCT	UK	Refugees of various nationalities	CBT/Control	26 (17)	14 ± 4.8 (11-15)	Depression (DSRS), anxiety (RCMAS), PTSD (R-IES)	6 weeks	6	Clinical psychology trainee	NR	-
Hinton et al. (2005)	RCT	USA	Cambodian refugees	CA-CBT/Delayed treatment	40 (16)	51.8 ± 6.8	Anxiety (ASI), PTSD (CAPS)	12 weeks	12	Psychiatrist	206.8 ± 42.4	6

(Continued)

Table 1. Continued.

Study	Study type	Country	Population	Intervention/control	Number of participants (males)	Age †	Outcome measures extracted	Total length of intervention (average)	Average number of sessions	Treatment provider	Time elapsed since arriving in country (months)	Maximum follow-up period (months)
Hinton et al. (2004)	RCT	USA	Vietnamese refugees	CA-CBT/Delayed treatment	12 (6)	NR	Depression (HSCL-25), anxiety (ASI), PTSD (HITQ)	11 weeks	11	Psychiatrist	NR	9
Neuner et al. (2004)	RCT	Uganda	Sudanese refugees	NET/SC	31 (14)	32.9 ± 6.8	PTSD (PDS)	2 weeks	4	Clinical psychologists	39.4 ± 9.1	12
Barrett et al. (2000)	CCT	Australia	Female adolescent refugees from former Yugoslavia	FRIENDS/WLC	20 (0)	16.3	Anxiety (SCAS)	10 weeks	10	Clinical psychologist	2.4	-

†Ages are reported as mean ± SD, mean (range) or mean alone.

RCT, randomised controlled trial; CCT, controlled clinical trial.

IDP, internally displaced persons.

PMH+, Problem Management Plus; gPMH+, group PMH+; CA-CBT, Culturally-Adapted Cognitive Behavioral Therapy; EASE, Early Adolescent Skills for Emotions; MBTR-R, Mindfulness-Based Trauma Recovery for Refugees; TRT, Teaching Recovery Techniques; KIDNET, Narrative Exposure Therapy for Traumatized Children and Adolescents.

CAU, care as usual; TAU, treatment as usual; ETAU, enhanced treatment as usual; EUC, Enhanced Usual Care; MG, No-Treatment Monitoring Group; SC, Supportive Counseling.

APA1, African Youth Psychosocial Assessment Instrument; ASI, Anxiety Sensitivity Index; CAPS, Clinician-Administered PTSD Scale for DSM-5; CES-D, Centre for Epidemiological Studies Depression; CES-DC, Centre for Epidemiological Studies Depression; CES-D, Centre for Epidemiological Studies Depression; CES-D, Centre for Epidemiological Studies Depression; HSC-25, Hopkins Symptom Checklist-25; HITQ, Harvard Trauma Questionnaire; ITQ, International Trauma Questionnaire; MINI, Mini International Neuropsychiatric Interview; PCL-5, PTSD Checklist for DSM-5; PDS, Posttraumatic Diagnostic Scale; PHQ-9, Patient Health Questionnaire; PHQ-A, PHQ-9 modified for Adolescents; RCMAS, Revised Children's Manifest Anxiety Scale; R-IES, Impact of Event Scale - Revised; SCAS, Spence Children's Anxiety Scale; SPTSS, Screen for Posttraumatic Stress Symptoms; STAI-5, State-Trait Anxiety Inventory; UPID, UCLA Child/Adolescent PTSD Reaction Index for DSM-5.

(lay persons: SMD  $-1.13$ , 95% CI  $-2.25$  to  $-0.01$ ,  $I^2 = 97\%$ ; trained psychologists: SMD  $-1.09$ , 95% CI  $-1.85$  to  $-0.33$ ,  $I^2 = 70\%$ ) and PTSD (lay persons: SMD  $-0.73$ , 95% CI  $-1.30$  to  $-0.16$ ,  $I^2 = 95\%$ ; trained psychologists: SMD  $-0.95$ ,  $-1.47$  to  $-0.44$ ,  $I^2 = 76\%$ ). For depression, there was also no significant difference between studies employing trained lay persons (SMD  $-1.27$ , 95% CI  $-2.63$  to  $0.08$ ,  $I^2 = 99\%$ ) compared to studies with interventions conducted by trained professionals (SMD  $-0.46$ , 95% CI  $-0.67$  to  $-0.25$ ,  $I^2 = 0\%$ ).

### 3.4.4. Intervention setting

We did not find any difference between interventions conducted in a low-to-medium resource setting versus a high-resource setting for anxiety, depression, and PTSD. (SM 5.3).

### 3.4.5. Population age

We divided the studies by whether they were performed on adults or children (8–18 years old) and found that positive effects of the intervention on anxiety were only present for adults (SMD  $-1.17$ , 95% CI  $-1.88$  to  $-0.45$ ,  $I^2 = 96\%$ ), whereas children did not experience a significant change in their symptoms (SMD  $-0.81$ , 95% CI  $-2.71$  to  $1.10$ ,  $I^2 = 0\%$ ). This was also apparent for depression outcomes (adults: SMD  $-1.12$ , 95% CI  $-2.21$  to  $-0.04$ ,  $I^2 = 98\%$ ; children: SMD  $-0.86$ ,  $-3.38$  to  $1.67$ ,  $I^2 = 99\%$ ) and PTSD outcomes (adults: SMD  $-0.85$ , 95% CI  $-1.22$  to  $-0.47$ ,  $I^2 = 90\%$ ; children: SMD  $-0.72$ ,  $-1.85$  to  $0.41$ ,  $I^2 = 97\%$ ) (Figure 6).

### 3.4.6. Type of mental health assessment tool

We did not find any difference between the type of mental health assessment tool that studies used to measure depression (e.g. PHQ-9), anxiety (e.g. HSCL-25), and PTSD outcomes (e.g. PCL-5) (SM 5.4). We did not show results on certain intervention methods (e.g. MBTR-R, Mein Weg) and types of mental health assessment tools (e.g. CES-D) as there were too few studies ( $< 3$ ) to conduct a meta-analysis.

## 3.5. Sensitivity analysis

Examining only studies that had low evidence of bias revealed a moderate positive effect of psychological interventions on PTSD (SMD  $-1.18$ , 95% CI  $-2.07$  to  $-0.28$ ,  $I^2 = 86\%$ ) [Bryant et al., 2022a; Bryant, Malik et al., 2022; Tol et al., 2020; Hinton et al., 2004, 2005]. However, in the four studies assessing depression (Bryant et al., 2022a; Bryant, Malik et al., 2022; Tol et al., 2020; Hinton et al., 2004), we found no significant improvement in depression symptoms (SMD  $-1.64$ , 95% CI  $-8.02$  to  $4.73$ ,  $I^2 = 100\%$ ). Similarly, there was no significant effect of psychological

**Table 2.** Reported outcomes of included studies.

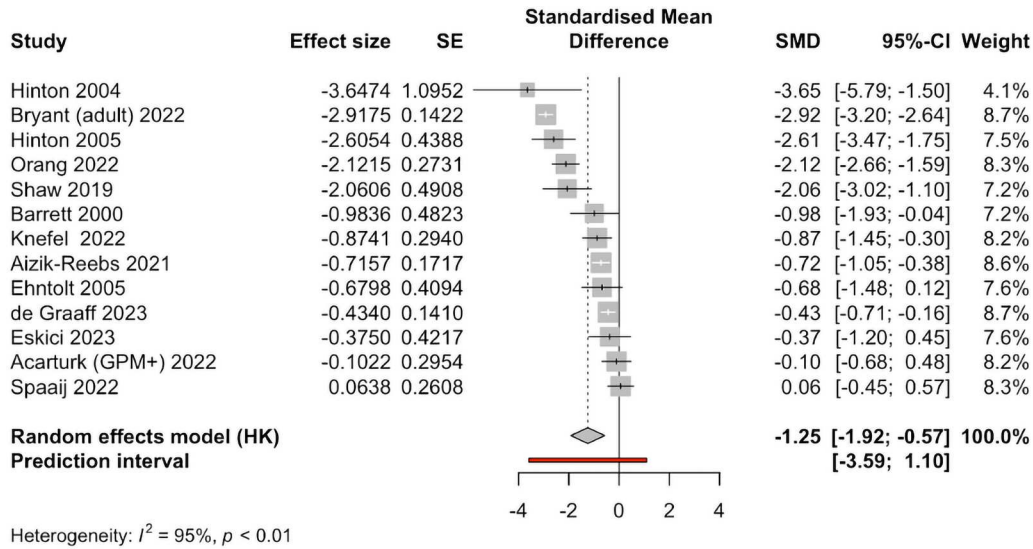
Study	Assessment measure used	Arm	No. of participants	Pre-intervention baseline	Post-intervention	3-month follow-up	6-month follow-up	12-month follow-up
De Graaff et al. (2020)	Anxiety (HSCL-25)	PM+	103	2.16 (0.66)	1.85 (0.65)	1.84 (0.64)	-	-
		CAU	103	2.24 (0.61)	2.21 (0.64)	2.15 (0.64)	-	-
	Depression (HSCL-25)	PM+	103	2.39 (0.69)	1.92 (0.64)	1.91 (0.63)	-	-
		CAU	103	2.47 (0.72)	2.33 (0.77)	2.28 (0.69)	-	-
Eskici et al., (2023)	PTSD (PCL-5)	PM+	103	33.22 (17.84)	20.89 (17.49)	19.79 (16.59)	-	-
		CAU	103	35.57 (15.96)	28.76 (16.52)	28.21 (16.38)	-	-
	Anxiety (HSCL-25)	CA-CBT	12	2.39 (0.49)	2.09 (0.51)	-	-	-
		TAU	11	2.48 (0.65)	2.39 (0.70)	-	-	-
Jordans et al. (2023)	Depression (HSCL-25)	CA-CBT	12	2.39 (0.49)	2.09 (0.51)	-	-	-
		TAU	11	2.48 (0.65)	2.39 (0.70)	-	-	-
	PTSD (HTQ)	CA-CBT	12	2.23 (0.43)	2.39 (0.70)	-	-	-
		TAU	11	2.1 (0.61)	-	-	-	-
Acarturk et al. (2022)	Depression (PHQ-A)	EASE	80	9.5 (0.8)	8.3 (0.8)	7.4 (0.9)	-	9.7 (0.8)
		ETAU	118	9.6 (1.4)	8.3 (1.4)	8.3 (1.4)	-	10.7 (1.4)
	PTSD (CRIES-13)	EASE	80	26.1 (2.2)	26.7 (2.2)	24.9 (2.3)	-	28.2 (2.4)
		ETAU	118	26.3 (4.0)	24.8 (4.0)	25.0 (4.1)	-	27.5 (4.1)
Acarturk et al. (2022)	Anxiety (HSCL-25)	gPM+	24	2.37 (0.58)	2.01 (0.59)	-	-	-
		ECAU	22	2.31 (0.64)	2.01 (0.43)	2.07 (0.52)	-	-
	Depression (HSCL-25)	gPM+	24	2.37 (0.58)	2.01 (0.59)	2.14 (0.43)	-	-
		ECAU	22	2.31 (0.64)	2.01 (0.43)	2.12 (0.85)	-	-
Acarturk et al. (2022)	PTSD (PCL-5)	gPM+	24	1.84 (0.88)	1.27 (0.7)	1.26 (0.70)	-	-
		ECAU	22	1.7 (0.86)	1.59 (0.86)	-	-	-
	Depression (PHQ-9)	SH+	322	6.45 (4.70)	5.24 (4.91)	4.93 (5.05)	-	-
		ECAU	320	6.30 (4.73)	5.32 (5.12)	6.70 (5.46)	-	-
Bryant et al. (2022a)	PTSD (PCL-5)	SH+	322	20.72 (14.90)	16.82 (12.83)	-	-	-
		ECAU	320	20.14 (14.28)	14.81 (14.60)	15.09 (12.86)	-	-
	Anxiety (HSCL-25)	gPM+	204	24.81 (0.43)	20.39 (0.5)	20.03 (0.50)	-	19.34 (0.54)
		EUC	206	25 (0.43)	21.93 (0.48)	19.65 (0.48)	-	17.85 (0.50)
Bryant et al. (2022b)	Depression (HSCL-25)	gPM+	204	36.57 (0.63)	28.98 (0.73)	29.04 (0.72)	-	28.26 (0.78)
		EUC	206	35.15 (0.63)	32.44 (0.70)	31.30 (0.72)	-	25.85 (0.73)
	PTSD (PCL-5)	gPM+	204	25.98 (1.02)	16.12 (1.05)	10.31 (1.02)	-	2.60 (1.07)
		EUC	206	26.72 (1.02)	17.58 (1.01)	10.73 (0.97)	-	3.29 (1.00)
Knefel et al. (2022)	Depression (PHQ-A)	EASE	185	15.06 (0.43)	12.80 (0.36)	12.42 (0.35)	-	-
		EUC	286	15.39 (0.27)	12.37 (0.29)	12.36 (0.28)	-	-
	PTSD (CRIES-13)	EASE	185	24.19 (0.89)	18.39 (0.63)	18.79 (0.72)	-	-
		EUC	286	23.29 (0.71)	18.23 (0.5)	18.87 (0.58)	-	-
Orang et al. (2022)	Anxiety (GHQ)	aPM+	26	1.89 (0.43)	1.37 (0.66)	-	-	-
		TAU	25	1.77 (0.75)	1.86 (0.81)	-	-	-
	Depression (GHQ)	aPM+	26	1.31 (0.63)	0.84 (0.56)	-	-	-
		TAU	25	1.49 (0.94)	1.41 (0.81)	-	-	-
Orang et al. (2022)	PTSD (ITQ)	aPM+	26	13.67 (4.22)	10.96 (5.5)	-	-	-
		TAU	25	14.8 (4.44)	13.96 (5.98)	-	-	-
	Anxiety (GAD-7)	VBC	42	13.54 (5.1)	3.9 (4.41)	2.51 (2.6)	-	-
		WLC	43	13.32 (5.78)	14.81 (5.19)	-	-	-
Orang et al. (2022)	Depression (PHQ-9)	VBC	42	15.14 (6.09)	4.40 (4.6)	3.8 (3.6)	-	-
		WLC	43	16.27 (6.56)	17.39 (6.49)	-	-	-
	PTSD (PCL-5)	VBC	28	44.7 (14.46)	13.82 (10.78)	10.03 (7.77)	-	-
		WLC	28	44.7 (14.46)	13.82 (10.78)	-	-	-

(Continued)

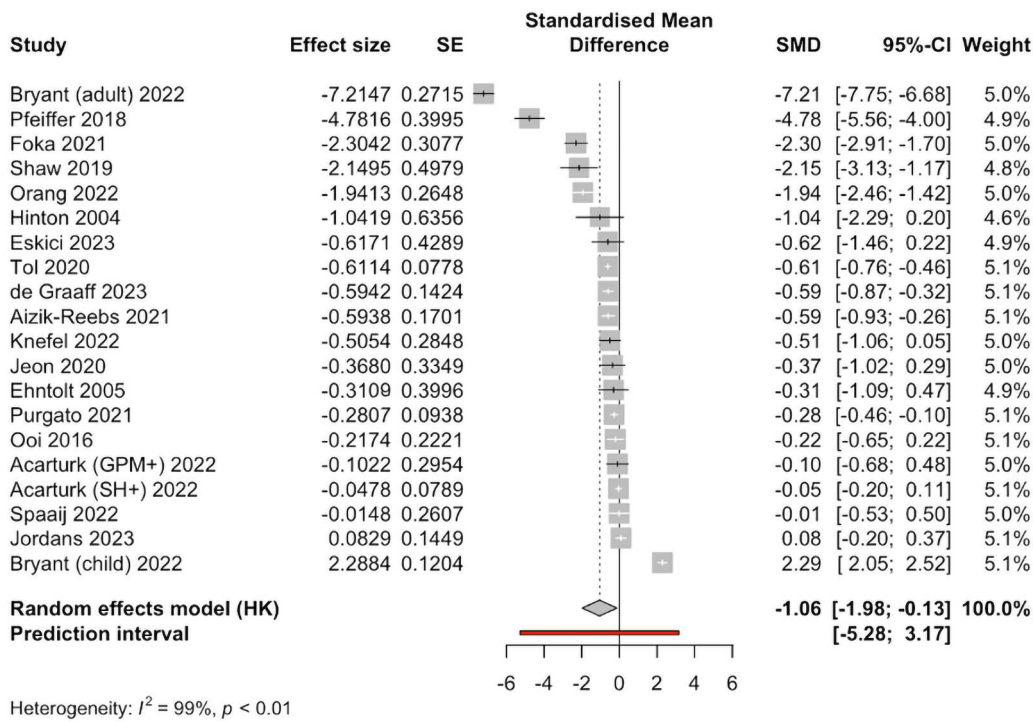
Table 2. Continued.

Study	Assessment measure used	Arm	No. of participants	Pre-intervention baseline	Post-intervention	3-month follow-up	6-month follow-up	12-month follow-up
Spaaij et al. (2022)	Anxiety (GAD-7)	WLC	34	44.55 (14.9)	48.17 (17.99)	—	—	—
		PM+	31	22.45 (8.48)	21 (7.6)	19.55 (7.2)	—	—
		ETAU	28	19 (7.14)	17.03 (8.43)	18.05 (5.86)	—	—
	Depression (PHQ-9)	PM+	31	35.41 (11.09)	31.09 (7.53)	31.61 (9.73)	—	—
		ETAU	28	29.86 (11.26)	25.69 (9.1)	28.18 (9.04)	—	—
		PM+	31	39.26 (18.53)	26.39 (16.62)	28.51 (18.91)	—	—
Alizik-Reebs et al. (2021)	Anxiety (Beck Anxiety Inventory)	ETAU	28	26.63 (17.92)	17.44 (16.19)	20.42 (17.17)	—	—
		MBTR-R	95	32.68 (9.25)	23.53 (14.15)	—	—	—
		WLC	58	31.63 (13.18)	31.62 (14.33)	—	—	—
	Depression (PHQ-9)	MBTR-R	95	15.12 (4.08)	11.41 (5.76)	—	—	—
		WLC	58	16.03 (4.46)	15.27 (5.16)	—	—	—
		MBTR-R	95	2.71 (0.45)	2.10 (0.59)	—	—	—
Fine et al. (2021)	PTSD (HTQ)	WLC	58	2.85 (0.45)	2.63 (0.48)	—	—	—
		EASE	38	7.55 (8.66)	6.12 (5.91)	—	—	—
		ETAU	44	7.52 (9.98)	6.70 (8.25)	—	—	—
Foka et al. (2021)	Depression (CES-DC)	SEJ	33	17.09 (7.06)	4.4 (4.39)	—	—	—
		WLC	39	17.13 (6.86)	19.04 (5.96)	—	—	—
		SH+	230	8.48 (5.82)	6.10 (5.41)	—	6.06 (5.57)	4.03 (5.42)
Purgato et al. (2021)	Depression (PHQ-9)	ETAU	229	8.38 (5.55)	7.60 (5.82)	—	6.49 (5.75)	5.81 (6.05)
		SH+	230	24.69 (16.35)	19.22 (15.82)	—	17.06 (16.10)	12.45 (15.30)
		ETAU	229	22.77 (16.24)	20.93 (17.00)	—	16.79 (15.30)	14.61 (15.31)
Alsheikh (2020)	PTSD (PCL-5)	ETAU	20	57.65 (11.19)	41.55 (7.11)	—	—	—
		Group counselling	20	59.45 (8.01)	58 (8.16)	—	—	—
		No counselling	20	22.33 (13.87)	16.4 (9.12)	—	—	—
Jeon et al. (2020)	Depression (CES-D)	CBT	15	20.39 (13)	19.61 (14.95)	—	—	—
		Simple relaxation	23	15.1 (4.7)	9.7 (5.4)	9.5 (4.2)	—	—
		SH+	331	15.1 (4.8)	12.8 (5.3)	10.8 (5.1)	—	—
Tol et al. (2020)	Depression (PHQ-9)	ECAU	363	22 (4.7)	16.1 (5.5)	16.1 (4.9)	—	—
		SH+	331	21.8 (4.8)	19.2 (5.5)	17.7 (5.8)	—	—
		ECAU	363	2.76 (0.49)	2.17 (0.1)	2.10 (0.16)	—	—
Shaw et al. (2019)	Anxiety (HSCL-25)	CA-CBT	20	2.71 (0.43)	2.86 (0.14)	—	—	—
		WLC	9	2.79 (0.61)	1.99 (0.15)	1.92 (0.16)	—	—
		CA-CBT	20	2.8 (0.76)	3.08 (0.22)	—	—	—
	Depression (HSCL-25)	WLC	9	2.58 (0.57)	2.34 (0.13)	2.15 (0.17)	—	—
		CA-CBT	20	2.49 (0.71)	3.01 (0.19)	—	—	—
		WLC	9	11.52 (0.71)	8.25 (0.75)	—	—	—
Pfeiffer et al. (2018)	Depression (PHQ-8)	Mein Weg	50	11.47 (0.71)	11.76 (0.76)	—	—	—
		UC	49	29.97 (1.22)	23.52 (1.77)	—	—	—
		Mein Weg	50	31.85 (1.23)	30.27 (1.73)	—	—	—
Ooi et al. (2016)	Depression (DSRS)	UC	49	10.96 (5.26)	8.68 (5.48)	8.29 (4.46)	—	—
		TRT	44	9.17 (4.61)	8.03 (5.13)	—	—	—
		WLC	38	23.02 (10.51)	15.88 (9.58)	12.71 (10.24)	—	—
Hijazi et al. (2014)	PTSD (CRIES-13)	TRT	43	17.92 (11.86)	14.17 (11.06)	—	—	—
		WLC	37	33.91 (10.46)	2 months: 27.45 (13.54)	4 months: 25.08 (13.27)	—	—
		Brief NET	41	33.45 (11.45)	2 months: 27.38 (10.85)	4 months: 27.38 (10.85)	—	—
Ertl et al. (2011)	PTSD (HTQ)	Brief NET	41	2.79 (0.49)	2 months: 2.60 (0.66)	4 months: 2.55 (0.66)	—	—
		WLC	22	2.76 (0.44)	2 months: 2.76 (0.48)	4 months: 2.65 (0.52)	—	—
		NET	29	2.76 (2.87)	—	3.96 (2.72)	3.08 (2.95)	1.8 (2.18)
	Depression (MINI)	WLC	28	1.71 (1.98)	—	3.68 (2.86)	3.21 (3.01)	1.75 (2.56)
		NET	28	67.03 (14.74)	—	46.73 (19.24)	43.00 (21.49)	32.44 (22.84)
		NET	29	63.61 (16.42)	—	52.93 (20.83)	48.61 (23.74)	44.29 (29.56)

Neuner et al. (2010)	Depression (HSCL-25)	NET	16	3.0 (0.4)	-	-	2.6 (0.6)	-
		TAU	16	3.0 (0.5)	-	-	2.9 (0.5)	-
	PTSD (PDS)	NET	16	38.9 (6.4)	-	-	26.0 (9.2)	-
		TAU	16	36.9 (8.0)	-	-	34.1 (6.1)	-
Ruf et al. (2010)	PTSD (UPID)	KIDNET	13	43.3 (12.3)	22.3 (18.6)	-	17.2 (14.6)	18.8 (14.8)
		WLC	13	38.3 (8.6)	-	-	33.8 (17.4)	-
Catani et al. (2009)	PTSD (UPID)	KIDNET	16	37.94 (14.8)	12.41 (14.15)	-	12.3 (10.87)	-
		MED-RELAX	15	36.56 (14.9)	12.59 (11.06)	-	9.75 (8.63)	-
Neuner et al. (2008)	PTSD (PDS)	NET	111	25.9 (13.2)	-	5.4 (6.6)	6.1 (6.8)	-
		MG	111	26.7 (12.5)	-	5.3 (5.7)	5.0 (6.6)	-
Ehnholt et al. (2005)	Anxiety (RCMAS)	CBT	15	16.87 (7.22)	14.67 (7.12)	-	-	-
		Control	11	16.18 (6.57)	8.91 (6.04)	-	-	-
	Depression (DSRS)	CBT	15	12.33 (4.7)	11.67 (3.62)	-	-	-
		Control	11	12 (5.37)	3 (6.57)	-	-	-
	PTSD (R-IES)	CBT	15	39.8 (8.4)	33.8 (9.71)	-	-	-
		Control	11	38.55 (8.37)	2.18 (9.38)	-	-	-
Hinton et al. (2005)	Anxiety (ASI)	CA-CBT	20	3.08 (0.61)	1.65 (0.45)	1.86 (0.32)	1.98 (0.40)	-
		Delayed treatment	20	3.27 (0.53)	3.19 (0.36)	1.91 (0.49)	-	-
	PTSD (CAPS)	CA-CBT	20	74.85 (14.67)	39.25 (19.92)	41.30 (13.95)	44.59 (14.58)	-
		Delayed treatment	20	75.91 (11.5)	73.05 (9.43)	43.56 (10.22)	-	-
Hinton et al. (2004)	Anxiety (ASI)	CA-CBT	6	43.5 (9.1)	18.5 (6.4)	-	8 months: 21.0 (8.0)	-
		Delayed treatment	6	38 (7.4)	20.2 (4.9)	-	-	-
	Depression (HSCL-25)	CA-CBT	6	3.1 (0.7)	2.1 (0.5)	-	8 months: 1.6 (0.6)	-
		Delayed treatment	6	3.3 (0.9)	3.2 (0.6)	-	-	-
	PTSD (HTQ)	CA-CBT	6	3.3 (0.4)	1.7 (0.5)	-	8 months: 1.8 (0.7)	-
		Delayed treatment	6	3.1 (0.7)	3.3 (0.8)	-	-	-
Neuner et al. (2004)	PTSD (PDS)	NET	17	25.2 (7.4)	19.1 (11.7)	4 months: 24.5 (7.8)	-	-
		SC	14	22.0 (8.0)	19.8 (10.9)	4 months: 22.8 (10.1)	-	-
Barrett et al. (2000)	Anxiety (SCAS)	FRIENDS	9	39.89 (13.22)	30.43 (11.37)	-	-	-
		WLC	11	30.64 (13.54)	34.2 (8.45)	-	-	-



**Figure 2.** Effectiveness of brief CBT-based psychological interventions in treating anxiety in refugees and asylum seekers.



**Figure 3.** Effectiveness of brief CBT-based psychological interventions in treating depression in refugees and asylum seekers.

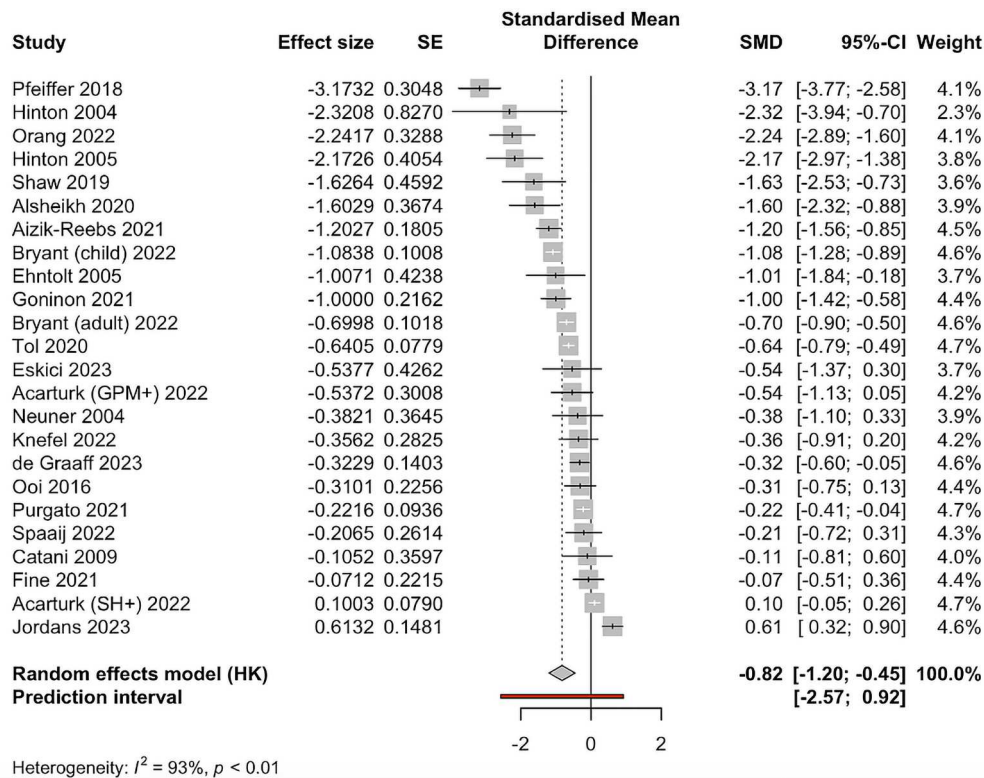
interventions on anxiety (SMD  $-2.22$ , 95% CI  $-4.94$  to  $0.51$ ,  $I^2 = 82\%$ ) [Bryant et al., 2022a; Hinton et al., 2004, 2005] (Figure 7).

We divided RCT and CCT studies to conduct a sensitivity analysis. For depression, both the pooled analysis from 17 RCTs SMD of  $-1.05$  (95% CI  $-2.14$  to  $0.04$ ,  $I^2 = 99\%$ ) and the 3 CCTs [Foka et al., 2021; Jeon et al., 2020; Ehntolt et al. (2005)] for depression found no significant effect (SMD  $-1.01$ , 95% CI  $-3.84$  to  $1.82$ ,  $I^2 = 92\%$ ). There was a significant effect for anxiety when examining only RCTs (SMD  $-1.17$ , 95% CI  $-1.88$  to  $-0.45$ ,  $I^2 = 96\%$ ), but not for the 2 CCTs [Barrett

et al., 2000; Ehntolt et al. (2005)] (SMD  $-0.81$ , 95% CI  $-2.71$  to  $1.10$ ,  $I^2 = 0\%$ ). Regarding PTSD, both the RCTs (SMD  $-0.81$ , 95% CI  $-1.22$  to  $-0.40$ ,  $I^2 = 94\%$ ) and 2 CCTs [Goninon et al., 2021; Ehntolt et al. (2005)] (SMD  $-1.00$ , 95% CI  $-1.04$  to  $-0.97$ ,  $I^2 = 0\%$ ) showed a significant effect of intervention on symptoms (Figure 8).

### 3.5.1. Sample size

Our sensitivity analysis revealed no significant differences in outcomes for anxiety, depression, and PTSD between interventions conducted in a large patient



**Figure 4.** Effectiveness of brief CBT-based psychological interventions in treating PTSD in refugees and asylum seekers.

population ( $n > 100$ ) versus a smaller patient population ( $n < 100$ ) (SM 5.5).

### 3.6. Long-term follow-up

Several studies reporting long-term follow-up were identified, and a post-hoc analysis of these outcomes was conducted. Follow-up durations were categorised into short-term (3–6 months) and long-term (7–12 months), in line with classifications used in similar systematic reviews (Roberts et al., 2019; Schäfer, Thomas, et al., 2023). No study extended long-term follow-up beyond 12 months.

For short-term follow-up, there were four studies for anxiety, 9 for depression, and 12 for PTSD included in the analysis (SM6). The analysis revealed no significant effect for anxiety (SMD 0.24, 95% CI  $-0.94$  to  $1.42$ ), depression (SMD  $-0.73$ , 95% CI  $-2.14$  to  $0.68$ ), or PTSD (SMD 0.29, 95% CI  $-0.94$  to  $1.53$ ).

For the long-term follow-up period, only three studies (Bryant et al., 2022b; Jordans et al., 2023; Neuner et al., 2004) conducted assessments, which were all at 12 months. Two studies reported results for depression, 1 for anxiety, and 3 for PTSD, with varying results. Bryant et al. (2022b) found no significant differences between treatment arms for depression, anxiety, and PTSD despite significant effects at post-intervention and short-term follow-up (Bryant et al., 2022a). Jordans et al. (2023) reported no significant long-term effects for depression or PTSD. In contrast,

Neuner et al. (2004) found significant effects of the intervention on PTSD scores.

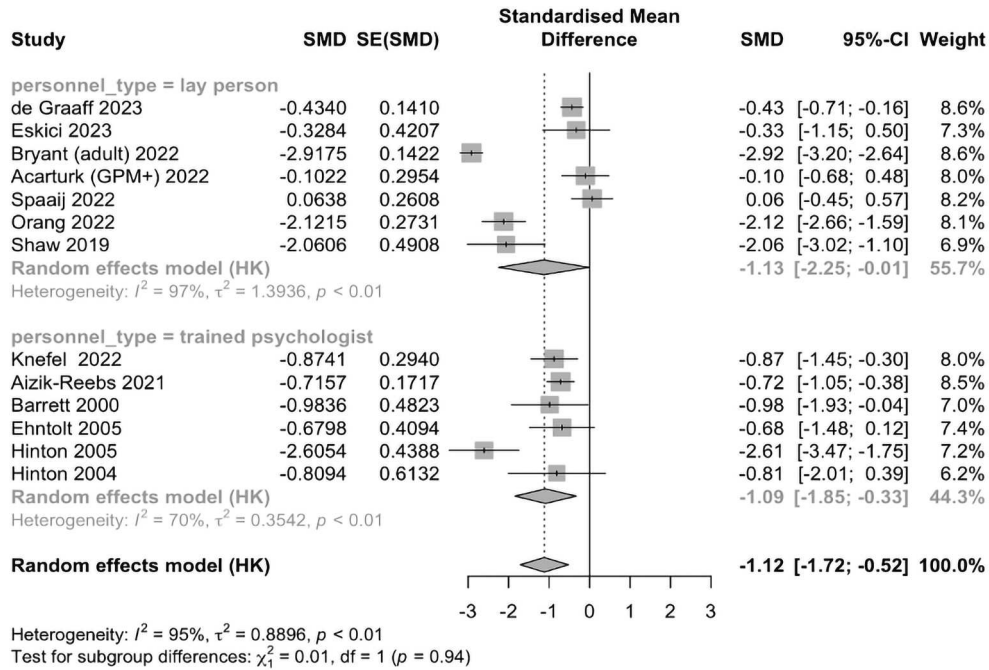
## 4. Discussion

This systematic review aimed to investigate CBT-based psychological interventions conducted in a brief time period (under three months) in forcibly displaced persons. We found low-quality evidence for the favourable effects of brief psychological interventions compared to the control group interventions on varied mental health outcomes. The results remained significant after removing low-quality studies for PTSD, but not for depression and anxiety. Additionally, the results remained significant after excluding non-randomised trials for PTSD and anxiety, but not for depression. The effects disappeared at short-term follow-up at 3–6 months and long-term follow-up 7–12 months. Subgroup analysis revealed a strong effect of brief interventions for adults compared to children and adolescents. Subgroup analysis also revealed that there was no significant difference between interventions conducted by trained psychologists and those conducted by lay persons.

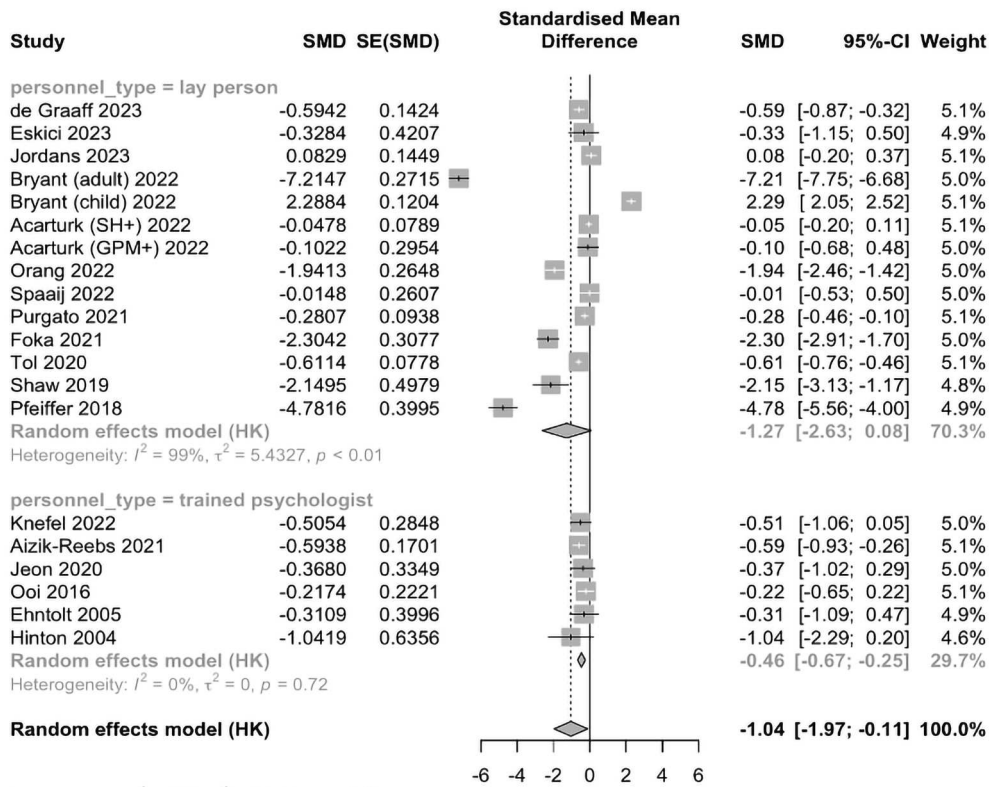
Subgroup analysis revealed that Problem Management Plus (PM+) was an effective intervention method for alleviating PTSD, but there was no significant effect on anxiety or depression. However, ascertaining the effectiveness of various intervention types on anxiety, depression, and PTSD outcomes was challenging due to the limited number of studies in each

subgroup. Many intervention categories were under-represented, with several groups consisting of fewer than three studies, which complicates drawing robust conclusions from the data.

Studies were more likely to report PTSD symptoms (24 studies) compared to symptoms of depression (20 studies) or anxiety (13 studies). The increased focus on PTSD symptoms by researchers may be due to the



(a)



(b)

**Figure 5.** a. Effectiveness of interventions carried out by lay persons versus trained professionals in treating anxiety. b. Effectiveness of interventions carried out by lay persons versus trained professionals in treating depression. c. Effectiveness of interventions carried out by lay persons versus trained professionals in treating anxiety, depression, and PTSD.

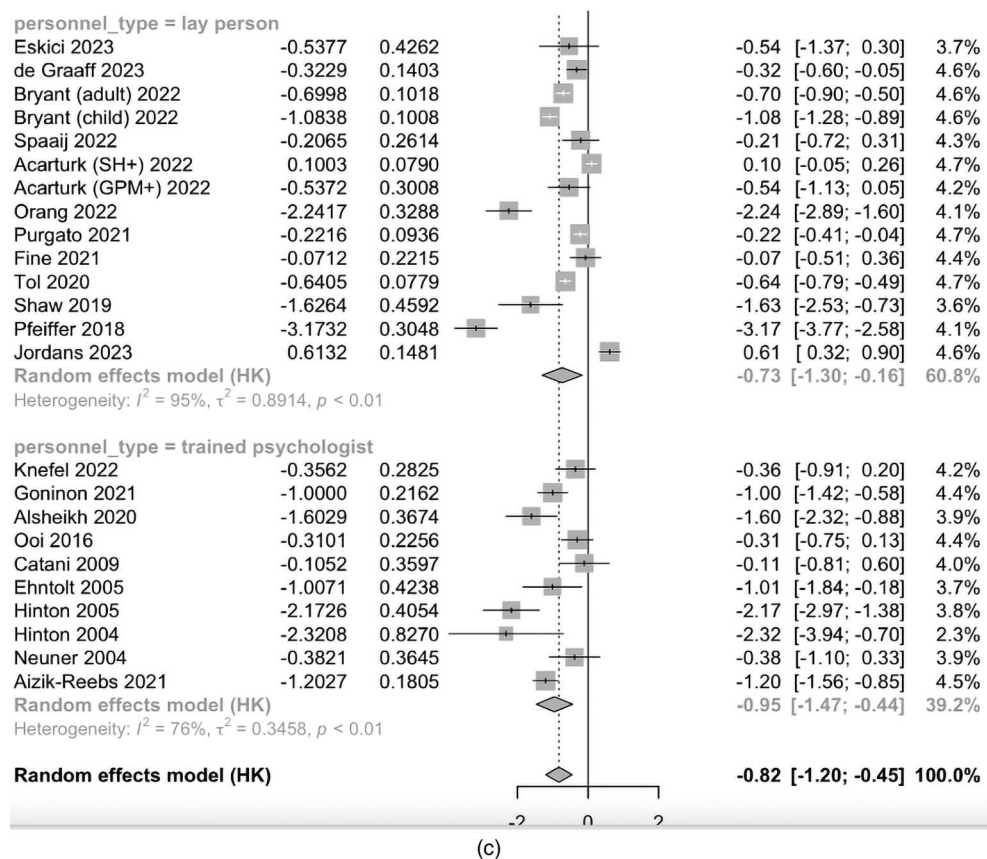


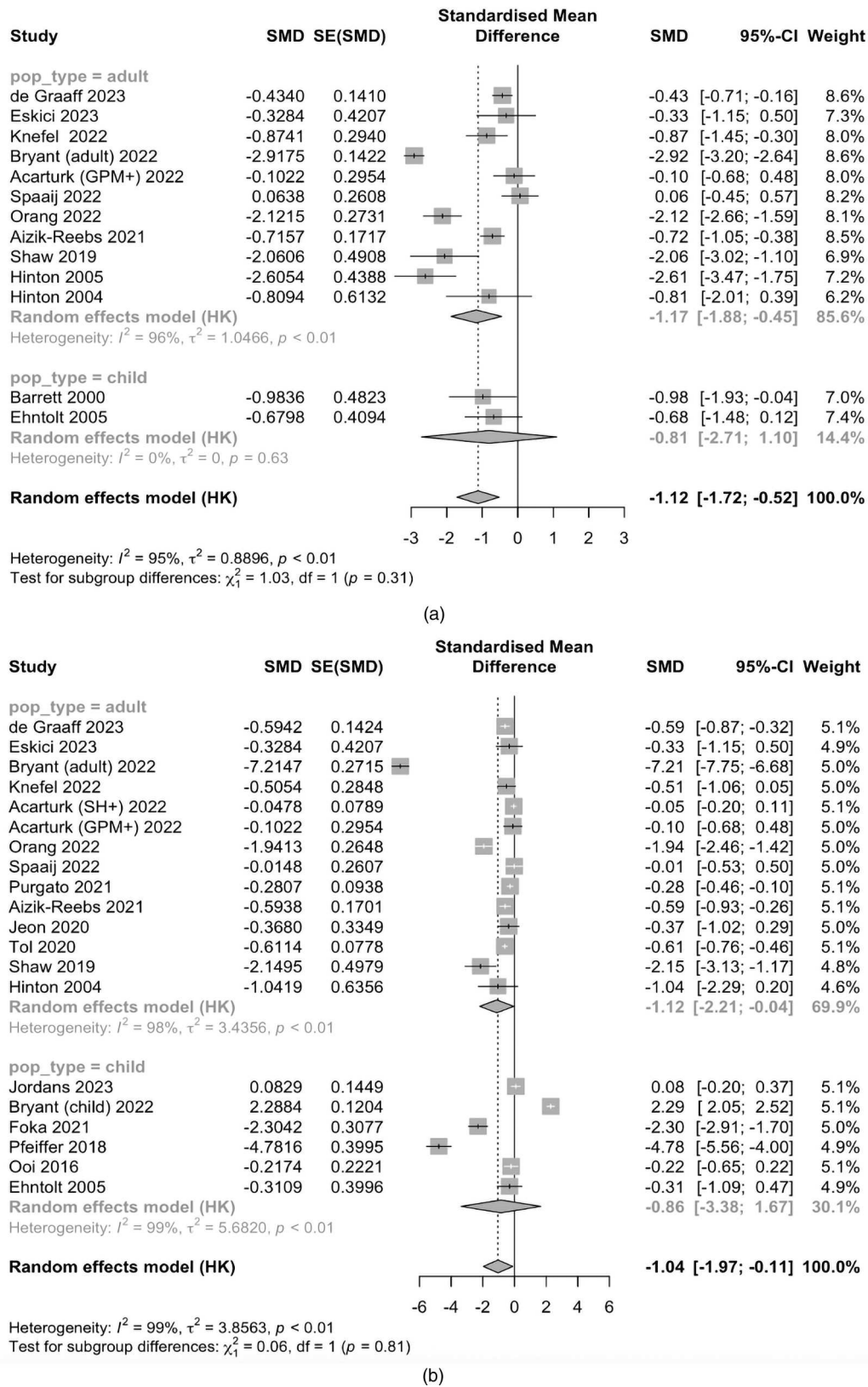
Figure 5. Continued.

lower rates of anxiety and depression compared to PTSD found in the forcibly displaced population (Blackmore et al., 2020). Nevertheless, the prevalence of anxiety and depression (Blackmore et al., 2020) in the forcibly displaced population remains significantly higher than the general population (GBD 2019 Mental Disorders Collaborators 2022). This may be related to high rates of comorbidity between anxiety, depressive disorders, and PTSD (Flory & Yehuda, 2015; Sundquist et al., 2005). The studies included in this systematic review have demonstrated that psychological interventions can effectively alleviate symptoms of both depression and anxiety. Therefore, studies on the effects of psychological interventions in forcibly displaced persons should encompass a comprehensive range of mental health outcomes.

The interventional effects did not remain significant for anxiety, depression and PTSD in both short-term follow-ups of 3–6 months and in the majority of studies reporting long-term follow-ups of 7–12 months. This suggests that the benefits of these interventions may not endure despite the initial alleviation of symptoms, indicating that brief interventions are unable to comprehensively address the substantial mental health challenges faced by this population. In contrast, evidence suggests that in the general population, the effects of brief psychological interventions on mental health symptoms may be sustained long-term (McDevitt-Petrovic & Kirby, 2020;

Smith et al., 2022; Weber et al., 2021; van Dis et al., 2020). The lack of long-term effect in the forcibly displaced population may be attributable to ongoing stressors. Many studies took place in refugee camps, with well-documented stressors such as challenges meeting basic survival needs or unsafe living conditions (Benjeddi et al., 2023; Oldroyd et al., 2022; van de Wiel et al., 2021). Stressors that impact mental health continue even after resettlement, including uncertainty about visa status, host-country competency strain, and fear for family members still living in conflict zones (Byrow et al., 2022; Cange et al., 2019; Djelantik et al., 2020; Nickerson et al., 2010). However, more evidence is needed to determine if the benefits of brief psychological interventions diminish over time in the forcibly displaced, as not all studies conducted short-term follow-ups, and only a few conducted long-term follow-ups. Additionally, there are often increasing losses to follow-up over time (Bryant et al., 2022b; Jordans et al., 2023; Neuner et al., 2004; Turrini et al., 2022). If a lack of persistent effect is confirmed, strategies should be identified to mitigate this decline, such as interventions administered over a longer timeframe, the provision of booster sessions (Gearing et al., 2013), or social support to alleviate ongoing stressors.

Analysis of subgroups comprising studies conducted by trained psychologists and briefly trained lay persons found no significant difference in the



**Figure 6.** a. Effectiveness of interventions on adult and child populations for anxiety. b. Effectiveness of interventions on adult and child populations for depression. c. Effectiveness of interventions on adult and child populations for PTSD.

effects of these interventions. Furthermore, psychological interventions conducted by lay persons had significant beneficial effects on PTSD symptoms, which is consistent with previous systematic reviews (Schäfer, Thomas, et al., 2023; Schäfer et al., 2023). The effectiveness of these interventions may partially

stem the robustness of the underlying therapeutic materials (Dawson et al., 2015; Epping-Jordan et al., 2016). Additionally, the success of interventions could be attributed to the briefly trained lay persons, who often share the same cultural background as the recipients (Acarturk et al., 2022; De Graaff et al.,

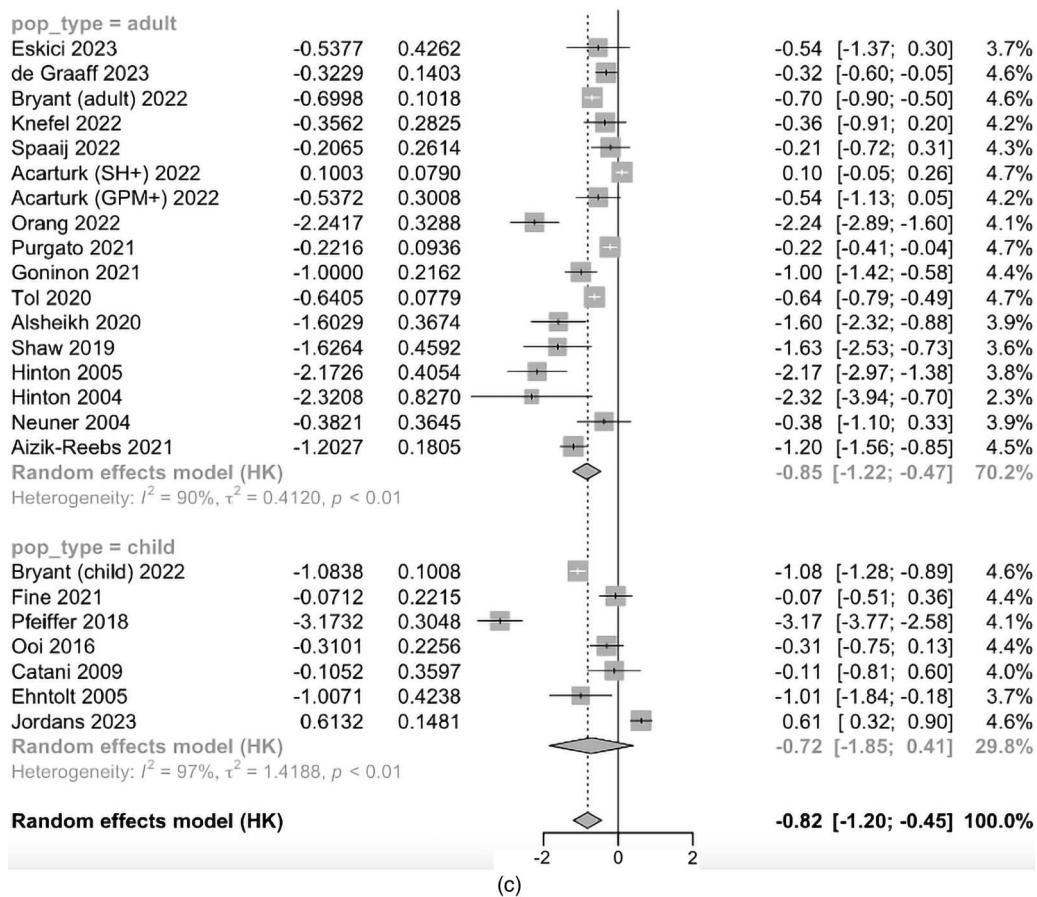


Figure 6. Continued.

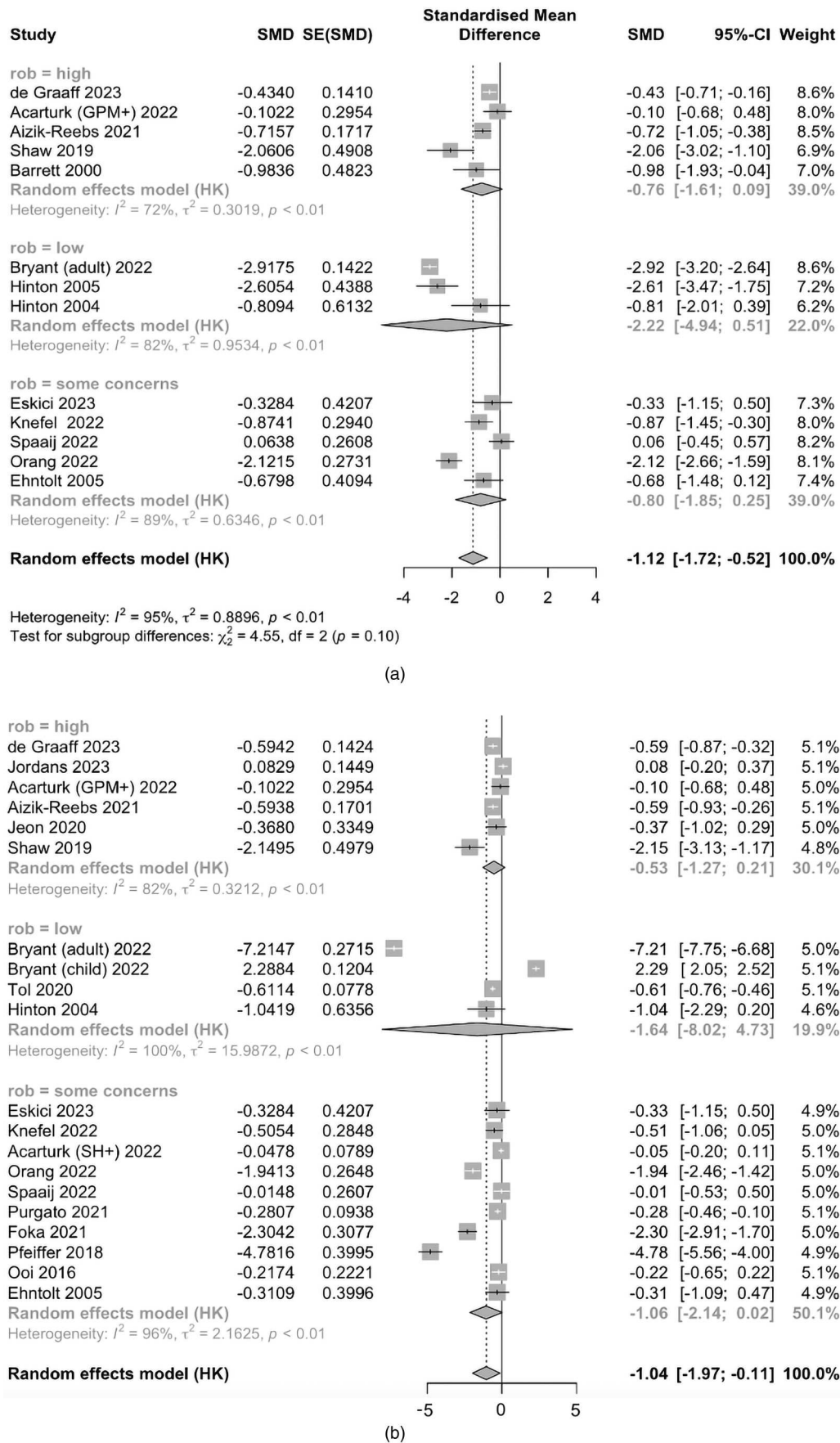
2020; Orang et al., 2022; Purgato et al., 2021). Barriers to engaging forcibly displaced persons in mental health services include a lack of cultural competency among healthcare providers, language barriers, and perceived discrimination (DeSa et al., 2022; van der Boor & White, 2020). Trained lay persons who speak the same language and understand the cultural context of the individuals can help overcome these barriers, fostering trust and delivering materials sensitively, thereby enhancing the efficacy of the interventions (Naseh et al., 2019; Taylor et al., 2023). Moreover, deploying briefly trained lay persons could reduce resource requirements, which is advantageous for the resource-limited settings where forcibly displaced persons are usually situated (Global Trends, 2023; Refugee Camps | Definition, facts and statistics 2024).

Subgroup analysis of age groups revealed no evidence for favourable effects of the brief CBT-based psychological interventions in children and adolescents compared with adults, in line with previous findings (Alzaghoul et al., 2022; Schäfer et al., 2023; Morina & Sterr, 2019). This is concerning given the high prevalence of mental health problems in forcibly displaced children and adolescents (Fazel et al., 2005; Reed et al., 2012). Furthermore, effective psychological interventions for this group is particularly important as early interventions for children and adolescents

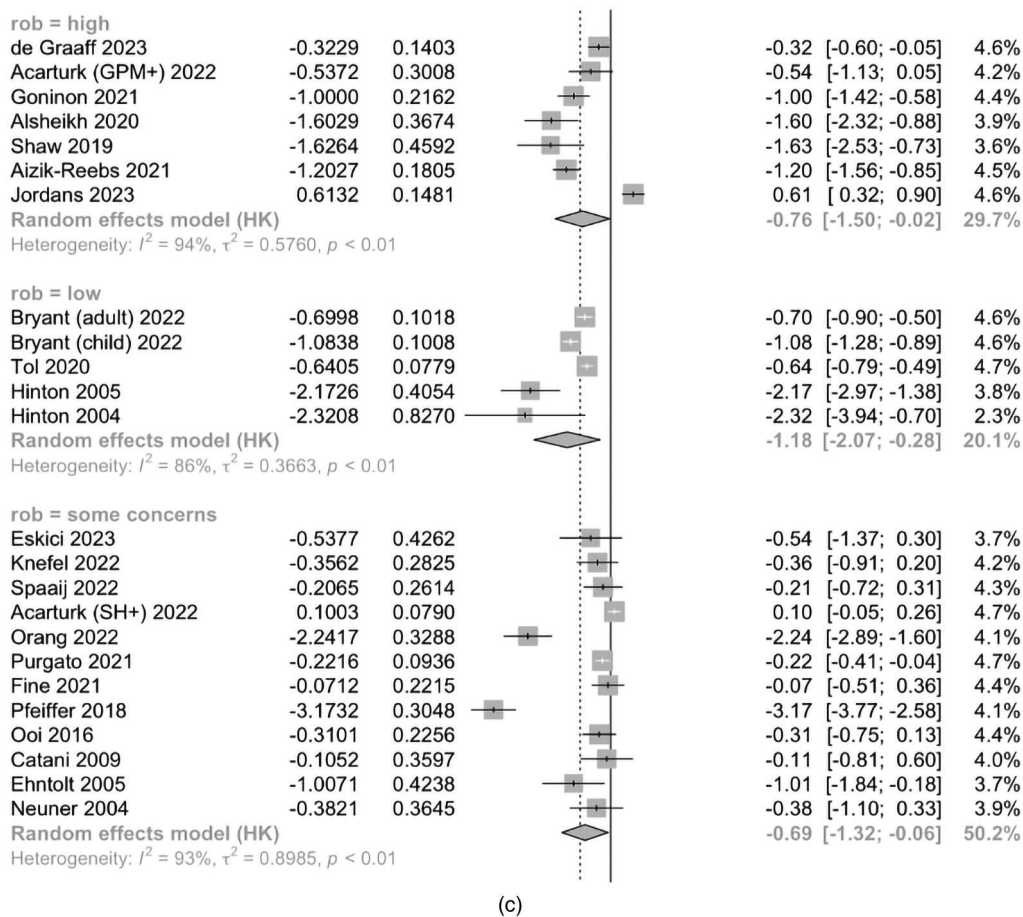
can prevent long-term psychological problems (Kerbage et al., 2022; Mullen, 2018). The lack of significant effect in this demographic may stem from various factors. There was an overall poor quality of evidence, with the majority of studies involving this population (89%) receiving a risk of bias ratings of ‘some concerns’ or ‘high’. This may reflect the inherent challenges of conducting research involving children, such as ethical constraints related to utilisation of control groups for forcibly displaced youth. Additionally, the success of psychological interventions in children may be enhanced by parental involvement (Kerbage et al., 2022), but this may be challenging in research due to the substantial number of unaccompanied and separated children in the refugee population (Global Appeal, 2023; Vaghri et al., 2019). Further research is critical to identify interventions that are effective for this age group and the determinants of their success.

#### 4.1. Limitations

The results of this study should be interpreted in light of some limitations. Firstly, searches were conducted across only five databases, potentially resulting in the omission of relevant studies. While efforts were made to mitigate this through a comprehensive search strategy (e.g. extensive citation searching of related



**Figure 7.** a. Sensitivity analysis: effectiveness of interventions carried out in studies with low, moderate, or high risk of bias for anxiety. b. Sensitivity analysis: effectiveness of interventions carried out in studies with low, moderate, or high risk of bias for depression. c. Sensitivity analysis: effectiveness of interventions carried out in studies with low, moderate, or high risk of bias for PTSD.



**Figure 7.** Continued.

systematic reviews and included studies), it is possible that other relevant studies exist that were not captured by our search.

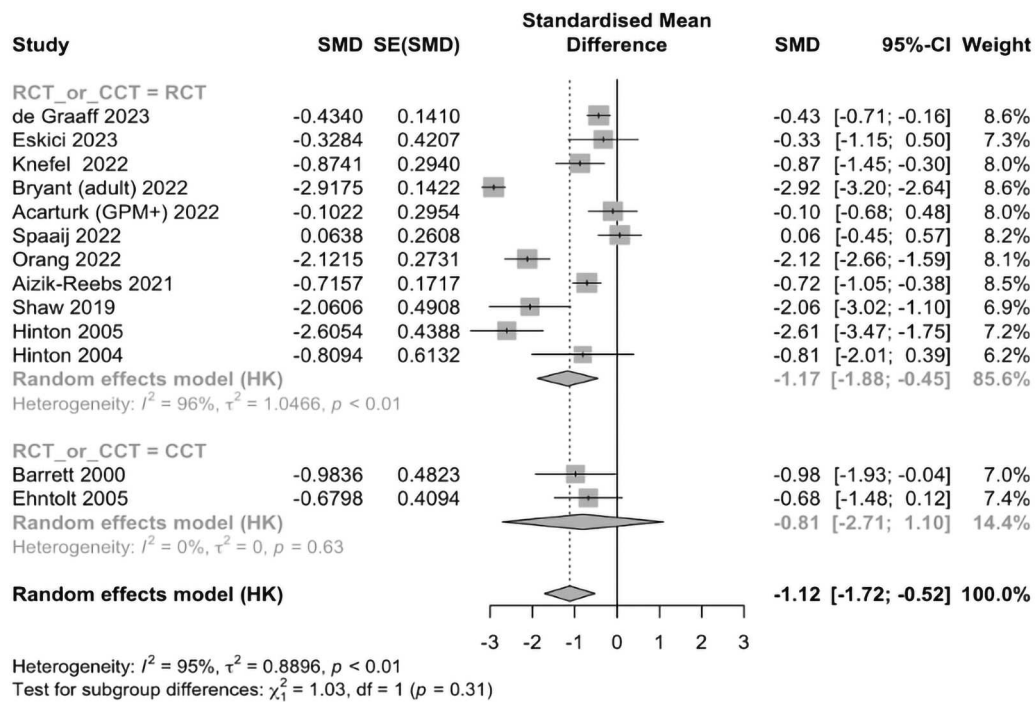
Our decision to impose a 3-month time limit for the duration of psychological intervention may have led to the exclusion of relevant studies. However, this limit was chosen to align with the focus on brief psychological interventions, which are commonly defined as interventions lasting less than 3 months. Brief psychological interventions may be more suitable for forcibly displaced persons, given the transient nature of their living situations and limited mental health resources available.

We found high statistical heterogeneity across all analyses. This could be attributed to multiple factors, including intervention type, intervention setting, and demographic characteristics of the study population. We performed sensitivity analysis by the quality of the study, which removed the heterogeneity for anxiety; however, only three studies were considered high quality. However, we reported the pooled estimates as the majority of studies lie in the same direction, including studies with non-significant results. When restricting this to studies

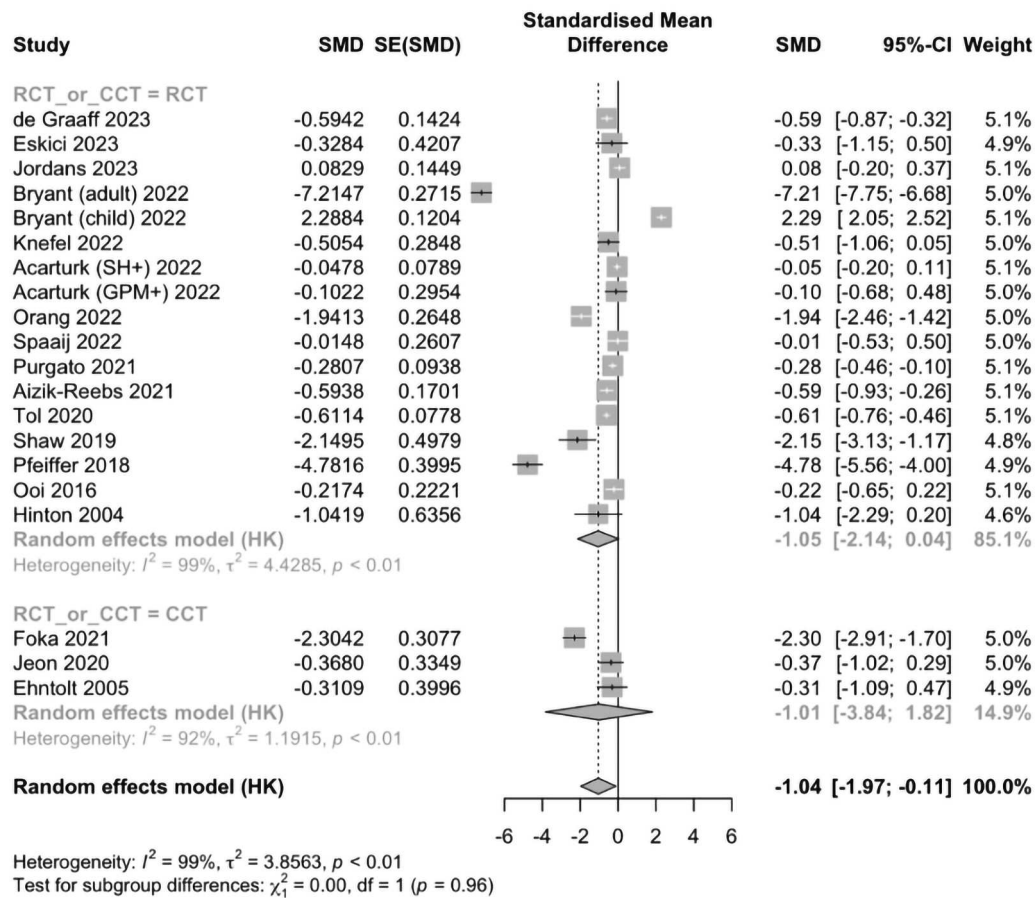
with significant effects, i.e. not crossing the null line, 9/13 studies for anxiety, 9/20 studies for depression, and 14/24 studies for PTSD found a positive outcome.

We were unable to perform subgroup analysis by type of care in the control group due to the varied nature of these interventions, which included waitlist control, care as usual, treatment as usual, enhanced treatment as usual, meditation-relaxation, no-treatment monitoring group and supportive counselling. Better descriptions of the control group care and standardisation would facilitate pooled group analysis and likely reduce the heterogeneity of the estimates.

Overall, the risk of bias was high, which undermined our confidence in the results. This may reflect challenges associated with conducting research with forcibly displaced populations, such as high dropout rates. Additionally, both randomised and non-randomised trials were included. Finally, digital interventions, which may be effective in reducing mental health symptoms and less resource-intensive than face-to-face interventions (Abtahi et al., 2023; Cuijpers et al., 2022; Röhr et al., 2021), were excluded.



(a)



(b)

**Figure 8.** a. Sensitivity analysis: effectiveness of interventions carried out in studies carried out as either RCTs or CCTs on anxiety. b. Sensitivity analysis: effectiveness of interventions carried out in studies carried out as either RCTs or CCTs on depression. c. Sensitivity analysis: effectiveness of interventions carried out in studies carried out as either RCTs or CCTs on PTSD.

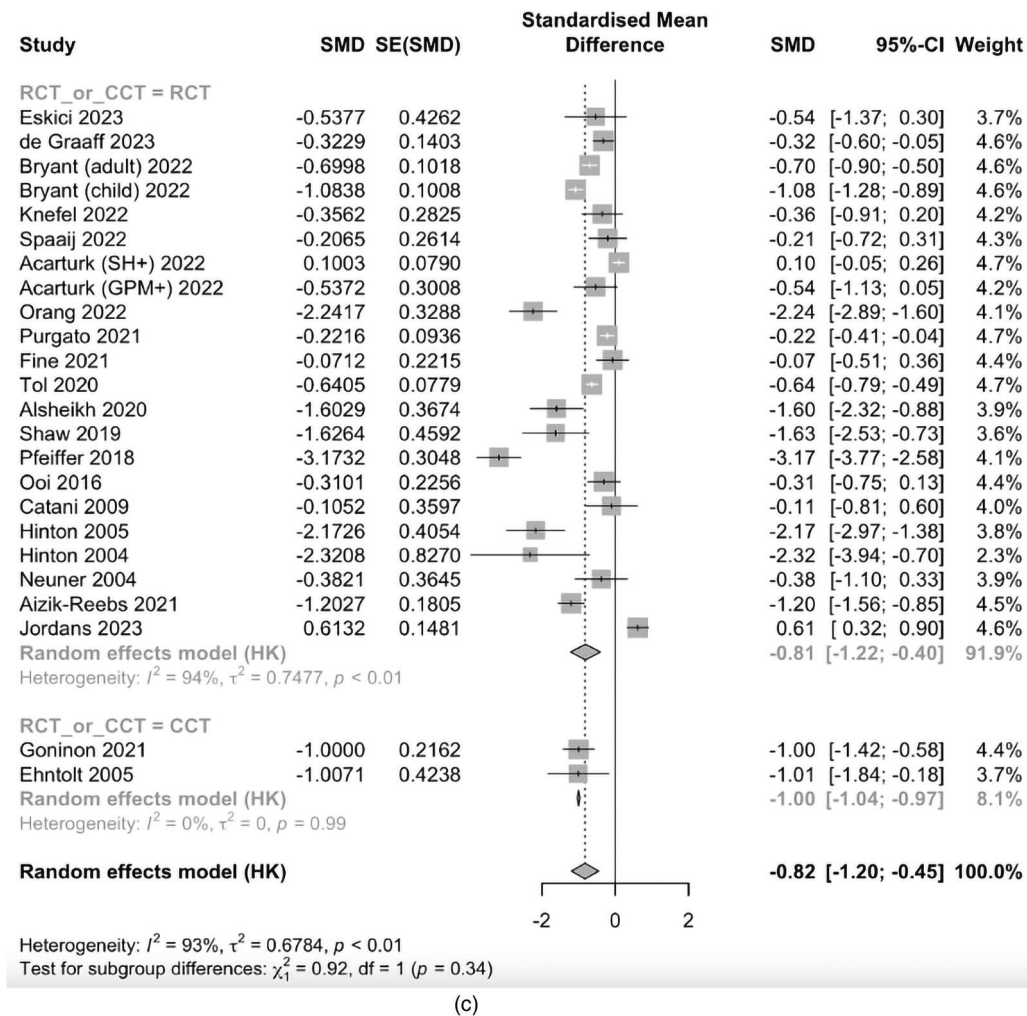


Figure 8. Continued.

#### 4.2. Implications for practice, policy, and research

There is sufficient evidence to warrant brief psychological interventions for refugee populations. It is likely that these interventions have a positive impact on symptoms of depression, anxiety, and PTSD. Our findings suggest that to optimise the use of resources, brief psychological interventions can be delivered by lay people, and policymakers should consider how refugees themselves can be trained to deliver such interventions to improve the mental health outcomes of refugee populations.

Our findings indicate that the positive effects of brief psychological interventions do not persist in the long-term. This loss of benefit may be attributed to the ongoing stressors experienced by forcibly displaced populations. Future research should explore long-term follow-up to investigate the reasons for diminished effects of the interventions. Additionally, future studies could identify strategies to mitigate the attenuated effect on mental health, such as providing booster sessions or enhancing social support to alleviate ongoing stressors.

From a research perspective, there is a need to undertake high-quality trials with long-term follow-up and develop reporting standards that facilitate improved descriptions of the interventions and core outcomes to aid pooled analysis. This is a particularly pressing issue in the forcibly displaced youth, in whom interventions have generally been found to be ineffective. The role of digital interventions warrants further research exploring their performance as well as accessibility and applicability.

#### 5. Conclusion

This systematic review and meta-analysis presented a comprehensive and robust synthesis of the use of brief psychological interventions to improve mental health outcomes in forcibly displaced people. The results of this study showed low-quality evidence that brief psychological interventions have positive effects in forcibly displaced persons as compared to control. There was considerable heterogeneity among studies, which remained unexplained even after conducting several subgroup and sensitivity analyses. Subgroup analysis showed that while brief

psychological interventions were effective in adults, they did not appear to be effective in children and adolescents. There was no significant difference observed between interventions conducted by mental health professionals and those by briefly trained peer refugees/lay persons. The effects of the interventions did not appear to translate into long-term positive effects on mental health at three months and beyond.

These findings point towards the feasibility of training peer refugees to deliver psychological interventions in lower-resource settings, a need for more rigorous studies in child and adolescent populations, and more sustained intervention in order to produce positive long-term psychological effects.

### Author contributions

Conception and design: ND, LX, EED, ET, CH

Data collection: ND, LX, EED

Data analysis and interpretation: ND, LX, ET, EA

Writing (original draft): ND, LX

Review and editing: ND, LX, ET, CH

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### Disclosure statement

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

### Data availability statement

The authors confirm that the data supporting the findings of this study are available within the article and its supplementary material. Raw data is available from the corresponding author, upon reasonable request.

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