Literature Review: Mental Health Interventions for Refugee and Asylum-Seeking Children

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This literature review is designed to be a resource to inform clinical decision-making.

The review is focused on current mental health intervention research benefitting refugee and asylum seeking children (primarily adolescents).

Introduction

Literature reviews are of several types and can take several forms. Considerations in selecting a type of literature review include: purpose, time, and resources. Some types of literature review are fast, flexible, yet prone to bias and lacking in systematic methods. Others are highly structured, minimizing bias and providing precise conclusions, yet time and resource intensive. While there is some variation in terminology, typical classifications include: *Narrative Review, Rapid Review, Scoping Review, Umbrella Review, Systematic Review, and Meta-Analysis* (see Annex I: Table 1 for details).

This literature review sits somewhere between a *Narrative* and *Rapid Review.* The purpose is to provide **guidance for clinical staff and others at the Center for Victims of Torture (CVT)** based on the current state of the mental health intervention research literature focused on refugee and asylum seeking children (primarily adolescents, but inclusive of ages 5-19 years). For such purposes and in light of current resources, this broad nonsystematic review is a reasonable fit. The hope is that this will be a useful tool for evidence-informed decision making within and even potentially beyond CVT.

This review builds on and extends an initial brief literature review of a similar style and approach conducted 11 years ago, expanding the scope and pulling from a broader and more recent literature. The initial review was conducted in 2015 by Valerie Waters, University of Denver graduate student consultant. In early 2026 it was updated by CVT staff from the Evaluation and Research Department: Lisa Hattori, Evaluation and Research Lead, with inputs from Courtney Welton-Mitchell, Director of Evaluation and Research, and reviewed by additional colleagues.

Published research on mental health interventions for refugee and asylum-seeking children from 2004 to 2025 is included in this review, 112 articles in total. The focus was primarily on interventions aspiring to produce change in mental health symptoms, primarily depression, anxiety, and posttraumatic stress. The article search process for this update included a search of several databases (e.g., Google Scholar, PsycInfo, PubMed, ScienceDirect) using predefined keywords (e.g., refugee, children, youth, mental health). Additional studies were found by reviewing reference lists of key publications, supplemented by some additional articles suggested by reviewers. The review focuses on mental health interventions, intervention components, and population or demographic factors (e.g., age, developmental considerations, gender, cultural frameworks), important elements to inform intervention selection.

Each intervention is rated by the *strength of existing evidence*. Strength is nonsystematically determined primarily by

the number of and consistency of results among studies with experimental and quasi-experimental methods (e.g., ideally control groups providing counterfactuals).[1] In the Details section, qualitative or pre-post studies are included if experimental evidence is limited and/or emerging research exists on specific subpopulations typically served by CVT. For more on why control groups matter in intervention research see: Control Group in Research: Why It's Crucial for Scientific Accuracy.

This literature review does not include grey literature (information published outside of traditional academic frameworks, typically not peer reviewed). It does not include interventions not represented in peer-reviewed journals. CVT-developed interventions such as child and preadolescent counseling groups and child trauma resilience workshops are not included as these do not appear in the published evidence, although their content draws on some elements from well researched interventions and related frameworks. This absence of published research on CVT designed interventions is notable, underscoring the value of CVT contributing to the evidence base, especially for core long standing interventions.

In total, nine interventions have been reviewed:

1. cognitive behavioral therapy (CBT),
2. narrative exposure therapy (NET),
3. eye movement desensitization and reprocessing (EMDR),
4. acceptance and commitment therapy (ACT),
5. common elements treatment approach (CETA),
6. creative and play-based groups,
7. psychosocial skill building groups,
8. single session interventions, and
9. caregiver/parenting groups.

Each section includes an intervention summary, a rating for the strength of the evidence and associated details.
For more information on what a literature review can and can't tell us, associated limitations and strengths, see companion presentation slides, Annex II.

[1] Counterfactuals are fundamental to intervention research because they allow us to estimate what would have happened in the absence of the intervention, which is critical for establishing causal effects (understanding if a given outcome can be attributed to the intervention).

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Types of Mental Health Interventions

Mental health interventions are structured, provider-facilitated approaches intended to support individuals in enhancing wellbeing, reducing psychological distress and related symptoms. Nine interventions have been identified and detailed in this literature review.

They are ordered from the highest level of evidence to the least. *Strength of evidence* is determined primarily by the number of and consistency of results among studies with experimental and quasi-experimental methods. It does not refer to the effectiveness of the intervention with any population, but focuses on the quality and quantity of research studies conducted with refugee and asylum seeking children.

Of the 9 interventions in this section, Cognitive Behavioral Therapy and Narrative Exposure Therapy have the strongest evidence of efficacy for refugee and asylum seeking children. There are various reasons why evidence may not exist or may be limited (low) for other interventions, including for new interventions that are only recently being researched.

Cognitive Behavior Therapy (CBT) – Individual, Group, and Trauma-Focused (TF)

*Typical framework: over 8–20 sessions.

Summary: Cognitive behavioral therapy in a group format has reliably resulted in reduced symptoms of PTSD, depression, and anxiety for refugee and asylum-seeking children.

Strength of evidence: Moderate (for individual and TF) to High (for group)

Details: This intervention type has been the most studied for refugee and asylum-seeking children. Systematic reviews (e.g., Cowling & Anderson, 2023; Chipalo, 2021; Lawton & Spencer, 2021) that include individual, group and TF-CBT reliably indicate reductions in PTSD, depression, and anxiety symptoms as a result of the intervention. Individual CBT instead of group CBT may be more effective for addressing anxiety disorders among adolescents than with children (Guo, 2021). Studies were conducted in middle to high income countries such as Australia, Turkey, and Germany and were often delivered in schools or community settings. The participant's country of origin did not appear to impact outcomes (Cowling & Anderson, 2023).

Studies examining cognitive behavioral groups (with control comparisons) reported reductions in emotional regulation difficulties and symptoms of posttraumatic stress and depression (Ehntholt, 2005; Ooi, 2016). Three studies that specifically focused on unaccompanied refugee or asylum-seeking minors – one study with a control group – suggest cognitive behavioral therapy group approaches such as Teaching Recovery Techniques (TRT) appear to be an acceptable and effective intervention in reducing posttraumatic stress symptoms (King, 2019; Sarkadi, 2018; Unterhitzenberger, 2015). For refugee and asylee youth with symptoms of PTSD, anxiety, and/or depression that don't respond to the recommended first line treatment - *brief, community-based psychosocial support interventions* - guidelines and systematic reviews highlight trauma-focused CBT (TF-CBT) as an effective evidence-based treatment (Schottelkorb, 2012; WHO, 2020).

Narrative Exposure Therapy (NET) – Typically Individual[2]

*Typical framework: over 8-12 sessions.

Summary: Studies suggest that NET can be effective at reducing posttraumatic stress symptoms and may even improve symptoms of depression and insomnia for refugee and asylum-seeking children.

Strength of evidence: Moderate

Details: In four studies with control groups, evidence on the impact of NET on youth ages 7 to 17 years old suggests that NET may reduce symptoms of posttraumatic stress (Peltonen, 2019; Ruf, 2010; Samarah, 2024). One of the studies reported symptom reduction for up to 12-months after the intervention (Ruf, 2010). A study with North Korean refugee youth additionally reported improvements in depression, internalizing and externalizing symptoms, and sleep quality (Park, 2020). Location of study, and participant age and country of origin did not seem to impact effectiveness (Cowling & Anderson, 2023). Though a small sample of four and absent of a control group, one study with unaccompanied asylum-seeking minors reported promising results in improving functional outcomes (Said, 2020).

Eye Movement Desensitization and Reprocessing (EMDR) – Individual and Groups

*Typical framework: 4-8 sessions, although may extend up to 20+ sessions.

Summary: There are a limited number of studies on group EMDR among refugee and asylum-seeking children, and even less on individual EMDR. Some of the limited research is inconsistent, but overall suggests that group EMDR yields promising results in reducing depression and posttraumatic stress symptoms. One study on individual EMDR suggests a psychodynamic approach may reduce depressive symptoms.

Strength of evidence: Low

Details: The few studies that exist with refugee and asylum-seeking youth on EMDR are typically conducted in a group format. The only randomized control study was with 61 Syrian refugee children (ages 6 to 15) in Turkey in a group format. The study reported a reduction in depression and posttraumatic stress symptoms, as well as an increase in well-being (Banoğlu, 2022). Non-experimental group EMDR studies also reported a reduction in posttraumatic stress symptoms though in one of the studies, preschool teachers reported a change in symptoms while parents did not (Lempertz, 2020; Perilli, 2019). One study on individual EMDR used a psychodynamic approach on 13 children and reported a reduction of depressive symptoms, but not with PTSD-related symptoms (Oras, 2004). All studies were implemented in middle to high income countries, and participants ranged from 4 to 18 years old.

Creative & Play-based Group Therapies

*Typical framework: 6-20+ sessions.

Summary: Despite numerous studies on creative and play-based group therapies, interventions varied in implementation and measurement limiting the ability to compare studies and assess the effectiveness of the intervention. Outcomes of studies are mixed and promising results include increased life satisfaction and hope, and reductions in behavioral concerns and trauma

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[2] NET is a variant of PE (prolonged exposure) therapy. Peer-reviewed PTSD treatment research with refugees has focused far more on Narrative Exposure Therapy (NET) and its child adaptation (KIDNET) rather than standard PE.

symptoms. Practitioners perceive arts-based therapies as an appropriate intervention for refugee and asylum-seeking children as it mitigates language barriers and is less stigmatized than traditional mental health interventions. Structured play-based therapies appear to be more effective than unstructured.

Strength of evidence: Low

Details: At this point in time, the literature on the effectiveness of creative and play therapies on trauma-related symptoms is limited (Annous, 2022; Cowling & Anderson, 2023; Trimboli, 2021). Limitations in the literature include few studies with an adequate sample size and/or control group to attribute outcomes to the intervention, and the numerous ways in which this type of therapy can be implemented (e.g., writing, dance, play, drama) and measured that makes it difficult to compare studies. Factors of country of implementation; participants' countries of origin; and school- or community-based did not seem to impact results (Cowling & Anderson, 2023).

Although there were mixed results, the few studies with control groups reported reductions in trauma symptoms and behavioral concerns, or increased life satisfaction and hope (Meyer DeMott, 2017; Quinlan, 2015; Schottelkorb, 2012; Tucker, 2021). One of these studies used the manualized expressive arts group intervention called Expressive Arts In Transition (EXIT). Professionals also perceive arts-based therapies as a promising intervention providing a safe space to heal and be heard that is culturally responsive and less stigmatizing than traditional mental health services (Akthar, 2018; Knettel, 2023). More specifically within play therapy, a structured format yielded positive psychosocial outcomes, while unstructured formats demonstrated no effect (Trimboli, 2021). Structured play therapy may be an effective approach for children as young as three years old (Tucker, 2021).

Psychosocial Skill-building Group Interventions

*Typical framework: 6-12 sessions.

Summary: Similar to creative and play group therapies, there are a number of studies on psychosocial skill-building; however, varied implementation and low study quality limits the strength of the evidence base. Skills-based and psychoeducational interventions show promising results in improving emotional regulation skills, behavioral conduct, and trauma-related symptoms.

Strength of evidence: Low

Details: These programs typically aim to help children learn to regulate their mood, relax their bodies, develop social skills, solve conflicts with their friends and families, and adapt to a new country. To date, there is insufficient evidence on the impact of psychosocial interventions on trauma-related symptoms. Literature on interventions that combine psychoeducation components with creative approaches is also inconclusive (Cowling & Anderson, 2023).

However, systematic reviews suggest that it may improve internalizing behavioral problems that, in turn, may lead to decreased risk of anxiety and depression such as withdrawing from social situations (Bryant, 2022, Erdemir, 2021). Studies with control groups were conducted with children ranging from 5 to 15 years old and other observed outcomes included improved emotional regulation and social skills.

Two non-experimental pilot studies reported promising outcomes for unaccompanied minors on depressive or PTSD symptoms following a mindfulness-based intervention in Belgium or a group intervention called Mein Weg (My Way) in Germany (Pfeiffer, 2017; Van der Gucht, 2019). Further non-experimental studies that were conducted in schools with refugee children (ranging

from 5 to 15) showed encouraging results of improved emotional regulation or reduction in depression and anxiety symptoms (Erdemir 2021; Fox, 2005; Mancini, 2020).

Caregiving / Parenting Groups

*Typical framework: 6-12 sessions.

Summary: Evidence on parenting/caregiving groups improving parental efficacy and behavior is strong; however, there is less evidence on the impact of parenting programs on child mental health. These types of groups seem to be an appropriate intervention for immigrant parents when linguistically and culturally adapted. Studies report promising results on improving child behavior and emotional difficulties.

Strength of evidence: Low (when considering the impact on child mental health outcomes); moderate (when considering impact on parental behavior)

Details: The mental health of caregivers directly impacts the child's mental health as it influences their capacity to parent and support their child (Bryant, 2021; Kapel Lev-ari, 2024; Kelstrup, 2022; Roche, 2019; Yap, 2014). Thus, parenting groups – which often include a psychoeducation component – can presumably be a pathway towards promoting a child's wellbeing. Caregiving group interventions report high acceptability among immigrant parents, especially when tailored to linguistic needs and cultural beliefs (Hamari, 2022).

Studies with control groups suggest improvements in behavioral and emotional difficulties in children as well as psychosocial well-being of caregivers (Gillespie, 2022; Shaw, 2021; Yap, 2016). Studies on parenting have been conducted across low-, middle-, and high-income countries. Many caregiving group interventions were facilitated by a non-specialized or peer provider with supervision by licensed professionals (Bunn, 2022). As for facilitators of a successful program, participants highlighted the learning of new skills, working with trusted people, and finding a convenient time and place (Mytton, 2014). Although literature is sparse or non-existent with refugee and asylum-seeking parents and children, Positive Parenting Program (Triple P), and Incredible Years have strong evidence on improving child behavioral outcomes and may be appropriate for refugee and asylum-seeking children (Arif, 2021; Danbolt, 2020; Gagné, 2023; Menting, 2013).

Acceptance and Commitment Therapy (ACT) – Individual and Groups

*Typical framework: 5-8 sessions.

Summary: Although randomized controlled trials were conducted with adult refugees and asylum-seekers on Self Help Plus (SH+), there is no evidence for refugee and asylum-seeking children. One study with unaccompanied minors on psychological flexibility (PF) – a primary component of ACT – suggested that PF may mitigate anxiety and posttraumatic stress. For children overall, growing literature suggests ACT may reduce symptoms of stress, anxiety, and depression.

Strength of evidence: None, but emerging evidence with other youth and refugee and asylum seeking adults is promising.

Details: Although studies on ACT do not exist with refugee and asylum-seeking children, there is emerging evidence for children and adolescents (ages 10-18) as a whole on reducing symptoms of stress, anxiety, and depression (Binder, 2024; Harris, 2020; Keulen, 2025; López-Pinar, 2025; Tayyebi, 2024). Inconsistency in implementation and measured outcomes limits the ability to compare studies and thereby assess its effectiveness. The majority of studies were conducted in

middle to high income countries such as the United States, Australia, Sweden, and Iran. ACT appears to remain effective across delivery formats of school-based; in-person or virtual; or individual or group settings. One article on psychological flexibility (PF) – a central aspect of ACT – with 100 unaccompanied minors living in shelters in Cyprus, suggested that greater PF may reduce the risk of anxiety and stress from posttraumatic stress (Freymann, 2024).

Common Elements Treatment Approach (CETA)– Individual

*Typical framework: 6-12 sessions.

Summary: There is little to no evidence on CETA among refugee and asylum-seeking children with only one pilot randomized controlled trial. Limited studies have been implemented in refugee settlements, and results suggest that CETA may reduce symptoms in anxiety, depression and posttraumatic stress.

Strength of evidence: None to low

Details: There is only one study with a control group involving 20 Syrian children (ages 8-17) in a refugee settlement in Lebanon. Although the sample size is small, this study delivered CETA remotely over the telephone and reported promising results in reducing mental health symptoms of anxiety, depression, and posttraumatic stress disorder (Pluess, 2024). A non-experimental study conducted in three Somali refugee camps observed a reduction in internalizing, externalizing, and posttraumatic stress symptoms among 37 children (Murray, 2018). These two studies combined suggest that CETA may be effective when delivered by a non-specialist mental health provider under supervision, allowing for easier scalability.

Single Session Interventions

*Typical framework: 1 session or 1 session at a time (with each considered a complete session).

Summary: There is no evidence on single session mental health interventions for refugee and asylum-seeking children. More evidence is needed among this population and in children in general.

Strength of evidence: None, but emerging evidence with other youth is promising.

Details: Literature on single session interventions for refugee and asylum-seeking children is nonexistent. With other groups of youth, a meta-analysis synthesizing 50 randomized control trials reported a 58% chance that youth receiving SSI would fare better than the control group with the largest impacts on anxiety and conduct problems (Schleider, 2017). Although the impact on symptom improvement is less than multi-session psychotherapy, the brevity of the design may have greater potential in reaching more youth especially with one study reporting effects lasting up to 9 months (Schleider, 2017; Schleider, 2018). In another study with youth reporting alcohol use and aggression, depressive symptoms were reduced among the treatment group who received a computer- or therapist-delivered brief intervention (Ranney, 2017).
A review of single session interventions for youth suggested incorporating the following in design: teach how the brain works in relation to our emotions, treat youth as an expert rather than a passive recipient, use 'saying-is-believing' activities, and utilize testimonies from older peers and role models (Schleider, 2020).

Intervention Components

Mental health intervention components refer to the specific elements through which an intervention is implemented or adapted to further promote mental health outcomes. This literature review examines four such components. Of these, evidence is strongest for school and technology based interventions.

School- or Community-based Interventions

Growing evidence suggests that school-based universal social and emotional learning (SEL) interventions across any level from kindergarten to high school improve social-emotional skills, academic performance, and well-being (Durlak, 2011; Taylor, 2017). Countless studies on mental health interventions for refugee and asylum-seeking children have been implemented in schools or community locations (in contrast to clinics or hospitals). These studies typically report improvements in trauma-related symptoms as well as increased connection to others (Durà-Vilà, 2012; Noyes, 2025; Tyrer, 2014). The school environment may be uniquely positioned to promote belonging, inclusion, and safety (Bennouna, 2019; Cardeli, 2020; Mongomery, 2011; Kia-Keating, 2007). This is important as the desire to belong and stigma regarding refugee status influence emotional well-being among children and adolescents (Kulari, 2025). One study proposes a three-tiered model in school starting with a universal level of mental health programming to an intensive level for students experiencing the most significant mental health problems (Arora, 2021).

Technology-based Interventions

Growing evidence suggests both feasibility and efficacy in refugee-hosting contexts for mental health interventions implemented through technology. Studies have shown stronger support in reducing symptoms of depression and anxiety than PTSD (El-Refaay, 2024). More specifically, Bryant et al. (2026) conducted a randomized clinical trial of a guided chatbot-based psychological intervention in Jordan, which significantly reduced distress among psychologically distressed older adolescents and young adults. Cuijpers et al. (2022) found that a WHO-guided digital depression intervention produced meaningful reductions in depressive symptoms among Syrian refugees in Lebanon. Technology-based interventions also have the potential to overcome language barriers and expand access to mental health interventions for refugee and asylum-seeking youth (Mabil-Atem, 2024).

Family-based Interventions

As for family-based interventions for refugee and asylum seeking youth, there is limited evidence on their effectiveness at this point in time (Bunn, 2022; Mak, 2022; Slobodin, 2015). Findings for outcomes are mixed, but promising results are reported for children (e.g., reduced depression symptoms and behavioral concerns), caregiver (e.g., reduced PTSD symptoms, increased social support for mental health), and the overall family (e.g., fewer arguments).

Caregiver Involvement

There is no evidence on the impact of involving a caregiver in a mental health intervention with refugee and asylum-seeking children. However, when expanding to the broader child and youth population, there are mixed results on the impact of caregiver involvement due to a variety of ways to operationalize and measure involvement (Haine-Schlagel, 2022). More specifically, evidence is also inconclusive on parental involvement for CBT on youth anxiety (Byrne, 2023).

A systematic review on caregiver involvement with children and adolescents – up to age 21 with trauma symptoms – reported symptom reductions on PTSD (as reported by the parent), as well as anxiety and depressive symptoms (as reported by the child) (Szota, 2023). Some studies suggest parent involvement may benefit younger children (Comer, 2019). As for improving the behavior of children, psychoeducation and parenting interventions for caregivers are more effective than direct services for the child themselves (Furlong, 2012; Helander, 2022; Kuhn, 2022).

Population Factors

Population factors are defined as population-specific characteristics that may influence the effective implementation and adaptation of mental health interventions. Six factors are included in this review: age; age-specific presentations of psychological distress; gender; cultural adaptations; perceptions of mental health and help-seeking behaviors; and considerations specific to Latiné immigrant communities.

Age

- There is a dearth of studies around the impact of mental health interventions on young children compared to adolescents. Although psychotherapy can be effective with children and adolescents, a systematic review suggests that it may help young adults (ages 18 to 24) more than children (Cuijpers, 2020).
- The emotional regulation of younger children is highly influenced by their parents, suggesting that working with the caregiver may be more effective than working directly with a younger child (Gee, 2023).

Presentation of Psychological Distress by Age

- Post-traumatic reactions can vary depending upon the age of the client.
- Young children may reenact their most distressing experiences through play, losing previously acquired skills like bladder control, and experience separation anxiety (Ehntholt, 2006).
- More specifically, children ages 2 to 6 often express distress through behavioral problems, while children ages 7 to 12 present emotional symptoms (Parviainen, 2023). Both age groups experience challenges in interacting with their peers.
- Older children ages 15 to 17 exhibit more severe PTSD symptoms compared to younger age groups (WHO, 2023).
- Trauma exposure at a younger age may increase risk of developing both PTSD and depression when compared to exposure at an older age (Center for Disease Control and Prevention, 2025; Kongshøi, 2023; Maercker, 2004).

Gender

- Girls and boys often show different types of symptoms after experiencing trauma: girls are more likely to experience depression and anxiety, while boys are more likely to display behavioral difficulties (WHO, 2023).
- Limited literature on unaccompanied refugee minors, compiled in a systematic review, suggest similar gender differences (Mohwinkel, 2018).
- As a result, it may be easier for parents to tell when their sons are experiencing difficulties than when their daughters are suffering.

Cultural adaptations

- Cultural adaptations to therapies ensure that treatments are appropriate for the child and their cultural background. Cultural considerations are key to effectiveness with interventions being twice as effective when conducted in the client's native language (Griner, 2006).
- According to scoping and systematic reviews, adapted interventions most often included changes to treatment procedures, language, or content, and reported reductions in anxiety and depression symptoms (Mishu, 2023; Lange, 2022; Schaechter, 2025). For example, in implementing CBT in Zambia, therapists added a customized script for caregivers to read to their children telling them that it was ok to discuss their feelings or traumatic experiences in therapy as people do not typically speak about these topics (Murray, 2013).
- There are also promising results on Transcultural Psychotherapy (TPT) for migrant adolescents developed in France (Carretier, 2020; Grau, 2020).
- To manage differing rates of cultural adaptation/acculturation between parents and children, one study suggests tailoring interventions to help immigrant parents understand their child's new communication methods (Piedra, 2012).

Perceptions of Mental Health and Help-Seeking Behaviors

- The literature on health-seeking behaviors among refugee and asylum-seeking youth is limited, but growing. A systematic review on mental health literacy among asylum-seeking and refugee youth reported that youth had varied definitions of mental health such as a mind-body connection, inherently tied to their life situation, or explained through supernatural or religious causes (Sandsgård-Hilmarsen, 2025).
- For 15 unaccompanied adolescents, ages 15 to 18, in the United Kingdom, few participants were unfamiliar with the concept of mental health and those who were familiar held negative perceptions (Majumder, 2015). Cultural backgrounds may influence definitions of mental health and any stigma associated with it (Byrow, 2020).
- Help-seeking was often through religious networks (e.g., prayer, priest) and trusted social circles of family and friends (Anstiss, 2010; Sandsgård-Hilmarsen, 2025). A lack of trust of professionals was consistent across refugees and asylum-seeking adolescents, as well as unaccompanied adolescents. Among unaccompanied adolescents, participants noted an overemphasis by professionals on past histories rather than addressing their present and future concerns, or expressed privacy concerns linked to their immigration status amidst an anti-immigrant climate (Byrow, 2020; Majumder, 2015; Sandsgård-Hilmarsen, 2025).
- A study in Germany with asylum-seeking and refugee adolescents from ages 11 to 18 found that participants were more likely to engage in therapy if someone close to them suggested they do so (Namer, 2022).
- Adolescents with lower externalizing symptoms but higher internalizing symptoms were more likely to seek help from outside the formal healthcare system like family members and religious leaders. Meanwhile, participants with higher externalizing symptoms were more likely to seek psychotherapy services (Namer, 2022).
- Despite seeking help, many adolescents reported administrative and insurance barriers, financial strain, and language barriers (Byrow, 2020; Namer, 2022).

Specific to Latiné Communities

- Among Latiné migrants, pre-migration poverty and clandestine entry into the US increased the risk of PTSD symptoms (Perreira, 2013).
- Once settled in the U.S., experiences of discrimination and neighborhood disorder (e.g., physical decay, threatening behavior from strangers) further intensified this risk. Social support and familismo – the strong connection, sense of belonging, and obligation to family – mitigated it (Ayón, 2010; Perreira, 2013). Familismo may also serve as a risk factor among families living in poverty due to scarce financial resources and networks (Calzada, 2012).
- Given the strong family values in many Latiné cultures, family interventions can be effective in addressing substance use, risky sexual behaviors, conduct disorder, and internalizing symptoms among youth (Pineros-Leano, 2023).
- In a study with 203 youth, there were no significant differences in experiencing traumatic events between U.S-born and foreign-born Latiné youth; however, foreign-born youth utilized health services at lower rates than U.S.-born youth (Bridges, 2010). This study was published in 2010 so the experiences of foreign-born youth arriving later may differ from those included in this study.
- In a study with 60 mothers and their children, trauma exposure was not a predictor of maternal mental health nor was their child's mental health. However, in the same study, higher maternal education levels were associated with lower levels of anxiety and depressive symptoms with the authors suggesting that "education can increase a person's awareness of available resources and their willingness to seek help, which may subsequently lead to the de-stigmatization of mental health in the affected group" (Torres, 2022).

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Annex I: Types of Literature Reviews

Table 1. Types of Literature Reviews

Type of Literature Review	Purpose	When to Use	Pros	Cons
Narrative Review	Provides a broad summary and synthesis of existing research on a topic.	When exploring a new topic or providing background context.	Flexible structure, easy to write, identifies key trends.	Prone to bias, lacks systematic methodology.
Rapid Review	Summarizes existing research quickly for decision-making.	When time constraints prevent a full systematic review.	Fast results, useful for policy or urgent topics.	May omit important studies due to time limits.
Scoping Review	Explores the breadth of research on a topic and identifies gaps.	When needing an overview of a broad topic before conducting a full review.	Maps key concepts, includes diverse study designs.	Does not critically assess study quality.
Umbrella Review	Summarizes multiple systematic reviews on a topic.	When needing a high-level synthesis of research findings.	Provides a broad perspective, useful for decision-makers.	Depends on the quality of the original systematic reviews.
Systematic Review	Uses a structured and transparent method to synthesize research on a specific question.	When needing comprehensive and unbiased evidence.	Minimizes bias, follows a clear methodology.	Time-consuming and resource-intensive.
Meta-Analysis	Statistically combines results from multiple studies to identify overall trends.	When needing quantitative evidence across multiple studies.	Increases statistical power, provides precise conclusions.	Requires high-quality, comparable data.

Note. Reprinted from Litmaps. *What are the different types of literature review?* https://www.litmaps.com/learn/what-are-the-different-types-of-literature-review

Annex II: Presentation Slides

Evidence for Mental Health Interventions in the Research Literature

Focus on Refugee and Asylum-Seeking Children (ages 5-19)

Evaluation and Research Department
Bites and Insights March 2026

Lit Review lead author: Lisa Hattori

Why Evidence Matters

Evidence Helps Us:

- **Identify interventions** that are more likely to improve mental health and other outcomes
- **Avoid unintended harm** from untested approaches
- **Use limited resources** wisely in humanitarian and nonprofit settings
- **Strengthen accountability** to communities, partners, and donors
- **Improve programs** through learning and adaptation

Evidence-based practice strengthens — rather than replaces — practitioner expertise.

Limitations: This is why it is so important for CVT to contribute to the evidence base with CVT designed and implemented interventions.

Whose knowledge or evidence is prioritized in the research literature?

Historically, much research has been led **by institutions in the Global North**, using frameworks and measures developed in **Western contexts**.

- This begs question such as - *whose knowledge is prioritized, who leads the research, and are interventions imposed without cultural adaptation?*

Things have changed in recent years. Many current global mental health projects now prioritize **local leadership, participatory methods, cultural adaptation, and implementation science** to ensure interventions are appropriate and relevant.

The danger: If we dismiss the research literature entirely, and are not aware of new evidence on historical and emerging interventions, the vacuum can be filled by *untested interventions that may be ineffective or even harmful*. Research evidence helps correct bias in human judgment and helps us to understand what is effective.

This is part of why it is so important for CVT to contribute to the evidence base with CVT designed and implemented interventions.

Literature Review on Child Mental Health Interventions -

specific to refugee and asylum seeking children

Background

- Current state of the mental health intervention research literature
- Initial brief review conducted in 2015 by Valerie Waters, graduate student consultant
- Interest in updating and expanding the review to support the Proyecto Mariposa/Mexico team in their planning for child/adolescent programming

Content

- Includes 112 articles published between 2004 to 2025
- Article search - several databases (e.g., Google Scholar, PsycInfo, PubMed, ScienceDirect), using predefined keywords (e.g., refugee, children, youth, mental health). Additional studies were found by reviewing reference lists of key publications, supplemented by some additional articles suggested by reviewers.

Type of Literature Review	Purpose	When to Use	Pros	Cons
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Why conduct a Literature Review on Child Mental Health Interventions *specific to refugee and asylum seeking children?*

There is robust evidence that:

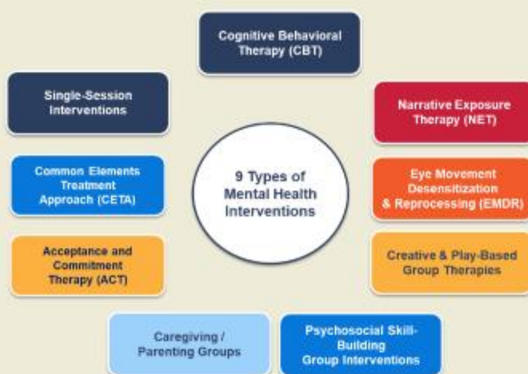
- Findings from **adult populations do not reliably generalize to adolescents**
- Findings from **non-refugee populations do not reliably generalize to displaced populations**

Without a focused review, programs risk relying on **evidence that lacks external validity** for the population of interest.

- Adolescence is a sensitive **developmental period**; developmentally specific needs include identity formation.
- Refugee and asylum seeking children and adolescents have **unique exposure profiles and risk contexts** - pre, during and post migration experiences can shape distinct mental health presentations.
- **Mechanism of change** related to symptom reduction may differ for certain populations (safety may play a key role in recovery for example).
- **Culture and context** can play important role in symptom presentation and recovery (e.g., local idioms of distress, different help seeking norms, necessary cultural adaptation of interventions).
- **Structural and access barriers** must be taken into account (legal status, language, distrust of institutions).

Mental Health Interventions Overview –

State of the Evidence specific to refugee and asylum seeking children and adolescents



Strength of Evidence Rating

- Strength of evidence is determined by the number of and consistency of results among studies using *experimental and quasi-experimental methods 1*

None: Little or no research evidence

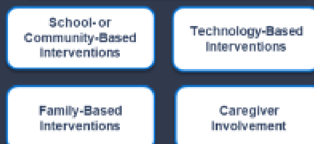
Low: Small studies, pilot studies, emerging evidence

Moderate: Multiple studies with generally positive findings

High: Multiple rigorous studies (e.g., RCTs) with consistent results

1 - these methods allow for counterfactuals which are necessary to determine efficacy.

Intervention Components



Population Factors

- Age
- Presentation of Psychological Distress by Age
- Gender
- Cultural Adaptations
- Perceptions of Mental Health and Help-Seeking Behaviors
- Specific to Latiné Communities

Intervention Type

Cognitive Behavior Therapy (CBT)

Strength of Evidence: Moderate (for individual and TF) to High (for group)

About the Studies

- Typical framework: over 8–20 sessions
- Most studied for refugee and asylum-seeking children
- Conducted in middle to high-income countries (e.g., Australia, Turkey, Germany)

Reported Outcomes

- Reductions in PTSD, depression, and anxiety symptoms *(individual, group, trauma-focused)*
- Reductions in emotional regulation difficulties *(groups)*

Intervention Type

Narrative Exposure Therapy (NET)

Strength of Evidence: Moderate

About the Studies

- Typical framework: over 8-12 sessions
- Conducted in high-income countries (e.g., Finland, Germany, South Korea)

Reported Outcomes

- Reductions in PTSD symptoms
- One study reported improvement in sleep quality and reductions in depression, internalizing and externalizing symptoms

Intervention Type

Creative & Play-based Group Therapies

Strength of Evidence: Low

About the Studies

- Typical framework: over 6-20+ sessions
- Varied implementation and measurement tools
- Conducted in all-income countries (e.g., Myanmar, Turkey, United States)

Promising Outcomes

- Mixed results of reductions in trauma symptoms and behavioral concerns; increased life satisfaction and hope
- Potentially less stigmatizing than traditional mental health services
- Structured play therapy yielded positive psychosocial outcomes, while unstructured formats demonstrated no effect

Intervention Type

Psychosocial Skill-building Group Interventions

Strength of Evidence: Low

About the Studies

- Typical framework: over 6-12 sessions
- Varied implementation
- Conducted in middle-income countries (e.g., Jordan, Turkey)

Promising Outcomes

- Improvement of internalizing behavioral problems and emotional regulation that, in turn, may lead to decreased risk of anxiety and depression

Intervention Type

Caregiving / Parenting Groups

Strength of Evidence: Low (when considering the impact on child mental health outcomes); Moderate (when considering impact on parental behavior)

About the Studies

- Typical framework: over 6-12 sessions
- Primarily focused on parental mental health
- Conducted in all-income countries (e.g., Ethiopia, Lebanon, Canada)

Promising Outcomes

- High acceptability among immigrant parents, especially when culturally and linguistically tailored
- Improvements in behavioral and emotional difficulties in children and psychosocial well-being in caregivers

Intervention Component

School or Community-based Interventions

Reported Outcomes:

- Improvements in social-emotional skills, academic performance, and well-being
- Increased connection to others

Why notable?

- School environment may be uniquely positioned to promote belonging, inclusion, and safety
- Universal interventions may normalize discussions around mental health, reducing stigma
  - One study proposes a three-tier model with universal education, and more intensive interventions for students with significant symptoms

Intervention Component

Technology-based

Reported Outcomes:

- Growing evidence base
- May have greater capacity in reducing symptoms of depression and anxiety; results less conclusive for PTSD

Examples: *a randomized clinical trial of a guided chatbot-based psychological intervention in Jordan significantly reduced distress among older adolescents and young adults; a WHO digital depression intervention, supported by trained non-specialist e-helpers, produced reductions in depressive symptoms among Syrian refugees in Lebanon.*

Why notable?

- Ability to overcome language barriers (assuming tech literacy)
- Potential to expand access

Population Factors

Age: Intervention Responsiveness and Psychological Distress

- There is a dearth of studies around the impact of mental health interventions on young children compared to adolescents.
- Although psychotherapy can be effective with children and adolescents, a systematic review suggests that it may help young adults (ages 18 to 24) more than children (Cuijpers, 2020).
- The emotional regulation of younger children is highly influenced by their parents, suggesting that *working with the caregiver may be more effective than working directly with a younger child* (Gee, 2023).

Post-traumatic reactions can vary depending upon the age of the client.

- Children ages 2 to 6 often express distress through behavioral problems, while children ages 7 to 12 present emotional symptoms (Parviainen, 2023).
  - Both age groups may experience challenges in interacting with their peers.
- Older children ages 15 to 17 often exhibit more severe PTSD symptoms compared to younger age groups (WHO, 2023).

Specific to Latiné Communities

- Among Latiné migrants, pre-migration poverty and clandestine entry into the US increased the risk of PTSD symptoms (Perreira, 2013).
    - Once settled in the U.S., experiences of discrimination and neighborhood disorder (e.g., physical decay, threatening behavior from strangers) further intensified this risk. Social support and the strong connection, sense of belonging, and obligation to family mitigated it (Ayón, 2010; Perreira, 2013).

Given the strong family values in many Latiné cultures, **family interventions** can be effective in addressing substance use, risky sexual behaviors, conduct disorder, and internalizing symptoms among youth (Pineros-Leano, 2023).

In a study with 203 youth, there were no significant differences in experiencing traumatic events between U.S-born and foreign-born Latiné youth; however, **foreign-born youth utilized health services at lower rates** than U.S.-born youth (Bridges, 2010).