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A SYSTEMATIC REVIEW OF MENTAL HEALTH ASSESSMENTS FOR REFUGEES IN EUROPE

Dissertação para a obtenção do grau de Mestre em Psicologia Clínica e de Aconselhamento

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Resumo

Esta revisão sistemática analisa as ferramentas e métodos de avaliação da saúde mental utilizados em refugiados adultos na Europa, com foco na forma como funcionam considerando as diferentes culturas, bem como podem ser esses métodos utilizados na terapia. A revisão analisa 46 estudos de diferentes países europeus e conclui que o Questionário de Trauma de Harvard (HTQ), a Lista de Verificação de Sintomas de Hopkins (HSCL-25) e a Escala de Perturbação de Stress Pós-Traumático para o DSM-5 (PCL-5) são ferramentas amplamente utilizadas para testar a PSPT, a depressão e a ansiedade. Os principais resultados demonstram amplas diferenças nos instrumentos utilizados, a importância de incluir o comprometimento funcional e de identificar os fatores de stress pós-migração, bem como ainda considerar os métodos de avaliação multidimensional. O estudo revela diferenças importantes entre homens e mulheres refugiados na forma como reportam os seus sintomas, assim como enfatiza a importância de se utilizar métodos de avaliação culturalmente sensíveis, como entrevistas qualitativas e presença de intérpretes nos momentos de avaliação e de investigação científica. A conclusão apela a uma forma flexível, completa e culturalmente consciente de avaliar a saúde mental dos refugiados na Europa. Isto deve incluir testes de autorrelato estruturados, entrevistas clínicas e métodos qualitativos, bem como uma análise cuidada dos maiores fatores sociais que afetam a saúde mental.

Palavras-chave: Métodos de avaliação, saúde mental, refugiados, sensibilidade cultural, Europa

Abstract

This systematic review looks at the mental health assessment tools and methods that are used with adult refugees in Europe, focusing on how well they work with different cultures and how they can be used in therapy. The review looks at 46 studies from different European countries and finds that the Harvard Trauma Questionnaire (HTQ), the Hopkins Symptom Checklist (HSCL-25), and the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) are widely used tools for testing PTSD, depression, and anxiety. Results show differences in the instruments used, how important it is to include functional impairment and post-migration stress factors, and how multidimensional assessment methods are becoming more popular. The study shows important differences between men and women in how they report their symptoms and stresses how important it is to use culturally sensitive assessment methods like qualitative interviews and interpreters. The conclusion calls for a flexible, thorough, and culturally aware way to evaluate the mental health of refugees in Europe. It should include structured self-report tests, interviews with clinicians, and qualitative methods, as well as looking at the bigger social factors that affect mental health.

Keywords: Assessment methods, mental health, refugees, cultural sensitivity, Europe

Table of Contents

List of Tables and Graphs

Part 1: Introduction

1.1 Refugees and asylum seekers

It is abundantly clear that the decision to leave one's nation because of the atrocities of war is profoundly based in the intricate interaction of psychological, social, and environmental elements (Li et al., 2016). The trauma, anxiety, and loss that people go through during times of conflict have a significant effect on the human psyche (Volkan, 2018). As a result, individuals and families are frequently driven to seek shelter in foreign places in the hope of finding protection, stability, and some semblance of normalcy (Volkan, 2018). When faced with unimaginable pain and misfortune, the decision to become a refugee of war is not made lightly; rather, it is frequently a last resort that is made in the face of the situation (Lambert, 2017).

One of the most fundamental aspects of the experience of being a refugee is the constant risk of being subjected to violence and persecution, which leaves survivors with profound psychological scars. Individuals who are subjected to horrific events such as bombs, shelling, armed attacks, and crimes are left traumatized and scarred, with memories of misery and sorrow that will last lifetimes (Figueiredo & Ndiaye, 2025). Witnessing the death and devastation of loved ones and communities can have a dramatic impact on a person's mental health, with feelings of helplessness, hopelessness, and despair frequently resulting from the experience (Schlaudt et al., 2020). The desire to run is driven by a natural need for survival for many refugees, as remaining in their current location would mean putting themselves at risk of suffering additional pain or perhaps death in an environment that is hostile and dangerous (Evans Cameron, 2008).

Beyond the immediate shock of violence, the psychological impact of war includes the loss of homes, belongings, and social networks that provide a sense of identity, belonging, and security. This is in addition to the trauma that is specifically caused by the violence itself. A person is left adrift in a sea of uncertainty and upheaval when they are displaced because it causes disruptions to the fundamental structures that make up their everyday lives (Figueiredo et al., 2024). The psychological anguish that refugees endure is further compounded by the fact that they have lost familiar surroundings, habits, and support systems, which exacerbates feelings of disorientation, alienation, and vulnerability (Evans Cameron, 2008).

The psychological scars that are inflicted on refugees are further deepened by the persecution, discrimination, and violations of human rights that are committed by armed groups, militias, and governmental actors acting in their entirety (Schlaudt et al., 2020). In war zones, individuals are targeted based on their affiliations, beliefs, or perceived loyalties, which makes ethnic, religious, political, and social identities dangerous liabilities. These identities include political, social, and political identities (Steiner et al., 2013). A pervasive sense of paranoia and mistrust is fueled among refugees as a result of the dread of being persecuted and the continual danger of violence. This fear undermines social cohesion and contributes to the erosion of trust (Steiner et al., 2013).

Many layers of trauma can be experienced by refugees who are forced to flee their countries due to conflict, including the destruction of their homeland and personal (and collective) experiences of violence, loss, and displacement (Ellis et al., 2019). Upon arriving in a new country, the psychological scars of conflict do not disappear; rather, they persist in complicated and often incapacitating ways. It is important to address these traumas in a compassionate and informed manner to ensure the individual well-being of refugees and the societal cohesion of the host country (Zepinic et al., 2012).

Direct exposure to violence, such as bombings, armed attacks, and other forms of warfare, is one of the primary forms of trauma that refugees experience. The deaths of family members, friends, or community members have been observed by a significant number of refugees (Volkan, 2018). Post-traumatic stress disorder (PTSD) can result from these experiences, which are often characterized by emotional detachment, hypervigilance/paranoia, nightmares, and flashbacks (Istiaque Mahmud Dowllah & Melville, 2023). These experiences can have particularly long-lasting effects on the cognitive and emotional development of children who flee conflict zones (Volkan, 2018).

Forced displacement has its own unique set of traumatic experiences. A serious identity crisis can result from the loss of a sense of belonging, community, and home (Wehrle et al., 2018). Refugees often encounter dangerous circumstances, including the necessity of residing in refugee settlements for extended periods, often in hazardous and unfavorable conditions (Volkan, 2018). The psychological stress is further exacerbated by the pressure of assimilating to a new country and the uncertainty of their future. This displacement trauma is further worsened by the fact that a significant number of refugees are also separated from their loved ones, resulting in prolonged mourning and feelings of isolation (Zepinic et al., 2012).

Cultural trauma is another significant trauma that refugees may suffer. The condition arises when pressured migration changes a group's collective identity, often resulting in feelings of alienation, confusion, and shame in their new host country (Im & Swan, 2021). Language barriers, discrimination, and unfamiliar cultural norms can exacerbate mental health challenges, contributing to the difficulty of integrating into a new society caused by cultural trauma (Wylie et al., 2018).

The psychological effects of being displaced are significant and far-reaching, and they have long-lasting repercussions for people, families, and communities (Mattar & Gellatly, 2022).

Displaced populations are faced with a wide range of difficulties, such as the loss of their means of subsistence, the separation from members of their families, and the exposure to additional dangers and vulnerabilities (Volkan, 2018). A significant sense of disempowerment and despair is created among refugees as a result of the combination of the tragedy of the past and the unpredictability of the future (Procter et al., 2017). As a result, many refugees feel powerless and pessimistic about their chances of achieving a better life (Ellis et al., 2019).

It is important to acknowledge the resiliency and strength of migrants in the midst of the immense challenges they encounter (Derya Güngör et al., 2020). A significant number of refugees exhibit amazing endurance, ingenuity, and flexibility in the face of the deep obstacles they confront. This is especially true when it comes to coping with the psychological and social effects of displacement (Newman et al., 2017). By drawing on their intrinsic capabilities, cultural resources, and social networks, refugees frequently discover methods to reconstruct their lives and communities in spite of the insurmountable challenges and difficulties they have been forced to endure (Walther et al., 2021).

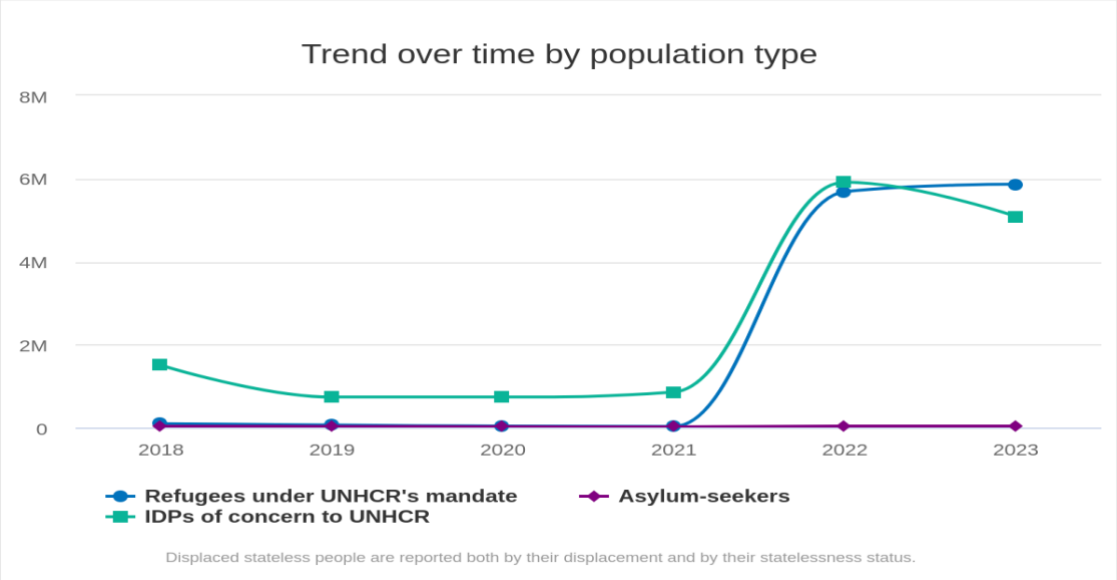
The provision of access to mental health services, psychosocial support, and trauma-informed care is also absolutely necessary in order to address the psychological scars that have been inflicted upon refugees as a result of conflict and displacement, as well as to promote healing and recovery among refugees (Kronick, 2018). Furthermore, in order to promote resilience and well-being among refugees as they rebuild their lives in new territories, it is essential to provide surroundings that are secure and supportive, and that encourage a sense of belonging, dignity, and empowerment (Krause & Schmidt, 2019).

It is of the utmost importance to advocate for policies and programs that give priority to the mental health and well-being of refugees, as well as to ensuring that they have access to vital services and support. We can work toward constructing an environment that is more

compassionate, inclusive, and resilient by addressing the psychological repercussions of war and displacement and promote healing and recovery among refugees.

As a result of the crisis in Ukraine, which culminated in a full-scale invasion by Russia in February 2022, Europe is currently experiencing one of the most severe refugee crises this continent has seen since World War II (Ellison et al., 2023). As of May of 2024, 6.5 million Ukrainian people have fled to neighboring countries and even further afield in search of safety and a fresh start as a result of the mass displacement of Ukrainian civilians (UNHCR, 2024). The United Nations Refugee Agency shows data (Figure 1), year ending 2023, which indicates the surge and magnitude of the migration (United Nations, 2023).

Figure 1 Migratory trends of displaced individuals over time



United Nations Refugee Agency, 2023

The rapid migration of refugees has major and immediate effects not only on the refugees themselves but also on the communities that are responsible for their care. The responsibility that it places on the host country is one of the most significant repercussions (Stockemer et al.,

2019). The unexpected entry of a significant number of migrants can test local services such as healthcare, education, housing, and sanitation, which can result in shortages and poor supply of key services for both refugees and the people who are hosting them (Konstantinov et al., 2022). Additionally, the manner in which the hosting country structures its response gives substance to how the refugees are able to attain the support needed to regain or maintain their human rights, deal with pre-existing mental health issues and, certainly, the mental and emotional impact of their forced immigration (Kronick et al., 2021). Having such a large number of people leave one country and enter others in such a short period of time also creates a sense of pressure on hosting countries as they may be under a need to provide mental health services, along with others, as soon as it may be possible (Grasser, 2022).

A key point of observation is that the resources (financial, time, labor etc.) necessary to meet the needs of refugees are finite. And with the aforementioned need to provide assistance and relief as quickly as possible, it would be well advised to ensure that the hosting country assesses, with careful consideration, the mental health state of the refugees it receives (Volkan, 2018). By doing so, those entering the state as a result of forced relocation stand a better chance of receiving the most applicable and helpful assistance (Kronick et al., 2021).

Furthermore, rapid influx of refugees can have significant repercussions for the social and cultural life of the communities that are hosting them (Claas Schneiderheinze & Matthias Lücke, 2020). It has the potential to worsen social inequities, weaken social cohesion, and cause tensions and disputes over resources by causing these things (Maystadt et al., 2019). The unexpected influx of refugees may cause communities that are hosting them to experience sentiments of being overpowered, which can result in feelings of anger, xenophobia, and discrimination (Obeid et al., 2019). Rapid migration of refugees can also pose a threat to the

traditional cultural norms and values that have been established, which can result in cultural conflicts and identity problems within the communities that are hosting them (Stevens et al., 2024).

Rapid migration might make the stress and difficulties that refugees have already endured even more severe for the refugees themselves. As they attempt to reconstruct their lives and navigate unfamiliar situations, refugees may experience elevated levels of stress, anxiety, and uncertainty (Hameed et al., 2019). This is because they are forced to escape their homes without any prior notice or preparation. Not only may rapid migration increase the risk of exploitation, abuse, and trafficking, but it can also increase the chance of these things happening to vulnerable groups, such as women, children, and the elderly (Freccero et al., 2017).

The rapid migration of refugees can have significant and extensive impacts on both the communities that are hosting refugees and the refugees themselves, influencing the socioeconomic, political, and cultural dynamics of the communities (Sourav Kumar Das & Nidhi Chowdhary, 2020). A coordinated and comprehensive response from governments, humanitarian organizations, and civil society is required in order to address the challenges that are posed by rapid migration. This response should include measures to strengthen social support systems, promote social cohesion, and ensure the protection and rights of refugees as well as populations that are hosting them (Greenberg et al., 2018).

1.2 Purpose of the study

To provide insight on formulating a comprehensive and effective way of assisting those who enter Portugal as refugees. The review focuses on what areas of mental health are assessed, and

what instruments are used by European countries to assess the mental health of refugees, and how these methods compare with each other.

Portugal has made immense efforts to promote the social and psychological well-being of Ukrainian refugees. The government has expedited access to healthcare, housing, education, and work, allowing for easier integration. Portuguese language classes are widely offered for overcoming communication challenges. However, difficulties remain, particularly in providing effective and efficient mental health examinations and treatment to individuals who require it. Psychological help is vital for many refugees dealing with war-related trauma and anxiety about their future.

With a particular comparison to Portugal, the objective of this research is to investigate and evaluate the approaches that several European nations have used in order to evaluate the impact of war-related trauma, displacement and migration on the mental health of refugees. A comprehensive evaluation of the available literature on mental health assessment among asylum seekers and migrant refugees is going to be conducted as part of this project. In order to answer this question, the research investigates a number of sub-questions which include:

- What specific procedures and mental health instruments are utilized in Portugal and other European countries?
- What characteristics of the instruments such as version and year of assessment have been used in the last 10 years in European countries.
- What is the socio-demographic characteristics of the samples (Age, occupation, gender/sex) of refugees assessed through these mental health instruments in European countries.

The evaluation of the mental health of refugees for disorders stemming from trauma involves a number of particular obstacles (Uphoff et al., 2020). Both language limitations and cultural differences can make it difficult for refugees and mental health specialists to effectively communicate with one another (Morrice et al., 2019). Cultural variations can have an impact on how mental health disorders are presented and perceived (Kirmayer et al., 2021). It is also possible that the stigma that is associated with mental disorders in certain cultures may discourage refugees from seeking assistance, which would make the evaluation process more difficult (Ahad et al., 2023).

This systematic review will examine practices in several key areas, focusing on which specific mental health elements are assessed, which instruments are used and how they are administered, with the goal of gaining an understanding of how Portugal's approach to assessing the mental health of refugees could be as optimal as possible, learning from other European countries. Identifying best practices and opportunities for improvement can be accomplished by conducting an investigation into these areas within a comparative perspective.

The psychological impact of being uprooted is significant for refugees, despite the fact that they may be surrounded by a supportive atmosphere (Kim et al., 2018). It is possible for a variety of mental health problems to arise as a result of the trauma caused by war, the separation from family, the loss of home and community, and the uncertainty regarding the future (Au et al., 2019). In the population of refugees, symptoms such as anxiety, depression, post-traumatic stress disorder (PTSD), and other stress-related disorders are frequently recognized (Nosè et al., 2017).

Language obstacles, cultural differences, and the pressure to find a job can all contribute to added stress, which can make these mental health challenges even more difficult to manage (Gurer, 2019). Integration into a new society is a process that can worsen these challenges (Schlaudt et al., 2020). As a consequence of this, determining the mental health requirements of refugee immigrants and providing assistance to them is an essential component of their effective integration into Portugal and other European nations (Hodes et al., 2018).

The findings of this systematic review will provide insights into how Portugal may better support the mental health of refugees, ensuring that their psychological well-being is emphasized alongside other areas of integration. These insights will be shown in the findings of this systematic review. Understanding the mental health needs of refugees and treating those needs is ultimately necessary for the development of communities that are compassionate, welcoming to diverse people and invest in the appropriate mental health areas for those who are in this specific situation.

1.3 Mental health instruments

The emphasis on evaluation methods is largely due to the potential impact of cultural and contextual differences. Standardized psychological assessments frequently embody Western norms and assumptions, potentially leading to inadequate applicability across diverse cultures (Leany, 2020). Refugees originate from varied backgrounds, possessing distinct beliefs regarding mental health, coping strategies, and the expression of symptoms. Disregarding cultural sensitivity in evaluations can lead to misdiagnosis or under diagnosis (Davidson et al., 2010). Some cultures show psychological distress via somatic symptoms instead of emotional or cognitive signs (Bagayogo et al., 2013). Therefore, a culturally adapted evaluation process guarantees that symptoms are accurately comprehended and contextualized.

The procedures associated with evaluation hold significant importance due to the logistical and ethical considerations involved (Leany, 2020). Refugees frequently stay in unstable environments, including refugee camps or detention facilities, where privacy, security, and time are often restricted. Conducting mental health evaluations in these environments necessitates careful adherence to procedures that safeguard the individual's safety and well-being. Trust-building is crucial in these contexts, as refugees may be hesitant to disclose personal information due to previous experiences of persecution or concerns regarding legal consequences. Establishing rapport and employing trauma-informed care techniques can reduce anxiety and enhance assessment accuracy (Davidson et al., 2010).

Language barriers represent a significant factor to consider. Miscommunication may arise when interpreters lack adequate training in mental health terminology or when culturally specific expressions of distress are misinterpreted. Thus, the use of trained interpreters and culturally competent clinicians is essential for keeping the integrity of the evaluation (Gong-Guy et al., 1991).

Emphasizing evaluation methods and procedures in the assessment of refugees' mental health is crucial for achieving accurate diagnoses, culturally appropriate care, and the overall well-being of this vulnerable group. Culturally sensitive, trauma-informed, and ethically sound approaches address the unique challenges faced by refugees and establish a foundation for effective mental health interventions (Davidson et al., 2010).

1.4 Recent sources and validity of instruments

It is crucial to evaluate the characteristics of assessment instruments, including their version and year of publication, especially within the last decade in European countries. This focus on detail improves the rigor, validity, and comparability of research findings among studies.

The version of an instrument used for psychological assessment is essential, as these instruments frequently undergo revisions. Revisions may address psychometric shortcomings, revise norms, or integrate developments in psychological theory and measurement. Personality assessments, such as the NEO Personality Inventory, have undergone revisions to enhance measurement reliability and cultural relevance (Groth-Marnat & Wright, 2016). Using an outdated version may produce inaccurate or biased results, particularly if newer versions demonstrate improved cross-cultural validity for European populations.

The year of assessment is significant as psychological norms may evolve over time in response to social, cultural, and environmental changes. Instruments that are developed or standardized during a specific period may lose relevance or accuracy over time. The Flynn Effect (Trahan et al., 2014) illustrates the increase in intelligence test scores over time, which requires the periodic re-norming of these assessments. Outdated normative data from an instrument may result in misinterpretation of results (Kate & Christopher, 2020). The use of modern tools is absolutely necessary to accurately express the present psychological situation in studies in Europe, defined by great cultural diversity and rapid socio-political changes in recent years.

Moreover, numerous psychological assessments and tools are validated within particular populations (Arafat et al., 2016). Evaluating the adaptation or validation of the instruments used in a European context for specific cultural and linguistic settings is essential.

Psychological measures validated in one country or specific language group may not be appropriate for application in another context without cultural adaptation, potentially leading to biased findings (Arafat et al., 2016). Updating or adapting the instrument within the last decade enhances the likelihood that it has been suitably revised for various European populations.

The utilization of the most recent versions of assessment tools enhances comparability across studies (Kate & Christopher, 2020). The use of varying test versions by different researchers complicates the comparison of results across studies, thereby restricting the generalizability of findings (Borsa et al., 2012). This is crucial for thesis work, as it relies heavily on the foundation established by prior research. Using contemporary, standardized versions of tools helps researchers make more consistent comparisons and draw more applicable conclusions across historical and cultural settings.

It is essential to consider the sociodemographic elements of the studies used, including age, sex, occupation, and language, to ensure the accuracy, relevance, and generalizability of this research (Picco et al., 2016). Sociodemographic variables significantly impact psychological phenomena, influencing individual experiences and behaviors. Neglecting these variables may result in misleading or inapplicable conclusions for the populations relevant to this study (Picco et al., 2016). Comprehending these factors facilitates a more refined interpretation and guarantees that the results of this research can be used effectively in various contexts.

Age

Age serves as a significant variable in psychological research, as cognitive, emotional, and behavioral processes develop through the lifespan (Urbina, 2014). A phenomenon observed in

children may not present similarly in adults or the elderly. Developmental differences can affect outcomes in memory, attention, and emotional regulation. Considering the age of participants in the source material ensures that conclusions are appropriate and relevant to the studied population (Urbina, 2014). A study on stress may produce varying results between young adults and older people, related to differences in life stages and coping mechanisms. When using source material focused on a specific age group, it is crucial to acknowledge that the results may not be relevant to other age groups unless clearly indicated (Picco et al., 2016).

Sexuality

Sex and gender represent significant sociodemographic variables that can affect psychological outcomes. Biological and sociocultural differences between men and women often result in differences in behavior, mental health outcomes, and cognitive processes (Brabender & Mihura, 2016). Research indicates that women are more prone to anxiety and depression, whereas men tend to show higher rates of externalizing behaviors, including aggression (Jalnapurkar, 2018). Sex-based differences should be taken into account when evaluating studies as sources. When examining a mixed-sex population, it is essential that the referenced studies either consider sex differences or provide data that is applicable to both sexes (Brabender & Mihura, 2016). Neglecting these differences may lead to biased interpretations, particularly if the study's sample is predominantly male or female (Cislak et al., 2018).

Profession

Occupation significantly influences psychological well-being, stress levels, and personality traits. Some professions can show higher levels of stress or demands, potentially impacting individuals' mental health and cognitive functions (Drake & Wallach, 2020). High-pressure occupations such as healthcare, law enforcement, and corporate management often show

elevated levels of stress and burnout in comparison to positions that provide greater control over work-life balance (Chen & Wang, 2022). When evaluating a study that utilizes a sample from a particular occupation, it is crucial to comprehend the distinct demands and psychological traits of that demographic (Chen & Wang, 2022). The context of participants' professional environments is particularly significant in studies involving occupational psychology or stress, as it can greatly influence outcomes (Picco et al., 2016). Neglecting to consider occupational differences may result in inaccurate generalizations.

Linguistic and Cultural Framework

Language serves as a fundamental medium of communication, closely connected to culture, cognition, and identity. Evaluating source material requires consideration of the language of the study and the cultural context of the participants (Reynolds et al., 2021). Psychological instruments or questionnaires developed in one language and subsequently translated for use in another may lose certain nuances, which could impact the reliability and validity of the data (Bader et al., 2021). Cultural factors significantly impact behaviors, emotions, and cognitive processes, indicating that research findings from one cultural context may not be readily applicable in another (Bader et al., 2021). Research on emotional expression may produce varying outcomes in individualistic cultures, such as those found in many Western nations, in comparison with collectivist cultures common in numerous Asian or African countries. It is crucial to ensure that the referenced studies were conducted in similar contexts, or at a minimum, to consider how cultural differences may influence the findings (Bader et al., 2021).

Integrating sociodemographic variables

Considering sociodemographic variables, including age, sex, occupation, and language, enhances the rigor and relevance of the study to the population under investigation. The

interaction of these variables is often complex, affecting psychological outcomes across various contexts (Hubbard et al., 2021). Neglecting these factors may result in overgeneralizations or biased conclusions, potentially undermining the quality and relevance of our learning (Hubbard et al., 2021). Recognizing and evaluating these factors enables a critical assessment of the source material's validity and facilitates the application of its findings in a relevant and contextually appropriate way (Walther et al., 2020).

Part 2: Development

2.1 Design

The design of this study is based on some key questions which characterize the essence of what we are trying to understand. The most important question is, "In refugees, what areas of mental health are assessed, and what instruments are used by European countries to assess their mental health, and how do these methods compare with each other?" This is the central issue that provides the foundation for this systematic analysis.

With a more general comparison to Portugal, the objective of this research is to investigate and evaluate the approaches that several European nations have used in order to evaluate the psychological state and well-being of refugees. A comprehensive evaluation of the available literature on mental health assessment among asylum seekers and migrant refugees is going to be conducted as part of this project. In order to answer this question, the research investigates a number of sub-questions which include:

- What specific procedures and trauma measuring instruments are utilized in other European countries?
- What characteristics of the instruments such as version and year of assessment have been used in the last 10 years in European countries.

- What are the socio-demographic characteristics of the samples (Age, gender/sex) of refugees assessed through these mental health instruments in European countries.

2.2 Inclusion and exclusion criteria

Literature that will be included must be characterized by:

1. Mental health assessments carried out on adults (above the age of 18) who have refugee or asylum seeker status. In comparison to children and adolescents, adults are a distinct demographic group that possesses specific psychological features, developmental paths, and life experiences that set them apart from other age groups (Borsa et al., 2012). This gives us the opportunity to gain higher homogeneity in the sample characteristics, as well as possibly improve the comparability and generalizability of the findings, if we restrict the scope of the review to adult populations. This tailored strategy allows us to concentrate on topics and outcomes that are particularly relevant to adults, such as dealing with crises and distress, interpersonal relationships, coping methods, and mental health illnesses that are prominent in adulthood (for example, depression, anxiety, and substance abuse). By performing a systematic review that is solely focused on adult populations, it is possible to assist to mitigate some methodological issues and validity concerns that are connected with adding children or adolescents into the study. It is common for psychological evaluations and interventions that are created for adults to be based on assumptions about cognitive functioning, emotional control, and life experiences (Urbina, 2014). These assumptions may not be applicable or valid for younger age groups. We are able to reduce the likelihood of incorrectly interpreting or applying the findings of studies conducted with different age groups by omitting literature that relates to children and adolescents. This, in turn, may help in improving the validity and reliability of the conclusions that are drawn from this review. Omitting literature about children and adolescents from this systematic review is in accordance

with the particular aims and research questions contained within the study. The inclusion of literature about children and adolescents may dilute the emphasis of the review, and therefore diminish its relevance and application to adult-oriented results, outcomes and implications. If one of the major objectives of this review is to synthesize evidence regarding adult populations, then including literature about children and adolescents may be detrimental to that cause. We are able to ensure that the findings of the review are directly applicable to the groups and contexts of interest by maintaining a clear and specific focus on adult populations. This helps to enhance the study's utility and effect.

2. This study will include only situations where the subjects of assessments are considered refugees. A person is considered to be a refugee if they are an individual who has been compelled to leave their place of origin because of a well-founded fear of being persecuted, being involved in war, being subjected to violence, or having suffered abuses of human rights. This concept, which was established by the Refugee Convention of 1951 and its Protocol in 1967, serves as the foundation of international refugee law and offers a framework for identifying and safeguarding individuals who fit the conditions that it outlines (United Nations High Commissioner for Refugees, 1951). The idea of being displaced against one's will, the existence of a reasonable fear of being harmed, and the inability or reluctance of the person's home nation to offer adequate protection are all essential components of this description. It is important to note that refugees are unique from other types of migrants, such as economic migrants or asylum seekers (Chin & Cortes, 2015). In many cases, the choice to leave one's homeland is driven by the aspiration to flee from imminent danger, persecution, or violence. This makes the journey to safety a matter of life and death for the individual considering leaving their hometown. Asylum seekers may carry similar characteristics

> as refugees, however, the manner in which those people are received and categorized by the country of refuge may very well have a direct impact on their access to social and welfare support systems (Lambert, 2017). Refugees are people, in contrast to economic migrants, who may be looking for better prospects or greater living conditions in another nation, and are motivated by a fundamental need for safety and survival (Chin & Cortes, 2015).

Persecution is a concept that is essential to the experience of being a refugee. Persecution is defined as the systematic violation of an individual's fundamental human rights on the basis of their race, religion, nationality, political opinion, or membership in a certain social group. An individual may be subjected to a variety of forms of persecution, such as arbitrary arrest and incarceration, torture, discrimination, murder or other crime, or threats to their life or freedom. People are compelled to seek refuge in other nations because they are afraid of being persecuted, and they do so in the expectation that they will find safety and protection from harm there (Lambert, 2017).

Individuals may be forced to flee their homes for a variety of reasons, including but not limited to persecution, armed conflict, war, or generalized violence (Schlaudt et al., 2020). In many cases, these kinds of circumstances lead to massive displacement, in which entire communities are compelled to leave their homes in search of a safer location to live. In spite of the fact that not all people who have been impacted by violence may be declared refugees according to the legal definition, a significant number of them are classified as internally displaced persons (IDPs) or asylum seekers, depending on their circumstances and legal status (Hampton, 2014). The legal definition of a refugee serves as the basis for international protection and assistance programs that are designed to meet the requirements of people that have been displaced by conflict or persecution. It is through this definition that refugees are granted certain rights and protections under international law. These include the right to seek asylum, protection from

refoulement (which is the forced return to a country where they face persecution), access to fundamental services such as healthcare and education, and the possibility of resettlement in a third country in the event that it is not possible for them to return to their country of origin (Hathaway, 2018).

3. The country of reception must be a member of the European Union (EU). Having the literature describe work completed in this region provides a reasonable middle ground between a global perspective and a contextual and culturally appropriate approach to mental health at large. While there is an inherent difference between governments and healthcare professionals (amongst others) in different places, there are a number of shared healthcare, education and humanitarian frameworks across the EU (World Health Organization; 2023). By relying on the values, missions and goals of organizations, as well as the guidelines and laws which form the governance of the region, we stand a better chance of learning how and why any differences we observe may be a certain way. In scenarios where there are similarities between countries, in how refugees are treated, we are able to better understand what cultural inputs there may be in the creation of less desirable regimens and work towards improving those national characteristics. The opposite may also be true, where we understand what makes a country particularly effective or efficient in helping people and we reinforce those perspectives and learn from them in a way that allows us to apply them in other countries, locally and internationally. The United Kingdom will be included. The departure of the U.K. from the EU occurred in January of 2020 meaning their contribution would have happened over the majority of the ten-year period this study focuses on (Graham John Taylor, 2017).

4. Literature produced more than ten years ago (equal and older than 2013) will not be considered in this review.

Mental health assessments, protocols and practices, like many fields, have changed significantly over the past ten years. The body of psychological knowledge and, subsequently, our understanding of disorders in general populations has improved massively (Rust & Golombok, 2014). This means we have more opportunity to apply the newly gained knowledge in understanding wellness, disorders and illness than ever before. A big part of these advances is in applying mental health treatments to specific populations, such as refugees, in ways that considers cultural and situational sensitivities. Elements like language, linguistics and norms are a few of the characteristics that have, over the past decade, have become important when understanding people and their mental health (Ellis et al., 2019). There is also the possibility that including older literature, that may predate newer techniques and perspectives, could lead us to incorrectly attributing positive outcomes to practices which have been improved upon since (Rust & Golombok, 2014).

Over the past ten years, global political, social, and environmental environments have changed dramatically, impacting the mental health states and stresses refugees face. Modern political conflicts, displacement caused by climate change, and changing immigration laws help to define refugee populations today (Ellis et al., 2019). The' psychological effects of these elements, as well as the assessment instruments', might differ significantly from those used in earlier research. Research greater than ten years old may not fit new mental health concerns or diagnostic issues related to more recent migration trends, so it may be less helpful for understanding the current setting.

Older publications could not fairly represent the most current versions of the diagnostic criteria applied in mental health evaluations. Periodically, for example, the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) are

revised to represent new discoveries and changes in clinical agreement. For example, the fifth iteration of the DSM was published in 2013. A study of the literature including research published before the most recent DSM or ICD versions runs the danger of depending on diagnostic categories and criteria that have since changed or replaced (World Health Organization, 2022) (American Psychiatric Association, 2022). This can cause discrepancies in how mental illnesses adult migrants are evaluated for and how these tests are administered.

5. The decision of solely using English-language resources is based on a number of practical and methodological reasons for this study. Although valuable and relevant research in other languages is acknowledged, the decision to limit the evaluation to English-language publications is in order to ensure uniformity, guarantee accessibility, and enable a more complete synthesis of results.

In the field of psychology and mental health research, English is the language most often used in academic correspondence (Jenkins, 2013). Most of the widely known publications and peer-reviewed journals are either published in English or have formalized English translations (Jenkins, 2013). This increases the extent of easily available, high quality research. Focusing only on English-language sources helps the literature review to use studies that have been shared with and critiqued by a global academic audience, which can improve the credibility and generalizability of the results.

Doing a literature review which includes non-English sources may create practical problems with translations and interpretation. Being able to translate nuanced and/or technical elements of studies requires expert input. If that expertise is not available or is untrue there stands a great risk for inaccurate perceptions of highly specific ideas presented in the sources. Particularly when considering complex language which is connected to psychological assessments and

mental health issues, the tools needed for accurate translation—in terms of time and money for example—may be too great to realize. Incorrect interpretation of study results/outcomes or diagnostic criteria might lead to unsound conclusions and thereby compromising the quality of the research (Duszak & Lewkowicz, 2008).

Using English-language resources allows a more coherent and effective review mechanism. Including studies in other languages might result in fragmentation, where study insights from one language might not be able to be compared because of differences in terminology, technique, or cultural setting. Limiting the scope to English publications helps the research process to be more simplified and enables a focus on data synthesis and meaningful conclusions which avoid the extra complication of multiple-language study (Jenkins, 2013).

A healthy number of studies and written reports on refugee mental health evaluations carried out in Europe are available in English, particularly in international publications or reports by groups like the World Health Organization (WHO) and United Nations High Commissioner for Refugees (UNHCR). Global facing organizations, as such, often publish information and insights on linked peripheral issues too. Having access to them in the English language supports the general body of knowledge used to understand the topic of review. As mentioned above, globally released insights, studies, cases and reports allows a broader panel of critique which can indicate higher quality of work (Jenkins, 2013).

2.3 Mesh terms for literature resources

The mesh terms selected for the critical literature review on the mental health assessments of adult refugees in Europe were chosen to fully articulate the extent of relevant issues and allow an extensive literature search in appropriate research databases and literature sources.

The keywords include the central points of the research focus: the variations of mental illnesses searched for, the specific tests applied, and the European geographical background. There is

also the inclusion of a range of phrases which may increase the likelihood of the search query producing applicable studies from databases and scholarly publications.

Mesh terms such as “refugee mental health”, “adult refugee assessment”, and “psychological testing for refugees” allows us to ensure a focus on the target population. Broader terms like “mental health screening” and “psychological evaluations” allows for review of literature that may not highlight the target population but does consider the assessments and methods used on them.

More specific terms focusing on mental health disorders, like “PTSD”, “anxiety disorders”, and “depression” were selected because of the general consensus of there being a high prevalence of those disorders amongst refugee populations. This can assist in targeting studies which have a central theme of frequently tested mental health conditions.

Terms such as “trauma assessment” and “psychological trauma in refugees” indicate the established impact that forced migration has on people. Assisting people with trauma is a primary goal for psychologists and identifying studies that consider that element of refugee life is important.

Including terms like “culturally sensitive assessments” and “cultural competence in mental health” reference the importance of cultural sensitivities in diagnostic tools and methods. Observing the cultures of countries of origin for refugees and those of the recipient country. Including “Europe” in search terms is also important, as it serves to limit results to the geographically defined area of the study being carried out. Additionally, it is important to be specific in finding sources that make use of established and sound frameworks for diagnosis. “DSM-5” and “ICD-11”, for example, serve as indicators that the practices and methodologies within a study, at the very least, consulted a professionally approved standard and approach.

The following databases were searched: APA PsycInfo, APA PsycArticles, Psychology and Behavioral Sciences Collection, Humanities International Complete, MEDLINE.

- Refugee mental health
- Mental disorders in refugees
- Anxiety disorders in refugees
- Depression in refugees
- Mental health assessment tools refugees
- Europe refugee mental health
- Diagnostic criteria for refugees
- Mental health evaluation methods
- Refugee psychology
- Mental health outcomes in refugees
- Psychological trauma in refugees
- Screening tools for refugees
- Mental health services for refugees
- DSM-5 and refugees
- Cross-cultural psychology
- Trauma-informed care refugees
- Psychosocial assessments refugees
- Clinical assessments in refugees
- Immigrant mental health

2.4 Literature search process

The “Preferred Reporting Items for Systematic Reviews and Meta-Analyses”, also referred to as “PRISMA”, is a set of guidelines which are designed to improve the quality of reporting in systematic reviews and meta-analyses. The reporting elements it aims to assist in, are transparency, structure and comprehensiveness. While the framework was originally developed for use in quantitative research, it can, and has, been adapted, effectively, for use in critical reviews to achieve greater rigor and clarity. PRISMA, in this study, can provide great value in how the review process is structured.

A thorough checklist and a flow diagram meant to help researchers to precisely record the method for conducting a systematic review are available with PRISMA. It addresses various aspects of the evaluation, including:

Identification: An outline of the methods that are used to find relevant literature.

Screening: Description on how the studies were screened and appraised in light of the established inclusion and exclusion criteria.

Eligibility: Explaining clear reasons for excluding certain literature at specific points in the study.

Inclusion: Showing the literature that was eventually selected to synthesize and analyze.

Search strategy: A precise and accurate search strategy includes a clear definition of search queries and used filters, as well as the databases, journals or websites being used (eg., PubMed, PsychINFO etc.). By being explicit in using the keywords described above, it assists readers of

the study to understand the extent of the scope and the depth of the search. This aids the integrity of the search, too, as it can be repeated.

Table 1 Appraisal Checklist based in Joanna Briggs Institute tool (JBI)

	Yes	No	Unclear	N/A
1. Is there congruity between the state's philosophical perspective and the research methodology?	x	□	□	□
2. Is there congruity between the research methodology and the research question or objectives?	x	□	□	□
3. Is there congruity between the research methodology and the methods used to collect data?	x	□	□	□
4. Is there congruity between the research methodology and the representation and analysis of data?	x	□	□	□
5. Is there congruity between the research methodology and the interpretation of results?	x	□	□	□
6. Is there a statement locating the researcher culturally or theoretically?	□	x	□	□
7. Is the influence of the researcher on the research, and vice-versa, addressed?	□	x	□	□

8. Are participants, and their voices, adequately represented? □ □ □ x

9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by appropriate body? □ □ □ x

10. Do the conclusions drawn on the research report flow from the analysis, or interpretation, of the data? x □ □ □

11. Were the criteria for inclusion in the sample clearly defined? x □ □ □

12. Were the study subjects and the setting described in detail? x □ □ □

13.Were the study subjects consecutive included? □ □ □ x

14. Was the exposure measured in a valid and reliable way? □ □ □ x

15. Were objective, standard criteria used for measurement of the condition? x □ □ □

16. Were confounding factors identified? x □ □ □

17. Were strategies to deal with confounding factors stated? x □ □ □

18. Were outcomes measured in a valid and reliable way? x □ □ □

19. Was appropriate statistical analysis used? x □ □ □

Source of the tool: Aromataris, et al. (2015).

Criteria for selection: Maintaining the criteria selected for inclusion or exclusion is essential to the PRISMA process. A review could, for example, contain only English language, peer-reviewed papers on adult aged refugees produced in the past ten years. Exclusion criteria might exclude research on minor refugees or those with a perspective on the more non-clinical elements of mental health. Observing PRISMA's focus on well defined criteria helps lower the possible risk of bias and improve the quality of the produced synthesis.

The flow diagram: A graphic description of the selection/exclusion process, the PRISMA flow diagram shows the reasons for exclusions at multiple levels, it displays the number of records that were found, how many were processed and then excluded, and the overall number of studies which were included. The systematic literature review depends greatly on the diagram because it guarantees that the process is explicitly accessible and gives readers a summary of how the studies were screened.

Using PRISMA in a systematic literature review has some strong advantages which enhance the general credibility and quality of the review. Guaranteeing that each stage of the process is carefully recorded, the framework improves rigor and openness, which serves in enabling readers to follow along with the approach and build confidence in the results. By sharing every element of the search, screening, and selection processes, PRISMA encourages the ability to reproduce, which is an important component of scientific validity, and it helps other researchers to repeat the work. Its disciplined methodology lowers prejudice/bias by the use of well-defined

inclusion and exclusion rules, therefore producing a more objective and balanced synthesis of the material. Also, by means of a checklist and flow diagram sharing the databases searched, search time periods, and selection criteria, PRISMA promotes clear reporting, and assures that the approach is open and easily available for academic examination and practical use.

Even though PRISMA adds a great deal of value to systematic reviews, it can be time-consuming and resource intensive. Making sure every element in the checklist is exactly observed and followed requires significant preparation and extensive documentation. Additionally, although PRISMA is quite appropriate for studies focused on quantitative synthesis and data extraction, it might require some modification depending on the nature of the review where mixed techniques are used or qualitative research is conducted.

2.6

Figure 2 PRISMA Flow Diagram

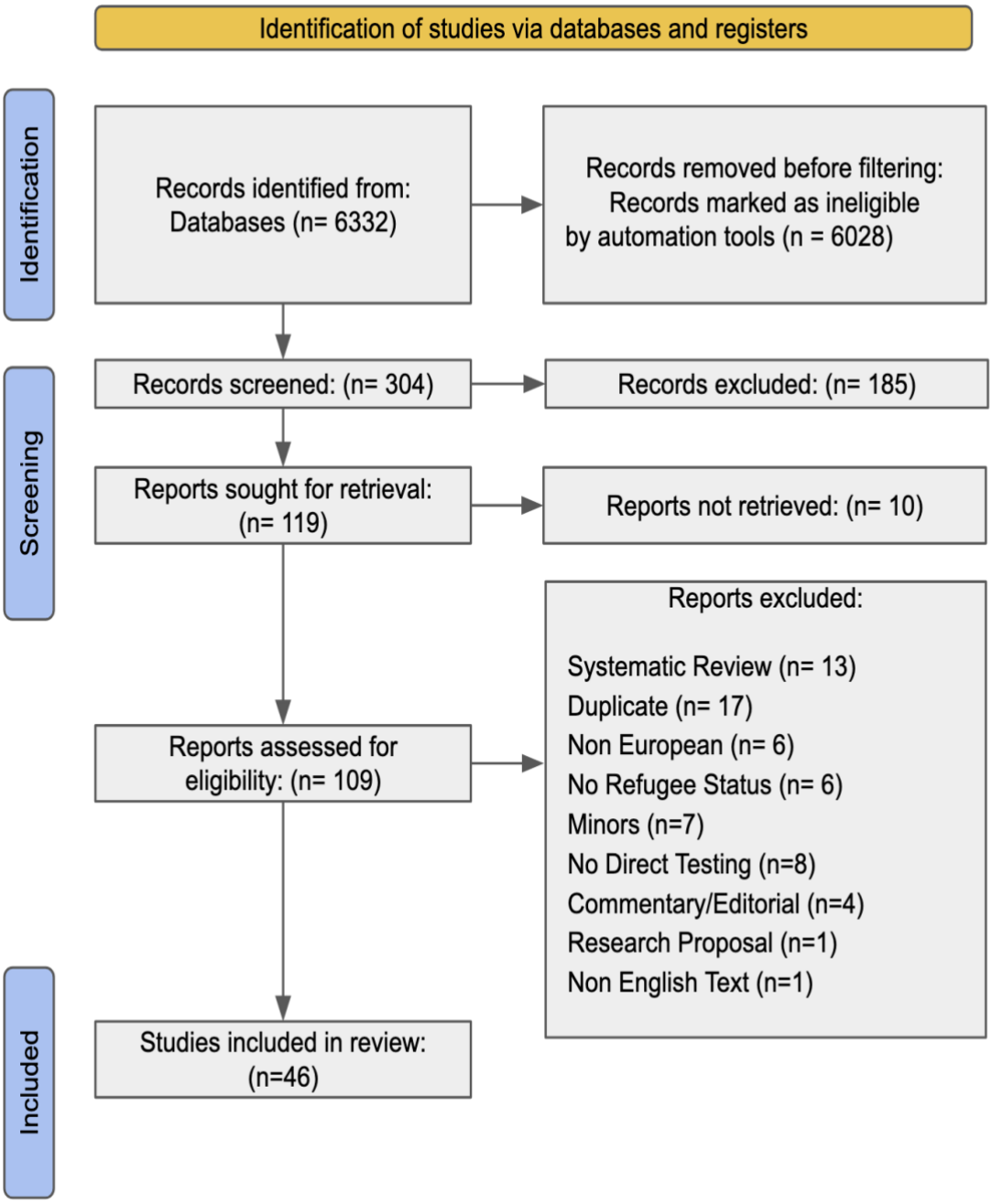


Table 2 Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Aarethun et al., 2021	Norway	Syria	31	Varying 18+	Men: 67.7% Women: 32.3%	Semi-structured focus group interviews using a vignette technique. The vignettes displayed a fictional person suffering from symptoms of either PTSD or depression, in line with the criteria of the DSM-5 and the ICD-10	PTSD Depression

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Alexander et al., 2021	Sweden	Syria	1215	Varying 18+	Male: 63% Female: 37%	WHO-5 Well-being Index (WHO-5) Refugee Post-Migration Stress Scale (RPMS) ENRICHD Social Support Instrument Refugee Trauma History Checklist (RTHC) Hopkins Symptom Checklist (HSCL-25) Harvard Trauma Questionnaire (HTQ)	Subjective well-being (SWB) Post-migration stress Social support Anxiety Depression Post-traumatic stress disorder (PTSD)

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Anne et al., 2023	The Netherlands	Syria	206	37 mean Varying 18+	Male: 62% Female: 38%	Kessler Psychological Distress Scale (K10) WHO Disability Assessment Schedule (WHODAS 2.0) Hopkins Symptom Checklist (HSCL-25) PTSD Checklist for Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (PCL-5) Psychological Outcomes Profiles (PSYCHLOPS)	Common Mental Disorders (CMDs) Depression Anxiety Post-Traumatic Stress Disorder (PTSD) Functional Impairment

Bajbouj et al., 2021	Germany	Not Specified	3096	29.7 mean Varying 18+	Male: 66.3% Female: 33.7%	Clinical interviews	Unipolar depression (40.4%) Posttraumatic stress disorder (24.3%) Adjustment disorder (19.6%)

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Beck et al., 2021	Denmark	Syria Palestine Kurdistan Iraq Bosnia Kosovo Lebanon Iran Afghanistan Somalia Sri Lanka Chechnya	74	Varying 18+	Male: 58% Female: 42%	Harvard Trauma Questionnaire, section IV (HTQ-IV) Somatoform Dissociation Questionnaire (SDQ-20) Dissociative Symptoms Scale (DSS-20) Revised Adult Attachment Scale (RAAS) WHO Well-being Index (WHO-5)	Posttraumatic stress disorder (PTSD)

Ben Farhat et al., 2018	Greece	Syria	728	Varying 18+	Male: 58.7% Female: 41.3%	Refugee Health Screener 15 (RHS-15)	Anxiety disorder

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Borho et al., 2021	Germany	Syria	116	Varying 18+	Male:69% Female: 31%	Patient Health Questionnaire (PHQ-15) Patient Health Questionnaire (PHQ-9) Generalized Anxiety Disorder Scale (GAD-7) Essen Trauma Inventory (ETI) Barcelona Immigration Stress Scale (BISS) A self-developed demographic, migration-specific, and health related questionnaire	Somatic distress (SOD) Depression Generalized anxiety disorder Post-traumatic stress disorder (PTSD)

Comtesse et al., 2021	Germany	Syria Iraq Iran Afghanistan	87	30.6 mean Varying 18+	Male: 67.8% Female: 32.2%	Life Events Checklist (LEC-5) DUKE–UNC Functional Social Support Questionnaire (FSSQ) Traumatic Grief Inventory Self-Report Version (TGI-SR) Post-traumatic Stress Disorder Checklist-5 (PCL-5) Patient Health Questionnaire (PHQ-9)	Prolonged grief disorder (PGD) Post-traumatic stress disorder (PTSD) Depression

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Dietrich et al., 2019	Germany	Syria Iraq	175	22 mean Varying 18+	Male: 87.4% Female: 12.6%	Essen Trauma Inventory (ETI) Short Screening Scale for Posttraumatic Stress Disorder (SSS-PSD) Symptom Checklist 10 (SCL-10) Short Form 12 (SF-12)	PTSD
Dixie Brea Larios, 2024	Norway	Syria	96	Varying 18+	Male: 60% Female: 40%	Brief COPE Hopkins Symptom Checklist (HSCL-13) Immigration Policy Lab index (IPL-12/24)	Depression

Dumke et al., 2024	Germany	Middle East Africa Other	166	Varying 18+	Male: 69.3% Female: 30.7%	Refugee Health Screener-15 (RHS-15) Primary Care PTSD Screen for DSM-5 (PC-PTSD-5) Patient Health Questionnaire-4 (PHQ-4)	Somatization Anxiety Depression PTSD

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Harris et al., 2021	Norway	Syria	92	Varying 18+	Male: 59.7% Female: 40.3%	Integration indices based on Harder et al. Social Integration Index Psychological Integration Index Linguistic Integration Navigational Integration Economic Integration Single item measures to examine number of Norwegian and Syrian friends in Norway	The study explores help-seeking preferences related to symptoms in line with ICD-10 and DSM-5 criteria for depression

						Help-Seeking Preferences measured using a vignette describing an individual experiencing symptoms in line with DSM-V and ICD-10 criteria for depression Barriers to Seeking Help From the GP HSCL-25 to measure common mental disorders	
Heeke et al., 2020	Germany	Syria Afghanistan Iraq Turkey	167	34 mean Varying 18+	Male: 75% Female: 25%	Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) Hopkins Symptom Checklist-25 (HSCL-25)	Posttraumatic stress disorder (PTSD) Depression Anxiety

						EUROHIS-Quality of Life (EUROHIS-QOL) scale	

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Høyvik et al., 2018	Norway	Eritrea Syria Somalia	173	Varying 18+	Male: 67% Female: 33%	Modified Dental Anxiety Scale (MDAS) Harvard Trauma Questionnaire-PTSS16	Post-traumatic Stress Disorder Dental Anxiety
Husby et al., 2020	Denmark	Arabic speaking refugees	91	Varying 18+	Male: 34.8% Female: 64.1%	Baseline demographic questionnaire Outcome questionnaire World Health Organization (WHO)-5 well-being questionnaire	Prevention of trauma-related mental health problems Depression Post-traumatic stress disorder (PTSD)

						MS-specific satisfaction and outcome survey Sociodemographic questionnaire Semi-structured interview	
Kallakorpi et al., 2018	Finland	Africa Middle East South-East Asia Europe South America	14	Varying 18+	Male: 42.9% Female: 57.1%	Interviews using Spradley's descriptive, structural, and contrast questions. Observation Field notes	Depression Anxiety Somatization Psychosis

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Kananian et al., 2020	Germany	Afghanistan Iran	24	22.1 mean Varying 18+	Male: 100%	General Health Questionnaire (GHQ-28) Posttraumatic Stress Disorder Checklist (PCL-5) Patient Health Questionnaire (PHQ-9) Somatic Symptom Scale (SSS-8) World Health Organization Quality of Life (WHOQOL-BREF)	PTSD (Posttraumatic Stress Disorder) Major Depressive Disorder Anxiety Disorders Somatoform symptoms Trauma- and stressor-related disorder

						Emotion Regulation Scale (ERS) Mini-International Neuropsychiatric Interview (M.I.N.I.)	
Knefel et al., 2022	Austria	Afghanistan	88	34.3 mean Varying 18+	Male: 51% Female: 49%	General Health Questionnaire 28 (GHQ-28) Post-Migration Living Difficulties Checklist (PMLDC) International Trauma Questionnaire (ITQ) WHO Quality of Life Questionnaire (WHOQOL BREF)	General health problems Distress by Post-Migration Living Difficulties (PMLDs) Symptoms of Complex PTSD Self-identified problems Quality of life Integration PTSD

						Psychological Outcome Profiles (PSYCHLOPS) Immigrant Integration Index (IPL-12) Refugee Health Screener (RHS-15) (used for screening at baseline) Harvard Trauma Questionnaire Checklist (HTQ)	Depression Anxiety

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Knipscheer et al., 2015	The Netherlands	Middle East Sub-Saharan Africa Balkan Europe Other Regions	585	Varying 18+	Not Specified	Harvard Trauma Questionnaire (HTQ) Hopkins Symptom Checklist (HSCL-25)	Post-traumatic stress disorder (PTSD) Depression
Koch et al., 2019	Germany	Afghanistan	74	20.49 mean Varying 18+	Male: 100%	Difficulties in Emotion Regulation Scale (DERS) PTSD Checklist for DSM–5 (PCL-5) General Health Questionnaire (GHQ–28)	Posttraumatic stress disorder (PTSD) Depression Anxiety/insomnia Social impairment

						Posttraumatic Stress Diagnostic Scale Harvard Trauma Questionnaire event list	

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Lamkaddem et al., 2015	The Netherlands	Afghanistan Iran Somalia	172	Varying 18+	Male: 49% Female: 51%	The first item of the SF-36 (Short Form Health Survey-36) to measure general health The HSCL-25 (Hopkins Symptoms Checklist-25) to assess anxiety and depression The Harvard Trauma Questionnaire, part IV to measure PTSD A checklist of 18 post migration living difficulties	Self-reported general health The number of chronic conditions reported Post-traumatic stress disorder (PTSD) Anxiety and depression

Lindegaard et al., 2019	Sweden	Kurdistan	50	33.86 mean Varying 18+	Male: 54% Female: 46%	Beck Depression Inventory-II (BDI-II) Beck Anxiety Inventory (BAI) Generalized Anxiety Disorder-7 (GAD-7) Patient Health Questionnaire (PHQ-9) Insomnia Severity Index (ISI)	Depression

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Mangrio et al., 2021	Sweden	Arabic-speaking refugees	638	Varying 18+	Male: 64% Female: 36%	General Health Questionnaire (GHQ-12)	Risk for mental illness
Matos et al., 2022	Portugal	Syria	43	37 mean Varying 18+	Not Specified	Global Meaning Violations Scale (GMVS) Harvard Trauma Questionnaire (HTQ)	Meaning violations
Michał Bilewicz et al., 2024	Poland	Ukraine	4972	40.4 mean	Male: 9.6%	PTSD-8 scale	Post-traumatic Stress Disorder (PTSD)

				Varying 18+	Female: 90.2%	Riverside Acculturation Stress Inventory A brief, 2-item instrument to measure intolerance of uncertainty A single question to measure control deprivation A question asking about the reasons for leaving Ukraine, which was aggregated into a variable labelled 'war experience'	
Mooren et al., 2024	The Netherlands	Not Specified	136	43.7 mean Varying 18+	Male: 69% Female: 31%	Moral Injury Appraisals Scale (MIAS) PTSD Checklist for DSM-5 (PCL-5) Brief Symptom Inventory (BSI)	Posttraumatic stress disorder (PTSD) Moral injury (MI) General psychopathology

						Patient Health Questionnaire-9 (PHQ-9)	Depression

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Nesterko et al., 2019)	Germany	Cameroon Eritrea Iraq Nigeria Syria Turkey Venezuela Other	569	29.73 mean Varying 18+	Male: 69.3% Female: 30.7%	PTSD Checklist (PCL-5) Patient Health Questionnaire-9 (PHQ-9) Somatic Symptom Scale-8 (SSS-8) Revised DSM-5 Life Events Checklist (LEC-5)	Post-traumatic stress disorder (PTSD) Depression Somatisation
Nissen et al., 2021	Norway	Syria	902	Varying 18+	Male 64.5%	Harvard Trauma Questionnaire (HTQ)	Post-traumatic stress disorder (PTSD) Anxiety

					Females 35.5%	Hopkins Symptom Checklist (HSCL-25) Refugee Trauma History Checklist (RTHC)	Depression

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Olena Lytvynenko & König, 2023	Germany	Ukraine	619	Varying 18+	Male: 11.6% Female: 88.4%	Food Frequency Questionnaire (FFQ; Winkler & Döring, 1995, 1998) Impact of events scale (IES; Hyer & Brown, 2008; Ukrainian adaptation—Krupelnytska et al., 2022) Patient's health questionnaire – 9 (PHQ-9; Kroenke et al., 2001; Patient's Health Questionnaire-9, 2012)	Stress (acute and chronic) Anxiety Depressive symptoms

						Beck anxiety inventory (BAI; Beck et al., 1988; Ukrainian adaptation—UI CBT, 2012) Preference for intuition and deliberation in eating decision-making (E-PID; König et al., 2018, 2021)	
Omid Dadras & Diaz, 2024	Norway	Syria	154	41 mean Varying 18+	Male: 46% Female: 54%	Hopkins Symptom Checklist (HSCL-10) Harvard Trauma Questionnaire (HTQ)	Psychological distress Posttraumatic stress disorder

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Pandya, 2018	Italy Germany Greece Spain France Slovenia Croatia Albania Austria	Syria (63%) Afghanistan (17%) Iraq (10%) Eritrea (5%) Somalia (5%)	4504	Varying 18+	Male: 56% Female: 44%	The trauma screening questionnaire (TSQ) Life orientation test-revised (LOT-R) Mental health inventory-38 (MHI-38)	Trauma Factors influencing positive mental health Stress indicators Optimism versus pessimism Overall mental health status Psychological well-being Distress

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Purgato et al., 2021	Italy Germany Austria Finland UK	Syria Afghanistan Pakistan Iraq Nigeria	459	33 mean Varying 18+	Men: 70% Female: 30%	Mini International Neuropsychiatric Interview (MINI) General Health Questionnaire (GHQ ≥3) PTSD Checklist for DSM-5 (PCL-5) Patient Health Questionnaire, 9-item version (PHQ-9) Psychological Outcome Profiles instrument (PSYCHLOPS)	Major depressive disorders Anxiety disorders PTSD

						WHO Disability Assessment Schedule 2.0 (WHODAS) WHO-5 Wellbeing Index (WHO-5) EQ-5D-3L questionnaire Harvard Trauma Questionnaire (HTQ)-Part A Checklist for Post-Migration Living Difficulties (PMLD)	

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Röhr et al., 2021	Germany	Syria	133	Varying 18+	Male: 61.7% Female: 38.3%	PDS-5 (Posttraumatic Diagnostic Scale for DSM-5) PHQ-9 (Patient Health Questionnaire) GAD-7 (Generalized Anxiety Disorders PHQ-15 (Physical Health Questionnaire) GSE (General Self-Efficacy)	Posttraumatic stress Symptoms of depression Symptoms of generalized anxiety Somatic symptoms

						SSMIS-SF (Self-Stigma of Mental Illness Scale–Short Form) RS-13 (Resilience Scale) LSNS-6 (short form of the Lubben Social Network Scale) ESSI (ENRICHD Social Support Inventory) EQ-5D-5L (EuroQoL 5-Dimension 5-Level) EQ-VAS (visual analog scale) PGI (Posttraumatic Growth Inventory) SUS (System Usability Scale)	

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Schnyder et al., 2015	Switzerland	Turkey Iran Sri Lanka Bosnia Iraq Afghanistan Others	134	42 mean Varying 18+	Male: 78.4% Female: 21.6%	Harvard Trauma Questionnaire (HTQ) Posttraumatic Diagnostic Scale (PDS) A therapist-assisted computer-based assessment tool (MultiCASI)	PTSD
Sengoelge et al., 2022	Sweden	Syria	1215	Varying 18+	Male: 62.8% Female: 37.2%	European Quality of Life Five Dimensions Five Level (EQ–5D–5L) questionnaire	Post-migration stressors

						Refugee Post-Migration Stress Scale Refugee Trauma History Checklist	Health-related quality of life (HRQoL) PTSD Anxiety Depression

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Spaaij et al., n.d.	Switzerland	Syria	59	Varying 18+	Male: 49% Female: 51%	Kessler Screening Scale for Psychological Distress (K10) WHO Disability Assessment Schedule (WHODAS 2.0) Hopkins Symptom Checklist (HSCL-25) (measuring depression and anxiety) Trauma experiences checklist (combining items of the Posttraumatic Diagnostic Scale and the Harvard Trauma Questionnaire)	Symptoms of depression Symptoms of anxiety disorders Symptoms of post-traumatic stress disorder (PTSD) Impaired psychosocial functioning

						Post-Migration Living Difficulties Checklist (PMLDC) PTSD Checklist for DSM-5 (PCL-5) Client Service Receipt Inventory (CSRI) EQUIP competency rating scale (used to assess helper fidelity) Semi-structured interviews (conducted with various stakeholders)	

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Steil et al., 2021	Germany	Not Specified	90	Varying 18+	Male: 67% Female: 33%	Clinician Administered PTSD Scale for DSM-5 (CAPS) Complex PTSD Item Set additional to the CAPS (COPISAC) Mini International Neuropsychiatric Interview for DSM-5 (MINI) Life Events Checklist (LEC)	Posttraumatic Stress Disorder (PTSD) Complex Posttraumatic Stress Disorder (CPTSD)

						Client Sociodemographic and Service Receipt Inventory (CSSRI) International Trauma Questionnaire (ITQ) General Health Questionnaire (GHQ-28) Adolescent Dissociative Experiences Scale (ADES-8) Pittsburgh Sleep Quality Inventory (PSQI) Euroqol-5D (EQ-5D) Forcedness Scale (FS6) Traumatic Grief Inventory–Self Report (TGI-SR)	

						Post-Migration Living Difficulties Questionnaire (PMLD) Helping Alliance Questionnaire (HAQ) Client Satisfaction Questionnaire (CSQ-8)	

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Vukovic et al., 2024	Croatia	Bosnia & Herzegovina	526	Varying 18+	Male: 40.5% Female: 59.5%	Harvard Trauma Questionnaire (HTQ) Hopkins Symptom Checklist 25 (HCSL-25) Self-reported history of physical health disorders	Posttraumatic Stress Disorder (PTSD) Major Depression Various physical health disorders, including hypertension, cardiovascular diseases, asthma, arthritis, anaemia, tuberculosis, diabetes, peptic ulcer, cirrhosis or liver disease, alcohol or drug abuse, gynaecological disorder, epilepsy

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Walther et al., 2020	Germany	Syria Afghanistan Iraq Eritrea	2569	Varying 18+	Male: 63.4% Female: 36.6%	Refugee Health Screener-13 (RHS-13)	Depression Anxiety Post-traumatic stress disorder (PTSD
Walther et al., 2021	Germany	Syria Afghanistan Iran Pakistan Palestine Libya	54	Varying 18+	Male: 55.6% Female: 44.4%	Semi-structured interviews	Refugee mental health

		Sudan					
Woltin et al., 2018	Germany	Syria	169	Mean 27.90 Varying 18+	Male: 90% Female: 10%	The 11-item Regulatory Focus Questionnaire (RFQ) The 53-item COPE Scale The 25-item Hopkins Symptoms Checklist-25 (HSCL)	Anxiety Depression
Yang et al., 2023	Sweden	Iran Somalia Syria	7192	Varying 18+	Male: 49.9% Female: 50.1%	Public health registry analysis	Depression Anxiety disorders Stress-related disorders Post-traumatic stress disorder (PTSD)

Table 1 continued. Summary of characteristics and results of included studies

Author/Year	Host Country	Refugee Origin Country	Sample Size	Age	Gender	Instruments	Disorder
Zbidat et al., 2020	Germany	Syria	16	35.5 mean Varying 18+	Male: 50% Female: 50%	A semi-structured interview based on the Cultural Formulation Interview (CFI) of the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5)	Somatization Depression Posttraumatic stress disorder
Zinfandel & Svensson, 2024	Sweden	Middle East South America Asia Europe	10	Varying 18+	Male: 60% Female: 40%	Psychotherapy Outcome Interview Schedule (POISE)	Posttraumatic stress disorder (PTSD)

Part 3: Results

3.1 Discussion

The systematic study showed a wide variety of psychological assessment instruments used in several European countries to evaluate various elements of refugee mental health. There were 46 studies from countries—including Germany, Sweden, Norway, the Netherlands, Denmark, and Greece—showing notable differences in the tools employed to assess mental health results. Among these were evaluations for general psychological distress, somatization, anxiety, depression, and post-traumatic stress disorder (PTSD). The Harvard Trauma Questionnaire (HTQ), the Hopkins Symptom Checklist (HSCL-25), and the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) were the most often used measures for PTSD, depression, and anxiety. Broader assessments of anxiety and functional impairment were commonly performed using tools including the Patient Health Questionnaire (PHQ-9), General Health Questionnaire (GHQ-28), and Refugee Health Screener (RHS-15).

A key finding was the significant variance in instrument choice among studies, suggesting differences in assessment emphasis, cultural suitability, and therapeutic relevance. Although clinician-administered interviews and culturally customized assessments provide a more complete picture of refugee psychological health, standardized self-report measures such as the HSCL-25 and PHQ-9 were often used because of their accessibility and simplicity of administration. By showing more sensitivity to cultural variations in symptom manifestation, vignette-based semi-structured interviews helped to lower the possibility of misdiagnosis. Moreover, some research included functional impairment metrics—such as the WHO Disability Assessment Schedule (WHODAS 2.0)—to reflect the actual influence of mental

health disorders on everyday living, an area usually ignored by conventional symptom-based surveys.

Psychological assessments including post-migration stress variables were another important result. Highlighting the influence of environmental stresses in forming mental health results, several studies used tools including the Refugee Post-Migration Stress Scale (RPMS) and the Post-Migration Living Difficulties Checklist (PMLD). Often refugees struggled with housing insecurity, legal status, social integration, and financial problems, all of which greatly affected their psychological well-being. Evaluations using post-migration stress indicators offered an increased understanding of refugee mental health outside the direct influence of trauma.

A developing trend in the literature showed the growing application of multidimensional assessment techniques. Some research included psychological distress indicators with evaluations of social well-being and quality of life since they understood the interaction between mental health and social functioning. Overall well-being was measured using the EUROHIS Quality of Life Scale and the WHO-5 Well-Being Index; resilience and coping strategies were investigated using the General Self-Efficacy Scale and the Brief COPE. These extra components to conventional mental health assessments offered insights on possible protective elements that can reduce psychological suffering in refugee populations.

Moreover, research revealed notable gender variations in mental health results and the efficacy of assessment instruments. While they showed more avoidance behaviors that can cause symptom underreporting in self-report tools, male migrants claimed less psychological suffering. By contrast, female refugees—especially those with children—showed more expressed sadness and anxiety, underlining the importance of gender-sensitive evaluation

methods. A number of studies indicated that integrating qualitative interviews with standardized tests might increase accuracy in identifying mental health problems among various demographic groups.

The findings also highlighted the need for culturally sensitive assessment techniques. Although often used, standardized Western tools like the PHQ-9 and HSCL-25 raised significant doubts about their relevance for various immigrant groups. Research that either used translated versions with psychometric validation or modified these tools to fit certain cultural settings showed greater dependability and validity. The accuracy of mental health assessments was further improved by including interpreters and cultural mediators in evaluation procedures, guaranteeing that refugees' expressions of suffering were properly interpreted within their cultural context.

The study underlined at last the requirement of a consistent yet adaptable method for assessing refugee mental health. An ideal evaluation methodology would combine structured self-report measures, clinician-administered diagnostic interviews, and post-migration stress assessments given the variety of instruments available. The HTQ and PCL-5 were advised for PTSD symptoms and trauma exposure; the HSCL-25 and PHQ-9 were appropriate for depression and anxiety; the WHODAS 2.0 was helpful for functional impairment; and the PMLD was found to be useful for post-migration stress. Adding qualitative evaluations—such as semi-structured interviews and culturally tailored vignettes—would increase the thoroughness of mental health exams even more.

The results of this systematic review show generally that although some instruments are useful in measuring refugee mental health, a multidimensional, culturally sensitive approach is

absolutely necessary. Future studies should concentrate on improving diagnostic accuracy by means of refined assessment techniques and on creating integrated models taking into consideration post-migration stressors as well as pre-migration trauma. Mental health experts can better handle the particular psychological demands of refugee populations and improve their access to suitable treatment and assistance by doing this.

3.2 Discussion

Assessing mental health in refugee communities is still a complex and difficult job (Kiselev et al., 2020). This systematic review highlights the need to employ a multifaceted approach that includes culturally adapted instruments, clinician-administered interviews, and self-report assessments. Particularly with people from different cultural backgrounds, the variety of assessment methods highlights the more general problem of cross-cultural validity in psychiatric examinations (Shiraev & Levy, 2020). While instruments such as the Harvard Trauma Questionnaire (HTQ), Hopkins Symptom Checklist (HSCL-25), and Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) have been widely employed, results suggest that no single instrument completely captures the full spectrum of refugee mental health challenges. A proper understanding of refugee psychological well-being depends more on a holistic approach including functional impairment and post-migration stress elements than with any one instrument (Hogan, 2019).

One important finding from the study is how mental health evaluations are influenced by cultural and contextual factors (Shiraev & Levy, 2020). While confirmed in different clinical situations, standardized Western diagnostic methods do not always fit the culturally unique symptoms of refugees (Kitayama & Salvador, 2023). Among refugee groups, mental distress typically shows itself in culturally subtle forms like physical symptoms, spiritual distress, or community-based displays of suffering (Zbidat et al., 2020). This is why testing methods that overlook these cultural factors could result in misdiagnosis or symptom underreporting

(Shiraev & Levy, 2020). The use of culturally adapted evaluations, including qualitative approaches such as vignette-based semi-structured interviews, has shown improved sensitivity in detecting mental health difficulties within refugee groups (Van & Leung, 2021). Future studies could encourage the further development of culturally relevant assessment methods that fit the various backgrounds of displaced people.

The analysis additionally underlines the key role of post-migration stressors in establishing refugee mental health results. Many mental health evaluations center mostly on pre-migration trauma, including war exposure and forced displacement. Psychological suffering of refugees, the meantime, does not stop on arrival in a host nation (James et al., 2019). Legal confusion, social isolation, prejudice, financial insecurity, and healthcare access limits are among challenges that still greatly affect mental well-being (Solberg et al., 2023). Tools such as the Post-Migration Living Difficulties Checklist (PMLD) and the Refugee Post-Migration Stress Scale (RPMS) demonstrate their utility in capturing these continuous stressors. A more thorough mental health assessment system should include pre-migration trauma evaluations with post-migration stress assessments to give a whole picture of psychological suffering and resiliency (Solberg et al., 2023).

Another important aspect in refugee mental health evaluations is resilience as well as protective factors. Although much of the current study focuses on identifying signs of suffering, recent work points out the need of assessing social support systems, coping strategies, and resilience (Derya Güngör & Strohmeier, 2020). Refugees' adaptation capacity in the face of hardship have been assessed with psychological measures such the Brief COPE and General Self-Efficacy Scale (Fino et al., 2020). Results suggest that those with strong social support systems and active coping techniques are better able to control psychological suffering (Oviedo et al.,

2022). Including resilience-based measures into mental health evaluations can offer a more balanced view, above a deficit-oriented model of immigrant mental health toward a strengths-based approach..

Differences between men and women are also very important when judging mental health results. The review found that male refugees often don't report their symptoms because of the social stigmas surrounding mental health (Brabender & Mihura, 2016). On the other hand, female refugees, especially those with children, tend to report higher levels of anxiety and sadness (Buchcik et al., 2023). Traditional self-report questionnaires might not work as well for men as they do for women. This is because male refugees may show avoidance behaviors or externalizing symptoms that are harder for normal tests to pick up on (Chung et al., 2017). Gender-sensitive evaluation tools, like gender-specific symptom scales and qualitative conversations, could help fix these problems and make diagnoses more accurate.

The issues associated with common diagnostic tools make the need for a holistic assessment approach even stronger. Although self-report tests like the PHQ-9 and HSCL-25 are very useful, they depend on the person being able to correctly understand and describe their mental pain in a structured way (Hogan, 2019). The accuracy of these tools can be affected by things like low literacy, language barriers, and different national views on mental health (Shiraev & Levy, 2020). Studies have shown that interviews and observations led by a therapist can often give more nuanced insights, especially for groups that don't know much about Western psychological ideas (Dunwoodie et al., 2022). To make refugee mental health evaluations more accessible and accurate, future research should look into new ways of carrying out assessments, such as digital mental health screenings and diagnostic tools that use AI.

Based on these results, lawmakers and mental health professionals should make sure that assessments of refugee mental health are flexible and take into account different cultures (Esses et al., 2017). Structured clinical interviews, self-report measures, and culturally appropriate qualitative assessments should all be part of standardized assessment procedures (Shiraev & Levy, 2020). Mental health evaluations must also take into account the bigger social factors that affect mental health, such as having access to safe housing, jobs, and legal help (Posselt et al., 2018). Adding mental health services to refugee support programs should be a top priority for lawmakers who want to make sure that people get complete and lasting care.

3.3 Conclusion

This systematic review shows how important it is for Europe to quickly adopt a thorough and culturally sensitive way to evaluate the mental health of refugees. Standardized tests like the Harvard Trauma Questionnaire (HTQ) and the Hopkins Symptom Checklist (HSCL-25) are helpful for diagnosis, but they work much better when used with qualitative methods, interviews with a clinician, and instruments that are tailored to a person's culture. The data show that a one-size-fits-all approach is not enough because refugee populations come from different places, have different experiences, and show different symptoms. In future study and clinical applications, it should be more important to use a model that takes into account functional impairment, post-migration stressors, and resilience factors.

One very important result of this study is how stressors after migration affect the mental health of refugees. Uncertainty about rules and regulations, housing, finances, and problems integrating into society can all make mental discomfort more severe. Traditional diagnostic tools tend to focus on trauma that happened before migration. However, this review shows how important it is to include problems that happened after migration in assessment procedures.

Mental health professionals can better understand the ongoing problems refugees face and make solutions that help them by using tools like the Refugee Post-Migration Stress Scale (RPMS) and the Post-Migration Living Difficulties Checklist (PMLD).

In addition, this study shows why resilience-based evaluations are important. A lot of research is done on how to spot psychological pain, but it is also important to look at ways to cope and things that keep you safe. Tools like the General Self-Efficacy Scale and the Brief COPE can help us understand how refugees deal with problems. Mental health treatments and policy suggestions can work better if they take a more balanced view, one that looks at both strengths and weaknesses.

Cross-cultural validation, post-migration stress evaluations, and a multidimensional approach that takes into account both distress and resilience should be the main goals of future research that aims to improve mental health assessment methods. Policymakers and health care providers need to understand that refugee mental health is always changing and push for assessment methods that are both consistent and flexible enough to account for differences in culture and setting. By pushing these efforts forward, the accuracy of diagnoses can be improved, make intervention methods better, and ultimately help refugee populations across Europe have better mental health outcomes.

3.4 Limitations

The results of this systematic review should be interpreted with consideration for several limitations it has. The wide range of the evaluation tools applied in multiple studies is one main obstacle. Direct comparisons between tools—from self-report questionnaires to clinical interviews—making sense of them is difficult and can result in discrepancies in the diagnosis and measurement of mental health disorders among refugees. Although some instruments have been culturally modified, many often used assessments, including the PHQ-9 and HSCL-25,

were first established for Western populations and might not adequately reflect the particular symptom presentations and distress manifestations of different immigrant groups. This demands concerns regarding the cultural validity and sensitivity of these tests.

The dependence on cross-sectional studies adds still another limitation as it prevents an understanding of how mental health symptoms change with time. Most studies offer just a picture of psychological discomfort rather than tracking changes in mental health status post-migration or in response to treatments. The dynamic nature of refugee mental health would be more suited for longitudinal investigations. Demographic features and sample sizes varied greatly among studies; some had small sample sizes or gender imbalances that would restrict the generalizability of the results.

Among refugee communities, language barriers and literacy rates often provide major difficulties. Many tests rely on translated versions or need competence of the language of the host nation, which may cause prejudice or change the meaning of psychological concepts. Furthermore, influencing the accuracy of assessments are elements like stigma, mistrust of mental health care, and trauma-related avoidance which could cause underreporting of symptoms.

Finally, the review is limited by possible publication bias since research revealing major mental health problems could be more likely to be published than those with null results. Future studies should concentrate on developing multimodal strategies for improving refugee mental health assessment and on refining culturally sensitive assessment instruments.

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