Journal Homepage: -www.journalijar.com

INTERNATIONAL JOURNAL OF ADVANCED RESEARCH (IJAR)

Article DOI:10.21474/IJAR01/21191
DOI URL: http://dx.doi.org/10.21474/IJAR01/21191

RESEARCH ARTICLE

PSYCHOTHERAPEUTIC INTERVENTIONS TO MANAGE ANXIETY, DEPRESSION, AND POST-TRAUMATIC SYMPTOMS AMONG IMMIGRANT AND REFUGEE CHILDREN AND ADOLESCENTS: A NARRATIVE REVIEW

Honey Susan Paul, Arnesh Shukla and Christine Shaw

Manuscript Info

Manuscript History
Received: 14 April 2025
Final Accepted: 17 May 2025
Published: June 2025

Abstract

Background: Immigrant and refugee children and adolescents are at increased risk for developing mental health problems like anxiety, depression and posttraumatic stress symptoms due to displacement, trauma and acculturation stressors. There is a growing need to evaluate psychotherapeutic interventions tailored to this population.
Objective: The goal of this study is to delineate major intervention approaches, evaluate their effectiveness, delivery contexts and outcomes in the target populations.
Methods: A comprehensive literature search was conducted of studies published in the past 3 decades evaluating psychotherapeutic interventions for immigrant and refugee children and adolescents.
Results: Reviewed articles are categorized under 5 major categories: 1) Cognitive-behavioral and trauma-focused interventions, 2) Creative arts and play-based therapies, 3) Combined/multimodal interventions, 4) Family and community-based interventions, 5) Preventive and skills-building interventions.
Conclusion: A range of psychotherapeutic approaches have been utilized to support the mental health of immigrant, refugee children and adolescents demonstrating effectiveness. Involving families and communities in these interventions can lead to better outcomes by having a positive influence on the overall well-being. Importance of accessible setting like school or community is also highlighted in some of the studies reviewed.

Introduction and Background: -

Defined most broadly, the term immigrant youth refers to children from birth to age seventeen, with at least one foreign-born parent.[1] According to the International Organization of Migration, an immigrant is a person who moves into a country other than that of his or her nationality or usual residence, so that the country of destination effectively becomes his or her new country of residence. [2]The UN Refugee convention defines a refugee as someone with a defined legal status who, because of a well-founded fear of being persecuted for their race, religion, nationality, membership in a social group or political opinion, who is outside of his or her country of nationality, and will not or cannot be protected by that country, is unable or unwilling to return to the country's territory due to

Corresponding Author:-Honey Susan Paul

fear of harm. [3] Individuals who are seeking international protection[2], that are waiting for their legally defined refugee status are "asylum seekers." [3]
Analysis of research studies completed between 2016 and 2022 found that the prevalence of anxiety and depression increased in US children aged 3-17 years.[4]It is possible that this trend of increased mental health symptoms in youth, and the subsequent need for youth focused mental health services can be tied to the growing immigrant population. In 2002 Jaycox et al., empirically documented high violence exposure, and subsequent mental health symptoms in children who had recently immigrated to a new country. Immigrant status in association with the presence of distress symptoms, high levels of posttraumatic stress, and depressive symptoms, are highly correlated with one another.[5] Enduring contextual factors before and after displacement has effects on mental health and amplifies the prevalence of mental health issues for immigrants.[6] Refugee families subjected to severe losses or trauma often experience mental health difficulties like PTSD, depression, anxiety, and grief.[7] Significant positive correlations were observed between anxiety, depression, and PTSD, indicating high co-morbidity. Associations were also present between trauma during migration and post migration, PTSD and depression, and trauma premigration and anxiety.[8]Evidence-based clinical guidelines for immigrants and refugees published in Canada also underscore the co-occurrence of symptoms that meet criteria for depression with PTSD and the presence of other anxiety disorders among refugees.[9]

The stigma and public perception associated with immigrant status can also have a negative impact on mental health. Salient factors affecting various adolescent minority populations, from families who have recently immigrated to the US include the negative effects of language acculturation [10], and the perception of having personally experienced discrimination and social exclusion causing depression. [11] Racial and Ethnic discrimination experiences were associated with multiple mental health conditions including depression.[12]Additional research has supported the assertion that phenotype and gender discrimination have a negative impact on positive mental health outcomes. [13] Racial/ethnic discrimination led to the development of posttraumatic stress symptoms [14], and the perception of having experienced institutional, educational, or peer prejudice was linked with emotional distress.[15] Notably, a 2020 study done in Florida, USA found relatively good perceived mental health despite some life stressors and acculturation pressure, if societal stigma and lack of comfort and trust did not bias responses.[16]

In 2024 Ijadi-Maghsoodi Ret al., emphasized the importance of needing to focus efforts to support the strengths and needs of immigrant youth and families to equip them to better thrive under community barriers and stressors they may endure. Their plan asserted that the school environment plays an essential role in the social, academic, and mental health of immigrants.[13] American Academy of Pediatrics (AAP) and the United States Preventive Services Task Force (USPSTF) recommend screening for mental health issues in children and adolescents.[17,18] Staffing shortages or limited access to bilingual-bicultural professionals can compromise standards of mental health care,[19,20] along with reluctance of parents to seek mental health help[21] are challenges in supporting immigrant youth's social and emotional functioning. In this context, involvement of community and school-based services may be best able to support the needs of disadvantaged children[22, 5].

This review aims to explore the types of psychotherapeutic interventions studied for efficacy in the management of anxiety, depression and posttraumatic stress symptoms with immigrant and refugee children and adolescents.

Methods: -

Sources of information: PUBMED, google scholar, Scopus, PsychINFO
Terms used for search: immigrant, migrant, refugee, mental health, children, adolescent, psychotherapy, therapy, anxiety, depression, depressive, post-traumatic stress, PTSD.

We reviewed studies published over the past 30 years.

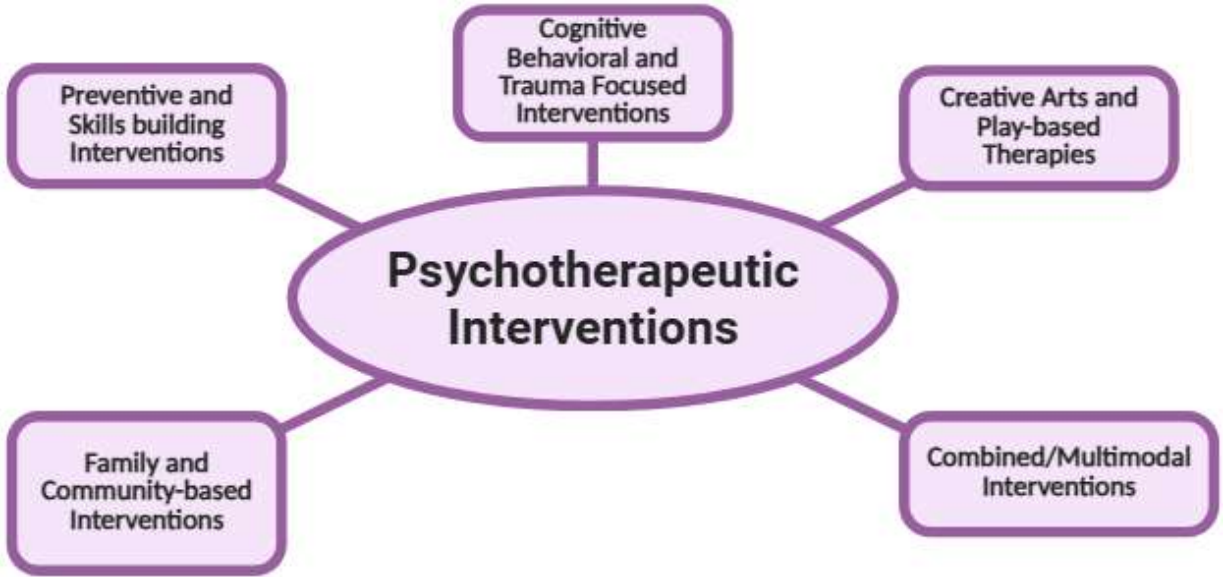
Inclusion Criteria	Exclusion Criteria
Studies on psychotherapeutic intervention in immigrant and refugee children and adolescents	Studies that were not done on children or adolescents
Studies published in the English language	Studies not addressing depression, anxiety or PTSD
Studies done all over the world	Studies focusing only on externalizing symptoms, cultural adaptations or family interventions
Original studies	Studies done in the context of Covid 19 lockdown

Literature Review: -

In 2020 the number of international migrants reached 281 million, with 36 million being children.[23] As previously mentioned, relocation can impose many difficulties for many immigrants and refugees. Barriers include language, living conditions, work, education, transportation, healthcare access, and dealing with past, and ongoing trauma and it's associated mental health challenges. Jongedijk RA et al., in 2020 [24] emphasized the development of broad range of psychopathology in severely traumatized refugees, and studied severity profiles of posttraumatic stress, depression, anxiety and somatization symptoms in treatment seeking traumatized refugees. The authors recommend providers not only focus on PTSD symptoms but also address comorbid mental disorders. They assert that early management and proper support of mental health issues is of utmost importance for the best outcomes. There are several well documented studies on psychosocial interventions and psychotherapeutic approaches to support immigrants and refugees with posttraumatic symptoms. Study of psychotherapeutic interventions for anxiety, depression, along with PTSD are limited. We are reviewing literatures implementing psychotherapeutic approaches to manage post-traumatic stress symptoms along with anxiety and depression, given the high prevalence of cooccurrence in the immigrant and refugee population who are under 18. In 2017 Chavira DAet al., in their research suggested that rural Latino parents are mostly positive about counseling/psychotherapy interventions as a first line treatment approach, verses use of medications to treat anxiety in their children. [25]

Name of Country	Number of Studies Done
United States	12
Germany	6
Australia	4
United Kingdom	3
Turkey	2
Belgium	2
Sweden	2
South Korea	1
China	1
Africa	1
Lebanon	1
Italy	1

Based on the literatures reviewed, the psychotherapeutic interventions studied to manage anxiety, depression, and posttraumatic stress in immigrant and refugee children and adolescents are as follows.



Cognitive-behavioral and trauma-focused interventions:

Kataoka et al., 2003, used Mental Health for Immigrants Program (MHIP) a child intervention based on the Cognitive Behavioral Intervention for Trauma to address PTSD, anxiety, and depression symptoms in school aged children. The results provided evidence that this trauma-focused, CBT intervention had a modest reduction of PTSD and depression symptoms. Authors asserted that their findings suggest that CBT can be effectively delivered in community settings such as schools. These changes could address unmet mental health care needs of Latino immigrant children. [26]

Cardeli et al., in 2020 included 34 Bhutanese refugee students who attend middle school in New England, US. The students participated in a 12- week group curriculum, utilizing the Trauma Systems Therapy for Refugees, (TST-R), a skills-based, empirically supported, mental health intervention and the associated pre-evaluation/post-evaluation. Reduction in mental health symptoms, such as those associated with depression or PTSD were seen as secondary to group participation. [27]Ehntholt KAet al., 2005 presented data on a pilot study of a manualized cognitive-behavioral therapy (CBT) intervention, conducted with children who were refugees or asylum-seekers in London. Children who participated in the CBT intervention showed a significant decrease in overall PTSD symptom severity, and intrusive PTSD symptoms. Teachers reported significant improvement in overall behavior and emotional symptoms in the intervention group. Despite the statistically significant improvements in PTSD symptoms, the majority of children continued to experience PTSD symptoms and decline in functioning at the follow-up. This was hypothesized as influenced by international events taking place at the time of reassessment[28].

The FRIENDS program for youth is a 10-week, cognitive-behavioral, group-based anxiety intervention for youth between 12 and 17. This pilot study was done in Australia. Findings from the pilot study utilizing the FRIENDS intervention suggest the treatment reduces anxiety symptoms in young non-English speaking background (NSEB) refugees and was deemed culturally acceptable by participants. [29] A subsequent study of the utility of the FRIENDS program to reduce psychological distress in young culturally diverse migrant youth who migrated to Australia. Findings suggest that FRIENDS is likely effective in building emotional resilience against cultural adjustment difficulties. Elementary school children who completed the intervention reported a significant improvement in self-esteem, decrease in anxiety symptoms, and improvement in their expectations for the future. High school students reported significantly reduced levels of anxiety, depression, anger, post-traumatic stress, and dissociation. [30]

Gormez et al., in 2017 presented a prospective experimental group cognitive behavioral therapy (CBT) program with a pre-test/post-test design, delivered by trained teachers. Clinically significant improvement in trauma-related and emotional symptoms was noted at the post-test evaluation, with the most significant reduction observed in total anxiety score and reduction in intrusive symptoms. [31]A pilot study integrating religious and spiritual themes to Mindfulness-based CBT was conducted on unaccompanied immigrant children (UIC). This study found that religiosity and spirituality are very important for UIC's coping and conceptualization of trauma. Themes related to religion and faith served as facilitating factors of engagement for UIC in psychotherapy and seemed to help with improvement of posttraumatic cognitions and symptoms[32].

Ooi et al., reported on the efficacy of group CBT with immigrant youth populationsin the Perth, Australia. The intervention used was TRT, Teaching Recovery Techniques, a group-based CBT program. Findings from the research suggested the intervention had no significant effect for PTSD symptoms, but participants in the intervention had significantly lower depression symptoms with changes in functioning maintained at the 3-month follow-up.[33]TRT, was also studied with 60 unaccompanied refugee minors. Results found that 33% of the participants had subclinical depression symptoms and 22% no longer met criteria for a diagnosis of PTSD after treatment, despite 62% of the participants experiencing negative life events while in the program and being in the middle of their asylum-seeking process.[34] A TRT + Parenting intervention was delivered to Syrian refugee children and their families living in Turkey. Findings from the study suggested a decline in intrusion scores, which were associated with post traumatic symptoms. There was also a notable reduction in parent-reported behavioral problems.[35]

A modified version of trauma focused cognitive behavior therapy (TF-CBT), was utilized with unaccompanied refugee minors (URMs), in Germany, who exhibited high levels of post-traumatic stress symptoms at baseline. Participants appeared to have a significant decrease in symptoms post TF-CBT intervention. [36]Unterhitzenberger J, and Rosner R.has published a case study of beneficial effects of manualized TF-CBT in clinically improving PTSD symptoms for a 17-year-old, URM in Germany, who had stable reduction of symptoms post intervention at 6 months.[37] A pilot study utilizing manualized individual TF-CBT with URMs, who met the PTSD diagnostic criteria found significantly decreased PTSD symptoms post intervention. Changes in symptomology remained stable at the

6 weeks, and 6 months follow up. Findings also suggested participants experienced decreased depressive and behavioral symptoms post intervention. [38]
Vickers B explained successful outcome using cognitive behavioral model of PTSD using a case vignette of a 14-year-old refugee with a diagnosis of PTSD following multiple traumatic experiences from war and the process of becoming a refugee. Treatment model including both exposure and cognitive restructuring led to extremely good general outcome and a different cognitive appraisal of her life[39].

A pilot study of KIDNET, a child-friendly version of Narrative Exposure Therapy (NET), was conducted with Somali children, in a refugee settlement in Uganda. Results showed a reduction in posttraumatic symptoms, at posttest and at 9 months follow up. Remission of clinically significant depression symptoms were also observed. [40]Research of NET efficacy in reduction of trauma symptoms was completed with a sample of 20 North Korean refugee youth. Participants resided in Seoul, South Korea. The findings showed significant reductions in symptoms of PTSD and depression, and less internalizing and externalizing symptoms for the NET participant group. [41] Another NET study was conducted In Germany. Findings from the study suggest intervention with KIDNET was helpful for reducing symptoms on all PTSD relevant measures. [42]

Eye Movement Desensitization and Reprocessing (EMDR) was utilized with refugee children diagnosed with PTSD in Sweden. Results from the study of the intervention suggested improvements in symptoms of PTSD, most significantly reducing re-experiencing symptoms and depression symptoms. [43] Results from an EMDR Integrative Group Treatment Protocol (EMDR-IGTP) suggested improvements in psychological well-being and reduced PTSD symptoms for the child refugee participants, living in a Turkey orphanage near the Syrian border. [44]

The Cognitive -behavioral intervention, Creating Opportunities for Patient Empowerment (COPE) is an evidence-based research-tested intervention program. The COPE intervention was delivered to Syrian refugees, in Lebanon. Findings from the research indicated that COPE program decreased depression, anxiety significantly and increased quality of life for youth in the program. [45]

The intervention model Mein Weg (My Way), a trauma focused group intervention, was used with youth under 18, who had a trauma history, were unaccompanied by adults, and reported post-traumatic stress symptoms. After the group intervention, the participants reported significantly fewer overall post-traumatic stress symptoms. [46]

Creative arts and play-based therapies:
A study of the therapy outcomes of refugee children attending 3 elementary schools, in the northwest US, was completed. Based on child and parent reports, both child-centered play therapy (CCPT) and trauma-focused cognitive-behavioral therapy (TF-CBT), were effective in reducing symptoms of PTSD, thus providing more treatment options for children who have experienced refugee trauma. [47]A cross-over design pilot study used short-term music therapy program to examine effects on classroom behaviors in refugee students in Australia. Although a significant decrease in externalizing behaviors such as hyperactivity and aggression were found, no significant differences were found in other studied behaviors. Authors emphasized that it could be that internalizing behaviors like anxiety, depression, somatization are often difficult to observe, a lack of participant language skills may have prevented students from communicating their feelings and symptoms, subsequently these subscales were rarely scored by teachers.[48]

A group of 120 elementary school children from both refugee and nonrefugee migration backgrounds were randomly assigned to a creative arts-based expression program or control condition. The results of the study indicated improvement in classroom climate as well as reduction of posttraumatic symptomatology following intervention.[49]Attachment-based modalities using play, activities and games was studied with Syrian refugee children, and their parents. This study, that was conducted in Turkey showed significant improvement in children's post-traumatic stress and other mental health symptoms, as well as parent-rated attachment relationship difficulties. [50]A group of 15 Syrian refugee children between ages 7 and 14 participated in the art therapy program in the US. Findings from the research incited a statistically significant effect of art therapy on posttraumatic stress and separation anxiety. Additionally, there were moderate effects on anxiety, panic disorder and GAD compared to no treatment controls. [51]

Combined/multimodal interventions:
A school – based mental health (SBMH) program for traumatized immigrant children and adolescents, calledCATS, conducted a collaborative study of cultural adjustment and trauma services (CATS) TF-CBT, was implemented with a subset of available students. CATS services such as CBT led to improved functioning for participants. Researchers found TF-CBT reduced PTSD, anxiety symptoms and helped alleviate stressors experienced by the diverse group of immigrant students. [52]The Cultural adjustment group is a 12-week, school-based group intervention created for recently arrived (<3 years) immigrant middle school students. The group intervention was conducted in Spanish, Arabic, or Bangla the participant's native languages. Clinically significant reduction in clinical symptoms such as depression, anxiety, somatic complaints, conduct problems, and acculturative stress were noted at post-testby Bangla-speaking group, but no clinically significant changes were seen in the other two groups. However participants reported overall positive experience, and assisted in adjusting to American culture, and connect more closely with peers about issues like family separation, and bullying. [53]

Family and community-based interventions:
A qualitative pilot case study examined the utility of an after-school mentoring program intended to support participants who were either Bhutan refugees or the children of Bhutan refugees. Activities were designed to help participants with self-esteem, self-confidence, social skills development, and problem-solving. Mentors realized that the children may need more professional assistance, like mental health screenings for depression, anxiety, and symptoms of post-traumatic stress in the schools.[54]A study of Somali Bantu, and Bhutanese families were randomized into groups to receive Family Strengthening Intervention for refugees (FSI-R) or, care-as-usual (CAU). Children who received the intervention for both communities reported significant improvements in mental health, indicated by lower levels of traumatic stress reactions, and caregivers from families across both communities reported that childrenin the intervention exhibited fewer depression symptoms, compared to CAU children. [55]

Preventive and skills-building interventions:
Project SHIFA is a study done in Somali and Somali Bantu refugee youths living in New England. Services were delivered by two Somali and two non-Somali clinicians/social work interns. Students across all tiers showed significant improvement in symptoms of depression and PTSD for the top tier of participants.[56]A collaborative program presented an eight-week school-based program to Southeast Asian refugee children utilizing cognitive-behavioral interaction. The program emphasized skills building, such as coping, and led to reduction of depression symptoms.[57]

A pilot study of the effectiveness of a school-based somatic soothing intervention to help children manage dissociative and dysregulation symptoms, provided the intervention to 34 mostly refugee and immigrant youth. The intervention was completed in the United States. Participants in the intervention, Somatic Soothing and Emotional Regulation Skill Development intervention (SSERSD), reported statistically significant improvement in anxiety, depression, psychological functioning, and trauma symptomatology.[58]A pilot study of mindfulness-based intervention (MBI) for unaccompanied refugee minors was completed in Belgium. Preliminary findings suggested that MBI may be effective in reducing symptoms of depression with a large effect size and may also improve positive emotional affect.[59] Two intervention groups, mindfulness training (MT) and MT + life-skills (LS) mentorship, were compared to waitlist control groups in China. Results indicated MT + LS training reduced harm avoidance and anxiety in migrant students. [60]

Based on the UN refugee agency, UNHCR global website, at the end of 2023, of the 117.3 million forcibly displaced people, an estimated 47 million, 40% are children < 18 years of age. Low- and middle-income countries host 71% of the world's refugees and other people in need of international protection [61]. However, the research from developing countries is not proportional to the number of migrants they host, which could be because of the lack of resources in those countries. This literature review suggests the need for more research in these areas with a focus on psychotherapeutic interventions for vulnerable displaced children. The overall generalizability of some of the studies are questionable as they are specifically done among one ethnicity or migrant or refugee group. More research among different immigrant populations, or multiple locations and repeated studies can shed more light into the crucial topic of supporting the mental health of immigrant and refugee, children and adolescents.

First Author	Year	Study design	Psychotherapy Intervention	Number of Participants	Age Range of Participants	Study Findings
Kataoka S.H., et al	2003	Experimental pilot study	Trauma-focused group CBT	198	8-14 yrs	Intervention group showed a significantly greater reduction in PTSD and depressive symptoms at 3month followup compared to control. Supports FRIENDS efficacy across diverse migrant groups.
Cardeli E., et al	2020	Pre-post evaluation	Trauma systems group therapy	34	11-14 yrs	Avoidance symptoms significantly decreased post-intervention. Higher school belonging associated with lower depressive and PTSD symptoms.
Ehnthol K.A., et al	2005	Waitlist-controlled school trial	Schoolbased group CBT	26	11-15 yrs	Post-intervention showed significantreductions in PTSD, behavioral, and emotional symptoms vs. waitlist.
Barrett P.M., et al	2000	Pilot waitlist-controlled trial	FRIENDS group CBT program	20	14-19 yrs	Intervention group (n = 9) showed significant reductions in internalizing and anxiety symptoms vs. waitlist (n = 11).High participant satisfaction and suggested cultural adaptations.
Barrett P.M., et al	2003	Waitlist-controlled national trial	10-week FRIENDS group CBT program	320	6-19 yrs	Intervention students showed higher selfesteem, fewer internalizing

						symptoms and less pessimistic outlook at post-test and 6month followup vs. waitlist.
Gormez V., et al	2017	Pre-post evaluation	Group CBT	32	10-15 yrs	Significant reductions in anxiety (SCAS) and PTSD symptoms (CPTS-RI). Demonstrates feasibility and benefit of teacherdelivered school programs.
Fortuna L.R., et al	2023	Mixed-methods pilot study	Mindfulness based CBT integrating spirituality	6	15-17 yrs	Spirituality integration facilitated engagement. Significant reductions in PTSD and post-traumatic cognitions.
Ooi C.S., et al	2016	Cluster randomized controlled trial	Teaching Recovery Techniques Group CBT	82	10-17 yrs	Intervention group had significantly greater reductions in PTSD, depression, internalizing and externalizing symptoms at post-test vs. waitlist. Effects were maintained at 3month followup.
Sarkadi A., et al	2018	Pre-post evaluation	Teaching Recovery Techniques Group CBT	46	14-18 yrs	Significant decreases in PTSD (CRIES-8) and depression (MADRS-S) symptoms after intervention. Qualitative feedback highlighted social support and coping skills.
El-Khani A., et al	2018	Pilot pre-post feasibility study	Teaching Recovery Techniques + 3 parenting skills sessions	16	6-12 yrs	High recruitment and 93% retention. Significant reductions in post

						traumatic stress intrusions and parentrated behavioral problems.
Unterhitzenberger J., et al	2015	Case series	Trauma-focused CBT	6	17-18 yrs	Clinically significant decrease in PTSS post-treatment. TF-CBT feasible with minor protocol adaptations.
Unterhitzenberger J., et al	2016	Single case report	Trauma-focused CBT	1	17 yrs	PTSD symptoms decreased to subclinical range. Recovery maintained at 6month followup
Unterhitzenberger J., et al	2019	Uncontrolled pilot study	Trauma-focused CBT	26	16-18 yrs	Large PTSD symptom reduction (d = 1.08) maintained through 6 months; 84 % recovered. Asylum rejections associated with relapse risk.
Vickers B., et al	2005	Case vignette	CBT using Ehlers & Clark PTSD model	1 out of 2	14 yrs	Clinical improvement was seen. Paper demonstrates feasibility of applying adult cognitive model to child/adolescent PTSD and stresses collaborative formulation, parental support, and cultural adaptations.
Onyut L.P., et al	2005	Case series pilot study	KIDNET – childfriendly Narrative Exposure Therapy	6	12-17 yrs	Marked PTSD and depression symptom reduction immediately post-treatment, which was sustained at 9month followup.
Park J.K., et al	2020	Randomized controlled trial	Narrative Exposure Therapy (NET) vs. TAU	20	Not specified	NET produced large reductions in PTSD, depression, internalizing and externalizing symptoms and

						improved insomnia and sleep quality.
Ruf M., et al	2010	Randomized controlled trial	KIDNET (Narrative Exposure Therapy for Children)	26	7–16 yrs	KIDNET proved superior to the waiting list condition in all PTSD relevant measures.
Oras R., et al	2004	Pre-post case series	EMDR within psychodynamic therapy	13	Not specified	Significant improvements in PTSS-C re-experiencing, avoidance, hyperarousal and global functioning post-treatment.
Perilli S., et al	2019	Field study (pre-post)	EMDR Integrative Group Treatment Protocol (EMDR-IGTP) group EMDR	14	3-18 yrs	Significant decrease in CRIES PTSD scores 45 days posttreatment.
Doumit R., et al	2020	Pre-experimental pre-post feasibility study	COPE 7-session brief cognitive-behavioral skill-building program	31	13-17 yrs	Significant decreases in depression and anxiety and increased quality of life.
Pfeiffer E., et al	2017	Pilot pre-post study	“Mein Weg” trauma-focused group CBT	29	14-18 yrs	Significant reductions in PTSD symptoms (CATS) post-intervention.
Schottelkorb A.A., et al	2012	Randomized controlled trial	Child-Centered Play Therapy vs. TF-CBT	31	6-13 yrs	CCPT yielded significant reductions in PTSD symptoms and improved functioning, with outcomes comparable to goldstandard TF-CBT.
Baker F., et al	2006	Crossover pilot study	Classroom group music therapy	31	12-16 yrs	Significant decrease in externalizing behaviors. No significant differences in other behavior composites.
Kevers R., et al	2022	Cluster randomized controlled trial	School based creative expression program	120	8-12 yrs	Improved classroom climate (d = .33). No overall symptom

						change, but children with high baseline PTSS, especially refugees, showed large PTSD reduction.
Eruyar S., et al	2020	Feasibility pre-post pilot study	Group Theraplay(Attachmentbased play therapy)	15	8-14 yrs	Significant reductions in PTSD (CRIES) and parent-rated hyperactivity, along with improved attachment relationships.
Feen-Calligan H., et al	2020	12-week quasi-experimental pre-post study	Art therapy program	12	≤17 yrs	83 % retention and significant decrease in separation anxiety and large effect on PTSS.Moderate effects on anxiety, panic, GAD.
Beehler S., et al	2012	Practice-based longitudinal evaluation	Cultural Adjustment and Trauma Services (CATS)	149	6-21 yrs	Greater cumulative supportive therapy, CBT and TF-CBT predicted improved functioning; TF-CBT and coordinating services reduced PTSD symptoms, indicating overall effectiveness of the CATS model.
Ma P.W., et al	2023	Pre-post feasibility pilot study	School-based psychosocial group for newcomer immigrant students	70	10-16 yrs	Banglaspeaking subgroup showed clinically significant reductions in clinical symptoms andacculturative stress.
Nabors L.A., et al	2022	Qualitative pilot case study	After-school mentoring & social-emotional skill-building program	16	6-11 yrs	Mentors and staff reported improved self-esteem and social development in refugee children.
Betancourt T.S., et al	2020	Randomized controlled pilot feasibility trial	Family Strengthening Intervention for Refugees	152	Not specified	FSI-R families had reduced child traumatic stress and depression vs.

						careasusual. High retention (82.5%) and satisfaction (81.5%) show feasibility and acceptability.
Ellis B.H., et al	2013	Prospective cohort	Project SHIFA multi-tier program	30	11-14 yrs	Significant decreases in PTSD and depression symptoms over 6 and 12month followup.
Fox P.G., et al	2005	Pre-post schoolbased intervention study	8week culturallysensitivecognitivebehavioral group program	58	6-15 yrs	Children's Depression Inventory scores decreased significantly from baseline to week 4, week 8, and 1month followup, indicating reduced depressive symptoms.
Mancini M.A., et al	2020	Pilot singlegroup pre-post study	Schoolbased somatic soothing group intervention	34	6-11 yrs	Significant improvements in anxiety, depression, psychological functioning and trauma symptoms after intervention.
Van der Gucht K., et al	2019	Pilot mixed-methods pre-post study	8week mindfulnessbased intervention	13	13-18 yrs	Medium reductions in negative affect, improved positive affect, and large reduction in depression.
Lan L., et al	2024	Randomized controlled trial	Mindfulness training (MT) ± lifeskills mentorship (MT + LS)	653	9-17 yrs	MT enhanced cognitive reappraisal but increased physical anxiety among highly integrated children; MT + LS reduced harm-avoidance and physical anxiety in highly integrated children, and lowered separation and harm-avoidance anxiety at 3month

						followup for moderately integrated peers.

Limitations: -

We did not clarify the specific diagnoses of participating populations in the studies reviewed, which makes it difficult to separate the effects on anxiety, depression, and PTSD. As we focused only on psychotherapy, the potential confounding effects of medications were not accounted for. Some of the studies used small sample sizes and some of the studies were early-stage pilot studies, and case reports, which made it harder for their findings to be applied to larger groups. As this study was not a systematic review, the selection process may have introduced bias or omitted relevant literature.

Conclusions: -

Our narrative review examining the role of psychotherapeutic interventions to support mental health challenges like anxiety, depression, and PTSD among immigrant, refugee, child and adolescent population, highlighted the trauma, stress, and difficulties experienced during migration. It underlined the need for early intervention. Our review demonstrated the beneficial effects of different modalities of psychotherapy, individual or group therapy interventions, in different settings, helping our target population. This further helped in managing the past and ongoing trauma and mental health symptoms by, developing positive coping skills, cognitive behavioral approaches, trauma focused services, art and play therapy, group-based anxiety intervention, family based preventive intervention, mindfulness and attachment-based approaches. Involving families and communities helps to improve overall well-being of the targeted population. This review highlights the value of delivering interventions in accessible setting (school, community), to support compliance. Some studies emphasized the importance of maintaining psychotherapy due to the immigrant and refugee population being affected by ongoing incidents happening globally.

References: -

1. Tienda M, Haskins R. Immigrant Children: Introducing the Issue. The Future of Children. 2011;21(1). doi:10.1353/foc.2011.0010
2. Key Migration Terms. International Organization for Migration. https://www.iom.int/key-migration-terms
3. Handbook on Procedures and Criteria for Determining Refugee Status under the 1951 Convention and the 1967 Protocol relating...
4. Casseus M, Reichman NE. Anxiety, Depression, and Behavioural Problems Among US Children and Adolescents, 2016–2022. Infant and Child Development. 2025;34(2):e70008. doi:10.1002/icd.70008
5. Jaycox LH, Stein BD, Kataoka SH, et al. Violence Exposure, Posttraumatic Stress Disorder, and Depressive Symptoms Among Recent Immigrant Schoolchildren. Journal of the American Academy of Child & Adolescent Psychiatry. 2002;41(9):1104-1110. doi:10.1097/00004583-200209000-00011
6. Porter M, Haslam N. Predisplacement and Postdisplacement Factors Associated With Mental Health of Refugees and Internally Displaced PersonsA Meta-analysis. JAMA. 2005;294(5):602-612. doi:10.1001/jama.294.5.602
7. Ehntholt KA, Yule W. Practitioner Review: Assessment and treatment of refugee children and adolescents who have experienced war-related trauma. Journal of Child Psychology and Psychiatry. 2006;47(12):1197-1210. doi:10.1111/j.1469-7610.2006.01638.x
8. Cleary SD, Snead R, Dietz-Chavez D, Rivera I, Edberg MC. Immigrant Trauma and Mental Health Outcomes Among Latino Youth. J Immigr Minor Health. 2018;20(5):1053-1059. doi:10.1007/s10903-017-0673-6
9. Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ. 2011;183(12):E824-E925. doi:10.1503/cmaj.090313
10. Finch BK, Frank R, Vega WA. Acculturation and Acculturation Stress: A Social-Epidemiological Approach to Mexican Migrant Farmworkers' Health. The International Migration Review. 2004;38(1):236-262.
11. Finch BK, Kolody B, Vega WA. Perceived discrimination and depression among Mexican-origin adults in California. Journal of Health and Social Behavior. 2000;41(3):295-313.
12. Coker TR, Elliott MN, Kanouse DE, et al. Perceived Racial/Ethnic Discrimination Among Fifth-Grade Students and Its Association With Mental Health. Am J Public Health. 2009;99(5):878-884. doi:10.2105/AJPH.2008.144329

13. Ijadi-Maghsoodi R, Meza JI, Bravo L, Lee K, Kataoka S. Reimagining Social and Emotional Supports in Schools for Immigrant Students: A Contextual and Structural Approach. Academic Pediatrics. 2024;24(5):32-41. doi:10.1016/j.acap.2023.11.007
14. Flores E, Tschann JM, Dimas JM, Pasch LA, de Groat CL. Perceived racial/ethnic discrimination, posttraumatic stress symptoms, and health risk behaviors among Mexican American adolescents. Journal of Counseling Psychology. 2010;57(3):264-273. doi:10.1037/a0020026
15. Fisher CB, Wallace SA, Fenton RE. Discrimination Distress During Adolescence. Journal of Youth and Adolescence. 2000;29(6):679-695. doi:10.1023/A:1026455906512
16. Kahar P, Negroni LK. Assessment of Self-Reported Mental Health and Acculturation Stress Among Foreign-Born and U.S.-Born Latinos in Immokalee, Florida: A Pilot Study. JSBHS. 2020;14(1). doi:10.5590/JSBHS.2020.14.1.03
17. US Preventive Services Task Force, Mangione CM, Barry MJ, et al. Screening for Anxiety in Children and Adolescents: US Preventive Services Task Force Recommendation Statement. JAMA. 2022;328(14):1438. doi:10.1001/jama.2022.16936
18. Bright Futures Toolkit: Links to Commonly Used Screening Instruments and Tools. Published online February 26, 2024. https://publications.aap.org/toolkits/resources/15625/Bright-Futures-Toolkit-Links-to-Commonly-Used
19. Gong-Guy E, Cravens RB, Patterson TE. Clinical Issues in Mental Health Service Ddivery to Refugees.
20. Garrison EG, Roy IS, Azar V. Responding to the mental health needs of latino children and families through school-based services. Clinical Psychology Review. 1999;19(2):199-219. doi:10.1016/S0272-7358(98)00070-1
21. McMILLER WP, Weisz JR. Help-Seeking Preceding Mental Health Clinic Intake among African-American, Latino, and Caucasian Youths. Journal of the American Academy of Child & Adolescent Psychiatry. 1996;35(8):1086-1094. doi:10.1097/00004583-199608000-00020
22. Willis DJ. Psychotherapy in the real world. Psychotherapy. 1996;33(1):131-134. doi:10.1037/0033-3204.33.1.131
23. Child Migration. UNICEF DATA. https://data.unicef.org/topic/child-migration-and-displacement/migration/
24. Jongedijk RA, Eising DD, van der Aa N, Kleber RJ, Boelen PA. Severity profiles of posttraumatic stress, depression, anxiety, and somatization symptoms in treatment seeking traumatized refugees. Journal of Affective Disorders. 2020;266:71-81. doi:10.1016/j.jad.2020.01.077
25. Chavira DA, Bustos CE, Garcia MS, Ng B, Camacho A. Delivering CBT to Rural Latino Children with Anxiety Disorders: A Qualitative Study. Community Ment Health J. 2017;53(1):53-61. doi:10.1007/s10597-015-9903-3
26. Kataoka SH, Stein BD, Jaycox LH, et al. A School-Based Mental Health Program for Traumatized Latino Immigrant Children. Journal of the American Academy of Child & Adolescent Psychiatry. 2003;42(3):311-318. doi:10.1097/00004583-200303000-00011
27. Cardeli E, Phan J, Mulder L, Benson M, Adhikari R, Ellis BH. Bhutanese Refugee Youth: The Importance of Assessing and Addressing Psychosocial Needs in a School Setting. Journal of School Health. 2020;90(9):731-742. doi:10.1111/josh.12935
28. Ehntholt KA, Smith PA, Yule W. School-based Cognitive-Behavioural Therapy Group Intervention for Refugee Children who have Experienced War-related Trauma. Clin Child Psychol Psychiatry. 2005;10(2):235-250. doi:10.1177/1359104505051214
29. Barrett PM, Moore AF, Sonderegger R. The FRIENDS program for young former-Yugoslavian refugees in Australia: A pilot study. Behaviour Change. 2000;17(3):124.
30. 30. Barrett PM, Sonderegger R, Xenos S. Using Friends to Combat Anxiety and Adjustment Problems among Young Migrants to Australia: A National Trial. Clin Child Psychol Psychiatry. 2003;8(2):241-260. doi:10.1177/1359104503008002008
31. Gormez V, Kılıç HN, Orengul AC, et al. Evaluation of a school-based, teacher-delivered psychological intervention group program for trauma-affected Syrian refugee children in Istanbul, Turkey. Psychiatry and Clinical Psychopharmacology. 2017;27(2):125-131. doi:10.1080/24750573.2017.1304748
32. Fortuna LR, Martinez W, Porche MV. Integrating spirituality and religious beliefs in a mindfulness based cognitive behavioral therapy for PTSD with Latinx unaccompanied immigrant children. Journal of Child & Adolescent Trauma. 2023;16(3):481. doi:10.1007/s40653-023-00541-1
33. Ooi CS, Rooney RM, Roberts C, Kane RT, Wright B, Chatzisarantis N. The Efficacy of a Group Cognitive Behavioral Therapy for War-Affected Young Migrants Living in Australia: A Cluster Randomized Controlled Trial. Frontiers in psychology. 2016;7:1641. doi:10.3389/fpsyg.2016.01641

34. Sarkadi A, Ådahl K, Stenvall E, et al. Teaching Recovery Techniques: evaluation of a group intervention for unaccompanied refugee minors with symptoms of PTSD in Sweden. European Child & Adolescent Psychiatry. 2018;27(4):467-479. doi:10.1007/s00787-017-1093-9
35. El-Khani A, Cartwright K, Ang C, Henshaw E, Tanveer M, Calam R. Testing the feasibility of delivering and evaluating a child mental health recovery program enhanced with additional parenting sessions for families displaced by the Syrian conflict: A pilot study. Peace and Conflict: Journal of Peace Psychology. 2018;24(2):188-200. doi:10.1037/pac0000287
36. Unterhitzenberger J, Eberle-Sejari R, Rassenhofer M, Sukale T, Rosner R, Goldbeck L. Trauma-focused cognitive behavioral therapy with unaccompanied refugee minors: a case series. BMC Psychiatry. 2015;15. https://www.proquest.com/docview/1779860631/abstract/D811437743084A98PQ/1
37. Unterhitzenberger J, Rosner R. Case report: manualized trauma-focused cognitive behavioral therapy with an unaccompanied refugee minor girl. European Journal of Psychotraumatology. 2016;7(1). doi:10.3402/ejpt.v7.29246
38. Unterhitzenberger J, Wintersohl S, Lang M, König J, Rosner R. Providing manualized individual trauma-focused CBT to unaccompanied refugee minors with uncertain residence status: a pilot study. Child and Adolescent Psychiatry and Mental Health. 2019;13. doi:10.1186/s13034-019-0282-3
39. Vickers B. Cognitive Model of the Maintenance and Treatment of Post-traumatic Stress Disorder Applied to Children and Adolescents. Clin Child Psychol Psychiatry. 2005;10(2):217-234. doi:10.1177/1359104505051212
40. Onyut LP, Neuner F, Schauer E, et al. Narrative Exposure Therapy as a treatment for child war survivors with posttraumatic stress disorder: Two case reports and a pilot study in an African refugee settlement. BMC Psychiatry. 2005;5:7. doi:10.1186/1471-244X-5-7
41. Park JK, Park J, Elbert T, Kim SJ. Effects of Narrative Exposure Therapy on Posttraumatic Stress Disorder, Depression, and Insomnia in Traumatized North Korean Refugee Youth. Journal of Traumatic Stress. 2020;33(3):353-359. doi:10.1002/jts.22492
42. Ruf M, Schauer M, Neuner F, Catani C, Schauer E, Elbert T. Narrative exposure therapy for 7- to 16-year-olds: A randomized controlled trial with traumatized refugee children. Journal of Traumatic Stress. 2010;23(4):437-445. doi:10.1002/jts.20548
43. Oras R, De Ezpeleta SC, Ahmad A. Treatment of traumatized refugee children with Eye Movement Desensitization and Reprocessing in a psychodynamic context. Nordic Journal of Psychiatry. 2004;58(3):199-203. doi:10.1080/08039480410006232
44. (PDF) EMDR Group Treatment of Children Refugees—A Field Study. ResearchGate. Published online December 9, 2024. https://www.researchgate.net/publication/333741472_EMDR_Group_Treatment_of_Children_Refugees-A_Field_Study
45. Doumit R, Kazandjian C, Militello LK. COPE for Adolescent Syrian Refugees in Lebanon: A Brief Cognitive–Behavioral Skill-Building Intervention to Improve Quality of Life and Promote Positive Mental Health. Clin Nurs Res. 2020;29(4):226-234. doi:10.1177/1054773818808114
46. Pfeiffer E, Goldbeck L. Evaluation of a Trauma-Focused Group Intervention for Unaccompanied Young Refugees: A Pilot Study. Journal of Traumatic Stress. 2017;30(5):531-536. doi:10.1002/jts.22218
47. Schottelkorb AA, Doumas DM, Garcia R. Treatment for childhood refugee trauma: A randomized, controlled trial. International Journal of Play Therapy. 2012;21(2):57-73. doi:10.1037/a0027430
48. Baker F, Jones C. The effect of music therapy services on classroom behaviours of newly arrived refugee students in Australia—a pilot study. Emotional &Behavioural Difficulties. 2006;11(4):249-260. doi:10.1080/13632750601022170
49. Kevers R, Spaas C, Derluyn I, et al. The effect of a school-based creative expression program on immigrant and refugee children's mental health and classroom social relationships: A cluster randomized trial in elementary school. American Journal of Orthopsychiatry. 2022;92(5):599-615. doi:10.1037/ort0000628
50. Eruyar S, Vostanis P. Feasibility of group theraplay with refugee children in Turkey. Counselling and Psychotherapy Research. 2020;20(4):626-637. doi:10.1002/capr.12354
51. Feen-Calligan H, Ruvolo Grasser L, Debryn J, et al. Art therapy with Syrian refugee youth in the United States: An intervention study. The Arts in Psychotherapy. 2020;69:101665. doi:10.1016/j.aip.2020.101665
52. Beehler S, Birman D, Campbell R. The Effectiveness of Cultural Adjustment and Trauma Services (CATS): Generating Practice-Based Evidence on a Comprehensive, School-Based Mental Health Intervention for Immigrant Youth. American Journal of Community Psychology. 2012;50(1-2):155-168. doi:10.1007/s10464-011-9486-2

53. Ma PWW, Torres A, Akoto MA. Feasibility, acceptability, and preliminary findings of a school-based intervention for recently arrived immigrant middle-school students. Psychology in the Schools. 2023;60(6):2072-2089. doi:10.1002/pits.22861
54. Nabors LA, Stanton-Chapman TL, Toledano-Toledano F. A University and Community-Based Partnership: After-School Mentoring Activities to Support Positive Mental Health for Children Who Are Refugees. International Journal of Environmental Research and Public Health. 2022;19(10):6328. doi:10.3390/ijerph19106328
55. Betancourt TS, Berent JM, Freeman J, et al. Family-Based Mental Health Promotion for Somali Bantu and Bhutanese Refugees: Feasibility and Acceptability Trial. J Adolesc Health. 2020;66(3):336-344. doi:10.1016/j.jadohealth.2019.08.023
56. Ellis BH, Miller AB, Abdi S, Barrett C, Blood EA, Betancourt TS. Multi-tier mental health program for refugee youth. Journal of Consulting and Clinical Psychology. 2013;81(1):129-140. doi:10.1037/a0029844
57. PG F, J R, KR B, J P. Southeast Asian refugee children: a school-based mental health intervention. International Journal of Psychiatric Nursing Research. 2005;11(1):1227-1236.
58. Mancini MA. A Pilot Study Evaluating a School-Based, Trauma-Focused Intervention for Immigrant and Refugee Youth. Child & Adolescent Social Work Journal: C & A. 2020;37(3):287-300. doi:10.1007/s10560-019-00641-8
59. Gucht KV der, Glas J, De Haene L, Kuppens P, Raes F. A Mindfulness-Based Intervention for Unaccompanied Refugee Minors: A Pilot Study with Mixed Methods Evaluation. Journal of Child and Family Studies. 2019;28(4):1084-1093. doi:10.1007/s10826-019-01336-5
60. Lan L, Liu W, Liu C, et al. Effects of Mindfulness and Life-Skills Training on Emotion Regulation and Anxiety Symptoms in Chinese Migrant Children: A Randomized Controlled Trial. Journal of Adolescent Health. 2024;75(3):404-415. doi:10.1016/j.jadohealth.2024.05.024
61. https://www.unhcr.org/external/component/header. UNHCR.