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Trauma, Displacement and Meaning-Making: A Scoping Review of Psycho-Spiritual Interventions for Refugees and Asylum Seekers

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ABSTRACT

This scoping review maps how spirituality is operationalised within trauma care for adult refugees and asylum seekers. Following Arksey and O'Malley's (2005) five-stage framework with PRISMA-ScR reporting, 5 databases were searched, and 12 studies were included. Five intervention families were identified, spanning secular meaning-centred, contemplative, faith-integrated, ritual-based and culturally integrated approaches. Across the corpus, spirituality functioned as an active mechanism of change through meaning-making, prayer and ritual, moral repair and collective belonging. The following three critical gaps were identified: the absence of safeguards against spiritual harm, the misalignment of outcome measurement with the dimensions actually targeted by the interventions and the unresolved boundaries between therapeutic, spiritual and cultural roles. Four preliminary implications for ethically grounded practice are proposed: client-led spiritual engagement; co-designed safeguarding for dual roles; community involvement in intervention design; and outcome evaluation aligned to the dimensions targeted. These are offered as provisional and intended to be tested through future empirical research.

1 | Introduction

Forced displacement worldwide has reached unprecedented levels. By the end of 2025, UNHCR reported that 117.8 million people were forcibly displaced worldwide, approximately one in every 70 people globally, including 41.6 million refugees and 9 million asylum seekers (UNHCR 2026). Many of these individuals live with layered adversities spanning pre-migration persecution and violence, perilous transit and the chronic insecurities of post-migration life. The loss of home, community, livelihood and spiritual anchors may deepen both the psychological and existential burden of displacement (Sultani et al. 2024; Tesfai et al. 2023). Even where support services are available, refugees and asylum seekers frequently report persistent distress, depression, anxiety and trauma-related difficulties that extend well beyond initial resettlement (Blackmore et al. 2020; Henkelmann et al. 2020; Sukiasyan 2024). Post-migration stressors, including family separation, barriers to employment and education and prolonged uncertainty within the asylum process, can

Abbreviations: ADAPT, adaptation and development after persecution and trauma; ATLA, American Theological Library Association (database); CBT, cognitive behavioural therapy; CINAHL, Cumulative Index to Nursing and Allied Health Literature; DBT, dialectical behaviour therapy; DSM, Diagnostic and Statistical Manual of Mental Disorders; IAT, Integrative Adapt Therapy; IPT, interpersonal therapy; ITH, Islamic Trauma Healing; MBTR-R, Mindfulness-Based Trauma Recovery for Refugees; MHPSS, mental health and psychosocial support; NGO, non-governmental organisation; PM+, Problem Management Plus; PRISMA-ScR, Preferred Reporting Items for Systematic Reviews and Meta-Analyses, extension for Scoping Reviews; PsycINFO, Psychological Information Database (American Psychological Association); PTSD, post-traumatic stress disorder; RAS, refugees and asylum seekers; RCT, randomised controlled trial; SEP, Spiritual Education Programme; SocINDEX, sociological index (EBSCO); UN, United Nations; UNHCR, United Nations High Commissioner for Refugees; WEIRD, western, educated, industrialised, rich and democratic; WHO, World Health Organization.

further intensify distress and hinder adaptation (Byrow et al. 2022). At the same time, service provision is often community-based, multilingual and resource-constrained (Sultani et al. 2024), whereas help-seeking may be shaped by stigma, mistrust of institutions, language barriers and precarious legal status (Miller and Rasmussen 2010; Priebe et al. 2016; Blackmore et al. 2020; Farhat et al. 2018).

1.1 | Who Is Regarded as a Refugee or Asylum Seeker?

Within international law, refugee and asylum seeker are juridical categories derived from the 1951 Geneva Convention and its 1967 Protocol. The Convention defines a refugee as a person who, 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country' (UN General Assembly 1951, Article 1A(2)). An asylum seeker is, by extension, an individual who has sought such protection but whose claim has not yet been determined (UNHCR 2014).

Although these classifications may appear administrative, they function as powerful social designations: they shape how displaced people are perceived, governed and responded to by states, institutions and the public, and they influence how research and services construct 'refugees and asylum seekers' as a population. What unites those grouped under these labels is therefore not cultural, psychological or experiential uniformity, but a legal status that is provisional and politically contingent and that flattens the profound diversity of biography, faith, language and trajectory into a single administrative category.

In much of the literature, refugees and asylum seekers are positioned as a single, homogeneous 'population' (Fraser and Murakami 2021). Such framing risks obscuring the profound diversity of those it names. Individuals encompassed by these labels differ markedly in language, worldview, ethnicity, gendered experience, community structures, faith traditions and the migration trajectories that shape their embodied, relational and spiritual worlds (Taheri et al. 2024). Any account of trauma care must therefore resist reducing refugees and asylum seekers to a homogeneous, deficit-oriented or pathologised category.

Therefore, a phenomenologically grounded approach is warranted, as it recognises that each displaced person lives within a distinct constellation of embodied trauma, relational history, cultural belonging and spiritual meaning-making that cannot be reduced to legal terminology alone. In some contexts, public narratives problematically recast refugees and asylum seekers as deviant, threatening or burdensome. This review acknowledges the discursive context while remaining focused on how clinical and community practices respond to the complex lived worlds of displaced people (Banks 2011; Klocker and Dunn 2003).

1.2 | Trauma and the Limits of Current Care

Across host settings, refugees and asylum seekers (RAS) present with elevated rates of PTSD, complex PTSD, depression, anxiety, psychosis and somatic distress compared with host-country populations (Charlson et al. 2019; Steel et al. 2009). Reviews also indicate increased suicidality, underscoring the need for sustained support beyond initial resettlement (Cogo et al. 2022). Although prevalence data are important for understanding the scale of psychological distress and informing service provision, there has been growing recognition that a psychiatric lens alone can narrow how distress is understood, directing attention primarily towards diagnosis and biomedical treatment of symptoms (Murphy et al. 2021; Santambrogio et al. 2025). For example, somatic manifestations of trauma, including chronic pain, autonomic dysregulation and embodied fear, are common (Morina et al. 2018). Some refugees and asylum seekers report unexplained headaches or chest pain; others present with states that may be interpreted as paranoia-like experiences (Gagliardi 2021), or with bodily disconnection, shame and dissociation (Luci and Kahn 2021; Ter Heide et al. 2024). Psychogenic nonepileptic seizures (PNES) have also been reported at elevated rates in displaced populations and account for a substantial proportion of presentations in some camp settings (Hallab and Sen 2021). Emerging work on embodied trauma therefore points to the need for transdisciplinary responses that also attend to social, cultural, relational and spiritual dimensions of suffering (O'Brien and Charura 2023; O'Brien and Charura 2024a; O'Brien and Charura 2024b; O'Brien, Charura, et al. 2024; Schaeffer and Cornelius-White 2021; Chaudhari et al. 2025).

In the mental health field, most trauma interventions for refugees and asylum seekers are designed to reduce diagnosable symptoms. Although this approach has value for standardising, scaling and evaluating treatments, it remains grounded primarily in a biomedical framework of distress that focuses on symptom reduction. In contexts of forced displacement, however, distress is often entwined with moral violation, existential rupture and spiritual struggle. Disruptions to meaning, identity continuity and moral order are therefore not adequately captured by symptom-based models alone (Camia and Zafar 2021; Watkins et al. 2018). Nickerson et al. (2018, 2022) and McEwen et al. (2022) found that moral injury, understood as exposure to or betrayal of deeply held moral beliefs, is significantly associated with mental health outcomes in refugees and asylum seekers, independent of trauma severity. Similarly, Silove (2013) and Ager and Strang (2008) showed that disruptions to meaning, belonging and identity are central to distress and recovery, yet are rarely measured or addressed in mental health work. Psycho-spiritual interventions may therefore be particularly relevant, as they are positioned to engage these dimensions of harm more directly.

Traditional trauma-informed treatment is often oriented towards resolving past events and assumes some degree of temporal closure: stabilisation, integration or return to a pre-trauma baseline. For refugees and asylum seekers, however, this temporal structure is often disrupted. Displacement is not a single, time-limited event, but an ongoing condition of structural vulnerability in which pre-migration persecution, dangers during transit and post-migration adversities overlap and accumulate rather than unfold sequentially (Sultani et al. 2024; Tesfai et al. 2023). For many refugees and asylum seekers, there is no clear or stable 'post' in post-traumatic. Ongoing post-migration stressors, including protracted asylum procedures and fear of deportation, are strongly associated with elevated PTSD, depression and anxiety and can also undermine treatment engagement and outcomes (Gleeson et al. 2020; Li et al. 2016). Recovery models that assume temporal closure therefore sit uneasily with the realities of displacement, where continuity is fractured and threat remains ongoing.

For refugees and asylum seekers, moral injury may arise through multiple and overlapping experiences. These can include witnessing atrocities, being forced to participate in violence, being unable to protect loved ones, betrayal by state institutions or trusted figures, persecution by authorities, exploitation during migration and the erosion of core values, identities and spiritual practices (Hoffman et al. 2019; Nickerson et al. 2018, 2022; McEwen et al. 2022). Forced displacement may also disrupt access to faith communities, religious practices and other sources of moral orientation, whereas prolonged uncertainty and structural dependency can erode a person's sense of agency (Schlechter et al. 2021; Mooren et al. 2022). Taken together, these experiences suggest that harm in forced displacement cannot always be understood through fear-based trauma models alone.

This underrepresentation in the evidence base may reflect the dominance of diagnostic assessment tools developed in Western, educated, industrialised, rich and democratic (WEIRD) contexts (Henrich et al. 2010), alongside a historical prioritisation of symptom reduction over meaning-making and spiritual well-being as indicators of recovery. Although forced displacement is often imagined through the lens of Western host nations, most refugees live in low- and middle-income countries, and around 65% remain in countries neighbouring their own (UNHCR 2026). Existing intervention research, however, has been concentrated largely in high-income settings (Blackmore et al. 2020), raising questions about the generalisability and cultural fit of dominant treatment models. The literature has also noted dropout and poor engagement in manualised trauma therapies among refugee populations (Nosè et al. 2017), suggesting a possible mismatch between what services offer and what displaced people experience as relevant or helpful.

Although such measures can provide valuable structure and consistency in assessment, they may not fully capture the complexity of refugees' lived experiences or the culturally embedded ways in which distress is expressed and understood. Experiences of trauma, loss, displacement and ongoing adversity may be communicated through culturally specific idioms of distress, somatic complaints, relational concerns or spiritual narratives that fall outside the categories recognised by standardised diagnostic instruments (O'Brien and Charura 2024b).

A qualitative meta-synthesis of refugees' and asylum seekers' experiences of individual psychological therapy (Khairat et al. 2023) suggests that therapeutic helpfulness is often mediated by relational safety, trust and experiences of being understood, rather than symptom reduction alone. This has particular relevance for counselling psychology, whose holistic, relational and contextual orientation offers a framework for engaging meaning-making, culture and subjectivity in trauma work that exceeds symptom-focused models (O'Brien and Charura 2024a). It is from this position that the present review proceeds.

1.3 | The Importance of Spirituality and Psycho-Spiritual Integration in Forced Displacement

If distress in forced displacement cannot be understood through symptom frameworks alone, it becomes necessary to consider the wider meaning-making systems through which refugees and asylum seekers experience suffering and recovery. Earlier psychiatric literature often associated religiosity with poorer mental or physical health outcomes when beliefs were experienced as rigid, guilt-charged or spiritually conflictual (Koenig 2012). More recent literature on refugees and asylum seekers, however, suggests that religious coping can also function as a protective resource when it supports meaning-making and resilience (Sultani et al. 2024). For example, one study found that religion served as an important source of psychological support among asylum seekers and refugees in the United Kingdom, with resilience and post-traumatic growth described alongside experiences of trauma and loss (O'Brien, Charura, et al. 2024). Religion may therefore function both as a source of protection and meaning and as a site of conflict and distress, depending on how it is experienced.

However, not all refugees and asylum seekers are religious. This review therefore uses a broader conception of spirituality, one that encompasses both religious and secular-existential frameworks of meaning. Spirituality has increasingly been recognised as an important dimension of holistic care, alongside biological, psychological and social understandings of distress (Saad et al. 2017; Sulmasy 2002) and is therefore clinically relevant to how suffering is understood and responded to.

In this review, religion or faith refers to religious traditions, beliefs, rituals, practices and authorities located within communities or institutions, such as clergy, faith leaders or scripture-guided forms of practice. Spirituality is used in a broader sense, reflecting the variability of the literature. Here, it refers to lived experiences of meaning, purpose, transcendence, connection and moral orientation, whether expressed through religious or secular-existential frameworks. This distinction is important because many refugees and asylum seekers draw on these processes to make sense of suffering, orient themselves to values and seek recovery. At the same time, integrating spirituality into therapy requires care. West (2000) cautions that Western therapists drawing on transpersonal or 'shamanic' metaphors may impose culturally incongruent frameworks or inadvertently trigger spiritual crisis. The boundaries between spirituality, religion and healing may also become blurred, raising concerns about cultural safety, power and ethical practice.

The term psycho-spiritual integration is used descriptively to refer to therapeutic approaches in which spiritual dimensions of experience are intentionally engaged within psychological care for trauma, where these dimensions are meaningful to the individual (Viftrup et al. 2013). The term does not denote a single intervention model; rather, it captures the varied ways in which meaning, values, belief systems and existential concerns may be drawn on as active resources or mechanisms of change, while remaining ethically bounded and client-led.

Yet, despite this recognised relevance, spirituality is seldom assessed or engaged with in routine therapy (Vieten et al. 2023;

Milner et al. 2019), even though the significance of meaning-making, coping and spiritual struggle for many refugees and asylum seekers is well documented (Paudyal et al. 2021; Shannonhouse et al. 2024). Given that most international migrants worldwide are religiously affiliated, it is likely that host-country services regularly encounter clients for whom faith or spirituality is clinically salient. Even so, these dimensions remain largely peripheral to mainstream intervention design and outcome measurement.

This gap is structurally produced. Milner et al. (2019) describe the distance between recognising spirituality's importance and engaging with it in practice as a 'religiosity gap'. Vieten et al. (2023) found a growing consensus that practitioners should be trained in spiritual competencies; however, such training remains largely absent from professional programmes (Pearce et al. 2024). Guidance from professional bodies internationally remains limited, with major ethical frameworks either omitting spirituality altogether or referring to it only briefly, without offering guidance on how spiritual issues might be engaged with constructively. In this context, practitioner uncertainty is unsurprising; it is produced, at least in part, by the structures within which practice is organised (Barnett and Johnson 2011; Poole et al. 2024).

1.4 | Rationale for This Scoping Review

A body of research on spirituality and psycho-spiritual interventions in trauma care with refugees and asylum seekers has developed in recent years (Al-Nuaimi and Qoronfleh 2022; Maier et al. 2022); however, the field remains difficult to bring together. Studies use different terms, draw on different theoretical frameworks and vary widely in design and scope. More importantly, it is not always clear what is being counted as a psycho-spiritual intervention in this context, or how such work is being understood across studies. A review is therefore needed to map the range of interventions that have been empirically described or evaluated with refugees and asylum seekers and to clarify how spirituality and psycho-spiritual integration are being conceptualised in the literature. It is also important to examine how ethical issues are addressed, and which populations, settings and spiritual traditions are represented.

Existing reviews of refugee mental health interventions have predominantly focused on psychosocial and psychological treatments for DSM-defined trauma symptoms (Tribe et al. 2019), unmet needs and resettlement barriers (Ghahari et al. 2020), broader integration outcomes (Namata et al. 2025) or embodied trauma and practitioner perspectives (O'Brien and Charura 2023). Although these reviews map important aspects of the intervention landscape, none has specifically examined psycho-spiritual integration, interventions that engage spirituality and moral injury as primary therapeutic dimensions. This gap is significant given growing recognition that, for many refugees and asylum seekers, distress is bound up with disrupted meaning, spiritual rupture and moral injury that fall outside the conceptual reach of symptom-focused frameworks.

Counselling psychologists and the wider multidisciplinary teams surrounding refugees and asylum seekers regularly encounter spiritual and existential material in assessment, formulation and therapeutic work, yet have little synthesised evidence to guide whether and how to engage it. Clarifying what psycho-spiritual integration looks like in practice, and where its ethical risks lie, is a necessary step towards responsive, safe and culturally grounded care.

Given the early and varied state of the evidence base, a scoping review was considered the most appropriate approach (Munn et al. 2018). The purpose of this review is to map the field rather than to determine effectiveness. A systematic review would require greater comparability in intervention design and outcomes than the literature currently allows, whereas a narrative review would offer less transparency in search and charting procedures.

1.5 | Review Aims

The aim of this scoping review is to map psycho-spiritual interventions for adult refugees and asylum seekers in the empirical trauma care literature, clarifying how spirituality is operationalised within them, across clinical, community, faith-based and camp or settlement settings.

1.6 | Objectives

1. Identify the types of psycho-spiritual interventions used with refugees and asylum seekers experiencing trauma.
2. Examine how psycho-spiritual interventions are operationalised, including the proposed mechanisms or therapeutic processes of change described across studies.
3. Map providers, settings and modes of delivery.
4. Summarise reported outcomes, implementation issues and ethical and safeguarding considerations.

2 | Methods

This scoping review followed Arksey and O'Malley's (2005) five-stage framework and is reported in line with the PRISMA-ScR checklist (Tricco et al. 2018).

This specific review proceeded through the following five stages: (1) identifying the research question; (2) identifying the relevant literature; (3) selecting the studies; (4) charting the data; and (5) collating, summarising and reporting the results.

2.1 | Stage 1: Identifying the Research Questions

The research questions identified for this scoping review, after Tricco et al. (2018), were as follows:

What psycho-spiritual interventions are used with adult refugees and asylum seekers experiencing trauma, and how are they conceptualised and operationalised?

Sub-questions.

- Which intervention families are reported and how is spirituality operationalised (e.g., meaning/purpose; transcendence/numinous; belonging/identity; moral repair; prayer/ritual; chaplaincy/pastoral; and explicitly spiritual embodied practices)?

- Who delivers interventions (counsellors/psychologists; chaplains/faith leaders; and peers/NGO staff) and where (clinical; community/faith; camp/settlement; and online)?
- Which outcomes are reported (symptoms; meaning/spiritual wellbeing; belonging/integration; moral repair; engagement; and acceptability/feasibility)?
- What safeguards/ethical practices are described to support safe and acceptable delivery (consent/choice and language-matching)?
- To what extent does the evidence reflect local authorship/leadership, local adaptation/development, Global-South origins, community/faith delivery and low-resource contexts?

2.2 | Stage 2: Identifying the Relevant Literature

The following electronic databases were searched for this scoping review to ensure coverage of the literature: Web of Science; PsycINFO; SocINDEX; CINAHL Ultimate; and ATLA Religion with AtlaSerials.

2.2.1 | *Search Strategy*

Strings were built from three lists (see Table 1).

2.2.2 | *Selection Criteria*

The following selection criteria were applied to the results by characteristics (see Table 2).

2.3 | Stage 3: Selecting the Studies

Records retrieved from each database (see Figure 1) were downloaded in RIS format and imported into the review software Rayyan. Duplicate records were identified and removed in accordance with Cochrane guidance (Deeks et al. 2008).

TABLE 1 | Search terms.

Concept	Search terms (combined within concept with OR)
Population (refugees/asylum seekers)	refugee* OR 'asylum seek*' OR asylee* OR 'forced migrant' OR displaced OR 'forcibly displaced'
Spirituality	spiritual* OR relig* OR faith* OR 'faith-based' OR chaplain* OR pastoral OR 'spiritual care' OR 'spiritually integrat*' OR 'spiritually inform*'
Intervention/mental health	therap* OR counsel* OR 'mental health' OR psychosocial OR 'psychological support' OR 'support group'OR 'group intervention' OR 'community intervention*' OR PTSD OR 'trauma focused' OR 'post-traumatic growth' OR 'social support' OR 'moral injur*' OR 'trauma healing' OR 'spiritual-psycho-social support'

Note: The three concept blocks were combined with AND (Concept 1 AND Concept 2 AND Concept 3), adapted to each database's syntax. Limits: English language; 2015–2025.

Screening was conducted in two stages: title and abstract screening, followed by full-text review.

At the first stage, titles and abstracts were screened against the broad population–concept–context criteria (Table 2). Screening was undertaken by the primary reviewer, who classified records as include ('Y'), exclude ('N') or uncertain ('Maybe'), with reasons recorded for exclusions. Where eligibility could not be determined from the title and abstract alone, the full text was retrieved to minimise the risk of false exclusion.

At the second stage, full texts were assessed against the full inclusion and exclusion criteria. To strengthen rigour, a calibration sample of approximately 15–20% of titles and abstracts, together with a small number of full texts, was independently screened by the second author and verified by the third and last author. Any discrepancies were discussed, and the eligibility criteria were refined for clarity before the remaining records were screened. The study identification, screening, eligibility and inclusion process are presented in a PRISMA-ScR flow diagram (Figure 1). (The raw data for all the studies are provided through this link https://figshare.com/s/fd108f389da893fb6cae for peer-review purposes.) A new link will be provided for the public once the article is accepted for publication.

2.4 | Stage 4: Charting the Data

The findings were organised around three overarching dimensions: amount, where and with whom psycho-spiritual interventions have been studied; focus, how spirituality is operationalised within them; and nature, who delivers them, where, and with what outcomes.

2.5 | Stage 5: Collating, Summarising and Reporting the Results

A descriptive summary was produced from the extracted data in Excel using pivot tables. The aim was to provide an overall account of the main characteristics of the included studies in relation to the review questions, rather than a formal quantitative synthesis such as meta-analysis. Particular attention was given to how interventions engaged themes such as meaning-making, religious and spiritual coping, moral repair, embodied practice, community belonging and cultural identity.

Consistent with the scoping review framework (Arksey and O'Malley 2005), the collating and reporting stage drew on thematic synthesis (Thomas and Harden 2008), applying the principles of thematic analysis (Braun and Clarke 2006, 2019) to the findings reported across the 12 included studies. Rather than remaining at the level of study characteristics, the synthesis focused on the nature and mechanisms of psychological change through which spirituality was operationalised across the interventions.

Through coding and constant comparison across studies, these mechanisms of change were grouped into broader analytical themes, from which the five intervention families reported in this review were derived. Coding was carried out manually in Microsoft Excel, without qualitative analysis software such as NVivo. To strengthen rigour, the extracted data were reviewed

TABLE 2 | Inclusion and exclusion selection criteria (population–concept–context + limits).

Criterion	Inclusion criteria	Exclusion criteria
Population	Adults (18+) refugees or asylum seekers. All nationalities, religions, genders and sexual orientations included. No geographic restrictions	Children/adolescents < 18 years; nondisplaced populations. Migration for economic opportunity (without persecution/protection claim)
Concept	Psycho-spiritual interventions with an explicit mental-health/psychological aim that intentionally engage spirituality (meaning/purpose, transcendence/numinous, spiritual belonging/identity and moral orientation/repair) OR enact spirituality through embodied or ritual practices (e.g., ceremonial, art-based or culturally framed approaches) as part of care	Purely psychological interventions without spiritual/existential component (standard CBT/DBT/IPT); purely religious activities without therapeutic intent (worship attendance and religious education); biomedical/pharmacological interventions without psycho-spiritual content
Context	Clinical services (mental health clinics, counselling centres, hospital-based programmes); community/faith organisations; refugee camps/settlement programmes; online services explicitly linked to one of the above	Purely educational settings; websites/apps without clinical oversight; services in nonhumanitarian contexts (e.g., workplace spirituality programmes); residential rehabilitation without mental health focus
Type of studies	Empirical quantitative, qualitative or mixed method; pilot/feasibility study; conceptual papers with empirical grounding; community-based participatory research	Systematic/scoping reviews and meta-analyses (only used for study identification but not charted to avoid double-counting). Review articles or primary research that do not consider RAS populations
Outcomes (not required for inclusion but charted if present)	Any outcomes related to psychological/mental health (symptoms, meaning/spiritual wellbeing, belonging/integration, moral repair, engagement/retention; acceptability/feasibility)	—
Type of publication	Published peer-reviewed journal articles; curated grey literature (e.g., NGO/UN reports) describing or evaluating an eligible intervention	Opinion editorials; letters to the editor; dissertations without peer review; studies without access to full text
Language	English language (because of lack of translation capacity)	Non-English language
Publication Date	2015–2025	Articles before 2015

independently by the first author and then the third author, and the emerging themes were refined through comparison of similarities and differences across studies.

3 | Results

3.1 | Overview of Included Studies

Twelve studies met the inclusion criteria for this scoping review. The studies were published between 2015 and 2025, reflecting a relatively recent and emerging body of work about psycho-spiritual and existential dimensions within interventions for refugees and asylum seekers experiencing trauma.

Geographically, studies were conducted across various contexts, including Malaysia, Israel, the United States, the United Kingdom, Finland, Bangladesh (Cox's Bazar refugee camps) and multiple European refugee camps. Delivery settings include community centres, refugee camps, mosques, outpatient clinics and temporary accommodation.

The methodological designs were heterogeneous: three randomised controlled trials (Integrative Adapt Therapy; Mindfulness-Based Trauma Recovery; and a lay-led trial of Islamic Trauma Healing), two feasibility or pilot studies (an earlier feasibility study of Islamic Trauma Healing; culturally adapted PM+), three qualitative or case studies (art therapy and mindfulness; culturally integrated dreamwork; an Islamic counselling case study), one implementation study (a lay-counsellor delivery study), one programme-description paper (a mosque-based Islamic trauma therapy) and two community-based programme evaluations (collective ritual in Cox's Bazar; a spiritual psychoeducation programme). Together these comprise the 12 included studies. One study (Farah 2025) was a master's thesis rather than a peer-reviewed journal article, included as curated grey literature meeting the eligibility criteria.

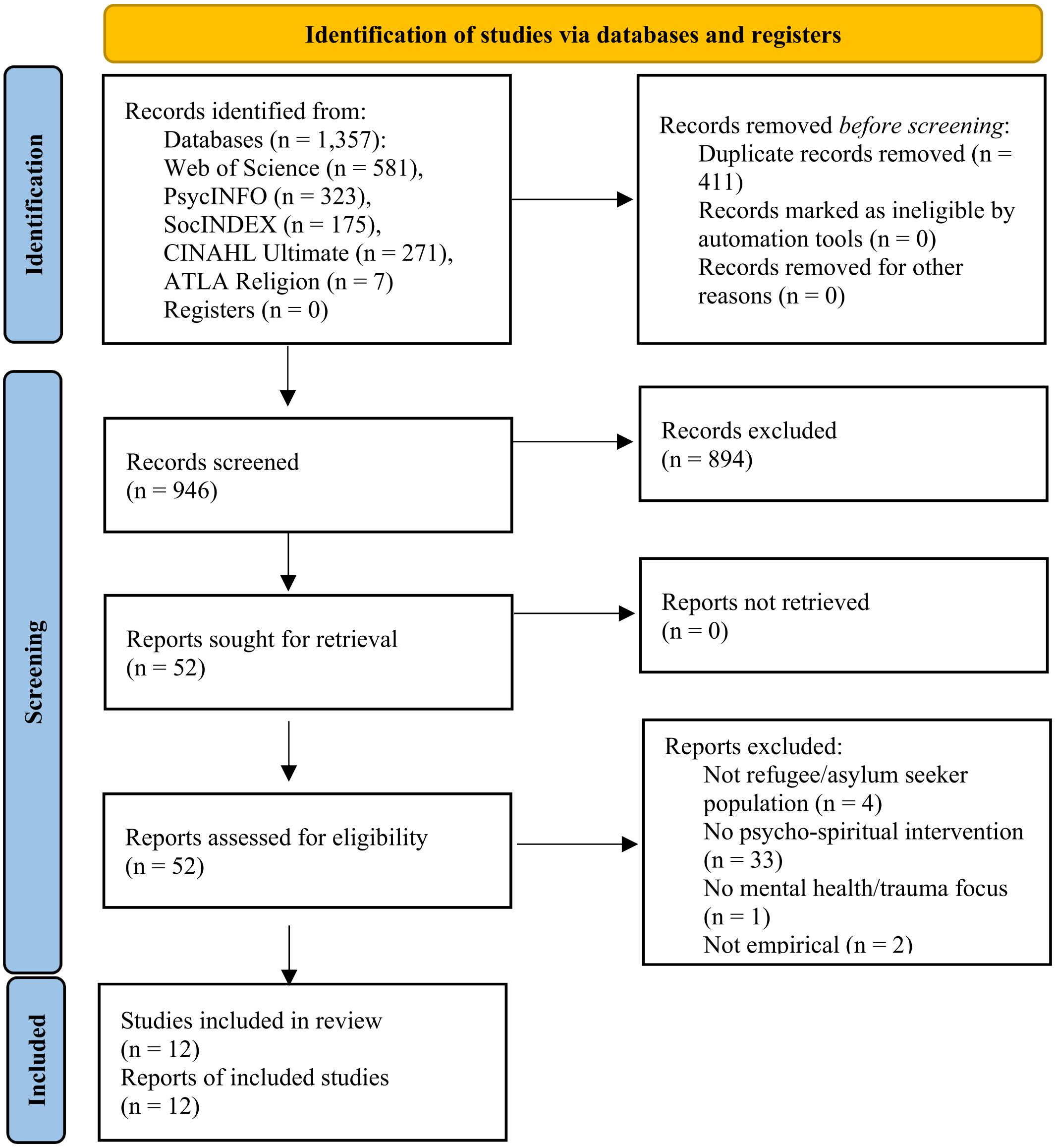

FIGURE 1 | PRISMA-ScR flow diagram of the study selection process. *Source:* Page et al. BMJ 2021; 372:n71. https://doi.org/10.1136/bmj.n71.

Across the studies, delivery models varied substantially. Interventions were facilitated by lay refugee counsellors, trained nonspecialists, faith leaders, spiritual organisation trainers, clinical psychotherapists and Mental Health and Psychosocial Support (MHPSS) practitioners. Several interventions explicitly adopted task-shifting approaches to increase accessibility in low-resource contexts (see Table 3).

3.2 | Focus of Research

The focus of the included studies centred on different models of psycho-spiritual intervention.

Five broad intervention families were identified.

3.2.1 | *Secular Existential and Meaning-Centred Trauma Therapies*

First, existential or meaning-centred trauma therapies were represented by models such as Integrative Adapt Therapy, structured narrative-based trauma interventions delivered by trained lay counsellors (Tay et al. 2019, 2020). IAT conceptualised trauma as a broader, chronic disruption of adaptive responses, building on Silove's ADAPT model, which includes meaning, identity and social coherence. Spiritual or existential dimensions were operationalised primarily through narrative reconstruction, meaning-making and the restoration of autobiographical continuity rather than through explicit religious practice.

3.2.2 | *Contemplative and Affect-Regulation Interventions*

Second, contemplative interventions grounded in mindfulness and compassion practices addressed trauma-related distress and, in some instances, moral injury. Models such as MBTR-R, art therapy combined with mindfulness workshops and the Spiritual Education Programme (Kalmanowitz and Ho 2017; Bernstein et al. 2025; Pandya 2018) operationalised psycho-spiritual engagement through structured contemplative exercises: mindfulness practice, loving-kindness meditation, compassion cultivation, breathing techniques and guided

TABLE 3 | Summary characteristics of included studies ($N = 12$).

Author (Year)	Country/setting	Design	Sample	Intervention family	How spirituality is operationalised	Reported outcomes
Tay et al. (2020)	Malaysia (urban/community)	Single-blind RCT	$N = 331$ (170 IAT, 161 CBT)	Secular existential; IAT (ADAPT/CBT-based)	ADAPT pillars; contextualised meaning-making	PTSD, CPTSD, depression, anxiety and prolonged grief reduced; adaptive stress across ADAPT pillars (including existential meaning) and resilience improved
Tay et al. (2019)	Malaysia (community)	Implementation/descriptive	12 Rohingya lay counsellors (focus-group implementation study) + 115 Rohingya clients receiving IAT over 6 months	Secular existential; IAT (ADAPT-based)	ADAPT pillars; logotherapy-informed meaning-making	Counsellor-reported gains in fear and safety, relationships, anger and justice, roles and identity and sense of purpose and meaning (ADAPT pillars); implementation feasible
Kalmanowitz and Ho (2017)	Hong Kong (studio/NGO-linked)	Qualitative phenomenological study	$N = 12$	Art therapy + mindfulness (Inhabited Studio)	Mindfulness; meaning and identity; faith-responsive coping	Qualitative gains in self-regulation, communication, imagination, resilience and worldview
Bernstein et al. (2025)	Israel (community)	Single-blind RCT	$N = 158$	Mindfulness/compassion (MBTR-R)	Moral injury; shame; mindful compassion	PTSD and depression reduced; effects mediated by shame and anger, with MBTR-R moderating the moral injury to anger to symptom pathway
Noor and Maynard (2023)	UK (hotel/temporary accommodation, then resettlement)	Case study	$N = 1$	Faith-integrated Islamic counselling	Prayer; relationship with God; spiritual reframing; Muslim identity	Descriptive improvement in safety, grounding and symptoms over 12 weeks; relapse after disrupted resettlement and a break in care

(Continues)

TABLE 3 | (Continued)

Author (Year)	Country/setting	Design	Sample	Intervention family	How spirituality is operationalised	Reported outcomes
Bentley et al. (2021)	USA (mosque/community)	Programme description	$N = 41$	Faith-integrated Islamic (+exposure/CBT)	Prophet narratives; dua as imaginal exposure; Qur'anic meaning; community belonging	Large pre–post reductions in PTSD, depression and somatic symptoms; improved wellbeing; high faith congruence and acceptability
Zoellner et al. (2018)	USA (Somali refugee community; mosque and community centre)	Feasibility/pilot (community survey + uncontrolled pre–post)	Study 1($N = 39$) study 2($N = 13$)	Faith-integrated Islamic (+exposure/CBT)	Dua; prophet narratives; Islamic values (patience, trust)	High community need for and interest in trauma-healing groups; large pre–post reductions in PTSD, depression and somatic symptoms; improved wellbeing and high faith congruence
Zoellner et al. (2024)	USA (Seattle and Columbus; mosques + virtual groups)	Single-blind RCT	$N = 11$	Faith-integrated Islamic; ITH (lay-led)	Prophet narratives and Qur'anic verses; dua; mosque-based belonging	Feasible, lay-led, mosque-embedded faith-integrated trauma-focused group; high fidelity and retention; rated highly consistent with religious and cultural practice
Rebolledo (2019)	Bangladesh (Cox's Bazar camps; multiple settlements)	Programme report + focus group evaluation (no control)	$N = 850$	Community ritual (Mental Health and Psychosocial support (MHPSS))	Collective ritual, music and art; identity and belonging	Qualitative gains in calmness, solidarity, coping, social support, identity and hope; more participants able to recognise personal strengths.
Schubert and Punamäki (2016)	Finland (refugee outpatient clinic)	Case study	$N = 2$	Culturally integrated (dreamwork)	Dreams as ancestral communication; cultural-religious meaning	Nightmares reduced or ceased and PTSD symptoms decreased; clients gained new meaning and agency while retaining spiritual and cultural dream beliefs

(Continues)

TABLE 3 | (Continued)

Author (Year)	Country/setting	Design	Sample	Intervention family	How spirituality is operationalised	Reported outcomes
Farah (2025)	USA (King County, WA; community setting via Neighbourhood House)	Mixed-methods acceptability study	$N = 10$	Faith-integrated Islamic (PM+)	Dua; Prophetic problem-solving; sabr and tawakkul	High acceptability, appropriateness and feasibility of Islamic adaptations; faith integration experienced as strengthening therapeutic techniques
Pandya (2018)	Europe (38 camps across 9 countries)	Pre–post experimental study (no control)	$N = 4504$	Spiritual psychoeducation (SEP)	Meditation; mindfulness (spirituality asserted and thinly operationalised)	Trauma screening scores lowered; optimism and mental health improved; self-practice predicted better mental health outcomes

self-reflection. The emphasis fell on affect regulation, reduction of negative emotional states such as shame, anger and distress and the cultivation of self-awareness and relational consciousness. Although these approaches engaged moral and existential dimensions of suffering, their mechanisms were predominantly experiential and self-regulatory.

3.2.3 | *Faith-Integrated (Islamic) Trauma Therapies*

Third, faith-integrated trauma interventions incorporated Islamic theological concepts within structured psychological models. Islamic Trauma Healing, culturally adapted PM+ and Islamic counselling (Noor and Maynard 2023; Bentley et al. 2021; L. A. Zoellner et al. 2018; L. Zoellner et al. 2024; Farah 2025) each integrated structured trauma memory processing—including imaginal exposure.

3.2.4 | *Ritualised Collective Healing (MHPSS) Interventions*

Fourth, ritualised collective psychosocial interventions engaged symbolic and cultural practices within Mental Health and Psychosocial Support (MHPSS) frameworks. In the Cox's Bazar healing ceremonies programme (Rebolledo 2019), the therapeutic vehicle was collective ritual itself: communal music, songs, art, embroidery, henna and collective storytelling were used to explore identity ('who are we?') and to process grief and displacement through shared symbolic expression. Psychospiritual engagement was operationalised through the restoration of cultural memory and communal belonging rather than through individual symptom processing. The emphasis was on collective meaning-making, historical trauma narratives and the re-establishment of community coherence within camp settings.

3.2.5 | *Culturally Integrated Psychotherapies*

Fifth, culturally integrated psychotherapies incorporated spiritual cosmologies within individual therapeutic processes. In the dream-based intervention (Schubert and Punamäki 2016), trauma-related nightmares were explored through culturally meaningful symbolic frameworks that included ancestor imagery and ritual enactment. Spiritual and cultural meaning systems were woven into structured psychotherapy to facilitate trauma processing at the level of individual identity and personal narrative, rather than through collective-ritual participation.

The included studies, read as a body of work, demonstrate that psycho-spiritual engagement within refugee trauma interventions operates through multiple structurally distinct pathways: narrative meaning reconstruction, contemplative affect regulation, faith-integrated trauma processing, ritualised collective symbolic practice and culturally integrated individual psychotherapy. Across these pathways, embodied and contemplative modalities—art-making, music, ritual enactment and mindfulness meditation—recurred as the means through which spiritual meaning, ritual or belonging were engaged; these functioned as delivery modalities rather than as distinct psycho-spiritual mechanisms in their own right.

Read across the five families, the matrix of mechanisms engaged (Table 4) reveals patterns that the family groupings alone obscure. Two mechanisms recurred regardless of intervention

TABLE 4 | Psycho-spiritual mechanisms engaged across the 12 included Studies.

Study	Intervention family	Meaning-making	Prayer/ritual	Moral repair	Belonging/identity	Transcendence/numinous
Tay et al. (2020)—IAT	Secular existential	✓			✓	
Tay et al. (2019)—IAT implementation	Secular existential	✓		✓	✓	
Kalmanowitz and Ho (2017)	Contemplative/relational	✓	✓		✓	
Bernstein et al. (2025)—MBTR-R	Contemplative/relational			✓		
Noor and Maynard (2023)	Faith-integrated (Islamic)	✓	✓		✓	✓
Bentley et al. (2021)—ITH	Faith-integrated (Islamic)	✓	✓	✓	✓	
L. A. Zoellner et al. (2018)—ITH	Faith-integrated (Islamic)	✓	✓		✓	
L. Zoellner et al. (2024)—ITH	Faith-integrated (Islamic)	✓	✓		✓	
Rebolledo (2019)—community ritual	Community ritual	✓	✓		✓	
Schubert and Punamäki (2016)	Culturally integrated (dreamwork)	✓	✓			
Farah (2025)—PM+	Faith-integrated (Islamic)	✓	✓			
Pandya (2018)—SEP	Contemplative/relational					
Studies (n)		10	8	3	8	1

Note: A tick indicates that the mechanism was operationalised or explicitly theorised as a working component of the intervention, rather than merely implicitly present. Mindfulness-based and arts-based or embodied components (e.g., meditation, art-making and ritual arts) appeared in several interventions but functioned as delivery modalities rather than distinct psycho-spiritual mechanisms and are therefore not charted here.

family: meaning-making, engaged in 10 of the 12 studies, and prayer or ritual, in 8—present in secular existential, contemplative, faith-integrated and collective-ritual interventions alike. Belonging and identity were similarly widespread (eight studies), whereas moral repair was engaged in only three. Most notable was an asymmetry around the transcendent or numinous. Prayer to God or Allah always involves a relationship with the divine, so this relational dimension was present wherever prayer occurred. What differed was whether that relationship was itself treated as a mechanism of change, or whether prayer served other ends, petition, coping or, in the Islamic Trauma Healing models, a reframed form of imaginal exposure. Only one study (Noor and Maynard 2023) theorised the relationship with the divine as the working mechanism. Across the corpus, the interventions converged on a narrow band of mechanisms, chiefly the reconstruction of meaning and the practice of prayer or ritual, with the transcendent dimension the least operationalised.

3.3 | Nature of Research

3.3.1 | *Ethics and Safeguarding*

The nature of the research on psycho-spiritual interventions reflected diversity in delivery structures and in approaches to ethical safeguards. Structured clinical trials and manualised interventions such as Integrative Adapt Therapy and MBTR-R reported detailed procedural safeguards: institutional ethical approval, informed consent processes, structured facilitator training, supervision frameworks and, in some cases, formal risk assessment and referral protocols for suicidality or acute distress. These studies described trauma-sensitive delivery procedures and clearly delineated facilitator roles within defined therapeutic boundaries.

In faith-integrated and community-based interventions, safeguarding practices were also described, though they took varied forms. Islamic Trauma Healing and culturally adapted PM + outlined structured lay-leader training, supervision by mental health professionals and gender-sensitive group organisation within mosque settings; these models emphasised integrating religious authority within psychologically informed frameworks rather than offering unstructured devotional practice. Community ritual programmes reported facilitated group processes within Mental Health and Psychosocial Support (MHPSS) structures, including structured session design and attention to group safety; however, formalised risk management procedures were less consistently detailed than in the clinical trials.

3.3.2 | *Community and Participant Involvement and Cultural Adaptation*

Task-shifting models were prominent in low-resource or camp-based settings. Several interventions were co-designed with refugee communities or delivered by trained refugee lay counsellors. When researcher- or institution-led, delivery was often community-based or emphasised the adoption of community, cultural and collective narratives. When clinic-based and therapist-led, the interventions still explicitly used clients' own cosmologies and symbolic systems as central material.

3.3.3 | Reported Outcomes

Outcome measurements vary across studies, reflecting the heterogeneity of intervention models and conceptualisations of psycho-spiritual engagement. Quantitative trials primarily assess reductions in PTSD, depressive symptoms and related distress indicators; MBTR-R explored moral injury-related constructs, such as shame and anger. Other studies reported subjective improvements in wellbeing, optimism, relational functioning, belonging and identity coherence, as well as indicators of acceptability. For example, Faith-integrated and contemplative interventions used measures of feasibility and participant satisfaction. For qualitative phenomenological and case studies, outcomes were reported as reduced nightmare frequency, enhanced coping and restored sense of grounding.

4 | Discussion

4.1 | Overview of Key Findings

This scoping review mapped how, and through which mechanisms, spirituality is operationalised in trauma care for adult refugees and asylum seekers. The findings show both shared patterns across the corpus and notable absences.

The discussion that follows interprets the findings across the following four main areas: the pluralism of mechanisms observed across intervention families; the gaps identified in safeguarding, outcome measurement and role boundaries; preliminary implications for ethically grounded practice drawn from patterns and absences in the corpus; and the reflexive and epistemic limitations of the review itself, followed by implications for future research and counselling psychology practice.

4.2 | Pluralism of Mechanisms and Different Conceptualisations of Meaning-Making, Healing, Resettlement and Recovery

This scoping review identified five broad intervention families across the 12 studies: secular existential or meaning-centred trauma therapies, contemplative affect-regulation interventions grounded in mindfulness and compassion, faith-integrated trauma therapies drawing on Islamic theological concepts, ritualised collective healing interventions and culturally integrated psychotherapies informed by clients' spiritual cosmologies. These families differ not only in form but also in the point at which spirituality enters the therapeutic process. In some approaches, spirituality is explicitly addressed through theological concepts, ritual or faith practice. In others, it is engaged more indirectly through meaning-making, compassion, embodied regulation, cultural identity or communal belonging.

In existential and meaning-centred models such as Integrative Adapt Therapy, the primary therapeutic work centres on contextualising the experiences of conflict, distress and displacement within the ADAPT five-pillar framework. The emphasis is less on formal religious content than on restoring narrative coherence and meaning within the pillars to address the disruption of identity and purpose in the face of forced displacement (Park 2010; Silove 2013).

Contemplative models engage moral emotions, including shame, anger and guilt, through experiential and self-regulatory practices, while also cultivating relational awareness. Faith-integrated interventions, by contrast, embed theological constructs and religious coping, such as sabr, tawakkul and du'a (Abu-Raiya and Pargament 2011), within structured trauma memory processing and spiritual trauma reframing. In the Cox's Bazar healing ceremonies programme (Rebolledo 2019), the therapeutic vehicle is collective ritual itself: communal symbolic expression, collective memory and historical trauma narratives, rather than individual processing. However, in culturally integrated psychotherapy, the client's own cosmological system, including ancestor imagery and ritual enactment, provides the material through which trauma is processed at the level of individual subconsciousness and personal narrative (Schubert and Punamäki 2016).

It is important to state that these five listed families should not be understood as a rigid taxonomy or as competing models of psycho-spiritual intervention. Rather, they reflect the reality that forced displacement disrupts multiple dimensions of human experience, affect regulation, narrative coherence, moral order, communal and relational belonging and transcendence. Depending on the individual, the community and the displacement context, different dimensions may be foregrounded as most salient to an individual's distress and recovery. As noted in Section 1, individuals who fall under the RAS population differ greatly in language, worldviews, ethnicity, faith traditions and migration journeys (Taheri et al. 2024), and it is therefore essential to resist collapsing this heterogeneity into a single manualised model. For example, a Rohingya community engaged in collective healing ceremonies in Cox's Bazar is not undertaking the same therapeutic process as an individual Muslim client in a UK outpatient clinic processing traumatic memories through theological reframing; however, both are legitimately psycho-spiritual in that spiritual material is doing therapeutic work within the intervention. This review therefore suggests that this pluralism is an appropriate and necessary feature of the field, not a limitation requiring resolution (Kirmayer 2012).

Having noted this pluralistic operational mechanism, several observations about its character and implications warrant further consideration. Islamic faith-integrated models account for 5 of the 12 reviewed studies, making this the most represented religious tradition in the corpus. This likely reflects the demographic reality that several of the largest displaced populations are Muslim-majority. It does not, the authors stress, mean that other faith traditions—Christian, Hindu, Buddhist and indigenous spiritual systems—or nonreligious existential frameworks are irrelevant; rather, it signals a gap in the literature that future research should address, given that spirituality and faith-based coping have been documented across diverse displaced populations (Sultani et al. 2024; Lusk et al. 2021). Shannonhouse et al. (2024), for example, reported that Christian faith was experienced as a key coping resource for refugees, with participants practising trust in God and meaning-making alongside spiritual struggle and growth. Reviews of traditional and indigenous healing similarly report rich magico-religious and ritual practices that addressed psychological distress through symbolic transference and cognitive restructuring (Pham et al. 2021). Yet, these studies primarily concern refugees' own coping practices rather than how mental health practitioners actively engage such spiritual material within the intervention context itself. How practitioners respond to and work with these populations therefore remains underexplored, and competence in this area is limited.

Existing conceptualisations in the literature often give little attention to non-Western, indigenous, diasporic and syncretic spiritual systems, for example, African cosmologies, folk healing traditions and Vodou, despite their significance in many displaced communities (Rose and Kalathil 2019; Moodley 2007). This pattern reflects a broader Eurocentric tendency to privilege institutionalised or Westernised forms of spirituality, while paying less attention to culturally embedded, community-based frameworks. Faith leaders, community elders and traditional healers may hold central roles in displaced communities; however, their contributions are often marginal within academic accounts, producing a divide between what is recognised as clinical and what is treated as cultural or informed healing. From this perspective, a decolonial lens is useful not as a political add-on, but as an ethical and epistemic tool for examining how certain forms of knowledge, suffering and healing come to be authorised within counselling psychology and psychotraumatology, whereas others remain peripheral or unheard (O'Brien and Charura 2023; Mills 2014).

4.3 | Importance of Methodological Pluralism

This scoping review also revealed that methodological conventions can shape which psycho-spiritual interventions become visible and credible within the evidence-based literature. Across the 12 studies, the interventions that were methodologically designed as randomised controlled trials and feasibility studies were the ones that could be standardised and evaluated through individual outcome measures. The IAT and mindfulness-based Trauma Recovery lent themselves to RCT design because their mechanisms could be operationalised within a structured protocol and measured through validated instruments for PTSD and depression. However, other forms of psycho-spiritual practice identified in this review were documented through qualitative, descriptive or programme evaluation methods. In these studies, they engaged with symbolic expression, communal participation, ancestral cosmology and cultural integration, which, as therapeutic processes, tend to be relational, situated and idiosyncratic by nature and do not lend themselves to manualisation or measurement through individual symptom reduction.

The psycho-spiritual intervention mechanisms identified in this review do not appear to work through a single pathway. It follows that the methodological approaches used to understand and evaluate them may also need to be plural. This argument is consistent with wider debates in psychotraumatology and global mental health, where scholars have questioned whether culturally grounded, community-based and context-sensitive interventions can be adequately understood through manualised controlled designs alone (van Ommeren et al. 2015; Summerfield 2001). When such designs are treated as the primary standard of evidence, they may lend legitimacy to certain forms of intervention while pushing others to the margins of the evidence base, particularly those grounded in collective ritual, oral tradition, relational healing or cosmologies of suffering and recovery. Trauma in displaced populations is not only intrapsychic; it is fundamentally relational, affecting communal bonds, moral worlds and shared systems of meaning. Healing may therefore take place through community, relationships, shared narrative and practices that are not isolated into discrete, measurable components. Therefore, a broader methodological approach, such as participatory research, ethnographic case study, practice-based evidence and community-defined outcome measures alongside controlled trials, should be included if the evidence base is to reflect the range of healing practices used in displaced communities.

4.4 | Gaps in Safeguarding, Measurement and the Naming of Spiritual Harm

What this scoping review has not found warrants equal attention to what it has found. The mapping revealed a significant absence in three areas, each carrying direct implications for the ethical practice of psycho-spiritual work with displaced populations: the recognition of spiritual harm as a distinct category of risk, the adequacy of outcome measurement and the clarity of boundaries between therapeutic and religious roles.

4.4.1 | Spiritual Harm as an Unaddressed Risk

Across the reviewed studies, psychological safeguards were described with varying levels of detail. Structured clinical trials and manualised interventions—Integrative Adapt Therapy and MBTR-R—reported institutional ethical approval, informed consent processes, structured facilitator training, supervision frameworks and, in some cases, formal risk assessment and referral protocols for suicidality or acute distress. Faith-integrated and community-based interventions also described safeguarding measures, including lay-leader training, supervision by mental health professionals, and gender-sensitive group organisation (Islamic Trauma Healing; culturally adapted PM+).

However, what was notably absent throughout the corpus was explicit attention to spiritual harm in the context of incorporating spirituality in therapy. No study in the corpus engaged with the term 'spiritual harm' or offered a framework for 'recognising', 'preventing' or 'responding' to it. There are adjacent constructs that exist in the wider literature, such as 'spiritual struggle' (Exline and Rose 2013), spiritual abuse (Oakley and Kinmond 2014) and existential and spiritual dimensions of trauma. This might be salient in displaced contexts, where individuals may be experiencing disrupted faith, moral injury, spiritual struggle, loss of spiritual community or questioning of previously held beliefs about divine justice (Donovan et al. 2025; Potts and Abadal 2023), this might be experienced as a collapse of spiritual meaning as qualitatively different from 'symptoms', even sometimes they co-occur with anxiety or depression.

This concern has been raised in the broader spirituality and therapy literature. In reviewing spirituality and religion in psychiatric care, Dein reflected on how religious coping can undermine mental health through negative forms, for example, viewing suffering as religious punishment or reappraising God's power (Dein 2018), which are associated with poor mental health. His findings pointed out the need for mental health professionals to distinguish between positive and negative coping, as this could link to guilt and spiritual despair, which could mediate the relationship between adverse appraisals and poorer wellbeing among refugees (Maier et al. 2022).

What was evident in the 12 studies was that some level of careful attention was given to cultural sensitivity and client-led engagement, yet there was no shared language for explicitly acknowledging spiritual harm, or for describing how it might be anticipated and addressed in practice. This matters because psycho-spiritual work may be experienced as supportive or invalidating depending on how it is introduced, framed and negotiated. For example, Paudyal et al. (2021) found that some Syrian refugees experienced spirituality in mental health support as a 'ticked box' exercise, suggesting that superficial engagement may itself constitute a form of spiritual invalidation. Earlier literature has already shown that spiritually oriented work can become harmful when it is culturally incongruent, overly prescriptive or superficially applied (West 2000; Koenig 2012). What stands out in this review is that explicit safeguards against such harm were rarely described. Clearer ethical guidance is therefore needed if psycho-spiritual interventions are to be practised safely.

4.4.2 | *Outcome Measurement and Misalignment With the Mechanism*

As mentioned in the section on spiritual harm earlier, this review identified five intervention families, indicating the pluralistic nature of the mechanism of psycho-spiritual intervention and its targeting of a difficult level of suffering and the healing process. This observation aligns with contemporary psychotraumatology as it increasingly acknowledges that trauma in displacement contexts is multilayered and not reducible to intrapsychic symptoms. Silove's (2013) ADAPT model conceptualises displacement trauma as disrupting safety, bonds, justice, roles and identity and existential meaning. The moral injury literature documents that betrayal, guilt and violated moral order constitute dimensions of trauma-related distress that are independent of fear-based PTSD symptomatology (Donovan et al. 2025; Nickerson et al. 2018). O'Brien and Charura (2023) have advocated for a bio-psycho-social-sexual-spiritual approach to assessment and formulation that attends to the embodied, relational and existential dimensions of trauma in displaced populations.

However, at the outcome measurement level, that diversity largely disappears. Regardless of whether the intervention processes trauma through theological reframing, collective ritual, ancestral cosmology or contemplative compassion, the reported outcomes converge on a narrow cluster: PTSD, depression, somatic symptoms and, in some cases, acceptability or feasibility. Even with the noticeable Islamic Trauma Healing studies (Papers 5, 6, 7 and 8) that are explicitly engaging with constructs such as meaning and identity, the actual mechanism used was du'a as trauma memory processing and theological reframing of suffering. Regarding outcome measures, they were the same as those used for standard CBT, and the spiritual content within the mechanism expected to drive change was not captured. Across all studies, the concern remains that outcome measurement for psycho-spiritual interventions is still largely symptom-focused; the evidence-based practice only presents and evaluates the symptom changes, rather than the moral, relational, existential or collective dimensions, making the evaluation frameworks inconsistent with the current conceptualisation of what displacement trauma is (Miller and Rasmussen 2010).

4.4.3 | *Boundaries Between Therapeutic and Religious Roles*

The third observation from the review concerns overlapping roles across the included studies. Psycho-spiritual interventions were delivered by a range of practitioners, including clinical psychotherapists, Mental Health and Psychosocial Support (MHPSS) practitioners, trained lay refugee counsellors, faith leaders and spiritual organisation trainers. This diversity is partially pragmatic, particularly in low-resource and camp-based settings where task-shifting may increase access to support. It is also conceptually important. The findings suggest that psycho-spiritual care is not confined to formal clinical settings and may be embedded within the communities and cultural contexts where displaced people already seek help. In many cultural and religious contexts, healing roles are not sharply divided: spiritual, relational and therapeutic authority may be held by the same person or shared across community figures. This may be experienced not as boundary confusion, but as a familiar and legitimate form of care. Pham et al. (2021), for example, describe Nepal healers as providing symptom relief, spiritual protection, explanatory frameworks for distress and mediation of community relationships in a single role.

Yet, these overlapping roles can also introduce ethical tensions that were not clearly acknowledged in the reviewed studies. Dual relationships have long been recognised as ethically complex because they can make the power dynamic harder for clients to navigate in the therapy room (Lomax et al. 2002). In displacement contexts, therapeutic and spiritual authority may be held by the same person, which can intensify dependency, deference or hesitation about disclosure. As Ward (2 011) notes, spiritual authority may inhibit disclosure in therapeutic settings.

The unexamined overlapping roles also raise safeguarding concerns that were not clearly addressed in the reviewed studies. When spiritual authority and therapeutic power coincide, informed consent may become more difficult to secure in practice, particularly where clients feel unable to question or decline spiritually framed interventions. Oakley and Kinmond (2014) note that deference and obedience attached to spiritual leadership can make it harder to distinguish support from undue influence. In this context, it may be more difficult to recognise when a strong influence becomes misuse of spiritual authority or spiritual abuse. As Szumer and Arnold (2023) observe in the broader healthcare ethics literature, overlapping relationships raise distinct safeguarding challenges that often outpace existing policy guidance. Without explicit policy language on overlapping relationships, existing guidance may not be sufficient to prevent conflicts of interest, role confusion and exploitation in interventions in which prayer, ritual or theological advice is built into the healing relationship.

Across refugee and asylum seeker intervention research, effectiveness is most commonly operationalised through changes in symptom outcomes such as PTSD, depression and anxiety, which supports comparability across trials and scalability decisions internationally (Schäfer et al. 2023; Nosè et al. 2017; Chaudhari et al. 2025). Although diagnostic lenses are essential for understanding the distress experienced by refugees and asylum seekers and planning mental health services, they are often conceptualised from WEIRD contexts (Henrich et al. 2010). This means that they struggle to fully capture the scope of refugee and asylum seeker experiences when used alone and therefore risk causing partial understanding or disengagement from services and mental health support (Miller and Rasmussen 2010). Consequently, there is a risk that forms of suffering are overlooked, misunderstood or misdiagnosed when practitioners rely uncritically on assessment approaches that have not been validated across diverse cultural contexts. Moreover, dominant diagnostic frameworks often privilege individualised and symptom-focused understandings of distress, potentially marginalising alternative conceptualisations of healing and recovery that draw upon spirituality, faith traditions, community relationships, collective resilience and traditional healing practices (O'Brien and Charura 2023). Without critical attention to these limitations, assessments and interventions may fail to recognise culturally meaningful sources of distress and wellbeing, thereby reducing their relevance and responsiveness for refugee and asylum-seeking populations.

When working with clients who find spiritual and religious coping meaningful, omitting this aspect in understanding their psychological distress could cause clients to disengage from therapy and weaken the therapeutic alliance. When assessment and formulation miss disrupted moral frameworks, sources of meaning and spiritual or communal identities (Potts and Abadal 2023), clients may not return. On the other hand, when practitioners do engage but do so inadequately, this can also pose risks. There are risks of practitioners imposing their own spiritual framework, pathologising belief, such as treating spiritual experiences as psychotic symptoms (Koenig 2012; Milner et al. 2019), or overstepping their competence within the therapeutic domain (Barnett and Johnson 2011; Lomax et al. 2002). In practice, navigating these tensions frequently leaves mental health practitioners uncertain about the limits of their competence, the boundaries of their role and where ethical responsibility ultimately lies (Charzyńska and Heszen-Celińska 2020). The real question is not whether ethical engagement is necessary, but how it can be enacted without exposing practitioners or clients to unintended harm.

4.5 | Implications for Best Practice

The synthesis in Table 5 shows a growing recognition of spirituality as a mechanism of therapeutic change; however, a critical gap runs across the corpus: the absence of explicit frameworks for identifying and addressing spiritual harm. Where spirituality is positioned as a resource for recovery, little attention is paid to its risks, the imposition of meaning systems, spiritual bypassing or the conflation of therapeutic and spiritual authority (Welwood 2000; Fox et al. 2017), each of which can reproduce power imbalances or silence alternative interpretations of suffering.

Two further tensions are notable. First, interventions were often delivered by practitioners holding multiple roles (therapist, faith leader and community elder); however, few examined the ethical complexities of combined spiritual and therapeutic authority; the most ethically attentive models centred the client's own beliefs rather than an imported framework (Schubert and Punamäki 2016; Noor and Maynard 2023; Farah 2025). Second, although interventions increasingly targeted meaning, moral repair and belonging, their evaluation remained largely symptom-focused: PTSD, anxiety, depression (Tay et al. 2020; Bentley et al. 2021; L. A. Zoellner et al. 2018; Bernstein et al. 2025), a mismatch calling for outcome measures sensitive to spiritual wellbeing, meaning and collective belonging.

Drawing on the patterns and absences summarised in Table 5, four preliminary implications for ethically grounded psycho-spiritual practice with displaced populations are proposed. These are not prescriptive guidelines but provisional observations, grounded in what the literature mapping reveals and what it leaves unaddressed. They should be read with caution, as they derive from a small and heterogeneous evidence base of 12 studies, several of which were pilot or feasibility studies. They assume that spirituality is intentionally operationalised within the intervention, as was the case across the reviewed studies to varying degrees, and they are offered to be tested through future empirical research.

The first implication concerns the recognition of spiritual harm. When spirituality is operationalised as a mechanism of therapeutic change, it carries mechanism-specific risks that are not reducible to psychological harm and not addressed by existing psychological safeguarding frameworks (Holton and Snodgrass 2023). Where displaced communities are excluded from defining what spiritual safety means within their context, safeguarding protocols are likely to reflect the assumptions of the professionals who designed them rather than the realities of those they are intended to protect, a form of epistemic injustice (Fricker 2007). Safeguarding protocols for psycho-spiritual interventions should therefore be co-designed with displaced communities, with refugees and asylum seekers actively involved in identifying the risks specific to their cultural and spiritual context.

The second implication is that intervention design should begin with the client's own spiritual orientation rather than a framework imported from outside their experience. Across the reviewed corpus, the most ethically attentive models engaged the client's own beliefs, practices, struggles and sources of meaning, even where these were disrupted, evolving or in question. This matters especially in displacement contexts, where individuals may be experiencing spiritual struggle, disrupted faith or questioning of previously held beliefs. Imposing a coherent spiritual framework risks spiritual harm, whereas following the client's own spiritual landscape, including its contradictions and ruptures, allows therapeutic engagement with spiritual material as it is actually lived (Pargament 2007).

TABLE 5 | Patterns identified, gaps observed and implications for best practice across the 12 reviewed studies.

Pattern identified across the 12 studies	Gap/absence in the reviewed corpus	Implication for best practice
Spirituality is operationalised as a mechanism of therapeutic change (e.g., religious coping concepts, ritual and meaning-making frameworks)	No explicit safeguarding frameworks against spiritual harm; no shared language for recognising or responding to it (e.g., imposition of meaning frameworks, spiritual bypassing (Welwood 2000; Fox et al. 2017) and conflation of therapeutic and spiritual authority)	Develop shared language and protocols for recognising and preventing spiritual harm; co-design these with displaced communities
Interventions are often delivered by individuals holding multiple roles. For example, therapist and faith leader, community elder and trauma facilitator and spiritual authority and lay counsellor	No procedural safeguards for the dynamics of spiritual authority within the therapeutic relationship; the most ethically attentive models engaged the client's own spiritual framework rather than one imposed	Centre interventions on client-led spiritual engagement, drawing on the client's own beliefs, practices and sources of meaning rather than an imported framework
Several interventions were co-designed with refugee communities or delivered by trained refugee lay counsellors	Community co-design was not consistent across the corpus; some interventions were designed externally and delivered without documented community involvement	Involve community members, faith leaders or cultural consultants in the design, adaptation and evaluation of interventions, beyond safeguarding
Interventions increasingly target meaning, moral repair, collective belonging and identity, dimensions consistent with expanded conceptualisations of displacement trauma	Outcome evaluation remains predominantly symptom-focused (PTSD, depression and anxiety), with limited measurement of the dimensions actually targeted by the interventions	Align outcome evaluation with the dimensions targeted by the intervention, supplementing (not replacing) symptom measurement with tools sensitive to meaning, spiritual wellbeing, moral repair and collective belonging

Note: Patterns and gaps are derived from the synthesis presented in the preceding discussion sections. Implications are preliminary and intended to be tested through future empirical work, including the practitioner and lived-experience studies that follow this review.

The third implication extends community involvement beyond safeguarding into the design and adaptation of interventions themselves. Where reviewed studies described co-design with refugee communities, or delivery by trained refugee lay counsellors, interventions appeared more likely to engage spiritual material in ways that were meaningful and culturally coherent. Future psycho-spiritual interventions should therefore, where possible, draw on community members, faith leaders or cultural consultants not only in safeguarding but in the design, adaptation and evaluation of interventions (Wallerstein and Duran 2010).

The fourth implication concerns outcome evaluation. If psychotraumatology increasingly recognises that displacement trauma disrupts meaning, moral order, belonging and identity alongside symptom profiles (Silove 2013; O'Brien and Charura 2023), and if psycho-spiritual interventions target these dimensions as mechanisms of change, then evaluation should be capable of detecting whether change occurs in those domains. Evaluation approaches should therefore reflect the dimensions actually targeted by the intervention: supplementing, not replacing, symptom measurement with tools sensitive to meaning, spiritual wellbeing, moral repair or collective belonging as appropriate to the intervention and context.

These four implications are offered as preliminary and provisional. They are also not always mutually reinforcing: centring the client's own spiritual framework and embedding interventions within community and faith structures can pull in different directions, particularly where communal spiritual authority is itself implicated in the power imbalances noted earlier. They represent what can be observed from the current literature; they cannot yet account for how displaced individuals themselves experience spiritually engaged care, what practitioners actually do when they encounter spiritual material in their therapeutic work or what institutional and systemic factors enable or constrain psycho-spiritual integration in practice. Future empirical investigation in these areas is needed to refine and test the implications proposed here.

5 | Conclusion

This scoping review mapped the existing empirical literature on psycho-spiritual interventions for adult refugees and asylum seekers experiencing trauma. Twelve studies published between 2015 and 2025 met the inclusion criteria, revealing five structurally distinct intervention families. The findings suggest that psycho-spiritual engagement in refugee trauma care is characterised by mechanism pluralism rather than by a single integrative model—reflecting the diverse ways in which displacement disrupts meaning, moral order, belonging and identity.

The review also identified significant gaps. No study in the corpus addressed spiritual harm as a distinct category of risk, despite the recognised potential for spiritual engagement to cause harm when poorly managed. Outcome measurement remained predominantly symptom-focused, failing to capture changes in meaning, moral repair, spiritual wellbeing or collective belonging. The boundaries between therapeutic and religious roles were poorly delineated, and no study offered a framework for managing the ethical complexities of dual spiritual-therapeutic authority.

Several limitations should be acknowledged. The review was restricted to English-language publications, which likely excluded relevant work published in other languages, particularly from regions where the majority of refugees reside. Screening and data extraction were conducted by a single reviewer, with a calibration sample independently reviewed by a supervisor to enhance rigour. Consistent with scoping review methodology, no formal quality appraisal of included studies was undertaken; the aim was to map the breadth and nature of the evidence rather than to evaluate intervention effectiveness.

Based on patterns and absences across the included studies, preliminary implications of ethically grounded psycho-spiritual practice were proposed: the explicit recognition and safeguarding against spiritual harm, client-led spiritual engagement, co-designed safeguarding protocols for dual and multiple roles, community involvement in intervention design and adaptation and alignment of outcome evaluation with the dimensions targeted by the intervention. These implications are provisional and require testing through future empirical investigation, for example, through qualitative research exploring refugees' and asylum seekers' lived experiences of spiritually engaged care and practitioners' perspectives on navigating psycho-spiritual material in practice.

The findings carry implications for counselling and psychotherapy training, supervision and clinical practice. The reviewed corpus operationalised spirituality inconsistently, sometimes as discrete clinical content and sometimes embedded implicitly in relational or cultural framing. Practice needs to do better than this. Assessment should surface psycho-spiritual dimensions, meaning systems, sources of resilience and experiences of spiritual rupture as standard, not as a specialist add-on, without requiring religiosity from the client. Formulation should hold the four-dimensional biopsychosocial-spiritual model as a working orientation; treating spirituality as optional is no longer defensible given the evidence reviewed here. In the therapeutic encounter, the implication of client-led spiritual engagement points to a clear stance: the therapist accompanies the client's meaning system rather than translating it into more familiar frames. Spiritual harm, a category that this review found to be largely unaddressed in the existing evidence base, must become a recognised dimension of safeguarding and risk assessment. These shifts require explicit spiritual competency in doctoral and accredited training and supervision that can hold religious and spiritual diversity, including diversity between therapist and client.

The corpus also raises system-level questions for the multidisciplinary teams that typically surround refugees and asylum seekers. Psycho-spiritual engagement, where it occurred, was carried by discrete, standalone interventions, often by individual practitioners or small delivery teams, rather than by coordinated, service-level responses integrated across the care pathway. No study described how psycho-spiritual needs are recognised, formulated or held across the care pathway from first contact through to resettlement. That silence is the finding. Responsiveness cannot rest on individual clinicians; it requires shared assessment language, supervision structures and care pathways that hold spirituality alongside the biological, psychological and social. Without these, even attentive practitioners cannot act on what they notice. The unresolved boundary between therapeutic and religious roles is the corpus's most striking gap. Co-designed safeguarding, bringing faith leaders, clinicians and service users into shared decision-making, is one direction the more ethically attentive studies pointed towards, but the field lacks empirical investigation of how such collaboration works in practice.

5.1 | Reflexivity and Epistemic Limitations

The research team comprised three members with different roles, positionalities and contexts of engagement. The first author, as lead analyst, designed and conducted the review. The second author provided reciprocal independent screening at the inclusion stage as part of a paired peer-check across two parallel reviews. The third author supervised the work and supported analytic decision-making through regular review meetings. Throughout the review, the team met to discuss inclusion decisions, charting choices and emerging patterns and to surface the assumptions each member brought to the topic.

Each member brought a different positionality to the material. The first author is a Chinese trainee counselling psychologist whose orientation to spirituality draws on Buddhist, Confucian and Taoist philosophical traditions and a humanistic, social justice-oriented approach to practice. The second author is a Black African doctoral trainee in counselling psychology who arrived in England as a young child and has personally navigated the asylum-seeking process; identifying as Christian, he brings a faith-informed conviction that every displaced person retains an inherent dignity that no legal status can diminish and that healing must be psychosocial and spiritual as well as clinical. The third author's research expertise is in embodied trauma, decolonised approaches to research and the mental health of refugees and asylum seekers.

The team approached the material from a range of cultural, faith and experiential standpoints and acknowledged at the outset that even this range does not represent the full diversity of communities and faith traditions whose interventions the reviewed studies describe. To anchor analytic decisions, the review used a predefined search strategy, inclusion criteria and charting framework, with group discussion as a dialogic check on subjective drift. Further empirical research with refugees, asylum seekers and frontline practitioners would help to extend and refine the readings offered here.

Author Contributions

Ruying Shi: conceptualization, methodology, writing – original draft, writing – review and editing, formal analysis, data curation. **Herbert Zakia:** formal analysis, methodology, writing – original draft. **Divine Charura:** conceptualization, methodology, writing – review and editing, formal analysis, supervision.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are openly available as Supporting Information S1 accompanying this article.

References

Abu-Raiya, H., and K. I. Pargament. 2011. "Empirically Based Psychology of Islam: Summary and Critique of the Literature." *Mental Health, Religion & Culture* 14, no. 2: 93–115. https://doi.org/10.1080/13674670903426482.

Ager, A., and A. Strang. 2008. "Understanding Integration: A Conceptual Framework." *Journal of Refugee Studies* 21, no. 2: 166–191. https://doi.org/10.1093/jrs/fen016.

Al-Nuaimi, S., and M. Qoronfleh. 2022. "Adaptation and Innovation in Spiritual-Psycho-Social Support of Displaced Muslim Refugees." *Pastoral Psychology* 71, no. 5: 615–622. https://doi.org/10.1007/s11089-022-01025-z.

Arksey, H., and L. O'Malley. 2005. "Scoping Studies: Towards a Methodological Framework." *International Journal of Social Research Methodology* 8, no. 1: 19–32. https://doi.org/10.1080/1364557032000119616.

Banks, J. 2011. "Unmasking Deviance: The Visual Construction of Asylum Seekers and Refugees in English National Newspapers." *Critical Criminology* 20, no. 3: 293–310. https://doi.org/10.1007/s10612-011-9144-x.

Barnett, J. E., and W. B. Johnson. 2011. "Integrating Spirituality and Religion into Psychotherapy: Persistent Dilemmas, Ethical Issues, and a Proposed Decision-Making Process." *Ethics & Behavior* 21, no. 2: 147–164. https://doi.org/10.1080/10508422.2011.551471.

Bentley, J. A., N. C. Feeny, M. L. Dolezal, et al. 2021. "Islamic Trauma Healing: Integrating Faith and Empirically Supported Principles in a Community-Based Program." *Cognitive and Behavioral Practice* 28, no. 2: 167–192. https://doi.org/10.1016/j.cbpra.2020.10.005.

Bernstein, A., A. Aizik-Reebs, Y. Phung, K. Yuval, S. Gebreyohans Gebremariam, and A. A. Vujanovic. 2025. "Affective Mechanisms of Moral Injury in Trauma Recovery Among Asylum Seekers: Exploring the Protective Effects of Mindfulness and Compassion Training." *Clinical Psychological Science*, Advance online publication 14, no. 1: 60–73. https://doi.org/10.1177/21677026251344148.

Blackmore, R., J. Boyle, M. Fazel, et al. 2020. "The Prevalence of Mental Illness in Refugees and Asylum Seekers: A Systematic Review and Meta-Analysis." *PLoS Medicine* 17, no. 9: e1003337. https://doi.org/10.1371/journal.pmed.1003337.

Braun, V., and V. Clarke. 2006. "Using Thematic Analysis in Psychology." *Qualitative Research in Psychology* 3, no. 2: 77–101. https://doi.org/10.1191/1478088706qp063oa.

Braun, V., and V. Clarke. 2019. "Reflecting on Reflexive Thematic Analysis." *Qualitative Research in Sport, Exercise and Health* 11, no. 4: 589–597. https://doi.org/10.1080/2159676X.2019.1628806.

Byrow, Y., R. Pajak, P. Specker, and A. Nickerson. 2022. "Perceptions of Mental Health and Perceived Barriers to Mental Health Help-Seeking Amongst Refugees: A Systematic Review." *Clinical Psychology Review* 98: 102213. https://doi.org/10.1016/j.cpr.2022.102213.

Camia, C., and R. Zafar. 2021. "Autobiographical Meaning Making Protects the Sense of Self-Continuity Past Forced Migration." *Frontiers in Psychology*, Article 618343 12: 618343. https://doi.org/10.3389/fpsyg.2021.618343.

Charlson, F., M. van Ommeren, A. Flaxman, J. Cornett, H. Whiteford, and S. Saxena. 2019. "New WHO Prevalence Estimates of Mental Disorders in Conflict Settings: A Systematic Review and Meta-Analysis." *Lancet* 394, no. 10194: 240–248. https://doi.org/10.1016/S0140-6736(19)30934-1.

Charzyńska, E., and I. Heszen-Celińska. 2020. "Spirituality and Mental Health Care in a Religiously Homogeneous Country: Definitions, Opinions, and Practices Among Polish Mental Health Professionals." *Journal of Religion and Health* 59, no. 1: 113–134. https://doi.org/10.1007/s10943-019-00911-w.

Chaudhari, A., A. Chaudhari, S. O'Frans, R. Jayasuriya, and A. K. Tay. 2025. "Efficacy of Integrated Physical and Psychological Interventions on PTSD Among Forcibly Displaced Persons: A Systematic Review and Meta-Analysis." *Psychological Medicine* 55: e109. https://doi.org/10.1017/S0033291725000698.

Cogo, E., M. Murray, G. Villanueva, et al. 2022. "Suicide Rates and Suicidal Behaviour in Displaced People: A Systematic Review." *PLoS One* 17, no. 3: e0263797. https://doi.org/10.1371/journal.pone.0263797.

Deeks, J. J., J. P. T. Higgins, and D. G. Altman. 2008. "Analysing Data and Undertaking Meta-Analyses." In *Cochrane Handbook for Systematic Reviews of Interventions*, edited by J. P. T. Higgins and S. Green, 243–296. Wiley. https://doi.org/10.1002/9780470712184.ch9.

Dein, S. 2018. "Against the Stream: Religion and Mental Health—The Case for the Inclusion of Religion and Spirituality into Psychiatric Care." *BJPsych Bulletin* 42, no. 3: 127–131. https://doi.org/10.1192/bjb.2017.13.

Donovan, N., G. Lukic, and O. Mason. 2025. "A Scoping Review of Moral Injury in Refugees." *European Journal of Psychotraumatology* 16, no. 1: 2501369. https://doi.org/10.1080/20008066.2025.2501369.

Exline, J. J., and E. D. Rose. 2013. "Religious and Spiritual Struggles." In *Handbook of the Psychology of Religion and Spirituality*, edited by R. F. Paloutzian and C. L. Park, 2nd ed., 380–398. Guilford Press.

Farah, S. H. 2025. "'Somali? Muslim? Hey, You Already Got Me': Acceptability of Islamic Problem-Solving and Stress Management Techniques in Adapted Problem Management Plus (PM+) Intervention Among Somali Muslim Women." Master's Thesis, University of Washington. ResearchWorks. https://hdl.handle.net/1773/53304.

Farhat, J. B., K. Blanchet, P. J. Bjertrup, et al. 2018. "Syrian Refugees in Greece: Experience With Violence, Mental Health Status, and Access to Information During the Journey and While in Greece." *BMC Medicine* 16, no. 1: 40. https://doi.org/10.1186/s12916-018-1028-4.

Fox, J., C. S. Cashwell, and G. Picciotto. 2017. "The Opiate of the Masses: Measuring Spiritual Bypass and Its Relationship to Spirituality, Religion, Mindfulness, Psychological Distress, and Personality." *Spirituality in Clinical Practice* 4, no. 4: 274–287. https://doi.org/10.1037/scp0000141.

Fraser, N., and L. Murakami. 2021. "The Need for Transparency: Responding to the "Refugee Crisis" in Europe." *Journal of Refugee Studies* 34, no. 2: 1521–1539.

Fricker, M. 2007. *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford University Press.

Gagliardi, R. 2021. "Traumatic Situations and Mental Disorders in Migrants, Refugees and Asylum Seekers." In *Psychiatry and Neuroscience*

Update, edited by P. Á. Gargiulo and H. L. Mesones Arroyo. Springer. https://doi.org/10.1007/978-3-030-61721-9_36.

Ghahari, S., J. Lui, S. Nagra, and S. Morassaei. 2020. "The Life Experiences of Refugees in Canada: A Comprehensive Scoping Review to Identify Unmet Needs and Barriers." *Journal of International Migration and Integration* 21, no. 4: 1249–1261. https://doi.org/10.1007/s12134-019-00727-3.

Gleeson, C., R. Frost, L. Sherwood, et al. 2020. "Post-Migration Factors and Mental Health Outcomes in Asylum-Seeking and Refugee Populations: A Systematic Review." *European Journal of Psychotraumatology* 11, no. 1: 1793567. https://doi.org/10.1080/20008198.2020.1793567.

Hallab, A., and A. Sen. 2021. "Epilepsy and Psychogenic Non-Epileptic Seizures in Forcibly Displaced People: A Scoping Review." *Seizure* 92: 128–148. https://doi.org/10.1016/j.seizure.2021.08.004.

Henkelmann, J., S. de Best, C. Deckers, et al. 2020. "Anxiety, Depression and Post-Traumatic Stress Disorder in Refugees Resettling in High-Income Countries: Systematic Review and Meta-Analysis." *BJPsych Open* 6, no. 4: e68. https://doi.org/10.1192/bjo.2020.54.

Henrich, J., S. J. Heine, and A. Norenzayan. 2010. "The Weirdest People in the World?" *Behavioral and Brain Sciences* 33, no. 2–3: 61–83. https://doi.org/10.1017/S0140525X0999152X.

Hoffman, J., B. Liddell, R. A. Bryant, and A. Nickerson. 2019. "A Latent Profile Analysis of Moral Injury Appraisals in Refugees." *European Journal of Psychotraumatology* 10, no. 1: 1686805: Article 1686805. https://doi.org/10.1080/20008198.2019.1686805.

Holton, M., and J. Snodgrass. 2023. "A Theoretical and Theological Reframing of Trauma." *Pastoral Psychology* 72, no. 3: 337–351. https://doi.org/10.1007/s11089-023-01063-1.

Kalmanowitz, D., and R. T. H. Ho. 2017. "Art Therapy and Mindfulness With Survivors of Political Violence: A Qualitative Study." Supplement, *Psychological Trauma: Theory, Research, Practice, and Policy* 9, no. S1: S107–S113. https://doi.org/10.1037/tra0000174.

Khairat, M., S. Hodge, and A. Duxbury. 2023. "Refugees' and Asylum Seekers' Experiences of Individual Psychological Therapy: A Qualitative Meta-Synthesis." *Psychology and Psychotherapy: Theory, Research and Practice* 96, no. 4: 811–832. https://doi.org/10.1111/papt.12470.

Kirmayer, L. J. 2012. "Rethinking Cultural Competence." *Transcultural Psychiatry* 49, no. 2: 149–164. https://doi.org/10.1177/1363461512444673.

Klocker, N., and K. M. Dunn. 2003. "Who's Driving the Asylum Debate? Newspaper and Government Representations of Asylum Seekers." *Media International Australia* 109, no. 1: 71–92. https://doi.org/10.1177/1329878x0310900109.

Koenig, H. G. 2012. "Religion, Spirituality, and Health: The Research and Clinical Implications." *ISRN Psychiatry* 2012: 1–33. https://doi.org/10.5402/2012/278730.

Li, S. S. Y., B. J. Liddell, and A. Nickerson. 2016. "The Relationship Between Post-Migration Stress and Psychological Disorders in Refugees and Asylum Seekers." *Current Psychiatry Reports* 18, no. 9: 82. https://doi.org/10.1007/s11920-016-0723-0.

Lomax, J. W., R. S. Karff, and G. P. McKenny. 2002. "Ethical Considerations in the Integration of Religion and Psychotherapy: Three Perspectives." *Psychiatric Clinics of North America* 25, no. 3: A547–A559. https://doi.org/10.1016/s0193-953x(01)00015-6.

Luci, M., and M. Kahn. 2021. "Analytic Therapy With Refugees: Between Silence and Embodied Narratives." *Psychoanalytic Inquiry* 41, no. 2: 103–114. https://doi.org/10.1080/07351690.2021.1865766.

Lusk, M., S. Terrazas, J. Caro, P. Chaparro, and D. Puga Antúnez. 2021. "Resilience, Faith, and Social Supports Among Migrants and Refugees From Central America and Mexico." *Journal of Spirituality in Mental Health* 23, no. 1: 1–22. https://doi.org/10.1080/19349637.2019.1620668.

Maier, K., K. Konaszewski, S. Skalski, A. Büssing, and J. Surzykiewicz. 2022. "Spiritual Needs, Religious Coping and Mental Wellbeing: A Cross-Sectional Study Among Migrants and Refugees in Germany." *International Journal of Environmental Research and Public Health* 19, no. 6: 3415. https://doi.org/10.3390/ijerph19063415.

McEwen, C., E. Alisic, and L. Jobson. 2022. "Moral Injury Appraisals in Young People From Refugee Backgrounds in Melbourne, Australia." *Psychological Trauma: Theory, Research, Practice, and Policy* 15, no. 1: 153–162. https://doi.org/10.1037/tra0001214.

Miller, K., and A. Rasmussen. 2010. "War Exposure, Daily Stressors, and Mental Health in Conflict and Post-Conflict Settings: Bridging the Divide Between Trauma-Focused and Psychosocial Frameworks." *Social Science & Medicine* 70, no. 1: 7–16. https://doi.org/10.1016/j.socscimed.2009.09.029.

Mills, C. 2014. *Decolonizing Global Mental Health: The Psychiatrization of the Majority World*. Routledge.

Milner, K., P. Crawford, A. Edgley, L. Hare-Duke, and M. Slade. 2019. "The Experiences of Spirituality Among Adults With Mental Health Difficulties: A Qualitative Systematic Review." *Epidemiology and Psychiatric Sciences* 29: e34. https://doi.org/10.1017/S2045796019000234.

Moodley, R. 2007. "(Re)Placing Multiculturalism in Counselling and Psychotherapy." *British Journal of Guidance and Counselling* 35, no. 1: 1–22. https://doi.org/10.1080/03069880601106740.

Mooren, N., P. A. Boelen, and S. M. de la Rie. 2022. "The Impact of Morally Injurious Events in a Refugee Sample: A Quantitative and Qualitative Study." *Frontiers in Psychiatry* 13: 904808: Article 904808. https://doi.org/10.3389/fpsyt.2022.904808.

Morina, N., A. Akhtar, J. Barber, and P. Cuijpers. 2018. "Treatment of Posttraumatic Stress Disorder in Adult Civilian Refugees and Asylum Seekers." *Depression and Anxiety* 35, no. 12: 1199–1209. https://doi.org/10.1002/da.22832.

Munn, Z., M. D. J. Peters, C. Stern, C. Tufanaru, A. McArthur, and E. Aromataris. 2018. "Systematic Review or Scoping Review? Guidance for Authors When Choosing Between a Systematic or Scoping Review Approach." *BMC Medical Research Methodology* 18, no. 1: 143. https://doi.org/10.1186/s12874-018-0611-x.

Murphy, D., V. Williamson, J. Baumann, W. Busuttil, and N. T. Fear. 2021. "Exploring the Impact of COVID-19 and Restrictions to Treatment as Usual for Adults With Complex Post-Traumatic Stress Disorder: A Qualitative Study." *Traumatology* 27, no. 1: 20–32. https://doi.org/10.1037/trm0000302.

Namata, C., E. Hatzidimitriadou, and E. Mccallum. 2025. "Integration of Refugees and Asylum Seekers in Europe: A Scoping Review of Interventions." *Journal of International Migration and Integration* 26, no. 1: 513–541. https://doi.org/10.1007/s12134-025-01244-2.

Nickerson, A., Y. Byrow, J. Hoffman, et al. 2022. "The Longitudinal Association Between Moral Injury Appraisals and Psychological Outcomes in Refugees." *Psychological Medicine* 52, no. 12: 2352–2364. https://doi.org/10.1017/S0033291720004262.

Nickerson, A., C. Katona, U. Segal, R. A. Bryant, A. Nickerson, and M. Steel. 2018. "The Association of Post-traumatic and Postmigration Stress With Pain and Other Somatic Symptoms: An Explorative Analysis in Traumatized Refugees and Asylum Seekers." *Pain Medicine* 19, no. 6: 1237–1246. https://doi.org/10.1093/pm/pnx196.

Noor, R., and S. Maynard. 2023. "Therapeutic Work With Afghan Refugees in the Context of the 2021 Evacuation." *Psychotherapy Section Review* 1, no. 68: 30–35. https://doi.org/10.53841/bpspsr.2023.1.68.30.

Nosè, M., F. Ballette, I. Bighelli, et al. 2017. "Psychosocial Interventions for Post-Traumatic Stress Disorder in Refugees and Asylum Seekers Resettled in High-Income Countries: Systematic Review and Meta-Analysis." *PLoS One* 12, no. 2: e0171030. https://doi.org/10.1371/journal.pone.0171030.

Oakley, L., and K. Kinmond. 2014. "Developing Safeguarding Policy and Practice for Spiritual Abuse."*Journal of Adult Protection* 16, no. 2: 87–95. https://doi.org/10.1108/JAP-07-2013-0033.

O'Brien, C., and D. Charura. 2023. "Refugees, Asylum Seekers, and Practitioners' Perspectives of Embodied Trauma: A Comprehensive Scoping Review." *Psychological Trauma: Theory, Research, Practice, and Policy* 15, no. 7: 1115–1127. https://doi.org/10.1037/tra0001342.

O'Brien, C., and D. Charura. 2024a. "Advancing Transculturally Informed, Humanistic Therapeutic Practice for Refugees and Asylum Seekers Presenting With Embodied Trauma." *Counseling and Psychotherapy Research* 24, no. 4: 1612–1631. https://doi.org/10.1002/capr.12808.

O'Brien, C., and D. Charura. 2024b. "Body Mapping Refugees and Asylum Seekers' Perspectives of Embodied Trauma: An Innovative Method for Psychotraumatology Research & Practice." *Qualitative Research in Psychology* 21, no. 1: 71–106. https://doi.org/10.1080/14780887.2023.2289964.

O'Brien, C., D. Charura, G. Williams, et al. 2024. "Loss, Grief, and Growth: An Interpretative Phenomenological Analysis of Experiences of Trauma in Asylum Seekers and Refugees." *Traumatology* 30, no. 1: 103–112. https://doi.org/10.1037/trm0000250.

Pandya, S. 2018. "Spirituality for Mental Health and Well-Being of Adult Refugees in Europe." *Journal of Immigrant and Minority Health* 20, no. 6: 1396–1403. https://doi.org/10.1007/s10903-018-0717-6.

Pargament, K. I. 2007. *Spiritually Integrated Psychotherapy: Understanding and Addressing the Sacred*. Guilford Press.

Park, C. L. 2010. "Making Sense of the Meaning Literature: An Integrative Review of Meaning Making and Its Effects on Adjustment to Stressful Life Events." *Psychological Bulletin* 136, no. 2: 257–301. https://doi.org/10.1037/a0018301.

Paudyal, P., M. Tattan, and M. Cooper. 2021. "Qualitative Study on Mental Health and Well-Being of Syrian Refugees and Their Coping Mechanisms Towards Integration in the UK." *BMJ Open* 11, no. 8: e046065. https://doi.org/10.1136/bmjopen-2020-046065.

Pearce, M. J., K. I. Pargament, S. Wong, et al. 2024. "Enhancing Training in Spiritual and Religious Competencies in Mental Health Graduate Education: Evaluation of an Integrated Curricular Approach." *PLoS One* 19, no. 9: e0306114: Article e0306114. https://doi.org/10.1371/journal.pone.0306114.

Pham, T. V., B. N. Kaiser, R. Koirala, et al. 2021. "Traditional Healers and Mental Health in Nepal: A Scoping Review." *Culture, Medicine and Psychiatry* 45, no. 1: 97–140. https://doi.org/10.1007/s11013-020-09676-4.

Poole, R., C. C. H. Cook, R. Song, and C. A. Robinson. 2024. "Psychiatrists' Attitudes to Professional Boundaries Concerning Spirituality and Religion: Mixed-Methods Study." *BJPsych Bulletin* 48, no. 4: 221–225. https://doi.org/10.1192/bjb.2023.66.

Potts, G., and L. Abadal. 2023. "Moral Injury in Refugee Communities: The Connection Between Displacement and Disorientation." *Great Power Competition* 5: 239–253. https://doi.org/10.1007/978-3-031-40451-1_12.

Priebe, S., D. Giacco, and R. El-Nagib. 2016. *Public Health Aspects of Mental Health Among Migrants and Refugees: A Review of the Evidence on Mental Health Care for Refugees, Asylum Seekers and Irregular Migrants in the WHO European Region*. WHO Regional Office for Europe.

Rebolledo, O. 2019. "Rituals and Healing Ceremonies Help to Promote Psychosocial Wellbeing by Increasing Sense of Identity and Community in Rohingya Refugees in Bangladesh." *Intervention* 17, no. 2: 278. https://doi.org/10.4103/INTV.INTV_52_19.

Rose, D., and J. Kalathil. 2019. "Power, Privilege and Knowledge: The Untenable Promise of Co-Production in Mental "Health"." *Frontiers in Sociology* 4: 57: Article 57. https://doi.org/10.3389/fsoc.2019.00057.

Saad, M., R. de Medeiros, and A. C. Mosini. 2017. "Are We Ready for a True Biopsychosocial-Spiritual Model?" *Medicines* 4, no. 4: 79. https://doi.org/10.3390/medicines4040079.

Santambrogio, J., E. Leon, A. M. Auxilia, et al. 2025. "Clinical and Screening Tools for Psychic Illness in Asylum Seekers and Refugees: A Narrative Review." *Rivista di Psichiatria* 60, no. 3: 93–102. https://doi.org/10.1708/4509.45084.

Schaeffer, A. J., and J. H. D. Cornelius-White. 2021. "Qualitative Studies on Body-Based Interventions for Refugees: A Meta-Synthesis." *Body, Movement and Dance in Psychotherapy* 16, no. 4: 267–285. https://doi.org/10.1080/17432979.2021.1893810.

Schäfer, S., L. Thomas, S. Lindner, and K. Lieb. 2023. "World Health Organization's Low-Intensity Psychosocial Interventions: A Systematic Review and Meta-Analysis of the Effects of Problem Management Plus and Step-by-Step." *World Psychiatry* 22, no. 3: 449–462. https://doi.org/10.1002/wps.21129.

Schlechter, P., I. M. Rodriguez, N. Morina, J. Knausenberger, P. O. Wilkinson, and J. H. Hellmann. 2021. "Psychological Distress in Refugees: The Role of Traumatic Events, Resilience, Social Support, and Support by Religious Faith." *Psychiatry Research* 304: 114121: Article 114121. https://doi.org/10.1016/j.psychres.2021.114121.

Schubert, C., and R. Punamäki. 2016. "Posttraumatic Nightmares of Traumatized Refugees: Dream Work Integrating Cultural Values." *Dreaming* 26, no. 1: 10–28. https://doi.org/10.1037/drm0000021.

Shannonhouse, L., D. Dosal-Terminel, D. Kwag, et al. 2024. ""God Was With Me": A Qualitative Study of Christian Meaning-Making Among Refugees." *Journal of Traumatic Stress* 37, no. 1: 166–177. https://doi.org/10.1002/jts.22997.

Silove, D. 2013. "The ADAPT Model: A Conceptual Framework for Mental Health and Psychosocial Programming in Post Conflict Settings." *Intervention* 11, no. 3: 237–248. https://doi.org/10.1097/WTF.0000000000000005.

Steel, Z., T. Chey, D. Silove, C. Marnane, R. A. Bryant, and M. van Ommeren. 2009. "Association of Torture and Other Potentially Traumatic Events With Mental Health Outcomes Among Populations Exposed to Mass Conflict and Displacement: A Systematic Review and Meta-Analysis." *JAMA* 302, no. 5: 537–549. https://doi.org/10.1001/jama.2009.1132.

Sukiasyan, S. G. 2024. "The Mental Health of Refugees and Forcibly Displaced People: A Narrative Review." *Consortium Psychiatricum* 5, no. 4: 78–92. https://doi.org/10.17816/cp15552.

Sulmasy, D. P. 2002. "A Biopsychosocial-Spiritual Model for the Care of Patients at the End of Life." Supplement, *Gerontologist* 42, no. S3: S24–S33. https://doi.org/10.1093/geront/42.suppl_3.24.

Sultani, G., M. Heinsch, J. Wilson, P. Pallas, C. Tickner, and F. Kay-Lambkin. 2024. ""Now I Have Dreams in Place of the Nightmares": An Updated Systematic Review of Post-Traumatic Growth Among Refugee Populations." *Trauma, Violence, & Abuse* 25, no. 1: 795–812. https://doi.org/10.1177/15248380231163641.

Summerfield, D. 2001. "The Invention of Post-traumatic Stress Disorder and the Social Usefulness of a Psychiatric Category." *BMJ* 322, no. 7278: 95–98. https://doi.org/10.1136/bmj.322.7278.95.

Szumer, R. T. O., and M. Arnold. 2023. "The Ethics of Overlapping Relationships in Rural and Remote Healthcare: A Narrative Review." *Journal of Bioethical Inquiry* 20, no. 2: 10–190. https://doi.org/10.1007/s11673-023-10243-w.

Taheri, M., N. Harding, S. Fitzpatrick, and L. McCormack. 2024. "Trauma and Posttraumatic Growth in Women Refugees: A Bibliometric Analysis of Research Output Over Time." *Traumatology* 30, no. 2: 143–152. https://doi.org/10.1037/trm0000410.

Tay, A. K., M. Miah, S. Khan, et al. 2019. "Implementing Integrative Adapt Therapy With Rohingya Refugees in Malaysia: A Training-

Implementation Model Involving Lay Counselors." *Intervention* 17, no. 2: 267. https://doi.org/10.4103/INTV.INTV_45_19.

Tay, A. K., H. Mung, M. Miah, et al. 2020. "An Integrative Adapt Therapy for Common Mental Health Symptoms and Adaptive Stress Amongst Rohingya, Chin, and Kachin Refugees Living in Malaysia: A Randomized Controlled Trial." *PLoS Medicine* 17, no. 3: e1003073. https://doi.org/10.1371/journal.pmed.1003073.

Ter Heide, F. J. J., P. Goorden, and M. J. Nijdam. 2024. "Dissociative Subtype of Posttraumatic Stress Disorder and Its Correlates Among Treatment-Seeking Refugees." *Journal of Trauma & Dissociation* 26, no. 1: 23–36. https://doi.org/10.1080/15299732.2024.2407765.

Tesfai, A., L. E. Captari, A. Meyer-Weitz, and R. G. Cowden. 2023. "Coping Resources Among Forced Migrants in South Africa: Exploring the Role of Character Strengths in Coping, Adjustment, and Flourishing." *International Journal of Environmental Research and Public Health* 21, no. 1: 50: Article 50. https://doi.org/10.3390/ijerph21010050.

Thomas, J., and A. Harden. 2008. "Methods for the Thematic Synthesis of Qualitative Research in Systematic Reviews." *BMC Medical Research Methodology* 8, no. 1: 45: Article 45. https://doi.org/10.1186/1471-2288-8-45.

Tribe, R. H., K.-V. Sendt, and D. K. Tracy. 2019. "A Systematic Review of Psychosocial Interventions for Adult Refugees and Asylum Seekers." *Journal of Mental Health* 28, no. 6: 662–676. https://doi.org/10.1080/09638237.2017.1322182.

Tricco, A. C., E. Lillie, W. Zarin, et al. 2018. "PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation." *Annals of Internal Medicine* 169, no. 7: 467–473. https://doi.org/10.7326/M18-0850.

UN General Assembly. 1951. *Convention Relating to the Status of Refugees*, Vol. 189, 137. United Nations Treaty Series. https://www.unhcr.org/media/convention-and-protocol-relating-status-refugees.

UNHCR. 2014. *Asylum-Seekers*. United Nations High Commissioner for Refugees. https://www.unhcr.org/asylum-seekers.html.

UNHCR. 2026. *Global Trends: Forced Displacement in 2025*. United Nations High Commissioner for Refugees. https://www.unhcr.org/global-trends.

van Ommeren, M., F. Hanna, I. Weissbecker, and P. Ventevogel. 2015. "Mental Health and Psychosocial Support in Humanitarian Emergencies." *Eastern Mediterranean Health Journal* 21, no. 7: 498–502. https://doi.org/10.26719/2015.21.7.498.

Vieten, C., H. K. Oxhandler, M. Pearce, N. Freelon, C. Tatini, and K. Pargament. 2023. "Mental Health Professionals' Perspectives on the Relevance of Religion and Spirituality to Mental Health Care." *Spirituality in Clinical Practice*. https://doi.org/10.1037/scp0000340.

Viftrup, D., N. Hvidt, and N. Buus. 2013. "Spiritually and Religiously Integrated Group Psychotherapy: A Systematic Literature Review." *Evidence-Based Complementary and Alternative Medicine* 2013: 274625. https://doi.org/10.1155/2013/274625.

Wallerstein, N., and B. Duran. 2010. "Community-Based Participatory Research Contributions to Intervention Research: The Intersection of Science and Practice to Improve Health Equity." Supplement, *American Journal of Public Health* 100, no. S1: S40–S46. https://doi.org/10.2105/AJPH.2009.184036.

Ward, D. 2011. "The Lived Experience of Spiritual Abuse." *Mental Health, Religion & Culture* 14, no. 9: 899–915. https://doi.org/10.1080/13674676.2010.536206.

Watkins, L., K. Sprang, and B. Rothbaum. 2018. "Treating PTSD: A Review of Evidence-Based Psychotherapy Interventions." *Frontiers in Behavioral Neuroscience* 12: 258. https://doi.org/10.3389/fnbeh.2018.00258.

Welwood, J. 2000. *Toward a Psychology of Awakening: Buddhism, Psychotherapy, and the Path of Personal and Spiritual Transformation*. Shambhala.

West, W. 2000. *Psychotherapy and Spirituality: Crossing the Line Between Therapy and Religion*. Sage Publications.

Zoellner, L., J. Bentley, K. Musa, et al. 2024. "Lay-Led Intervention for War and Refugee Trauma: A Randomized Clinical Trial." *JAMA Network Open* 7, no. 8: e2429661. https://doi.org/10.1001/jamanetworkopen.2024.29661.

Zoellner, L. A., B. Graham, E. Marks, et al. 2018. "Islamic Trauma Healing: Initial Feasibility and Pilot Data." *Societies* 8, no. 3: 47: Article 47. https://doi.org/10.3390/soc8030047.

Supporting Information

Additional supporting information can be found online in the Supporting Information section.
Supporting Information S1: mps270018-sup-0001-suppl-data.xlsx.