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Addressing challenges faced by young refugees in the Netherlands: Adapting problem management plus (PM+) with an emotional processing module

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Research Article

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Abstract

Young refugees face numerous challenges before, during, and after their journey, leading to higher rates of mental health issues such as depression, anxiety, and posttraumatic stress disorder. These problems often remain untreated due to barriers like limited services, stigma, and varied distress expressions. One effective scalable intervention that bridges this treatment gap is problem management plus (PM+), a transdiagnostic program delivered by trained nonspecialists. However, PM+ lacks a module directly targeting posttraumatic stress, which is a common problem in young refugees. This study presents the cultural and contextual adaptation process of PM+ for young refugees in the Netherlands that includes a newly developed emotional processing module. Qualitative data collection included free list interviews with youngsters (n = 33), key informant interviews with professionals (n = 9), policymakers (n = 5), key people from communities (n = 10), focus group discussions (n = 11) and one focused interview. A new module targeting distressing memories was developed and reviewed by experts (n = 14). Results supported protocol adaptations, including culturally and age-appropriate language, examples, illustrations and length. This research aims to develop feasible, culturally sensitive mental health interventions tailored to the unique needs of young refugees.

Impact statement

This qualitative study aims to shed light on the experiences, daily problems and challenges young refugees, particularly ones from Syria, Eritrea and Afghanistan face while living in the Netherlands, with the view of developing a suitable adaptation of Problem Management Plus (PM+) to address posttraumatic stress. Young refugees may be at risk for common mental disorders such as depression and posttraumatic stress disorder (PTSD). However, they experience several barriers and challenges reaching mental health services available in the Netherlands. By adapting an effective scalable intervention PM+ for young refugees from Syria, Eritrea and Afghanistan in the Netherlands, this study aimed to develop a potentially acceptable and safe treatment strategy, contextually adapted for use in youth refugee care. This study also contributes significantly by introducing a newly developed, brief module that can be delivered through task-sharing and designed to address the processing of emotions associated with memories of negative or traumatic past experiences and reduce symptoms of PTSD. This module can be used in future randomized controlled trials among refugee youth exposed to traumatic experiences. Given the prevalence rates of PTSD among young refugees, integrating a module specifically targeting traumatic experiences into a scalable intervention like PM+ holds substantial promise. PM+ with the emotional processing module, adapted for use among young refugees, has the potential to yield improved outcomes in terms of reducing PTSD symptoms and related mental health problems among young refugees.

Introduction

Every year, millions of individuals are displaced globally due to wars, conflicts or various atrocities. The experience of such life-altering events during adolescence or young adulthood profoundly impacts psychological well-being. While prevalence rates differ across studies, most

research demonstrates elevated rates of mental health problems among young refugees (Fazel, 2018; Kien et al., 2019; Nesterko et al., 2019). Given the heightened distress levels and the critical nature of formative years, prioritizing mental health interventions for young refugees is essential (Kien et al., 2019). Furthermore, research also underlines the profound impact of distress related to the ongoing stressors in the host country (Miller and Rasmussen, 2017; Dangmann et al., 2021). Understanding these daily stressors, alongside the potentially traumatic experiences, is crucial for developing psychological interventions tailored to address common mental health problems.

Refugees face barriers to accessing psychological interventions even in host countries with established mental health services (Sijbrandij et al., 2017). A systematic review revealed that despite asylum seekers and refugees in Europe utilizing physical and emergency care at hospitals more frequently than the host population, they underutilize mental health services (Satinsky et al., 2019). In a recent study examining the responsiveness of health systems for Syrian refugees in Europe and the Middle East, researchers found that in European countries, the most important challenges hindering mental health service utilization included prolonged waiting periods and language-related barriers (Woodward et al., 2023). These challenges were compounded by additional issues concerning stigma and lack of mental health awareness (Woodward et al., 2023). Similarly, refugee youth who are resettled in Europe access mental health services less frequently than their peers in the host country, as demonstrated in studies conducted in Denmark (Barghadouch et al., 2016) and the Netherlands (Bean et al., 2006).

The utilization of scalable psychological interventions, which are defined by the World Health Organization (WHO) as brief transdiagnostic interventions that aim to reach more people at lower costs (World Health Organization, 2017; Schafer et al., 2018) can be a solution to improve access to mental health care. The necessity for scalable interventions emerged due to the inadequacies of mental health systems in conflict-affected settings, particularly in low- and middle-income countries (LMICs) (Rathod et al., 2017). A task-shifting strategy, in which the intervention is carried out by trained, nonspecialized people often from the same cultural backgrounds as the people who need these interventions, is often used. In the context of refugees having difficulties in accessing mainstream mental health services, scalable interventions have been beneficial for refugee populations in both LMICs and high-income countries that may have insufficient mental health specialists fluent in the refugees' languages, or where refugees do not utilize services due to mental health stigma (Bryant, 2023; Woodward et al., 2023).

One scalable intervention with strong evidence of its effectiveness is Problem Management Plus (PM+; Dawson et al., 2015; World Health Organization, 2017). PM+ has different modalities including an individual version (Dawson et al., 2015; World Health Organization, 2016), a group version (World Health Organization, 2020), a digital version (step-by-step; Carswell et al., 2018) and a version that can be used with young children between 10 and 14 years old (Early Adolescents Skills for Emotions [EASE]; Dawson et al., 2019). A recent meta-analysis that included 23 studies with individual PM+ or the digital version, step-by-step, reported a small to moderate effect on distress indicators such as general distress, anxiety, depression and PTSD symptom outcomes (Schäfer et al., 2023). While initially developed for LMICs, recent research has shown that PM+ can also be effective in high-income settings in reducing symptoms of depression and anxiety, PTSD symptoms and self-identified problems (e.g., the main unique problems participants report, such as problems with work or study; de Graaff et al., 2023). However, no study to date focused on its feasibility for older adolescents (16–18) and young adults (18–25) specifically.

PM+ is considered a transdiagnostic intervention, aiming to reduce symptoms of various common mental disorders, such as depression, anxiety and PTSD. Indeed, PM+ has been found to reduce symptoms of PTSD such as re-experiencing and avoidance (Akhtar et al., 2022). Although PM+ does not include trauma-focused strategies, the strategies taught in the PM+ program may facilitate emotional processing (EP) which could potentially contribute to reductions in PTSD symptoms (Akhtar et al., 2022). Even though some studies found improvement in PTSD symptoms (Rahman et al., 2016; de Graaff et al., 2023), other trials encompassing trauma-exposed populations found PM+ did not reduce PTSD symptoms (Jordans et al., 2021; Bryant et al., 2022). This may be explained by the lack of trauma-focused strategies in PM+ (e.g., exposure to traumatic memories), which is recommended for individuals with PTSD symptoms (ISTSS GC, 2018). Given the high prevalence rates of PTSD symptoms or experiences that might lead to PTSD among young refugees (Björkenstam et al., 2020), integrating a scalable EP component into the PM+ intervention is an important topic to investigate.

Scalable interventions are easily adaptable across different cultures and contexts (Schafer et al., 2018). Research on the effectiveness of culturally adapted interventions has several methodological limitations (Rathod et al., 2018). It has been found, for example, that active control arms or non-adapted versions of the same intervention are often absent (Rathod et al., 2018). Despite these limitations, there is evidence that adapted interventions have larger effect sizes (Chowdhary et al., 2014) and to ensure the acceptability, feasibility and effectiveness of the interventions, carrying out cultural adaptations while maintaining the fidelity and core components of the intervention is recommended (Bernal et al., 2009; Fendt-Newlin et al., 2020). Various frameworks have been proposed for cultural adaptation. Among these, the ecological validity model (EVM) by Bernal et al. (2009), which recommends adaptations across eight domains (*language, persons, metaphors, content, concepts, goals, methods and context*), is widely used.

This study aimed to adapt PM+ to the context of refugee youth (16–18 years old) in the Netherlands while acknowledging the diversity of young refugees resettled in high-income countries. We developed a scalable EP module that can be integrated alongside the existing modules of the PM+ intervention. In this article, we describe the adaptation of PM+ with the EP module for refugee youth in the Netherlands, using a rapid qualitative assessment (RQA).

Methods

Setting and population

The total number of asylum applications in the Netherlands was recorded as 29,435 in 2019 and 19,132 in 2020 (IND, 2020). In 2019 and 2020, 1,470 asylum applications were submitted by young refugees aged between 16 and 18 years, with 1,005 of these being unaccompanied minors (IND, 2020). Most asylum applications in this age group were from Syria, followed by Morocco, Eritrea, Algeria, Afghanistan, Iran and Iraq (IND, 2020). For this study, we focused on the three most prevalent war-affected countries among this demographic (Syria, Eritrea and Afghanistan).

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Participants and data collection

To adapt PM+ to the relevant context of young refugees living in the Netherlands, we conducted an RQA composed of three phases based on the Development, Implementation, Monitoring and Evaluation (DIME) Model (Applied Mental Health Research Group, 2013). These three phases were (a) free listing (FL) interviews (n = 33), (b) key informant interviews (KI) (n = 24) and (c) focus group discussions (FGD) (n = 11 and one focused interview).

FL interviews are brief, structured interviews, which consist of a series of questions designed to elicit responses in a list format (Applied Mental Health Research Group, 2013). For FL interviews, a purposive sampling method called maximum variation in which participants are selected based on variations of some key characteristics (Suri, 2011) was used. Relevant characteristics were country of origin, gender and age. Participants were young refugees, aged 16–18 years old and who had fled from Syria, Eritrea and Afghanistan.

KI interviews were semi-structured interviews administered to professionals working with refugee youth (mental health professionals, teachers, NGO staff, etc.), policymakers and influential members of the target communities. Policymakers and professionals working with adolescents were interviewed to get more information on the problems of refugee adolescents. KIs from relevant communities were individuals without mental health training to gather insights reflecting commonly held community views on selected problems. A purposive sampling method was used; professionals and policymakers were contacted via professional networks, with a focus on their significant roles and expertise in refugee care and policies. KIs from the communities were identified either via young refugees' responses from the FL interviews or through local organizations. Additionally, three separate FGDs were planned, one for each target refugee population (Syrian, Eritrean and Afghan). Purposive sampling and snowball sampling methods were used to recruit participants for FGDs. During the COVID-19 pandemic, recruitment relied on social media.

Procedure

This study was conducted in the Netherlands between October 2019 and July 2020. Ethical approval was received from the VUmc Medical Ethical Committee (2019.441). Three research assistants (one native Tigrinya speaker, one native Arabic speaker and one native Dari speaker) conducted interviews with refugee youth and key people. The researcher interviewed English-speaking KIs. Beforehand, they underwent a 3-day training which included principles of the DIME module, basic communication skills, interviewing, research ethics and data management. Two additional assistants (one Eritrean one Syrian) facilitated FGDs as co-facilitators after receiving training.

In FL interviews, participants were asked to list problems faced by their peers and common activities they are engaged in. Participants were prompted to list all problems affecting their communities and to further elaborate on identified mental health and psychosocial issues. Additionally, the participants were asked to identify influential members of their communities for subsequent KI interviews. The second part of the interviews centered on the daily activities of their peers caring for themselves, their families and their communities.

Separate topic lists were prepared for the semi-structured KI interviews with professionals working with refugee youth, policymakers and key people from the communities. Professional and policymaker interviews addressed refugee youth issues, mental health literacy, care-seeking behaviors, the Dutch mental health system and opinions on PM+ implementation. KIs from communities focused on three priority problems identified from FL interviews within each cultural group, covering problem characteristics, perceived causes of mental health problems in the community, effects on individuals and ideal solutions with adequate resources.

The goals of the FGDs were to (a) expand on the responses collected during the free listing interviews, (b) obtain participants' opinions on how PM+ will be best implemented for their peers, (c) obtain information on the health care-seeking behaviors and (d) see if there are differences between the three communities regarding above-listed issues. The FGDs were divided into three key sections: first, participants reviewed FL interview outcomes and added overlooked aspects; second, they discussed help-seeking behaviors among their peers; and finally, the PM+ intervention was introduced for their input.

Initial interviews were conducted face-to-face. However, due to the COVID-19 pandemic interrupting recruitment, the study was temporarily put on hold. With approval from the medical ethical review committee (METc) of the Amsterdam UMC, the remaining interviews with refugee youth, KIs and FGDs were conducted via teleconferencing. Remote interviews were conducted with the Skype for Business program (Version 7.0.2046.116, 2019), which allowed encrypted network communications.

Participants provided informed consent before the interviews. All forms were prepared in English and translated into Arabic, Tigrinya and Dari. Participants were informed that their answers would be confidential, all personal information would be pseudonymized and they could opt out without explanation. Following the transition to teleconferencing, informed consent was obtained orally and was recorded with a professional audio recorder separately from the interview responses and securely stored in an encrypted environment.

Interviews with refugee youth and refugee key people were carried out in their native languages. Detailed notes were taken during FL interviews by research assistants; no audio recordings were made to avoid discomfort. Similarly, during FGDs, co-facilitators took detailed notes, and no audio recording was taken. All KIs were recorded on an audio recorder and transcribed verbatim. Non-English interviews were translated into English post-transcription. KI interviews took approximately 45 min and FGDs took 1 to 1.5 h. Refugee youth and refugee KIs received €10 vouchers per hour for their participation.

Intervention

PM+ is a brief and transdiagnostic psychological intervention that relies on task-shifting. It was developed by the WHO for people who have experienced adversities (WHO, 2016). The individual PM + consists of five 90-min sessions and includes four main strategies derived from cognitive behavioral therapy (CBT). In each session, a new strategy is introduced and previously introduced strategies are practiced. Session 1 focuses on stress management, session 2 on managing problems, session 3 on behavioral activation, session 4 on strengthening social support and session 5 on relapse prevention.

As part of a wider study (Alozkan Sever et al., 2021), we developed a new module for PM+, named "Managing Emotions and Memories." This module helps participants to discuss challenging emotions and memories across multiple sessions for effective processing. The initial draft of the module was prepared in parallel

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with the data collection process and introduced to refugee youth during the FGDs. Facilitators explained the module's aim and its components. They then invited participants to provide feedback, particularly regarding the metaphors employed to represent life narratives (namely, a puzzle or rollercoaster). Insights from PM+ discussions significantly shaped the module, influencing its structure, language and duration.

The initial module, along with the adapted PM+ protocol, was shared with 14 experts in the fields of child psychotherapy and psychiatry or refugee mental health care. Their feedback and evaluation led to revisions of the module. These changes included modifications to the length of the psychoeducational section, the use of metaphors to explain traumatic responses, the addition of grounding exercise within the stress management segment, as well as recommendations for the training of helpers. Subsequently, the revised module underwent further refinement before finalization, incorporating insights provided by these experts.

In the "Managing Emotions and Memories" module, participants are asked to think about all their memories as pieces of a jigsaw puzzle and select three significant ones, including distressing memory. Additionally, participants recall two positive memories, as research indicates that focusing on positive memories can improve mental health and reduce PTSD severity (Contractor et al., 2021). These positive memories can include everyday events (e.g. "the day I helped my sister and made her happy") or any other positive experiences that made the participants feel good about themselves. The EP module is carried out over a total of three sessions. In session 3, after reviewing the previous weeks, 30 min are dedicated to the EP module, followed by a 10-min stress reduction exercise (grounding). In the subsequent weeks, the module is repeated, with 15 min allocated to it, followed by a 10-min stress reduction exercise (grounding). In sessions 3–5, participants imagine those memories and talk about them in detail. Furthermore, participants are asked to evaluate their emotions before and after discussing the distressing memory. This distressing event should be a significant adverse event with a negative emotional impact for the youngster but does not need to represent the worst event. In session 5, they envision their "good-enough self" 5 years from now. By discussing these life events in terms of emotions, thoughts and future expectations, the module aims to process difficult emotions and foster hope. This adapted PM + intervention comprises six 75-min sessions, with the new module introduced in session 3 and practiced in sessions 4 and 5.

The intervention is delivered by trained nonprofessionals (helpers) from the same cultural backgrounds as participants, in their native language. These helpers receive a 9-day training which focuses on the core strategies of PM+, common mental health problems, basic counseling skills and strategies on self-care as well as the new module. After completing one practice case, helpers start working with the participants and receive supervision from two trained PM+ supervisors throughout the implementation.

Table 1. Problems faced by refugee youth

Cultural group	Problems (most frequently mentioned)	Count	Total	Percentage within group
SYR	School and education	10	77	12.99
	Problems with adaptation (rules)	9		11.69
	Language	8		10.39
	Work	7		9.09
	Financial problems	6		7.79
	Problems about families	5		6.49
	Discrimination	5		6.49
ERT	Language	13	89	14.61
	Stress	9		10.11
	Missing family and friends	9		10.11
	Loneliness	8		8.99
	Problems about the status in NL	7		7.87
	Alcohol and substance use	7		7.87
	School and education	5		5.62
	Cultural differences	5		5.62
AFG	Problems about the status in NL	5	29	17.24
	Financial problems	3		10.34
	Loneliness	3		10.34
	Cultural differences	3		10.34
	Language	3		10.34
	School and education	3		10.34
	Work	2		6.90
All	Language	24	195	12.31
	School and education	18		9.23
	Loneliness	14		7.18
	Missing family and friends	12		6.15
	Problems with adaptation (rules)	12		6.15
	Financial problems	12		6.15
	Problems about the status in NL	12		6.15

Abbreviations: AFG, Afghanistan; ERT, Eritrea; SYR, Syria.

Data analysis

KI and FGD transcripts were entered in ATLAS.ti (Version 8; Scientific Software Development GmbH, 1997) for analyses. FL interview data guided the selection of problem topics for KI interviews and FGDs. To generate a response list, responses were categorized separately for each cultural group, similar responses were grouped and unclear ones were discussed with research assistants (Table 1). Codes were generated inductively in ATLAS.ti using KI interviews and FGD transcripts. FGD data were analyzed at the group level for each cultural group. The same codes generated during the coding of KIs were used for analyzing FGDs. The co-occurrence function and network analyses of ATLAS.ti were used to understand which codes frequently appear together and to create broader themes. All subsequent adaptations of the intervention were based on the information collected during the study and were guided by the EVM (Bernal et al., 2009).

Results

FL interviews provided insights used to shape KIs and FGDs. A total of 33 young refugees from Syria (n = 10), Eritrea (n = 16) and Afghanistan (n = 7) were interviewed. Analyses highlighted

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34 problem categories and 195 responses across all cultural groups. Primary challenges included Dutch language difficulties, educational issues and loneliness, but variations existed among cultural groups. Syrians faced challenges with education and language barriers, while Eritreans emphasized stress, family separation and concerns about alcohol, drugs and suicide. Afghans underlined problems with receiving legal status in the Netherlands and cultural differences. Despite coping mechanisms such as sports, hobbies and socializing, some turned into less adaptive coping strategies such as smoking or alcohol. Many contributed to family and community through various activities. These FL findings aligned with information conveyed during FGDs and informed subsequent KI interviews (see Table 1).

We interviewed KI professionals working with refugee youth (n = 9), policymakers (n = 5) and 10 key people from the communities (three Syrians, four Eritreans and three Afghans). FGD participants were recruited through social media and local organizations. Two separate sessions were conducted: one with Eritrean youth (n = 6) and another with Syrian youth (n = 5). Despite using identical recruitment strategies across three cultural groups, we only recruited one Afghan participant and conducted a focused interview using the FGD questions. Data from the KI interviews and FGDs were analyzed together and based on them 75 codes were generated, leading to the emergence of eight broader themes. These themes are summarized below, with illustrative quotes for each theme presented in Table 2. The following broader topics were identified:

1) *Mental health problems*: The most frequently mentioned problems were stress, loneliness, traumatic experiences, feelings of isolation and problems related to alcohol and drug use. Stress was mostly mentioned alongside legal status in the Netherlands, education, integration and adaptation. Among the three groups, Afghans were concerned about their asylum status in the Netherlands most frequently. Concentration problems and isolation were often mentioned along with stress. Loneliness often co-occurred with cultural differences, language and isolation from the host community. Isolation often co-occurred with depression. Drugs and alcohol were mentioned as a coping mechanism for some youth (FL and KI from communities).
2) *Mental health awareness*: Most KIs agreed that the mental health knowledge and awareness of refugee youth was low. Help-seeking often co-occurred with the following codes: cultural differences, stigma, shame and trust. Eritrean and Afghan key people mentioned that talking about mental health problems is viewed as something to be ashamed of. In FGDs, both cultural groups mentioned girls tend to seek help more than boys. Syrians emphasized the cultural pressure on men to appear strong, which discourages help-seeking. Afghans expressed fear of jeopardizing asylum status by seeking mental health care. According to the participants, to reach youth about participating in the PM+ program it is important to work with key people from the communities.
3) *Mental health services in the Netherlands*: Many professionals and policymakers stated the need for more culturally sensitive treatments. According to them, there are culturally sensitive treatments, but they are not available across the Netherlands and vary widely according to the region. They also mentioned that coordination should be better between the different parties

Table 2. Findings about eight themes and quotes

Theme	Main findings	Example quotes
1) Mental health problems	– Stress, loneliness, trauma, isolation and low mood were the most frequently mentioned problems. – Stress seems to be often mentioned along with the status in the Netherlands, education, integration and adaptation. Concentration problems and isolation seem to be frequently mentioned with stress as well. – Among the three groups, Afghans were concerned about their legal status in the Netherlands most. – Loneliness appeared together with cultural differences, language and isolation. – Isolation is often mentioned together with depression. – Drug and alcohol use seems to be used as a coping mechanism for some youth.	– *…especially 10 percent we always say of children who develop severe post–traumatic stress disorder or symptoms but nevertheless part of this is chronic stress or ongoing stress because of the situation in the Netherlands which is the long waiting for the asylum for the outcome of the asylum procedure, the stress of not knowing, because most children are applying for family reunification that also takes too long and that really is killing (Professional KI)* – *Mostly you see them under pressure. They keep everything inside till they explode. They stay away from family and don't go back home. Or they might stay outside/home all the time. They also isolate and don't socialize with others. Lack of concentration at school/work. Very difficult to obtain and continue study and work. (Syrian key person)* – *They are aggressive so it affects their relationships with their families or friends. But drinking does not have any effect on their work. They know the system, if they don't go they will be kicked out. They don't want to lose work. But maybe it affects their studies. (Eritrean Key person)*
2) Mental health awareness	– There was a consensus that mental health awareness of refugee youth was low. – Help seeking often mentioned together with cultural differences, stigma, shame and trust. – Participants mostly favored working with key people to reach youth.	– *… there is a lot of shame also as in Eritrea when I lived there, people don't talk, they don't know mental illnesses but they also feel very ashamed and they think also with mental problems you are crazy so there is a stigma on it. (Professional)* – *A lot of them are afraid even talking with a white man. Maybe it is because of our culture, background (Eritrean Key person).* – *Refugees need someone to talk to, someone who they can trust, they need someone who encourages them to talk about their problems for example a teacher someone from work or psychologist). Afghan refugee youth often think that it is not good to talk about problems, they feel like they have to be strong or they are ashamed of it. (Afghan Key person)*

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Table 2. (*Continued*)

Theme	Main findings	Example quotes
3) Mental health services in the Netherlands	– Many professionals and policy makers stated the need for more culturally sensitive treatments. – It seems to be the mental health care services in the Netherlands varies according to the region. – Many people mentioned the coordination should be better.	– *…we need also more mixed professionals with a different background, migrant background, this is important so this is all what I call the cultural sensitivity. (Professional)* – *I feel and lots of people agree that youth mental health care the most organizations are not aware yet that when you work with refugee minors that sometimes different things are needed than when working with children that are born and raised in the Netherlands. (Policymaker)* – *But it is too much scattered around and a lot of times depending on finances. And that doesn't give a stable ground to build up, now, the whole project or to make contacts with all the organizations (Professional)* – *…when we get these people, who needs to go to the hospitals. That people are very mental ill. People say okay let me go to this very special hospital. But there are always waiting lists for 7 or 8 months. And people, they don't lie. And in the meantime, they are still wondering around in the cities. So, you don't have the information and you don't really have enough places in the special hospitals because of the waiting lists. (Policymaker)*
4) Personal identity	– Culture seems to be an important determinant of the personal identity. – Many youth and key people mentioned the clash between youth and their parents because of the cultural differences. – Gender differences might influence seeking help (Males – less seeking help) and adaptation (Females – adapt easier). – All three groups mentioned that their cultures are more collectivistic than the Dutch culture.	– *For Eritrea people they are happy when they are social – it is totally different with family and friends all together. Here you go to school you come back alone. It is good if they make same like community, to enjoy something like that especially in weekend. To make community events. (Eritrean Key person)* – *And sometimes they really have problems with the parents and the culture. Because they want to be free, they have all this freedom around and the possibilities/ But it is not what the parents see. So they are sometimes, they feel lonely and a little bit lost. And that's also stressful (Policymaker)* – *Some youth have problems with the two cultures. They want to adapt to the Dutch culture, but some parents are very strict and don't let them, which makes them less involved with the other group. It makes them feel more insecure, they want to get involved and belong to the other group. (Afghan participant, FL)*
5) Family and problems related to family	– Missing family and friends were a common problem for all groups. But especially for the unaccompanied youth being alone without family seems to be an important stressor. – For some youth who are living with their families, cultural clash seems to be an important problem. – Family reunification processes are listed as another source of stress.	– *They really felt loneliness. Because I talked with a lot of Eritrean youth, some of them also cried, they need their parents. If our parents are with us, they can care us (Eritrean Key Person)* – *Knowing that their family in Afghanistan are unsafe and not being able to help them (by working for example) gives these youth more stress. (Afghan Key Person)* – *So I think if you can have family sessions, it does not always have to directly focus on how they manage in the family but if you already talk about what is normal in the Netherlands, so the children and the parents then there is no discussion in the house where the children picked up the information and how they view it. (Policymaker)* – *Parents impose stress on children not to change "become western" (Syrian participant, FL)*
6) Work, study and integration	– Language seems to be linked to integration and adaptation since they are often mentioned together. – Often the refugee youth do not have enough time to rest and recover from the difficult journey. They must immediately start learning language and integrate which might be difficult after all the things they have experienced. – Most of the participants mentioned if the young refugees can go to school or work, they would feel less alone and isolate themselves less. – Individual interviews with youth showed that one problem they frequently mentioned was getting adapted to the rules in the Netherlands. – Education system is different than the refugee youth is used to. The expectations of youth and their potentials' according to the teachers do not meet. – The loan they receive from the government for their Dutch education and integration is an important stress factor for youth.	– *Integration starts from the language of the Netherlands, otherwise it will be a problem for your whole life, then you will be dependent on someone, always. Integration starts with the language. (Eritrean Key Person)* – *That is focused on – okay these people come and we will push them as much as we can towards job. Because if you let them stay in their rooms and adjust it will get much more difficult to get them active to find a job and we want them to be active, to be productive all day. (Professional)* – *For them it is already a rush. It's school, it's swimming lessons, it's their interview, it's the Nidos, it's their contact person, it's their family home. It's because they are just new in Holland, everything is new and they don't realize actually where the trip starts. (Policymaker)* – *Afghan youth need to work again, to study and to be busy. In this way they get motivated to be active in the community, they get motivated to work on their problems and their future. Through work or school, they also get the chance to get in touch with other people and other pupils (Afghan Key Person)* – *Different education system. Different way of teaching than used to. (Syrian participant, FL)*

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Table 2. (*Continued*)

Theme	Main findings	Example quotes
		– *…doesn't like the type of school and the subjects. There is language barrier, disagreement with teachers (Eritrean participant, FL)* – *There is a controlling system. You can't stay outside later than 10:30 PM. You are allowed only 3 days to travel and visit a family or a friend. (Eritrean participant, FL)* – *It was obvious that they have to lend a lot of money for education and they were threatened to lose that loan if they didn't finish it in time (Professional)*
7) Other problems	– Most pronounced other problems were language, problems with the status in the Netherlands, high expectations before arrival and financial difficulties. – Language seems to be important in terms of integration, help seeking and loneliness. – Problems with the status in the Netherlands and the high expectations seems to cause stress.	– *Language barrier, being classified at school under one's own level and therefore having to perform less than usual. (Syrian participant, FL)* – *Stress among Afghan refugee youth is a common consequence of living with uncertainty, without knowing you will be able to stay or you will get deported. Thinking about this, gives them a lot of stress. (Afghan key person)* – *There is a quite a wide gap between what client wants and what we think is the best study to follow. In those situations, we are not very competent, we are not very much skilled in closing that gap in these ways. (Policymaker)* – *Most participants mentioned not getting into work quickly is also the root of their problems. They think that starting work sooner would have helped to get used to the Dutch system quickly and it would have also helped them improve their language skills (Eritrean FGD).*
8) Inputs about PM+	– Almost all participants thought PM+ would be an important intervention to fill the treatment gap. – There was no consensus between individual or group PM+. Many professionals thought group version might be applicable for youth, but they also agreed there should also be individual sessions. Young refugees also favored the group format, but they thought some issues need to be discussed privately. – When asked, participants mentioned that shorter sessions are better than 90 min sessions. – In terms of the emotional processing module there was no consensus on choosing rollercoaster or puzzle. For some participants rollercoaster was something that created fear. Some key informants mentioned that puzzle metaphor would be more familiar for most of the refugees. – Most participants thought informing parents would be good, some favored for family session as well. – It seems that trust is an important factor that might influence the acceptability of the PM+ program. – In terms of nonprofessional helpers, there were mixed comments. Some believe coming from same cultural background would be important, but some thought refugees might trust a specialist or a Dutch person more. – Young refugees mentioned that the gender of the helper will not be important.	– *PM+ is really going to do something substantial to fill this gap because there is a huge treatment gap, and we haven't been able at all to do anything about it and when you see when the people get treatment it is also a nightmare (Professional)* – *I think that's a really good one because I told it also before you know the help within the mental health institutions themselves it is hard to find it, or they are not working in the culturally sensitive manner or the waiting lists. (Policymaker)* – *I think if you use people from the own community, it's a kind of investment also in a kind of social capital or professional capital. Yeah, why not? It's a good idea. (Professional)* – *You also see that young people prefer to seek help from a Dutch person or a foreigner than to request it from a Syrian person. There is a lot of mistrust towards each other. It is good to make it clear that privacy is guaranteed, and that no information will be shared with others. (Syrian FGD)* – *For me is no preference but for others with trust issues will never choose to have group sessions. They prefer individual sessions to be more relaxed and speak up about their problems without worrying about others present during the session. Trust is a key issue for Afghans. (Focused Interview, Afg)* – *It's also cultural. I think with Eritrean you always have to talk about them not you because their culture is different. But if you talk about Afghanistan or Syria they know what it is to be to go to school and they know what it is to be an individual. If you talk them about the group they don't feel that important as they would feel in individual. But with Eritreans you can handle them as groups because they are sensitive for that. (Policymaker)* – *The ones from the cities once in their lives would be in other countries for holidays they have experienced. But I can imagine for the ones who were from the rural areas would not relate with the feeling of sitting on a rollercoaster (about Eritreans, KI Professional)*

who work closely with refugee youth. Finally, they mentioned long waiting lists for services, which poses a significant challenge in accessing care.

4) *Personal identity*: Culture was deemed to be an important determinant of personal identity. According to the key people from the communities and inputs from FGDs, gender differences potentially affect help-seeking behavior (males showing less inclination to seek help) and adaptation (girls exhibiting greater ease in adaptation). Moreover, all three groups mentioned a stronger inclination toward collectivistic norms compared to Dutch cultural norms.
5) *Family and problems related to family:* Another recurring theme from the interviews was the issues and challenges regarding family. For all three groups, missing family and close friends was a common issue as reported by young refugees. According to the KI professionals, this was more pronounced among

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unaccompanied youth who are without parents or guardians in the Netherlands, this seems like an important stressor. Furthermore, the prolonged and uncertain nature of the family reunification process compounded this stress, adding to their emotional burden. Comparatively, for Syrian youth, cultural clashes seemed to be a significant issue, possibly because they are mostly here with their families. During the FL interviews, several participants mentioned that young people want to live independently, while their parents do not permit it, leading to disagreements. KIs from the communities reported their impression that parents are concerned that their children will "become too Westernized" and potentially experience a detachment from their cultural heritage. Meanwhile, according to the KIs, youth seem to be more inclined to behave more like their native peers.

6) *Work, study and integration:* An important challenge faced by youth from all three groups seems to be learning the Dutch language. Problems related to language were often mentioned in the context of integration and adaptation, which also appear to be linked to seeking assistance and feelings of loneliness. Refugee youth, as noted in interviews, often lack adequate time to rest and recover from their difficult journey (KI professionals). They start courses on language and integration, which can be challenging after difficult life events they have endured. Moreover, the loan extended by the government for Dutch language education becomes a substantial source of stress, since they need to repay it if they fail to pass language exams. This pressure to learn the language quickly seems to add an extra burden, making the learning process even more stressful. Most participants mentioned if the youth could go to school or work, they would feel less alone and isolate themselves less (FL). However, the ones who are already in the education system also face challenges such as different teaching methods, being placed in a lower academic level, encountering unfamiliar school subjects, language barriers and lack of support (FL). Additionally, delays in starting school and the nonrecognition of diplomas cause further frustration. For example, one participant stated, "We have to do everything alone and we are not helped," while another noted, "Because the education system differs, your diplomas are not recognized, causing delays or cancelation."
7) *Other problems:* The most notable additional challenges were issues related to one's legal status in the Netherlands, unrealistic pre-arrival expectations and financial constraints. Many young refugees expected life in the Netherlands to be easier, including better education, quicker employment and smoother cultural integration. However, these unfulfilled expectations, combined with status-related challenges, may have been a source of stress.
8) *Inputs about PM+:* KI and FGD participants positively received the PM+ program, considering it a valuable addition to existing interventions, after receiving information about its content. KIs highlighted its potential in addressing a treatment gap within mental health interventions available. Participants provided varied feedback on several aspects of the program. Preferences regarding the program format – individual or group sessions – were divided, with considerations for sensitivity of topics discussed in such programs leading to suggestions for the availability of both formats. Shorter sessions were favored over longer ones. Involving parents or holding family sessions was seen as beneficial. Trust was highlighted as pivotal in how the PM+ program and the helpers would be perceived. Some emphasized the importance of cultural background alignment with the helper, while others preferred specialists or individuals of Dutch origin for increased trust (FGD). The majority mentioned that helper gender was not a crucial factor (FGD).

Findings from the study led to several adaptations in the generic PM+ protocol and its delivery (see Table 3). The final intervention, individual PM+, consisted of six 75-min sessions, available either in person or via teleconferencing. The term 'client' was replaced with 'participant' across the manual. Activities predominantly pursued by young refugees, such as internet use, sports and biking, were included in the behavioral activation module. Cases were adapted to resonate more with the youth's experiences. Insights from the interviews acknowledged the diversity of young refugees, highlighting common issues like cultural adaptation, while also noting specific challenges such as family conflicts among Syrians and loneliness experienced by Eritrean and Afghan youth traveling alone. These distinctions informed recommendations for targeted training and supervision processes.

Discussion

This study aimed to investigate challenges encountered by young refugees arriving in the Netherlands to inform the adaptation of the PM+ individual and the newly developed EP module for use in young people with a refugee background. To achieve this, we conducted FL interviews, KI interviews and FGDs among Syrian, Eritrean and Afghan young refugees (16–18 years old) and community members and professionals knowledgeable about young refugees in the Netherlands. Our aims while implementing this assessment were to identify problems encountered by refugee youth in the Netherlands, grasp concepts such as health and distress through the lens of their cultural backgrounds and acquire valuable information regarding the implementation of PM+ with the new EP module.

Both FL interviews and KI interviews revealed that the primary challenge for young refugees in the Netherlands revolves around difficulties in learning the language. This was a common issue expressed among all three cultural groups in the study impacting their daily lives, integration and likely contributing to feelings of isolation. This finding aligns with previous research showing that refugees consider language proficiency a key factor in integration (Earnest et al., 2015). Language proficiency has a special importance since many studies have also proved its connection with mental health problems. Lower language proficiency seems to be associated with higher mental health problems in migrant populations (Montemitro et al., 2021), and this relationship is more pronounced in refugee children and adolescents (Fazel et al., 2005). While our study does not definitively link language struggles to increased mental health issues, it highlights the need for further investigation. The process of integration for refugees involves passing Dutch language exams, which many refugees prepare for with a loan (DUO, n.d.). However, this loan adds stress to young refugees' lives, potentially overwhelming them with immediate responsibilities before addressing their pre-migration challenges as reported by the participants in our study (FL interviews and KIs).

For all three groups, educational challenges were mentioned by young refugees (FL interviews and FGDs), notably differences in teaching styles from their respective countries. This insight is important since teachers' understanding of cultural backgrounds and facilitating culturally appropriate school transitions are recognized as valuable resources in school adaptation (Graham et al., 2016). Moreover, young refugees in our study emphasized the

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Table 3. Example adaptations made in line with the Bernal framework

Domain	Operationalization	Implementation	Rationale	Relevancy
Language	Protocol language, differences in dialects	Use less mental health related words. For the emotional processing module do not use 'traumatic' memories but use adjectives such as 'upsetting, frightening, etc.'	The stigma over mental health problems are not as strong as the adult populations from these cultures, but youth also thinks these terms such as "mental" might affect people's approach to the intervention and might keep them away.	Adaptation, training, implementation
Persons	Therapist–client relationships/roles	Participant–helper gender do not have to match. But always check with the participants first if they are fine with having a cross–gender helper. There might be trust issues with the helpers from older generations and the youth participants.	Youth thinks their peers would not see it as a problem to have a cross–gender helper to deliver the intervention. Their concerns were more about the issue of trust. In some cultures, there appeared to be conflicts between the ones who arrived some decades ago to the Netherlands and the newcomers.	Training, implementation
Metaphor	Idioms, symbols	Do not use the teacher–student metaphor while introducing the rationale of PM+. Rather than that use "the sports coach" metaphor.	For youth teacher metaphor resembles school environment and might not be attractive for everyone. On the other hand, sports coach is more favorable.	Adaptation, implementation
Content	Incorporating values, traditions, other content related changes	Add grounding exercise as an additional stress management technique.	The newly developed emotional processing module guides participants to expose them to the difficult life events they experienced.	Adaptation, training, implementation
		Add activities and tasks more related to current youth context such as spending time on social media, playing football etc. and remove the ones that are not relevant in the urban context such as "cleaning the hut."	Youth spends considerable time on social media and connect to each other that way. They also have hobbies such as sports, reading, etc.	
Concept	Treatment concepts consonant with culture and context	Underline the differences between different cultural groups during the trainings.	Youth across three cultures have many similarities. But at the same time, there are some differences related with how they arrive in the Netherlands, their status here, their levels of language proficiency, etc.	Training
Goals	Agreement between the therapist–client for the aim	Emphasize social contact in case examples. Add new goal: to process difficult memories and emotions.	Many youth mentioned one of the biggest problems as feeling lonely. This feeling affects adaptation and integration highly. New emotional processing module helps to process difficult emotions and memories.	Adaptation, training, implementation
Methods	Ways to achieve the goals	Implement six sessions of 75–min. Possibility of conducting sessions online.	Youth are in favor of shorter sessions. Due to newly added module one additional session is needed. Due to COVID–19 impact the possibility of online sessions are also added.	Implementation
Context	Broader social, political, economic context	Flexible solutions for the continuity of sessions such as reimbursing travel costs, arranging closer locations for the sessions or online sessions, etc.	Youth, especially who are still in their asylum processes live in relatively remote locations in the Netherlands. To enable their participation flexibility and alternative solutions might be needed.	Implementation

importance of continuing their education, particularly for their integration (FL). Similarly, a study conducted in the Netherlands with refugee youth reported that schooling is seen as both crucial for adaptation and a strategy to cope with traumatic memories, yet it also serves as a source of stress (Sleijpen et al., 2017).

Our research revealed that refugee youth, regardless of cultural background, often experience loneliness, stress and low mood. Eritrean and Afghan youth mentioned more frequently loneliness and longing for their families and friends back home. It is known that family reunions play a vital role in improving the well-being of unaccompanied minors (Fegert et al., 2018). Similarly, the participants in our study mentioned prolonged waiting periods for family reunification is a stress factor for them (FL). Additionally, Syrian youth highlighted conflicts with parents due to cultural differences, reflecting challenges in parenting after resettlement. Some participants also mentioned that the cultural clashes between Dutch and Syrian norms led to tensions within families (KI Syrians). These conflicts with families are anticipated considering the previous studies which have consistently highlighted challenges in parenting following resettlement in a new country (Merry et al., 2017; Pangas et al., 2019; Västhagen et al., 2022). This study is not equipped to understand why distinct cultural groups highlighted specific issues, possibly influenced by family presence, the refugee status process and urgent concerns unique to each group.

The insights from this study prompted several adaptations in the PM+ protocol. The majority of the suggested adaptations were in the domains of language (such as not using technical words, using youth-friendly metaphors, translation of short protocols and the worksheets into the native language), context (offering online

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sessions or reimbursing travel costs for more accessibility, sending additional reminders for the sessions, flexibility in scheduling the sessions) and content (adding a new module for EP, adding a new technique, adapting the case examples, adding activities young people engage in) of the intervention. The adaptations we implemented closely resemble those highlighted in a systematic review that emphasized cultural modifications in depression interventions, mostly concentrating on language, context and persons domains (Chowdhary et al., 2014). Additionally, we aimed to enhance PM+ by incorporating an EP component. The development of this component was enriched by the inputs of the expert panel and participants of FGDs. There is growing body of evidence about task-shifting approaches (Purgato et al., 2020; van Ginneken et al., 2021). Studies show that trauma-focused treatments like trauma-focused CBT (TF-CBT; Cohen & Mannarino, 2008) and narrative exposure therapy (NET; Schauer et al., 2005) can be effectively used to treat PTSD treatment in refugee populations, even when delivered by nonprofessional helpers (Goninon et al., 2021; Ellis and Jones, 2022). However, there is heterogeneity in the findings, especially for NET (Turrini et al., 2021). Additionally, neither TF-CBT nor NET are transdiagnostic, as they specifically target PTSD symptoms, nor scalable as they require more extensive training and consist of more sessions (8–16 sessions). Our aim in developing the new EP Module was to contribute to the literature by investigating the feasibility of delivering elements targeting difficult life events as a part of a transdiagnostic and scalable intervention.

While this study offers valuable insights into the challenges faced by refugee youth and proposes a scalable trauma processing module within an effective intervention, it faces several limitations. Firstly, despite efforts to achieve maximum variation in sampling across cultural groups, not all groups are equally represented. Recruiting Afghan youth for FLs and FGDs proved challenging, resulting in their underrepresentation in the sample and hindering our ability to draw strong conclusions about this group. This may be due to the smaller Afghan population in the Netherlands compared to the Syrians and Eritreans, making recruitment more difficult. Although an expert group familiar with young refugees reviewed and provided feedback on the adapted protocol, time constraints prevented us from conducting additional cognitive interviews with local community members regarding the final version. Due to these limitations, it is important to underline the limited generalizability of our findings. However, we believe that despite these limitations, the finalized protocol represents an adapted PM+ protocol, with an integrated new EP module, tailored to the unique context and challenges faced by refugee youth in the Netherlands. Future research should focus on larger and more diverse samples, incorporate both qualitative and quantitative methodologies and involve multiple systems such as family, school and friends to comprehensively understand the multifaceted challenges encountered by young refugees and how these might inform intervention development. Additionally, it is important for researchers to transparently document and share the qualitative and formative processes undertaken before testing interventions to enhance the reproducibility and transparency of future studies.

Conclusion

To conclude, our study provided valuable insights into the challenges faced by refugee youth in the Netherlands, highlighting language barriers, educational challenges and integration. These findings informed the adaptation of the PM+ intervention, including a new EP module, tailored to address these specific issues. The adapted PM+ protocol now includes context-specific modifications and language, as well as additional support mechanisms. The adapted PM+ intervention, incorporating the novel EP module, requires piloting and testing in randomized controlled trials to investigate its feasibility and efficacy, ensuring it effectively meets the unique needs of refugee youth.

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