Journal of open psychology data

Data from the YOURGROWTH/YOURCARE Study on the Mental Health of Young Refugees in Germany

COLLECTION:
DATA ON MIGRATION AND INTEGRATION FOR PSYCHOLOGICAL RESEARCH

DATA PAPERS

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ABSTRACT

This study investigates mental health, well-being, and adjustment processes among refugee children and adolescents aged 7–20 years from the Middle East living in Germany. Using a longitudinal design with up to three annual waves (2019–2022), the study examines psychological symptoms, stress experiences, coping and acculturation strategies, personal and social resources, and barriers to service utilization, and additional relevant factors. Data were collected from 553 participants using multilingual, standardized self-report instruments. Grounded in transactional stress theory and a risk–protective factor framework, the dataset enables analyses of risk exposure, resilience, and developmental trajectories, offering substantial potential for future research on psychosocial adaptation.

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KEYWORDS:
Refugee youths; mental health; acculturation; coping strategies; longitudinal data

TO CITE THIS ARTICLE:
EL-Awad, U., Braig, J., Frețian, A., Kerkhoff, D., Podar, D., Nilles, H., Rueth, J.-E., Schmees, P., Razum, O., Namer, Y., Eschenbeck, H., & Lohaus, A. (2026). Data from the YOURGROWTH/YOURCARE Study on the Mental Health of Young Refugees in Germany. *Journal of Open Psychology Data,* 14: 10, pp. 1–17. DOI: https://doi.org/10.5334/jopd.176

(1) BACKGROUND

1.1 BASIC RESEARCH QUESTIONS

Germany experienced a historically unprecedented increase in the arrival of refugees and asylum seekers in 2015 and 2016, with approximately 1.17 million people arriving during this period. The refugee population was notably young, with the proportion of asylum applicants under the age of 18 increasing from 31.1% in 2015 to 36.2% in 2016 (Bundesamt für Migration und Flüchtlinge [BAMF], 2016, 2017). The main countries of origin during this period were Syria, Afghanistan, and Iraq, with Syrians constituting by far the largest group. Against this background, the present study focuses on refugees from these three countries, most of whom arrived in Germany during the large-scale refugee migration of 2015 and 2016.

The main objectives of the YOURGROWTH/YOURCARE study are (1) to analyze differential psychological adjustment patterns of young refugees aged 7 to 20 years after their arrival in Germany, (2) to identify risk factors and resources that may support or impede their adjustment processes and (3) to identify the patterns of mental health service utilization and the barriers to accessing such services. These objectives are particularly relevant given the multiple stressors and challenges that young refugees may encounter. They may have had problematic or even traumatic experiences before or during their flight to Germany (e.g., war experiences, hunger, exhaustion). After their arrival in the host country, they are confronted with a new cultural and social context (e.g., foreign language, unfamiliar environment, new requirements). Compared with their native peers, young refugees are exposed to a greater number of past and ongoing critical life events as well as daily hassles, potentially leading to elevated stress levels (EL-Awad et al., 2021a).

The dataset originates from two sub-studies with different research foci. One sub-study (YOURGROWTH) primarily examined the mental health and well-being of refugee children and adolescents (and related influencing factors), whereas the second sub-study (YOURCARE) focused mainly on barriers to the use of intervention services aimed at improving psychosocial well-being.

1.2 THEORETICAL BACKGROUND

According to the transactional stress theory (Lazarus & Folkman, 1984), stress arises if a situation is evaluated as stress-evoking and if the available coping resources are evaluated as insufficient. Because children and adolescents have typically limited experience in coping with potentially stress-evoking situations, it can be expected that the problematic life events they have experienced or continue to experience may have a heightened impact on their mental well-being. While short-term stress experiences (e.g., a sudden fright) typically lead to a short-term activation of the sympathetic nervous system, long-term stress is associated with chronic activation of the hypothalamic–pituitary–adrenal (HPA) axis. Activation of the HPA axis triggers the release of cortisol, which increases energy availability and accelerates metabolic processes. Prolonged activation of the HPA axis can have detrimental effects on the organism, as it disrupts the balance between activation and recovery. Continuous physiological activation may ultimately lead to exhaustion over extended periods of time (McEwen, 2007). Therefore, increased stress symptoms such as feelings of exhaustion, headaches, or stomach pain may be observed under such circumstances. This is indeed underlined by several studies focusing on mental health and somatic symptoms of refugee children and adolescents (Daniel-Calveras et al., 2022; Oleimat et al., 2022).

Besides the transactional stress theory, this research is based on a risk-protective factor model (Scheithauer & Petermann, 1999; Zimmerman, 2013) which means that certain risk factors (such as forced migration experiences) might increase the likelihood of stress experiences and the emergence of stress reactions. However, there may also be protective resources that act as health promoting factors. These can counteract risk factors or represent general health promoting mechanisms (such as the availability of social support).

Protective factors can be divided into personal and social resources (Nussbeck & Lohaus, 2016). Examples for protective personal resources can be self-efficacy, self-esteem and optimism, while parental support, authoritative parenting, integration into the peer-group and school integration are examples for social resources. As these resources may foster resilience in the face of increased risks and stress experiences (Jafari et al., 2022), it is necessary to look not only at risks and adversities, but also at available resources to understand the developmental outcomes of young refugees. The resources further extend to formal and informal social support and care structures available in the environment.

Among refugees, personal resources include not only personality characteristics but also orientations toward the host and heritage culture, including its norms and values. According to Berry (1980), four possible acculturation strategies can be distinguished based on these orientations: (1) integration means maintaining traditional norms and values but also trying to adjust to the host culture. (2) Separation means focusing only on maintaining traditional norms and values while having little engagement with the host culture. On the other hand, (3) assimilation involves abandoning traditional values and trying to be maximally in line with the host culture. (4) Marginalization is related to rejecting the norms and values of both cultures. It can be assumed that integration is typically the most adaptive strategy,

because integrated individuals are confronted with less cultural conflicts, which therefore can be expected to be associated with reduced stress experiences (Yeresyan & Lohaus, 2013). Therefore, this strategy is also expected to positively impact well-being.

Not only may the type of acculturation strategy be important for the adaptation to a new context, but also the kind of coping strategy may play a crucial role. According to the transactional stress theory (Lazarus & Folkman, 1984) there are two main types of coping strategies that can be differentiated: emotion-focused and problem-focused coping. While emotion-focused coping is related to reducing emotional reactions to a stressful situation (e.g., reducing anxiety), problem-focused coping is directly related to changing stressful situations. Although both strategy types can be helpful in coping with a stress-evoking situation, there may be cultural differences regarding the extent different coping strategies are used. To improve integration processes, this study also intended to get more information about preferred coping strategies in refugee children and adolescents (e.g., on the role of social support in the adjustment process).

1.3 CONCLUSION

To conclude, the extent and intensity of the resulting effects on mental health and well-being in refugee children and adolescents may depend on the presence of past and concurrent risk factors, including traumatic experiences and challenges, as well as on compensating resources, such as personal and social resources, acculturation strategies, and coping strategies, and access to support services in Germany (including potential barriers to their utilization). The ratio between risk factors and compensating resources may not only determine the immediate effects after the arrival, but also the adjustment process in the host country. To be able to identify not only risk factors and resources, but also developmental trajectories, the study follows a longitudinal design with three yearly assessments over a two-year period.

(2) METHODS

2.1 STUDY DESIGN

A total of 553 children and adolescents were recruited to take part in the initial assessment of the longitudinal study (405 in the first wave and 148 in the second wave, one year later). Of the 553 participants, 268 completed a second assessment, and 97 completed a third assessment. Reassessments in the second and third waves proved to be unexpectedly difficult due to accessibility challenges during the COVID-19 pandemic and frequent relocations of participants during their stay in the host country (EL-Awad et al., 2025b). Children under the age of 12 at their initial participation were administered a shortened assessment battery to account for their limited attention span and the complexity of some questionnaires and individual items made the full assessment inappropriate for this age group (n = 193). Due to COVID-19 restrictions, in some cases a short form of the assessment battery had to be applied at the initial participation (n = 23) and at the second participation (n = 82). Most of these assessments took place in 2020 (101 out of 105) when the COVID-19 restrictions began. The differences between the versions will be outlined below.

2.2 TIME OF DATA COLLECTION

The data collection took place between 2019 and 2022 with three waves ranging from January 15, 2019, to October 11, 2019 (Wave 1), from January 20, 2020, to January 02, 2021 (Wave 2), and from January 11, 2021, to February 08, 2022 (Wave 3). The varying lengths of the data collection periods are mostly due to rearrangements that were necessary due to COVID-19 restrictions. Figure 1 provides an overview for the longitudinal design, the participant flow, and the attrition rates across the assessment points. The Figure also shows the number of participants who received a shortened version of the assessment battery due to COVID-19 restrictions (mainly for assessments conducted in 2020).

2.3 LOCATION OF DATA COLLECTION

Data collection took place mainly at three different regions in Germany: Stuttgart (representing the southern part of Germany), Bielefeld (representing the north-western part of Germany), and Hamburg (representing the northern part of Germany).

2.4 SAMPLING, SAMPLE, AND DATA COLLECTION

The participants came from Syria, Iraq, and Afghanistan and were recruited mostly via schools, refugee housing facilities, and sports clubs (convenience sample). Participation required written consent from their parents or legal guardians if they were 18 years old or younger. Children and adolescents received a €20 voucher for their participation in each wave. Participants who completed questionnaires at all three waves were additionally rewarded with a bonus voucher €30 for children and adolescents. Table 1 provides an overview of the sample characteristics.

The data collection took place with individual participants or in small groups in paper-pencil- or computer-based versions. Trained research assistants were available who mainly spoke the participants' native language for support, typically supervised by a trained psychologist. During COVID-19 lockdown times, the participants received the assessment material by mail to answer them in paper-pencil- or computer-based format with support from a research assistant via telephone.

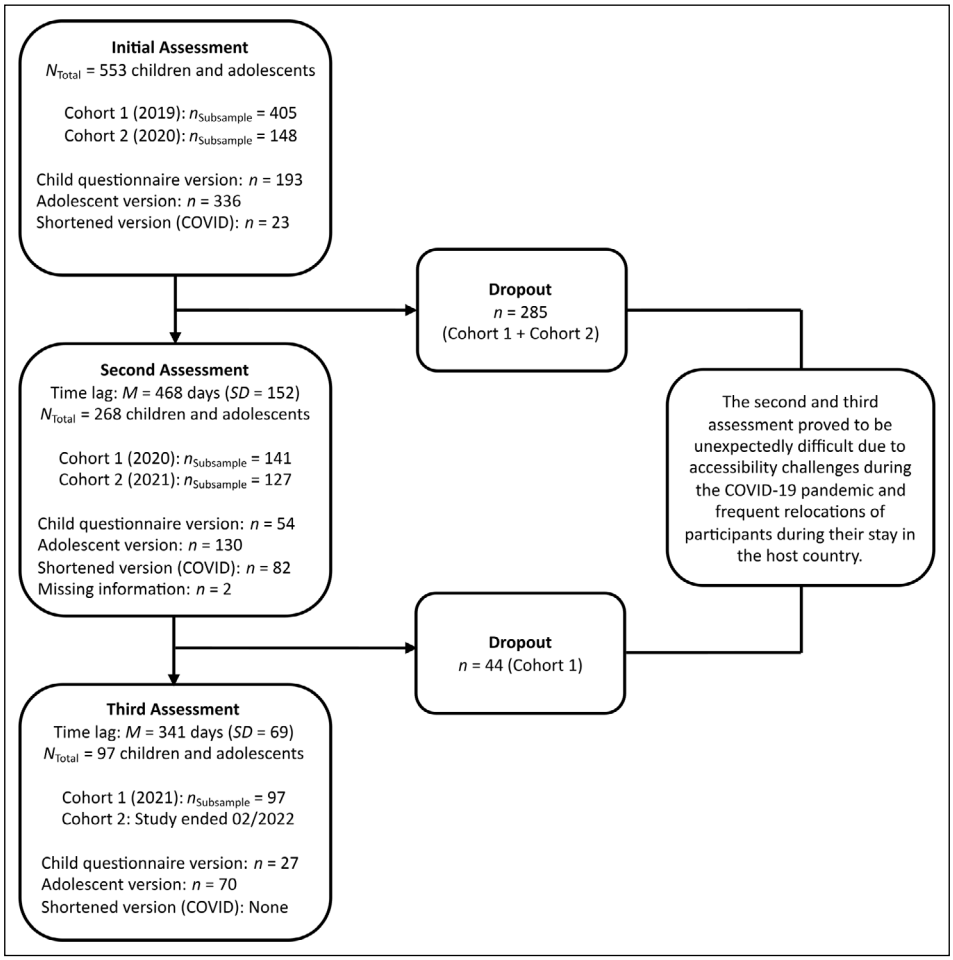


Figure 1 Overview of the longitudinal design of the study.

Data collection took approximately 2 to 2.5 hours for the complete assessment battery and about 30 minutes for the shortened COVID-19 assessment version. All procedures of the research project were approved by the Ethics Committee of Bielefeld University.

All assessment instruments used in this study were provided in the participants' native language (Arabic, Persian or Kurmancî/Sorani Kurdish), but also in German. In most cases, this required translation of the instruments, because they were not available in the respective languages. In these cases, the assessment instruments were translated forth and back to ensure appropriateness of the translation.

2.5 MATERIALS/SURVEY INSTRUMENT

The assessment battery used in the YOURGROWTH study focuses on self-report questionnaires mainly related to risk and protective factors. More specifically, the focus is on (1) past or present traumatic experiences and challenges, (2) health and well-being, (3) personal and social resources, (4) acculturation strategies, (5) coping strategies, and (6) the use of support services in Germany as a source of social support (and possible barriers in the access to such services). Moreover, there were questions related to sociodemographic topics and about the perceived psychological burden caused by the COVID-19 pandemic. Table 2 provides an overview of the measurement instruments used in the study across the study waves and the COVID-19 short form questionnaire. Unless otherwise noted, the reported internal consistency coefficients (Cronbach's α) are based on previously published studies using subsamples of the present dataset, which were selected according to study-specific inclusion criteria.

2.5.1 Past or present traumatic experiences and challenges

SLE. Previously experienced *stressful life events* were recorded using the Stressful Life Events Checklist (SLE; Bean et al., 2004a) which asks about the exposure to traumatic events predominately experienced in the areas of family affairs, traumatic grief, life-threatening illness or medical trauma, accidents and natural disasters, violent and sexual assault, and other traumatic experiences on a yes/no scale (12 items). In addition, the questionnaire contains an open question about experiences not listed. The responses can be quantified to create an overall score. Goodman et al. (1998) confirm good test-retest reliability (kappa = 0.73) and sufficient convergent validity (kappa = 0.64).

AHQ. *Stressors during the acculturation process* in the host country were assessed using the Acculturation

CHARACTERISTIC	CATEGORY	T1	T2	T3
Sample size	Observations, *n*	553	268	97
	Unique participants, *n*	553	268	97
Study site	Valid *n*	553	268	97
	Stuttgart	221 (40.0%)	152 (56.7%)	78 (80.4%)
	Bielefeld	281 (50.8%)	71 (26.5%)	19 (19.6%)
	Hamburg[a]	51 (9.2%)	45 (16.8%)	
Gender	Valid *n*	539	262	97
	Female	245 (45.5%)	120 (45.8%)	41 (42.3%)
	Male	294 (54.5%)	142 (54.2%)	56 (57.7%)
Age group	Valid *n*[b]	520	264	97
	7–10 years	118 (22.7%)	48 (18.2%)	7 (7.2%)
	11–13 years	160 (30.8%)	84 (31.8%)	32 (33.0%)
	14–17 years	212 (40.8%)	98 (37.1%)	42 (43.3%)
	18+ years	30 (5.8%)	34 (12.9%)	16 (16.5%)
Country of origin	Valid *n*	482	259	97
	Syria	254 (52.7%)	143 (55.2%)	50 (51.5%)
	Iraq	149 (30.9%)	64 (24.7%)	26 (26.8%)
	Afghanistan	65 (13.5%)	44 (17.0%)	21 (21.6%)
	Other	14 (2.9%)	8 (3.1%)	
Religion	Valid *n*	389	170	93
	Islam	298 (76.6%)	143 (84.1%)	67 (72.0%)
	Other	91 (23.4%)	27 (15.9%)	26 (28.0%)
Arrival period in Germany	Valid *n*	467	262	96
	2014/2015 or earlier	107 (22.9%)	41 (15.6%)	14 (14.6%)
	2015/2016	161 (34.5%)	102 (38.9%)	34 (35.4%)
	2016/2017	91 (19.5%)	45 (17.2%)	16 (16.7%)
	2017/2018	61 (13.1%)	39 (14.9%)	19 (19.8%)
	2018/2019 or later	47 (10.1%)	35 (13.4%)	13 (13.5%)
Assessment setting	Valid *n*	452	225	94
	Accommodation center	173 (38.3%)	79 (35.1%)	
	School	212 (46.9%)	10 (4.4%)	
	Postal	67 (14.8%)	136 (60.4%)	94 (100.0%)
Questionnaire language	Valid *n*	552	267	97
	German	466 (84.4%)	211 (79.0%)	85 (87.6%)
	Arabic	63 (11.4%)	56 (21.0%)	12 (12.4%)
	Kurmanci	10 (1.8%)		
	Dari	13 (2.4%)		
Questionnaire version	Valid *n*	552	266	97
	Child version	193 (35.0%)	54 (20.3%)	27 (27.8%)
	Adolescent version	336 (60.9%)	130 (48.9%)	70 (72.2%)
	Ultra-short COVID version	23 (4.2%)	82 (30.8%)	

(Contd.)

CHARACTERISTIC	CATEGORY	T1	T2	T3
Administration mode	Valid *n*	545	267	97
	Digital	453 (83.1%)	40 (15.0%)	21 (21.6%)
	Paper-pencil	92 (16.9%)	227 (85.0%)	76 (78.4%)
School type	Valid *n*	439	158	86
	Primary school	114 (26.0%)	31 (19.6%)	10 (11.6%)
	Secondary school	290 (66.1%)	111 (70.3%)	69 (80.2%)
	Vocational school/college	35 (8.0%)	16 (10.1%)	7 (8.1%)
Preparatory/welcome/international class	Valid *n*	432	156	85
	Yes	219 (50.7%)	49 (31.4%)	18 (21.2%)
	No	213 (49.3%)	107 (68.6%)	67 (78.8%)
Main language used with friends in Germany	Valid *n*	449	168	92
	First language/mother tongue	79 (17.6%)	26 (15.5%)	14 (15.2%)
	German	340 (75.7%)	128 (76.2%)	60 (65.2%)
	Other or multiple languages	30 (6.7%)	14 (8.3%)	18 (19.6%)
Supportive adult available	Valid *n*	499	171	92
	No supportive adult named	28 (5.6%)	9 (5.3%)	1 (1.1%)
	Guardian	22 (4.4%)	48 (28.1%)	13 (14.1%)
	Mother/father	388 (77.8%)	93 (54.4%)	61 (66.3%)
	Sibling	18 (3.6%)	6 (3.5%)	4 (4.3%)
	Caregiver/social worker	3 (0.6%)		1 (1.1%)
	Friend	19 (3.8%)	4 (2.3%)	6 (6.5%)
	Teacher	2 (0.4%)	1 (0.6%)	
	Other person	19 (3.8%)	5 (2.9%)	1 (1.1%)
	Multiple persons		5 (2.9%)	5 (5.4%)
Supportive adult lives in Germany	Valid *n*	425	164	92
	Yes	398 (93.6%)	154 (93.9%)	91 (98.9%)
	No	27 (6.4%)	10 (6.1%)	1 (1.1%)
Reasons for leaving country of origin	Fear of violent conflict/war	311 (85.9%)	153 (95.6%)	80 (94.1%)
	Persecution/discrimination due to ethnicity	9 (2.7%)	12 (12.0%)	11 (25.6%)
	Persecution/discrimination due to religion	21 (6.2%)	18 (17.6%)	11 (25.6%)
	Persecution/discrimination due to political views/activities	22 (6.5%)	17 (16.7%)	16 (33.3%)
	Poor living conditions	53 (15.5%)	27 (24.5%)	26 (48.1%)
	Lack of prospects/poverty	23 (6.8%)	11 (10.8%)	13 (28.9%)

Table 1 Sample characteristics by participation order.

Note. Values are n (%) unless otherwise indicated. T1, T2, and T3 refer to first, second, and third participation, respectively, reflecting participation order rather than fixed measurement occasions. The dataset uses –95 as general missing value code. Percentages are based on valid cases within each assessment occasion.

[a] At the Hamburg site, only the first and second participation were possible, as recruitment for this subsample began in Wave 2.

[b] As part of the data anonymization process, age was categorized; the original age values can be obtained from the authors upon request.

Hassles Questionnaire (AHQ; Titzmann et al., 2011) with a focus on acculturation hassles resulting from perceived discrimination, language problems, and family problems (15 items). Another 7 items related to socio-cultural adaptation hassles (Stoessel, et al., 2014) were added related to difficulties in establishing contact with natives in the host country. A 5-point response scale (never to more than 10 times) was used to indicate how often the described daily hassles are experienced by the participants. According to Lohaus et al. (2026), the internal consistencies were α = .86 for discrimination hassles, α = .89 for language hassles, α = .67 for family hassles, and α = .85 for socio-cultural adaptation hassles. In addition, a total score across all 22 items can be computed (α = .93).

PMD. *Post-migration stressors* were assessed by the Post-Migration Difficulties Checklist for Adolescents (PMD-A), which was developed for the YOURGROWTH study based on an extensive review of existing post-migration and acculturative stress inventories (e.g., Silove et al., 1998). A list of 23 possible stressors was generated and rated by 18 experts working with refugee minors in Germany in a counseling or caring function. The participants assessed the degree to which 12 potential stressors were perceived as burdensome in everyday life, using a 5-point scale (not at all burdensome to very burdensome). The PMD-A was used only for adolescents older than 12 years. Based on a longitudinal subsample of 94 participants, the internal consistency was α = .90 in EL-Awad et al. (2025b). It ranged from α = .57 (T1) to α = .87 (T3) in Schmees et al. (2026) based on a larger subsample with 210 participants at T1.

PDQ. *Perceived discrimination* as a possible current stressful challenge for refugee youth was assessed with 16 items, based on the Perceived Discrimination Questionnaire (PDQ; Brondolo et al., 2005). The scale measures the frequency of perceived discrimination on a 7-point scale (never to very often) in areas such as exclusion/rejection (α = .67), stigmatization/degradation (α = .78), discrimination at work/school (α = .73), and threats/aggression (α = .85). As suggested by Keum et al. (2018) a total score across all items can be calculated (α = .73; EL-Awad et al., 2025a).

2.5.2 Health and well-being

HSCL. The Hopkins Symptom Checklist-37A (HSCL-37A; Bean et al., 2004b) was used to assess *refugees' mental health*. The instrument comprises 37 items assessing symptom frequency on a 4-point Likert scale (never to always). It includes five subscales: depression (15 items, α = .91), anxiety (10 items, α = .87), conduct disorder (5 items, α = .75), substance use (5 items, α = .78), and oppositional defiant disorder (2 items, α = .55). The depression and anxiety subscales can be combined to represent internalizing symptoms (α = .94), whereas the remaining three subscales reflect externalizing symptoms (α = .85; EL-Awad et al., 2021b).

KIDSCREEN. *Well-being or health-related quality of life* was assessed using the KIDSCREEN-10 (The KIDSCREEN Group Europe, 2006). It consists of 10 items using a 5-point Likert scale (never to always). A total score across all items can be calculated. The internal consistency was reported as α = .89 (Schmees et al., 2022).

RATS. The Reactions of Adolescents to Traumatic Stress Questionnaire (RATS; Bean et al., 2006) consists of 22 items assessing *posttraumatic stress symptoms* on a 4-point Likert scale (not at all to very much) and was developed particularly for the use in refugee populations. It comprises three subscales: intrusion (6 items), numbing/avoidance (9 items), and hyperarousal (7 items). The questionnaire is available in several languages and demonstrates good psychometric properties, including good internal consistency and evidence of content, construct, and criterion validity (Bean et al., 2006). However, it has not been included in previous publications arising from the YOURGROWTH or YOURCARE studies.

SSKJ. The Stress and Coping Questionnaire for Children and Adolescents (SSKJ 3–8 R; Lohaus et al., 2018; Gillé et al., 2021) was used to assess *psychological and somatic stress symptoms, and well-being*. Psychological stress symptoms were assessed using 12 items (α = .79), somatic stress symptoms using 6 items (α = .66), and well-being using 4 items (α = .71) (Lohaus et al., 2026), each assessed with a 3-point rating scale (not experienced, experienced once, or experienced several times in the past week). Total scores can be calculated across the respective items.

2.5.3 Personal and social resources

FRKJ. The *perceived personal and social resources* were measured by means of the German Questionnaire to Assess Resources for Children and Adolescents (QARCA; Lohaus & Nussbeck, 2016). The QARCA assesses 6 personal resources: (1) empathy/perspective taking, (2) self-efficacy, (3) self-control, (4) self-esteem, (5) optimism, and (6) sense of coherence. In addition, the questionnaire assesses four social resources: (1) parental social and emotional support, (2) authoritative parenting, (3) integration into peer group, and (4) school integration) with 6 items each to be answered on a 4-point rating scale (never true to always true). Total scores can be calculated for the primary scales as well as for the two secondary scales measuring personal resources (36 items) and social resources (24 items). Internal consistencies for the secondary scales were α = .95 (personal resources) and α = .93 (social resources), and $.74 \leq \alpha \leq .88$ for the primary scales on personal and $.77 \leq \alpha \leq .89$ on social resources (Lohaus et al., 2026).

2.5.4 Acculturation and cultural identity

FRAKK. The Frankfurt Acculturation Scale for Children and Adolescents (FRAKK-KJ; Frankenberg & Bongard, 2013) was used to assess *acculturation orientations*. The

degree of agreement with various cultural preferences in the areas of languages, travel, entertainment and music, social circumstances, identity, and migration intentions is measured using a 5-point rating scale (strongly disagree to strongly agree). Total scores across the 12 items can be calculated for cultural orientation towards the dominant society (6 items; α = .74) and for orientation towards the culture of origin (6 items; α = .73) (EL-Awad et al., 2025b).

ID. The Ethnic and National Identity Questionnaire for Children and Adolescents by Leszczensky and Gräbs Santiago (2015) was used to assess the *ethnic and national identity* of refugee youth with 4 items each, using a 5-point rating scale (does not apply at all to fully applies). There are additional items for self-categorization of the ethnic group belonging. Internal consistency for the subscale ethnic identity was α = .78 (Schmees et al., 2022).

SRQ. The Social Role Questionnaire (SRQ; Baber & Tucker, 2006) measures participants' *gender-linked and gender-transcendent attitudes* which may reflect cultural differences in viewing gender roles. Participants indicated their agreement with statements such as "Mothers should work only if necessary" (gender-linked, 8 items) or "We should stop thinking about whether people are male or female and focus on other characteristics (e.g., kindness, ability, etc.)" (gender-transcendent, 5 items) on an 11-point rating scale (not at all to completely agree). According to Nilles et al. (2023), the reliabilities were α = .82 for the gender-linked and α = .76 for the gender-transcendent scale in the refugee youth sample. Total scores can be calculated for both subscales.

2.5.5 Coping strategies

SSKJ. The Revised Stress and Coping Questionnaire for Children and Adolescents (SSKJ-3–8 R; Lohaus et al., 2018) was used to assess *coping strategies*. Participants rated on a 5-point rating scale (never to always) how often they used certain coping behaviors in a stressful situation (i.e., an argument with a close friend). Five coping strategies were recorded using 5 items each with total scores for (1) seeking social support (α = .69), (2) problem-focused coping (α = .76), (3) palliative emotion regulation (α = .66), (4) avoidant coping (α = .68), and (5) anger-related emotion regulation (α = .63) (EL-Awad et al., 2025a). The subscales on coping strategies were also used in Nilles et al. (2022), with internal consistencies generally similar across samples, albeit with some minor differences in individual subscales.

REL. *Religiosity* can serve as a resource and can be supportive in coping with challenges (Schmees et al., 2023). Therefore, the extent to which the minors identify with their religion was assessed, as well as how often they practice it. Religious identity was measured by a 4-item scale (Fleischmann et al., 2019; e.g., "It bothers me when someone speaks badly about my religion"). Religious practice was assessed by two items (e.g., "How often do you pray?"). All items were assessed using 5-point rating scales, with response options ranging from frequency-based categories (never to several times) to agreement-based categories (does not apply at all to fully applies). The internal consistency for refugee minors was α = .78 (religious identity), while the correlation between the two items related to religious practice was *r* = .49 (Schmees et al., 2023).

2.5.6 Use of social support services

There are additional questionnaire scales in the YOURGROWTH data set which were part of the YOURCARE subproject and not used in the YOURGROWTH data analyses. These scales will be described shortly in the following sections. The YOURCARE subproject focused on the perceptions, knowledge, and utilization of support services as well as potential barriers to accessing such services in Germany. The dataset consists of the quantitative part of this mixed-method study.

EXP. The Past Help-Seeking Experience questionnaire is related to *past experiences in getting support from mental health professionals* (in particular by psychotherapists). It contains a set of items with varying response formats that capture past experiences with getting mental health support (based on Bean et al., 2006, and Rickwood, et al., 2005).

Stigma. *Mental illness stigma* was assessed using the Revised Attribution Questionnaire (r-AQ; Pinto, et al., 2012) on attitudes about mental illness. The participants were asked to respond to a set of eight items with attributions to mental illness corresponding to the domains of blame, anger, pity, help, dangerousness, fear, avoidance, and coercion. They were instructed to respond to these items in reference to a new student whom they had heard had a mental illness using a 7-point rating scale. A total score can be calculated indicating the magnitude of mental illness stigma.

Self-Stigma. The Child Stigma Scale (Moses, 2009) is related to the *self-concept of youths* regarding shame, embarrassment, and worry about others' responses to their mental health problems. It contains five items with a 4-point Likert scale (almost never to very often). A total score across the items can be used to indicate the self-concept of young people receiving mental health treatment.

Bar Exp/Bar No Exp. An adapted version of the Intrinsic and Extrinsic Barriers to Mental Health Care Among Older Adults questionnaire by Pepin et al. (2009) was used to address *barriers to mental health care* in young refugees. The questionnaire consists of 12 items related to language/cultural barriers (e.g., language barriers in communication with a psychotherapist) and structural barriers (e.g., insurance or payment concerns). Total scores can be calculated for both subscales with 6 items each. The data set contains a second version of this questionnaire with 19 items. The first two subscales are identical to the previously described version, but this version contains an additional subscale with 7 items related to knowledge and attitudes about mental health professionals.

Need Use. Based on Bean et al. (2006) a questionnaire was integrated asking about the *perceived need for mental healthcare* and *actual help-seeking behavior*. It asks whether respondents recognize emotional difficulties, know how to access psychotherapy, have been advised to seek professional help, and with whom they have discussed their problems, all assessed using dichotomous response options (yes/no). It also captures past and intended use of psychotherapy and the sources of support or referral (e.g., family, professionals, community members).

SoDi. This questionnaire is based on Wahl et al. (2011) and measures *social distancing attitudes toward people with mental illness*. It assesses the willingness to engage in varying levels of social contact ranging from casual interaction to close personal relationships with individuals who have mental health conditions. The scale consists of 8 items with a 5-point response format (not at all willing to very willing). A total score can be calculated indicating the degree of acceptance toward people (especially peers) with mental illness.

Sources. This questionnaire, adapted from Rickwood et al. (2005) assesses the *perceived helpfulness of formal and informal help-seeking sources* for emotional or mental health difficulties. Respondents rate how helpful they consider various sources of support (such as family, friends, professionals, and community members). Based on 13 items with a 5-point response scale (very helpful to not helpful, with an additional option for not applicable), the instrument allows for differentiation between formal (e.g., therapists, doctors; 6 items) and informal (e.g., family, peers; 7 items) help-seeking pathways. Total scores can be computed across all items and across the subscale items (formal and informal).

INSTRUMENT/ABBREVIATION	CONSTRUCT	ORIGINAL LANGUAGE VERSION	W1	W2	W3	COVID-SF
SLE	Stressful life events	E	✓	✓	✓	
AHQ	Acculturation hassles	E	✓	✓	✓	
PMD	Post-migration living difficulties	G	✓	✓	✓	
PDQ	Perceived discrimination	E	✓	✓	✓	
HSCL-37A	Mental health symptoms	E	✓	✓	✓	✓
KIDSCREEN-10	Health-related quality of life	G	✓	✓	✓	✓
RATS	Traumatic stress reactions	G	✓	✓	✓	✓
SSKJ 3–8 R	Stress and coping	G	✓	✓	✓	✓
FRKJ	Resources	G	✓	✓	✓	✓
FRAKK-KJ	Acculturation	G	✓	✓	✓	✓
ID	Ethnic and national identity	E	✓	✓	✓	✓
SRQ	Gender role attitudes	E	✓	✓	✓	✓
REL	Religiosity and religious identity	E	✓	✓	✓	✓
Exp	Past help-seeking experience	E	✓	✓	✓	
Stigma	Attitudes toward mental illness	E	✓	✓		
Self-stigma	Self-stigma	E	✓	✓	✓	
BarExp	Barriers to mental health care (prior experience)	E	✓	✓	✓	
BarNoExp	Barriers to mental health care (no prior experience)	E	✓	✓	✓	
Need Use	Mental healthcare need and use	E	✓	✓	✓	✓
SoDi	Social distance	E	✓	✓	✓	
Sources	Perceived helpfulness of help sources	E	✓	✓	✓	
Demographic and structural variables	Sample and study characteristics	G	✓	✓	✓	✓
COVID-19 restrictions	COVID-related restrictions	G		✓	✓	
COVID-19-related stress and life satisfaction	COVID-related stress and life satisfaction	G	✓	✓	✓	✓
SEK	Social desirability	G	✓	✓	✓	✓

Table 2 Measurement instruments by study wave and COVID-19 short form.

Note. W1/W2/W3 = Wave 1, Wave 2, Wave 3. COVID-SF = COVID-19 short form questionnaire; E = English, G = German.

2.5.7 Sociodemographic topics, COVID-19 related stressors, and social desirability

Structural Variables. This section documents structural and administrative information about data collection. It includes participant and site identifiers, type and location of the setting (e.g., school or accommodation), language and version of the questionnaire, and mode of administration. In addition, it records participation history across waves, timing of assessments, links between siblings, notes on data quality or exclusions, and whether data were collected before or during/after the COVID-19 pandemic. The items are in varying response formats.

Demographics. This data section is related to demographic, linguistic, educational, and migration-related background information. It includes questions on age, gender, country of origin, ethnic affiliation, and religion, as well as year of arrival and residence status in Germany and reasons for leaving the country of origin. In addition, it covers language skills, schooling and educational history, work experience, family situation and social support, living conditions, and everyday circumstances such as mobility and school attendance. The items are in varying response formats.

COVID-19 Restrictions/COVID-related stress and life satisfaction. The *COVID-19 Restrictions* questionnaire captures school arrangements, contact restrictions with friends, and limitations on leaving home during the COVID-19 pandemic. It contains 4 items with varying response formats. The *Perceived COVID-related Stress and Life Satisfaction* questionnaire measures emotional distress related to the pandemic (e.g., worries, loneliness, school difficulties) as well as satisfaction with home atmosphere, peer contact, and time use before and during COVID-19. Responses can be used to derive two scales: COVID-related stress (4 items; $\alpha = 0.74$; Braig et al., 2024; adapted from Andresen et al., 2020) and COVID-related life satisfaction (4 items; adapted from Andresen et al., 2020).

SEK. Social desirability was assessed using a short scale from the *Anxiety Questionnaire for Students* (Wieczerkowski et al., 2016). The questionnaire consists of 3 dichotomous (yes/no) items capturing the tendency to present oneself in an overly positive or socially desirable manner (e.g., claiming to always behave well or to never have lied). Increased total scores indicate a stronger tendency toward socially desirable responding.

2.6 QUALITY CONTROL

Regular meetings were held both within and across participating working groups to discuss emerging issues. In addition, a considerable amount of time was devoted to developing the different language versions of the surveys, primarily through systematic back-translations and comparisons with the original version, followed by final decisions on the wording based on these processes. Table 2 shows the original language versions of the measurement instruments included in the study. In a few cases, translations of German instruments into English were already available (e.g., FRKJ, SSKJ-3-8 R), as were German translations of English-language instruments (e.g., HSCL-37A, KIDSCREEN-10). However, in almost all cases, translations into the participants' native languages (Arabic, Persian, or Kurmancî/Sorani Kurdish) were necessary. The instruments used in this study may be made available by the authors upon reasonable request, subject to applicable copyright and licensing restrictions.

The longitudinal follow-up of the sample turned out to be more resource-intensive than expected. A wide range of measures were employed to support sample retention, including the involvement of accommodation facilities, residents' registration offices, and other institutions. Nevertheless, for a variety of reasons – further compounded by the COVID-19 pandemic – missing data occurred, which in some cases had to be addressed through imputation procedures. If imputation procedures were used, they are documented in the respective papers. The data file itself does not contain any imputed data.

Training the test administrators was also demanding, as data collection was almost exclusively carried out by individuals who were familiar with the languages of the children and adolescents being surveyed, but who did not always have extensive experience with conducting surveys. A trained psychologist was also present during data collection to support and manage any emerging emotional reactions. The quality of data entry had to be monitored in cases where questionnaires were entered manually, with random checks being conducted on an intended proportion of 10% of the entries. Moreover, out-of-range entries were identified by inspecting item frequency tables for incorrect values. Any discrepancies were resolved by checking the participants' original responses. For the portion of the data collected via tablets, data entry checks were not necessary because the range of possible entries was restricted to valid responses. In the case of longitudinal assessments, additionally plausibility checks were conducted (e.g. by comparing participants' reported ages across assessment time points).

2.7 DATA ANONYMIZATION AND ETHICAL ISSUES

Two weeks prior to the survey, the parents received an information letter including a consent form, which explained the content and objectives of the survey. It was explicitly emphasized that both the parents (if the participants were under 18 years of age) and the participating children and adolescents could refuse participation without any disadvantages resulting from this decision. The children and adolescents were also able to withdraw from the survey at any time during data collection. In order to enable a longitudinal matching of the data, a coding procedure was used (pseudonymization). As asking about potentially traumatic experiences could lead to psychological

distress, participants and their parents were informed about possible counseling services they could contact if needed. The Ethics Committee of Bielefeld University reviewed the entire procedure and classified it as ethically unobjectionable in a letter dated August 27, 2018 (EUB 2018-101), with procedural adaptations implemented during the COVID-19 pandemic, including a temporary shift to postal data collection.

Before the data were made available, measures were taken to minimize the possibility of identifying individual participants. For example, variables were grouped into broader categories (e.g., age was recoded into age categories, and school type was reduced to a distinction between primary and secondary school). In addition, responses to open-ended questions were removed because they frequently contained personal information. In general, the data were processed in a way that prevents the re-identification of individual participants.

2.8 EXISTING USE OF DATA

Braig, J., Schmees, P., Kilinc, Y., EL-Awad, U., Nilles, H., Kerkhoff, D., Rueth, J.-E., Lohaus, A., & Eschenbeck, H. (2024). Health-related quality of life of young refugees in Germany during the COVID-19 pandemic: Comparisons to non-refugees and pre-pandemic times. *Current Psychology, 43*, 18824–18835. https://doi.org/10.1007/s12144-023-04838-0.

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Table 3 provides a short overview about the usage of the survey instruments from the YOURGROWTH/YOURCARE subprojects in previous publications. The sequence of the described measure use is in line with the sequence of the publications in the previous section.

(3) DATASET DESCRIPTION AND ACCESS

The following sections refer to the data files of the YOURGROWTH/YOURCARE project (see Eschenbeck et al., 2024). They are freely available to the scientific community.

MANUSCRIPT	APPLIED MEASURES
Braig et al. (2024)	• Health-Related Quality of Life (KIDSCREEN-10) • Perceived COVID-Related Stress Scale for Children and Adolescents • Hopkins Symptom Checklist-37 (HSCL-A) • Stressful Life Events Checklist (SLE)
Braig et al. (2025)	• Acculturative Hassles Questionnaire (Subscale Language Hassles) • Language Skills (from the demographics part of the questionnaire) • Hopkins Symptom Checklist-37 (HSCL-A)
EL-Awad et al. (2025a)	• Perceived Discrimination Questionnaire • Frankfurt Acculturation Scale for Children and Adolescents (FRAKK-KJ) • Revised Stress and Coping Questionnaire for Children and Adolescents (SSKJ-3–8 R) • Hopkins Symptom Checklist-37 (HSCL-A) • Stressful Life Events Checklist (SLE)
EL-Awad et al. (2025b)	• Revised Stress and Coping Questionnaire for Children and Adolescents (SSKJ-3–8 R) • Frankfurt Acculturation Scale for Children and Adolescents (FRAKK-KJ) • Hopkins Symptom Checklist-37 (HSCL-A) • Perceived Post-Migration Stress (PMD)
EL-Awad et al. (2021a)	• Stressful Life Events Checklist (SLE) • Hopkins Symptom Checklist-37 (HSCL-A) • Perceived Post-Migration Stress
Frețian et al. (2020)	• Hopkins Symptom Checklist-37 (HSCL-A) • Use of a single item to assess the subjective need for mental health care
Lohaus et al. (2026)	• Stressful Life Events Checklist (SLE) • Acculturation Hassles Questionnaire (AHQ) • German Questionnaire to Assess Resources for Children and Adolescents (FRKJ/QARCA) • Symptom subscales from the Stress and Coping Questionnaire for Children and Adolescents (SSKJ 3–8 R)
Podar et al. (2022)	• Mainly based on an interview study conducted in addition to the YOURCARE study
Namer et al. (2022a)	• Hopkins Symptom Checklist-37 (HSCL-A) • Items from different scales related to mental help health seeking behavior • Satisfaction with psychotherapy, barriers to psychotherapy, and social resources
Namer et al. (2022b)	• Stressful Life Events Checklist (SLE) • Items related to subjective mental health and subjective need of help
Nilles et al. (2023)	• Social Role Questionnaire (SRQ) • Symptom Subscales from the Revised Stress and Coping Questionnaire for Children and Adolescents (SSKJ-3–8 R)
Nilles et al. (2022)	• Social Role Questionnaire (SRQ) • Coping Subscales from the Revised Stress and Coping Questionnaire for Children and Adolescents (SSKJ-3–8 R)
Schmees et al. (2023)	• Religious Identity and Religious Practice (Religiosity questionnaire) • Health-Related Quality of Life (KIDSCREEN-10) • Perceived COVID-Related Stress Scale for Children and Adolescents • Ethnic and National Identity Questionnaire for Children and Adolescents • Sense of Coherence and Integration into Peer Group Subscales from the German Questionnaire to Assess Resources for Children and Adolescents (FRKJ/QARCA)
Schmees et al. (2022)	• Religious Identity and Religious Practice (Religiosity questionnaire) • German Questionnaire to Assess Resources for Children and Adolescents (FRKJ/QARCA) • Ethnic and National Identity Questionnaire for Children and Adolescents (ID) • Language skills
Schmees et al. (2026)	• Health-Related Quality of Life (KIDSCREEN-10) • Perceived Post-Migration Stress (PMD)

Table 3 Measurement instruments used in previous publications.

3.1 REPOSITORY LOCATION

The data files are available via the Research Data Center at the Leibniz Institute for Psychology (ZPID). The access link is http://dx.doi.org/10.5160/psychdata.ekhe22pr18.

3.2 OBJECT/FILE NAME AND DATA TYPE

There are three files related to (1) the description of the files (ekhe22pr18_readme.txt; available in German and English), (2) the primary data set (ekhe22pr18_pd.txt), and (3) the codebook for the primary data set (ekhe22pr18_kb.txt; available in German and English).

3.3 FORMAT NAMES AND VERSIONS

The file format for all files is text file (.txt).

3.4 LANGUAGE

The main language is German, but also English is used, because several questionnaires were originally in English language.

3.5 LICENSE AND LIMITS TO SHARING

The dataset is available to researchers upon completion of a data use agreement due to the sensitive nature of the data. To request access, researchers can follow the dataset DOI and complete a form specifying their name, affiliation, contact information, and intended use. The signed agreement must be submitted to RDCservice.info@leibniz-psychology.org. Following a standard review process by the Research Data Center (RDC), including consultation with the data contributors, researchers receive a download link to the dataset via email.

3.6 PUBLICATION DATE

The data files were published in the data repository in 2024.

(4) REUSE POTENTIAL

As was already mentioned, the dataset originates from two sub-studies: YOURGROWTH focused on mental health and well-being among refugee children and adolescents, whereas YOURCARE examined barriers to accessing psychosocial intervention services. Against this background, the publications available to date have each addressed research questions within the respective sub-studies, while there have been virtually no cross-project analyses so far. This results in considerable potential for further use of the data. One possible research question, for example, could be the role of the degree of impairment in mental health or well-being for perceived need to use of intervention services. Furthermore, it can be analyzed to what extent the perceived barriers to accessing health-related intervention services contribute to hindering psychosocial adaptation processes. It could also be interesting to analyze the role of stigma related to mental illnesses in relation to self-reported mental health and well-being. In summary, the focus is on the relationships between the data from Sections 2.5.1–2.5.5 and those from Section 2.5.6. Since sociodemographic factors may also be relevant in this context (Section 2.5.7), variables from this domain could also be included in the analyses.

To date, there are only few project publications that make use of the longitudinal data. In principle, the dataset also offers further potential in this regard, with analyses of directionality (e.g., between acculturation and coping strategies on the one hand and indicators of psychosocial adjustment on the other hand) being particularly promising. The longitudinal significance of available personal and structural resources has also received little attention so far. In addition, only few analyses have examined longitudinal developmental trajectories, although it would be highly informative to identify adjustment processes in the host country and the factors influencing them – particularly with regard to potential targets for prevention and intervention measures. However, it should be noted as a limitation that analyses including all three measurement waves are associated with a substantial reduction in sample size. There was also very little actual utilization of services reported by the participants. It therefore appears advisable to restrict longitudinal analyses to the first two measurement waves; nevertheless, this approach should be sufficient to address the research questions outlined above.

Furthermore, posttraumatic stress symptoms (as assessed with the RATS) have received little attention in the project's publications to date. Relevant research questions concern the role of coping and acculturation strategies, psychosocial resources, stress experiences before and during flight, and demographic characteristics in the development and severity of posttraumatic stress symptoms. In this context as well, longitudinal analyses (at least across two measurement waves) could make a meaningful contribution to advancing knowledge.

In summary, the available data offer substantial potential for addressing additional research questions. Within the project consortium, it was possible to examine several core research objectives; however, it was not feasible to fully exploit the overall potential arising from the extensive data collection.

FUNDING STATEMENT

This work was supported by the German Federal Ministry of Education and Research [#GR-01GL1749A, GR-01GL1749B].

COMPETING INTERESTS

The authors have no competing interests to declare.

AUTHOR CONTRIBUTIONS

UE/AL contributed to data collection, data analysis, and manuscript writing.

JB/AF/DK/DP/HN/J-ER/PS/YN contributed to data collection and were involved in manuscript editing.

OR/YN/HE/AL supervised the project.

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Journal of Open Psychology Data has blind peer review, which is unblinded upon article acceptance. The editorial history of this article can be downloaded here:

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TO CITE THIS ARTICLE:
EL-Awad, U., Braig, J., Frețian, A., Kerkhoff, D., Podar, D., Nilles, H., Rueth, J.-E., Schmees, P., Razum, O., Namer, Y., Eschenbeck, H., & Lohaus, A. (2026). Data from the YOURGROWTH/YOURCARE Study on the Mental Health of Young Refugees in Germany. *Journal of Open Psychology Data,* 14: 10, pp. 1–17. DOI: https://doi.org/10.5334/jopd.176

Submitted: 30 April 2026 **Accepted:** 01 November 2026 **Published:** 17 November 2026

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