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INVISIBLE WOUNDS, VISIBLE OBLIGATIONS: LEGAL PROVISION FOR REFUGEE MENTAL HEALTH

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*The purpose of the study is to provide a synthetic analysis of both the legal and psycho-social dimensions of the refugee crisis, aiming to reveal systemic flaws in the protection of refugees' mental health. Furthermore, the study seeks to identify and analyze key problems within this field, including the limited availability of psychological services, the deficit of culturally sensitive approaches, chronic stress caused by legal status uncertainty, and the social barriers encountered during the integration process. **Research methods:** in the article, the research was conducted by using historical, comparative-legal, and normative methods, dictated by the complex nature of the issue. The historical method was applied to identify the root causes of forced displacement and to evaluate how international policy has transformed into legal norms over time. The comparative-legal method was utilized to analyze the migration and asylum policies of various countries, alongside their legal and institutional mechanisms for protecting refugee mental health, thereby highlighting best practices and identifying legal and administrative barriers. The normative method was used to focus on the normative content of the law, outlining refugee rights within the Georgian Law "On International Protection," international conventions, and European legislation to assess how clearly mental health guarantees and special procedural needs are defined at the normative level. **Results:** empirical research indicates a significantly increased risk among refugees of developing mental health disorders, including depression, anxiety disorders, and post-traumatic stress disorder (PTSD), as well as facing crises of adaptation, identity, and belonging. The findings highlight that these psychological burdens are frequently the direct result of traumatic experiences (such as violence, persecution, and the loss of family members), forced displacement, legal uncertainty, and severe difficulties in integrating into host societies. **Discussion:** considering the destructive trends in the modern world, including political instability, economic crises, numerous localized wars and armed conflicts, climate change, and natural disasters, the issue of migration and its associated challenges is becoming increasingly urgent. The refugee issue is inherently interdisciplinary. On one hand, it encompasses a legal dimension involving migration procedures, legal status determination, asylum mechanisms, and state obligations. On the other hand, it represents a complex medical and psycho-social problem that directly impacts the physical and mental well-being of refugees, falling squarely within the competence of social protection, healthcare, psychology, and psychiatry. Reconciling these two dimensions is crucial for overcoming the administrative and social barriers that hinder effective psychosocial support.*

Keywords: migration; mental health; PTSD; interdisciplinary approach; asylum policy; international protection.

1. LEGAL GUARANTEES FOR THE
MENTAL WELL-BEING OF REFUGEES

The Legal Status of Refugees in International Law. The post-World War II period proved to be a turning point in the history of international humani-

tarian and human rights law development, as the deficit of a robust legal framework defining refugee status became glaringly apparent. The fragmented approaches applicable prior to this period failed to ensure the comprehensive protection of the rights of forcibly displaced persons, which necessitated the adoption of an agreement that would establish a general legal definition of the concept of a refugee. To this end, the Convention Relating to the Status of Refugees was adopted on July 28, 1951 (entered into force on April 21, 1954), which formulated a new standard for international protection mechanisms and laid the foundation for the subjective legal guarantees of refugee rights.

The 1951 Convention establishes a universal definition of a refugee, predicated on objective and subjective criteria of individual persecution. Pursuant to Article 1(A)(2) of the Convention, a refugee is a person who:

"as a result of events occurring before 1 January 1951 and owing to well-founded fear of being persecuted... is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country" [1].

It is noteworthy that the original redaction of the Convention contained both a temporal limitation (events occurring before 1951) and a geographical reservation, reflecting the specific needs of post-war Europe. However, the dynamics of international relations and the increasing scale of forced migration brought the issue of universalizing this definition to the forefront of the agenda. This lacuna was addressed by the 1967 Protocol, which abolished the aforementioned restrictions and rendered the protection mechanisms envisaged by the Convention global in scope.

From the perspective of legal dogmatics, the "well-founded fear of being persecuted" is decisive for the granting of refugee status, which implies the existence of a threat for reasons of race, religion, nationality, membership of a particular social group, or political opinion. It is precisely this element that constitutes the principal line of demarcation between refugees and other forms of migration.

Professor Guy S. Goodwin-Gill posits that refugees covered by the Convention can be identified according to four characteristics: (1) they are outside their country of origin; (2) they are unable or

unwilling to claim or avail themselves of the protection of that country, or to return there; (3) such inability or unwillingness is attributable to a well-founded fear of being persecuted; and (4) the fear of persecution is based on reasons of race, religion, nationality, membership of a particular social group, or political opinion [2]. Crucially, the fear of persecution must be real and substantiated, rather than a mere subjective perception.

Refugees vs IDPs. Regrettably, a majority of the global population faces difficulties in differentiating between a refugee and related terms, largely due to the conflation of the concepts of "refugee" and "internally displaced person" (IDP). It is all the more unfortunate that this terminological confusion is prevalent in Georgia as well. Internally displaced persons from Abkhazia are still frequently referred to as "refugees," which is fundamentally absurd.

In general, there are two forms of forced migration: (1) Internal Displacement, which, as the name implies, entails remaining within state borders and changing administrative territories entirely within the same state; and (2) International Migration, which occurs when an individual crosses the border of one state and enters the sovereign territory of another.

Accordingly, internally displaced persons (IDPs) from Abkhazia fall under the first category of forced migration internal displacement, whereas refugees fall under international migration. Based on this premise, we can conclude that: 1. All refugees are migrants, but not all migrants are refugees; and 2. The moment we label an internally displaced person from Abkhazia a "refugee," we implicitly recognize the independence of Abkhazia.

2. MENTAL HEALTH AS A FUNDAMENTAL RIGHT.

Types of Mental Disorders. Conceptualizing mental well-being as a rights-based standard necessitates establishing its substantive nexus with mental disorders. Given the complexity of the issue, it is imperative to delineate the criteria that render a mental disorder an independent, yet intrinsically linked, component of mental health.

According to the 11th Revision of the International Classification of Diseases (ICD-11), a mental disorder is defined as a clinically significant syndrome characterized by a disturbance in an individ-

ual's cognition, emotional regulation, or behavior [3]. Such dysfunction reflects deficiencies in the psychological, biological, or developmental processes that underlie normal human functioning. From a legal perspective, it is essential to consider that such disturbances typically induce profound distress and impede personal realization across personal, social, educational, or occupational fields, thereby serving as a basis for the activation of appropriate protective mechanisms by the state.

According to World Health Organization (WHO) data for 2024-2025, over 1 billion individuals are living with mental health conditions. Although numerous nations have fortified their mental health policies and programs, significantly greater global investment and concerted action are required to scale up services aimed at the protection and promotion of human mental health [4].

Among refugee populations, taking into account pre- and post-migration factors, the most prominently identified conditions are Post-Traumatic Stress Disorder (PTSD), Major Depressive Disorder (MDD), and Generalized Anxiety Disorder (GAD).

Post-Traumatic Stress Disorder (PTSD): A disorder that may develop when an individual experiences or witnesses an event which, in their perception, poses a threat to life or physical integrity and safety, thereby inducing fear, horror, or helplessness. Its symptomatology is characterized by: (a) re-experiencing the trauma in the form of distressing memories, flashbacks, or recurrent dreams and nightmares; (b) avoidance of activities or places that serve as reminders of the traumatic event, accompanied by diminished responsiveness (emotional anesthesia or numbing), a lack of interest in significant activities, and feelings of detachment and alienation from others; and (c) chronic physiological hyperarousal, leading to symptoms such as an exaggerated startle response, sleep disturbances, difficulties in concentration or memory, and survivor's guilt for having survived the trauma when others did not [5].

Major Depressive Disorder (MDD): A mood disorder characterized by persistent sadness and other symptoms of a major depressive episode, but devoid of concurrent episodes of manic or hypo-

manic symptoms, or mixed episodes of depressive and manic/hypomanic symptoms [6].

Generalized Anxiety Disorder (GAD): Entails excessive anxiety and worry concerning various matters, accompanied by symptoms such as restlessness, fatigue, impaired concentration, irritability, muscle tension, and sleep disturbances [7].

The aforementioned observations demonstrate that the identification of post-traumatic and other mental disorders among refugees is directly correlated with their capacity for a dignified existence and social integration. Consequently, the implementation of international standards (including the ICD-11) into national legislation is crucial for the establishment of adequate legal protective mechanisms. Ultimately, the recognition of mental well-being as a rights-based standard serves as a guarantee that the rehabilitation of vulnerable groups and their full integration into society will be underpinned by a tangible legal foundation.

Mental health and human rights. An individual's mental state is not a static condition; it is fundamentally shaped by the continuous interaction between personal characteristics and the socio-environmental structures in which they live. Mental health disorders frequently arise from a disruption in the equilibrium between an individual's internal resilience and external stressors. For displaced populations, chronic stressors, such as war, forced migration, social vulnerability, and legal precarity, play a decisive role in undermining mental equilibrium. Consequently, the State's role in protecting the right to health must extend beyond mere medical intervention. States hold a positive obligation to cultivate environments that mitigate stress and foster psychological resilience.

This is supported by the World Health Organization (WHO), which highlights that socially marginalized groups, including refugees, exhibit significantly higher rates of mental disorders compared to the general population [8, 9].

Conceptualizing mental well-being as the foundation of personal functioning provides the necessary ground for defining its legal status. Mental health is no longer viewed exclusively as a medical condition but is recognized as an inalienable and fundamental component of the universal right to

health. This normative foundation is consolidated in key international instruments:

The International Covenant on Economic, Social and Cultural Rights (ICESCR): Article 12 explicitly recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" [10].

CESCR General Comment No. 14: The relevant Committee emphasizes that the right to health transcends medical care to include the underlying determinants that impact mental well-being. It imposes a binding obligation on States to ensure equitable access to health services and protective mechanisms for the most vulnerable cohorts, specifically including asylum seekers, internally displaced persons (IDPs), and detained individuals [11].

The Universal Declaration of Human Rights (UDHR): The Declaration inextricably links the right to an adequate standard of living (encompassing housing, nutrition, and medical care) to individual health and well-being, affirming mental health as a universal right [12].

In international human rights jurisprudence, the European Court of Human Rights (ECtHR) has established critical precedents regarding mental well-being. In cases such as *Bensaid v. the United Kingdom*, the Court underscores that mental health is an essential facet of private life and human identity. Crucially, the Court's interpretation dictates that severe mental suffering can equate to physical suffering, thereby falling under the absolute protection of Article 3 of the European Convention on Human Rights (the prohibition of torture and inhuman or degrading treatment) [13].

As the UN Secretary-General has articulated, "There is no health without mental health" [14]. Nevertheless, millions of forcibly displaced persons are denied necessary psychosocial support due to structural barriers, stigma, and discrimination in host countries.

In legal doctrine, the elements constituting the right to health are bifurcated into two categories: 1. Healthcare provision (preventative and curative medical services) and 2. Underlying conditions of health (safe drinking water, adequate sanitation, proper nutrition, and healthy occupational conditions) [15].

In contemporary legal frameworks, mental health is a fundamental human right inextricably linked to an adequate standard of living and personal identity. International standards and ECtHR jurisprudence confirm that mental well-being relies not only on clinical services but on the foundational socio-economic conditions that guarantee a dignified existence. Therefore, it is the strict legal obligation of the State to eradicate the structural and social barriers that could subject an individual to severe mental anguish and the subsequent degradation of their rights and legal status.

Refugee Mental Trauma as Legal Damage. In legal doctrine, the concept of "harm", "damage" or "injury" is frequently associated with physical violation or material loss. However, within the framework of contemporary legal standards, non-material harm, specifically psychological harm, holds equal priority. The mental trauma sustained by a refugee during forced migration is not merely a clinical diagnosis, it constitutes a legally significant injury that demands appropriate legal responses and the activation of effective protective mechanisms by the State.

To comprehend the substance of such harm, it is essential to consider psychiatric standards, most notably the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* published by the American Psychiatric Association (APA). The DSM-V defines trauma as any disturbing experience that induces intense fear, helplessness, dissociation, or other overwhelming emotions of sufficient intensity to exert long-lasting negative effects on a person's attitudes, behavior, and various aspects of functioning [16].

From a legal standpoint, the prolonged negative impact on an individual's functioning, as emphasized by the DSM-V, is decisive. When mental trauma impedes a refugee's capacity to fully realize their rights, it transforms into an object of legal protection, imposing a positive obligation on the State to ensure the individual's psychosocial rehabilitation.

The high prevalence of anxiety and depression symptoms across diverse refugee groups is directly correlated with the traumatic experiences inherent to forced displacement. For instance, research by Ao et al. on Bhutanese refugees revealed an alarm-

ing mental health landscape: a 21% prevalence of depression, 19% for anxiety symptoms, and a 4.5% rate of Post-Traumatic Stress Disorder (PTSD) [17].

The scale of this issue is further underscored by a large-scale study by Henkelmann et al., encompassing populations from Asia, Europe, and Africa. Their data indicates that one in three refugees may currently meet the diagnostic criteria for depression or PTSD, while anxiety disorders are present in one to two out of every ten refugees [18]. These figures demonstrate that the rate of mental health disorders among forcibly displaced persons significantly exceeds the statistical average, indicating an urgent need to re-evaluate legal and social protection mechanisms.

Refugees frequently encounter barriers to accessing healthcare due to unfamiliarity with existing systems, language barriers, or a lack of trust in public institutions. Such difficulties directly impact mental health by hindering timely diagnosis and treatment, often leading to the exacerbation or chronicity of the condition [19].

Furthermore, acculturative stress plays a significant role in refugee mental health. This encompasses the difficulties of navigating a new country (e.g., learning a new language, adapting to cultural expectations) as well as intra-familial stress arising when parents and children adapt at different rates. These factors contribute to high levels of acculturative stress, fostering crises of identity and belonging [20].

Beyond pre-migration trauma, legal uncertainty serves as a critical stressor, as it is intrinsically linked to a refugee's sense of security and the predictability of their future. Uncertain status, protracted administrative procedures, and the instability of the asylum process amplify anxiety, feelings of vulnerability, and the perception of a loss of control.

This is starkly illustrated by the asylum procedures in Hungary. While the granting of refugee status is formally regulated by the Act LXXX of 2007 on Asylum [21], recent years have seen the procedure become significantly more complex. Following 2020, migrants and asylum seekers can only submit an application with so-called "declaration of

intent", at Hungarian embassies located outside Hungarian borders (e.g., in Belgrade or Kyiv) [22].

The right to seek asylum is guaranteed by international law, founded upon the 1951 Convention, and should be accessible upon entry into any country, even without legal documentation. The "declaration of intent" restricts this right by imposing an administrative barrier. For individuals fleeing war and immediate persecution, such bureaucratic labyrinths and delays in securing safety act as a direct catalyst for the relapse or exacerbation of PTSD.

The psychological trauma experienced by refugees transcends a narrow medical diagnosis; it is classified as a substantive legal injury because it directly obstructs the individual from fully exercising their fundamental rights. The prolonged impairment of functioning, as defined by DSM-V standards, renders such trauma an object of legal protection, triggering the State's positive obligation to provide social and psychological rehabilitation.

Furthermore, legal uncertainty and artificial administrative barriers such as the practices observed in Hungary act as aggravating circumstances of harm, constituting "institutional trauma" that further deteriorates the refugee's condition. When bureaucratic processes delay the attainment of safety, the State apparatus, instead of providing protection, becomes an additional stressor. Consequently, the infringement of mental health must be treated as a violation of a protected legal interest, necessitating the transformation of existing administrative practices into trauma-informed approaches.

3. STATE OBLIGATIONS IN THE PROTECTION OF REFUGEE MENTAL HEALTH

The highest attainable standard of health as a state obligation. In contemporary legal frameworks, the protection of displaced persons extends beyond the provision of physical security and asylum to encompass mental well-being. Refugees represent an exceptionally vulnerable cohort, according to the World Health Organization (WHO), one in five individuals fleeing conflict zones exhibits mental health conditions such as Post-Traumatic Stress Disorder (PTSD), depression, or anxiety [23].

While early human rights law relied on "negative obligations" that restricted State interference,

the modern legal framework heavily emphasizes "positive obligations" that require active State participation to protect individuals. Health has transitioned from a secondary socio-economic consideration to human rights priority. While a State cannot guarantee "absolute health" for every individual, it is legally bound to purposefully invest resources to create a systemic environment where the right to health is protected and equitably accessible.

The right to the highest attainable standard of physical and mental health is codified in imperative international treaties and recognized in at least 115 national constitutions [24]. Crucially, Article 23 of the 1951 Geneva Convention on the Status of Refugees mandates that member states accord refugees the same medical care as their own nationals [25]. Although the Convention's text does not explicitly isolate "mental health," the United Nations High Commissioner for Refugees (UNHCR) guidelines establish that the right to healthcare is indivisible and fully encompasses psychological and psychiatric support [26].

To fulfill these codified obligations, host states must ensure that mental healthcare systems adhere to the AAAQ framework: Availability, Accessibility, Acceptability, and Quality. For refugees suffering from severe trauma, a State's failure to provide these services is not merely an administrative shortcoming; it may equate to inhuman or degrading treatment.

Judicial precedent plays a critical role in solidifying these positive obligations:

The European Court of Human Rights (ECtHR): Articles 3 (prohibition of torture and inhuman or degrading treatment) and 8 (right to respect for private and family life) of the ECHR create powerful leverage for refugee protection. In the landmark case *M.S.S. v. Belgium and Greece*, the Strasbourg Court emphasized that asylum seekers constitute a "particularly vulnerable group" requiring special protection. The Court ruled that severe living conditions coupled with the absence of medical and psychological support in Greece constituted a violation of Article 3 [27].

The German Federal Constitutional Court (*Bundesverfassungsgericht*): German constitutional doctrine intimately links mental health to human dignity (*Menschenwürde*). The State bears a posi-

tive protective duty (*Schutzpflicht*) to safeguard physical and mental integrity, which necessitates guaranteeing a "minimum of dignified existence" (*Existenzminimum*) [28]. In the context of forced migration, this standard dictates that the State must provide culturally and linguistically adapted psychotherapeutic assistance.

The State's obligation to protect refugee mental health is no longer a matter of humanitarian goodwill; it is a strictly regulated legal imperative. However, implementing this right requires addressing the practical reality of resource scarcity. As noted in Georgian academic discourse (e.g., Zurab Chiaberashvili), the "highest attainable standard" of mental health relies on the doctrine of progressive realization [29]. States must align their actionable steps with available resources, making the full realization of physical and mental health a structurally supported, long-term objective, while simultaneously fulfilling their immediate positive obligations to modify national legal frameworks, such as overcoming language barriers and integrating trauma-focused programs into primary healthcare.

Germany stands as a significant role model in the European context by establishing a robust legal framework that balances national economic interests with profound humanitarian obligations. Central to this approach is the Residence Act (*Aufenthaltsgesetz*) of 2005, which serves as the foundational legal instrument for managing the entry, employment, and integration of foreign nationals. A primary example of Germany's commitment to its state obligations is the implementation of *Aufenthaltserlaubnis §24 AufenthG* for Ukrainian refugees. This provision ensures immediate access to temporary protection, residency, and essential social services, thereby streamlining the path to both physical healthcare and labor market participation during times of crisis.

Beyond basic residency, the German state provides comprehensive support systems to facilitate long-term integration. The total number of officially registered Ukrainian refugees in Germany from March 2022 to December 2025 is 1, 329, 742 [30]. Ukrainian refugees are eligible for free integration and language courses, which are essential for navigating a new society. Furthermore, the state actively promotes professional retraining and vocational

development, with specialized government agencies assisting individuals in finding suitable employment that matches their skills. To foster social cohesion, the framework also includes organized meetings and workshops where participants can share cultural characteristics and traditions. These platforms serve as a bridge between the host society and the refugee community, helping to demystify local norms and build mutual understanding.

Legal and Cultural Implications of the AAAQ Framework. As we already mention, the efficacy of the legal provision for refugee mental health is intrinsically linked to the AAAQ framework (Availability, Accessibility, Acceptability, Quality) established in international law. This standard is derived from Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which recognizes the right of everyone to "the enjoyment of the highest attainable standard of physical and mental health" [31]. The interpretation of this article is provided by the Committee on Economic, Social and Cultural Rights in its General Comment No. 14, which clarifies that the right to health is not merely the right to be healthy, but encompasses a set of freedoms and entitlements, including equal access to healthcare services [32].

Availability. First and foremost, Availability refers to the State's obligation to ensure a sufficient quantity of mental health services, psycho-social rehabilitation centers, and qualified personnel. In the context of refugees, this entails not only general psychiatric care but also specialized programs directed at the management of Post-Traumatic Stress Disorder (PTSD) and the specific challenges of displacement. The State is obligated to ensure these services function for all individuals within its jurisdiction, regardless of their legal status [33]. Research indicates that the prevalence of PTSD, depression, and anxiety among refugee and migrant populations is significantly higher compared to host country populations. For instance, while the PTSD rate in the general population is approximately 1-3%, among refugees, this figure frequently exceeds 30% [34].

Accessibility However, the mere existence of services does not equate to Accessibility. From a legal perspective, the principle of non-

discrimination is paramount: refugees must have physical and economic access to treatment on a par with the citizens of the host country. Informational accessibility constitutes another critical link in this chain; a legal mechanism cannot function effectively if the beneficiary is not provided with information regarding their rights and available assistance in a language they comprehend.

Acceptability. A further crucial element is the criterion of Acceptability, where legal provision directly intersects with cultural integration. According to General Comment No. 14, all medical facilities and services must be "culturally appropriate" [35]. The perception of mental health is stigmatized in many cultures; therefore, it is the State's obligation to structure services in a manner that precludes the marginalization of the refugee's cultural identity. Cultural sensitivity in this context is not an act of goodwill but a mandatory legal standard: treatment methodologies must account for the individual's religious, ethnic, and social background. It is at this juncture that healthcare becomes an instrument of integration, mitigating alienation and fostering trust in the institutions of the host country.

The practical significance of the Acceptability criterion is well illustrated by the experience of Germany. Following the 2015 migration crisis, the German healthcare system discovered that despite the physical availability of services, many refugees (particularly from the Middle East and Africa) did not utilize clinics. The root cause was cultural dissonance: in these cultures, mental health problems are frequently somatized (the patient complains of physical pain rather than sadness) or heavily stigmatized [36]. In response to this legal and clinical shortcoming, the "Cultural Formulation Interview" (CFI) was introduced, which serves as a direct example of the cultural adaptation (Acceptability) of services in accordance with the AAAQ framework.

Quality. Finally, all the aforementioned elements are unified by the Quality component. Legal provision is rendered a fiction if the service is not scientifically sound and professionally qualified. In the case of refugees, quality necessitates the continuous training of personnel in trauma-informed approaches and intercultural communication [37].

In this regard, the "Healthy Migrant Effect" is of particular interest. Statistics demonstrate that refu-

gees frequently arrive in the destination country with better mental resources than they possess 2-3 years later. The subsequent deterioration in their condition is often triggered by post-migration stressors, such as isolation and substandard social support [38]. This indicates that legal provision should not be confined to acute crisis management but must be oriented towards long-term, high-quality integrative therapy.

Consequently, the AAAQ framework establishes a cohesive system wherein the protection of mental health transcends a purely clinical issue, evolving into a fundamental legal prerequisite for the dignified reception of refugees and their full integration into society.

Conclusion. In the contemporary international legal framework, the analysis of the legal status of refugees and internally displaced persons (IDPs) necessitates not merely a formalistic legal approach, but a profound interdisciplinary inquiry situated at the nexus of law, medicine, and psychology. The psychic trauma endured by refugees, precipitated by persecution and forced displacement, transcends the boundaries of a medical diagnosis and is qualified as substantial legal harm, which directly impedes the individual's full enjoyment of fundamental rights. Consequently, when psychic trauma exerts a prolonged negative impact on an individual's functioning, it is rendered an object of legal protection, thereby imposing a positive obligation upon the State to ensure the individual's psychosocial rehabilitation.

It is the obligation of the State to protect the highest attainable standard of physical and mental health, a peremptory requirement enshrined in international law. The realization of this right is unattainable without the full implementation of the AAAQ framework (Availability, Accessibility, Acceptability, and Quality), wherein particular emphasis is placed on the **cultural acceptability** of services. Cultural sensitivity constitutes a rigorous legal standard, within the scope of which treatment modalities must account for an individual's religious, ethnic, and social background to prevent the marginalization of a refugee's cultural identity and to foster trust toward host institutions.

In this context, comparative legal analysis has demonstrated that the mental well-being of refugees

is directly contingent upon the legal stability within the host State. For instance, the German experience illustrates the implementation of culturally adapted approaches, such as the Cultural Formulation Interview (CFI), to effectively mitigate linguistic dissonance and stigmatization. Furthermore, the automatic extension of residency rights for Ukrainian refugees functions as a fundamental psychological protective mechanism, whereas for refugees from other nations, protracted bureaucratic procedures and precarious legal status significantly exacerbate their mental condition.

Thus, the paper shows that the effectiveness of legal guarantees for mental health protection is determined not only by the availability of medical services, but also by the state's willingness to adapt its legal instruments to the individual cultural and psychological needs of internally displaced persons.

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НЕВИДИМІ РАНИ, ВИДИМІ ЗОБОВ'ЯЗАННЯ: ПРАВОВЕ ЗАБЕЗПЕЧЕННЯ ПСИХІЧНОГО ЗДОРОВ'Я БІЖЕНЦІВ

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Метою дослідження є синтетичний аналіз як правових, так і психосоціальних аспектів кризи біженців, спрямований на виявлення системних недоліків у захисті психічного здоров'я біженців. Крім того, дослідження спрямоване на виявлення та аналіз ключових проблем у цій галузі, включаючи обмежену доступність психологічних послуг, дефіцит культурно чутливих підходів, хронічний стрес, спричинений невизначеністю правового статусу, та соціальні бар'єри, що виникають під час процесу інтеграції. **Методи дослідження:** у статті дослідження проводилося з використанням історичних, порівняльно-правових та нормативних методів, що продиктовано складним характером питання. Історичний метод було застосовано для виявлення корінних причин вимушеного переміщення та оцінки того, як міжнародна політика з часом трансформувалася в правові норми. Порівняльно-правовий метод було використано для аналізу міграційної та притулкової політики різних країн, а також їхніх правових та інституційних механізмів захисту психічного здоров'я біженців, тим самим висвітлюючи передовий досвід та визначаючи правові та адміністративні бар'єри. Нормативний метод було використано для зосередження уваги на нормативному змісті закону, окреслюючи права біженців у грузинському Законі «Про міжнародний захист», міжнародних конвенціях та європейському законодавстві, щоб оцінити, наскільки чітко гарантії психічного здоров'я та спеціальні процедурні потреби визначені на нормативному рівні. **Результати:** емпіричне дослідження вказує на значно підвищений ризик розвитку серед біженців розладів психічного здоров'я, включаючи депресію, тривожні розлади та посттравматичний стресовий розлад (ПТСР), а також криз адаптації, ідентичності та приналежності. **Результати дослідження** підкреслюють, що ці психологічні тягарі часто є прямим наслідком травматичного досвіду (такого як насильство, переслідування та втрата членів сім'ї), вимушеного переміщення, правової невизначеності та серйозних труднощів в інтеграції в приймаючі суспільства. **Обговорення:** враховуючи деструктивні тенденції сучасного світу, включаючи політичну нестабільність, економічні кризи, численні локальні війни та збройні конфлікти, зміну клімату та стихійні лиха, питання міграції та пов'язані з нею проблеми стають дедалі актуальнішими. Питання біженців за своєю суттю є міждисциплінарним. З одного боку, воно охоплює правовий вимір, що включає міграційні процедури, визначення правового статусу, механізми надання притулку та державні зобов'язання. З іншого боку, воно являє собою складну медичну та психосоціальну проблему, яка безпосередньо впливає на фізичне та психічне благополуччя біженців, що повністю належить до компетенції соціального захисту, охорони здоров'я, психології та психіатрії. Узгодження цих двох вимірів має вирішальне значення для подолання адміністративних та соціальних бар'єрів, які перешкоджають ефективній психосоціальній підтримці.

Ключові слова: міграція; психічне здоров'я; посттравматичний стресовий розлад; міждисциплінарний підхід; політика надання притулку; міжнародний захист.

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