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connecting resettlement experts

EVIDENCE SUMMARY
January 2025[1]

What is the evidence for strengths-based and trauma-informed approaches?

Two impact and three suggestive studies indicate positive outcomes from strengths-based approaches.

- Five studies were identified that have examined the outcomes of strengths-based approaches with refugee clients. These studies have addressed diverse outcomes including health, mental health, social support, English proficiency, and cultural and community connections.
- Strengths-based approaches can take many forms and have shown promising results with newcomers of diverse genders, ages, national origins, and ethnicities.

One source of strong evidence, and three moderate to suggestive studies, indicate positive outcomes for trauma-informed programming with newcomers.

- One systematic review, one randomized control trial, and two suggestive studies of trauma-informed programs for newcomers saw positive outcomes on almost all measures. Topics included education, parenting, and mental health.
- Important elements of trauma-informed approaches include using facilitators with lived experience, facilitating peer support, transparency and trustworthiness of staff, and participant control of conversations.

Three sources of suggestive evidence indicate training providers in trauma-informed practice can increase the confidence of providers and help newcomers feel safe.

- Providers reported increased knowledge of trauma in newcomer contexts and confidence in working with clients who have faced trauma after receiving training on trauma-informed approaches.
- Studies that looked at client outcomes also indicated positive outcomes in areas of safety and security.

[1] This is an update to the original evidence summary published in August 2020.

Purpose of this summary

Strengths-based and trauma-informed approaches are widely endorsed in refugee resettlement programs. The purpose of this summary is to assess the state of the evidence regarding the effectiveness of these approaches with refugee populations. Specifically, the following questions are addressed:

- What are the impacts of strengths-based and trauma-informed approaches with refugees?
- What is the strength of the evidence base for these approaches?

What is meant by "strengths-based and trauma-informed approaches"?

- Strengths-based approaches view clients as resourceful and resilient in the face of adversity. In collaboration with the client, the service provider (sometimes referred to as a "helper") identifies and amplifies existing client system capacities to resolve problems and improve quality of life. Strengths-based approaches can be viewed as respectful toward and empowering of oppressed and vulnerable people.[2]
- The trauma-informed approach realizes the direct impact that trauma can have on access to services and responds by changing policies, procedures, and practices to minimize potential barriers. A system utilizing a trauma-informed approach also fully integrates knowledge about trauma into all aspects of services and trains staff to recognize the signs and symptoms of trauma and thus minimize the possibility of re-traumatization.[3] The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control (CDC)[4] acknowledge six key principles of trauma-informed approaches: "(1) safety; (2) trustworthiness and transparency; (3) peer support; (4) collaboration and mutuality; (5) empowerment, voice, and choice; and (6) cultural, historical, and gender issues" (Jaradeh, 2023, p. 332).
- It is important to distinguish the trauma-informed approach from trauma-specific interventions. Trauma-specific interventions are prevention, intervention, or treatment services that address traumatic stress. In contrast, the trauma-informed approach is grounded in an understanding of and responsiveness to the impact of trauma, emphasizes physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment. It involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma. Finally, it upholds the importance of client participation in the development, delivery, and evaluation of services.[5]
- Strengths-based and trauma-informed approaches share several common features, including client-helper collaboration and client empowerment. These approaches serve as underlying perspectives that can be applied in any social service, such as case management, health and mental health services, psychosocial support, or economic empowerment services.

What does the evidence show?

Two impact and three suggestive studies indicate positive outcomes from strengths-based approaches.

[2] Corcoran, J. (2011). Strengths-Based Models in Social Work. Oxford Bibliographies Online.
[3] The Institute for Trauma and Trauma-Informed Care (2020). What is trauma-informed care?
[4] https://stacks.cdc.gov/view/cdc/56843
[5] Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). Trauma informed care in behavioral health services: A treatment protocol (TIP) SERIES 57. HHS Publication No. (SMA) 14-4816. Rockville, MD.

- A strengths-based social justice approach to reducing high rates of distress among refugees was tested in a randomized controlled trial (Goodkind et al., 2020). The six-month, multilevel Refugee Well-Being Project (RWP) was located in the U.S. The intervention **brought together university students enrolled in a two-semester course and recently resettled refugees to engage in mutual learning and collaborative efforts** to mobilize community resources and improve community and systems responsiveness to refugees. Students were paired with a refugee family for six months to assist them with navigating their community, accessing resources, and reducing social isolation. The students and families participated in Learning Circles that allowed for cultural exchange and learning opportunities. Researchers collected data from 290 Afghan, Great Lakes African, Iraqi, and Syrian refugees at four time points over 12 months. This data was used to test the effectiveness of RWP in reducing distress (depression and anxiety symptoms) and increasing protective factors (English proficiency, social support, and connection to home and American cultures). **The findings revealed significant positive intervention effects for all the outcomes studied**.

- Health Realization (HR) is a strengths-based stress and coping intervention used to promote the use of internal and external coping resources. In a quasi-experimental impact evaluation, Robertson et al. (2019) adapted the HR framework to a community-delivered mental health intervention emphasizing health and resilience over psychopathology. HR is a non-invasive, strengths-based approach that focuses on gaining perspective in the present. Strategies do not encourage the retelling of past traumatic experiences or active attempts to change thoughts. **Participants are taught to manage and cope with their perceived stresses through a responsive thought process**. HR directly affects internal coping resources, while also shifting primary and secondary appraisal of stressors ("stress appraisal" is a term referring to the process by which individuals evaluate and cope with stressful events). The study examined the effects of the intervention on coping and mental health outcomes in 65 Somali refugee women post-resettlement. **The intervention significantly affected multiple dimensions of coping**: distancing, seeking social support, and positive reappraisal. **Participants also demonstrated improvement in depression symptom ratings**.

- Block et al. (2018) evaluated a strengths-based peer support group approach[6]. The groups were led by trained para-professional peer educators from Bhutanese, Congolese, and Iraqi refugee communities in Pittsburgh. The groups built upon the Center for Torture and Trauma Survivors Clubhouse model. Group leaders sought to provide supports to 1) decrease feelings of isolation; 2) build community networks; and 3) increase feelings of empowerment within the community. Pre-post results indicated that **the groups were successful in helping participants make friends, get information, become more independent, and feel better about life in America**. Additionally, participants reported a higher number of individuals whom they could "talk to about problems or worries" and connect to with a sense of trust within their ethnic communities.

- A strengths-based approach with adolescent refugees was evaluated in Australia. Khawaja et al. (2019) investigated the effectiveness of Building Resilience in Transcultural Australians (BRiTA Futures) for Adolescents, a group intervention developed to build the resilience of culturally and linguistically diverse adolescents who experience acculturation in the context of their migration and resettlement journey. A total of 229 participants, whose ages ranged from 12 to 20 years, took part in the intervention, offered to them in three formats (weekly, over four weeks, or as two to three full days). They completed pre- and post- questionnaires measuring wellbeing and resilience associated with acculturation processes. The participants as well as the facilitators of the intervention completed open-ended questionnaires about the process and the short-term impact of the intervention. Findings indicated an **overall improvement in participants' well-**

[6] See What is the impact of peer support groups on refugees' mental health? for more information on this topic.

being and resilience associated with the acculturation process, regardless of the format of the intervention, gender, visa status (refugee versus migrant), or duration of stay in Australia.

- A strengths-based approach formed the basis of a community health program for Cambodian older adults in Massachusetts. The program incorporated community assets, including interpersonal relationships to build support and overcome distrust; the strength of the extended family; and the presence of Cambodian Buddhist temples, community-based organizations, and businesses in the community. The program also incorporated the availability of cultural events to reinforce cultural connections; strong ties with program staff; and access to local, Khmer-language radio and TV programs. **Improvements were documented in participants' individual health behaviors and knowledge of health issues; participants' access to the health care system through trained medical interpreters; and health care providers' awareness of Cambodian health beliefs** (Grigg-Saito et al., 2008).

One source of strong evidence, and three moderate to suggestive studies, indicate positive outcomes for trauma-informed programming with newcomers.

- Berger (2019) conducted a systematic review of multi-tiered trauma-informed programming in schools for students with a history of trauma, two of which specifically targeted refugee youth. To be included, an article needed to address how the intervention addressed at least three different levels (e.g., parents, teachers, full student body, at-risk students). The review included 13 articles; 10 had three levels of intervention, and the remaining three covered four levels. One of the included studies was a randomized controlled trial, while the rest used pre- and post-, qualitative, or post-program evaluation. Twelve of the 13 articles reported positive results in at least one measured outcome. **Four of the evaluated programs reported positive improvements in academic achievement and behavior**. **Three indicated reduced PTSD symptoms of participants** when evaluated with the Depression Self-Rating Scale or UCLA PTSD Index**. Four articles reported increases in self-reported knowledge and confidence of school staff**. Berger indicated that there is a need for more consistent use of validated and standardized assessment tools for measuring student and staff outcomes. Six of the included studies failed to situate their findings within the existing School-wide Positive Behavior Support (PBS) and Multi-tiered Systems of Support (MTSS) frameworks, as the existing literature recommends.

- Bajwa et al. (2020) piloted and evaluated a 14-week trauma-informed course for refugees in Canada that addressed barriers and obstacles to higher education. The course was divided into weekly four-hour workshops addressing different barriers related to the Canadian academic system, personal circumstances, trauma, and the resettlement process. **The course design was informed by interviews the researchers conducted with refugees in the initial phase of the project**. The program had two cohorts consisting of 41 total participants. To make the program trauma-informed, there was a focus on creating a sense of safety among participants, feelings of trustworthiness and transparency with staff, facilitating peer support, and giving voice and control to the participants. At the end of the program **participants exhibited improvement on all measures, with significant improvements in self-esteem, resilience, and life satisfaction**. During the final two interviews with participants, 98% reported having a clear vision of their educational goals and plans. Additionally, **90% shared a noticed change in disposition, attitude, and sense of self, and 85% attributed this change to the availability of the support system created by the program structure and staff**. The researchers indicated that extensive training and coaching of faculty on trauma-informed strategies is imperative to creating a successful program. A potential limitation is that participants voluntarily participated in the program, indicating they may have already had a higher level of confidence or social adjustment compared to other members of the refugee population.

- The Baby TALK home visiting program model, an evidence-based relational approach to supporting pregnant mothers and families with children less than three years old, was evaluated in a randomized controlled trial. The study examined the program's impact on child and maternal outcomes among 200 refugee and immigrant participants. The intervention group consisted of 101 parents who received 60-minute home visit sessions twice a month for 12 months. The control group (99 parents) received one visit every three months to deliver a package of diapers to ensure retention. The core concepts and framework of the model emphasize the importance of meeting families where they are; using effective communication strategies that honor culture and promote parent confidence and self-efficacy; and ensuring families are engaged from a place of respect and curiosity. **There was a significant positive effect for language development and a significant gain in socio-emotional development**. In addition, all the other effects in the maternal health, referral, and economic self-sufficiency domains were in the desired direction. Overall, parents receiving Baby TALK home visiting **experienced less parental stress** as compared to the control group. In the area of trauma symptoms, the treatment group coped better as a result of the intervention. Parents receiving home visits were also more likely to be employed and were more proactive in seeking community resources than those without the service (Hilado et al., 2019).

- Kristen et al. (2023) conducted a feasibility study and evaluation of an online version of the *Connect* program titled *eConnect Online*. *Connect* is a trauma-informed "attachment-based intervention designed for parents and alternative caregivers of youth aged 8-18 years old" (p. 2). Over 50% of the parent participants in *eConnect* were fathers, which is of note as fathers are generally underrepresented in similar interventions. The virtual version used the original program's components, such as roleplays, reflective exercises, and real-time group interactive elements. *eConnect* also has a tech support staff member to help parents access the virtual environment and facilitate group exercises. The main facilitators, who all had lived experience with forced displacement, hosted a technology orientation session for participants before the first official session. Participants completed self-report measures (Brief Child and Family Phone Interview (BCFPI) and Adolescent Attachment Anxiety & Avoidance Inventory (AAAAI) at pre-intervention, immediately post-intervention, and at two months post-intervention. Three program sessions, one each for Dari, Somali, and Arabic speakers, were completed between September and December 2021. Complete data were available for 23 participants. **Program uptake and completion were very high as every participant attended at least seven sessions and completed the program**. Acceptability and feasibility of the online component varied across cultural groups. The Arabic-speaking group (n=5) had positive feedback, sharing that the online delivery allowed both parents to attend and reduced the stressors of needing to leave the home to attend. They felt that the delivery of the roleplays was excellent, and did not feel that being virtual inhibited relationship building. The Somali-speaking group (n=8) had mixed feedback on the virtual components, as some parents were unable to attend at times due to challenges with the technology. Overall, they still felt that they were able to fully engage. The Dari-speaking group (n=10) faced significant challenges with technology, and program delivery had to be adjusted to where they came to a central location, and the facilitator still joined virtually. The parents reported that being in person together was very important to their learning. Results from the BCFPI showed **significant decreases in youth mental health problems** as reported by the parents, and these decreases remained consistent to the two-month follow-up. **Family functioning also showed improvements between each measurement point**. Participants reported that it was very important that the facilitators had lived experience, and the virtual format allowed the program to identify facilitators from different areas, making the program more widely accessible and applicable to different communities.

Three sources of suggestive evidence indicate training providers in trauma-informed practice can increase the confidence of providers and help newcomers feel safe.

- Im and Swan (2020) developed and evaluated a culturally sensitive and trauma-informed refugee mental health training called Cross-Cultural Trauma-Informed Care (CC-TIC). The program aimed to train refugee service providers to increase competencies in trauma-informed care and develop community partnerships to improve referrals and coordination of care. The program was offered over two days and included 13 hours of training split across eight instructional sessions and one reflection/discussion session. This evaluation assessed six different training series delivered across five locations in two states. Data was collected retrospectively as participants were asked to reflect on their pre-training competencies after completing the training. **Seven core competencies were measured across all sites, plus four to five additional topics tailored to meet the needs of specific sites**. These competencies included topics such as interpretation, complex trauma, integrated care, psychoeducation, self-care, common mental health issues among refugees, and community-based interventions for refugees. Compete assessment data was available for 120 participants. **The differences in average pre- and post-test scores were significant for every measure**. There was a noticeably greater change in scores for participants without previous training in mental health. **Participants reported that the mutual learning and networking opportunities in the training were valuable to their overall experience**.

- Im and Swan (2022) expanded the CC-TIC training curriculum to include service providers and refugee community leaders with the goal of building skills and partnerships between the two groups. There were 54 participants spread across four cohorts, 28 of whom were resettlement or community health service providers, while 26 of whom were refugee or immigrant community leaders. The majority of participants were women (n=47). This version of the training included four half-day sessions to total 20 hours of training. The sessions included the following topics: background and introduction to refugee mental health; training expectations and discussion of mental health needs in the refugee community; refugee trauma and its impact on individuals and community; the role of culture, acculturation, and adjustment in the experience of trauma; and recommendations, resources, and partnership building for supporting trauma-impacted refugees and personal self-care practices. The curriculum was run by mental health professionals with either previous experience working with refugees or high levels of cross-cultural sensitivity. The evaluation was conducted through self-reflection after each session and focus group interviews after the final session. Findings indicated that **participants gained knowledge and awareness of various topics, including common stress/trauma responses, trauma during migration and resettlement, and cultural values that may impact mental health experience and help-seeking**. Participants indicated they began using self-care skills from the training in their professional lives—such as setting boundaries—and in their personal lives—such as better understanding family members' struggles. **There was a deep appreciation for the group dynamics created by the training, which allowed for connectedness, bonding, trust, and partnership** with other members. The program facilitators also reported feeling inspired and encouraged by the participants.

- Jaradeh et al. (2023) incorporated trauma-informed principles into the student-run asylum clinic (SRAC) at the University of California, San Francisco. During the April 2019 and April 2022 evaluation period, the clinic provided three to 10 pro bono forensic medical evaluations (FMEs) per month. FMEs can be used by those seeking asylum to corroborate evidence of persecution. A medical provider will document an individual's trauma history and perform physical and/or psychological assessments. The clinic was set up so that multiple FMEs would occur on the same day to allow asylum seekers access to community support and collaboration. The provider teams were made up of a lead clinician, a training clinician, a medical student, and a certified interpreter. The medical students all completed an 11-week elective covering the asylum process, trauma-informed interviewing, injury description, and psychiatric assessment. The clinicians were required to have received training with the SRAC or similar organizations and shadow one FME before independently performing any FMEs themselves. Clinicians were also trained by immigration legal professionals on medicolegal communication and communicated with referring

attorneys about the FMEs. Interpreters were trained in secondary trauma minimization strategies. The team would pre-brief and debrief each FME among themselves, and they were invited to debrief with psychological professionals as desired. Providers allowed the client to dictate start, stop, and break times during FMEs to reinforce autonomy and control. The clinic space was organized so that interviewing was completed with the clinician, student, interpreter, and client sitting in a circle. The clinic performed 160 FMEs during the evaluation period: 86 combined medical and psychological evaluations, with 61 psychological only and 13 medical only. All the clients seen had experienced psychological trauma, 82% had experienced physical violence, and 63% had experienced sexual violence. **All 24 cases adjudicated during the evaluation period were granted asylum or similar protective status**. Medical students not involved with the clinic performed a nine-question survey with 65 of the adult clients who received an FME. **Clients noted they felt safe during the FME, despite feeling fearful or ashamed when entering the clinic. Clients also reported feeling listened to during the FME and empowered as a result**.

What are the implications for practice and research?

"Most of these trauma-responsive interventions work toward offering the clients a sense of safety anchored in new trusting and dependable relationships in which the client's agency and voice are respected."

(Bajwa et al. 2020)

Strengths-based approaches are flexible and widely applicable and have shown notable positive outcomes across different populations.

- Practitioners should utilize a strengths-based approach to recognize and build on each individual's personal capacity and abilities. Participants in strengths-based programs have consistently reported reduced mental health concerns and increased feelings of community and self-efficacy.

Trauma-informed approaches can create safe environments for newcomers that reduce adverse mental health symptoms.

- Incorporating trauma-informed approaches into programming for newcomers has consistently shown positive outcomes in aspects such as self-assurance, family functioning, and mental health. Participants also appreciate the sense of community, safety, and trust that trauma-informed approaches facilitate.
- Newcomers find the ability to have control over the conversation, group bonding, and transparency and trustworthiness of staff to be particularly important elements of trauma-informed programming.
- Having a facilitator with lived experience and shared cultural background was reported as a key element of programming for participants. Creating virtual programming could expand the potential pool of facilitators but should be balanced with the need for additional technological support and access.

Service providers should be trained in trauma-informed approaches, as they have shown improvements in knowledge and self-efficacy.

- Training service providers in trauma-informed approaches have been shown to improve knowledge of the trauma of forced displacement, common trauma responses, and confidence in working with newcomers who have endured trauma. Results from these programs indicate that newcomers receiving services have also experienced positive outcomes.
- Training should focus on skills related to using interpreters, fostering safe group dynamics among participants, self-care, complex trauma, and community-based interventions in newcomer communities.

Research is needed on the joint effects of the two approaches.

- There is a lack of research comparing outcomes from strengths-based and trauma-informed approaches to their counterparts. It is important to understand the true breadth of these types of programs' impact by looking at differences in outcomes in non-strengths-based or trauma-informed approaches.
- As noted, strengths-based and trauma-informed approaches share some commonalities. Further research is needed on how the two approaches interact and their joint impact on client outcomes.

How did we identify evidence for this summary?

Included Studies

The Switchboard evidence database includes the following types of studies, categorized by their strength of evidence:

Strong Evidence

Meta-analyses: systematic analyses of sets of existing evaluations of similar programs

Systematic reviews: syntheses of the best available evidence on specific research questions that use narrative synthesis focused on evaluations of the impacts of at least one specific policy, program, or intervention.

Moderate Evidence

Published individual **impact evaluations** using randomized controlled trials (RCTs/C-RCTs), natural experiments, quasi-experimental techniques such as difference-in-difference (DID), instrumental variables (IV), regression discontinuity design (RDD), propensity score matching (PSM) or other forms of synthetic matching, as well as fixed effects techniques with interaction terms.

Suggestive Evidence

Published studies using methods including non-systematic literature review, uncontrolled before and after tests, post-test only, interrupted time series (ITS), cross-sectional regressions, longitudinal panels, cohort

and case-controls, as well as purely qualitative techniques.

Excluded Studies

The Switchboard evidence database excludes case studies, unpublished suggestive research, opinion papers, descriptive studies, and unpublished literature reviews.

Search Protocol

Studies included in the database focused on high-income or upper middle-income countries, including but not limited to the U.S. Studies included must have been published since 2000. To identify evidence, we searched the following websites and databases using the following population, methodology, and target intervention terms:

Websites and Databases	Population Terms	Methodology Terms	Target Intervention Terms
Campbell Collaboration Cochrane Collaboration Mathematica Policy Research Evidence Aid Urban Institute Migration Policy Institute HHS OPRE ASSIA Social Services Abstracts Social Work Abstracts CINAHL PsycInfo PILOTS	refugee OR “unaccompanied minor” OR asylee OR “temporary protected status” OR “victims of traffick*” OR “traffick* victims” OR T-Visa OR U-Visa OR Cuban OR Haitian OR Amerasian	evaluation OR impact OR program OR intervention OR policy OR Project OR train* OR therapy OR treatment OR counseling OR workshop OR review OR meta-analysis OR synthesis	“strengths-based” OR “trauma-informed”

For databases or websites that permitted only basic searches, free-text terms and limited term combinations were selected out of the lists above, and all resultant studies were reviewed for relevance. Conversely, for databases or websites with advanced search capability, we made use of relevant filters available. All search terms were searched in the title and abstract fields only in order to exclude studies that made only passing mention of the topic under consideration.

After initial screening, Switchboard evidence mapping is prioritized as follows: First priority is given to

meta-analyses and systematic reviews, followed by individual impact evaluations when no meta-analyses or systematic reviews are available. Evaluations that are rated as impact evidence are considered before those rated as suggestive, with the latter only being included for outcomes where no evidence is available from the former.

Studies Included

Database and website searching identified 263 studies. After removing duplicates, 189 studies were then screened. Of these, 156 were determined to be irrelevant to this search. Thirty-three full-text articles were assessed for eligibility. Twenty-one full-text articles were excluded due to not meeting one or more of the inclusion criteria pertaining to resettlement country, year of publication, population, methodology, or target problem. Twelve studies were eligible for inclusion. They are listed below, with hyperlinks to the abstracts or full text (when available).

Meta-Analyses and Systematic Reviews

Berger, E. (2019). Multi-tiered approaches to trauma-informed care in schools: A systematic review. *School Mental Health, 11*, 650–664. Abstract.

Impact Evaluations

Goodkind, J. R., Bybee, D., Hess, J. M., Amer, S., Ndayisenga, M., Greene, R. N., ... & Pannah, M. (2020). Randomized controlled trial of a multilevel intervention to address social determinants of refugee mental health. *American Journal of Community Psychology*. Full text.

Hilado, A., Leow, C., & Yang, Y. (2019). Understanding immigration trauma and the potential of home visiting among immigrant and refugee families. *Zero to Three*, 39(6), 44-53. Abstract.

Robertson, C. L., Halcon, L., Hoffman, S. J., Osman, N., Mohamed, A., Areba, E., ... & Mathiason, M. A. (2019). Health realization community coping intervention for Somali refugee women. *Journal of Immigrant and Minority Health, 21*(5), 1077-1084. Full text.

Suggestive Studies

Bajwa, J. K., Kidd, S., Abaim, M., Knouzi, I., Couto, S., & McKenzie, K. (2020). Trauma-informed education-support program for refugee survivors. The Canadian Journal for the Study of Adult Education, 32(1), 75–96. Full Text.

Block, A. M., Aizenman, L., Saad, A., Harrison, S., Sloan, A., Vecchio, S., & Wilson, V. (2018). Peer support groups: Evaluating a culturally grounded, strengths-based approach for work with refugees. *Advances in Social Work, 18*(3), 930-948. Full text.

Grigg-Saito, D., Och, S., Liang, S., Toof, R., & Silka, L. (2008). Building on the strengths of a Cambodian refugee community through community-based outreach. *Health Promotion Practice, 9*(4), 415-425. Abstract.

Im, H. & Swan, L. E. T. (2020). Capacity building for refugee mental health in resettlement: Implementation and evaluation of cross-cultural trauma-informed care training. *Journal of Immigrant and Minority Health, 22*, 923–934. Abstract.

Im, H. & Swan, L. E. T. (2022). “We learn and teach each other”: Interactive training for cross-cultural

trauma-informed care in the refugee community. *Community Mental Health Journal, 58*, 917–929. Abstract.

Jaradeh, K., Sergi, F., Kivlahan, C., Gonzalez, C. N., Cury, M., & DeFries, T. (2023). Implementing a trauma-informed approach at a student-run clinic for individuals seeking asylum. *Academic Medicine, 98*(3), 332–336. Full Text.

Khawaja, N. G., & Ramirez, E. (2019). Building resilience in transcultural adolescents: An evaluation of a group program. *Journal of Child and Family Studies, 28*(11), 2977-2987. Abstract.

Kristen, A., Salari, R., Moretti, M., & Osman, F. (2023). Attachment and trauma-informed programme to support forcibly displaced parents of youth in Sweden: Feasibility and preliminary outcomes of the *eConnect Online* program. *BMJ Open,* 13, 1–9. Full Text.

Supplemental Resources

The following studies did not meet the criteria to be included in the evidence summary but may provide additional context, guidance, or understanding of the topic.

Alvarez, C., Sanchez-Roman, M. J., Vrany, E. A., Mata López, L. R., Smith, O., Escobar-Acosta, L., & Hill-Briggs, F. (2024). Cuidándome: A trauma-informed and cultural adaptation of a chronic disease self-management program for Latina immigrant survivors with a history of adverse childhood experiences and depression or anxiety symptoms. *Cultural Diversity and Ethnic Minority Psychology.* Advance online publication. Full Text.

Ballard-Kang, J. L. (2017). Using culturally appropriate, trauma-informed support to promote bicultural self-efficacy among resettled refugees: A conceptual model. *Journal of Ethnic & Cultural Diversity in Social Work, 29*(1–3), 23–42. Abstract.

Castellanos, F. (2018). *Teaching refugee children: Increasing teacher self-efficacy through trauma-informed trainings*. [Master's Thesis, University of Texas at Austin]. UT Electronic Theses and Dissertations. Full Text.

Cuthrell, K. M. (2023). Trauma-informed legal advocacy: Medicolegal approaches & best practices for immigration attorneys. *International Neuropsychiatric Disease Journal, 20*(2), 62–74. Full Text.

Duffee, J., Szilagyi, M., Forkey, H., & Kelly, E. T. (2021). Trauma-informed care in child health systems. *Pediatrics, 148*(2), 1–12. Full Text.

Elmore Borbon, D., Tant Blackmon, E., & Fairbank, J. A. (2024). Trauma-informed care for unaccompanied children: Lessons learned for practice and policy development. *Psychological Trauma: Theory, Research, Practice, and Policy, 16*(S2), S456–S459. Abstract.

Im, H., Rodriguez, C., & Grumbine, J. M. (2021). A multitier model of refugee mental health and psychosocial support in resettlement: Toward trauma-informed and culture-informed systems of care. *Psychological Services, 18*(3), 345–364. Abstract.

Im, H. & Swan, L. E. T. (2021). Working towards culturally responsive trauma-informed care in the refugee resettlement process: Qualitative inquiry with refugee-serving professionals in the United States. *Behavioral Sciences, 11*(11), 1–18. Full Text.

Isakson, B. L., Legerski, J. P., & Layne, C. M. (2015). Adapting and implementing evidence-based interventions for trauma-exposed refugee youth and families. *Journal of Contemporary*

Psychotherapy, 45(4), 245–253. Abstract.

Jolof, L., Rocca, P., & Carlsson, T. (2024). Trauma-informed care for women who are forced migrants: A qualitative study among service providers. *Scandinavian Journal of Public Health,* 1–6. Full Text.

Kostouros, P., Scarff, B., Millar, N., & Crossman, K. K. (2023). Trauma-informed teaching for teachers of English as an additional language. *Traumatology, 29*(2), 183–190. Abstract.

Kusmaul, N., Wolf, M. R., Sahoo, S., Green, S. A., & Nochajski, T. H. (2019). Client experiences of trauma-informed care in social service agencies. *Journal of Social Service Research, 45*(4), 589–599. Abstract.

Lemke, M. & Nickerson, A. (2020). Educating refugee and hurricane displaced youth in troubled times: Countering the politics of fear through culturally responsive and trauma-informed schooling. *Children's Geography, 18*(5), 529–543. Abstract.

Matlow, R. B., Shapiro, A., & Wang, N. E. (2023). Pediatric perspectives and tools for attorneys representing immigrant children: Conducting trauma-informed interviews of children from Mexico and Central America. *Laws, 12*(1), 1–26. Full Text.

Miller, K. K., Brown, C. R., Shramko, M., & Svetaz, M. V. (2019). Applying trauma-informed practices to the care of refugee and immigrant youth: 10 clinical pearls. *Children, 6*(8), 1–11. Full Text.

Montero, M. K. & Al Zouhouri, A. (2022). Fear not the trauma story: A trauma-informed perspective to supporting war-affected refugees in schools and classrooms. In Pentón Herrera, L. J. (Ed.), *English and students with limited or interrupted formal education: Global perspectives on teacher preparation and classroom practices* (vol. 54, pp. 83–100). Springer, Cham. Abstract.

Ostrander, J., Melville, A., & Berthold, S. M. (2017). Working with refugees in the US: Trauma-informed and structurally competent social work approaches. *Advances in Social Work, 18*(1), 66–79. Full Text.

Palanac, A. (2019). Towards a trauma-informed ELT pedagogy for refugees. *Language Issues: The ESOL Journal, 30*(2), 3–14. Abstract.

Record-Lemon, R. M. & Buchanan, M. J. (2017). Trauma-informed practices in schools: A narrative literature review. *Canadian Journal of Counseling and Psychotherapy, 51*(4). Full Text.

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