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Developing a Trauma-Informed Culturally-Based Intervention (TICBI) Approach for Refugee Resettlement Practices

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Abstract

Trauma-informed interventions have recently received more attention in the field of refugee resettlement and mental health. Although these interventions can be helpful to all trauma survivors, our model offers enhanced and cultural-based practice benefiting war-related trauma survivors, especially those from Post-Colonial nations. This model is based on needs identified by participants and collaboratively developed with the research team and the community. Our community-based participatory research (CBPR) began with three objectives. The first was to explore the current use of culturally-based, trauma-informed interventions and to assess service users' (SUs) and service providers (SPs) experiences. This was accopmlished by collaborating with a local community agency. The second objective was to identify service needs and gaps. The third objective involved working with the project's steering community members to develop a more effective model of interventions that can be used by resettlement and mental health agencies supporting refugees. During analysis, we examined the unique challenges identified by SUs and SPs to create a trauma-informed culturally-based intervention model (TICBI).

We used a mixed-method study involving focus groups, individual interviews, and surveys with 23 service users (SUs) and 20 service providers (SPs). The barriers identified by the SUs included lack of access to needs-based assistance, cultural and linguistic misunderstandings, and marginalization. The barriers identified by the SPs included lack of structural/organizational support, lack of funding, large caseloads, and burnout risk.

Keywords: refugees, trauma, forced migration stages, culture, brain/body response, healing processes, trauma-informed intervention.

1. Introduction

1.1 Refugees

With Russia's invasion of Ukraine, once again we are witnessing the devastation of war and the unfolding of another refugee crisis. Over the past two decades, other conflicts, such as in Iraq, Syria, Yemen, and Afghanistan, similarly have produced large numbers of refugees creating high levels of both internal and external displacement (Im et al., 2017; Miller, et. al., 2019; UNHCR, 2021). According to UNHCR Global Trends, in May 2021, more than 1% of the world's population was displaced by the end of 2021, despite the global pandemic and its resulting restrictions on mobility. In the past decade, the number of dislocated people has been steadily increasing from 1 in 159 in 2010 to 1 in 95 in 2020 (UNHCR, 2021). The number of displaced persons reached 89.3 million by the end of 2021, increasing by 8% from the previous year. Displaced people have reached a "dramatic milestone of 100 million people", a 12% increase from the previous year (UNHCR, 2022). According to the UNHCR Global Trends June 2022 report, the Russian invasion of Ukraine alone is causing "the most significant forced displacement of known European crises since World War II" (UNHCR, 2022).

1.2 Humanitarian Response

Part of a humanitarian response for displaced people demands finding durable solutions, which must include resettling refugees in countries where they will be protected. Before the COVID pandemic and its resulting travel restrictions, Canada was one of the leaders in resettlement among Western nations (Figure 1), as the liberal government promised to resettle 30,000 refugees annually (Government of Canada, 2021).

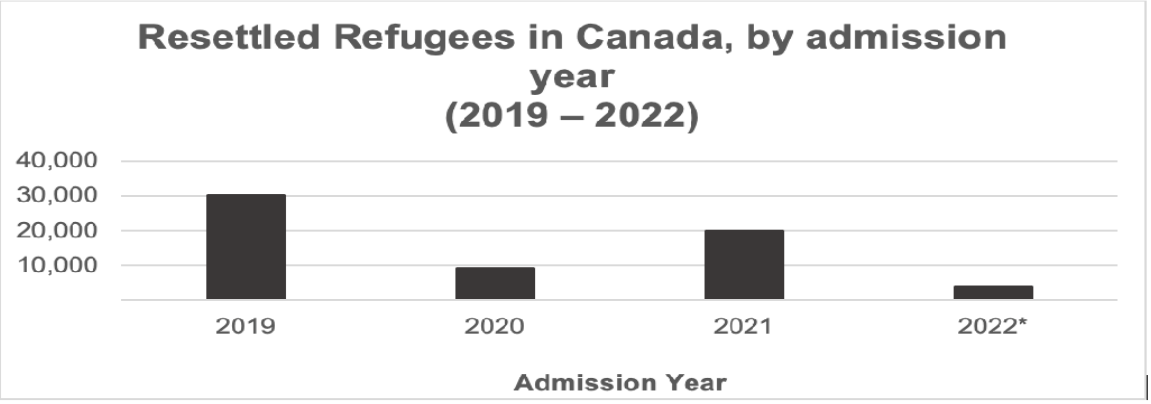

Figure 1. Resettled refugees in Canada, by admission year (2019-2022)

Note. Source – Immigration, Refugees and Citizenship Canada, Permanent Residents – Monthly IRCC Updates (May 2022)

These numbers are less than one-tenth of the total number of newcomers annually arriving in Canada to contribute to economic growth and demographic replacement (IRCC, 2022). As a humanitarian contribution each year, Canada also resettles refugees through its three resettlement programs: Government Assisted Refugees (GARs) or Convention refugees referred by the UNHCR through 100 percent financial assistance by the federal government during resettlement. Privately Sponsored Refugees (PSRs) are a blend of refugees and those in refugee-like situations resettled through Aid organizations or private individuals. Blended sponsorship or Blended Visa Office-Referred (BVORs) are also Convention refugees referred by the UNHCR and are resettled through 50 percent financial assistance from the federal government and 50 percent by private sponsors.

1.3 Service Needs

Even though these groups of refugees are arriving within various categories and different support systems, some need more than financial assistance when they arrive. Effectively assisting those who have endured the trauma of forced displacement requires an understanding of how forced displacement affects some refugees' physical and mental well-being. For some, the unexpected and highly stressful events of war and forced migration shatters or shakes their core beliefs leading them to post-traumatic stress disorder (PTSD).

Studies show that not all who experience similar traumatic events show symptoms of PTSD (Hadad, 2013; Mattson et al., 2018; Tedeschi et al., 2018; Tedeschi & Calhoun, 1995 &1996).

While PTSD impacts some, others, through various reasons, including their core religious beliefs and survival-based cultural teachings, activate an inner strength and internal resiliency fostering post-traumatic growth (PTG). Understanding the variation of resettlement needs and emotional response, the UNHCR's Executive Committee recently passed Conclusion No. 116 (LXXIII), highlighting the need for mental health and psychosocial support for refugees (UNHCR, October 2022).

The data from our study also showed emotional responses emphasizing the need for these services. This variation in service needs and timely emotional response allowed us to explore what an appropriate intervention might look like as a team. Therefore, we developed a new model which considers past experiences, current emotions and cultural values as an integral part of providing mental health and resettlement services. In their narrative of survival, some of our research participants (SUs) credited culture and religion as the source of strength for their recovery from traumatic experiences, helping them to make sense of their situation and enhance resilience and survival.

Research shows the benefits of integrating cultural values as part of the localization of services and the creation of durable solutions promoting well-being and integration (Bokore, 2017; Im et al., 2017; Miller et al., 2019; De Haene et al., 2010; Gwozdziewycz & Mehl-Madrona, 2013). As a result, localization for this study means prioritization of services to meet the needs of a particular refugee group in a specific place. It means making local services inclusive and sensitive to the refugee's needs, language, culture, and values. It redirects current services and aligns with the recent global equity movements.

1.4 Trauma-Informed Intervention

Within the past decade, health care has shifted towards a trauma-informed approach to addressing refugee clients' service needs. As a result, various disciplines have contributed to trauma research, promoting an interdisciplinary understanding of trauma and body/brain responses (Cozolino, 2010; Dana, 2018; Ogden & Fisher, 2015; Siegel, 2011; van der Kolk, 2014). It has become common to hear the words' trauma' and 'culturally informed services' used in current practice. However, as our data show and recent literature elucidates, clear explanations of the connection between culture, responses to trauma and implications for effective interventions are still missing (Danso, 2016; Fisher-Borne et al., 2014). This gap may impede existing culturally-centred intervention claims or make culture a mere token rather than a fully integrated component of the practice, as outlined in TICBI.

1.5 Trauma-informed Culturally-Based Intervention

Our participants' responses, supported by existing literature, make it clear that in many cultures, religious beliefs have a transformative power in defining and shaping one's life (Danso, 2016; Fisher-Borne et al., 2014; Ames & Fiske, 2010; Boehnlein, 2001). Religious beliefs and references to spiritual values have been used for millennia by people to overcome challenging conditions. For example, references to ancient Hebrew, Greek, Christian, Hindu, and Muslim writings show that religious traditions are ascribed as healing powers and are often used in culturally-based practices to overcome difficulties in life (Tedeschi & Calhoun,

1995, 1996 & 2004).

Supporting these studies, our participants repeatedly described in their narrative of survival the role of culture and religion as the source they relied on to stay mentally healthy and strong during during their traumatic experiences. Many participants credited their survival to the transformative power of their religious beliefs and culture. They indicated these beliefs gave them the strength to endure and survive highly stressful situations. One quote stood out in these discussions: "*Spirituality, prayers, patience and talking to elders helped. Our culture tells us to work together as a community to save our families and survive challenging times, which is what we did."* Research shows different brain activities between cultural groups. These differences exist in some brain regions involved in pain and visual perception, face recognition and self-regulation (Han, 2015). It shows why people from different cultures behave, think, and feel differently in similar stressful situations. Understanding these differences contribute to intervention planning and making services accessible.

1.6 The Role of Communities In developing TICBI

Our study aimed to involve community members in exploring existing culturally-based intervention methods and identifying gaps in these practices. After reviewing the data, we also used community-based participatory research (CBPR) techniques to develop a new supportive model. Our trauma-informed culturally-based intervention (TICBI) model is easy to understand. It can be used in combination with other practice-based theories, such as cognitive behaviour therapy (CBT), acceptance & commitment therapy (ACT) or narrative therapy (NT), to name a few, when working with survivors. We evaluated our new model by presenting it to SPs working with trauma survivors at a workshop and later organized a forum that produced valuable feedback (see table 1&2). This soon-to-be-published TICBI model includes detailed assessment and intervention skills considering culture and trauma response to provide accessible and need-based services and promote well-being.

2. Culturally-Based Trauma-Informed Intervention (TICBI)

After analyzing the data, we reviewed the literature, shedding light on the experiences of our SU participants focusing on war-forced migration and resettlement. Trauma studies show those impacts as negative experiences for some damaging their pre-war strong social connections and support system, particularly for communal communities when members began to prioritize their own family and individual survival (Ager, 1999; van der, Kolk, 2014). In this study, we identified three main stages such as the first stage being the pre-flight period the research participants acknowledged as the anxious times or when fear of the unknown begins. The stressful time starts the activation of fight or flight body/brain responses for survival (Levine, 2015). Our SU research participants identify the second stage as the start of the main traumatic experiences, including during the escape and before arrival at an interim or refugee-hosting country for safety. The severity of the response to the experience differs for everyone based on the factors mentioned earlier. Therefore, while some activate their fight or flight (sympathetic response), others freeze or faint (dorsal vagal activation and shutdown). Studies show these stress and fear become adaptive responses that create psychologically "stuck points" they use for other life stressors and continue affecting their well-being (Porges

& Dana, 2018; Dana, 2020; Levine, 2010 & 2015; van der Kolk, 2014). The third stage is resettlement experiences in a host or immigrant-receiving country, where they begin to feel safe but face many challenges. We developed TICBI based on participants' experiences and needs, as identified in our mixed-method data. We believe that TICBI is not a stand-alone model but will give those working with refugees trauma-informed and culturally-based added skills they can use along with their existing models to promote successful resettlement and integration.

2.1 Trauma Intervention

Studies show that trauma intervention comprises services that include information and resources/skills to build survivors' inner resilience and culture-based resistance (Chaze et al., 2015; MacDonnell, 2012; Tedeschi et al., 2018; Tedeschi & Calhoun, 2004; 27; van der Kolk, 2014). Traditional Western-based intervention methods, which focus primarily on mental health and symptomology, can, unfortunately, ignore the role of the refugees' traumatic experiences and the cultural apparatus through which they interpret and respond to them (Danso, 2016; Fisher-Borne et al., 2014).

Using culture and acknowledgment of internal resilience also recognizes that not all traumatic experiences lead to PTSD or cause significant psychological damage (Chaze et al., 2015; Gerber & Gerber, 2019; Tedeschi et al., 2018). At the same time, not all Western-based interventions make sense to survivors unless explained within a context-sensitive of cultural and religious references (Danso, 2016). Western-based interventions provided without regard to cultural contexts can create anxiety and limit clients' engagement in the therapeutic process. In our model, we provide a meaningful intervention plan that pays attention to culture and trauma responses to help survivors and promote well-being.

3. Theoretical Framework

This project is grounded in multiple theories used to understand better survivors' journey of forced migration, trauma responses and healing processes. Thus, for this study, CBPR is an ideal method for collaboratively exploring current practice issues, discussing community-based solutions, and assisting in developing TICBI (Hacker,2013; Wallerstein & Duran, 2010). We used CBPR principles throughout the project, including developing the TICBI model involving academic researchers, community members, SUs, and SPs. The selected steering committee members as community representatives also participated in the entire research process fully and actively.

Narrative Theory (NT) was also used in this study to highlight participants' stories about war, forced migration and services. We also used NT for our thematic analysis of SUs and SP's stories as they related their experiences or interpretations of traumatic events and barriers to services (Harvey,1996; Polkinghorne, 1995). NT goes beyond giving voice to participants as they tell their stories (Larsson & Sjöblom, 2010; Riessman,2005). It allowed us to analyze participants' stories within the cultural and religious contexts that shape them (De Haene et al., 2010; Larsson & Sjöblom, 2010; Reisman,2005 & 2008; Xu & Connelly, 2010).

We also used trauma theories such as the polyvagal developed by Stephen Porges, explaining

the human survival process to sustain life and promote healing (Porges & Dana, 2018; van der Kolk, 2014). Refugees develop adaptive, emotional responses during stages of forced migration, including resettlement. These adaptive behaviours trigger hierarchical autonomic responses mentioned above, including the ventral vagal (socialize) and sympathetic (fight or flight to escape) and dorsal vagal (play dead to survive), determining their emotional state at any given moment. Unfortunately for some survivors, these responses are dysregulated, locking them in the first two TICBI's survival mindset and hindering their resettlement and integration (see Figure 2). These emotions are visible in our participant stories as they discussed their feelings in each migration stage, including resettlement. In TICBI, this theory emphasizes the need for service providers' awareness of service users' emotional responses and barriers to creating connections or establishing feelings of safety.

4. Ethics Approval

We received ethical approval from Carlton University, where the principal investigator is based, and clearance was granted (project #113169) in compliance with the Canadian Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2). Throughout the study, we ensured the confidentiality and privacy of participants. We recorded the online focus groups and individual interviews after participants provided their written and verbal consent.

5. Method

5.1 Participant Recruitment

After receiving the ethics clearance, we began participant recruitment for our one-year-long mixed-method study. We recruited SPs and SUs primarily from our collaborating agency, the Somali Centre for Family Services (SCFS), in Ottawa, Canada. We also hired a community outreach worker to help us connect with other resettlement organizations and mental health agencies for further participant recruitment. In addition, using our pre-established contacts, we used email lists and telephone calls to invite SPs to participate and distribute posters through their listservs. We recruited two groups of participants (N=43) online (both SPs and SUs) between the ages of 19 and 66 (M=39.00, SD=12.63). Service providers (n=20) were 80.0% female (n=16) and 20.0% male (n=4) and between the ages of 26 and 61 (M=39.58, SD=13.34). Service users (n=23) were 52.2% female (n=12) and 47.8% male (n=11), between the ages of 19 and 66 (M=38.52, SD=12.29). They came from several war-affected countries (Colombia, Ethiopia, Iran, Iraq, Syria, Somalia, and Sri Lanka).

The SPs in this study were all English-speaking counsellors working within the resettlement sector and community health organizations. Given the focus of this study, we selected SPs specializing in mental health services. The SUs, as refugees to Canada, had all used resettlement services, and we prioritized those who sought mental health and other health services. Because this is a CBPR project, we asked SPs and community members to be involved in the project as steering committee members. The steering committee's role was to provide advice and to help us ensure the efficacy and soundness of the data collection and analysis. The committee also advised on delivering the project's outputs to achieve our

desired societal outcomes.

5.2 Data Collection

This mixed-method study was conducted between October 2020 and January 2021 in Ottawa, Canada. Generally, this type of CBPR requires face-to-face data collection. Due to the pandemic and Carleton University's COVID-19 restrictions and guidelines, the team modified the data collection protocol, shifting to online resources for data collection. After receiving email responses from those interested in participating in our study, we sent them a detailed consent form to be signed and returned. Upon receiving signed consent, we asked participants to complete an online questionnaire using a Qualtrics survey for demographic data collection (e.g., gender, age, ethnicity, education, etc.). To answer additional questions based on the Traumatic Life Events Questionnaire (TLEQ) to assess their war-related experiences. For SPs, we added the TLEQ measures about their current practices with clients requiring TICBI-based interventions. The Qualtrics survey included the Traumatic Life Events Questionnaire (TLEQ) to assess service users' experiences of trauma (Peirce, 2009). The 7-item TLEQ measures current and prior exposure to potentially traumatic events by evaluating different types of traumas. Follow-up questions asked whether participants felt fear, helplessness, or horror for each event and when the trauma occurred.

After receiving survey responses, we invited participants to a 1–2-hour online focus group or interview session. The three central questions for the SPs' focus group sessions and interviews concerned: (1) their current practices, including trauma-informed culturally-based interventions, trauma responses, culture, and the healing practices preferred by their clients, (2) the theories they use in their current practices and how they use them in trauma interventions, and (3) barriers to providing services to their clients.

We divided the question we asked SUs into two major categories. First, we asked about their experiences of forced migration and resettlement (e.g., resettling to Canada, access to services, etc.). Second, we asked about the experiences they considered traumatic in their journey and the benefits of their culture in their survival and healing. There were also follow-up questions. The focus groups comprised 2 - 4 participants. We ran separate focus groups for SPs and SUs –addressed in more detail below. With their consent, we recorded the sessions using Microsoft Teams. Based on the participants' preferences, we conducted the service users' focus group sessions in Arabic and English.

Before we started each online session, the research team re-emphasized the importance of confidentiality and the need for the participants not to disclose the content of the discussions outside the focus group. Similarly, we reminded participants of their option of withdrawing from the study at any time if they did not want to participate or share their stories. In data collection, we also followed a gender-neutral and inclusive approach. However, given that war affects women differently, we gave them the option to choose focus group sessions, i.e., to be in mixed-gender or women-only groups. The opportunity to be in women-only groups expressed our mindfulness of the impact of gender-based violence and cultural-based silencing, which might have stopped or limited some participants in their responses during mixed-gender group sessions.

6. Data Analysis

6.1 Survey Data

For quantitative data, statistical analysis of the TLEQ was performed using IBM SPSS Statistics for Windows, version 27.0. Due to the small sample size, a Shapiro-Wilk test was also performed, indicating that the TLEQ scores departed significantly from normality ($W = 0.898$, $p = .027$). Therefore, non-parametric tests were used. We used Mann-Whitney U tests to analyze the relationship between gender and trauma (Table 2) and Kruskal-Wallis tests to analyze the relationship between ethnicity and trauma (Table 3). We determined the statistical significance for calculations at $p<.05$ (two-tailed), and effect sizes were calculated (Cohen's d) as needed.

We analyzed SU's traumatic experiences [54] based on responses to the Traumatic Life Events Questionnaire (TLEQ). The 7-item TLEQ measured current and prior exposure to potentially traumatic events providing a differential analysis of the effects of different types of traumas (Table 3). Follow-up questions asked how frequently they experienced fear, helplessness, or horror at each migration stage (Table 2). We scored the type of trauma as either zero for not having experienced it or one for having experienced it. In addition, the total trauma score was calculated by summing across all items, with scores ranging from 0 to 7 ($\alpha = 0.75$) (Table 4). Mean trauma scores were calculated for each gender and ethnicity. There were no significant differences between SPs and SUs in age or gender (Table 1).

Table 1. Demographic Characteristics

Service Providers	***N***	**Percent**	**Range**	***M***	***SD***	χ^2	***p*-value**
Age	20		26-61	39.58	13.34	24.373	.610
Gender						3.647	.056
Male	4	20.0					
Female	16	80.0					
Education							
1-3 years of college/university	3	15.0					
Undergraduate university degree	5	25.0					
Master's degree	10	50.0					
Professional Degree	2	10.0					

Service Users							
Age	23		19-66	38.52	12.29	24.373	.610
Gender						3.647	.056
Male	11	47.8					
Female	12	52.2					
Ethnicity							
Arab/West Asian	9	39.1					
Black	7	30.4					
Latin American/Hispanic	2	8.7					
South Asian	2	8.7					
Southeast Asian	3	13.0					

Table 2. Frequency of Total Trauma Scores

Total Types of Traumas	***n***	**Percent**
0	3	13.0
1	1	4.3
2	1	4.3
3	2	8.7
4	6	26.1
5	3	13.0
6	4	17.4
7	3	13.0

Table 3. Difference Between Males and Females in their Experience of Traumatic Events

Variable	Gender	*N*	*M*	Mann-Whitney *U*	*p*-value	Cohen's *d*
Shock	Male	9/11		50.50	.232	0.456
	Female	7/12				
War/Refugee	Male	8/11		40.00	.065	1.010
	Female	4/12				
Loss	Male	9/11		34.00	**.022***	1.010
	Female	4/12				
Distress	Male	9/11		45.00	.118	0.626
	Female	6/12				
Assault	Male	3/10		58.00	.870	-0.068
	Female	4/12				
Discrimination	Male	9/10		51.00	.375	0.378
	Female	9/12				
Other	Male	8/10		23.00	**.010***	1.389
	Female	4/12				
Total Types of Traumas	Male	11	5.00	31.00	**.029***	0.887
	Female	12	3.17			

**p<.05*

Table 4. Difference Between Ethnicities in their Experience of Traumatic Events

Variable	Ethnicity	*N*	*M*	Kruskal-Wallis *H*	*p*-value
Shock	Arab/West Asian	7/9		8.518	.07
	Black	2/7			
	Latin American/Hispanic	2/2			
	South Asian	2/2			
	Southeast Asian	3/3			
War/Refugee	Arab/West Asian	5/9		6.910	.14
	Black	3/7			
	Latin American/Hispanic	2/2			
	South Asian	2/2			
	Southeast Asian	0/3			
Loss	Arab/West Asian	7/9		7.327	.12
	Black	3/7			
	Latin American/Hispanic	1/2			
	South Asian	2/2			
	Southeast Asian	0/3			
Distress	Arab/West Asian	7/9		3.293	.51
	Black	3/7			
	Latin American/Hispanic	1/2			
	South Asian	2/2			

	Southeast Asian	2/3		
Assault	Arab/West Asian	2/8	3.295	.51
	Black	1/7		
	Latin American/Hispanic	1/2		
	South Asian	1/2		
	Southeast Asian	2/3		
Discrimination	Arab/West Asian	7/8	4.385	.36
	Black	4/7		
	Latin American/Hispanic	2/2		
	South Asian	2/2		
	Southeast Asian	3/3		
Other	Arab/West Asian	3/8	3.942	.41
	Black	3/7		
	Latin American/Hispanic	2/2		
	South Asian	2/2		
	Southeast Asian	2/3		
Total Types of Traumas	Arab/West Asian	9 4.22	5.110	.28
	Black	7 2.71		
	Latin American/Hispanic	2 5.50		
	South Asian	2 6.50		
	Southeast Asian	3 4.00		

6.2 Focus Group Data

For the qualitative data, we did a two-step analysis where the project lead and research assistants did the first step using narrative and thematic evaluation (Riessman, 2005 &2008). We immersed ourselves in themes generated by listening to and repeatedly watching the video recordings and reading through the notes we had taken during the focus groups. Our objective was to understand the richness of the participants' stories. In the subsequent phases, we explored survivors' reflexive insights into their journeys of forced migration, as well as examined their construction of trauma stories with interpretative reference to trauma literature (De Haene, 2010; Park & Huang, 2010; Porges, 2007& 2022; Porges & Dana, 2018; Xu & Connelly, 2010).

We then shared the research analysis with the rest of the research team, members of the community partner agency, and the steering committee for further commentary, analysis, and feedback. During our phase-by-phase process, we identified specific responses to the research questions and analyzed the stories in participant narratives as we interpreted their meaning-making patterns (Fraser, 2004).

The steering committee helped to explain the participants' experiences meaning-making process by comparing them with the fundamental concepts identified by interdisciplinary trauma theories (Alemi et al., 2017; Cozolino, 2010; de Haene, 2010; Porges, 2007 & 2022; Porges & Dana, 2018; Levine, 2010 &2015; Ogden & Fisher, 2015; Siegel, 2011). Steering committee members discussed findings from the data and provided further analysis and feedback at each step.

6. 3 Service Providers

SPs described various strategies they use to assist SUs based on their educational background and practice mandate. They also repeatedly mentioned the challenges due to structural factors such as large caseloads, lack of training, burnout risks and cultural differences. Despite these challenges, they empathized with confidence and conviction how they followed mental health promotion strategies during the intervention, including storytelling and promoting social gatherings to share information and resources, seek support, and reduce isolation. Those with advanced training in their discipline described ways of including cultural practices. For example, they spoke about focusing on the client's emotional and physical reaction while using strength-based interventions informed by polyvagal theory and cognitive behavioural therapy.

During focus group discussions, SPs also talked about using stories to assess survivors' autonomic responses and evaluate the client's environmental cues for danger or wanting to connect with others. Some SPs with advanced training went further, describing how they use culturally-based communication to establish co-regulation and increase connection. They emphasized how using such practices benefits those from communal cultures impacted by disrupting their regular social interaction by replacing fear and mistrust with social contact. They also named other strategies, such as culturally-based mindfulness, peer support to enhance coping strategies and building relations to provide social support. There were no

clear answers when we asked for clarification of their methods or understanding of how they include culture in their practice. This quote from one of the focus group participants stood out to us as she explained the challenge of turning training knowledge into practice, "*I don't assume everything is due to culture, but I am not familiar with many cultures. Intervention is not always what you learn in textbooks, but it is about accommodating clients and using cultural sensitivity training."* In general, the service providers indicated that it was vital for them to develop a comfort level in integrating cultural sensitivity and knowledge from trauma theories into practice. Another SP describing her process said, "*Looking at clients' issues only through Western-based training is half lens missing part of the equation for the intervention. Yes, I also use trauma theories for psychoeducation and intervention planning."*

During a focus group discussion, a service provider with basic training (college diploma currently working in the resettlement services) said, "*trauma is a distressing event that impacts self-image, creating hopelessness and mistrust that affects the resettlement process. It requires a collaborative approach and active listening. I always try to listen"*. Another participant said, "*I try to be patient and avoid overloading them with information that I think is important in their resettlement process."* At the same time, agreeing on some skill sets, this group emphasized the importance of building a rapport before asking or exploring taboo subjects and personal experiences, even when they suspect they might be the problem. Most service providers working in resettlement services also discussed their high-stress levels due to large caseloads. They talked about the stress and personal responsibility of being part of the same community as the service users. Some SPs also discussed the need for a sensible move when they have ethnic similarities with SPs. They talked about not assuming the similarity is welcome because "*some survivors of them might avoid people [service providers] from their own culture because of past trauma and what they represent.*"

In these focus group discussions, some talked about working long hours, including weekends, to help fellow community members and their fear of burnout. They added how they depend on each other as colleagues for self-care and, at times, deal with triggers or when they are shocked by clients' stories. They also spoke about the challenges of working with increasingly diverse groups and the lack of additional training, especially in mental health. They also emphasized their commitment to serve despite the obstacles and planned their intervention based on their client's needs and pace. When asked what that looks like, some service providers on skill sets such as *"attuned listening"* to ensure they move at the client's pace. While others focused on trauma theories saying, *"The objective is to help to make the client comfortable enough to discuss taboo subjects."*

6.4 Service Users

The service user data showed a high level of trauma (past and present). The participants described their stress linking their survival mindsets to stages of migration, including their current struggle with everyday resettlement challenges, fear of cultural changes, and losing their identity. Poverty was identified as post-resettlement stress due to the lack of jobs and dealing with race-based challenges such as prejudice, discrimination, and being subjected to stereotypes. While the female participants mentioned some of their past traumas, they also

described their current stressors. Some of those stressors include identity loss for their children, changes in gender roles and family relationships as a powerful fear produced by living in a new country and society. Participants also talked about some service barriers, such as the lack of a culturally based information exchange, language barriers, and miscommunication, which were also the source of significant stressors.

7. Results

7.1 SPs Data

The SPs data show that providers have a wealth of experience (more than five years) working in resettlement and mental health. The data also indicate that 95% of participants currently work with racialized individuals, and 90% said they encountered clients dealing with past trauma. Our data show that 65% of the service providers in our study incorporated religion into their intervention plans. They described the methods they use to integrate culture into their practice as "cultural competency" or "cultural sensitivity" paired with a client-centred service model. Based on education and training backgrounds, there were apparent differences or gaps between service providers, variability in understanding how and why they use a particular method or how they assess the degree of its success.

SPs also addressed the risk of secondary or vicarious trauma (Devilly et al., 2009). Their direct exposure to trauma stories and witnessing the effects of trauma in their clients' lives makes them vulnerable to experiencing secondary or vicarious trauma. Research shows how exposure to vicarious trauma may create internal changes that shift SP's cognition and empathic engagement with SUs (Tedeschi et al., 2018). We discovered in our study that even though most SPs identified these vulnerabilities, only a few had access to professional support, including supervision.

Our participants also addressed how, despite these challenges, they feel they are in a personally rewarding profession where they get the chance to help their clients. However, the weight of job demands for SPs involved in trauma intervention is sometimes overwhelming and challenging, impacting their well-being. For others, the demanding job makes little impact on them as they realize through work their own internal strength. As a result, they can utilize their existing support system when they need one, contributing to their resiliency and providing them with growth opportunities by realizing their strength and power (Cohen & Collens, 2013).

7.2 SUs Data

The SUs data show survivors experienced trauma and high stress during forced migration and resettlement (see participant quotes and Tables 2 & 3). Barriers to receiving services included a lack of access to needs-based assistance, cultural and linguistic misunderstandings, and marginalization. The SUs response during the focus group discussions and individual interviews indicated the need for additional services beyond the essential resettlement. They identified those other needs as understanding their history, culture, and language to help them deal with past/present traumas and everyday settlement challenges in Canada. Due to cultural taboos, it was difficult for them to give specific details about what those challenges are;

therefore, they discussed, in general, the need for emotional support to promote well-being. They identified social isolation as part of the stress increasing their emotional crisis after resettlement. Some male participants discussed how they overcame isolation and problems by relying on healing processes through religious and cultural practices and health services (medical doctors). In contrast, women seeking to overcome isolation looked to friends and family for support. Having WhatsApp groups for information exchange and support was appreciated by both genders.

The survey data for SUs show that 87% of participants experienced at least one of the seven categories of trauma. We listed these categories in the survey:

- severe shock
- living in a war zone or refugee camps
- experiencing sudden or unexpected loss of a loved one
- witnessing a distressing thing happening to others
- experiencing physical or sexual violence
- experiencing a life-threatening injury
- Other traumatic experiences (See Table 4).

The survey data also indicate the gendered differences in reporting the experiences. Male participants reported a higher rate of trauma in all categories except sexual violence, where both genders showed low numbers. The gendered differences in reporting were significant in the categories of loss, other events, and overall trauma with large effect sizes (>0.8) (Table 2). When we asked the same question during the focus group discussions or individual interviews, we noticed avoidance of the topic of sexual violence in both genders, and we speculate that such avoidance likely affected participants' survey responses. Participants identified the direct discussion of mental health and sexually related topics as taboo subjects and, therefore, as a challenge when seeking services. We assumed that these topics are taboo subjects in many cultures as our data revealed no differences in reporting between ethnicities (Table 3).

In our comparison of the male and female experience of traumatic events, we saw differences in reporting certain types of traumas between genders (Table 2). In our survey, male participants reported significantly more traumatic events and experiences of loss. Effect sizes for these categories in our study ranged from 0.901 to 1.218, indicating a significant difference between gender-based reports (Table 2). However, in comparing the experience of traumatic events among different ethnicities, we saw no significant differences in reporting any kind of trauma or overall experience (see Table 3).

7.3 Culture and the Prevalence of Trauma

The survey data show variations in trauma responses according to culture, gender, and other factors. Culture influences trauma responses, decrease the psychological impact, increases

social support, and helps to connect with others. Culture also creates an environment for healing, creating the bases for developing new cultural-based growth and change-based narratives affecting meaning-making processes and promoting well-being (de Vries, 1996; Tedeschi et al., 2018). Some studies have examined how female survivors of wars use the benefits of their "bonding hormone" to decrease their fear and stress and seek familial and social connections to protect their offspring from the threat of war (Evans & Coccoma, 2014, pp. 23-26). Other studies explain how the human brain, body, and mind guide emotions defining thoughts, actions, and adaptations to the environment (Levine, 2015; Siegel, 2011). SUs also articulated during the qualitative section of the study how culture defines survival stories linking their emotional response to the traumatic event.

7.4 SUs Stories About First Stages of Forced-Migration

The following excerpts are from SUs thought processes and reactions to their traumatic experiences and emotions during each stage of forced migration. Some of the quotes that stood out for us at this stage include,

- "There were fears of government change and unknown sectorial violence."
- "It was stressful; I was afraid of the unknown."
- "We had difficulty deciding which country to go to if we needed to escape and how to get there."
- "I lost family members before I left, during the journey and in the camp."
- "The robbery, rape and danger scared me."
- "Because there were kidnappings of young girls and boys, I was afraid about what will happen to my children."

7.5 SUs Stories About Second Stages of Forced-Migration

In this transit stage, participants reported many uncertainties and dangers. The following quotes show their reactions to those experiences and related feelings. The following excerpts are some of the SUs stores that stood out for us.

- "Arriving at camp was confusing, and being there the first year was even more difficult."
- "I witnessed many things in the camp, like rape, beatings, other crimes, and they increased daily—no one could stop it."
- "I was separated from my family and felt isolated and lost until I reunited with my family at the camp in Turkey."
- "Camp life was scary, especially for my mother and sisters. I was always overstressed about what might happen to them."
- "The fear for me was lack of safety or food or not getting ID cards and being denied refugee status. I was always afraid."

Research shows that the receptions and services determine resettled refugee experiences in the resettlement country (Ager, 1999). Survival and growth follow as they develop connections, establish relationships and adapting or integrating their old with the news culture to strengthen relationships and support system.

7.6 SUs Stories About Third Stages of Forced-Migration and Resettlement

During focus group discussions and individual interviews, we provided SUs with a safe space to tell their stories about trauma, cultural response, and healing processes.

- "Finally, getting a resettlement in Canada was good for my family, but as a man, I am still struggling with staying strong for myself and the family."
- "I came alone. I miss the family I left behind in the camp, including my parents. I kept calling them because they do not have internet in the camp; I always told them I missed being with them in that place."
- "In my country, we have a circle of support—but I do not have a circle here. I feel lost."
- "I was fortunate to be a neighbour to someone who helped me with many things. My brother also took a significant role in my resettlement. They both helped me with all the paperwork and other needs."
- "I felt isolated because they (service providers) lacked understanding of my culture and the emotional challenges I was going through. Some service providers never ask about past or present trauma or my cultural values when we see them for services."
- "The government needs to know that people have to be in a safe place and have social and career rehabilitation. People need support when they arrive, especially if they have been traumatized."
- "I needed services with an understanding of my situation in a supportive way and clear communication. I was confused most of the time by personal questions, and maybe I did not understand the Canadian culture and resettlement process."
- "First, we lived in a crowded home with many people from different backgrounds and styles.
- "My English was not very good. Even though I took English at school, I did not want people to mock me, so I stayed silent. It was traumatic for me. I did not talk about what was happening to me with my family, but we were all distraught when we arrived."
- "Our image of Canada was different. During resettlement, the government puts different people in the same housing projects. That was difficult because we thought we could continue our dreams here, but we felt stuck in Ottawa because of language and housing difficulties."

- "I don't understand the culture, and communication was a struggle, but I am resourceful and found a job and (am) going to the adult learning center. I plan to go to college. I also have a roommate who is now a good friend to support me, but I miss my family, and I tell them that when I call."

During our focus group discussions and individual interviews, SUs also discussed the importance of their religious lives and cultural values in regulating their emotions while coping with life challenges, including resettlement, and as resources for healing.

7.7 Focus Group Discussions On The Role of Religion and Culture

Speaking about the role of religion and culture based on personal experiences, SUs often agreed that culture and religion were necessary forms of strength and helped them with their resilience-building actions. They also discussed the challenges, such as lack of culturally relevant information, inadequate financial support, and poverty. They also addressed the stigma and shame of living with the past, miscommunication and misunderstanding due to cultural differences, and sometimes discrimination. The following excerpts stood out for us as they connect their beliefs and healing process,

- "Spirituality and prayer helped me then and now with coping."
- "Family and a solid connection to nature, religion and community were my sources of survival. I think this is what keeps me going through life.
- "We believe that talking about it with the elders always helps."
- "Before and after the uprising, many of us in Syria choose religion/Spirituality and herbal treatments for various illnesses, including stress or sadness. When we were going through the war, what helped us the most was our tight-knit and family-oriented culture. When we struggle, we always turn to God to help us cope with the issues, including mental health."

Based on these stories and research findings, we developed an intervention model that pays attention to the three stages of migration, the traumatic experiences, body/brain responses and healing processes. The research team then worked collaboratively with the steering committee members to develop the TICBI model linking stages of migration and adaptive responses. TICBI is not a stand-alone model, but one that service providers in the resettlement and mental health service will use in collaboration with other practice models can use.

8. Three TICBI Mindsets and Survival Responses

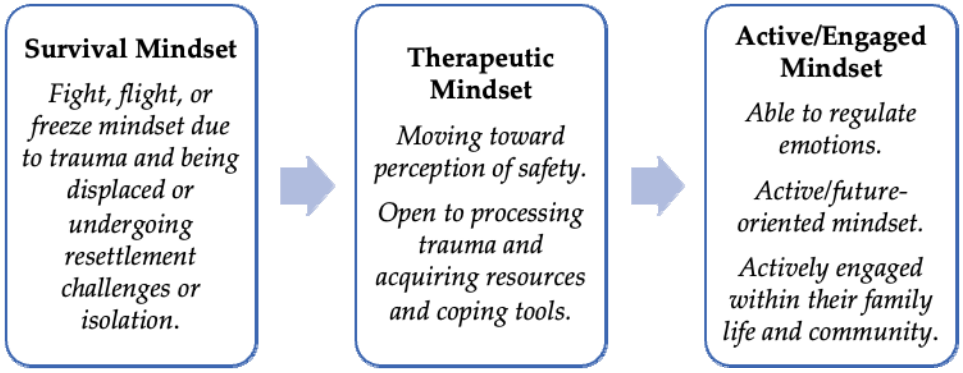

Figure 2. TICBI's Three Mindsets

8.1 The Survival Mindset

The identification and naming of this mindset emerged when most of our participants identified their emotions at this stage using words describing the action of the fight, flight, or freeze autonomic responses. They also mentioned their emotional stuck points, such as negative self-talk and fear-based adaptive behaviours (Ager, 1999; van der Kol, 2014). Some described their feelings during the first two stages of migration as having an overreactive or depressing thought or emotional numbness explained by researchers (Ager, 1999; Levine, 2015; van der Kolk, 2014). Others expressed more physical health issues and concerns (Porges & Dana, 2018; Siegel, 2011; van der Kolk, 2014).

8.2 The Therapeutic Mindset

We identified the therapeutic mindset in TIBI based on survivors' descriptions of their resettlement experiences, including dealing with their past but showing their adaptation to the new culture/lives and country. In this mindset, even though they continue to require assistance, they may also be ready to move toward positive resettlement goals by acquiring supportive resources.

8.3 An Actively Engaged Mindset

We identified the active/engaged mindset in TICBI as participants described their state of mind in their current resettlement process. These groups talked about their feelings more openly and with confidence and hope, showing their path to developing connections and looking more into the future. In this group, even though there are some challenges in their lives, the willingness to engage in the intervention, pursue future goals, and cope with everyday stressors is evident.

We developed detailed intervention methods not included in this paper and will be published soon. However, we presented the draft of the TICBI model in a workshop to service providers working at our collaborating agency, the Somali Center for Family Services of Ottawa, as

well as at an online forum attended by national and international service providers.

9. Evaluation

After our workshop and presentations, we surveyed the attendees to assess their experiences and determine whether the information we provided was relevant, helpful, and applicable to future interventions. We received valuable evaluation feedback, which confirmed that participants saw the relevance, utility, and applicability of the TICBI model we had developed (see Tables 5 & 6).

Table 5. Service Provider's Workshop Evaluation Response

Two Scale Question	Number of Participants	Responses
Extremely Informative, and I will use it	25	21
Somewhat informative, but I will use it.	25	4
Note informative, and I will not use it	25	0

We had a Q&A session at the end, extending our allocated time. As a result, seven participants left the online forum before completing the survey but sent positive follow-up emails.

Table 6. Forum Evaluation Response

Two-point Scales	Number of Participants	Responses
Extremely informative	30	17
Informative	30	6
Total number of participants	30	23

10. Discussion

War is known to disrupt, among other things, the common culturally-based bonds within communities. Humans have a biological necessity to acquire and adapt. These adaptations change and establish new perceptions of others and themselves. Going through war and forced migration disrupts previously learned social roles redefining survivors' mental models,

thoughts, and behaviours (Ames & Fiske, 2010; Cozolino, 2010; Siegel, 2011; van der Kolk, 2014). Studies show how these changes in both the exhibition and manifestation of trauma as either PTSD or post-migration growth (PTG) in refugee communities (Tedeschi, & Calhoun, 1995; Bernardi et al., 2019; Bowker, 1970; Liddell & Jobson,2016); Stoeber, 2003). TICBI fills the gap in current practice-based models providing detailed skills to use while working with survivors to promote well-being.

Issues of well-being include the SPs too. During focus group discussions, "self-care" was mentioned in providing trauma intervention and well-being. Social workers need to have the necessary care or nurture as they constantly health stories of traumatic experiences. Caring for oneself is as important as caring for others which social workers often forget due to deficiency within the system or as a behavioural impact of excessive compassion.

One of the social work discipline's strengths is understanding the role of advocacy in creating transformative change. Taking notes from Maurice Moreau's (1979) work about the definition of the structural approach, social workers can transform the current oppressive systems demanding a more manageable workload and support systems.

Healthy workplaces and social relations govern the service we provide. Therefore, advocating for support to create transformational change is needed. These changes include decreased workload, availability of support systems for SPs, and educational training opportunities to understand the process of trauma and best practices in trauma and culturally informed interventions. As the SPs pointed out, current workplace changes, especially in community service, needed additional funding to modify existing workplace structures by creating internally organized workplace support systems (i.e., demanding supervision and training) to stay healthy.

11. Limitations

We aimed to recruit SUs from war-affected areas and SPs working in the resettlement and mental health services. However, due to the COVID-19 pandemic in 2020, the nature of our online recruitment efforts, networks and data collection affected the demographic diversity of the SUs and SPs and getting their perspectives through face-to-face discussions about forced migration experiences, trauma, and culturally based intervention. It is important to note that the small sample size, recruited mainly from the Ottawa, Ontario-based urban multicultural setting, may also limit the transferability of the findings.

12. Conclusion

This paper describes our project's objectives, goals, and methods, including data collection, analysis, findings, and the development of TICBI for resettled refugees. Our model is drawn from qualitative and quantitative data results. It is intended to be a complementary model that provides additional knowledge and skills to current services helping SPs to understand the physiological and neurobiological process of trauma intervention tools that promote culturally-based communication of healing. Our findings indicate that incorporating SUs culture and forced migration stressor is necessary for planning a collaborative intervention. Our model provides step-by-step, culturally-based, detailed skills for therapeutic work with

traumatized refugees and ethnic minority groups.

The increasing rate of forced displacements now expanding to Europe and other parts of the world makes TICBI an essential intervention tool for those working with refugees at each migration stage, including resettlement. This is aligned with a humanitarian commitment solution for providing opportunities for survivors to rebuild their lives and enhance their well-being. Without effective interventions, their past and present traumatic experiences can diminish their potential to rebuild successful lives, increase social connections, and integrate into a new society.

TICBI urges service providers to increase their cultural awareness and to work with their clients to develop interventions based on their specific needs and to increase the accessibility of resettlement services. Each intervention step in TICBI is intended to establish safety and collaboration, reduce barriers, and improve communication to help survivors overwhelmed by the pain of their past wounds survive and ultimately thrive in unfamiliar surroundings, cultures, and social systems.

Unfortunately, many current western-based interventions are grounded in an assumption that all people, including refugees, will have 'typical' or even universal human responses to traumatic past and present experiences. Against such overgeneralization, we argue that the responses of refugees, and their reactions to life experiences, must be approached and understood as shaped by their past and within the culture of their home country or community. Such understandings of self and culture are by no means universal. Understanding the inner workings of refugees' emotional processing of their experiences as articulated through cultural, language, and social grouping is central when discussing their past trauma and present problems.

We believe that TICBI is a helpful model for service providers to consider when working with diverse groups affected by physiological and psychological responses to trauma. The evidence suggests that TICBI techniques will make services more inclusive by avoiding the inherent limits of traditional universalist western-based services that do not incorporate cultural differences. TICBI means rethinking refugee resettlement, personalization, and the localization of services.

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