Providing Trauma-Informed Care to Refugee Mothers

A Guide for Healthcare Providers

SCPOR

University of Regina

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PART 1: INTRODUCTION TO TRAUMA

What is Trauma?

Trauma refers to emotional stress in response to a deeply distressing or disturbing event. This event can be any experience that causes physical, emotional, or psychological harm, leaving the individual feeling unsafe or threatened (Kezelman & Stavropoulos, 2018). These events can be highly individualized—what one person finds traumatic, another might not. However, trauma can extend beyond the personal, and include community and societal trauma. Cultural differences and gendered social roles can also change the perception, and interpretation of a traumatic event (Clervil et al., 2013; Grossman et al., 2021).

Trauma in Refugee Women

Refugee mothers—by virtue of their roles as caregivers, their gender, and their refugee status—face a heightened risk of social and psychological stressors (Freedman, 2016; Hynes & Cardozo, 2004; Taheri et al., 2024; World Health Organization, 2021). According to the triple trauma paradigm, migrants and refugees can be exposed to stress factors at the pre-migration (e.g., war or armed conflict, persecution, betrayal, genocide, psychological distress, robbery, torture, massacre or genocide, loss or death), migration (exposure to life-threatening conditions, detention), post-migration (e.g., separation from support networks, lack of access to services, uncertainty, language barriers, poor living conditions). Some stressors are experienced more commonly or exclusively by refugee women and mothers, which can be explored through an adaptation of the triple trauma paradigm:

Pre-Migration	Migration	Post-Migration
Sexual violence (e.g., rape, forced impregnation, forced abortion, sexual trafficking, sexual slavery and the intentional spreading of sexually transmitted diseases)	Miscarriage, premature labor, or even death of a child during the journey	Altered role as traditional mothers (due to a more gender-equal society, language barriers, and different norms)
Gender-based violence	Exploitation	Domestic violence
Gender-based oppression	Physical and sexual abuse	Social isolation

THE CONSEQUENCES OF TRAUMA

For refugee mothers, their physical, emotional, and social well-being can be affected by trauma, creating unique challenges for them in the context of motherhood. Research suggests that post-migration challenges are the strongest predictor of traumatization, PTSD, anxiety, and depression, which may lead to dysfunctional behaviours that impair their ability to cope with social and family life (Gleeson et al., 2020).

Refugee mothers may feel overwhelmed by the demands of parenting in a new country, coupled with unresolved trauma. This can lead to increased stress and reduced emotional availability for children.

Mental barriers can also lead to challenges in breastfeeding (e.g., lack of supply, overstimulation, etc), and maternal bonding. For many refugee mothers, their sense of identity and belonging may be rooted in their roles as caregivers and community members, roles that may be difficult to maintain under these conditions (Zivot et al., 2020).

Experiencing trauma can lead to physical health impacts, including in the perinatal period (e.g., high blood pressure; Perera et al., 2023). Refugee mothers, particularly those who have experienced sexual violence, may also face reproductive health complications.

Despite these challenges, refugee mothers often demonstrate remarkable resilience. Cultural and community support, as well as personal strengths, can help mitigate some of the effects of trauma. Trauma-informed care that acknowledges these strengths is crucial for supporting their recovery and empowerment.

THE WINDOW OF TOLERANCE

The "**window of tolerance**" refers to the optimal zone in which individuals can effectively manage and process emotions, respond to stress, and engage with others (Miller et al., 2019).

- For refugee mothers, their window can become narrowed as a consequence of experiencing significant trauma. Ultimately, each patient has their limits. Triggers or stressors (e.g., navigating an unfamiliar healthcare system) can move individuals outside of this zone.
- They may either become hyper-aroused (i.e., experiencing anxiety, anger, or panic) or hypo-aroused (i.e., feeling numb, disconnected, or depressed). During these moments, a patient's behaviour is often out of their control.
- It is important for practitioners to recognize when patients are outside of their subjective window and learn how to use a trauma-informed approach to reduce stressors that may shift them outside of it.

TRAUMA-INFORMED CARE (TIC)

Trauma survivors need care that acknowledges their trauma and adapts to their specific needs—this is what trauma-informed care (TIC) aims to provide. It is true that numerous TIC training programs and educational materials exist, but this resource will specifically focus on the unique needs and contexts of refugee mothers. By centering our approach on this population, we aim to address their specific experiences and challenges while adhering to the five principles of TIC identified in a Canadian context:

Trauma Awareness and Acknowledgement

We will emphasize recognizing and validating the experiences of refugee mothers with trauma. This involves understanding the general impact of trauma, while acknowledging how past experiences influence various aspects of their lives.

Safety and Trustworthiness

Our material will help healthcare providers create a safe space for refugee mothers by focusing on predictability and consistency. It's essential to recognize their need for both physical and emotional safety during interactions.

Choice, Control, and Collaboration

We will advocate for empowering refugee mothers by actively involving them in their healing process. This will include providing informed choices, presenting both positive and negative options, and taking the time to build collaborative relationships that promote trust.

Strengths-Based and Skills-Building Care

Our modules will focus on recognizing the strengths of refugee mothers rather than solely their traumas. We will encourage healthcare providers to believe in their resilience and help them to build skills that enhance their ability to cope and thrive.

Cultural, Historical, and Gender Issues

Understanding the diverse identities of refugee mothers is crucial. Our material will incorporate processes that are sensitive to cultural, historical, and gender issues, ensuring that care is tailored to the specific backgrounds and experiences of each individual.

(Purkey et al., 2018)

CASE EXAMPLE

Background

Mariam, a 34-year-old Afghan refugee mother, has relocated to Canada with her husband and four children. Before migration, she experienced war-related trauma, gender-based oppression, and the emotional toll of forced displacement. Post-migration, she struggles with social isolation, language barriers, and a loss of autonomy, as she is unable to drive and heavily relies on her husband for mobility and communication. Mariam visits a maternal health clinic for persistent postnatal pain and breastfeeding difficulties. When asked about her symptoms, she hesitates, appearing withdrawn and anxious. The male physician's presence makes her visibly uncomfortable, and she declines further examination. Through a Dari-speaking interpreter, she expresses distress about her inability to access care independently and concerns about maintaining modesty during medical visits.

Consider...

- How might Mariam's past experiences of war-related trauma, gender-based oppression, and displacement influence her current healthcare needs and perceptions of care?
- How might social isolation, language barriers, and a loss of autonomy contribute to Mariam's anxiety and hesitation in seeking care?
- What role could cultural and religious needs play in Mariam's breastfeeding challenges, and how can healthcare providers address them effectively?
- How might the healthcare team continue to assess and adapt their approach to care as Mariam's needs evolve over time?

Adapted from Ray (2024)

Possible Course of Action...

The clinic staff apply trauma-informed principles by:

- Noticing Mariam's distress and validating her feelings (e.g., "I understand that this might be overwhelming, and I want to make sure you feel comfortable before we move forward. We can take our time.")
- Acknowledging the possible impact of past trauma rather than pressing for details, and explaining that many refugee mothers experience stress and uncertainty when navigating healthcare in a new country.
- Offering a female provider if possible or rescheduling for a day when one is available.
- Asking, "Would you like to have the exam today, or would you prefer to schedule another appointment after thinking it over?" instead of assuming Mariam is ready.
- Acknowledging Mariam's resilience and strength in caring for her children despite challenges, "It takes courage to come in today and seek care. You are doing your best for your health and your baby."
- Discussing breastfeeding support that aligns with her cultural and religious needs, and offering privacy screens and female lactation consultants.
- Connecting her with a peer-led mothers' group where she can share experiences and build confidence in navigating healthcare.

PART 2: SETTING THE STAGE FOR CULTURALLY SENSITIVE TIC

Culture is broadly understood as shared norms, beliefs, and values that are often intertwined with the social, economic, and geographical context.

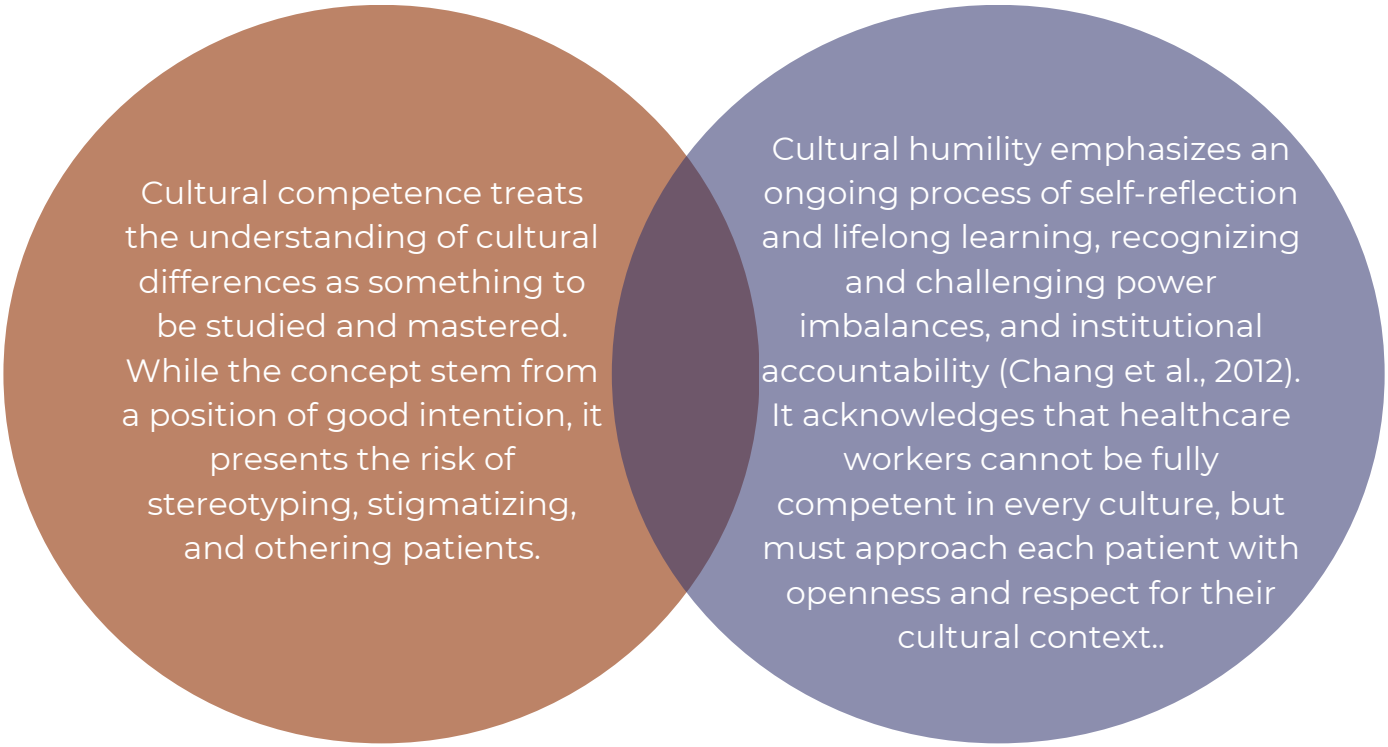
However, cultures and ethnic groups are not necessarily uniform or homogeneous; they consist of individuals with diverse beliefs, behaviours, and experiences. This can result in variations in traditions, values, and worldviews.

When professionals are perceived as culturally insensitive or lacking competence, patients may view the care as low quality or discriminatory, ultimately leading to a lack of trust in both services and providers (Cuevas et al., 2018).

Integrating cultural relevance into TIC helps individuals stay connected to what is meaningful to them, potentially serving as a protective factor against future mental and physical stress-related illnesses.

(Ranjbar et al., 2020)

- While cultural considerations are important—particularly as refugee women often struggle with having their cultural beliefs and practices misunderstood by healthcare providers—their primary concern is receiving respectful, individualized care, clear communication, and support in navigating healthcare systems and care practices in their new country (MacKenzie & Hatala, 2019).
    - Healthcare providers must balance cultural awareness with a person-centered approach, ensuring that care is guided by respect and responsiveness to the individual, rather than relying solely on cultural generalizations.
- In the context of culturally sensitive care, the distinction between *cultural competence* and *cultural humility* is critical.



- Cultural humility allows for an understanding of how culture influences health behaviours. To achieve this, healthcare workers must avoid making assumptions and instead engage in continuous learning and open, respectful conversations about each mother's unique experiences and beliefs. It is important to recognize the patient as the expert in their own experiences.
- It is important for healthcare providers to acknowledge that although client's diverse experiences, values, and beliefs influence how they access services, the cultural values of providers and service delivery systems can affect how services are delivered and received.

MATERNAL CARE AND CULTURE

It is important to recognize that different cultures have varied practices when it comes to pregnancy, childbirth, and raising children. Understanding and respecting these practices is essential when working with refugee mothers, as they can affect various aspects of maternal care.

Area of Maternal Healthcare	Examples of Potential Impacts of Cultural Beliefs
Prenatal Care	• Cultural belief that hospitals are for the sick, and pregnancy should remain private. This may lead to delayed initiation of care. • Reliance on traditional remedies and advice from elders rather than early medical intervention during pregnancy.
Intrapartum Care	• Resistance to medical interventions like cesarean sections and episiotomies, viewed as unnatural or harmful.
Postpartum Care	• Cultural practices may emphasize postpartum rest, the importance of keeping the mother warm, and specific dietary restrictions to ensure maternal recovery.
Breastfeeding Practices	• Expectations of how to guarantee a healthy supply, the proper way to breastfeed, and duration can differ drastically between cultures.
Healthcare Utilization	• Cultural significance of female genital circumcision may limit care-seeking behaviour due to concern of healthcare providers' judgment or ignorance.
Pain Management	• Crying out in pain during labour is seen as shameful in some cultures, making it harder for healthcare providers to assess labour.
Relationship with Healthcare Provider	• Religious and cultural modesty may drive a strong preference for female healthcare providers, particularly in intimate settings like childbirth.
Communication	• Limited English proficiency and discomfort with male interpreters can prevent effective communication and healthcare access.

(Yeo et al., 2023)

Refugee mothers can have complex perceptions of healthcare systems shaped by the combined influence of culture and past experiences...

They may have had past encounters with healthcare that differ greatly from the healthcare models in their new environment. Both healthcare providers and refugee mothers must navigate and adapt to the differing healthcare systems and beliefs that shape their understanding of health and care.

They may view healthcare workers as unquestionable authority figures, which can create a power dynamic that leaves refugee mothers feeling disempowered or hesitant to voice their concerns.

They may harbour deep distrust of unfamiliar healthcare systems, fearing that their cultural needs will not be understood or respected. Mistrust of institutional care can be heightened by past trauma, such as mistreatment in refugee camps.

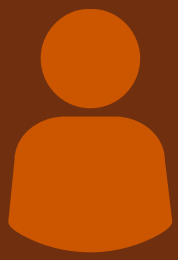
They may have been stereotyped based on their background in the past (e.g., assumptions about their health literacy, family dynamics, or care preferences). This can exacerbate feelings of isolation or mistrust, further discouraging refugee mothers from engaging with healthcare services.

For refugee mothers who may have experienced loss of control over many aspects of their lives, being given choices in their care—such as participation in decision-making or preferred treatment approaches—can be particularly healing (e.g., preference for female caregivers). Providers should also recognize how past trauma might influence a refugee mother's perception of care and adopt a trauma-informed approach that emphasizes trust, safety, and the provision of choices.

(Rambaldini-Gooding et al., 2024; Sherif et al. 2022)

TRAUMA AND CULTURE

- When working with refugee mothers, it is essential for healthcare providers to understand the potential impact of cultural trauma, such as experiences of genocide. Recognizing whether an individual has been exposed to these events helps guide appropriate care.
- Cultural brokers, who are individuals with authority or deep understanding within the culture, can be invaluable in interpreting cultural norms and serving as trusted supports. They can help ensure that the healthcare provider's approach is culturally sensitive and effective.
- Recognizing cultural differences in the expression and interpretation of symptoms ensures a holistic and compassionate approach to care.



People from individualistic cultures might emphasize the personal emotional experiences of distress and trauma

Individuals from collectivist cultures may focus on the impact of trauma on family or community rather than personal distress

(Schnyder et al. 2024)

- Trauma is experienced and expressed differently across cultures. What may be considered a traumatic event in one culture might be interpreted differently in another.
- Healthcare workers should be mindful of these variations and avoid assuming a uniform reaction to trauma, allowing space for different expressions of distress, from emotional suppression to more overt emotional expressions.
- In some cultures, mental health struggles or trauma may carry significant stigma, leading to suppression or denial of symptoms.
- Refugee mothers from these backgrounds may be reluctant to discuss their trauma, fearing judgment or shame.
- Mental health and trauma may be interpreted through spiritual or supernatural lenses in various cultures (Center for Substance Abuse Treatment, 2014).
    - For example, trauma symptoms may be viewed as a result of curses, possession, or punishment.

Examples of Cultural Concepts of Distress

CASE EXAMPLE

Faduma, a 29-year-old refugee mother from Somalia, is pregnant with her first child since arriving in Canada. She has not attended any prenatal appointments and is now in her third trimester. When asked by a community health worker why she has not sought care, she explains that she feels fine and believes that medical intervention is only necessary if there are complications. She also expresses concerns that doctors in Canada will pressure her into unnecessary tests or interventions that might interfere with a natural birth.

After much encouragement, Faduma reluctantly agrees to visit a prenatal clinic, but she is visibly uneasy. She does not ask questions during the visit and avoids eye contact. When the doctor recommends an ultrasound and routine bloodwork, she hesitates, stating that she does not want any tests that might harm her baby.

Consider...

- How can I communicate the importance of screening in a way that resonates with her beliefs?
- How can I ensure that Faduma feels empowered to ask questions rather than avoiding medical care?
- What strategies can I use to make her feel more comfortable with medical interventions?
- What steps can I take to provide Faduma with a clear birth plan that respects her cultural values?
- How can I ensure that Faduma receives prenatal education in a format that is accessible to her?

Adapted from Sacks et al. (2024)

Possible Course of Action...

The clinic staff may apply culturally sensitive care by:

- Acknowledging Faduma's cultural beliefs: "I understand that where you are from, women often seek care only if there are problems. In Canada, we do prenatal visits to help prevent complications before they arise. We want to honor your concerns while also making sure you and your baby stay healthy."
- Offering education in a way that respects her perspective. For instance, instead of simply recommending tests, explain their importance in a way that aligns with her concerns: "This ultrasound will help us ensure your baby is in a good position for a natural birth, just as you want."
- Encouraging shared decision-making: "You have choices in your healthcare experience. Let's create a plan together so that you feel comfortable with your care."
- Offering a tour of the clinic so that she feels more comfortable in the unfamiliar environment.

PART 3: BUILDING RELATIONSHIPS

Trust is the foundation of the healthcare relationship, built on the expectation that a provider's actions prioritize the patient's well-being(Robertshaw et al., 2017). For refugee mothers, establishing trust can help make them feel safe, respected, and empowered. When trust is established, refugees are more likely to engage with healthcare services and share their concerns, improving care quality. While compassion, empathy, and continuity of care are essential in building trust, other key factors also play a critical role, including:

EFFECTIVE COMMUNICATION

Explaining confidentiality and being transparent about procedures and processes are critical elements of patient-centered care, as is actively inviting women to communicate any discomfort before, during, or after procedures.

COLLABORATION

Determining the best course of action should be a collaborative process that combines your expertise in medical care with their insights into their personal experiences and needs.

CULTURAL-SENSITIVITY

Ensuring care is culturally responsive, such as respecting traditions after childbirth—like allowing family members to assist with breastfeeding or honoring cultural practices like holding the baby immediately after birth.

RESPONSIVE CARE

Incorporating flexibility into care plans when possible (e.g., offering female providers, modifying examinations, allowing the presence of a support person, catering to diverse screening preferences) and knowing how to respond to trauma.

ADDRESSING LINGUISTIC AND COMMUNICATION BARRIERS

Refugee women often face greater linguistic challenges compared to men due to fewer opportunities to learn the language and more barriers to accessing language classes (Cheung & Phillimore, 2017). Ensuring access to translation services is essential for effective communication. **However, communication barriers extend beyond language skills.**

Cultural differences can impact patterns of communication. For instance, refugee mothers may not actively request help, but wait for information or support to be offered. Healthcare providers should adopt a proactive approach, ensuring essential information is clearly and accessibly communicated, while remaining attentive to the cultural norms that may influence interactions with the healthcare system (Dastjerdi, 2012).

Cultural differences also influence how different topics are discussed. For example, some refugee women may describe feeling "heavy-headed" due to stress, without identifying it as a mental health concern due to discomfort with that label. Similarly, when sensitive topics (e.g., alcohol or drug use, suicidal thoughts, or domestic violence) are approached too directly or in a way that feels intrusive or judgmental, it can create a barrier to open and honest communication (Drapeau, 2012).

TIPS FOR COMMUNICATING EFFECTIVELY

1

Using Translation Services

- Speak to the patient, not the interpreter: Address the refugee mother directly to foster a sense of connection and trust.
- Ensure accuracy and satisfaction: When possible, assess their satisfaction with the interpreter and responding appropriately to their feedback (e.g., using a different interpreter, offering a written translator). While an interpreter from the same community can provide comfort through shared language and cultural understanding, it may also heighten fears of stigma or confidentiality breaches, making disclosure more difficult.
- Be mindful of gender preferences: Many refugee mothers may feel more comfortable discussing women's health issues with a female interpreter.

2

Verbal Communication

- Speak slowly and clearly: Avoid speaking too quickly, use plain language to ensure understanding, and avoid overwhelming the patient with unnecessary details.
- Check for understanding: Pause frequently and encourage questions to confirm that the information is understood.

3

Non-Verbal Communication

- Be mindful of cultural differences: Recognize that non-verbal gestures may not be universal. For example, in Canada, nodding up and down typically means "yes," but in countries such as Bulgaria or Iran, it may mean "no."
- Use open and welcoming body language: Convey empathy and attentiveness through your posture and facial expressions.

4

Listening

- Practice active listening: Focus on the refugee mother's words, repeat key points for clarity, and avoid interrupting.
- Show empathy and genuineness: Validate their feelings and experiences to build trust and demonstrate understanding.
- Maintain positive regard: Approach every interaction with respect and a non-judgmental attitude.

(Dastjerdiet al., 2012; Toke et al., 2024)

COMMUNICATING TRAUMA

Trauma screening is not a requirement of TIC. In fact, the Canadian Collaboration for Immigrant and Refugee Health advises against routine screening due to concern over harm (Sheth et al., 2022). However, many refugee women seek physical over mental health services, making primary care providers key in screening, education, and referrals. If screening is deemed necessary, it should prioritize safety, trust, and avoiding re-traumatization.

Establish a trusting relationship before asking about trauma history. Conversations about past trauma should only be conducted when the patient is ready.

Only conduct a screening when there is adequate time for women to share their experiences and for you to address their needs and questions.

Make sure they know that they have a choice in whether or not to answer questions, or when to take a break.

Normalize trauma, ensure confidentiality, and clarify its purpose and relevance for refugees.

When asking about trauma, ensure the woman are in a fully private setting, and feel physically safe and emotionally supported.

Understand which topics are appropriate and how to address them sensitively within cultural norms (e.g., domestic violence).

Have a flexible understanding of trauma. Refugee women may not directly express that they have experienced trauma or other mental health concerns; however, they may be willing to describe symptoms (e.g., self-blame, crying, difficulty focusing) or use metaphors and culturally-specific terms.

While many trauma-informed care protocols suggest looking for non-verbal signs of trauma (e.g., avoiding eye contact or body tension), it is important to recognize that some of these signs can be culturally bound (e.g., avoiding eye contact may be a sign of respect or deference rather than a potential indicator of trauma).

Minimize rescreening to reduce patient distress from revisiting trauma. Use appropriate privacy protections to document disclosure.

Screening should only be conducted if there are referrals in place. It is important to be able provide information about available resources and interventions. Referral options should be clearly communicated, ensuring that individuals who disclose trauma have access to the support they need.

(Afkhami & Gorentz, 2019; Cull et al., 2023; Due et al., 2022; Millar et al., 2021; Willey et al., 2020)

RESPONDING TO DISCLOSURE OF TRAUMA

Validate and Provide Emotional Support: Offer a compassionate, empathetic response. Let them know their feelings and experiences are heard and respected.

Allow Room for Silence: Do not feel pressured to have an immediate response. Silence can provide the individual space to process their feelings or continue sharing at their own pace.

Limit the Request for Further Details: Avoid probing for additional details beyond what is necessary for their current care. Allow them to disclose only what they are comfortable sharing.

Remain Professional: While it is natural to have an emotional response to disclosure, recognize that your feelings are secondary to the individual's needs. Focus on their experiences and emotional well-being.

Avoid Assumptions: Be careful not to make presumptive statements, such as, "You and your family must be so much happier here in Canada."

Acknowledge Courage: Recognize the vulnerability involved in sharing traumatic experiences and express appreciation for their trust.

Elicit Strengths and Develop a Plan: Collaborate to identify coping strategies that have worked in the past, supportive individuals in their lives, and ways healthcare visits could be more comfortable. Focus on the individual's strengths and resilience.

Provide Resources: Clearly communicate available resources, such as counseling services, or support groups. Ensure they understand how to access these resources and how they can follow up for continued support.

(Lanthier et al., 2016)

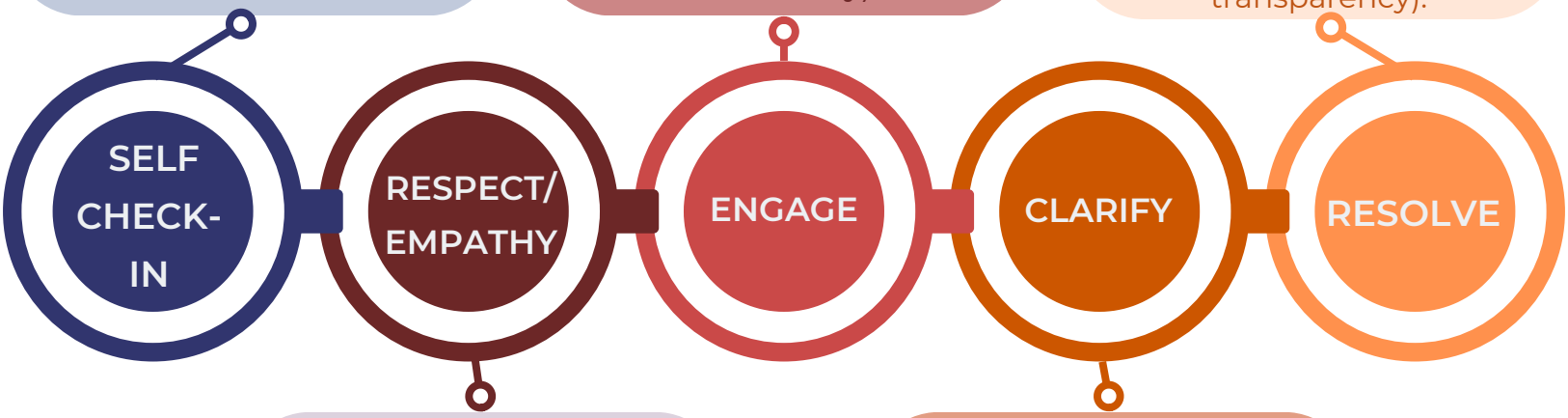
COLLABORATIVE DE-ESCALATION

When refugee mothers begin to show signs of emotional escalation, there are several strategies derived from trauma-informed practice that can be used. Collaborative de-escalation with refugee mothers involves using several skills to address heightened emotions and ensure safety in difficult situations. During this process, providers should recognize and build on the mother's existing resilience and coping skills.

Check-in with yourself to manage your emotional responses to remain calm and professional. Recognizing that the patient's reaction may stem from past trauma or systemic barriers, providers should focus on immediate, actionable steps.

Engaging collaboratively allows providers to meet the patient's immediate needs while preserving her autonomy, creating a sense of control (e.g., inviting her to sit, offering a comforting item like water, or involving additional staff or interpreters if necessary).

Resolving the issue requires working together to find practical solutions, balancing the mother's needs and cultural preferences with what is possible (e.g., offering clear options, compromising where feasible, and explaining decisions with honesty and transparency).



Approaching the situation with respect and empathy (e.g., provide clear explanations when possible, demonstrate genuineness) helps to de-escalate tensions by acknowledging the patient's feelings and validating her perspective.

Effective de-escalation requires clarifying the core issue by listening actively, asking open-ended questions, and ensuring the mother understands what can or cannot be done.

(Centre for Addiction and Mental Health, 2020)

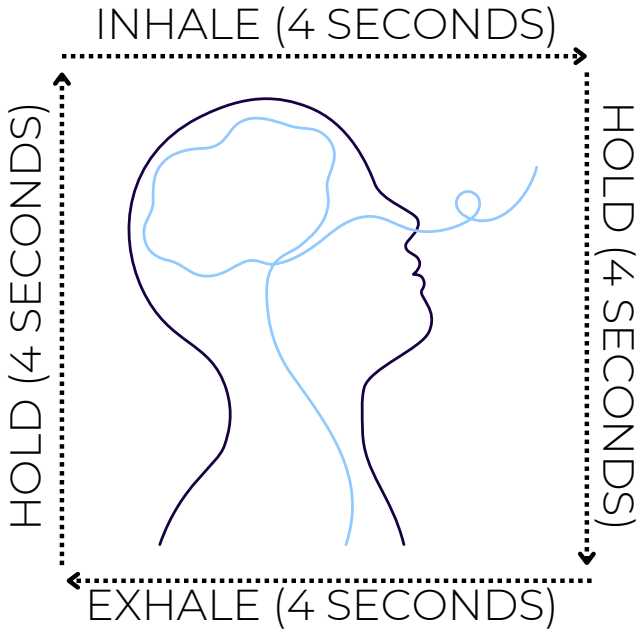
RELAXATION SKILL: BOX BREATHING

Breathing techniques are particularly helpful when patients are dysregulated because they are immediately accessible, require no external tools, and can be easily adapted to different settings. By teaching your patient how to connect with their breath, you can help bring them back inside their Window of Tolerance.

When teaching this skill...

- Explain that box breathing can help regulate emotions and reduce stress.
- Use visual aids, such as drawing a square or using their hands to guide the pacing
- Instruct mothers to inhale deeply through the nose for four counts, hold for four counts, exhale slowly through the mouth for four counts, and pause for another four counts before repeating the cycle.

To enhance engagement, providers can adapt the technique to the mothers' cultural backgrounds by incorporating familiar metaphors, such as imagining filling a balloon or tracing the sides of a window. Encouraging them to practice in a safe and quiet space, and reassuring them that it is normal to struggle at first, can help build trust and confidence in using the technique during moments of distress. This can be repeated as many times as needed.



CASE EXAMPLE

Aisha, a 34-year-old refugee mother from Syria, has brought her 4-year-old son, Omar, to a family doctor for a routine check-up. During the visit, the doctor asks about Omar's emotional well-being and behaviour at home. Aisha responds openly about her son but when the doctor inquires about Aisha's background (e.g., migrant status and education) and well-being, she becomes hesitant and confused by unfamiliar terms. Her doctor notices her confusion, but because Aisha does not try to ask any questions, the doctor moves on. Later, when the doctor mentions mental health support services available to families, Aisha abruptly ends the visit and leaves. A community health worker later reaches out to Aisha, who expresses uncertainty about why this information is needed and worries about how it might be used, fearing it might lead to child protection services getting involved.

Consider...

- Are there cultural nuances I should be aware of to build trust?
- How can I educate patients about the purpose of personal background questions to reduce feelings of intimidation?
- What strategies can be used to ensure that refugee mothers feel empowered to express their concerns and ask questions?
- What culturally sensitive approaches can be used to discuss mental health in a way that reduces stigma?
- How can I determine whether Aisha's confusion was due to language barriers or my own use of medical jargon?

Possible Course of Action...

For future appointments, Aisha's family doctor may...

- Emphasize confidentiality and explain that healthcare services do not automatically involve child protection agencies unless a child's immediate safety is at risk.
- Invite Aisha to share her comfort level and preferences regarding discussions about her background.
- Use culturally sensitive language and communication by framing discussions around "family well-being" or "stress management" instead of "mental health services" to reduce stigma.
- Explain why personal background information is collected before asking such questions: "We ask all parents these questions to better understand each family's current life situation and provide the best possible care."
- Check in regularly during the visit to ensure Aisha is comfortable and understands what is being discussed, asking, "Is everything clear so far?" or "Do you have any questions?"
- Ask Aisha if she would like to include a professional interpreters in the next appointment.
- Provide opportunities for Aisha to have a support person present if that helps her feel more secure.
- Offer written or visual resources in Arabic to reinforce verbal explanations.

PART 4: CREATING A SAFE AND SUPPORTIVE ENVIRONMENT

Environmental factors are an important consideration when providing trauma-informed, culturally sensitive care to refugee mothers. Healthcare environments can be sources of trauma, racism, and xenophobia for refugee mothers. To prevent this retraumatization, advocating for safe and inclusive spaces is vital. The physical environment—whether in the waiting area, at the check-in desk, or during the rooming process— can either create a sense of belonging or, conversely, make a patient feel unwelcome. While healthcare providers may experience challenges with recognizing or anticipating the stimuli or environmental factors that trigger trauma symptom responses, there are strategies that can be implemented on several levels to reduce these concerns (Miller et al., 2019).

DIMENSIONS OF THE ENVIRONMENT

PHYSICAL ENVIRONMENT SAFETY

- Ensure that spaces for breastfeeding, examinations, or consultations are private and shielded from unnecessary observation. Use curtains, screens, or dedicated rooms where possible.
- Display visible indicators of safety, such as signage about confidentiality and multilingual information on available support services.
- Involve diverse service users in the design or redesign of environments (e.g., breastfeeding rooms) to ensure spaces meet practical and emotional needs.

SENSORY CONSIDERATIONS

- Reduce environmental triggers by controlling noise levels
- Provide calming sensory inputs such as soft music, neutral colors in designated areas.
- Ensure temperature control to prevent discomfort during extended visits or breastfeeding sessions.

NAVIGATION AND MATERIALS

- Offer clear, multilingual signage to help mothers navigate the facility with ease.
- Use symbols and visuals for common areas like restrooms, breastfeeding rooms, and consultation spaces.
- Ensure any written materials provided (e.g., pamphlets) match patients' actual literacy level.
- Provide resources like breastfeeding pillows, blankets, and nursing covers for mothers to use if needed.

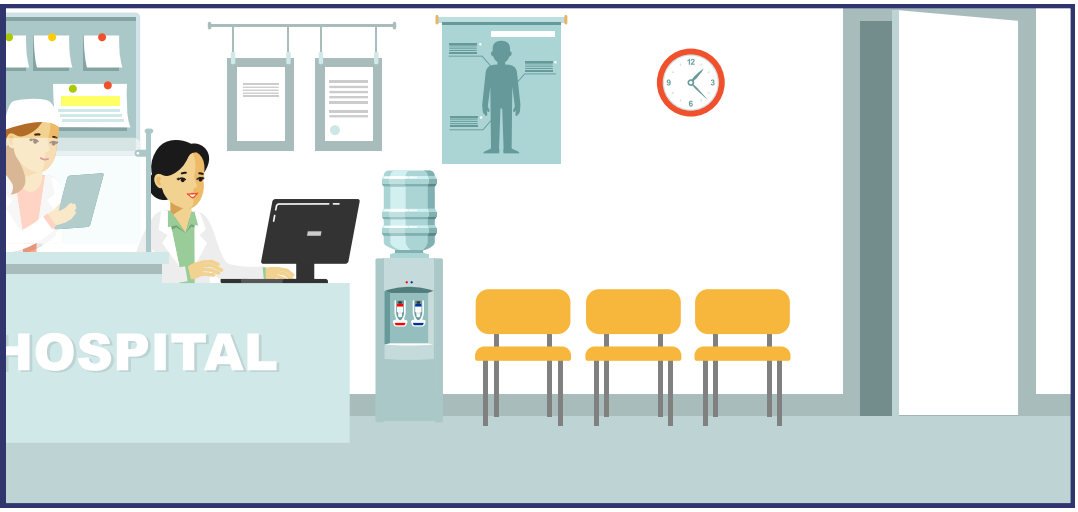
INCLUSIVE AND WELCOMING SPACES

- Design areas where mothers can gather for peer support or informal conversations.
- Ensure availability of clean and well-maintained facilities, such as diaper-changing stations and handwashing areas.
- Equip spaces with comfortable furniture, such as chairs with armrests, recliners, or soft lighting, to create a soothing atmosphere.
- Use inclusive signage to create a welcoming environment (e.g., welcome signs in multiple languages)

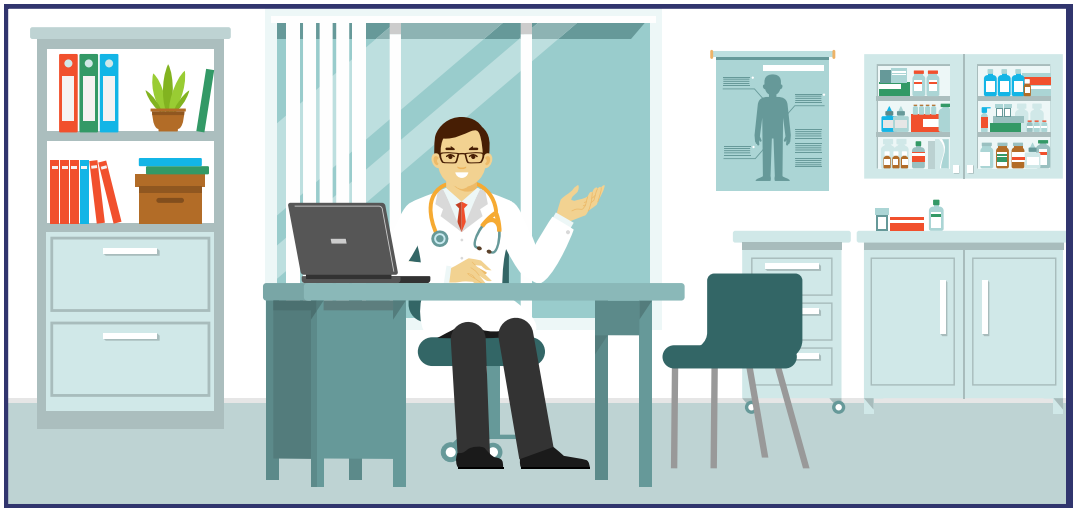
(Bulling & Hickle, 2023; Center for Health Care Strategies, 2018; Tucker et al., 2013)

IMPLEMENTING TRAUMA INFORMED CARE IN DIFFERENT STAGES

INITIAL ENCOUNTER



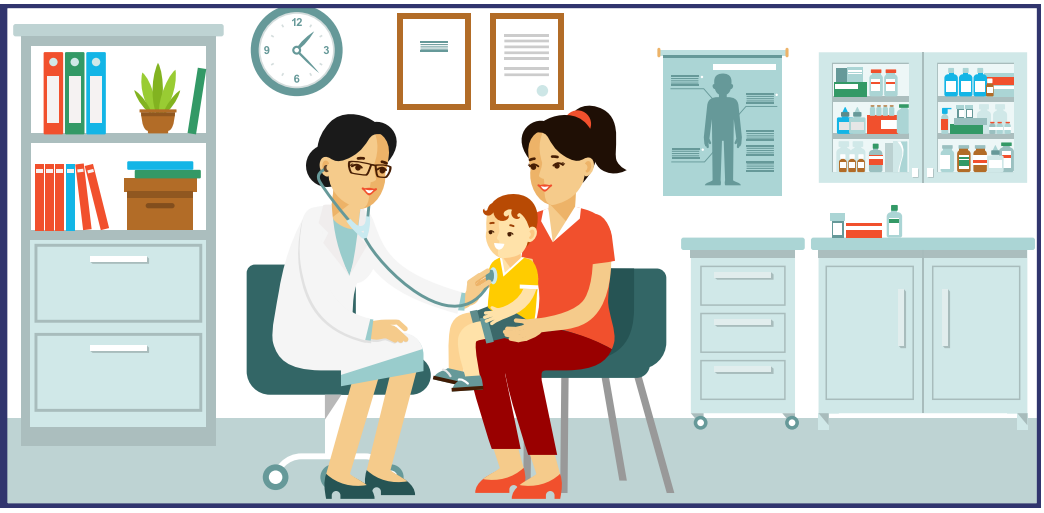
- Clarify patient's name, pronunciation
- Confirm if the patient wants to have others in the room with them
- Physically positioning oneself at the same level with the patient
- Be aware of negative reactions to patients (i.e., do not avoid certain patients, dismissive of their needs, or outright angry at the choices patients are making in their personal lives)
- Consider the ways in which de-escalation management may be traumatic (e.g., premature involvement of security personnel and physical restraint)



GATHERING INFORMATION

- Prepare the patient for what to expect for the duration of the visit along with any procedures, and encourage questions
- Avoid language that stigmatizes and/or places blame (e.g., victim, difficult, non-compliant)

PHYSICAL EXAMINATION OR PROCEDURE



- Increase patient comfort with clothing and draping (e.g., allowing them to keep as much clothing as possible on, allowing them to remove the clothing themselves)
- Guide the patient through the exam with supportive language
- Defer unnecessary exams and procedures
- Position oneself within the patient's line of sight
- Be clear in describing procedures

CLOSING THE VISIT

- Empower patients to take part in the decisions surrounding their care
- Provide appropriate referral information for community resources
- Encourage questions
- Confirm patients understanding by having the patient explain the discharge instructions in their own words back to the healthcare professional

(Greenwald et al., 2023)

CASE EXAMPLE

Marie, a 30-year-old pregnant woman from Haiti, attends a prenatal appointment at a hospital in Saskatoon. She speaks Haitian Creole and limited English. Upon arrival, Marie appears tense and somewhat unsure of where to go. The signage is only in English, and the waiting area is crowded and loud. A nurse calls her name quickly and with some mispronunciation. Marie hesitates before following the nurse. An interpreter is present in the room during her physical exam to help with communication. While this improves understanding, Marie appears increasingly uncomfortable—she avoids eye contact, remains tense, and flinches during parts of the procedure.

Consider...

- If I were a newcomer, is there anything about a Canadian hospital that I might find intimidating?
- Could the interpreter's presence during the physical exam be making her feel exposed or uncomfortable?
- Is the physical environment (e.g., noise, lighting, temperature) contributing to her discomfort?
- Am I creating an atmosphere that feels calm, private, and welcoming?
- Have I considered her cultural background and how it might affect her comfort with touch or communication?
- Have I offered her space to ask questions or share concerns?

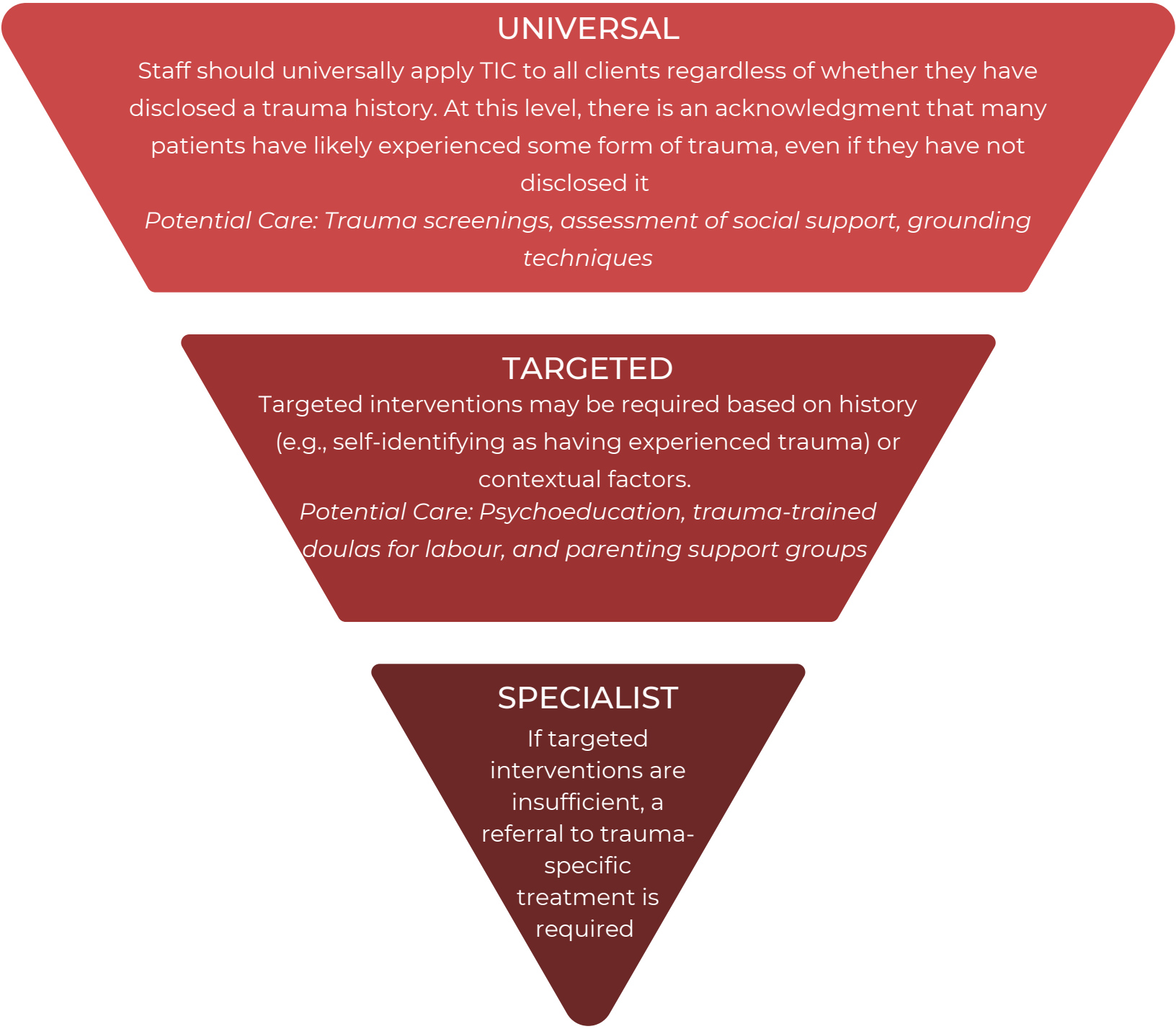
Possible Course of Action...

The healthcare workers may...

- Take some time to establish rapport to increase Marie's comfort.
- Emphasize that the primary goal is her comfort and safety, and that assistance is available throughout the visit. Ask if there's anything specific she needs to feel more at ease.
- Offer privacy options, such as using a privacy screen or arranging for remote interpretation, especially during sensitive parts of the exam.
- Check in about any environmental discomfort. If the noise, lighting, or temperature is affecting her, and make immediate adjustments as needed.
- Use soothing language and gestures to ensure Marie feels secure. Create a private and respectful atmosphere by asking permission before taking any actions and making sure the space feels inviting.
- Gently inquire about any cultural preferences regarding communication or physical touch, ensuring sensitivity to her background.
- Actively invite Marie to ask questions, ensuring she feels her concerns are heard. Make sure any written materials are clear and accessible in her language.

PART 5: INTERVENTIONS AND RESOURCES

Trauma-informed maternity care uses a stepped approach (Sperlich et al., 2017):



It is essential to recognize when, where, and how to refer clients for support beyond your role or expertise. The following information is not meant to be an exhaustive list of interventions and resources, but rather a quick guide to help healthcare providers identify and refer patients to appropriate support services.

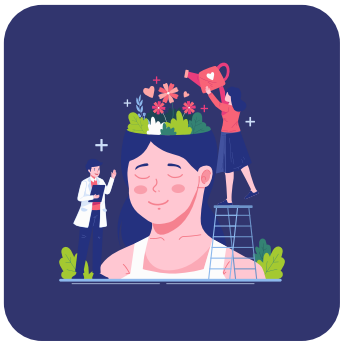
MENTAL HEALTH INTERVENTIONS

Evidence-based treatments for trauma and PTSD include...

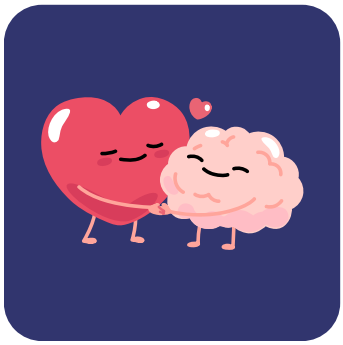
Narrative Exposure Therapy
Helps construct a coherent life narrative for contextualizing traumatic experiences (especially for refugees).

Cognitive Therapy
Targets negative evaluations and memories of trauma.

Cognitive Processing Therapy
Helps modify and challenge unhelpful trauma-related beliefs.



Prolonged Exposure
Encourages gradual exposure to trauma-related memories, feelings, and situations.



Cognitive Behavioral Therapy
Focuses on relationships among thoughts, feelings, and behaviours.

Eye Movement Desensitization and Reprocessing
Uses bilateral stimulation (e.g., eye movements) while recalling trauma memories.

(American Psychological Association, 2017; Thompson et al., 2018)

SASKATCHEWAN RESOURCES FOR REFUGEES

Regina

- Regina Immigrant Women Centre (RIWC) – https://reginaiwc.ca/
- Newcomer Welcome Centre – http://reginanewcomercentre.ca/
- Regina Open Door Society – http://rods.sk.ca/

Saskatoon

- Global Gathering Place – https://globalgatheringplace.com/
- Saskatoon Open Door Society – http://www.sods.sk.ca/
- International Women of Saskatoon (IWS) – Saskatoon Office – https://iwssaskatoon.org/
- Saskatchewan Intercultural Association – https://www.saskintercultural.org/

Francophone Settlement Services (Province-Wide)

- Assemblée Communautaire Fransaskoise – https://fransaskois.info/

Other

- Estevan – Southeast Newcomer Services – https://www.southeastnewcomer.com/
- Humboldt – Humboldt Regional Newcomer Centre – https://www.humboldt.ca/p/newcomers
- Lloydminster – Lloydminster Regional Newcomer Gateway – https://www.lloydminster.ca/en/living-in-lloydminster/newcomer-services.aspx
- Moose Jaw – Moose Jaw Newcomer Welcome Centre – https://www.mjnwc.ca/
- North Battleford – Battlefords Immigration Resource Center – https://www.battlefordsimmigration.ca/
- Prince Albert – Regional Newcomer Centre – https://www.panow.com/2023/01/25/regional-newcomer-centre-receives-additional-funding/
- Swift Current – Southwest Newcomer Welcome Centre – https://www.swnewcomer.ca/
- Tisdale – Northeast Newcomer Services – https://www.tisdale.ca/p/northeast-newcomer-services
- Yorkton – East Central Newcomer Welcome Centre – https://www.ecnewcomer.com

SASKATCHEWAN RESOURCES FOR PARENTS

Prenatal Support:

- Healthiest Babies Possible Program (Regina)
- Babies Best Start Program (Regina)
- Healthy Mother Healthy Baby Program (Saskatoon)
- Food for Thought Prenatal Support Program (Saskatoon)
- Regina Community Clinic: Prenatal information for newcomers to Canada.
- Regina Open Door Society: Prenatal classes and information for newcomers, immigrants, and refugees.

Breastfeeding Support:

- Breastfeeding Committee of Saskatchewan - https://www.breastfeedingsask.ca/
- Saskatoon Breastfeeding Matters - https://saskatoonbreastfeedingmatters.com/
- More Milk Sooner - https://www.moremilksooner.org/

Perinatal Support and Maternal Mental Health:

- Regina Perinatal Health Network Support Services - https://rphn.ca/
- HealthLine 811 - https://www.saskhealthauthority.ca/your-health/conditions-diseases-services/healthline-8-1-1
- Kids First Regina - https://www.kidsfirstregina.com/

FURTHER TRAINING OPPORTUNITIES

Trauma-Informed Care (TIC) e-Learning Series:
https://www.albertahealthservices.ca/info/page15526.aspx

Trauma- and Violence-Informed Care Workshop
https://equiphealthcare.ca/tvic-foundations

Immigrant and Refugee Mental Health Project Course:
https://www.camh.ca/en/professionals/professionals--projects/immigrant-and-refugee-mental-health-project/courses#irmh

Global Competency Standards for the Provision of Health Services to Refugees and Migrants:
https://whoacademy.org/

CASE EXAMPLE

Nadiya, a 35-year-old Ukranian mother of two-month-old twins, attends a routine infant wellness check-up at a community health centre in Regina. She arrived in Canada eight months ago. Nadiya is currently living in temporary housing and has no nearby family support. During the visit, the nurse practitioner notes that Nadiya seems distracted and emotionally distant. When one of the twins becomes fussy during the exam, she does not attempt to soothe him, instead staring blankly at the wall. She handles the other baby with care, but mechanically. When asked about her own health, Nadiya replies, “I don’t have time to think about that. I need to keep going.” Later in the visit, the nurse practitioner gently explores how Nadiya is coping emotionally as a new mother. Nadiya becomes visibly agitated and responds, “Talking doesn’t help. What happened, happened.” She quickly shifts the conversation back to the babies. Her tone is flat, and she appears emotionally shut down.

Consider...

- Could this patient be showing signs of unresolved trauma or postpartum depression?
- Are there appropriate services I can connect her to, and how can I introduce those options in a supportive way?
- How might past experiences of war, loss, and displacement impact her ability to trust healthcare providers or accept emotional support?

Possible Course of Action...

The nurse practitioner may...

- Acknowledge her resilience and normalize emotional challenges:
  - "Caring for twins in a new place, after everything you've been through, is incredibly hard. Many mothers in your situation feel overwhelmed—it's not just you."
- Avoid clinical or stigmatizing language, using softer alternatives like "parenting support," "stress management," or "someone to talk to if you want."
- Offer low-pressure resources such as brochures for local parenting programs or newcomer mother-and-baby drop-ins through local organizations.
- Build trust over time: If she declines support at first, follow up gently in future appointments without judgment. Repeated, consistent offers can make a difference.
- Provide a warm referral to a local trauma counsellor or perinatal mental health specialist, and offer to assist with booking and interpretation if needed.
- Encourage connection with other refugee mothers to reduce isolation and reinforce safety and community through shared experience.

References

Afkhami, A. A., & Gorentz, K. (2019). Addressing the invisible affliction: An assessment of behavioral health services for newly resettled refugees in the United States. Journal of International Migration and Integration, 20(1), 247–259. https://doi.org/10.1007/s12134-018-0631-6

American Psychological Association (2017). Treatments for posttraumatic stress disorder. American Psychological Association. Retrieved April 8, 2025, from https://www.apa.org/ptsd-guideline/treatments

Bulling, C., & Hickle, K. (2023, August). Creating a trauma-informed environment. The Innovate Project.

Center for Health Care Strategies. (2018). Creating safe health care environments for patients and staff. Center for Health Care Strategies.

Center for Substance Abuse Treatment (US). Improving Cultural Competence. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014. (Treatment Improvement Protocol (TIP) Series, No. 59.) Appendix E, Cultural Formulation in Diagnosis and Cultural Concepts of Distress. Available from: https://www.ncbi.nlm.nih.gov/books/NBK248426/

Centre for Addiction and Mental Health. (2020). Collaborative communication during escalated situations: Strategies for health care providers. Centre for Addiction and Mental Health.

Centre of Excellence for Women's Health. (2013). Trauma-Informed Practice Guide. British Columbia Provincial Mental Health and Substance Use Planning Council

Cheung, S. Y., & Phillimore, J. (2017). Gender and refugee integration: A quantitative analysis of integration and social policy outcomes. Journal of Social Policy, 46(2), 211-230.

Clervil, R., Guarino, K., DeCandia, C. J., & Beach, C. A. (2013). Trauma-informed care for displaced populations: A guide for community-based service providers. The National Center on Family Homelessness.

Cuevas, A. G., O'Brien, K., & Saha, S. (2017). What is the key to culturally competent care: Reducing bias or cultural tailoring?. Psychology & health, 32(4), 493–507. https://doi.org/10.1080/08870446.2017.1284221

Cull, J., Thomson, G., Downe, S., Fine, M., & Topalidou, A. (2023). Views from women and maternity care professionals on routine discussion of previous trauma in the perinatal period: A qualitative evidence synthesis. PloS one, 18(5), e0284119. https://doi.org/10.1371/journal.pone.0284119

Dastjerdi, M., Olson, K., & Ogilvie, L. (2012). A study of Iranian immigrants' experiences of accessing Canadian health care services: A grounded theory. International Journal for Equity in Health, 11, 55. https://doi.org/10.1186/1475-9276-11-55

Drapeau, A., Marchand, A., & Beaulieu-Prévost, D. (2012). Epidemiology of psychological distress. Mental Illnesses-understanding, prediction, and control, 69(2), 105–106.
Due, C., Walsh, M., Aldam, I., Winter, A., Cooper, S., Sheriff, J., & Ziersch, A. (2022). Perinatal care for women with refugee backgrounds from African countries: A qualitative study of intersections with psychological wellbeing. BMC Pregnancy and Childbirth, 22(1), 628. https://doi.org/10.1186/s12884-022-04957-9
Freedman, J. (2016). Sexual and gender-based violence against refugee women: A hidden aspect of the refugee “crisis.” Reproductive Health Matters, 24(47), 18–26. https://doi.org/10.1016/j.rhm.2016.05.003
Gleeson, C., Frost, R., Sherwood, L., Shevlin, M., Hyland, P., Halpin, R., Murphy, J., & Silove, D. (2020). Post-migration factors and mental health outcomes in asylum-seeking and refugee populations: A systematic review. European Journal of Psychotraumatology, 11(1), 1793567. https://doi.org/10.1080/20008198.2020.1793567
Greenwald, A., Kelly, A., & Thomas, L. (2023). Trauma-informed care in the emergency department: concepts and recommendations for integrating practices into emergency medicine. Medical education online, 28(1), 2178366. https://doi.org/10.1080/10872981.2023.2178366
Grossman, S., Cooper, Z., Buxton, H., Hendrickson, S., Lewis-O'Connor, A., Stevens, J., Wong, L. Y., & Bonne, S. (2021). Trauma-informed care: Recognizing and resisting re-traumatization in health care. Trauma Surgery & Acute Care Open, 6(1), e000815. https://doi.org/10.1136/tsaco-2021-000815
Hynes, M., & Cardozo, B. L. (2000). Observations from the CDC: Sexual Violence against Refugee Women. Journal of Women’s Health & Gender-Based Medicine, 9(8), 819–823. https://doi.org/10.1089/152460900750020847
Lanthier, S., Du Mont, J., & Mason, R. (2016). Responding to delayed disclosure of sexual assault in health settings: A systematic review. Trauma, Violence, & Abuse, 19(3), 251–265. https://doi.org/10.1177/1524838016659484
MacKenzie, L., & Hatala, A. (2019). Addressing culture within healthcare settings: the limits of cultural competence and the power of humility. Canadian medical education journal, 10(1), e124–e127.
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), 94. https://doi.org/10.3390/children6080094
Perera, E., Chou, S., Cousins, N. et al. Women’s experiences of trauma, the psychosocial impact and health service needs during the perinatal period. BMC Pregnancy Childbirth 23, 197 (2023). https://doi.org/10.1186/s12884-023-05509-5
Purkey, E., Patel, R., & Phillips, S. P. (2018). Trauma-informed care. Canadian Family Physician, 64(3), 170–172.

Rambaldini-Gooding, D., Olcoń, K., Molloy, L., Pitts, L., Lema, S., Baghdadi, E., Williams, J., & Degeling, C. (2024). Cultural humility in action: Learning from refugee and migrant women and healthcare providers to improve maternal health services in Australia. Health Expectations, 27(6), e70106. https://doi.org/10.1111/hex.70106
Ranjbar, N., Erb, M., Mohammad, O., & Moreno, F. A. (2020). Trauma-informed care and cultural humility in the mental health care of people from minoritized communities. Focus (American Psychiatric Publishing), 18(1), 8–15. https://doi.org/10.1176/appi.focus.20190027
Ray, R. (2024). Synthesizing cultural competency and reproductive justice: A case study of Afghan refugee mothers. Journal for Undergraduate Ethnography, 14(2). https://doi.org/10.15273/jue.v14i2.12256
Sacks, E., Brizuela, V., Javadi, D., Kim, Y., Elmi, N., Finlayson, K., Crossland, N., Langlois, E. V., Ziegler, D., Parmar, S. M., & Bonet, M. (2024). Immigrant women's and families' views and experiences of routine postnatal care: Findings from a qualitative evidence synthesis. BMJ Global Health, 8(Suppl 2), e014075. https://doi.org/10.1136/bmjgh-2023-014075
Schnyder, U., Bryant, R. A., Ehlers, A., Foa, E. B., Hasan, A., Mwiti, G., Kristensen, C. H., Neuner, F., Oe, M., & Yule, W. (2016). Culture-sensitive psychotraumatology. European Journal of Psychotraumatology, 7, 31179. https://doi.org/10.3402/ejpt.v7.31179
Sherif, B., Awaisu, A., & Kheir, N. (2022). Refugee healthcare needs and barriers to accessing healthcare services in New Zealand: A qualitative phenomenological approach. BMC Health Services Research, 22, 1310. https://doi.org/10.1186/s12913-022-08560-8
Sheth, N., O'Connor, S., Patel, S., & Dutton, M. A. (2022). To screen or not to screen: Exploring and addressing effective screening processes for trauma among forced migrants. Journal of Migration and Health, 7, 100148. https://doi.org/10.1016/j.jmh.2022.100148
Sperlich, M., Seng, J. S., Li, Y., Taylor, J., & Bradbury-Jones, C. (2017). Integrating Trauma-Informed Care Into Maternity Care Practice: Conceptual and Practical Issues. Journal of midwifery & women's health, 62(6), 661–672. https://doi.org/10.1111/jmwh.12674
Taheri, M., Harding, N., Stettaford, T., Fitzpatrick, S., & McCormack, L. (2024). Female-Specific Refugee Trauma Impacting Psychological Wellbeing Post-Settlement: A Scoping Review of Research. Journal of Loss and Trauma, 1–30. https://doi.org/10.1080/15325024.2024.2325077
Thompson, C. T., Vidgen, A., & Roberts, N. P. (2018). Psychological interventions for post-traumatic stress disorder in refugees and asylum seekers: A systematic review and meta-analysis. Clinical Psychology Review, 63, 66–79. https://doi.org/10.1016/j.cpr.2018.06.006

Toke, S., Correa-Velez, I., & Riggs, E. (2024). Exploring trauma- and violence-informed pregnancy care for Karen women of refugee background: A community-based participatory study. International Journal of Environmental Research and Public Health, 21(3), 254. https://doi.org/10.3390/ijerph21030254
Tucker, C. M., Arthur, T. M., Roncoroni, J., Wall, W., & Sanchez, J. (2013). Patient-centered, culturally sensitive health care. American Journal of Lifestyle Medicine, 9(1), 63–77. https://doi.org/10.1177/1559827613498065
Willey, S. M., Gibson-Helm, M. E., Finch, T. L., East, C. E., Khan, N. N., Boyd, L. M., & Boyle, J. A. (2020). Implementing innovative evidence-based perinatal mental health screening for women of refugee background. Women and birth : journal of the Australian College of Midwives, 33(3), e245–e255. https://doi.org/10.1016/j.wombi.2019.05.007
Yeo, S., Park, Y., McClelland, D. J., Ehiri, J., Ernst, K., Magrath, P., & Alaofè, H. (2023). A scoping review of maternal health among resettled refugee women in the United States. Frontiers in Public Health, 11, 1157098. https://doi.org/10.3389/fpubh.2023.1157098
Zivot, C., Dewey, C., Heasley, C., Srinivasan, S., & Little, M. (2020). Exploring the state of gender-centered health research in the context of refugee resettlement in Canada: A scoping review. International Journal of Environmental Research and Public Health, 17(20), 7511. https://doi.org/10.3390/ijerph17207511