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Ranking Trauma-Informed Care Needs Among Refugee Women

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A B S T R A C T

Objective: This study aimed to identify, categorize, and rank the trauma-informed care needs of refugee women through a mixed-method approach integrating qualitative literature synthesis and quantitative prioritization among refugee women in Germany.

Methods and Materials: The study employed a two-phase mixed-method design. In the first phase, an extensive qualitative literature review was conducted to identify key trauma-informed care dimensions relevant to refugee women, with data analyzed inductively using NVivo 14 until theoretical saturation was achieved. Seven overarching themes were extracted, including safety and protection, psychological support, cultural and linguistic sensitivity, empowerment and agency, social support networks, access to health and social services, and training for service providers. In the second phase, a structured questionnaire based on these themes was administered to 200 refugee women residing in Germany. Participants rated the importance of each care dimension on a five-point Likert scale, and data were analyzed using SPSS version 26 with descriptive statistics and the Friedman test to determine the relative ranking of themes.

Findings: The Friedman test indicated statistically significant differences in the perceived importance of trauma-informed care dimensions ($p < 0.001$). Safety and protection achieved the highest mean rank (4.78), followed by psychological support and healing (4.65) and cultural and linguistic sensitivity (4.39). Empowerment and agency (4.22) and social support networks (4.10) were moderately ranked, while access to health and social services (3.98) and training and capacity building for service providers (3.85) ranked lower.

Conclusion: Findings highlight the multidimensional nature of trauma-informed care, emphasizing that safety, psychological healing, and cultural alignment are essential for effective refugee support.

Keywords: *Trauma-informed care; refugee women; safety and protection; cultural sensitivity; psychological support; empowerment*

1. Introduction

Forced migration, displacement, and exposure to violence are increasingly shaping the psychosocial realities of millions of women worldwide. Refugee women, in particular, often experience cumulative and intersecting forms of trauma before, during, and after migration, which affect their health, identity, and overall well-being (Lee, 2022; Sharma et al., 2020). Experiences such as sexual violence, family separation, and loss of community are common during conflict and displacement, creating profound psychological distress that persists long after resettlement (Guo et al., 2021; Mathis et al., 2024). As a result, trauma-informed care (TIC) has gained increasing recognition as an essential framework for addressing the complex mental health and social support needs of refugee women (Isakov & Marković, 2024; Nkodo & Fadul, 2025). This framework emphasizes safety, empowerment, cultural sensitivity, and collaboration as key principles for promoting recovery and resilience among individuals exposed to traumatic experiences.

The concept of trauma-informed care extends beyond traditional clinical treatment, encompassing a holistic approach that integrates mental health, reproductive health, and social support services within resettlement systems (Ahmad & Reynolds, 2024; Hearn et al., 2023). For refugee women, trauma often manifests through multifaceted health outcomes—ranging from post-traumatic stress disorder (PTSD) and depression to chronic pain and perinatal complications (Mathis et al., 2024; Shahawy et al., 2022). Research underscores the need for culturally and gender-sensitive interventions that recognize how trauma interacts with pre-migration experiences, social isolation, and systemic inequalities in host societies (Baker & Naidoo, 2023; Larson et al., 2025). Trauma-informed systems acknowledge the centrality of safety, trust, and empowerment while minimizing the risk of retraumatization through empathetic and inclusive practices (Isakov & Marković, 2024; Moustafa & Hamza, 2025).

In recent years, TIC has been increasingly applied in mental health, educational, and community-based contexts involving refugees and asylum seekers (Im et al., 2021; Pan, 2025). Studies have shown that trauma-informed programs enhance engagement, reduce stigma, and foster recovery by aligning services with refugees' lived experiences (Im & Swan, 2020; Pottie et al., 2021). For example, trauma-informed healthcare frameworks emphasize emotional safety, peer support, and empowerment as core elements of healing (Ahmad & Reynolds, 2024; Hearn et al., 2023). However, gaps persist in understanding which components of trauma-informed care are most valued or urgently needed by refugee women across different contexts (Bobyn et al., 2025; Hambly & Sanmuhanathan, 2024). Given that refugee experiences vary by culture, migration route, and host country, prioritizing these needs through empirical ranking is critical for designing responsive and equitable services.

Evidence shows that refugee women often face cumulative traumas that exceed the psychological capacity of traditional care models (Guo et al., 2021; Nafari & Ruebottom, 2025). The transition from survival to recovery requires not only mental health support but also structural and cultural alignment between refugees and host systems (Moustafa & Hamza, 2025; Nkodo & Fadul, 2025). In countries like Germany, which hosts a large refugee population, women encounter intersecting barriers such as language limitations, cultural dissonance, and gender-based discrimination (Larson et al., 2024; Yalim et al., 2022). Many health and social service providers in Europe are trained under biomedical frameworks that inadequately address trauma's psychosocial dimensions (Isakov & Marković, 2024; Rivers, 2020). Hence, trauma-informed approaches offer a paradigm shift—one that moves from symptom treatment to systemic empathy and empowerment.

A growing body of literature highlights how trauma-informed principles can be operationalized across diverse care settings. In community-based refugee programs, TIC enhances participation and reduces mistrust by integrating safety and collaboration into service delivery (Pan, 2025; Pottie et al., 2021). In healthcare contexts, trauma-informed perinatal and reproductive care has been linked to improved maternal outcomes and greater patient satisfaction (Ahmad & Reynolds, 2024; Mathis et al., 2024). Within educational and employment programs, trauma-informed frameworks promote self-efficacy and resilience among refugee women (Baker & Naidoo, 2023; Nafari & Ruebottom, 2025). Yet, despite its conceptual appeal, TIC remains inconsistently implemented across host countries due to policy fragmentation, resource constraints, and limited cultural training among staff (Dzongowski & Dhar, 2020; Siddiq & Rosenberg, 2021). These inconsistencies raise important questions about which dimensions of trauma-informed care are most essential from the perspective of refugee women themselves.

Cultural and linguistic sensitivity consistently emerges as a determinant of effective trauma-informed care (Larson et al., 2025; Moustafa & Hamza, 2025). Language barriers, in

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particular, impede communication, reduce trust, and contribute to feelings of isolation (Shahawy et al., 2022; Yalim et al., 2022). Furthermore, cultural misunderstanding can inadvertently retraumatize clients if care providers misinterpret behaviors rooted in trauma or cultural norms (Im & Swan, 2021; Isakov & Marković, 2024). Gender dynamics also shape women's comfort levels with disclosure and help-seeking (Mathis et al., 2024; Toke et al., 2024). Thus, cultural responsiveness must be integrated with trauma-informed principles to ensure that care is both safe and meaningful. Programs in intercultural nursing and community health have begun to embed such approaches, demonstrating the importance of empathy and mutual respect in refugee care (Larson et al., 2024; Larson et al., 2025).

Beyond healthcare, empowerment and agency represent crucial but often overlooked aspects of trauma recovery. Trauma diminishes individuals' sense of control and identity, making empowerment central to the healing process (Im et al., 2021; Nafari & Ruebottom, 2025). Studies show that involving refugee women in decision-making about their care and community activities fosters resilience, self-efficacy, and long-term adaptation (Moustafa & Hamza, 2025; Nkodo & Fadul, 2025). Entrepreneurship, education, and peer mentoring programs grounded in trauma-informed principles enable women to reconstruct narratives of agency and hope (Nafari & Ruebottom, 2025; Siddiq & Rosenberg, 2021). Such models of care also prevent retraumatization by avoiding paternalistic structures and encouraging mutual collaboration between refugees and professionals (Bobyn et al., 2025; Hearn et al., 2023).

The literature also points to the critical importance of provider training and organizational support in sustaining trauma-informed systems (Im & Swan, 2020, 2021). Many professionals working with refugees experience secondary trauma or compassion fatigue, which can undermine service quality and emotional safety (Hearn et al., 2023; Rivers, 2020). Ongoing supervision, self-care programs, and institutional reflection are therefore vital to ensure that trauma-informed care remains ethical and sustainable (Im et al., 2021; Isakov & Marković, 2024). Cross-sector collaboration—linking healthcare, education, and legal services—has also been shown to enhance continuity of care and reduce systemic fragmentation (Moustafa & Hamza, 2025; Pottie et al., 2021). Such integration is particularly necessary for refugee women, whose trauma experiences intersect with multiple service domains including medical, social, and legal systems.

Despite the substantial body of research on refugee trauma, significant knowledge gaps remain regarding prioritization of care needs. Much of the existing literature offers descriptive or case-specific insights rather than comparative frameworks for policy design (Guo et al., 2021; Hambly & Sanmuhanathan, 2024). Furthermore, empirical evidence directly ranking trauma-informed care priorities from the perspective of refugee women remains scarce. Most frameworks have been developed by practitioners or policymakers without participatory input from the affected populations themselves (Baker & Naidoo, 2023; Pan, 2025). Consequently, interventions may fail to reflect the lived realities, preferences, and sociocultural values of refugee women (Ahmad & Reynolds, 2024; Shahawy et al., 2022). Addressing this gap requires methodologies that integrate both qualitative synthesis and quantitative prioritization to identify the most urgent and contextually relevant needs.

Recent studies advocate for participatory and intersectional approaches to trauma-informed care that account for gender, migration trajectory, and cultural background (Nkodo & Fadul, 2025; Toke et al., 2024). For example, the trauma-informed model for refugee women in HIV prevention emphasizes empowerment, safety, and culturally sensitive health education as mutually reinforcing pillars (Nkodo & Fadul, 2025). Similarly, initiatives that apply TIC principles to refugee entrepreneurship demonstrate how trauma recovery can coincide with economic empowerment and identity reconstruction (Nafari & Ruebottom, 2025). Integrating such interdisciplinary models offers a pathway for holistic healing and sustainable resettlement. However, the challenge lies in determining which aspects—safety, mental health support, empowerment, or systemic accessibility—should be prioritized to maximize outcomes.

The literature further suggests that trauma-informed frameworks must adapt to emerging global migration patterns and post-conflict contexts (Abdullatif et al., 2025; Larson et al., 2025). For instance, Afghan, Syrian, and Yazidi refugee women continue to face distinctive challenges related to cultural stigma, loss of status, and gender-based violence (Bobyn et al., 2025; Moustafa & Hamza, 2025). Comparative analyses indicate that care models effective in Western resettlement settings may not seamlessly translate across cultural contexts (Hearn et al., 2023; Mathis et al., 2024). Therefore, it becomes imperative to develop context-specific frameworks that incorporate refugee women's voices in shaping trauma-informed strategies (Guo et al., 2021; Pan, 2025). By listening to these

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perspectives, policymakers and practitioners can design services that are not only evidence-based but also ethically grounded and culturally resonant.

Given these complexities, there is a pressing need to systematically identify, categorize, and prioritize the trauma-informed care needs of refugee women. Qualitative synthesis can capture the depth and diversity of these needs, while quantitative ranking can reveal their relative importance in real-world settings. Integrating these approaches ensures that service design aligns with both theoretical frameworks and lived experiences (Im & Swan, 2021; Isakov & Marković, 2024; Moustafa & Hamza, 2025).

Therefore, the aim of this study is to identify, categorize, and rank the trauma-informed care needs of refugee women through a mixed-method approach combining qualitative literature analysis and quantitative prioritization among refugee women in Germany.

2. Methods and Materials

2.1. Study design and Participant

This study employed a two-phase mixed-method design combining qualitative content analysis and quantitative ranking. The first phase consisted of a qualitative exploration based on an extensive literature review to identify key trauma-informed care needs among refugee women. The review included peer-reviewed journal articles, organizational reports, and policy documents focusing on trauma, gender, and refugee health. Data collection continued until theoretical saturation was achieved, meaning no new themes or concepts emerged from the literature.

The second phase was a quantitative survey designed to prioritize and rank the identified care needs. The survey was conducted among 200 refugee women currently residing in Germany. Participants were recruited through local refugee support organizations, women's shelters, and community centers. Inclusion criteria required participants to (1) identify as female, (2) have refugee status or be in the asylum process, and (3) be at least 18 years old.

2.2. Measures

In the first (qualitative) phase, relevant literature was systematically collected using academic databases such as Scopus, Web of Science, PubMed, and PsycINFO. Keywords included "trauma-informed care," "refugee women," "mental health," "psychosocial support," and "post-migration stress." The selected studies were imported into NVivo 14 software for qualitative analysis. Through iterative reading and coding, recurrent themes and subthemes related to trauma-informed care principles, barriers, and needs were extracted and categorized.

In the second (quantitative) phase, a structured questionnaire was developed based on the qualitative findings. The instrument contained items representing the main categories and indicators derived from the literature review. Participants rated each care need on a five-point Likert scale, ranging from "not important" (1) to "extremely important" (5). Data collection was conducted both in-person and online, depending on participant accessibility and language needs. Trained bilingual facilitators assisted participants in completing the questionnaire in German, English, or Arabic, ensuring comprehension and cultural sensitivity.

2.3. Data Analysis

For the qualitative phase, thematic analysis was performed using NVivo 14. Codes were generated inductively, and patterns were compared across sources to identify overarching domains of trauma-informed care needs. The trustworthiness of the qualitative findings was enhanced through constant comparison, peer debriefing, and maintaining an audit trail of coding decisions.

For the quantitative phase, data were analyzed using SPSS version 26. Descriptive statistics were calculated to summarize demographic variables and mean importance ratings. The Friedman test was applied to rank the identified trauma-informed care needs based on participants' responses. Items with higher mean ranks indicated higher perceived priority. Reliability of the questionnaire was assessed through Cronbach's alpha coefficients.

3. Findings and Results

The qualitative phase of this study aimed to systematically identify and conceptualize the primary trauma-informed care needs of refugee women through an in-depth literature review. Using an inductive content analysis approach, the research synthesized findings from empirical and theoretical sources until theoretical saturation was achieved. All extracted texts and coded materials were analyzed using NVivo 14 to generate categories, subcategories, and conceptual codes. This process allowed for the integration of psychological, social, and structural dimensions of care, highlighting the multifaceted challenges refugee women face in accessing trauma-informed support

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systems. The final thematic structure comprised seven overarching themes, each encompassing several subthemes and open codes that collectively represent the diverse components of trauma-informed care for refugee women.

Table 1

Main Themes, Subthemes, and Concepts Extracted from the Qualitative Phase

Main Themes (Categories)	Subthemes (Subcategories)	Concepts (Open Codes)
1. Safety and Protection	Physical safety	Secure shelters; gender-segregated facilities; protection from violence; safe transportation
	Emotional safety	Trust-building; non-judgmental communication; confidentiality assurance; staff empathy
	Legal protection	Awareness of asylum rights; legal assistance; protection from deportation
2. Psychological Support and Healing	Access to trauma counseling	Culturally adapted therapy; female therapists; affordability; availability in native language
	Psychoeducation	Information on trauma symptoms; coping skill training; stress management workshops
	Group therapy and peer support	Sharing experiences; building community; empowerment circles
3. Cultural and Linguistic Sensitivity	Language accessibility	Trained interpreters; multilingual materials; translation of consent forms
	Cultural competence of staff	Understanding cultural taboos; gender norms; religion-informed care
4. Empowerment and Agency	Decision-making participation	Involving women in care planning; consent-based interventions; self-advocacy
	Skill development	Vocational training; digital literacy; language courses
	Self-efficacy building	Encouraging autonomy; recognition of strengths; goal-setting sessions
	Leadership involvement	Refugee women as peer mentors; participation in program governance
5. Social Support Networks	Family reunification	Support for family tracing; legal aid for reunification; cross-border coordination
	Community integration	Social inclusion programs; intercultural dialogue; local mentorships
	Peer connection	Refugee support groups; women's associations; storytelling sessions
6. Access to Health and Social Services	Healthcare accessibility	Mental health referrals; gynecological care; trauma-informed medical screening
	Case management	Coordination between NGOs; follow-up systems; holistic service plans
	Financial assistance	Emergency funds; housing stipends; childcare support
	Transportation support	Free transport vouchers; safe travel options; mobility access for rural areas
7. Training and Capacity Building for Service Providers	Trauma-informed training	Understanding trauma responses; recognizing triggers; self-care for providers
	Supervision and reflection	Clinical supervision sessions; reflective practice groups
	Cross-sector collaboration	Networking among agencies; integrated service delivery; interprofessional learning
	Evaluation and monitoring	Outcome assessment tools; continuous feedback; evidence-based improvement

The qualitative analysis revealed that safety and protection emerged as the most foundational need for refugee women, serving as the cornerstone of trauma-informed care. The reviewed literature consistently highlighted that many refugee women face ongoing threats to their physical, emotional, and legal security even after displacement. Ensuring physical safety through secure shelters, gender-segregated facilities, and safe transportation systems was found to be essential for restoring a basic sense of stability. Emotional safety was equally emphasized, requiring empathetic staff, non-judgmental communication, and the protection of privacy and confidentiality. Moreover, legal protection played a crucial role in enabling women to access asylum rights and feel safeguarded from deportation or violence. Without a sense of safety, engagement in psychological healing and empowerment processes becomes nearly impossible.

The second dominant theme identified was psychological support and healing, reflecting the centrality of mental health in trauma-informed interventions for refugee women. The literature underscored the high prevalence of post-traumatic stress disorder, depression, and anxiety in this population, stemming from cumulative experiences of war, displacement, and loss. Effective psychological support must include accessible and culturally adapted trauma counseling, preferably facilitated by female therapists who understand gender-specific trauma. Psychoeducation programs that teach coping mechanisms, emotional

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regulation, and awareness of trauma symptoms were also considered vital. Additionally, group therapy and peer-based interventions were recognized as powerful tools for reducing isolation, fostering mutual understanding, and building resilience within refugee communities.

A third major theme was cultural and linguistic sensitivity, which ensures that trauma-informed care is inclusive and contextually appropriate. The analysis indicated that communication barriers and cultural misunderstandings often hinder help-seeking and reduce treatment adherence among refugee women. Providing access to trained interpreters, multilingual information materials, and translated consent forms can significantly enhance participation in care. Equally important is cultural competence among service providers—particularly awareness of gender norms, family dynamics, and religious beliefs that shape women's perceptions of care. When cultural respect and understanding are integrated into service delivery, refugee women are more likely to trust professionals and engage actively in the recovery process.

Another significant finding centered on empowerment and agency, highlighting the need for trauma-informed systems to go beyond protection toward restoring autonomy and self-efficacy. Refugee women often experience a profound loss of control over their lives due to displacement, dependency, and bureaucratic constraints. Promoting decision-making participation in care planning helps rebuild confidence and personal agency. Skill development initiatives such as vocational and language training were consistently emphasized in the literature as pathways to independence and integration. Additionally, programs that encourage leadership involvement—such as training refugee women as peer mentors or community representatives—were shown to enhance their sense of value, dignity, and social contribution, thereby facilitating long-term recovery and adaptation.

The fifth major theme identified was social support networks, encompassing the crucial role of interpersonal and community relationships in trauma recovery. The literature repeatedly emphasized that social connectedness acts as a buffer against psychological distress. Family reunification emerged as one of the most emotionally charged needs, as separation from loved ones often deepens trauma and feelings of hopelessness. Equally important are community integration initiatives that facilitate intercultural dialogue and inclusion in local society. Peer connections through refugee women's associations, storytelling sessions, and social gatherings were also shown to promote resilience, belonging, and empowerment. These networks not only provide emotional support but also serve as informal channels for information sharing and resource access.

A sixth critical theme was access to health and social services, representing the structural dimension of trauma-informed care. Many refugee women encounter systemic barriers such as limited healthcare coverage, language obstacles, and lack of transportation. The literature underscored the importance of establishing easily accessible, affordable, and gender-sensitive healthcare services, including mental health, reproductive health, and preventive care. Effective case management—through coordinated efforts among NGOs, health agencies, and social services—was identified as vital for ensuring continuity and comprehensiveness of care. Financial assistance programs, childcare services, and transportation support were also emphasized as enablers that reduce practical barriers and facilitate participation in therapeutic or empowerment-oriented programs.

Finally, the theme of training and capacity building for service providers captured the systemic and professional aspects of trauma-informed care. The literature emphasized that the effectiveness of trauma-informed approaches depends heavily on the awareness, attitude, and competence of the professionals delivering them. Regular trauma-informed training enables service providers to recognize trauma responses, avoid re-traumatization, and implement empathetic, evidence-based interventions. Continuous supervision and reflective practices help maintain emotional resilience among staff working in high-stress contexts. Furthermore, cross-sector collaboration among health, legal, and social agencies promotes integrated care pathways, while ongoing evaluation and monitoring ensure accountability and quality improvement. Building institutional capacity thus strengthens the sustainability and impact of trauma-informed care systems for refugee women.

The second phase of the study aimed to empirically prioritize the trauma-informed care needs identified during the qualitative analysis. Using a structured questionnaire developed from the seven main qualitative themes, 200 refugee women residing in Germany were surveyed to rate the importance of each need on a five-point Likert scale. The collected data were analyzed using SPSS version 26, and the Friedman test was conducted to determine the relative ranking of the themes. Higher mean rank scores indicated greater perceived importance by participants. This phase provided quantitative validation for the thematic structure

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derived from the literature and offered insights into which areas require urgent attention in policy and practice.

Table 2

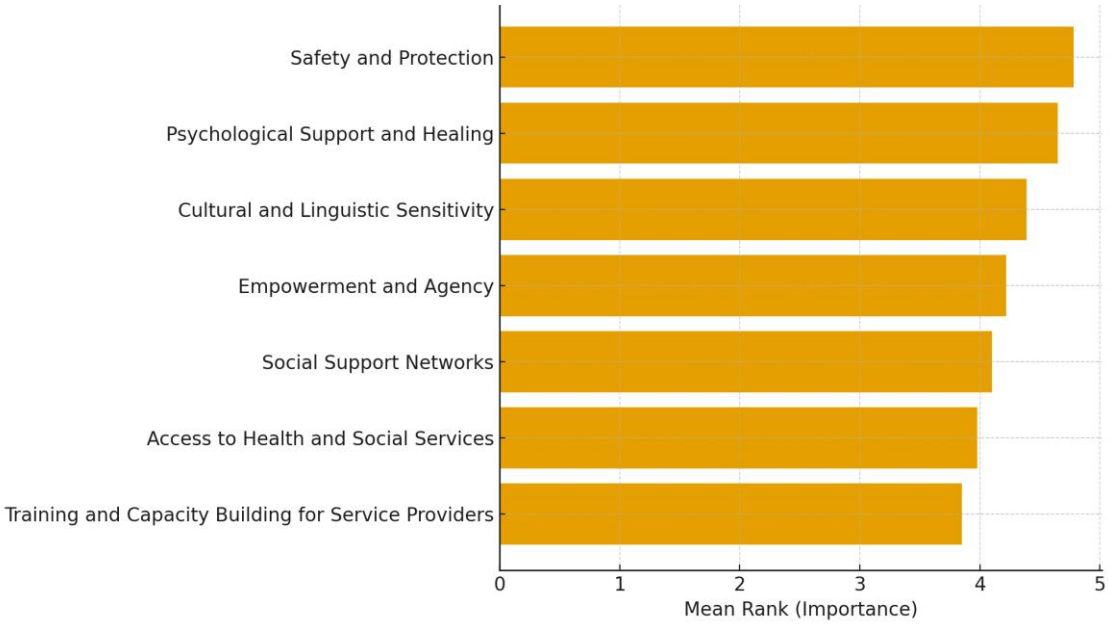
Ranking of Trauma-Informed Care Needs among Refugee Women (n = 200)

Rank	Trauma-Informed Care Theme	Mean Rank	Standard Deviation	Interpretation
1	Safety and Protection	4.78	0.32	Most critical need; foundational for recovery
2	Psychological Support and Healing	4.65	0.36	High mental health priority
3	Cultural and Linguistic Sensitivity	4.39	0.41	Essential for accessibility and trust
4	Empowerment and Agency	4.22	0.45	Needed for long-term resilience
5	Social Support Networks	4.10	0.48	Important for belonging and integration
6	Access to Health and Social Services	3.98	0.51	Structural and logistical support
7	Training and Capacity Building for Service Providers	3.85	0.49	Professional and institutional enhancement

The ranking results revealed that safety and protection was rated as the highest-priority need, confirming that security and stability are fundamental for refugee women's engagement in care and recovery. Psychological support and healing ranked second, underscoring the widespread impact of trauma-related mental health challenges. Cultural and linguistic sensitivity followed closely, indicating that effective communication and cultural respect are essential enablers of care accessibility. Themes related to empowerment and agency and social support networks were moderately prioritized, reflecting the importance of self-determination and community belonging in sustainable recovery. Access to health and social services and training for service providers received relatively lower rankings but were still regarded as vital elements within a holistic trauma-informed care framework. Collectively, the ranking outcomes highlight the interdependence of safety, psychological support, and cultural competence as key pillars for trauma recovery among refugee women in Germany.

Figure 1

Ranking of Trauma-Informed Care Needs among Refugee Women



4. Discussion and Conclusion

The findings of this study revealed that *safety and protection* ranked as the highest-priority need among refugee women, followed closely by *psychological support and healing* and *cultural and linguistic sensitivity*. These results align closely with the principles of trauma-informed care (TIC), which emphasize safety, trust, collaboration, and empowerment as foundational elements for supporting

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individuals affected by trauma (Isakov & Marković, 2024; Moustafa & Hamza, 2025). The prioritization of safety indicates that, despite physical relocation to host countries such as Germany, many refugee women continue to experience insecurity—whether through unstable housing, threats of deportation, or interpersonal violence. The emphasis on protection echoes findings from previous studies showing that trauma recovery is unattainable in the absence of physical and emotional safety (Ahmad & Reynolds, 2024; Nkodo & Fadul, 2025). Refugee women's lived experiences underscore that safety serves not only as a precondition for engagement in mental health interventions but also as a psychological foundation for trust, dignity, and empowerment.

The second-ranked theme, *psychological support and healing*, underscores the persistent mental health burden among refugee women. This is consistent with global evidence indicating high rates of post-traumatic stress disorder (PTSD), anxiety, depression, and complex grief in displaced populations (Guo et al., 2021; Lee, 2022). Many participants emphasized the importance of trauma-informed counseling, access to female therapists, and culturally adapted psychosocial support. These preferences reflect prior findings showing that refugee women often face barriers to conventional mental health services due to stigma, linguistic challenges, and distrust in institutions (Bobyn et al., 2025; Shahawy et al., 2022). Studies by Im and colleagues have also shown that trauma-informed systems of care—those that integrate mental health with cultural responsiveness—promote sustained recovery by addressing both psychological and contextual factors (Im et al., 2021; Im & Swan, 2020). Therefore, the present results reinforce the notion that effective trauma recovery requires not only access to psychological services but also the assurance of safety, cultural respect, and empowerment within therapeutic settings.

Cultural and linguistic sensitivity, ranking third, highlights the profound role of communication and cultural congruence in building trust between refugee women and service providers. Similar to the findings of Larson et al. (Larson et al., 2024; Larson et al., 2025), this study confirms that cultural misunderstanding often leads to retraumatization and withdrawal from support systems. In particular, linguistic barriers exacerbate emotional isolation and can undermine treatment efficacy, as women may struggle to articulate trauma narratives or understand care instructions. The findings are consistent with prior evidence that language accessibility, the presence of trained interpreters, and culturally competent staff significantly improve engagement and satisfaction with care (Hearn et al., 2023; Moustafa & Hamza, 2025). Additionally, programs integrating cultural humility and respect for religious values are more likely to produce positive outcomes, particularly among Middle Eastern and African refugee groups (Ahmad & Reynolds, 2024; Nkodo & Fadul, 2025). The ranking pattern suggests that, for refugee women, trauma-informed care cannot be separated from culturally responsive practice—language, belief systems, and social norms are all central to safety and recovery.

The theme of *empowerment and agency* emerged as the fourth priority, illustrating refugee women's desire to regain control over their lives after prolonged dependency and disempowerment during displacement. This aligns with research emphasizing the restorative power of agency in trauma recovery (Nafari & Ruebottom, 2025; Siddiq & Rosenberg, 2021). Empowerment-based interventions enable women to transition from passive recipients of aid to active agents in their own rehabilitation, fostering resilience and self-efficacy. Previous studies on refugee entrepreneurship and skill-building programs support this finding, demonstrating how trauma-informed empowerment initiatives can facilitate identity reconstruction, confidence, and sustainable livelihood opportunities (Moustafa & Hamza, 2025; Nafari & Ruebottom, 2025). However, empowerment must be situated within culturally safe and gender-sensitive contexts to avoid inadvertently reproducing systemic inequalities or retraumatizing participants. This interplay between empowerment and cultural respect underscores the need for participatory models that integrate refugee women's voices in program design and decision-making.

The fifth theme, *social support networks*, further reinforces the collective dimension of trauma recovery. Consistent with findings by Guo et al. (Guo et al., 2021) and Pottie et al. (Pottie et al., 2021), the presence of family, community, and peer relationships significantly mediates the impact of trauma by fostering belonging and emotional regulation. Refugee women often experience compounded loss—displacement not only severs familial ties but also disrupts community structures that traditionally provide emotional and practical support (Baker & Naidoo, 2023; Shahawy et al., 2022). The current study's ranking results indicate that while psychological counseling is vital, community-based interventions such as peer support groups and family reunification programs are equally important. These mechanisms help normalize shared experiences,

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strengthen coping strategies, and counteract the isolation that frequently characterizes the refugee experience. Indeed, studies show that peer-to-peer mentorship enhances trust and reduces stigma, enabling women to participate more openly in trauma-informed programs (Hearn et al., 2023; Pan, 2025).

Access to health and social services, ranked sixth, reflects the ongoing structural barriers refugee women face in navigating healthcare systems. Similar to previous studies, participants reported that bureaucratic procedures, language obstacles, and financial limitations often hinder access to essential medical and psychosocial services (Mathis et al., 2024; Rivers, 2020). Moreover, the intersection of trauma and gender-specific needs—such as reproductive health or perinatal care—requires integrative and trauma-informed service delivery models (Ahmad & Reynolds, 2024; Toke et al., 2024). The literature highlights that when care systems fail to acknowledge trauma histories, women may avoid medical environments altogether, fearing discrimination or retraumatization (Lee, 2022; Sharma et al., 2020). Therefore, this finding underscores the necessity for host countries to streamline access to care and ensure that all service points—from primary care to mental health clinics—adhere to trauma-informed standards. Integration across health, legal, and social systems is essential to bridge these gaps.

Finally, *training and capacity building for service providers* ranked seventh but remains a crucial determinant of trauma-informed care sustainability. As Im and Swan (Im & Swan, 2020, 2021) note, the effectiveness of trauma-informed interventions depends largely on providers' awareness, emotional resilience, and ability to translate theoretical principles into practice. Participants in this study recognized the importance of ongoing staff training, reflective supervision, and institutional support systems. Previous studies have demonstrated that without such professional development, providers risk perpetuating implicit biases or secondary trauma (Dzongowski & Dhar, 2020; Isakov & Marković, 2024). Hambly and Sanmuhanathan (Hambly & Sanmuhanathan, 2024) further argue that embedding trauma-informed principles within legal and administrative frameworks is equally vital to ensure consistent application across sectors. Thus, while training was ranked lowest, it forms the structural backbone for implementing all other care priorities effectively.

The integrated analysis of qualitative and quantitative data affirms that trauma-informed care must operate as a multi-level system, spanning individual, relational, and institutional dimensions. The convergence between literature-based themes and participants' rankings demonstrates that theoretical models of trauma-informed care align with lived experiences when adapted to specific contexts (Moustafa & Hamza, 2025; Nkodo & Fadul, 2025). The high prioritization of safety, psychological healing, and cultural sensitivity illustrates that trauma recovery is contingent on establishing trust within both personal and systemic environments. Moreover, the moderate emphasis on empowerment and social support underscores that refugee women's well-being extends beyond symptom reduction—it involves restoring agency, identity, and social connectedness. The relative deprioritization of access and training likely reflects an assumption that these are institutional responsibilities, less visible to participants but nonetheless indispensable for effective care delivery (Hearn et al., 2023; Isakov & Marković, 2024). Overall, the findings advocate for a comprehensive, culturally responsive, and participatory model of trauma-informed care tailored to the unique needs of refugee women in resettlement contexts.

5. Limitations and Suggestions

This study has several limitations that should be acknowledged. First, the quantitative ranking phase was limited to 200 participants from Germany, which may restrict the generalizability of findings to other refugee populations or cultural contexts. The specific experiences of Syrian, Afghan, or African refugee women may differ in ways not fully captured by this study's design. Second, the qualitative phase relied solely on literature-based data rather than direct interviews or focus groups, which may limit the depth of lived-experience perspectives. Although theoretical saturation was achieved, integrating primary qualitative data could provide more nuanced insights. Third, potential language and cultural differences between participants and researchers might have influenced interpretation during the survey phase. Lastly, the cross-sectional design does not allow causal inference; longitudinal studies are needed to explore how trauma-informed care needs evolve during resettlement.

Future research should focus on expanding the scope and diversity of participants to include multiple host countries and cultural groups, allowing for comparative cross-national analyses of trauma-informed care priorities. Mixed-method approaches incorporating interviews, ethnographic observation, and participatory co-design would enrich understanding of how refugee women conceptualize safety, empowerment, and healing. Additionally, longitudinal

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studies could track how priorities shift over time as women transition from initial resettlement to integration. Quantitative modeling of relationships among safety, psychological support, and empowerment variables could also illuminate causal pathways in trauma recovery. Lastly, future studies should explore the perspectives of service providers to better understand institutional barriers and training needs, fostering a two-way understanding between refugees and professionals.

Practically, the findings underscore the importance of embedding safety and cultural sensitivity at every level of trauma-informed service provision. Organizations should prioritize the creation of safe physical and emotional environments, supported by clear confidentiality policies and staff empathy training. Interventions must integrate psychological support with empowerment strategies, enabling refugee women to rebuild autonomy and agency. Health and social systems should adopt multi-sector collaboration models linking healthcare, legal aid, housing, and education services to ensure holistic care. Moreover, investing in provider training, reflective supervision, and burnout prevention is vital for sustaining trauma-informed practices. Finally, policy frameworks must institutionalize trauma-informed standards as part of national refugee integration programs, ensuring that services are consistent, equitable, and responsive to the complex realities of refugee women's lives.

Authors' Contributions

Authors contributed equally to this article.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

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