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From Rupture to Reconstruction: A Systematic Review on Trauma and Loss Interventions for Children in Displacement and Welfare System

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FROM RUPTURE TO RECONSTRUCTION: A SYSTEMATIC REVIEW ON TRAUMA AND LOSS INTERVENTIONS FOR CHILDREN IN DISPLACEMENT AND WELFARE SYSTEM

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Abstract

Children and adolescents exposed to adoption processes, displacement, or child welfare involvement often experience relational rupture, instability, and trauma and/or grief symptoms. Although psychological interventions for childhood trauma have been widely studied, less is known about how they address the intersection between trauma, grief, and retraumatization in these vulnerable populations. This systematic review analyzed empirical studies on psychological interventions for trauma and/or grief in adopted, displaced, or alternative-care children and adolescents, aiming to deepen the knowledge about empirically supported interventions and identifying the strategies used across the different models. A PICO question was formulated, and the review followed PRISMA guidelines, using Covidence software for study screening and selection. From the initial 1,052 articles identified, twelve studies met the inclusion criteria, including quantitative and qualitative designs. The interventions included Narrative Exposure Therapy, Trauma-Focused Cognitive Behavioral Therapy, Expressive Arts in Transition, and other trauma-focused approaches. Most studies focused on refugees, unaccompanied minors, and children in the child welfare system, with no adoption-specific studies identified. Several interventions were associated with reductions in PTSD or traumatic stress symptoms, although grief and retraumatization were not directly assessed. Recurrent components across those interventions included psychoeducation, stabilization and emotional regulation, narrative and autobiographical work, cognitive restructuring, gradual exposure, expressive techniques, and relational components focused on safety, belonging, peer support, identity continuity, and future-oriented work. Overall, this review identifies clinical strategies for vulnerable youth and highlights the need for stronger research designs, direct assessment of grief and retraumatization, and studies examining mediators and moderators of outcomes.

Keywords: childhood trauma interventions; disenfranchised grief; retraumatization; displaced children; child welfare; residential care

Resumo

Crianças e adolescentes com projeto de adotabilidade ou deslocados da sua casa experienciam frequentemente ruturas relacionais, instabilidade e sintomas de trauma e/ou luto. Apesar das intervenções psicológicas para trauma infantil terem sido amplamente investigadas, mostra-se lacunar a sistematização da abordagem à interseção entre trauma, luto e retraumatização nestas populações vulneráveis. Neste estudo, foi desenvolvida uma revisão sistemática para conhecer as estratégias terapêuticas de intervenções psicológicas para o trauma e/ou luto em criança e adolescentes adotados, deslocados ou em acolhimento. Foi formulada uma questão PICO, foram seguidas as orientações PRISMA, utilizando o software Covidence para apoio na triagem e seleção dos estudos. Dos 1.052 artigos identificados, doze cumpriram os critérios de inclusão, tendo sido considerados estudos quantitativos e qualitativos. As intervenções incluíram Terapia de Exposição Narrativa, Terapia Cognitivo-Comportamental Focada no Trauma e outras abordagens focadas no trauma. A maioria dos estudos centrou-se em refugiados (menores não acompanhados) e crianças em acolhimento, não tendo sido identificados estudos com crianças adotadas. Várias intervenções estiveram associadas à redução de sintomas de PSPT (Perturbação de Stress Pós-Traumático) ou stress traumático, embora o luto e a retraumatização não tenham sido avaliados diretamente. As estratégias mais utilizadas nas diversas intervenções incluíram psicoeducação, estabilização, regulação emocional, trabalho narrativo e autobiográfico, reestruturação cognitiva, exposição gradual, técnicas expressivas e componentes relacionais centrados na segurança, pertença, apoio entre pares, identidade e futuro. Globalmente, esta revisão mapeia estratégias clínicas para jovens vulneráveis com sintomatologia de trauma e destaca a necessidade de desenhos metodológicos robustos, avaliação direta do luto e retraumatização, e estudos sobre mediadores e moderadores da eficácia identificada.

Introduction

Adverse experiences, trauma, and child development

Childhood and adolescence are particularly sensitive periods of human development, during which fundamental emotional, cognitive, relational, and identity-related capacities are consolidated (Melamed et al., 2024; Mastorci et al., 2024). During these stages, children progressively build their ability to regulate emotions, understand their own internal states, trust others, organize their personal history, and project themselves into the future (Melamed et al., 2024; Mastorci et al., 2024). When this developmental pathway is marked by adverse or traumatic experiences, loss, or relational rupture, the psychological impact may be profound and long-lasting. Suffering is not necessarily limited to the event itself; it may affect the way the child relates to themselves, to others, and to the world (Downey & Crummy, 2022; Melamed et al., 2024; Mastorci et al., 2024).

Adverse Childhood Experiences (ACEs) provide an important framework for understanding this vulnerability. These experiences include potentially traumatic situations occurring before the age of 18, such as physical, emotional, or sexual abuse; physical or emotional neglect; exposure to domestic violence; substance use within the family context; parental mental illness; parental separation; incarceration of a family member; or other forms of family dysfunction (Anda et al., 2006; Touzvara et al., 2023). The pioneering research conducted by the Centers for Disease Control and Prevention and Kaiser Permanente demonstrated the association between exposure to these adversities and several physical and mental health problems across the lifespan, consolidating ACEs as a relevant field within public health and developmental psychology (Anda et al., 2006; Hughes et al., 2017; Touzvara et al., 2023).

Cumulative exposure to ACEs has been associated with a dose-response relationship: the greater the number of adversities experienced, the greater the risk of negative consequences for development, mental health, social functioning, and adaptation across the lifespan (Hughes et al., 2017; Smith & Pollak, 2020; Touzvara et al., 2023). One of the central mechanisms underlying this impact is toxic stress, understood as excessive and prolonged activation of stress-response systems, with possible effects on brain architecture and on areas involved in emotional regulation, memory, learning, and responses to threat, such as the prefrontal cortex,

hippocampus, and amygdala (Anda et al., 2006; Dannlowski et al., 2012; Hughes et al., 2017; Smith & Pollak, 2020).

However, the relationship between adversity and trauma should not be understood as linear or deterministic. Not all children exposed to an adverse experience develop a traumatic response, and not all childhood trauma results from the classical ACE categories (Hamby et al., 2021; Masten, 2001). The child's subjective experience, age at the time of the event, duration and intensity of exposure, affective proximity to the person involved, the existence of protective relationships, and access to psychological support all influence how the child integrates, or fails to integrate, the experience (Côté et al., 2025; Hamby et al., 2021; Han et al., 2023). Protective factors, such as secure supportive relationships, individual resilience, and early interventions, may mitigate the impact of adverse experiences and promote adaptive trajectories (Côté et al., 2025; Fritz et al., 2018; Hamby et al., 2021; Masten, 2001).

Childhood trauma and complex trauma

Childhood trauma should be understood not only as the adverse event itself, but as the child's psychological, physiological, and relational response to an experience perceived as overwhelming, threatening, or impossible to integrate. Trauma occurs when the child perceives their physical or psychological integrity as being at risk, feels that they have no control over what is happening, and lacks sufficient internal or external resources to cope with the experience (Cloitre et al., 2009; Plümacher et al., 2025; Remmers et al., 2024). This response may persist beyond the traumatic moment, affecting the body, memory, emotions, behavior, and attachments. In this sense, trauma does not belong only to the past; it may remain active in the present through symptoms, beliefs, bodily responses, and relational patterns shaped by threat (Cloitre et al., 2009; Plümacher et al., 2025; Remmers et al., 2024).

In many cases, especially when exposure is repeated, interpersonal, and occurs within caregiving relationships, the impact extends beyond classical traumatic symptomatology (Cloitre, 2020; Hébert et al., 2025).

This is where the concept of complex trauma becomes central. Complex trauma often results from prolonged and repeated exposure to adverse experiences, especially interpersonal ones, in contexts where the child should find safety and protection. Abuse, neglect, domestic violence, family instability, separation from caregivers, institutionalization, forced

displacement, and the absence of consistent protective figures are examples of conditions that may contribute to this form of trauma (Hébert et al., 2025; Haselgruber et al., 2021)

Complex trauma tends to compromise multiple developmental domains as it occurs during stages in which personality, emotional regulation, and internal models of relationships are still being formed (Cloitre et al., 2009; Cloitre, M., 2020; Haselgruber et al., 2021).

In children and adolescents, the manifestations of trauma may be varied. Some children present intrusive thoughts, nightmares, flashbacks, avoidance of reminders, hypervigilance, exaggerated startle responses, irritability, sleep difficulties, or concentration problems. Others express suffering through regression, somatic complaints, social withdrawal, aggressiveness, school difficulties, oppositional behaviors, or changes in play (Perry & Pollard, 1998; Plümacher et al., 2025; World Health Organization, 2019).

Among the most extensively studied consequences of childhood trauma is Post-Traumatic Stress Disorder (PTSD). PTSD involves symptoms of intrusion or re-experiencing, persistent avoidance of trauma-related stimuli, negative alterations in cognitions and mood, and changes in arousal and reactivity (American Psychiatric Association, 2013; Bartels et al., 2019).

The impact of trauma may also be observed at neurobiological, relational, emotional, and cognitive levels. Prolonged exposure to stress may affect the hypothalamic-pituitary-adrenal axis, contributing to stress responses that are chronically activated or, conversely, blunted (Lawrence & Scofield, 2024; Nemeroff, 2016). In the relational domain, trauma may compromise the child's ability to form secure attachments, leading to difficulties with trust, isolation, fear of closeness, or aggressive and avoidant behaviors (Bowlby, 1988; Fan & Kang,2025; Şar, 2025; Spinazzola et al., 2018). In the cognitive and academic domains, difficulties with concentration, memory, planning, and problem-solving may emerge, affecting school performance and everyday adaptation (Fan & Kang,2025; Iverson et al., 2024; Perry & Pollard, 1998).

Trauma, relational rupture, and vulnerable populations

Displaced children and adolescents refers to children and young people who have been forced or obliged to leave their home or habitual place of residence, either within their country

of origin or across international borders, as a result of conflict, persecution, violence, disasters, humanitarian crises, or other circumstances that threaten their safety, stability, and development (Taylor & Kaplan, 2023). This definition includes, refugees, asylum seekers, unaccompanied minors.

Children in the welfare system are children and adolescents involved with child protection services because their safety, well-being, or family care conditions require assessment, support, or protection (Simmel, 2012). This broader category includes children in alternative care, who don't live with their parents, temporarily or permanently, and are cared for by relatives, foster families, residential institutions, or other substitute care arrangements (Petrowski et al., 2017). It may also include children in adoption processes, defined as children and adolescents involved in legal or child welfare procedures aimed at establishing adoption, such as those declared eligible for adoption, awaiting placement, matched with prospective adoptive parents, or transitioning toward permanent adoptive family integration (Palacios et al., 2019).

Although they are distinct groups from legal, social, and cultural perspectives, children in adoption processes, children in welfare or alternative care, and displaced children often share experiences of rupture, separation, loss, instability, and threat to relational continuity. Children in alternative care frequently present histories of interpersonal trauma and placement instability, questions about origins, fear of abandonment, and difficulties integrating past and present experiences which may affect mental health, attachment, and emotional regulation (Greeson et al., 2011; Riebschleger & Damashek, 2015; Mitchell, 2018; Salazar et al., 2013; Williams, 2017). Similarly, children in adoption processes may also have histories of pre-placement adversity, separation from birth family, uncertainty about permanence, and difficulties integrating past and present experiences into identity development (Brodzinsky et al., 2022; Courtney, 2000; Haralambie, 2024). Similarly, displaced and refugee children may experience exposure to violence, loss of home and community, separation from caregivers, cultural disruption, legal uncertainty, and difficulties adapting to new contexts (Jones, 2020; Oberg & Sharma, 2023; Nickerson et al., 2014).

Thus, in these contexts, psychological suffering may therefore be associated not only with trauma as exposure to danger, but also with the loss of bonds, caregiver instability,

geographical displacement, loss of cultural references, uncertainty about the future, and difficulty constructing a coherent narrative about one's own history.

Childhood grief, ambiguous loss, and disenfranchised loss

Understanding these populations also requires considering childhood grief as a developmental response to the loss of someone or something significant (Worden, 1996). In children, grief may be expressed intermittently through sadness, silence, irritability, play, or apparent normality, and its expression depends on cognitive and emotional development, the nature of the loss, and the support available from caregivers and the social network (Stroebe et al., 2008). Therefore, childhood grief should not be assessed only through explicit manifestations of sadness.

In adopted, displaced, or alternative-care children, grief often extends beyond death and includes relational, symbolic, cultural, territorial, and identity-related losses, such as separation from family, siblings, home, routines, origins, language, culture, and a sense of belonging. Concepts such as disenfranchised grief**,** ambiguous loss**,** and symbolic loss are particularly relevant. Disenfranchised grief refers to losses that are not socially recognized or validated, which may lead children to feel that they have no legitimate right to suffer (Doka, 1989). Ambiguous loss occurs when significant figures are physically absent but psychologically present, or physically present but emotionally unavailable, as may happen with inaccessible parents or missing relatives (Boss, 1999). Symbolic loss involves the loss of intangible dimensions such as identity, safety, continuity, normality, belonging, or an imagined future (Rando, 1984).

Thus, trauma and grief are closely connected in these populations. Many traumatic experiences involve significant losses, and many losses may become traumatic when they are sudden, violent, disorganized, or unrecognized. Therefore, psychological interventions should not focus only on reducing PTSD symptoms, but also on helping children elaborate losses, reconstruct belonging, and integrate painful experiences into a coherent life narrative.

Risk of retraumatization

Retraumatization is a fundamental dimension in this field. It may be understood as the reactivation or intensification of traumatic responses in the face of new experiences that reproduce, concretely or symbolically, elements of the original traumatic experience (Duckworth & Follette, 2012; Harris & Fallot, 2001). Retraumatization may occur when the child is exposed to new adverse events, but also when institutional, educational, legal, or clinical practices reactivate feelings of threat, abandonment, shame, helplessness, or loss of control (Duckworth & Follette, 2012; Harris & Fallot, 2001; Courtois & Ford, 2013). Repeated interviews about painful events, successive placement changes, lack of predictability, emotional invalidation, rigid punishments, lack of privacy, or ruptures with caregivers may function as retraumatizing experiences (Duckworth & Follette, 2012; Harris & Fallot, 2001; Courtois & Ford, 2013).

Preventing retraumatization requires trauma-sensitive practices as psychological interventions with these populations must also consider the risk of retraumatization (Duckworth & Follette, 2012; Harris & Fallot, 2001). Trauma-focused interventions often involve remembering, narrating, or processing painful experiences, which may be clinically necessary but also emotionally demanding (Cohen, Mannarino, & Deblinger, 2017; Courtois & Ford, 2013). Therefore, this aspect should be carefully considered when implementing these interventions, ensuring that trauma processing is gradual, emotionally contained, and preceded by the establishment of safety, trust, and adequate coping resources (Duckworth & Follette, 2012; Cohen et al., 2017; Courtois & Ford, 2013).

Gaps in the literature and relevance of the present review

The available literature shows that several psychological interventions have been developed and studied for childhood trauma, particularly for PTSD and traumatic stress symptoms. However, this evidence is often organized around childhood trauma in general (Kooij et al.,2022) or around specific populations, such as refugee children and adolescents (Genç, 2022; Gkintoni et al., 2024; Katsonga-Phiri et al., 2017). As a result, less is known about how psychological interventions have been studied across children and adolescents who, despite belonging to different legal and social categories, share experiences of rupture, separation, displacement, relational instability, and loss.

This gap is also visible in recent systematic reviews and meta-analyses on psychological and psychosocial interventions with children and adolescents in vulnerable

contexts. Recent systematic reviews and meta-analyses have also examined psychological and psychosocial interventions for children and adolescents in vulnerable contexts. Some reviews have focused on refugee children, asylum-seeking children, unaccompanied minors, or children living in humanitarian settings, analysing the effects of interventions on PTSD symptoms, traumatic stress, psychological distress, anxiety, depression, resilience, and general mental health (Purgato et al., 2018; Cowling & Anderson, 2023; Velu et al., 2025). Other reviews have examined interventions with children and adolescents in foster care, kinship care, or child welfare contexts, also focusing mainly on trauma-related symptoms, emotional and behavioural difficulties, and mental health outcomes (Della Rocca et al., 2024; Sutton et al., 2025). However, grief does not appear as a central intervention target or outcome in these reviews, nor the mention of prevention of retraumatization.

Another relevant gap concerns the non-existent articulation between trauma, grief, and retraumatization in intervention research. Although these dimensions are clinically interconnected, they are often studied separately. As seen, Trauma-focused interventions tend to prioritize PTSD symptom reduction, including intrusion, avoidance, hyperarousal, and negative trauma-related beliefs. However, in this vulnerable populations, traumatic experiences are accompanied by significant losses, such as separation from caregivers, loss of home, loss of siblings, loss of cultural belonging, loss of stability, or loss of a coherent sense of personal history.

This reinforces the relevance of the present review, as it addresses a clinically important but underexplored intersection: the way psychological interventions for displaced, adopted, or alternative-care children consider trauma alongside loss, grief-related experiences, and the risk of retraumatization. By identifying the populations studied, interventions used, outcomes assessed, and therapeutic components described, this review clarifies what is currently known, what remains underexplored, and which clinical strategies appear recurrent across intervention models.

Purpose of this study

The aim is to understand which interventions address children’s traumatic and grief symptomatology, as well as the prevention of retraumatization. To this end, a systematic literature review was conducted to identify and systematize intervention models for children's

trauma and/or grief related symptomatology, analyzing theoretical models, intervention components, and empirical evidence.

This systematic review aims to provide a comprehensive narrative synthesis of interventions described in the literature, with studies including diverse therapeutic approaches and methodological designs. This broader approach allows the analysis of psychological interventions not only in terms of outcomes, but also in terms of feasibility, acceptability, clinical relevance and therapeutic strategies used across different models.

This review also seeks to identify transversal therapeutic components across different intervention models. This objective is scientifically relevant because the existing literature appears fragmented across populations, intervention approaches, and outcome measures. By analyzing the interventions, populations, methods, outcomes, and clinical strategies used in this field, the review contributes to clarifying what is currently done, what remains insufficiently studied, and how trauma, grief, and retraumatization have been integrated, or neglected, in intervention research with these vulnerable groups.

Method

The present systematic literature review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021). The PICO model was used to define the research question: In adopted, displaced, or alternative-care children and adolescents with symptoms of trauma and/or grief, which psychological interventions address traumatic and/or grief symptomatology and the prevention of retraumatization? More specifically, this review aims to: 1) identify the psychological interventions used with these populations; 2) describe the main findings of the included studies focused on these interventions; and 3) analyze recurrent therapeutic techniques and components across the different intervention approaches.

Eligibility Criteria

The present study included articles published from 2014 to October 2025, corresponding to the final search date, to cover literature produced after the publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and to prioritize more recent research,

potentially aligned with the diagnostic criteria currently used for post-traumatic stress disorder, psychological trauma and associated symptomatology.

Inclusion Criteria

To be included in this review, studies had to meet the following criteria: (1) to be published in peer-reviewed scientific journals; (2) to be written in English or Portuguese; (3) include clinical psychological, psychotherapeutic or psychosocial interventions aimed at children and adolescents; (4) include participants who were adopted, in the process of adoption, in alternative care, in residential care, involved in the child welfare system, refugees or asylum seekers; (5) include participants with symptoms of trauma, grief or loss; (6) include participants up to 19 years of age; and (7) include quantitative, qualitative or mixed-methods primary studies, namely randomized clinical trials, non-randomized controlled studies, quasi-experimental studies, pre-test/post-test studies, pilot studies, implementation studies or qualitative studies.

Exclusion Criteria

Studies were excluded if they met one or more of the following criteria: (1) did not specify the age of participants; (2) included participants whose age was outside the defined target population; (3) did not include children or adolescents in the previously established conditions, namely adopted, in the process of adoption, in alternative care, in residential care, involved in child welfare system, refugees or asylum seekers; (4) did not include psychological, psychotherapeutic or psychosocial interventions with an identifiable therapeutic component; (5) evaluated exclusively pharmacological, educational, social or institutional interventions without a psychological or psychotherapeutic component; and (6) did not assess outcomes related to trauma, grief, loss or retraumatization.

The decision on whether to include or exclude studies was made independently by two members of the research team. In cases of disagreement, the final decision was made through joint discussion or, when necessary, by consulting a third reviewer.

Search Strategy

The bibliographic search was conducted in the PsycINFO, PubMed/MEDLINE, Web of Science, Scopus and PsycARTICLES databases, covering studies published from 2014 up to October 2025, the final search date. The search strategy was structured according to the main

elements of the PICO question, combining keywords related to the target population, psychological interventions and outcomes related to trauma, grief and retraumatization.

For the target population, terms included adoption, adopted children, foster care, out-of-home care, alternative care, residential care, child*, adolescen*, youth, refugee* and asylum seeker* were used. Regarding interventions, terms such as psychotherapy, psychological intervention*, counseling, trauma focused therapy and grief focused therapy were included. For outcomes, terms associated with trauma, grief and retraumatization were used, namely trauma, psychological trauma, PTSD, grief, bereavement, loss, retraumatization and re-traumatization.

The full search string is presented in Appendix A.

Study Selection Process

Following the PRISMA guidelines, the flow diagram presented in Figure 1 provides step-by-step details of the study selection process.

All records identified in the databases were exported to the bibliographic management and systematic review platform Covidence. Two independent reviewers screened the articles, excluding studies that clearly did not meet the inclusion criteria. Disagreements were resolved by consensus or through consultation with a third reviewer.

After removal of duplicates, titles and abstracts were analyzed according to the previously defined eligibility criteria. In a second phase, the full texts of potentially eligible studies were assessed in detail.

Data Extraction Process

Data extraction was carried out with the aim of characterizing the included studies, analysing the effects of the interventions and identifying the main therapeutic components used. Information was extracted regarding reference, country, population context, number of participants, age range, mean age, study design, type of intervention, intervention format, number of sessions, assessment instruments used, presence of follow-up and main results related to traumatic symptoms, PTSD symptoms or grief and retraumatization.

Data on the therapeutic techniques described in each study were also extracted.

Data extraction will be carried out independently by two researchers, with discrepancies resolved through discussion and consensus.

Data Synthesis Strategy

A narrative synthesis of the results was established and conducted to integrate the findings of the included studies.

Data synthesis was organized at three levels. At the first level, the general characteristics of the included studies were described, including country, context, population, participants' age and methodological design.

At the second level, the psychological interventions identified and their respective results regarding traumatic or PTSD symptoms, grief and retraumatization were analyzed.

At the third level, the therapeutic components and strategies identified across the different interventions were analyzed to determine which elements could inform the development of a future intervention.

Assessment of Methodological Quality

The methodological quality of the included studies was assessed using the Mixed Methods Appraisal Tool (MMAT), which is suitable for quantitative, qualitative and mixed-methods studies. Risk of bias was analyzed by considering aspects related to study design, methodological procedures and the quality of statistical analyses.

Each study was analyzed independently by two researchers, followed by a final review to ensure consistency across the assessments carried out.

Results and Discussion

Study Selection Results

Figure 1 shows the PRISMA flow diagram illustrating the article selection process. A total of 1,052 records were identified through database searches, including 443 records from Scopus, 437 from PubMed, 122 from PsycINFO and 50 from Web of Science. After removal of 552 duplicate records identified through Covidence, 500 studies remained for the title and abstract screening phase.

During the screening phase, 405 studies were excluded based on the previously defined eligibility criteria. The remaining 95 studies were selected for full-text retrieval and

subsequently assessed for eligibility. After full-text reading, 83 studies were excluded for the following reasons: inadequate study design (*n* = 36), adult population (*n* = 21), inadequate intervention (*n* = 7), inadequate language (*n* = 6), full text unavailable (*n* = 5), inadequate patient population (*n* = 5) and inadequate outcomes (*n* = 3).

The full-text assessment led to the exclusion of 83 studies. The most frequent reason for exclusion was **wrong study design** (*n* = 36), which means that these studies did not correspond to the empirical designs defined in the eligibility criteria, and in this case were systematic reviews or meta-analysis.

A further 21 studies were excluded because they included an **adult population**. These studies did not focus on children or adolescents within the defined age range and therefore did not correspond to the target population of the review.

Seven studies were excluded due to **wrong intervention**. In these cases, the intervention was mainly pharmacological, educational, institutional, or social without a clinical psychological focus. They did not include an identifiable psychological, psychotherapeutic dimension.

Six studies were excluded because of **wrong language**, meaning that they were not written in one of the languages defined in the inclusion criteria.

Five studies were excluded because the **full text was not available**, which prevented complete assessment of eligibility and extraction of relevant data.

Another five studies were excluded because they included the **wrong patient population**. These studies did not focus on adopted children or adolescents, children in alternative care or outside the family context, refugees, asylum seekers, displaced youth, or related vulnerable populations defined in the PICO question.

Finally, three studies were excluded due to **wrong outcomes**. These studies did not assess outcomes related to trauma, grief, loss, PTSD symptoms, traumatic stress, or retraumatization, and therefore did not directly address the aims of the review.

Overall, 83 studies were excluded after full-text assessment,12 studies met all inclusion criteria and were included in the final review.

Gaps in Population and Outcome Coverage

A relevant finding concerns the absence of adoption-specific studies. Although the eligibility criteria included adopted children and adolescents and children in the process of adoption, none of the twelve included studies focused specifically on this population. The final sample was mainly composed of studies with refugees, unaccompanied minors, children in the child welfare system, and young people exposed to family violence (Peltonen & Kangaslampi, 2019; Ascienzo et al., 2022; Bryant et al., 2024; Garoff et al., 2019; Meyer DeMott et al., 2017; Patel et al., 2024; Schepp et al., 2024). Therefore, the results are more directly applicable to displaced and child welfare populations than to adopted children or children in adoption processes.

Another important finding concerns the limited assessment of grief and retraumatization. Although the review question included trauma, grief, and retraumatization, the included studies focused predominantly on PTSD symptoms, traumatic stress, and trauma-related outcomes.

This is relevant because several included studies acknowledged experiences of separation, forced displacement, family rupture, institutional placement, migration-related loss, or loss of continuity as part of the participants' life contexts, particularly among refugees, unaccompanied minors, and children in child welfare or out-of-home care (Peltonen & Kangaslampi, 2019; Garoff et al., 2019; Meyer DeMott et al., 2017; Said et al., 2021; Schapiro et al., 2024; Schepp et al., 2024). However, these dimensions were not operationalized through specific grief or retraumatization outcomes.

Consequently, the evidence identified in this review is stronger regarding PTSD and traumatic stress reduction than regarding grief intervention or retraumatization prevention.

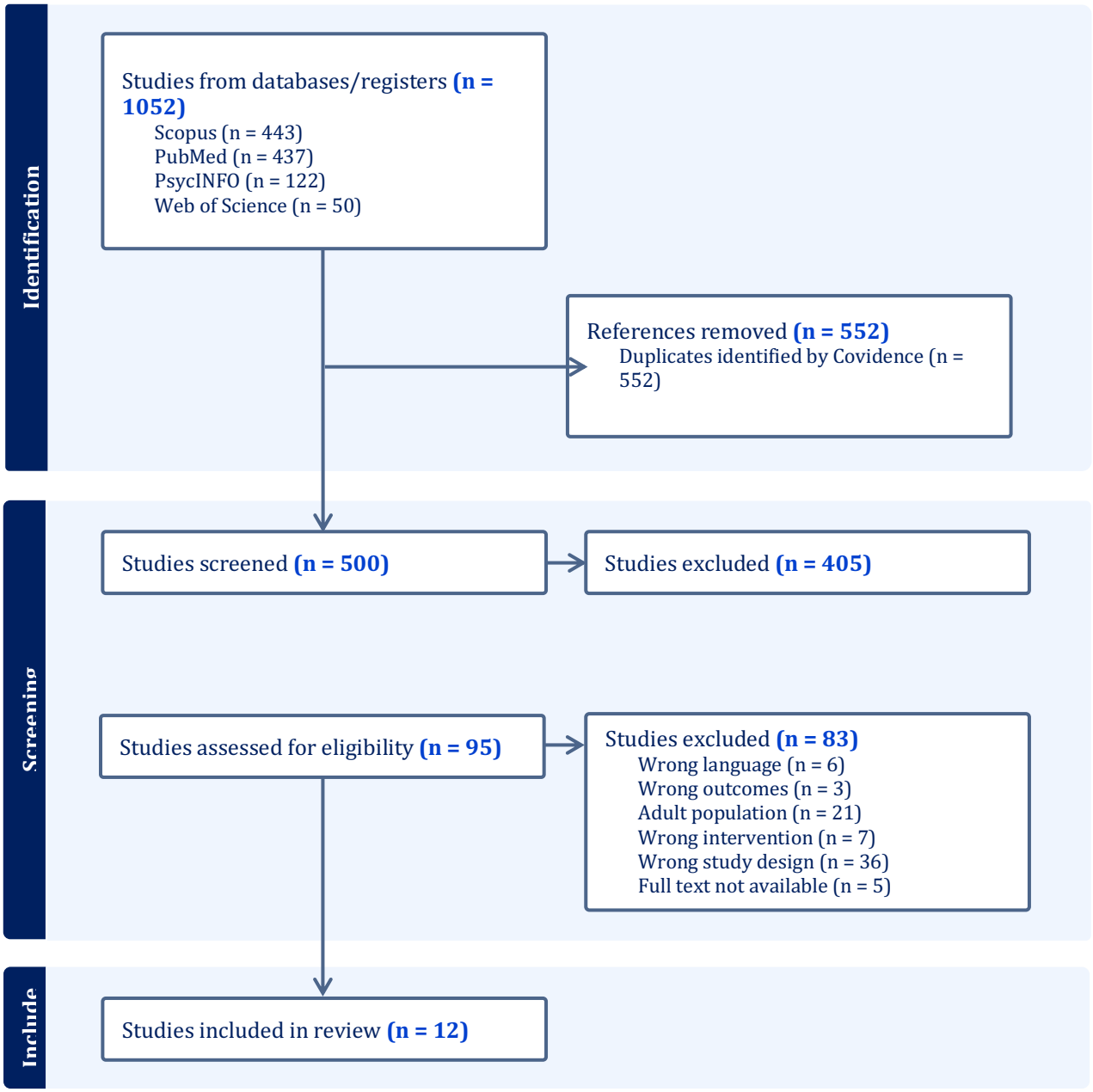

Figure 1

PRISMA Flow Diagram of the Study Selection Process.

Note. Extracted from Covidence

Study Contexts and Populations

Most studies focused on children and adolescents in contexts of migration, including refugees and unaccompanied minors. Refugee populations were examined in studies conducted in Finland, Jordan, and the United Kingdom. Peltonen and Kangaslampi (2019) focused on refugees exposed to family violence, while Kangaslampi and Peltonen (2020), Bryant et al. (2024), and Hurn and Barron (2018) examined refugee children and adolescents more broadly.

Unaccompanied minors represented another central population across the included studies. These participants were included in studies by Garoff et al. (2019), Meyer DeMott et al. (2017), Patel et al. (2024), Said et al. (2021), and Schapiro et al. (2024). These studies were conducted in Finland, Norway, the United States, and the United Kingdom, showing that unaccompanied minors constituted one of the most frequently represented high-risk groups in the review.

Children and adolescents involved in child welfare systems were examined in studies by Ascienzo et al. (2022), Kerns et al. (2022), and Schepp et al. (2024). These studies were conducted in the United States and Germany and focused on young people exposed to complex psychosocial adversity within protection or care systems

Overview of the Included Studies

Table 1 presents an overview of the characteristics of the included studies, including country, participants, context, age and study design. Table 2 contains the characterization of the interventions, mentioning the types of intervention, number of sessions, measures used, existence of follow-up and PTSD results.

Sample sizes varied considerably across studies. The smallest sample was reported by Said et al. (2021), with four unaccompanied minors, whereas the largest sample was reported by Kerns et al. (2022), with 1281 children and adolescents in the child welfare system. This variation indicates that the evidence base included both small-scale qualitative studies and larger quantitative studies

Methodological Characteristics

The methodological designs varied across the included studies. Randomized controlled trials were used in 4 studies namely Peltonen and Kangaslampi (2019), Bryant et al. (2024), Kangaslampi and Peltonen (2020), and Meyer DeMott et al. (2017).

Other 4 studies used one-group pre–post designs, including Ascienzo et al. (2022), Garoff et al. (2019), Kerns et al. (2022), and Patel et al. (2024). These studies allowed the assessment of symptom change over time but offered more limited evidence regarding causal effects due to the absence of a randomized comparison condition.

Qualitative studies were also included, namely 3 in 3 studies Hurn and Barron (2018), Said et al. (2021), and Schapiro et al. (2024). These studies provided clinically relevant information on perceived change, subjective experience, emotional processing, and acceptability of interventions, although they did not allow direct quantitative comparison of symptom change. The other is a single-arm pilot design, Schepp et al. (2024) contributing preliminary evidence on the feasibility and potential effects of the ANKOMMEN intervention.

Intervention Formats

The interventions were delivered in both individual and group formats. Individual interventions were reported in 6 studies using Narrative Exposure Therapy (NET), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Cognitive Behaviour Therapy Plus (CBT+), including Peltonen and Kangaslampi (2019), Ascienzo et al. (2022), Kangaslampi and Peltonen (2020), Kerns et al. (2022), Patel et al. (2024), and Said et al. (2021).

Group-based interventions were used in 6 studies Bryant et al. (2024), Garoff et al. (2019), Hurn and Barron (2018), Meyer DeMott et al. (2017), Schapiro et al. (2024), and Schepp et al. (2024). These interventions included Early Adolescent Skills for Emotions (EASE), group-based trauma intervention, Eye Movement Desensitization and Reprocessing Integrative Group Treatment Protocol (EMDR-IGTP), Expressive Arts in Transition (EXIT), Cognitive Behavioral Intervention for Trauma in Schools (CBITS), and ANKOMMEN Programme. The presence of both individual and group formats reflects the diversity of clinical approaches used with displaced, refugee, unaccompanied, and child welfare populations.

Intervention Duration

The included interventions also differed in duration, with variation in the number of sessions across therapeutic models.

The number of sessions in NET interventions ranged from 7–10 sessions in the quantitative studies to 9–20 sessions in the qualitative study by Said et al. (2021).

TF-CBT was examined in Ascienzo et al. (2022) and Patel et al. (2024). Ascienzo et al. (2022) reported 12–25 sessions, while Patel et al. (2024) reported an average of 9.71 sessions. Other interventions were generally shorter, including EMDR-IGTP with four sessions, EXIT

with five sessions, ANKOMMEN with eight sessions, CBITS with ten sessions, and EASE with seven sessions.

Table 1. *General characterization of the included studies.*

Reference	**Country**	**Setting**	**Sample**	**Age**	**Format**	**Study Design**
Peltonen & Kangaslampi (2019)	Finland	Refugees / family violence	Intervention: *n* = 29 TAU: *n* = 21	9–17 years; *M* = 13.30 (*SD* = 3.06)	Individual	RCT
Ascienzo et al. (2022)	USA	Child welfare	*n* = 138	7–18 years; *M* = 11.21 (*SD* = 3.09)	Individual	OGPP
Bryant et al. (2024)	Jordan	Refugees	Control group: *n* = 286 Intervention: *n* = 185	10–14 years; *M* = 11.6	Group	RCT
Garoff et al. (2019)	Finland	Unaccompanied minor refugees	*n* = 18	*M* = 15.08 (*SD* = 2.28)	Group	OGPP
Hurn & Barron (2018)	UK	Refugees	*n* = 8	6–11 years	Group	Qualitative
Kangaslampi & Peltonen (2020)	Finland	Refugees	Intervention: *n* = 23 TAU: *n* = 17	9–17 years; *M* = 13.30 (*SD* = 3.06)	Individual	RCT
Kerns et al. (2022)	USA	Child welfare	*n* = 1281	*M* = 11.17 (*SD* = 3.10)	Individual	OGPP
Meyer DeMott et al. (2017)	Norway	Unaccompanied minors	*n* = 140	15–18 years; EXIT: *M* = 16.3 (*SD* = 0.8);	Group	RCT

				LAU: *M* = 16.2 (*SD* = 0.9)		
Patel et al. (2024)	USA	Unaccompanied minors	*n* = 138	4–19 years; *M* = 14.7 (*SD* = 3.19)	Individual	OGPP
Said et al. (2021)	UK	Unaccompanied minors	*n* = 4	16–17 years	Individual	Qualitative
Schapiro et al. (2024)	USA	Unaccompanied minors	*n* = 16	14–19 years	Group	Qualitative
Schepp et al. (2024)	Germany	Child welfare	*n* = 123	12–17 years; *M* = 14.91 (*SD* = 1.45)	Group	SAP

Note: OGPP - One Group pretest-post test; SAP - Single arm pilot; RCT- Randomized Controlled Trial

Table 2. *Summary of Psychological Interventions, Measures, Follow-Up, and Main Findings Across Included Studies.*

Reference	Intervention	Sessions	Measures	Follow-up	Main Findings
Peltonen & Kangaslampi (2019)	NET	7–10 sessions	CRIES-13	Yes	Significant reduction in PTSD symptoms in the NET group, with a *CRIES-13* pre–post reduction of −10.33 (*SD* = 12.70).
Ascienzo et al. (2022)	TF-CBT	12–25 sessions	UCLA-PTSD RI	No	Significant reduction in PTSD symptoms, with *UCLA-PTSD RI* scores decreasing from 26.26 (*SD* = 15.3) at pre-test to 11.80 (*SD* = 8.62) at post-test, $p < .001$.
Bryant et al. (2024)	EASE	Intervention: 7 sessions; Control: 1 session	CRIES-13	Yes	PTSD symptoms decreased in both conditions at the 6-week screening; at 12-month follow-up, between-group differences were not significant.
Garoff et al. (2019)	Group-based trauma intervention	10 sessions	CRIES-13	No	No significant improvement in PTSD symptoms was found. *CRIES-13* scores changed from 32.90 (*SD* = 9.50) at pre-test to 36.80 (*SD* = 10.89) at post-test, $p = .23$.

Hurn & Barron (2018)	EMDR-IGTP	4 sessions	SUD	No	Reduction in traumatic stress was reported, with *SUD* scores decreasing from 10 to 0. Emotional improvement was also observed in drawings.
Kangaslampi & Peltonen (2020)	NET	7–10 sessions	CRIES-13; TMQQ	Yes	PTSD symptoms decreased and traumatic memory improved. Effects were reported for *CRIES* pre–post change, $d = 0.65$, $p < .001$, and *TMQQ*, $d = 0.26$, $p < .05$.
Kerns et al. (2022)	CBT+	Not specified	CATS	No	Significant improvement in PTSD symptoms was found, with *CATS* pre–post change reported as $b = -1.47$, $SE = 0.18$, $p < .001$.
Meyer DeMott et al. (2017)	EXIT	NET: 5 sessions; Control: not specified	PTSS	Yes	PTSD symptoms decreased after 25 months of follow-up, although no significant differences were found between groups.
Patel et al. (2024)	TF-CBT	Average of 9.71 sessions	CATS	No	PTSD symptoms decreased, with *CATS* scores changing from 12.60 (*SD* = 11.70) at pre-test to 4.60 (*SD* = 4.98) at post-test.
Said et al. (2021)	NET	9–20 sessions	Interviews	No	Qualitative improvement was reported, including greater understanding of PTSD,

					normalization of symptoms, and reduction of intrusive thoughts and flashbacks after NET.
Schapiro et al. (2024)	CBITS	10 sessions	Interviews	No	Qualitative findings indicated underreporting of traumatic experiences during initial screening. Participants reported perceived benefits, including fewer nightmares and increased feelings of safety and comfort through peer support.
Schepp et al. (2024)	ANKOMMEN	8 sessions	CATS-2	Yes	Significant reduction in PTSD symptoms was maintained at follow-up. Effects were reported for *CATS-2 self* pre–post, $p < .001$, $d = .58$; pre–3MFU, $p < .001$, $d = .72$; and *CATS-2 care* pre–3MFU, $p = .031$, $d = .70$.

Note: NET = Narrative Exposure Therapy; TF-CBT = Trauma-Focused Cognitive Behavioral Therapy; EASE = Early Adolescent Skills for Emotions; EMDR-IGTP = Eye Movement Desensitization and Reprocessing Integrative Group Treatment Protocol; CBT+ = Cognitive Behavioral Therapy Plus; EXIT = Expressive Arts in Transition; CBITS = Cognitive Behavioral Intervention for Trauma in Schools; CRIES-13 = Children's Revised Impact of Event Scale; UCLA-PTSD RI = University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index; SUD = Subjective Units of Distress; TMQQ = Traumatic Memory Quality Questionnaire; CATS = Child and Adolescent Trauma Screen; CATS-2 = Child and Adolescent Trauma Screen-2; PTSS = posttraumatic stress symptoms; 3MFU = three-month follow-up. Follow-up refers to the presence of an assessment after the immediate post-intervention evaluation. SD = standard deviation; SE = standard error; p = statistical significance value; d = effect size.

Measures

The studies used different instruments to assess trauma and PTSD symptoms. The most frequently used measures included Children's Revised Impact of Event Scale (CRIES-13) used in 4 studies, University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index(UCLA-PTSD RI) in 1 study, Child and Adolescent Trauma Screen– self report(CATS), Child and adolescent trauma screen version 2(CATS-2) in 3 studies, Post-traumatic Symptom Score(PTSS), Subjective Units of Distress (SUD) in 1 study, Trauma Memory Quality Questionnaire (TMQQ) in 1 study, and interviews in 2 studies.

CRIES-13 was used in studies involving NET and EASE, including Peltonen and Kangaslampi (2019), Kangaslampi and Peltonen (2020), Bryant et al. (2024), and Garoff et al. (2019). UCLA-PTSD RI was used by Ascienzo et al. (2022), while CATS was used by Kerns et al. (2022) and Patel et al. (2024). Schepp et al. (2024) used CATS-2. Qualitative studies used interviews or expressive indicators, as seen in Said et al. (2021), Schapiro et al. (2024), and Hurn and Barron (2018).

Follow-up Assessment

Follow-up assessments were not consistently included across studies. Follow-up was reported in Peltonen and Kangaslampi (2019), Bryant et al. (2024), Kangaslampi and Peltonen (2020), Meyer DeMott et al. (2017), and Schepp et al. (2024). These studies allowed some evaluation of whether intervention-related changes were maintained over time.

Several studies did not include follow-up assessments, including Ascienzo et al. (2022), Garoff et al. (2019), Hurn and Barron (2018), Kerns et al. (2022), Patel et al. (2024), Said et al. (2021), and Schapiro et al. (2024).

Main findings

Most studies reported reductions in PTSD or traumatic stress symptoms after intervention. Peltonen and Kangaslampi (2019) reported a significant reduction in PTSD symptoms in the NET group, with a CRIES-13 pre–post reduction of −10.33. Kangaslampi and Peltonen (2020) also found reductions in PTSD symptoms and improvements in traumatic memory, with reported effects for CRIES and TMQQ.

TF-CBT studies also showed positive outcomes. Ascienzo et al. (2022) reported a significant reduction in UCLA-PTSD RI scores from 26.26 at pre-test to 11.80 at post-test. Patel et al. (2024) also reported a reduction in CATS scores from 12.60 at pre-test to 4.60 at post-test.

CBT+ was associated with significant improvement in PTSD symptoms in Kerns et al. (2022), with a reported CATS pre–post change of $b = -1.47$, $SE = 0.18$, $p < .001$. Schepp et al. (2024) reported significant reductions in PTSD symptoms after ANKOMMEN, with effects maintained at follow-up.

Hurn and Barron (2018) reported reductions in traumatic stress following EMDR-IGTP, with SUD scores decreasing from 10 to 0. Said et al. (2021) reported qualitative improvements after NET, including increased understanding of PTSD, normalization of symptoms, and reduction of intrusive thoughts and flashbacks. Schapiro et al. (2024) reported perceived benefits of CBITS, including fewer nightmares and increased feelings of safety and comfort through peer support.

Overall, the evidence presented in Tables 1 and 2 suggests that psychological interventions were generally associated with reductions in PTSD or traumatic stress symptoms among children and adolescents exposed to displacement, forced migration, unaccompanied migration, child welfare involvement, or family violence. NET, TF-CBT, CBT+, EMDR-IGTP, ANKOMMEN, CBITS, EXIT, and EASE were all associated with some degree of clinical improvement, although the strength of evidence varied.

Quality Assessment of the Included Studies

The methodological quality of the included studies was assessed according to study design using Mixed Methods Appraisal Tool (MMAT).

The randomized controlled trials were summarized in Table 3**,** the quantitative non-randomized studies in Table 4, and the qualitative studies in Table 5**.** Overall, the assessment showed that the studies were generally coherent in their aims and used data that were mostly appropriate to address their research questions. However, the level of methodological robustness varied considerably across studies.

The methodological quality of the included studies varied according to study design. Overall, the randomized controlled trials presented the strongest methodological quality, as they generally included clear research questions, appropriate data collection, comparable groups at baseline, complete outcome data, and adequate adherence to the assigned intervention. However, some uncertainty remained regarding randomization and assessor blinding in Meyer DeMott et al. (2017), which reduces confidence in the internal validity of this study and requires cautious interpretation of its findings.

The quantitative non-randomized studies also presented clear research questions, appropriate outcome measures, complete outcome data, and adequate implementation of the interventions. Nevertheless, their main limitation was the absence of adequate control for confounding variables. This limits causal interpretation, since reported symptom changes may have been influenced by factors other than the intervention, such as natural recovery, concurrent psychosocial support, placement stability, legal changes, or broader contextual improvements. Therefore, these studies provide evidence of association and feasibility, but not strong evidence of causal effectiveness.

The qualitative studies contributed relevant information about participants' subjective experiences, perceived benefits, emotional change, and intervention acceptability. These findings were useful for understanding dimensions not fully captured by standardized measures, such as normalization of symptoms, perceived safety, emotional expression, and peer support. However, some methodological weaknesses were identified, particularly in the coherence between data collection, analysis, and interpretation, as well as in the substantiation of findings in some studies. Thus, qualitative evidence should be interpreted as complementary to quantitative findings, rather than as direct evidence of intervention effectiveness.

Table 3. *Quality Assessment of Randomized Controlled Trials.*

Reference	Clear research questions?	Data address research questions?	Randomization appropriately performed?	Groups comparable at baseline?	Complete outcome data?	Outcome assessors blinded to intervention?	Participants adhered to assigned intervention?
Peltonen & Kangaslampi (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Meyer DeMott et al. (2017)	Yes	Yes	Can't tell	Yes	Yes	Can't tell	Yes
Bryant et al. (2024)	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Table 4. *Quality Assessment of Quantitative Non-Randomized Studies.*

Reference	Clear research questions?	Data address research questions?	Participants representative of target population?	Measurements appropriate regarding outcome and intervention/exposure?	Complete outcome data?	Confounders accounted for in design and analysis?	Intervention administered as intended?
Patel et al. (2024)	Yes	Yes	No	Yes	Yes	No	Yes
Schepp et al. (2024)	Yes	Yes	Yes	Yes	Yes	No	Yes
Kangaslampi & Peltonen (2020)	Yes	Yes	Yes	Yes	Yes	No	Yes
Kerns et al. (2022)	Yes	Yes	Yes	Yes	Yes	No	Yes
Garoff et al. (2019)	Yes	Yes	Yes	Yes	Yes	No	Yes
Ascienzo et al. (2022)	Yes	Yes	Yes	Yes	Yes	No	Yes

Table 5. *Quality Assessment of Qualitative Studies.*

Reference	Clear research questions?	Data address research questions?	Qualitative approach appropriate to answer research question?	Qualitative data collection methods adequate?	Findings adequately derived from data?	Interpretation of results sufficiently substantiated by data?	Coherence between qualitative data sources, collection, analysis and interpretation?
Said et al. (2021)	Yes	Can't tell	Yes	Yes	Yes	Yes	No
Hurn & Barron (2018)	Yes	Yes	Yes	Yes	No	No	No
Schapiro et al. (2024)	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Description of the Main Intervention Strategies Identified

Table 6 presents a synthesis of the main therapeutic strategies identified across the psychological interventions included in the articles. This table organizes the core techniques used in each model, highlighting how different approaches addressed trauma-related symptoms.

Table 6. *Intervention Formats and Main Therapeutic Strategies Identified Across Studies.*

Intervention	Studies	Format	Main strategies
TF-CBT	Ascienzo et al. (2022); Patel et al. (2024)	Individual	• Psychoeducation about trauma and traumatic reactions. • Training in trauma-informed parenting skills. • Relaxation techniques. • Identification and modulation of affect. • Cognitive coping strategies. • Construction of the trauma narrative. • Gradual exposure to memories and stimuli associated with trauma. • Cognitive processing of the trauma narrative. • Development of future safety skills.
NET	Peltonen & Kangaslampi (2019); Kangaslampi & Peltonen (2020); Said et al. (2021)	Individual	• Diagnosis and psychoeducation. • Construction of the lifeline. • Identification of positive and traumatic events. • Chronological mapping of experiences. • Exposure to traumatic memories. • Exploration of emotions, thoughts, bodily sensations, and associated meanings.

			• Autobiographical organization of traumatic experiences. • Writing and signing of the final narrative. • Use of creative KIDNET elements during lifeline construction in younger children.
EASE	Bryant et al. (2024)	Group	• Brief intervention focused on emotional and behavioral skills. • Psychoeducation about psychological distress. • Identification of emotions and stress reactions. • Training in emotional regulation strategies. • Problem-solving. • Behavioral activation. • Management of daily difficulties. • Development of coping strategies.
Group-based trauma intervention	Garoff et al. (2019)	Group	• Group intervention focused on stabilization and psychological recovery. • Creation of a safe space. • Psychoeducation about trauma and post-traumatic symptoms. • Promotion of safety. • Emotional regulation training. • Development of coping strategies. • Structured peer sharing. • Psychosocial support. • Strengthening of individual and group resources. • Adaptation to the reception context of unaccompanied refugee minors.

EMDR-IGTP	Hurn & Barron (2018)	Group	• Creation of a safe space. • Emotional psychoeducation using videos, music, and drawings. • Abdominal breathing. • Use of the butterfly hug. • Bilateral stimulation. • Identification and drawing of a safe place. • Drawing of traumatic memories. • Individual tapping. • Reprocessing until more positive associations emerge. • Use of therapeutic metaphors, such as the chocolate factory, migratory birds, seeds, and the Tree of Life.
CBT+	Kerns et al. (2022)	Individual	• Components of cognitive-behavioral therapy. • Psychoeducation. • Identification of thoughts, emotions, and behaviors. • Development of coping strategies. • Emotional regulation. • Cognitive restructuring. • Gradual exposure. • Integration of TF-CBT components. • Behavioral management training for caregivers. • Positive reinforcement. • Limit-setting. • Consistency in caregiving responses. • Systematic symptom monitoring.

EXIT	Meyer DeMott et al. (2017)	Group	• Structured expressive intervention. • Opening and closing ritual. • Emotional barometer. • Rhythmic commands. • Breathing exercises. • Psychoeducation. • Visualization of a safe place. • Painting. • Body movement. • Exploration of identity. • Future projection. • Identification of resources. • Use of a resource animal. • Certificate of participation. • Co-facilitator role for participants who remained in the group.
CBITS	Schapiro et al. (2024)	Group	• Cognitive-behavioral trauma intervention. • Psychoeducation about trauma and PTSD symptoms. • Normalization of traumatic reactions. • Relaxation training. • Identification of thoughts and emotions. • Cognitive restructuring. • Gradual exposure to traumatic memories. • Development of coping skills. • Peer support. • Promotion of safety and comfort. • Attention to cultural, migratory, and linguistic barriers in disclosing traumatic experiences.

ANKOMMEN	Schepp et al. (2024)	Group	• Psychoeducation about children's rights and out-of-home care. • Establishment of group rules. • Identification and differentiation of emotions. • Exploration of the relationship between emotions, thoughts, and behaviors. • Life story work. • Completion of a personal profile sheet. • Construction of a map of places of residence. • Writing the story of out-of-home placement. • Exploration of loyalty conflicts. • Construction of a shared version of one's own story. • Letter to an imaginary young person arriving at the institution. • Problem-solving. • Definition of future goals. • Closing ceremony.

Note: TF-CBT = Trauma-Focused Cognitive Behavioral Therapy; NET = Narrative Exposure Therapy; KIDNET = Narrative Exposure Therapy for Children; EASE = Early Adolescent Skills for Emotions; EMDR-IGTP = Eye Movement Desensitization and Reprocessing Integrative Group Treatment Protocol; CBT+ = Cognitive Behavioral Therapy Plus; EXIT = Expressive Arts in Transition; CBITS = Cognitive Behavioral Intervention for Trauma in Schools; ANKOMMEN = German-language group intervention for children and adolescents in out-of-home care.

NET

NET was mainly centered on the narrative organization of traumatic experiences and was examined in the studies by Peltonen and Kangaslampi (2019),

Kangaslampi and Peltonen (2020), and Said et al. (2021). The core components included psychoeducation about trauma and its symptoms, construction of the lifeline, identification of positive and traumatic events, chronological mapping of experiences, and gradual exposure to traumatic memories. During this process, emotions, thoughts, bodily sensations, and meanings associated with traumatic events were explored in detail.

Its strategies were structured around the construction of a coherent autobiographical narrative, allowing traumatic memories to be placed within the broader continuity of the young person's life story. The intervention began with psychoeducation about trauma and PTSD, helping participants understand intrusive memories, avoidance, hyperarousal, and emotional reactions as trauma-related responses rather than as personal weakness or abnormality. This psychoeducational component functioned as preparation for later trauma processing.

A central strategy in NET was the construction of a coherent autobiographical narrative, in a forma of a lifeline where positive and traumatic events were represented chronologically. The use of flowers to symbolize positive memories and stones to symbolize traumatic or painful experiences allowed young people to externalize life events and organize them visually. Gradual exposure occurred through detailed narration of traumatic memories, including associated emotions, thoughts, bodily sensations, and meanings. The final rereading and signing of the narrative functioned as a process of integration, validation, and symbolic closure.

Across the studies, NET was used to help young people make sense of traumatic experiences, reduce intrusive symptoms, and regain a sense of continuity and control over their life story.

EASE

EASE was examined in the study by Bryant et al. (2024) and focused less on direct trauma processing and more on emotional and behavioral skills. Its main strategies included psychoeducation about psychological distress, identification of emotions and stress reactions, emotional regulation, problem-solving, behavioral activation, coping strategies, and management of daily difficulties. Rather than working

directly with traumatic memories, EASE aimed to strengthen the adolescent's capacity to understand distress, regulate emotional responses, and respond more adaptively to everyday problems. Therefore, its therapeutic focus was mainly stabilization, coping, and functional adaptation.

Group-Based Trauma Intervention

The group-based trauma intervention described by Garoff et al. (2019) prioritized stabilization, safety, emotional regulation, coping, structured peer sharing, psychosocial support, and strengthening of individual and group resources. Its main strategies included the creation of a safe space, psychoeducation about trauma and post-traumatic symptoms, promotion of safety, emotional regulation training, coping strategies, and adaptation to the reception context of unaccompanied refugee minors. The group format functioned as a therapeutic resource by allowing young people to normalize trauma reactions, reduce isolation, and share experiences with peers.

Therefore, this intervention was mainly stabilization-oriented, aiming to reduce distress through safety, normalization, emotional regulation, and group belonging.

TF-CBT

TF-CBT was examined in the studies by Ascienzo et al. (2022) and Patel et al. (2024). TF-CBT used a structured set of trauma-focused cognitive-behavioral strategies. The intervention began with psychoeducation about trauma and traumatic reactions, helping children and adolescents understand symptoms such as fear, avoidance, intrusive memories, guilt, shame, and emotional dysregulation. Relaxation and emotional regulation strategies were then used to increase the child's ability to tolerate distress before engaging in more demanding trauma-focused work.

Cognitive coping and cognitive restructuring were central strategies. These techniques aimed to identify and modify trauma-related beliefs, including self-blame, guilt, shame, persistent fear, negative beliefs about the self, and perceptions of the world as permanently unsafe. Another central strategy was the construction of the trauma narrative, which allowed gradual exposure to traumatic memories in a structured and supported way. Through narrative work, the child could reduce avoidance, organize

traumatic memories, and integrate emotional and cognitive meanings. TF-CBT also included future safety planning and, when applicable, caregiver involvement.

CBT+

CBT+ was examined in the study by Kerns et al. (2022) and was described as a modular and flexible cognitive-behavioral approach. Its strategies included psychoeducation, identification of thoughts, emotions, and behaviors, coping, emotional regulation, cognitive restructuring, gradual exposure, behavioral management training for caregivers, positive reinforcement, limit-setting, consistency in caregiving responses, and systematic symptom monitoring. Its flexibility allows adaptation to the young person's clinical evolution and to family or institutional contexts.

EMDR-IGTP

EMDR-IGTP was examined in the study by Hurn and Barron (2018). It adapted EMDR to a group format and relied strongly on non-verbal, symbolic, and body-based strategies. Its core strategies included the creation of a safe space, emotional psychoeducation using videos, music, and drawings, abdominal breathing, the butterfly hug, bilateral stimulation, identification and drawing of a safe place, drawing of traumatic memories, individual tapping, and reprocessing until more positive associations emerged. The use of drawing reduced the need for direct verbalization of trauma, which may be useful for children with language barriers, avoidance, or difficulty expressing traumatic memories verbally. The intervention also used metaphors and changes in drawings as indicators of emotional transformation, moving from negative representations to safer or more positive imagery.

EXIT Program

EXIT was examined in the study by Meyer DeMott et al. (2017) and used expressive and body-based strategies rather than direct verbal trauma narration. Its techniques included opening and closing rituals, emotional barometers, rhythmic commands, breathing exercises, psychoeducation, visualization of a safe place, painting, body movement, exploration of identity, future projection, identification of

resources, use of a resource animal, certificate of participation, and the possibility of a co-facilitator role for participants who remained in the group. These strategies aimed to promote emotional stabilization, bodily awareness, symbolic expression, safety, belonging, and therapeutic engagement.

CBITS

CBITS was examined in the study by Schapiro et al. (2024) and adapted trauma-focused cognitive-behavioral principles to a group format. Its main strategies included psychoeducation about trauma and PTSD symptoms, normalization of traumatic reactions, relaxation training, identification of thoughts and emotions, cognitive restructuring, gradual exposure to traumatic memories, development of coping skills, peer support, and promotion of safety and comfort. A relevant feature of CBITS was its attention to cultural, migratory, and linguistic barriers that may affect trauma disclosure, especially among unaccompanied minors.

ANKOMMEN

ANKOMMEN was examined in the study by Schepp et al. (2024) and combined psychoeducation, emotional understanding, life story work, identity reflection, problem-solving, group discussion, and future projection. Its strategies were particularly adapted to children and adolescents in residential care within child welfare system. The intervention began with psychoeducation about children's rights and the context of out-of-home placement, helping participants understand their situation and reduce confusion or self-blame. Group rules and structured activities contributed to safety and predictability.

A central strategy was autobiographical and narrative reconstruction. Activities such as the personal profile sheet, map of places of residence, writing the story of placement, and construction of a shared version of one's own story helped young people organize experiences of rupture, separation, and institutional placement. The exploration of loyalty conflicts was also clinically relevant, as children in care may experience divided feelings toward biological family, caregivers, and institutions. Emotional identification and the relationship between emotions, thoughts, and behaviours supported emotional regulation and self-understanding. Future-oriented

strategies, including problem-solving, definition of goals, and the letter to an imaginary young person arriving at the institution, promoted agency, continuity, and meaning.

Synthesis of Cross-Cutting Therapeutic Strategies

Integrative Structure

The findings of this review have relevant clinical implications for psychological work with children and adolescents exposed to displacement, child welfare involvement, relational rupture, and loss. Across the included studies, several therapeutic strategies appeared recurrently, including psychoeducation, emotional stabilization and regulation strategies, narrative and autobiographical work, cognitive strategies, expressive techniques, relational components and peer support, and identity, belonging and future-oriented exercises. These components suggest that interventions with these populations may benefit from integrative, phased, and flexible approaches that consider both traumatic symptomatology and the broader developmental consequences of rupture, separation, and instability.

Psychoeducation About Trauma and Stress Responses

The intervention should include an initial component of psychoeducation about trauma, PTSD symptoms, emotions, and physiological responses to stress. This dimension appears transversally in several structured interventions. In the studies by Ascienzo et al. (2022) and Patel et al. (2024), psychoeducation was an essential stage of TF-CBT, allowing young people to understand their emotional and cognitive reactions as responses associated with traumatic experience. Likewise, Said et al. (2021) showed that young people who underwent NET valued the possibility of better understanding symptoms such as intrusive thoughts, flashbacks, and intense emotional responses. In the context of residential care, psychoeducation may also help reduce shame, self-blame, and confusion about trauma-related reactions. Therefore, it may function as a stage of normalization, emotional validation, and preparation for subsequent therapeutic work.

Stabilization and Emotional Regulation

The results also point to the importance of integrating stabilization and emotional regulation techniques before the direct processing of traumatic memories. The TF-CBT interventions described by Ascienzo et al. (2022) and Patel et al. (2024) included relaxation training, emotional identification, coping strategies, and emotional regulation. Similarly, EASE focused on emotional regulation, problem-solving, behavioral activation, and coping with daily difficulties, while EXIT used expressive and body-based strategies to promote emotional stabilization and bodily awareness. Therefore, the intervention may include breathing exercises, relaxation, emotion identification, grounding strategies, safety resources, body-based activities, and expressive exercises. These strategies are especially relevant in residential care, where trauma-related distress may emerge through behavioral dysregulation, withdrawal, aggression, avoidance, or difficulty trusting adults.

Narrative and Autobiographical Work

Another central axis should be narrative and autobiographical work. NET-based studies showed the relevance of constructing a chronological narrative of traumatic experiences, using strategies such as the lifeline, identification of positive and traumatic events, and gradual narration of painful memories. ANKOMMEN also supported the value of life story work through activities such as personal profile sheets, mapping of places of residence, writing the story of out-of-home placement, and constructing a shared version of one's story. This component could be operationalized through gradual lifeline exercises, identification of significant events, differentiation between positive and painful experiences, exploration of placement history, and progressive construction of a personal narrative with therapeutic support. This is particularly relevant for children and adolescents in residential care, whose histories are often marked by discontinuity, rupture, separation, and fragmented autobiographical meaning.

Cognitive Strategies

The inclusion of cognitive techniques also seems relevant. TF-CBT and CBT+ included cognitive coping, cognitive restructuring, and identification of trauma-related beliefs. These strategies may help children and adolescents recognize and modify thoughts related to guilt, shame, self-blame, persistent fear, perceptions of danger, mistrust, and negative beliefs about the self, others, and the world. In residential care,

cognitive work may also address beliefs related to abandonment, rejection, loyalty conflicts, and the meaning attributed to being placed outside the family context. Therefore, the intervention should include exercises that help young people identify the relationship between thoughts, emotions, behaviors, and traumatic or relational experiences.

Expressive and Non-Verbal Techniques

The intervention should also integrate expressive and non-verbal techniques, including drawing, writing, metaphors, movement, symbolic expression, visual resources, and body-based activities. These strategies were particularly visible in EMDR-IGTP and EXIT. In EMDR-IGTP, drawing and bilateral stimulation allowed children to access traumatic material without relying exclusively on verbal narration. In EXIT, painting, movement, safe-place visualization, rhythm, and symbolic resources promoted emotional expression and stabilization. These techniques may be particularly useful for children and adolescents who have difficulty verbalizing traumatic experiences directly, who present avoidance, or who are not yet ready for structured trauma narration.

Relational Components and Peer Support

The intervention should include relational components adapted to the residential care context. TF-CBT and CBT+ highlighted the relevance of caregiver involvement, behavioral management, positive reinforcement, limit-setting, and consistency in caregiving responses. In residential care, these components should be adapted to residential staff, educators, or reference caregivers, since they are often the adults responsible for daily emotional containment and relational continuity. Group-based interventions, CBITS, EXIT, and ANKOMMEN also suggest the importance of peer support, group belonging, and shared experience. Therefore, the intervention may benefit from exercises that promote trust, group safety, cooperation, and recognition of shared experiences, while maintaining clear boundaries and emotional containment.

Identity, Belonging, and Future Projection

The intervention should include components focused on identity, belonging, and future projection. The ANKOMMEN program described by Schepp et al. (2024) supports the inclusion of modules focused on personal history, placement experiences, loyalty conflicts, resources, self-esteem, and future goals. EXIT also included identity exploration, identification of resources, and future projection. These components are especially relevant in residential care, where trauma is often associated with relational ruptures, discontinuity in caregiving relationships, institutional placement, and difficulties in constructing a coherent sense of self and future. Future-oriented work may help young people move beyond a narrative organized only around trauma and loss, supporting agency, continuity, and the possibility of personal reconstruction.

Limitations

This review was not prospectively registered in PROSPERO, mainly due to time constraints. Although PRISMA guidelines and predefined methodological procedures were followed, the absence of prior registration should be acknowledged as a limitation regarding review transparency.

Although the review question included adopted children and adolescents and children in the process of adoption, the final set of included studies did not specifically focus on these populations. The evidence was mainly concentrated on refugees, unaccompanied minors, children and adolescents in child welfare systems, and young people exposed to family violence. Consequently, the conclusions are more directly applicable to these groups than to adoption-specific populations. This represents an important gap, given the frequent association between adoption, early adversity, relational rupture, loss, and trauma.

Conclusion

This review contributes to the field by analyzing psychological interventions used with adopted, displaced, and alternative-care children and adolescents, and by identifying recurrent therapeutic strategies across different intervention models. The findings show that existing studies focus mainly on PTSD and traumatic stress symptoms, while grief, loss, and retraumatization remain insufficiently assessed, despite their clinical relevance in these populations.

The review also highlights important gaps for future research. There is a need for studies with stronger methodological designs studies as well as research examining the mediators and moderators of intervention outcomes, clearer descriptions of intervention components, longer follow-up periods, and more consistent outcome measures. The absence of adoption-specific studies also indicates that this population remains underrepresented in intervention research, despite its frequent association with early adversity, separation, and relational rupture.

A central implication of this review is the need to move beyond PTSD symptom reduction alone. Although several studies recognized experiences of separation, displacement, family rupture, institutional placement, and loss of continuity, no included study directly measured grief or retraumatization as specific outcomes. Future clinical research should therefore examine interventions capable of integrating trauma processing, grief elaboration, stabilization, relational safety, and narrative reconstruction.

Thus, the main value of this review lies in its contribution to clarifying a fragmented field. It synthesizes existing evidence, identifies clinically relevant strategies, and shows the need for future interventions that explicitly address the intersection between trauma, loss, and retraumatization in vulnerable children and adolescents.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., Dube, S. R., & Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. *European Archives of Psychiatry and Clinical Neuroscience, 256*(3), 174–186. https://doi.org/10.1007/s00406-005-0624-4

Ascienzo, S., Sprang, G., & Royse, D. (2022). Gender differences in the PTSD symptoms of polytraumatized youth during isolated phases of trauma-focused cognitive behavioral therapy. *Psychological Trauma: Theory, Research, Practice, and Policy, 14*(3), 488–496. https://doi.org/10.1037/tra0001028

Bartels, L., Berliner, L., Holt, T., Jensen, T., Jungbluth, N., Plener, P., Risch, E., Rojas, R., Rosner, R., & Sachser, C. (2019). The importance of the DSM-5 posttraumatic stress disorder symptoms of cognitions and mood in traumatized children and adolescents: Two network approaches. *Journal of Child Psychology and Psychiatry, 60*(5), 545–554. https://doi.org/10.1111/jcpp.13009

Boss, P. (1999). *Ambiguous loss: Learning to live with unresolved grief*. Harvard University Press.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. Basic Books.

Brodzinsky, D., Gunnar, M., & Palacios, J. (2022). Adoption and trauma: Risks, recovery, and the lived experience of adoption. *Child Abuse & Neglect, 130*(Part 2), Article 105309. https://doi.org/10.1016/j.chiabu.2021.105309

Bryant, R. A., Habashneh, R., Ghatasheh, M., Malik, A., Aqel, I. S., Dawson, K. S., Watts, S., Jordans, M. J. D., Brown, F. L., van Ommeren, M., & Akhtar, A. (2024). Twelve-month follow-up of a controlled trial of a brief behavioural intervention to reduce psychological distress in young adolescent Syrian refugees. *Epidemiology and Psychiatric Sciences, 33*, Article e80. https://doi.org/10.1017/S2045796024000817

Cloitre, M. (2020). ICD-11 complex post-traumatic stress disorder: Simplifying diagnosis in trauma populations. *British Journal of Psychiatry, 216*(3), 129–131. https://doi.org/10.1192/bjp.2020.43

Cloitre, M., Stolbach, B. C., Herman, J. L., van der Kolk, B., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Traumatic Stress, 22*(5), 399–408. https://doi.org/10.1002/jts.20444

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2017). *Treating trauma and traumatic grief in children and adolescents* (2nd ed.). Guilford Press.

Covidence. (2025). *Covidence systematic review software*. Veritas Health Innovation. https://www.covidence.org

Côté, C., Roy, D., Thiemann, R., Hartwick, C., Madigan, S., & Racine, N. (2025). Adverse childhood experiences and trauma symptoms in maltreated children: The role of child and caregiver protective factors. *Child Abuse & Neglect, 169*(Part 2), Article 107664. https://doi.org/10.1016/j.chiabu.2025.107664

Courtois, C. A., & Ford, J. D. (2013). *Treatment of complex trauma: A sequenced, relationship-based approach*. Guilford Press.

Courtney, A. (2000). Loss and grief in adoption: The impact of contact. *Adoption & Fostering, 24*(2), 33–44.

Cowling, M. M., & Anderson, J. R. (2023). The effectiveness of therapeutic interventions on psychological distress in refugee children: A systematic review. *Journal of Clinical Psychology, 79*(8), 1857–1874. https://doi.org/10.1002/jclp.23479

Curtis, A., Luchetti, M., Prendergast, C., Ahern, E., Creaven, A. M., Kirwan, E. M., Graham, E. K., & O'Súilleabháin, P. S. (2025). Adverse childhood experiences and loneliness: A systematic review and meta-analysis. *Social Science & Medicine, 370*, Article 117860. https://doi.org/10.1016/j.socscimed.2025.117860

Dannlowski, U., Stuhrmann, A., Beutelmann, V., Zwanzger, P., Lenzen, T., Grotegerd, D., Domschke, K., Hohoff, C., Ohrmann, P., Bauer, J., Lindner, C., Postert, C., Konrad, C., Arolt, V., Heindel, W., Suslow, T., & Kugel, H. (2012). Limbic scars: Long-term consequences of childhood maltreatment revealed by functional and structural magnetic resonance imaging. *Biological Psychiatry, 71*(4), 286–293. https://doi.org/10.1016/j.biopsych.2011.10.021

Della Rocca, B., Bello, R., Carbone, M., Pezzella, P., Toni, C., Sampogna, G., Tarsitani, L., Luciano, M., & Fiorillo, A. (2024). Promoting mental health and preventing mental health problems in child and adolescent refugees and asylum seekers: A systematic review on psychosocial interventions. *International Journal of Social Psychiatry, 70*(4), 653–666. https://doi.org/10.1177/00207640231214964

Doka, K. J. (1989). *Disenfranchised grief: Recognizing hidden sorrow*. Lexington Books.

Downey, C., & Crummy, A. (2022). The impact of childhood trauma on children's wellbeing and adult behavior. *European Journal of Trauma & Dissociation, 6*(1), Article 100237. https://doi.org/10.1016/j.ejtd.2021.100237

Duckworth, M. P., & Follette, V. M. (Eds.). (2012). *Retraumatization: Assessment, treatment, and prevention*. Routledge.

Fan, L., & Kang, T. (2025). Early childhood trauma and its long-term impact on cognitive and emotional development: A systematic review and meta-analysis. *Annals of Medicine, 57*(1), Article 2536199. https://doi.org/10.1080/07853890.2025.2536199

Fritz, J., de Graaff, A. M., Caisley, H., van Harmelen, A. L., & Wilkinson, P. O. (2018). A systematic review of amenable resilience factors that moderate and/or mediate the relationship between childhood adversity and mental health in young people. *Frontiers in Psychiatry, 9*, Article 230. https://doi.org/10.3389/fpsyt.2018.00230

Garoff, F., Kangaslampi, S., & Peltonen, K. (2019). Development and implementation of a group-based mental health intervention for unaccompanied minors. *Scandinavian Journal of Psychology, 60*(1), 7–15. https://doi.org/10.1111/sjop.12497

Genç, E. (2022). The effectiveness of trauma treatment approaches in refugee children and adolescents: A systematic review. *Children and Youth Services Review, 141*, Article 106602. https://doi.org/10.1016/j.childyouth.2022.106602

Gkintoni, E., Kourkoutas, E., Yotsidi, V., Stavrou, P. D., & Prinianaki, D. (2024). Clinical efficacy of psychotherapeutic interventions for post-traumatic stress disorder in children and adolescents: A systematic review and analysis. *Children, 11*(5), Article 579. https://doi.org/10.3390/children11050579

Greeson, J. K. P., Briggs, E. C., Kisiel, C. L., Layne, C. M., Ake, G. S., Ko, S. J., Gerrity, E. T., Steinberg, A. M., Howard, M. L., Pynoos, R. S., & Fairbank, J. A. (2011). Complex trauma and mental health in children and adolescents placed in foster care: Findings from the National Child Traumatic Stress Network. *Child Welfare, 90*(6), 91–108. https://www.jstor.org/stable/48625371

Hamby, S., Elm, J. H. L., Howell, K. H., & Merrick, M. T. (2021). Recognizing the cumulative burden of childhood adversities transforms science and practice for trauma and resilience. *American Psychologist, 76*(2), 230–242. https://doi.org/10.1037/amp0000763

Han, D., Dieujuste, N., Doom, J. R., & Narayan, A. J. (2023). A systematic review of positive childhood experiences and adult outcomes: Promotive and protective processes for resilience in the context of childhood adversity. *Child Abuse & Neglect, 144*, Article 106346. https://doi.org/10.1016/j.chiabu.2023.106346

Haralambie, A. M. (2024). Responding to the unacknowledged trauma and disenfranchised grief in infant adoption. *Family Court Review, 62*(4), 852–862. https://doi.org/10.1111/fcre.12831

Harris, M., & Fallot, R. D. (2001). Envisioning a trauma-informed service system: A vital paradigm shift. *New Directions for Mental Health Services, 2001*(89), 3–22. https://doi.org/10.1002/yd.23320018903

Haselgruber, A., Knefel, M., Sölva, K., & Lueger-Schuster, B. (2021). Foster children's complex psychopathology in the context of cumulative childhood trauma: The interplay

of ICD-11 complex PTSD, dissociation, depression, and emotion regulation. *Journal of Affective Disorders, 282*, 372–380. https://doi.org/10.1016/j.jad.2020.12.116

Hébert, M., Amédée, L. M., & Tremblay-Perreault, A. (2025). Identifying PTSD and complex PTSD profiles in child victims of sexual abuse. *Journal of Child Sexual Abuse, 34*(5–6), 520–538. https://doi.org/10.1080/10538712.2024.2403996

Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., Jones, L., & Dunne, M. P. (2017). The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. *The Lancet Public Health, 2*(8), e356–e366. https://doi.org/10.1016/S2468-2667(17)30118-4

Hurn, R., & Barron, I. (2018). The EMDR integrative group treatment protocol in a psychosocial program for refugee children: A qualitative pilot study. *Journal of EMDR Practice and Research, 12*(4), 208–223. https://doi.org/10.1891/1933-3196.12.4.208

Iverson, I. A., Cook, N. E., & Iverson, G. L. (2024). Adverse childhood experiences are associated with perceived cognitive difficulties among high school students in the United States. *Frontiers in Psychology, 15*, Article 1293013. https://doi.org/10.3389/fpsyg.2024.1293013

Jones, L. (2020). Grief and loss in displaced and refugee families. In S. Song & P. Ventevogel (Eds.), *Child, adolescent and family refugee mental health*. Springer. https://doi.org/10.1007/978-3-030-45278-0_8

Kangaslampi, S., & Peltonen, K. (2020). Changes in traumatic memories and posttraumatic cognitions associate with PTSD symptom improvement in treatment of multiply traumatized children and adolescents. *Journal of Child & Adolescent Trauma, 13*, 103–112. https://doi.org/10.1007/s40653-019-00255-3

Katsonga-Phiri, T., Grant, K. E., & Brown, M. (2017). Trauma intervention in Sub-Saharan African children: A systematic literature review. *Trauma, Violence, & Abuse, 20*(4), 453–469. https://doi.org/10.1177/1524838017717747

Kerns, S. E. U., Phillips, J. D., Berliner, L., & Barth, R. P. (2022). Partnering for Success symptom monitoring outcomes: Cognitive Behavioral Therapy Plus for

children and youth in child welfare. *Journal of Child and Family Studies, 31*(1), 247–259. https://doi.org/10.1007/s10826-021-02112-0

Kooij, L. H., van der Pol, T. M., Daams, J. G., Hein, I. M., & Lindauer, R. J. L. (2022). Common elements of evidence-based trauma therapy for children and adolescents. *European Journal of Psychotraumatology, 13*(1), Article 2079845. https://doi.org/10.1080/20008198.2022.2079845

Lawrence, S., & Scofield, R. H. (2024). Post traumatic stress disorder associated hypothalamic-pituitary-adrenal axis dysregulation and physical illness. *Brain, Behavior, & Immunity - Health, 41*, Article 100849. https://doi.org/10.1016/j.bbih.2024.100849

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist, 56*(3), 227–238. https://doi.org/10.1037/0003-066X.56.3.227

Mastorci, F., Lazzeri, M. F. L., Vassalle, C., & Pingitore, A. (2024). The transition from childhood to adolescence: Between health and vulnerability. *Children, 11*(8), Article 989. https://doi.org/10.3390/children11080989

Melamed, D. M., Botting, J., Lofthouse, K., Pass, L., & Meiser-Stedman, R. (2024). The relationship between negative self-concept, trauma, and maltreatment in children and adolescents: A meta-analysis. *Clinical Child and Family Psychology Review, 27*(1), 220–234. https://doi.org/10.1007/s10567-024-00472-9

Meyer DeMott, M. A., Jakobsen, M., Wentzel-Larsen, T., & Heir, T. (2017). A controlled early group intervention study for unaccompanied minors: Can expressive arts alleviate symptoms of trauma and enhance life satisfaction? *Scandinavian Journal of Psychology, 58*(6), 510–518. https://doi.org/10.1111/sjop.12395

Mitchell, M. B. (2018). “No one acknowledged my loss and hurt”: Non-death loss, grief, and trauma in foster care. *Child & Adolescent Social Work Journal, 35*(1), 1–9. https://doi.org/10.1007/s10560-017-0502-8

Nemeroff, C. B. (2016). Paradise lost: The neurobiological and clinical consequences of child abuse and neglect. *Neuron, 89*(5), 892–909. https://doi.org/10.1016/j.neuron.2016.01.019

Nickerson, A., Liddell, B. J., Maccallum, F., et al. (2014). Posttraumatic stress disorder and prolonged grief in refugees exposed to trauma and loss. *BMC Psychiatry, 14*, Article 106. https://doi.org/10.1186/1471-244X-14-106

Oberg, C., & Sharma, H. (2023). Post-traumatic stress disorder in unaccompanied refugee minors: Prevalence, contributing and protective factors, and effective interventions: A scoping review. *Children, 10*(6), Article 941. https://doi.org/10.3390/children10060941

Palacios, J., Adroher, S., Brodzinsky, D. M., Grotevant, H. D., Johnson, D. E., Juffer, F., Martínez-Mora, L., Muhamedrahimov, R. J., Selwyn, J., Simmonds, J., & Tarren-Sweeney, M. (2019). Adoption in the service of child protection: An international interdisciplinary perspective. *Psychology, Public Policy, and Law, 25*(2), 57–72. https://doi.org/10.1037/law0000192

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., McGuinness, L. A., ... Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ, 372*, Article n71. https://doi.org/10.1136/bmj.n71

Patel, S. M., Casline, E. P., Vera, C., Ramirez, V., & Jensen-Doss, A. (2024). Unaccompanied migrant children in the United States: Implementation and effectiveness of trauma-focused cognitive behavioral therapy. *Psychological Trauma: Theory, Research, Practice, and Policy, 16*(Suppl. 2), S389–S399. https://doi.org/10.1037/tra0001361

Peltonen, K., & Kangaslampi, S. (2019). Treating children and adolescents with multiple traumas: A randomized clinical trial of narrative exposure therapy. *European*

Journal of Psychotraumatology, 10(1), Article 1558708. https://doi.org/10.1080/20008198.2018.1558708

Perry, B. D., & Pollard, R. A. (1998). Homeostasis, stress, trauma, and adaptation: A neurodevelopmental view of childhood trauma. *Child and Adolescent Psychiatric Clinics of North America, 7*(1), 31–51.

Petrowski, N., Cappa, C., & Gross, P. (2017). Estimating the number of children in formal alternative care: Challenges and results. *Child Abuse & Neglect, 70*, 388–398. https://doi.org/10.1016/j.chiabu.2016.11.026

Plümacher, K. S., Loy, J. K., Bender, S., & Krischer, M. (2025). Psychopathological symptoms in school-aged children after a traumatic event. *Child and Adolescent Psychiatry and Mental Health, 19*(1), Article 12. https://doi.org/10.1186/s13034-025-00869-6

Purgato, M., Gross, A. L., Betancourt, T., Bolton, P., Bonetto, C., Gastaldon, C., Gordon, J., O'Callaghan, P., Papola, D., Peltonen, K., Punamaki, R. L., Richards, J., Staples, J. K., Unterhitzenberger, J., van Ommeren, M., de Jong, J., Jordans, M. J. D., Tol, W. A., & Barbui, C. (2018). Focused psychosocial interventions for children in low-resource humanitarian settings: A systematic review and individual participant data meta-analysis. *The Lancet Global Health, 6*(4), e390–e400. https://doi.org/10.1016/S2214-109X(18)30046-9

Rando, T. A. (1984). *Grief, dying, and death: Clinical interventions for caregivers*. Research Press. https://archive.org/details/griefdyingdeath00rand/page/n5/mode/2up

Remmers, M. C. C., Reijs, R. P., & Hoebe, C. J. P. A. (2024). Defining and distinguishing early life stress, trauma, adversity, toxic and chronic stress and allostatic load: A descriptive review. *Scandinavian Journal of Public Health*. Advance online publication. https://doi.org/10.1177/14034948241260105

Riebschleger, J., Day, A., & Damashek, A. (2015). Foster care youth share stories of trauma before, during, and after placement: Youth voices for building trauma-informed systems of care. *Journal of Aggression, Maltreatment & Trauma, 24*(4), 339–360. https://doi.org/10.1080/10926771.2015.1009603

Said, G., Alqadri, Y., & King, D. (2021). Unaccompanied minors' experiences of narrative exposure therapy. *The Cognitive Behaviour Therapist, 14*, Article e11. https://doi.org/10.1017/S1754470X21000088

Salazar, A. M., Keller, T. E., Gowen, L. K., et al. (2013). Trauma exposure and PTSD among older adolescents in foster care. *Social Psychiatry and Psychiatric Epidemiology, 48*, 545–551. https://doi.org/10.1007/s00127-012-0563-0

Şar, V. (2025). From attachment trauma to traumatic attachment: Invisible injuries of early childhood and subtle relational codes of self-regulation. *Clinical Neuropsychiatry, 22*(5), 417–422. https://doi.org/10.36131/cnfioritieditore20250513

Schapiro, N. A., Moore, E., Garcia, E., Gomes, E., Stimbra-Mora, M., & Greswold, W. (2024). When silence feels safer: Challenges and successes of delivering a school-based cognitive behavioral intervention to Central American unaccompanied immigrant youth. *Psychological Trauma: Theory, Research, Practice, and Policy, 16*(Suppl. 2), S400–S408. https://doi.org/10.1037/tra0001414

Schepp, S., Fegert, J. M., Rassenhofer, M., Regner, S., Witt, A., & Pfeiffer, E. (2024). Evaluation of ANKOMMEN as a group intervention based on life story work for adolescents in residential care in Germany: A single-arm pilot study. *Child and Adolescent Psychiatry and Mental Health, 18*, Article 135. https://doi.org/10.1186/s13034-024-00817-w

Simmel, C. (2012). Highlighting adolescents' involvement with the child welfare system: A review of recent trends, policy developments, and related research. *Children and Youth Services Review, 34*(7), 1197–1207. https://doi.org/10.1016/j.childyouth.2012.02.004

Simpson, J. E., Landers, A. L., & White Hawk, S. (2024). Longing to belong: The ambiguous loss of Indigenous fostered/adopted individuals. *Child Abuse & Neglect, 148*, Article 106441. https://doi.org/10.1016/j.chiabu.2023.106441

Smith, K. E., & Pollak, S. D. (2020). Early life stress and development: Potential mechanisms for adverse outcomes. *Journal of Neurodevelopmental Disorders, 12*(1), Article 34. https://doi.org/10.1186/s11689-020-09337-y

Spinazzola, J., van der Kolk, B., & Ford, J. D. (2018). When nowhere is safe: Interpersonal trauma and attachment adversity as antecedents of posttraumatic stress disorder and developmental trauma disorder. *Journal of Traumatic Stress, 31*(5), 631–642. https://doi.org/10.1002/jts.22320

Stroebe, M. S., Hansson, R. O., Stroebe, W., & Schut, H. (Eds.). (2008). *Handbook of bereavement research: Consequences, coping, and care*. American Psychological Association.

Sutton, A., Carroll, C., Simpson, E., Forsyth, J., Rayner, A., Ren, S., Franklin, M., & Wood, E. (2025). Clinical and cost-effectiveness of eye movement desensitisation and reprocessing for post-traumatic stress disorder in children and adolescents: A systematic review and meta-analysis. *Clinical Psychology & Psychotherapy, 32*(6), Article e70186. https://doi.org/10.1002/cpp.70186

Touzvara, V., Kupdere, P., Wilson, K., Matthews, L., Simpson, A., & Foye, U. (2023). Adverse childhood experiences, mental health, and social functioning: A scoping review of the literature. *Child Abuse & Neglect, 139*, Article 106092. https://doi.org/10.1016/j.chiabu.2023.106092

Velu, M. E., Kuiper, R. M., Schok, M., Sleijpen, M., de Roos, C., & Mooren, T. (2025). Effectiveness of trauma-focused treatments for refugee children: A systematic review and meta-analyses. *European Journal of Psychotraumatology, 16*(1), Article 2494362. https://doi.org/10.1080/20008066.2025.2494362

Williams, D. (2017). Grief, loss, and separation: Experiences of birth children of foster carers. *Child & Family Social Work, 22*, 1448–1455. https://doi.org/10.1111/cfs.12366

Worden, J. W. (1996). *Children and grief: When a parent dies*. Guilford Press.

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th ed.). https://icd.who.int/

Appendix A

Search query

((adoption OR adopted OR "in process of adoption" OR "foster care" OR "out-of-home care" OR "alternative care" OR "residential care" OR refugee* OR "asylum seeker*")

AND

(child* OR adolescen* OR youth))

AND

("psychological intervention*" OR psychotherapy OR counseling OR counselling OR "trauma-focused therapy" OR "trauma focused therapy" OR "grief-focused therapy" OR "grief focused therapy")

AND

(trauma OR "psychological trauma" OR PTSD OR grief OR bereavement OR loss OR retraumatization OR "re-traumatization")