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WORKING PAPER

Mental Health in Displaced Child and Youth Populations: A Developmental and Family Systems Lens

Zoe E. Taylor and Josiah Kaplan

September 2023

UNICEF INNOCENTI – GLOBAL OFFICE OF RESEARCH AND FORESIGHT

Executive summary

This working paper addresses the mental health of displaced children utilizing a developmental and family systems lens. Children who are displaced due to crises experience an array of adverse situations prior to, during and after their displacement that impact their well-being, health, adjustment and developmental trajectories. However, research remains limited with respect to understanding the impact of displacement on mental health and addressing the roles of children's ecological contexts (in particular the family). We summarize the knowledge base of mental health in displaced populations from peer-reviewed journal articles with a focus on the last 10 years and using meta-analyses of mental health research.

Based on this evidence (as well as gaps and limitations), we present a framework and recommendations for guiding future research. Sections address the following:

Section I: We summarize the contextual risks that displaced children experience and explain the need for child-sensitive research on this topic.

Section II: In this section, we summarize select findings from empirical research in the last 10 years (especially meta-analyses) on the mental health of displaced children. We present findings based on age, developmental stage and gender. We end with a summary of research focused on subpopulations of displaced children who are particularly vulnerable to mental health concerns.

Section III: This section presents important research gaps that are critical for researchers to address in the future. We highlight four areas of concern: 1) the need for family-level research, 2) the need to assess mental well-being, strengths and resilience in addition to risks and psychopathology, 3) the need for child-sensitive research, and 4) critical limitations in research methodology.

Section IV: This section presents our conceptual model of displaced children's mental health and discusses the frameworks that inform the model.

Section V: Our final section presents research recommendations for improving the knowledge base of displaced children's mental health.

Contents

I. Contextual risks facing displaced children and youth

1. Current context

Forced displacement (the movement of persons forced or obliged to flee or to leave their homes or places of habitual residence as a result of humanitarian crises) is one of the defining issues of this century.

Across the world, major humanitarian issues such as violent conflict, persecution, poverty, economic and political instability, environmental disasters, wars and climate change continue to impact the large-scale movement of peoples both within and outside their countries of origin.[1] The numbers are staggering. The United Nations High Commissioner for Refugees (UNHCR) estimates that, as of May 2022, more than 100 million people were forcibly displaced[a] from their homes around the world, an unprecedented number that has doubled in the last decade.[2] Over 1 per cent (or 1 in 95 people) of the world's population is now forcibly displaced, with most displaced inside their own countries or displaced to other low- or middle-income countries. Included in these statistics are a large, and growing, number of children – worldwide, an estimated 36.5 million children were forcibly displaced by the end of 2021.[3]

Children are disproportionately impacted by forced displacement – they form 30 per cent of the world's population but constitute 41 per cent of all forcibly displaced people.[2,4] Children of all ages are impacted by displacement. The UNHCR estimates that 29 per cent of displaced children are aged 0–4 years, 42 per cent are aged 5–11, and 29 per cent are aged 12–17.[4] Although age and gender data are not fully available in all countries, displaced children appear to be fairly evenly divided by gender (51 per cent boys and 49 per cent girls).[2] A large number of these children are unaccompanied, with distinct vulnerabilities and needs, due to separation from, and loss of, their families.[5,6]

Drivers of displacement are complex and interlinked with global megatrends, including armed conflict, persecution, climate change and environmental disasters, urbanization, and economic and political instability. These dynamics suggest that displacement crises – and their impacts on children – are not only a current global challenge for child rights and protection, but also set to dramatically increase in prevalence and scale in the near and mid-term future. Escalation in these trends in the absence of a strong humanitarian response may have disastrous consequences for the mental health and well-being of children around the world, both during their childhood and across the transition to adulthood.

More than 1 in 10 children worldwide are impacted by armed conflict,[7] with both immediate and long-term detrimental effects on their health, well-being, education and social-emotional development.[8–10] Situations of armed conflict put children at risk of bodily harm, as well as sexual violence and exploitation, abduction and forced recruitment by armed forces, and lack of access to schools and hospitals.[2,7,11]

[a] This number encompasses refugees, asylum seekers, internally displaced people, and other displaced people not covered by UNHCR's mandate (and excludes other categories such as returnees and non-displaced stateless people).

Crises resulting from climate change continue to contribute to displacement either through sudden-onset disasters (e.g., floods, monsoons and earthquakes) or protracted environmental ones (e.g., extreme temperatures, famine and drought).

Climate change disasters will severely impact child well-being given the far-reaching effects on Sustainable Development Goals for children, including food security and reduction of poverty, health, education, access to water and sanitation, and peace and justice.[12,13] Climate-induced disasters additionally increase the risk of political instability, conflict and violence, strain resources and increase inequality. Many of the formal legal protections guaranteed to refugees recognized under the UNHCR 1951 Refugee Convention do not apply to so-called 'climate migrants', further compounding their marginalization.

Children and their families are also displaced due to conditions of extreme poverty and food crises that additionally increase their susceptibility to other catastrophic events. Families with fewer resources are less equipped to successfully cope with disasters such as famine, or hurricanes forcing families to leave their homes in order to survive.[14] Economic instability and food crises have worsened since the COVID-19 pandemic began, both exacerbating existing socio-economic inequalities and aggravating other factors responsible for displacement such as armed conflict.[2] Many regions, such as sub-Saharan Africa and the Middle East, have been simultaneously impacted by both environmental disasters and conflict, creating extremely hazardous conditions – especially for children. Almost all conflict displacements are occurring in countries that are additionally vulnerable to climate change, which can result in multiple displacements.[2] People displaced due to complex crises such as these are also more likely to experience multiple traumas in a short time compared to other migrant groups.[14] These types of displacement are especially hard on children as they damage the systems and support available to families and communities which children can count on and that promote their resilience.[15,16] Complex crises can result in protracted displacement where children spend the majority of their childhood growing up in refugee camps, with an increasing number of children born into displacement and never seeing their 'home' countries.

The experience of displacement, driven by these intersecting crises, is an increasingly visible global phenomenon impacting children's health, psychosocial, emotional and cognitive development.[3,17] It is unknown how these intersecting crises will impact the long-term well-being, successes and future of displaced children around the world, therefore research that is child-sensitive and child-focused is greatly needed.[17]

2. A call for greater child-sensitive evidence on mental health

Children and youth who are displaced due to crises experience an array of adverse situations prior to, during and after their displacement that impact their well-being, health, adjustment and developmental trajectories.[7,21,22] Displaced children have not only been exposed to trauma prior to displacement, but often continue to be exposed to environmental, social and physical hazards during displacement. The migration journey can be dangerous and result in further traumas and risks, and many displaced and refugee children face lengthy stays in camps, or in other situations where stability is not provided. Even after arrival in a host location, children experience stressors in resettling related to social dislocation, acculturation and isolation.[8,23,24]

Although overall risks facing displaced children have been acknowledged, much less is known about the specific challenges and needs of children and youth across different stages of development, how specific traumas and different stages of mobility differentially impact their health and well-being, or how children are resilient to their experiences. Are the consequences of experiencing war the same as the consequences of severe poverty or having one's home rendered uninhabitable due to a natural disaster?[25] How does displacement impact younger versus older children, and how are their developmental trajectories changed as a result? For example, researchers have shown that experiencing violence and instability at a young age and at critical points in a child's cognitive and emotional development can have a lasting psychological impact.[8,26] In adolescence, displacement can greatly increase vulnerabilities to factors such as exploitation and violence (especially for girls) as well as disrupt critical developmental tasks such as completing secondary education.[27,28] All displaced children are disproportionately less likely to attend school, but older children are most likely to not be enrolled.[4,7] Factors such as gender, disability status, sexual identity, and religious and ethnic identity may additionally contribute to mental health vulnerabilities.

Exposure to severe and chronic stressors in childhood (particularly in early childhood, when developmental systems are still maturing) may result in prolonged activation of stress response systems, which can lead to damaged, weakened bodily systems and brain architecture or toxic stress.[29,30] Displaced children and youth have a high risk of toxic stress due to the intensity, number, and chronicity of stressors and adverse life events they experience.[8] Extreme and long-lasting exposure to toxic stress in childhood can have damaging effects on learning, behaviour and health across the lifespan.[31] Toxic stress in childhood can lead to stress-related mental health disorders such as depression, anxiety, alcoholism, post-traumatic stress (PTS) and poor coping.[31] Furthermore, displacement puts children at greater risk of separation from primary caregivers at a time when the physical and emotional security from caregivers is most critical and needed.[30]

Displaced children and youth have an elevated risk of clinically significant mental health problems due to exposure to prolonged and cumulative adverse experiences that can have long-term impacts across childhood and into adulthood.[26,32–34] Psychological distress in displaced children is the result of exposures occurring across the migration continuum[35,36] – highlighting the need for researchers and practitioners to assess both prior and current trauma (including the post-migration context). Children might have been exposed to severe poverty and violence before and during displacement and face further challenges such as adapting to a new setting, legal stressors relating to unauthorized status, marginalization, and discrimination upon resettlement.[3,6,36,37] These experiences impact children across multiple domains of their lives. Forcibly displaced children (especially those who have experienced war-related violence or violent crime in their country of origin) are particularly vulnerable to developing mental health problems and more likely to have experienced multiple traumas in a short period of time compared to other migrant or immigrant populations.[14,16,23] Unaccompanied minors are also especially vulnerable to psychological problems, given that they do not have support from parents to help mitigate migration-related stressors.

Overall, the basic rights and economic, social and psychological needs of millions of refugee children and youth are not being met.[4] The need for evidence-based, developmentally appropriate research to inform and improve policies on child displacement requires urgent action. Addressing the mental health concerns and needs of displaced children is essential for their adjustment, life successes, and (if displaced across borders) adaptation to host societies – and is a critical global public health priority.

II. Mental health and displaced children: Literature summary

In this section, we discuss the overall findings from empirical research assessing mental health in displaced children and youth. For the purpose of this working paper, we selected research on the mental health of displaced children and youth from the last 10 years (with a reliance on summaries produced by previous meta-analyses across individual studies). We present findings based on age and developmental timing, as well as gender. We end with a summary of research focused on subpopulations of displaced children who have been found to be especially vulnerable to mental health concerns.

Researchers have overwhelmingly focused on assessing psychopathology (e.g., depression, anxiety and PTS) in displaced children, and thus this review largely focuses on mental health problems. However, we note the importance of research that incorporates both mental health problems and well-being as critical for moving research forward. It should also be noted that research on vulnerable subpopulations of displaced children is extremely limited, and that other vulnerable subgroups – including gender, LGBTQ+ children, children with disabilities, children from specific political, geographic, ethnic, and religious communities – are not adequately represented.

1. Displacement and mental health

Witnessing violence and death, losing one's home and community, being exposed to destructive natural disasters or fearing for one's safety are traumatic experiences that are increasing in frequency and potentially severely impacting the mental health of children across the globe. No one should have to live through them. These experiences are often only the start of a series of adverse events and stressors that arise across the displacement experience and that negatively impact children's mental health.[18] Not surprisingly, this leads displaced children to have significantly higher mental health problems when compared with the general population, with the most commonly diagnosed problems including depression, anxiety and PTS.[10,19] With migration and displacement continuing to grow and detrimentally impact millions of children, the need to understand the mental health of displaced children in order to better provide psychosocial support is immense.

Stages of displacement and mental health

The mental health of displaced children can be affected by a multitude of potentially stressful or traumatic events across the migration journey. These experiences are often captured in cross-sectional research, but typically involve multiple phases of displacement and relocation. Moreover, displacement often is protracted, with many children spending significant amounts of time in a state of extended marginality, often totalling many years of childhood and adolescence. Research indicates that children are frequently exposed to multiple traumas during the pre-flight phase of displacement, including exposure to violence and killing, political persecution, extreme poverty, homelessness, physical and sexual violence, maltreatment, and loss of a family member. Those exposed to multiple and prolonged traumas typically report more severe PTS, depression and anxiety during resettlement.[20] Prior trauma often creates sensitivity to other stressful events and

amplifies mental health problems.[10] Research has not typically differentiated between types of trauma that can impact displaced children's mental health, although it is evident that children who experience or witness violence and killings have more severe negative mental health outcomes, in particular higher PTS.[20,21] Events that directly imperil the individual, family or home are particularly consequential.[22]

Children continue to be exposed to traumatic events en route (especially those children who are unaccompanied), including homelessness, challenging and dangerous terrain, separation from caregivers, violence, hunger, exploitation, and physical or sexual abuse.[6,20,22,23] Arrival in a new location often involves dealing with legal procedures, detention centres or refugee camps, which can be very stressful for children and contributes to both emotional and behavioural difficulties.[10,20,24] Children living in refugee camps continue to be exposed to unique stressors, including unstable housing, material hardships, threats to their security, and limited basic resources.[21,25,26] Once children and families reach their post-migration destinations, factors such as discrimination and marginalization, cultural differences, homesickness, loneliness, and conflict within their families can continue to negatively impact their mental health.[6,10,14,21,22,27] Economic circumstances in resettlement can also impact children by creating adverse family climates that increase depression and anxiety.[27]

It is important to note that children who are displaced may be coping not only with prior traumas and current challenges, but also commonly with emotional, cultural and social losses as well as grief from being displaced from their homes. Children report feeling homesick, missing their home and cultural traditions, and feeling uprooted.[28] Many are coping with losses of family members, either from separation or death.[29] Displaced children often leave home with very few of their possessions, may not have had the opportunity to say goodbye to their friends, teachers or family members, and are greatly distressed by not having a safe place or a home.[28,30] In contrast, children who are supported in creating a connection to, and feel a sense of belonging in, their new locations are likely to adjust better and to have better mental health.[31]

Overall mental health findings

Displaced children are not a homogeneous population. However, the limited research into this group of children clearly shows rates of mental health problems that are significantly higher than in other children. Meta-analyses of research studies have found that prevalence rates of PTS (both disorders and symptoms) in displaced children and youth range from 19 to 53 per cent across studies, with an approximate average of over a third of children having PTS across samples.[18,21,24,32] The small number of studies that have assessed PTS over time have found that these rates do not typically decline over time, suggesting both the long-term impact of severe trauma or the continuation of persistent negative events (or both).[32] The majority of these studies have taken place in the context of war-impacted children. However, there is also evidence that youth who have been exposed to climate events such as floods also have high levels of PTS in addition to grief, anger, feelings of hopelessness and helplessness, increased aggression, and higher suicidal ideation.[12] For depression, prevalence rates range between 10 and 33 per cent[21,24] (although one meta-analysis had rates ranging from 3 to 30 per cent[18]). Anxiety disorders range between 9 and 32 per cent,[21,24] and emotional and behavioural problems (which are less studied) range between 20 and 35 per cent.[24] Many children are likely to suffer from more than one mental health concern.

Specific subpopulations of displaced children and youth also show that some groups are more at risk of mental health problems than others. A meta-analysis of studies focused solely on unaccompanied youth found that PTS ranged from 17 to 85 per cent of study participants, depression ranged from 13 to 76 per cent, and anxiety ranged from 11 to 85 per cent.[5] A review of studies of children exposed to war found that 47 per cent of children met criteria for PTS, 43 per cent for depression, and 27 per cent for anxiety, although rates are lower among children with more remote exposures.[7]

Cumulative stress and the impact on mental health

Being exposed to continued and cumulative stress is especially detrimental to children's well-being, mental health and ability to cope with stress.[33] The cumulative number of adverse events, the degree of exposure and the duration of exposure all consistently increase the risk of poor mental health.[22] Displacement can be especially noxious as it exposes children to an accumulation of more adverse experiences in a cascade effect (e.g., conflict, followed by loss of home, followed by challenging migration journeys).[34] Exposure to significant numbers of adverse childhood experiences (especially with little or no support and protection) puts children at risk of serious psychological problems, with research finding that youth who reported four or more lifetime traumas were at elevated risk of sustained PTS, regardless of gender, age, family or area-level characteristics.[35] Researchers suggest that the number of lifetime traumatic events that displaced children experience could be more consequential for their mental health than just pre-displacement events, which suggests the need for accounting for the displaced child's whole migration experience.[27] This is especially important given that many displaced children continue to experience significant challenges even when 'settled'. Adverse events are particularly detrimental not only in the negative experiences they create, but because virtually all the protective systems for children embedded in normal routines and interactions are disrupted.

The high levels of mental health difficulties among displaced children appear to reflect not only the chronic adversity these children have experienced, but also the lack of intervention and treatment being provided to them. Indeed, researchers have found that continued stressor events and lack of support in resettlement continue to exacerbate mental health problems or create new ones.[36] Studies of unaccompanied minors have found that only 12 to 36 per cent report contact with mental health services.[5] Children who were associated with armed groups often face social stigma and challenges to reintegration, and have limited access to treatment and rehabilitative care.[7] Across all studies, there is a consensus that exposure to violence at any stage of the migration journey, separation from or loss of a parent, and lack of support in resettlement all increase vulnerability to mental health problems.[7,36] The COVID-19 pandemic further added to the cumulative stress experienced by displaced children and created another unique set of stressors, such as increased isolation.[11,37] Thus, dealing with both prior and current stressors that impact mental health is critical.

2. Developmental stages and mental health in displaced children

Not only is forced displacement inherently dangerous, but it also robs children of important developmental milestones that are critical for healthy growth and adjustment. These experiences typically have a detrimental impact across both childhood and adolescence, but exposures, experiences, coping, and mental health are all impacted by developmental timing.[31,38] Older children, for example, have greater coping strategies and independence than younger children; however, older children are more likely to have direct exposure to community-level stressors (e.g., witnessing violence) that precipitate displacement and more knowledge of the implications of forced displacement.[34,39] In contrast, the youngest children are highly vulnerable to the loss and deterioration of effective caregiving and support from their primary caregivers, especially if their parents are also experiencing trauma and mental health problems.[7,34]

Age differences

More and better-targeted, age-disaggregated research on displacement is critically needed. Researchers have largely not been able to examine mental health differences by age among displaced children, and available studies are limited and somewhat mixed in their findings. Researchers overall have reported higher rates of mental health problems in older children compared to younger ones, including higher rates of trauma and challenges to emotional self-control (e.g., 'emotional dysregulation'), PTS, depression and anxiety.[5,20–22,25,32,40] Higher rates in older youth are associated with cumulative and prolonged adversities such as exposure to community violence, sexual abuse, parental neglect, domestic violence, being unaccompanied, having to take on adult roles, and the breaking down of social interactions such as peer relationships.[20,22,25] Younger children are more likely to be accompanied by their parents and to have received refugee status and, therefore, do not have to worry about deportation, as older children often do.[31]

Research reporting higher rates of distress in younger children finds these are largely due to exposure to violence, war and armed conflict. Younger children may have higher risk of developing psychopathology in these conditions due to cognitive immaturity, difficulty in understanding events, disruptions to parenting and loss of caregivers.[20,29] In contrast, older children may be more psychologically resilient,[20] with some research finding that, as children got older, they were better protected against mental health problems.[26] The age when displacement occurs may also have implications for feelings of loss and for connection to place. Younger children may have weaker bonds to their country of origin and fewer memories than adolescents, may not experience as intense or as prolonged feelings of loss or homesickness, and may find it easier to acculturate to a new location.[31]

Contextual considerations

When accounting for age differences in mental health, it is important to consider what is occurring in the environmental context in addition to the developmental stage. For example, exposure to significant violence in early childhood may have long-term repercussions due to disruption of development of trust and feelings of autonomy, whereas young children displaced for other reasons, such as chronic poverty, may have been more sheltered. Youth displaced during adolescence after a short exposure to violent conflict may have benefited from a supportive childhood, increasing their likelihood of resilience to mental health problems.[27,31]

Children who have experienced prolonged and cumulative adversity (at all ages) are most likely to have their mental health detrimentally impacted.[15,41] It is also evident that displaced children who are unaccompanied (who overall are an older population) are especially vulnerable to mental health problems due to lack of parental support, higher risk of exploitation and exposure to community violence.[5,9,26] These youth in particular have a higher risk of PTS symptoms.[21] There are also differential mental health impacts by age depending on where (and if) children and youth are resettled. Children resettled outside of their home countries face risks to their mental health in relation to acculturation challenges, poverty, discrimination, parent mental health problems and family conflicts. Conduct and mental health problems are more commonly associated with older youth who may struggle to orient to the new host culture, compared with younger children.[26] Overall, studies have found that the longer the duration of time in the host country, the lower the levels of mental health problems and the greater the well-being.[21] However, the majority of displaced children and youth typically end up in low- and middle-income countries where resources are scarcer, and families and children are placed in camps for longer periods of time. Children in temporary settlements and camps experience exacerbated mental health problems the longer the length of stay.[26] For young children, camp settings may be especially detrimental as positive parenting behaviours and interactions are often compromised.[20] Resettlement can also lead to loss of income and status, which can impact family functioning and roles, and result in poor parent–child relationships (especially for older children), which affect mental health.[42]

Age and mental health limitations

Overall, the relationship between age and mental health in displaced youth and children is not always clear or consistent, and more research is urgently needed in this area. It is, however, evident that older and younger children may have different needs and experience different stressors during displacement. Most studies do not account for age, or the data provided are not accurate. Further, most studies of mental health focus on children over the age 11, while much less is known about early and middle childhood.[26,43] Symptoms may be missed in young children, or not assessed accurately.[5] For example, mental health problems in young children may manifest themselves in new fears, clinginess, increased aggression, temper tantrums, difficulty sleeping, and somatic symptoms such as stomach aches.[7] Applying a developmental lens when assessing mental health is therefore crucial.

3. Gender and mental health in displaced children

Taking gender into account when assessing mental health in displaced children and youth is also critically needed. Overall, studies have consistently found that girls have a higher risk of mental health problems (most notably depression) compared to boys, and that boys have a higher likelihood of experiencing behavioural problems such as aggression.[6,7,21,22,25,27,35] Researchers also report that mental health problems often co-occur with other diagnoses, such as experiencing both depression and PTS.[20,27] Older girls often report higher numbers of lifetime trauma events and are more likely to report rising and sustained distress which is linked to ongoing family-level domestic violence, mother literacy, poverty and caregiver mental health.[35] Girls' mental health is also linked to higher levels of dissatisfaction with living conditions, feelings of hopelessness for the future and poorer coping strategies.[20] A few studies reported no gender differences in mental health problems in refugee populations specifically, perhaps due to similar experiences of trauma or displacement.[20,25,40] Differences by gender in regard to PTS symptoms specifically appear

less inconsistent, with some studies finding girls having higher levels,[44] and others finding no differences.[21,27,32] Although few studies have looked at interactions between gender and age, some have found that boys have a higher risk for mental health problems prior to adolescence, with girls having a higher risk once they move into adolescence.[21,24]

Contextual considerations

As with age, gender differences in mental health are clearly fuelled by contextual differences, and trauma events at all stages of migration are often heavily gendered. Girls and boys have different likelihoods of exposure to gender-based violence or being recruited as child soldiers, and cultures also vary in the stigma associated with certain experiences such as rape, for boys and girls. Researchers report that girls have higher rates of experiencing sexual abuse and violence across all stages of displacement – in addition to forced marriage and prostitution.[6] Displaced boys also experience sexual violence but are less likely to report such occurrences.[7,11,22] Climate change events such as flooding and droughts also have been associated with significant declines in school attendance, with psychological and emotional consequences including feelings of hopelessness, grief, depression, anxiety and PTS.[12] As education is a tremendous source of resilience, this loss is especially detrimental. Globally, girls are especially vulnerable to educational exclusion, particularly when growing up in fragile or conflict-affected countries, when schools are destroyed by violence or extreme weather events, or if families can no longer afford to send children to school.[1,12]

During resettlement, gendered contextual factors continue to impact mental health. Researchers have found that boys in particular report experiencing high levels of discrimination that detrimentally impacts their mental health.[27] Girls more often report conflict with their caregivers around clothing and other social norms that may differ in their host country compared to their cultural background.[42] Girls may face bigger cultural transitions moving from the gender norms of their home countries to more independent roles in host countries, during a developmentally sensitive stage of identity formation.[6] As research with displaced children and youth continues to grow, these types of dynamics and contexts will be especially important to assess and acknowledge.

4. Subpopulations of special concern

Although all children are vulnerable to mental health concerns due to displacement, researchers have demonstrated that specific subpopulations are especially exposed to risks, marginalization and having reduced access to resources. Studies have most often focused on the mental health implications of displacement for orphaned or unaccompanied children, children with developmental disorders or disabilities, children directly exposed to armed conflict or forcibly recruited as child soldiers, and children living in refugee camps.[11,22] As most displaced children are in low-resource locations, the unique needs of these subpopulations are often not addressed.[b]

Unaccompanied minors

Unaccompanied children are a small percentage of the displaced child population but their numbers are rapidly growing, and they are especially vulnerable to negative life events that increase their susceptibility to poor mental health.[45]

Not only are unaccompanied minors exposed to the same adversities as other displaced children,

[b] There is a notable dearth of evidence and research dedicated to exploring how mental health, age and displacement are further influenced by other intersecting factors such as gender, disability status, sexual identity (LGBTQ+) and membership in marginalized religious and ethnic groups.

they must cope without the support of a caregiver (with many also facing grief and loss due to separation from, or the death of, their parents).[5] Lacking this critical protective source increases the risk of being exposed to additional traumatic experiences, abuse and exploitation.[22,40] Most unaccompanied minors are adolescent males aged 14 to 17 years, although the proportion of younger and unaccompanied minor girls is increasing.[6] Girls are especially vulnerable in the context of being unaccompanied, with an estimated 10 per cent being pregnant or mothers, adding even further emotional difficulties and challenges.[5,6]

Overall, researchers have found that unaccompanied children have higher levels of distress, greater incidence of mental health problems and elevated PTS scores compared with accompanied children.[5,6,40] Research shows that many unaccompanied youth continue to struggle in host countries, facing legal barriers, marginalization, challenges in their social roles, and limited possibilities in regard to education and work.[5] Longitudinal studies with this population of displaced youth show evidence of a chronic trajectory of mental health problems, demonstrating their continued challenges and distress even after resettlement.[26] Given the importance of caregivers for fostering positive adjustment across all stages of childhood, these disrupted relationships are likely to have a long-term impact on the mental health of unaccompanied children.[5]

Children in camps and contexts of detainment

Displacement can result in children living in camps (both in their home and host countries) that are severely under-resourced regarding health, educational and social services.[1,11] Children in camps experience a wide range of stressors that continue to detrimentally impact their mental health, such as substandard living conditions, continued exposure to violence and threats to their safety, lack of access to schooling, and poverty.[7,14,22,25,26] Many children are displaced for extensive periods, making camps a permanent situation rather than a transitory experience.[1,25]

There is additional concern for children who are detained while seeking asylum or engaging in irregular migration. These children have high rates of mental health disorders and significantly higher levels of mental health problems compared with non-detained children.[46] The forcible separation of children from their parents while detained is especially harmful to children's mental health and creates additional trauma.[10,36,46]

Children and youth exposed to armed conflict

Children and youth who experience, witness, or who are forced to participate in, conflict and violence are especially likely to have PTS, depression, anxiety, and behavioural and psychosomatic complaints.[9,20] Researchers note that this population is more vulnerable to toxic stress, with consequences for both their mental and physical health.[11] More frequent and severe trauma (e.g., exposure to bombing or combat, loss of a parent, or experiencing sexual violence) leads to worse psychological outcomes for war-affected children.[16] Youth who were associated with armed groups may additionally experience social stigma and limited access to services, and may be subject to detention.[9] War and armed conflict also increase the risk of children being separated from family members, and result in a higher likelihood of parental psychopathology, which impacts caregiving.[16,29,42]

III. Evidence, research gaps and implications

Although research on displaced children has a history dating back to World War II,[15] the well-being of displaced children remains a critically understudied topic in developmental research. As the literature continues to grow, there are numerous important gaps that will be important to address to move research on the mental health of displaced children and youth forward. As a starting point, in this section we summarize the following key areas as foci for future work: 1) There is a critical need to place children on the move in the context of their families and utilize a family systems approach when assessing mental health; 2) The majority of research on displaced children is focused on mental health risks and fails to integrate a more nuanced resilience perspective that also recognizes strengths and mental well-being of the individual child as well as the supports and protections embedded in their families, relationships and socio-cultural context; 3) More targeted child-sensitive and child-focused research is needed in the context of migration and displacement studies; and 4) Research methodology limitations need to be addressed. The evidence for these areas of importance is discussed below.

1. Family systems, attachment relationships and mental health

Family systems

Most displacements occur within the family context, with stressors impacting families both individually and collectively.[14] (In this sense, 'family' denotes primary caregivers of children, not solely biological parents.) The complexity of these dynamics requires looking at displacement through a family systems and developmental lens.[14] Family systems theory highlights that family members are interconnected, and that change in one individual is likely to influence the behaviours and emotional functioning of the other family members. Given this, it is critical to not just assess children's mental health, but to also understand how the mental health of displaced children is impacted by family functioning and parental stress. The effectiveness and health of primary caregivers is critical. Children's mental health is inextricably linked to their caregivers' mental health and well-being, highlighting the need for consideration of how cumulative adversities disrupt positive family functioning, and how mental health problems can cascade across generations.[20,37,42] While displaced children are exposed to significant adverse experiences across multiple layers of their ecological systems, the family is the most immediate system of influence on children.

Children's experiences of displacement, migration and resettlement are often filtered through the experiences and behaviours of their parents or primary caregivers.[42] The impact of parents who are stressed and experiencing poor mental health can spill over into higher levels of interpersonal conflict between family members, less warmth and harsher parenting behaviours and, in turn, poorer quality of parent–child interactions and lower levels of child well-being.[14,20,40,47] Parents and caregivers therefore can impact children positively – by providing a buffer or 'protective shield' during times of adversity – or they can accentuate the impact of the stress when they themselves are unable to manage the stressors they are experiencing.[34]

Thus, it is evident that the mental health of displaced children is greatly impacted (for better or worse) by parental mental health and coping and parenting behaviours.[14] However, research and intervention with displaced children and youth remain largely focused on the individual child rather than accounting for family relationships.[31]

Attachment relationships

There has also been little attention paid to the role of attachment relationships in the context of displacement. Attachment relationships with caregivers and family members are critical for every aspect of children's functioning, well-being and adjustment across their development. The presence (or absence) of a primary caregiver during exposure to displacement-related stressors can substantially mitigate – or exacerbate – the effect of migration-related stress exposure on children's outcomes.[10] Researchers across multiple contexts have noted the single most fundamental resilience factor for children is having at least one stable, secure relationship with a supportive parent or caregiver.[15,16,48–50] Through facilitating a sense of closeness, safety and confidence, caregivers help children navigate adverse and stressful situations, promote social and emotional development, and positively impact subsequent development and relationships across childhood and into adulthood.

A basic tenet of attachment theory is that children have an innate need to seek physical and psychological proximity to their primary caregivers when they feel distressed, threatened or overwhelmed and, in turn, caregivers provide a safe haven, comfort and support. Attachment relationships also nurture key resilience capacities for the future regarding how children regulate stress, develop emotional regulation, and build cognitive skills and coping strategies.[51,52] Therefore, displaced children and youth who have experienced – or maintain – secure, close relationships that provide a stabilizing sense of safety and security should have better outcomes, despite experiencing migration-related stress and adversity.[31]

Attachment relationships can also help to explain the link between displacement and poor mental health. Exposure to trauma at an early age can disrupt young children's development of trust and autonomy, and children who are separated from their parents can feel less connected to their parents or even abandoned.[29] Young children are particularly susceptible to disruptions to warm and sensitive caregiving, and the impact of these disruptions can equal (or be greater than) the adverse events themselves.[10,29,34] Separation and loss of a caregiver is also salient at later ages, where lack of support, scaffolding and safety is clearly linked to difficulties in interpersonal relationships, emotional distress and mental health problems.[5,10,36] Prior stable attachment relationships in childhood can also be a source of resilience for older youth, likely through building effective coping strategies, social competence and self-esteem.[27,31]

Attachment and family support

Attachment themes are mostly unexplored in the recent displacement literature, although qualitative studies have found that children's own narratives emphasize their need for a safe place or home base where they feel physically and psychologically safe and secure.[30] Children also reported that their relationship and bonds with their primary caregivers provided them with feelings of support and security, and confidence that their families were behind them. This is consistent with studies that have found that positive family life and support is critical for the psychological resilience of displaced children.[34,44] A small portion of the literature also provides evidence of the positive impact of supportive family bonds and family cohesion for displaced youth.[7,11,30]

For example, positive parenting has been found to buffer the impacts of stressful situations that can detrimentally impact the health of children,[18] and family cohesion and support are associated with improved mental health in displaced and refugee children.[27] Being cared for and supported provides important means for children to cope effectively with the stress and transitions across the course of displacement.[30]

Beyond emotional support, families also provide modelling and narratives around the family's ability to mobilize their strengths and cope with past or current adversity.[28,30,37] There is also evidence that efforts by families to provide normal child routines are especially important for children's well-being, notably during transitions such as temporary settlement in refugee camps, or during the lockdowns caused by the COVID-19 pandemic.[34,37,53] Family members, and especially parents, also contribute to children developing a healthy sense of self and of ethnic identity through teaching them their heritage language and cultural practices.[38] The role of the family is also critical in specific contexts – for example, greater familial acceptance and support from families has been associated with more positive mental health trajectories in former child soldiers who often experience high levels of social stigma and marginalization.[11]

Family dysfunction and parental mental health

The protective and buffering effects of primary caregivers and the family are highly dependent on the integrity and quality of the social relationships within the household, as well as the parental emotional well-being. Family dysfunction is the most universal risk factor for poor adjustment, mental health problems and negative outcomes for displaced children and youth.[20] In particular, parental psychopathology and poor mental health are strongly linked to compromised mental health in children and adolescents. These associations can be driven by the impact of mental health problems on poorer, harsher and more disengaged parenting, but also through increasing family conflict, intergenerational violence and trauma.[11,20,22] For example, adolescents in refugee camps who reported higher exposure to physical, verbal and sexual abuse also reported higher levels of anxiety and depression symptoms.[26] Other parental stressors such as barriers to services, financial worries, loss of status, and acculturation challenges can also spill over into the family system and influence children's emotional well-being and mental health.[22,27,37,42]

Recent reviews of the empirical literature have demonstrated that displaced and refugee adults have a high prevalence of both depression and PTS[22] with correlations between parental and children's symptoms,[11,29] as well as evidence that parental PTS and depression were linked to increased risk for harsher parenting and child maltreatment both during displacement and in resettlement.[26,36] Parents who are also affected by trauma are less likely to provide a safe and beneficial environment for their children,[30] with studies finding that parents reported that prior trauma was an impediment to protecting and caring for their children.[42] In contrast, evidence across multiple studies with displaced families in both high- and low-income countries found that the well-being of parents positively impacts children's mental health.[18,21,54] Understanding how displacement stressors impact parents is thus highly critical for understanding the mental health of displaced children, but is largely insufficiently studied.

2. Strengths and resilience

Given the many obstacles that displaced children and youth face, knowledge of how to promote positive adaptation is of critical importance for their future success and for the global societies they are integrating into.[38,55,56] Resilience is the process of adapting well despite experiencing adversity. It does not require extraordinary resources in most cases, but is facilitated by the interaction of basic adaptive systems at the individual, family and community level that foster and protect human development.[57,58] However, research directly focused on resilience and mental health in displaced children is rare. Although identifying the unique vulnerabilities and risks that displaced children face is important, focusing solely on risks paints an incomplete picture. Researchers are increasingly advocating the need to view children's experiences through a resilience and recovery lens, in particular through integrating a focus on assets, strengths, and coping.[15,31,35,37,44,59] While displacement clearly involves stress and loss, displaced children have also demonstrated a remarkable ability to adapt, build new skills and competencies, acquire intercultural competence, exercise agency and initiative, and build a better life.[6,31] Research should therefore assess and acknowledge both vulnerabilities and resilience.

Mental health and resilience

A strengths-based focus is especially important for research on mental health in displaced children, which has taken an overwhelmingly pathological approach. Further, it is important to consider the possibility that poor mental health may be an appropriate response to an aberrant situation, rather than an individual deficit. Although prevalence rates of disorders and distress in displaced children are strikingly high, it is also the case that many children do well despite exposure to severe adversity and stressors.[6,59] Positive mental health and resilience do not necessarily have a linear and unidirectional relationship – it is possible for an individual to show resilience as well as mental health problems.[37] It is also likely that there are mental health benefits in leaving a home community defined by instability and violence for a safer location with support and services. When research focuses solely on mental health problems, positive aspects of mental health such as flourishing, grit, coping, optimism and other 'strengths of the heart' (a term referring to various positive social and emotional skills and competencies) are ignored. Few researchers have examined the role of coping strategies in displaced children and youth, even though the ways these children cope with the adverse experiences and the resources they utilize are likely to be critical to their mental health.[26]

Resilience findings

Although research specifically focused on resilience in displaced children is limited, studies are mostly consistent with the overall resilience literature.[15] Resilience researchers have stressed the importance of assessing resilience utilizing a multisystemic, socio-ecological approach that nests individual, familial, community and societal systems in culturally meaningful ways.[38,43,58,60] At an individual level, studies have found that coping strategies and internal resources such as emotional regulation, cognitive reappraisals, maintaining hope and a positive outlook, and agency are associated with well-being and resilience in displaced children.[6,7,21,26,44] As discussed previously, the integrity and well-being of the whole family unit is crucial for children's mental health and well-being,[21] and research on resilience in displaced children has reinforced this conclusion. Parental support and warmth are fundamental for displaced children's mental health and well-being as well as other important developmental tasks such as school competence, life satisfaction, agency and autonomy.[7,21,30,42,44]

Support and a sense of belonging can also be provided by other individuals in children's broader environment, such as friends, teachers and other adults in the community.[38] Schools are especially important for the mental health and well-being of displaced children and are strongly linked to resilience as well as other positive factors that improve mental health such as self-esteem, self-efficacy, bicultural competence, a sense of belonging, and hope for the future.[7,21,34,44,61] Education is highly valued by many displaced children and their families as a means to improve their lives and futures.[7] Schools not only provide opportunities for learning, but also play a major role in the socialization and acculturation of displaced children.[21] Schools are also an important place for displaced children and youth to make new social connections, especially with their peers. Displaced children with higher levels of peer social support have lower levels of mental health problems such as anxiety and depression, better adjustment and fewer externalizing problems.[14,21] At a society level, maintaining a connection with home culture, religious faith and host community acceptance have been found to have protective effects on mental health and to promote resilience and adaptation to new environments.[7,44]

These studies highlight a few important points. First, just as stressors often snowball and create more adversities, the same is also true for resources – attainment of resources often helps individuals to acquire other resources resulting in what is termed 'resource caravans'.[42,60] Determining what resources spiral into further resources is critically important for creating effective interventions and programming to meet the needs of displaced children and youth. Focusing on biological as well as psychological factors that contribute to both vulnerability and resilience of displaced children is important, given the relationships between physiological markers of stress (such as cortisol) and mental health.[16] There is also a need to account for developmental stages and gender, as certain protective factors may be more important at one age than at another, and for boys or girls specifically.[30,31,43] Last, given the vast cultural backgrounds of displaced children and their families, it is critical for research to identify contextually relevant resilience outcomes and predictors.[11,32,43]

3. Child-sensitive research

Child-sensitive and child-focused research is greatly needed in studies of displacement, as international frameworks often do not take into account child experiences, voices or needs in the displacement or refugee process.[17] The need for solid evidence to develop better policies is critical given that child and youth displacement is likely to continue to dramatically grow in the coming decades. Child-sensitive research is needed to better inform policy to protect child rights and to encourage child and youth engagement and leadership across the migration and settlement process. A child-sensitive focus allows children's own perspectives and lived experiences to be at the forefront of any decision-making about their lives.

Displaced children are children first and foremost and have the same wants and needs as any other child – love and support from their family and friends, a safe place to call home, going to school and feeling they belong. A child-focused and child-sensitive lens on the well-being and mental health of displaced children addresses how best to support child development in the context of transitions that have the potential to both threaten or enhance a child or adolescent's well-being.[22] This involves both viewing children of different groups, ages and gender as active agents, and recognizing and acknowledging their strengths and resilience. Children have different sensitivities and strengths, and child-sensitive research must account for their diverse experiences and identities.

Children as active agents

The Convention on the Rights of the Child states that children have the right to participate in and influence decision-making processes that are relevant to their lives. It is important to not just see displaced children and youth as victims of terrible circumstances, but to recognize that they are active agents and protagonists in how they cope, build resources and navigate their everyday lives.[12,38,62] Displacement can also result in new opportunities, skills and competencies, friendships and the chance to create a better life.[31] Children's resilience, self-efficacy and agency are all fostered by actively incorporating children's voices into research, programming and policies relating to displacement. Promoting children's voices and experiences additionally helps counteract increasing rates of xenophobia and anti-immigrant sentiment around the globe.[6,38]

Children are resilient

As discussed above, a child-focused and sensitive lens also acknowledges the extraordinary resilience and strengths that displaced children have as they navigate the challenges of migration. Displaced children and youth are highly resourceful and demonstrate a remarkable coping capacity.[5,6,20] Much more work is needed on identifying and understanding the trajectories of children and youth who successfully adapt and flourish across their displacement journeys, especially in the context of family and community support. Further, examination of mental health should also include positive markers such as life satisfaction, sense of purpose, social competence, optimism, self-efficacy and self-esteem.[18,21,43] A strengths-based perspective situates children who have assets and capacities at individual, family and community level that promote health and well-being.

In contrast, focusing unilaterally on mental health disorders (while a critical issue) presents a deficit view of children and youth with problems that need to be solved, rather than viewing the potential of these young people as assets and resources to be developed. Most importantly, a strengths-based, child-sensitive perspective locates challenges and stressors in the contexts that surround them rather than in the children themselves.[6] As research progresses, it will be important to better assess different groups and subgroups of children in regard to their resilience capacities and resources depending on their age, backgrounds, and circumstances of their displacement experience.

4. Research methodology limitations

There are significant methodological limitations in research on displaced children and youth that severely limit knowledge and implementation of effective programming. Research can be improved by focusing on the following areas that have been highlighted as significant limitations in multiple systematic reviews.

Methodological limitations

Researchers have noted that there is a need for more scientifically rigorous research designs when working with displaced children and youth. First, much of the country-level data that is collected on displaced populations does not contain reliable age-disaggregated data, limiting knowledge and comparison of populations. This makes it incredibly difficult to apply a developmental lens when assessing displaced children, and most importantly significantly limits how research can meet the needs of differently aged children and youth.[18,25,63] There is a critical need for research to understand better the impact of age and developmental timing on mental health outcomes in

displaced children and youth.[13,17,20,25,29,31,63] Additionally, there are far fewer studies focused on early childhood, and even fewer that assess the impact of displacement across the critical periods of early childhood development.[26,29,43] Very few studies have addressed psychological disorders and distress in displaced young children.[18]

Exacerbating this problem is a lack of longitudinal studies, which results in knowledge gaps about developmental trajectories of adjustment in displaced children.[18,25–27,29,32,63] Cross-sectional studies provide important snapshots of how displaced children and youth are faring but are not instructive in elucidating how mental health symptomology changes over time, the causal mechanisms that contribute to or moderate mental health, or the trajectories of recovery. Having longitudinal data would, for example, allow better assessment of the long-term impacts of living in a refugee camp[25] and of exposure to war and armed conflict,[29] which factors contribute to recovery and resilience over time,[18,63] and what are the critical age points when interventions are most impactful.[18] It is also especially important for researchers to pay more attention to trajectories of positive mental health and markers of flourishing.[18,21,43]

Last, researchers note significant sampling problems, including small unrepresentative samples that are not balanced by child age or gender,[5,32,43] and heterogeneous samples and measures that cannot be applied across different displaced populations, making it difficult to draw unifying conclusions.[21] In particular, there is concern that the majority of scientific research on mental health in displaced children remains narrowly focused on populations in high-income countries, when the majority of refugees and displaced persons flee to neighbouring low- and middle-income countries.[5,18,26] This means that the true prevalence of mental health problems in displaced children and youth is not adequately represented or known.[21]

Contextual limitations

In addition to these methodological limitations, there are important contextual ones. First, researchers note the need for culturally sensitive, but methodologically comparable, studies.[18,25,43,62] Research with displaced persons is challenging due to studies involving many different languages, cultures and countries. Further, high-quality research can be difficult to conduct due to cultural variations in views of mental illness and the role of research.[18] However, the lack of consistency across studies in measures, method, reporters and translations makes it difficult to compare across different studies. Researchers suggest using consistent measurement tools, a combination of both common standardized measures and locally created ones, and better interaction between qualitative and quantitative methodology to better assess consistencies as well as cultural variations.[25,43,62] Culturally grounded measures of risk and resilience can be developed locally from in-depth qualitative work.[64] Although it is important for methods to be applicable across a variety of different contexts, it is also critical for research to recognize that displaced children and youth are not a homogeneous group. Resilience processes may differ as a result of important socio-cultural contexts, and interventions need to be relevant to children and their families to be effective.[32] Highly mobile populations make longitudinal research particularly challenging.

Second, research remains largely focused at the individual level and does not incorporate the family or broader environment. Researchers suggest studies and interventions include family-level variables given the importance of the family across development and the impact of parent well-being on children.[18,32] Studies with displaced children rarely assess family-level variables, and those that do typically only assess parent psychopathology such as PTS (mostly with mothers).[29]

Studies incorporating family-level risk and resilience variables will be important for providing a more complete picture of how proximal processes (both positive and negative) dynamically impact the mental health and well-being of displaced children, and also are critical for informing effective interventions and programming.[14,25] Despite developmental science clearly demonstrating that parenting interventions have a significant positive impact on children's adjustment, little is known about specific parenting difficulties, and the needs of displaced parents.[40] The challenges of parenting in the context of displacement are likely immense. For example, it is likely that displaced parents (as with other caregivers experiencing high levels of stress) engage in ineffective and harsher parenting methods.[40] Current research therefore misses an important entry point for informing interventions aimed holistically at the family unit. Qualitative studies have found that displaced children view resilience as based on a combination of personal strengths and having a supportive environment.[32]

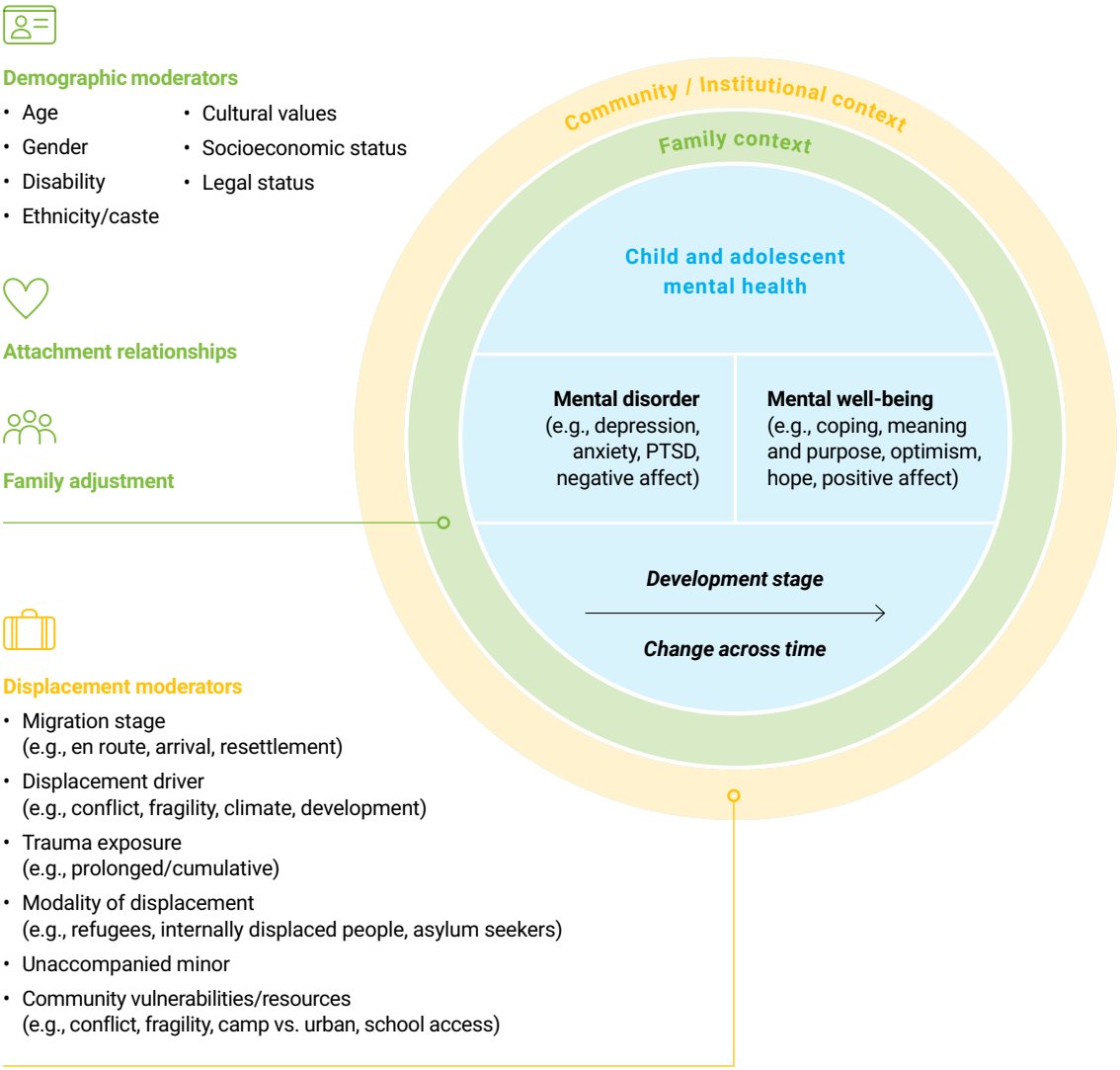
IV. Proposed theoretical framework of mental health in displaced children and youth

Given the present gaps and limitations of research on the mental health of displaced children and youth, we present a conceptual model (Figure 1) to guide future work with this population. Our model utilizes a developmental framework and situates displaced children in their ecological contexts – most importantly, accounting for their family environment. We draw from a socio-ecological approach that seeks to understand key factors shaping children's mental health at the individual, family/household, community and institutional levels. The application of a developmental framework is critical for understanding the mental health of displaced children and youth at different stages of their development, as well as for taking into consideration how mental health may change over time. A family systems lens highlights the family as a unit of analysis, and accounts for the impact of family relationships on mental health and the multiple associations between primary caregivers' mental health and the mental health of children. It also emphasizes the family context as an ecological context that can both buffer displaced children and youth from stressors and poor mental health, and contribute to maladjustment.

Our framework places children at the centre, highlighting the need for displacement research to more clearly focus on the mental health needs of children. We define mental health as including both **mental disorder** (e.g., psychopathology) **and mental well-being** (e.g., coping, positive affect resilience).

Although the majority of research is focused on mental health symptomatology in displaced child populations, it is critical for research to also address positive mental health. Mental well-being should not simply be viewed as absence of (or lower) mental health problems, but should also assess flourishing and positive mental health such as optimism and positive affect. We note the importance of taking into account **developmental stage** as well as **change across time** when assessing mental health in displaced children.

Figure 1: Conceptual model of displaced children's mental health



Central to a life-course approach is a focus on time, in terms of being explicit about the temporal order of exposure to risk factors and the mapping of these exposures onto developmental periods. The displacement experience is characterized as including pre-flight from place of origin, flight from home and living in transit or transitory placement, and resettlement in a new location or returning home. The timing and duration of these three phases can be critical to the mental health trajectories of refugee children and youth. For instance, exposure to the stressful experience of fleeing home during more sensitive periods of development may increase risk of psychiatric disorders.[17]

Next, we highlight the importance of the **family context** in shaping child and adolescent mental health. While displaced children are exposed to significant adverse experiences across multiple layers of their ecological systems, the family is the most immediate system of influence on children. It is critical to not just assess children's mental health, but to also understand how the mental health of displaced children is impacted (for better or worse) by family functioning and parental stress.

Based on the literature summarized above, we posit that addressing **family adjustment and attachment relationships** are important starting points for accounting for how a family system (or a lack thereof, in the case of unaccompanied minors) impacts the mental health of displaced children. Family adjustment accounts for how family members (especially parents) are coping during displacement, and for their mental health in particular. Attachment relationships refer to the family relationship dynamics that are present (or disrupted), such as warmth, cohesion, closeness and trust.

The model also highlights important **demographic moderators** (such as age, gender, ethnicity/caste and cultural values) at the individual and family level that should be accounted for when assessing child and adolescent mental health in the context of displacement. For example, cultural values may provide not only mental health protections (beliefs, practices, rituals, celebrations and community supports), but also cultural adversities such as discrimination, marginalization or stigma.

The model next accounts for the community/institutional context. This level calls for consideration of **moderators distinct to the context of displacement** that influence the family and individual level spheres. These include (a) the stage of a child's migratory journey during displacement – broadly divided into pre-displacement, transit, arrival, longer-term displacement, and later return/integration/resettlement. The driver (b) of initial or recent displacement is a critical determinant not only of a child's experiences in pre- and post-departure, but also influences the length of displacement, and conditions for potential return and reintegration. The presence and nature (c) of prolonged/cumulative trauma, and (d) modality of displacement, which may change several times along a child's journey, consider the profound differences in experience between those in the process of seeking asylum, those in cross-border refugee settings and those who are internally displaced. Closely related, but not synonymous, is the child's legal migratory status, which often determines access to services and rights (e.g., formally recognized refugees under the UNHCR 1951 Refugee Convention, documented versus undocumented status), and exposure to a wide range of vulnerabilities accordingly. The child's status as (e) accompanied vs. unaccompanied is also a critical moderator for understanding factors impacting their mental health, as are (f) the positive resources and negative challenges facing the community in which the child is residing during the various stages of their migratory journey.

Last, the framework identifies both the **original impetus for displacement and the current context of displacement at a point in time** as essential environmental considerations. These moderators call for consideration of the important contextual difference between conflict- and fragility-driven displacement versus climate-driven or development-driven displacement. They also ask researchers to consider the impact on a child's mental health of living amid ongoing conflict/fragility, versus protracted displacement that may persist years after the inciting events compelling a child to leave their community of origin, as well as differentiating between the physical environmental impacts of living in a camp versus urban settings.

V. Recommendations

Based on the present gaps in the research literature and this proposed theoretical model introduced above, we present the following recommendations as first steps for improving the evidence base around mental health for displaced children and youth:

1. **Assess the mental health of displaced children across all stages of their displacement.** Research typically assesses child mental health at one time at one stage of their journey. While this provides important information about the mental health of displaced children, it will be important for research to assess trajectories of children's mental health to better understand how mental health improves or declines (and in what circumstances). Successful adaptation of children over time is critical for the well-being of displaced children as well as for the communities and societies that receive them.[48]

2. **Incorporate a developmental perspective in the study of displaced children.** Currently research fails to differentiate between the mental health needs of children at different ages and stages of their development. Displaced children are developing individuals and their current (and future) mental health should be placed in this context. In particular, there is a need for those working with displaced children to have training and understanding of child development.[1,5] Research should be conducted with children at all stages of their development and should differentiate between the mental health challenges and needs of young children, school-age children and adolescents.

3. **Place the mental health of displaced children into the family context.** The mental health needs of displaced children are clearly situated in the context of their caregivers and family well-being. Family-centred approaches that assess and also target caregivers' mental health, stress and coping, and parenting practices will promote mental health and well-being in the children they tend to.[14,18,20,21,24,40,42]

4. **Identify the key risks that contribute to mental health problems at specific stages of migration and displacement.** There are clear risks that contribute to chronic mental health problems (such as exposure to violence), but research has not differentiated across different contexts such as climate disasters or poverty. Research is also needed that identifies specific risks and their impact on mental health across all stages of displacement, including the pre-migratory phase, migratory phase, and the immediate post-migratory phase.

5. **Focus research efforts on resilience and identify positive mechanisms that could be incorporated into programmes that foster mental well-being in displaced populations, and that buffer displaced children from the adversities that they experience.** It is vital for future research to continue to identify culturally relevant resilience factors that promote adaptive functioning during times of displacement and not solely psychopathology. For example, social connections are consistently highlighted as a protective factor for displaced children and adolescents' development.[59]

6. **Resilience-focused research on child migration must also be undertaken with the understanding that children are diverse.** As research with displaced children increases it will be important to understand and unpack evidence about the mental health of different groups and subgroups of displaced children who may have distinct needs, such as LGBTQ+ children, children with disabilities, street-connected children, and children belonging to marginalized or minority religious, political and geographical communities.

7. **There remains a translation gap between developmental scientists and international humanitarian agencies that needs to be filled.**[33, 65] Developmental scientists have focused less on children in low-income and low-resource countries around the globe but have much to offer the field. Humanitarian organizations often do not have the luxury to conduct or wait for robust evidence-based science in an urgent humanitarian crisis. Bringing humanitarian practitioners and developmental scientists together to span this divide is essential for facilitating best practice knowledge in the care and protection of children in crisis settings.

8. **A resilience-focused lens can also inform applied programmatic evidence generation.** A more nuanced understanding of child migration and mental health, informed by a resilience-focused approach introduced in this paper, can also be adopted by practitioners themselves as they conduct their own agency and cross-agency evaluations, internal monitoring and learnings on what works, and why, in child migration programmes. Embedding a resilience-focused approach into children's mental health is obviously relevant for the design of interventions aimed at enhancing children's psychosocial well-being (e.g., creative arts, play, group therapy and counselling provided through safe/child-friendly spaces in camps, settlements and host communities.) There is, however, equal opportunity for strengthening understanding of other, complementary child protection intervention areas with strong psychosocial elements, which evidence suggests are also particularly effective in achieving child protection outcomes for children and youth engaged in migration. These include programmes aimed at reducing violence against children and gender-based violence, strengthening care, reducing child labour, improving workforce training and preventing unsafe movement.[66]

References

1 Suárez-Orozco, Marcelo M., 'The Catastrophic Migrations of the Twenty-First Century', introduction to *Humanitarianism and Mass Migration: Confronting the world crisis*, 1st ed., edited by Marcelo M. Suárez-Orozco, University of California Press, Oakland, CA, 2019, pp. 1–40.

2 United Nations High Commissioner for Refugees, *Global Trends: Forced displacement in 2020*, UNHCR, Geneva, 2021.

3 United Nations High Commissioner for Refugees, 'Global Trends: Forced displacement', UNHCR, Geneva, 2022, <www.unhcr.org/globaltrends>, accessed 22 August 2022.

4 United Nations High Commissioner for Refugees, 'Refugee Data Finder', UNHCR, Geneva, <www.unhcr.org/refugee-statistics/>, accessed 7 July 2023.

5 von Werthern, Martha, Georgios Grigorakis and Eileen Vizard, 'The Mental Health and Wellbeing of Unaccompanied Refugee Minors (URMs)', *Child Abuse & Neglect*, vol. 98, December 2019, pp. 104–146.

6 Garcia, Maria F., and Dina Birman, 'Understanding the Migration Experience of Unaccompanied Youth: A review of the literature', *American Journal of Orthopsychiatry*, vol. 92, no. 1, 9 December 2021, pp. 79–102.

7 Kadir, Ayesha, et al., 'The Effects of Armed Conflict on Children', *Pediatrics*, vol. 142, no. 6, 5 November 2018, pp. 2018–2586.

8 Betancourt, Theresa S., et al., 'Adolescents and Armed Conflict: War, conflict, and child soldiers', ch. 10 in *Handbook of Adolescent Development Research and Its Impact on Global Policy*, edited by Jennifer E. Lansford and Prerna Banati, Oxford University Press, New York, 2018, pp. 197–216.

9 Kadir, Ayesha, Sherry Shenoda and Jeffrey Goldhagen, 'Effects of Armed Conflict on Child Health and Development: A systematic review', *PLoS One*, vol. 14, no. 1, 16 January 2019, art. e0210071.

10 Cohodes, Emily M., et al., 'Migration-Related Trauma and Mental Health Among Migrant Children Emigrating from Mexico and Central America to the United States: Effects on developmental neurobiology and implications for policy', *Developmental Psychobiology,* vol. 63, no. 6, 22 July 2021, art. e22158.

11 Ataullahjan, Anushka, et al. 'Mitigating Toxic Stress in Children Affected by Conflict and Displacement', *The British Medical Journal,* 371, 19 November 2020, art. m2876.

12 Sanson, Ann V., Judith Van Hoorn and Susie E. L. Burke, 'Responding to the Impacts of the Climate Crisis on Children and Youth', *Child Development Perspectives*, vol. 13, no. 4, December 2019, pp. 201–207.

13 Raikes, Abbie, et al., 'Children, Youth and Developmental Science in the 2015–2030 Global Sustainable Development Goals', *Social Policy Report*, vol. 30, no. 3, Summer 2017, pp. 1–23.

14 Vos, Saskia R., et al., 'The Family Crisis Migration Stress Framework: A framework to understand the mental health effects of crisis migration on children and families caused by disasters', *New Directions for Child and Adolescent Development*, vol. 2021, no. 176, March 2021, pp. 41–59.

15 Masten, Ann S., 'Resilience of Children in Disasters: A multisystem perspective', *International Journal of Psychology*, vol. 56, no. 1, February 2021, pp. 1–11.

16 Werner, Emmy E., 'Children and War: Risk, resilience, and recovery', *Development and Psychopathology*, vol. 24, no. 2, May 2012, pp. 553–558.

17 Yoshikawa, Hirokazu, Alice J. Wuermli and J. Lawrence Aber, 'Mitigating the Impact of Forced Displacement and Refugee and Unauthorized Status on Youth: Integrating developmental processes with intervention research', ch. 8 in *Humanitarianism and Mass Migration: Confronting the world crisis*, 1st ed., edited by Marcelo M. Suárez-Orozco, University of California Press, Oakland, CA, 2019, pp. 186–206.

18 Frounfelker, Rochelle L., et al., 'Mental Health of Refugee Children and Youth: Epidemiology, interventions, and future directions', *Annual Review of Public Health*, vol. 41, 2 April 2020, pp. 159–176.

19 Hou, Wai-Kai, et al., 'Everyday Life Experiences and Mental Health Among Conflict-Affected Forced Migrants: A meta-analysis', *Journal of Affective Disorders*, vol. 264, 1 March 2020, pp. 50–68.

20 Arakelyan, Stella, and Alastair Ager, 'Annual Research Review: A multilevel bioecological analysis of factors influencing the mental health and psychosocial well-being of refugee children', *Journal of Child Psychology and Psychiatry*, vol. 62, no. 5, May 2021, pp. 484–509.

21 Scharpf, Florian, et al., 'A Systematic Review of Socio-Ecological Factors Contributing to Risk and Protection of the Mental Health of Refugee Children and Adolescents', *Clinical Psychology Review*, vol. 83, February 2021, art. 101930.

22 Reed, Ruth V., et al., 'Mental Health of Displaced and Refugee Children Resettled in Low-Income and Middle-Income Countries: Risk and protective factors', *The Lancet*, vol. 379, no. 9812, 21 January 2012, pp. 250–265.

23 Fazel, Mina, Ruth V. Reed and Alan Stein, 'Refugee, Asylum-Seeking and Internally Displaced Children and Adolescents', ch. 44 in *Rutter's Child and Adolescent Psychiatry*, 6th ed., edited by Anita Thapar et al., John Wiley & Sons Ltd., Oxford, 2015, pp. 573–585.

24 Kien, Christina, et al., 'Prevalence of Mental Disorders in Young Refugees and Asylum Seekers in European Countries: A systematic review', *European Child & Adolescent Psychiatry*, vol. 28, no. 10, October 2019, pp. 1295–1310.

25 Vossoughi, Nadia, et al., 'Mental Health Outcomes for Youth Living in Refugee Camps: A review', *Trauma, Violence & Abuse*, vol. 19, no. 5, December 2018, pp. 528–542.

26 Scharpf, Florian, et al., 'A Socio-Ecological Analysis of Risk, Protective and Promotive Factors for the Mental Health of Burundian Refugee Children Living in Refugee Camps', *European Child & Adolescent Psychiatry*, vol. 30, no. 10, October 2021, pp. 1651–1662.

27 Fazel, Mina, et al., 'Mental Health of Displaced and Refugee Children Resettled in High-Income Countries: Risk and protective factors', *The Lancet*, vol. 379, no. 9812, 21 January 2012, pp. 266–282.

28 Iraklis, Grigoropoulos, 'Facing Forced Displacement: Overcoming adverse childhood experiences', *Journal of Child & Adolescent Trauma*, vol. 14, no. 2, 17 August 2020, pp. 261–269.

29 Slone, Michelle, and Shiri Mann, 'Effects of War, Terrorism and Armed Conflict on Young Children: A systematic review', *Child Psychiatry & Human Development*, vol. 47, no. 6, December 2016, pp. 950–965.

30 Iraklis, Grigoropoulos, 'Family Bonds in the Midst of Adversity: Insights into refugee children's coping ways', *Clinical Child Psychology and Psychiatry*, vol. 26, no. 1, January 2021, pp. 222–230.

31 Juang, Linda P., et al., 'Using Attachment and Relational Perspectives to Understand Adaptation and Resilience Among Immigrant and Refugee Youth', *American Psychologist*, vol. 73, no. 6. September 2018, pp. 787–811.

32 Tam, Stephanie Y., Shea Houlihan and G. J. Melendez-Torres, 'A Systematic Review of Longitudinal Risk and Protective Factors and Correlates for Posttraumatic Stress and Its Natural History in Forcibly Displaced Children', *Trauma, Violence & Abuse*, vol. 18, no. 4., October 2017, pp. 377–395.

33 Masten, Ann S., et al., 'Children in War and Disaster', vol. 4, ch. 18 in *Handbook of Child Psychology and Developmental Science*, 7th ed., edited by Richard M. Lerner, John Wiley & Sons Ltd., Oxford, 2015, pp. 1–42.

34 Oberg, Charles, Hopewell Hodges and Ann S. Masten, 'Risk and Resilience of Somali Children in the Context of Climate Change, Famine, and Conflict', *Journal of Applied Research on Children: Informing Policy for Children at Risk*, vol. 12, no. 1, November 2021, art. 10.

35 Panter-Brick, Catherine, et al. 'Trauma Memories, Mental Health, and Resilience: A prospective study of Afghan youth', *Journal of Child Psychology and Psychiatry*, vol. 56, no. 7, July 2015, pp. 814–825.

36 Mares, Sarah, 'Mental Health Consequences of Detaining Children and Families Who Seek Asylum: A scoping review', *European Child & Adolescent Psychiatry*, vol. 30, no. 10, October 2021, pp. 1615–1639.

37 Browne, Dillon T., Jackson A. Smith and Jean de Dieu Basabose, 'Refugee Children and Families During the COVID-19 Crisis: A resilience framework for mental health', *Journal of Refugee Studies*, vol. 34, no. 1, March 2021, pp. 1138–1149.

38 Pérez, Isabela E., et al. 'An Interdisciplinary Framework Examining Culture and Adaptation in Migrant Children and Adolescents', *New Directions for Child and Adolescent Development*, vol. 2021, no. 176, March 2021, pp. 13–39.

39 Joos, Celina M., Ashley McDonald and Martha E. Wadsworth, 'Extending the Toxic Stress Model into Adolescence: Profiles of cortisol reactivity', *Psychoneuroendocrinology*, vol. 107, September 2019, pp. 46–58.

40 Yaylaci, Fatima T., 'Trauma and Resilient Functioning among Syrian Refugee Children', *Development and Psychopathology*, vol. 30, no. 5, December 2018, pp. 1923–1936.

41 Masten, Ann S., and Frosso Motti-Stefanidi, 'Multisystem Resilience for Children and Youth in Disaster: Reflections in the context of COVID-19', *Adversity and Resilience Science*, vol. 1, no. 2, 25 June 2020, pp. 95–106.

42 Betancourt, Theresa S., et al., 'We Left One War and Came to Another: Resource loss, acculturative stress, and caregiver–child relationships in Somali refugee families', *Cultural Diversity and Ethnic Minority Psychology,* vol. 21, no. 1, January 2015, pp. 114–125.

43 Tol, Wietse A., Suzan Song and Mark J. D. Jordans, 'Annual Research Review: Resilience and mental health in children and adolescents living in areas of armed conflict – A systematic review of findings in low- and middle-income countries', *Journal of Child Psychology and Psychiatry*, vol. 54, no. 4, April 2013, pp. 445–460.

44 Pieloch, Kerrie A., Mary Beth McCullough and Amy K. Marks, 'Resilience of Children with Refugee Statuses: A research review', *Canadian Psychology*, vol. 57, no. 4, November 2016, pp. 330–339.

45 El Baba, Reem, and Erminia Colucci, 'Post-Traumatic Stress Disorders, Depression, and Anxiety in Unaccompanied Refugee Minors Exposed to War-Related Trauma: A systematic review', *International Journal of Culture and Mental Health*, vol. 11, no. 4, 20 August 2017, pp. 1–14.

46 von Werthern, Martha, et al., 'The Impact of Immigration Detention on Mental Health: A systematic review', *BMC Psychiatry*, vol. 18, no. 1, 6 December 2018, art. 382.

47 Masarik, April S., and Rand D Conger, 'Stress and Child Development: A review of the family stress model', *Current Opinion in Psychology*, vol. 13, February 2017, pp. 85–90.

48 Motti-Stefanidi, Frosso, 'A Multisystem Perspective on Immigrant Children and Youth Risk and Resilience: A commentary', *New Directions for Child and Adolescent Development*, vol. 2021, no. 177, May 2021, pp. 219–227.

49 Masten, Ann S., and Margaret O'Dougherty Wright, 'Resilience over the Lifespan: Developmental perspectives on resistance, recovery, and transformation', ch. 11 in *Handbook of Adult Resilience*, edited by John W. Reich, Alex J. Zautra and John Stuart Hall, The Guilford Press, New York, 2010, pp. 213–217.

50 Luthar, Suniya S., 'Resilience in Development: A synthesis of research across five decades', ch. 20 in *Developmental Psychopathology – Volume 3: Risk, disorder and adaptation*, 2nd ed., edited by Dante Cicchetti and Donald J. Cohen, John Wiley & Sons, Inc., Hoboken, NJ, 2006, pp. 739–735.

51 Center on the Developing Child, 'A Guide to Toxic Stress', Cambridge, MA, 2018, <https://developingchild.harvard.edu/guide/a-guide-to-toxic-stress/#:~:text=Excessive%20Stress%20Disrupts%20the%20Architecture,prolonged%20adversity%20without%20adult%20support>, accessed 7 July 2023.

52 Shonkoff, Jack P., et al., 'The Lifelong Effects of Early Childhood Adversity and Toxic Stress', *Pediatrics*, vol. 129, no. 1, January 2012, pp. e232–e246.

53 You, Danzhen, et al., 'Migrant and Displaced children in the Age of COVID-19: How the pandemic is impacting them and what can we do to help', *Migration Policy Practice*, vol. X, no. 2, April–June 2020, pp. 32–39.

54 Betancourt, Theresa S., et al., 'Addressing Mental Health Disparities in Refugee Children through Family and Community-Based Prevention', ch. 6 in *Humanitarianism and Mass Migration: Confronting the world crisis*, 1st ed., edited by Marcelo M. Suárez-Orozco, University of California Press, Oakland, CA, 2019, pp. 137–164.

55 Motti-Stefanidi, Frosso, 'Resilience Among Immigrant Youths: Who adapts well, and why?', *Current Directions in Psychological Science*, vol. 28, no. 5, August 2019, pp. 510–517.

56 Suárez-Orozco, Carola, et al., 'An Integrative Risk and Resilience Model for Understanding the Adaptation of Immigrant-Origin Children and Youth', *American Psychologist*, vol. 73, no. 6, September 2018, pp. 781–796.

57 Masten, Ann S., 'Ordinary Magic. Resilience processes in development', *American Psychologist*, vol. 56, no. 3, March 2001, pp. 227–238.

58 Ungar, Michael, Mehdi Ghazinour and Jörg Richter, 'Annual Research Review: What is resilience within the social ecology of human development?', *Journal of Child Psychology and Psychiatry*, vol. 54, no. 4, April 2013, pp. 348–366.

59 Motti-Stefanidi, Frosso, 'A Multisystem Perspective on Immigrant Children and Youth Risk and Resilience: A commentary', *New Directions for Child and Adolescent Development*, vol. 2021, no. 177, May 2021, pp. 219–227.

60 Ager, Alistair, and Janna Metzler, 'Where There Is No Intervention: Insights into processes of resilience supporting war-affected children', *Peace and Conflict: Journal of Peace Psychology*, vol. 23, no. 1, February 2017, pp. 67–75.

61 Dehnel, Rebecca, et al., 'Resilience and Mental Health Among Syrian Refugee Children in Jordan', *Journal of Immigrant and Minority Health*, vol. 24, no. 2, April 2022, pp. 420–429.

62 Noack, Peter, 'Migrant Youths: Typical aspects of development during the adolescent years, specific challenges of growing up somewhere else, and some things we need to understand better', *New Directions for Child and Adolescent Development*, vol. 2021, no. 176, March 2021, pp. 245–254.

63 Blackmore, Rebecca, et al., 'Systematic Review and Meta-Analysis: The prevalence of mental illness in child and adolescent refugees and asylum seekers', *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 59, no. 6, June 2020, pp. 705–714.

64 Panter-Brick, Catherine, et al., 'Resilience in Context: A brief and culturally grounded measure for Syrian refugee and Jordanian host-community adolescents', *Child Development*, vol. 89, no. 5, September/October 2018, pp. 1803–1820.

65 Ager, Alistair, et al., 'Defining Best Practice in Care and Protection of Children in Crisis-Affected Settings: A Delphi study', *Child Development*, vol. 81, no. 4, July/August 2010, pp. 1271–1286.

66 Overseas Development Institute, International Labour Organization, International Organization for Migration and United Nations High Commissioner for Refugees, *What Works to Protect Children on the Move: Rapid evidence assessment*, United Nations Children's Fund, New York, July 2020.

Acknowledgements

This working paper was written by: Zoe E. Taylor, PhD, Department of Human Development and Family Science, Purdue University, and Josiah Kaplan, PhD, UNICEF Innocenti – Global Office for Research and Foresight. The authors would like to thank Anne Masten, Regents Professor, Irving B. Harris Professor of Child Development and Distinguished McKnight University Professor at the Institute of Child Development in the College of Education and Human Development at the University of Minnesota, and April Masarik, Associate Professor in the Department of Psychological Science at Boise State University, for their review, and Bo Viktor Nylund, Ramya Subrahmanian, Satoshi Watarai, Tara Dooley, Kathleen Edison, and Grace Leong for further technical support.

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Via degli Alfani 58

50121, Florence, Italy

Tel: (+39) 055 20 330

Email: innocenti@unicef.org

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Suggested citation

Taylor, Zoe E., and Josiah Kaplan, 'Mental Health in Displaced Child and Youth Populations: A Developmental and Family Systems Lens', UNICEF Innocenti Working Paper, UNICEF Innocenti – Global Office of Research and Foresight, Florence, September 2023.

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