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Adolescent mental health and displacement from and into low- and middle-income countries

CONCEPTUAL MAP & LITERATURE REVIEW

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Conceptual map and literature review

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EXECUTIVE SUMMARY

BACKGROUND

The review was conceptualized as part of a wider effort to explore diverse experiences of displacement, to develop a shared understanding of displacement's relationship with mental health across academic disciplines, and to co-design methodologies for understanding the impacts of these diverse displacement experiences. The review represents the beginning of these efforts, as the inter-disciplinary team sought to develop a shared understanding of the state-of-the-art literature on this subject.

REVIEW QUESTIONS

To meet the overall aim of the review we identified literature to answer the following review questions:

- What is the nature and extent of literature on the impact of forced displacement from, within and between low- and middle-income countries on adolescent mental health? (RQ1)
- Which factors related to forced displacement from, within and between low- and middle-income countries are thought to impact adolescent mental health? (RQ2)

FINDINGS:

***Defining displacement*:**

- There was variation in how displaced adolescents are referred to across studies.
- None discussed displacement as a feeling of 'un-homing', but all of the studies focused on forced physical relocation either within a country or between countries
- Displaced adolescents were mainly referred to as 'refugees', even though in some cases they are not legally recognized as refugees by the host governments.
- 'Refugee unaccompanied children' was used interchangeably with 'refugee' / 'unaccompanied children' and the term internally displaced adolescents also featured.

Cross-Cutting Themes

Age and mental health outcomes

- Adolescents are sensitive to the adverse effects of exposure to highly negative social experiences, such as war (Mirabolfathi, 2020).
- Younger adolescents have stronger reactions to traumatic experiences than older children (Oppedal et al., 2018); which may be due to working memory capacity which is still developing (Mirabolfathi, 2020); as more highly developed cognitive abilities in older adolescents facilitated adaptive coping (Barenbaum 2004, Betancourt & Khan, 2008).
- However, older age was significantly associated with incidence of anxiety-related disorders (Gormez, 2018).

Gender and mental health outcomes

- Female gender was associated with all mental health problems, despite boys reporting more traumatic experiences (Eruyer, 2018, Kandemir, 2018).
- However, we note that most studies assess depression and anxiety, which are both internalising symptoms that are more typically associated with female gender.
- Environmental factors – particularly adolescents' mobility around their neighbourhood or camp – play a moderating role, which intersects with gender: girls' mobility is restricted and therefore less likely to build potential support networks outside of the home (Betancourt, 2012, also noted as a potential mental health factor by DeJong, 2017).

Mental Health Factors

Structural determinants

This review identified 11 structural determinants of health that caused or exacerbated mental health disorders. These determinants were:

- Experience of or exposure to violence
- Inability to go to school
- Lack of food or water
- Indirect exposure to violence
- Change or loss of culture (including acculturative stress)
- No shelter/ poor living conditions
- Restriction of movement
- Exposure to unhygienic conditions
- No access to medical care
- Poverty
- Undertreatment of mental health disorders

Proximal conditions

A total of 27 studies looked at one or more factors belonging to adolescents' proximal conditions. The factors identified under proximal conditions included:

- Difficulties adjusting to new country/society
- Being separated from family/communities
- Loss/death of family
- Loss of material possessions
- Living in a formal camp
- Feeling (un)safe
- Sexual abuse or assault
- Change in relationship with parents/parental stress
- Lack of social support
- Parental/caregiver depression (or other caregiver MH condition)
- Family conflicts
- Intimate partner violence

CONCLUSION

This review has shown that there is evidence that adolescents who have been displaced are at high risk of having poor mental health. The scholarship has shown that displacement is a multidimensional event, which can be associated with different dimensions and factors that affect mental health, across the displacement trajectory. Mechanisms which connect specific experiences of displacement with worse mental health outcomes are still poorly understood. Whilst all of the papers included in this review focused on adolescents, few compared mental health outcomes between age groups. Limitations of research findings might be partially due to difficulties conducting research with adolescents who have been displaced. However, few papers discussed methodologies and research contexts in detail, and therefore it is difficult to say what factors influenced research design. Thus, as mental health research is increasingly becoming focused on mechanisms, displaced adolescents living in LMICs must be included in developing understandings of mental health.

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INTRODUCTION

Purpose of the review

This systematic literature review was undertaken to understand the nature and extent of literature on the impact of forced displacement on adolescent mental health. It focused on forced displacement within and between low- and middle-income countries. It examined which factors and mechanisms related to forced displacement are thought to impact adolescent mental health in the existing literature.

The review was conceptualized as part of a wider effort to explore diverse experiences of displacement, to develop a shared understanding of displacement's relationship with mental health across academic disciplines, and to co-design methodologies for understanding the impacts of these diverse displacement experiences. The review represents the beginning of these efforts, as the inter-disciplinary team sought to develop a shared understanding of the state-of-the-art literature on this subject. The team was from social science, child health, global health and urban planning, and team members worked collaboratively to produce a search and analytical framework for the systematic review.

Questions we have asked in the review focus on definitions of displacement in the literature, and on the ways that scholars have conceptualized the relationship between displacement and mental health. Specifically, in this report, we focus on definitions of displacement and the conceptualisations of the relationship between displacement and mental health by drawing on key empirical literature.

Defining adolescence, mental health and displacement

Displacement, adolescence and mental health all occupy important places in international policy. Displaced people are implicitly and explicitly included in principals underpinning the Sustainable Development Goals (SDGs). Adolescent girls are mentioned in relation to Goal 2.2 (malnutrition), and Goal 3.7 (sexual and reproductive healthcare). Mental health is mentioned in SDG 3.4: reduce pre-mature mortality from non-communicable diseases. However, there is no dedicated Goal for addressing the health of displaced people, let alone adolescents and their mental health. Understanding the link between displacement, adolescence and mental health can support the achievement of the SGDs and to adolescents affected by displacement, by indicating areas of focus for interventions and guiding the design of those interventions.

All three of these key terms are associated with a wide range of literature, and there is considerable disparity in the definitions which scholars use for each term. This impinges on any systematic review of these three terms and the relationship between them. We briefly summarise our definition of each term, drawing on contemporary debates in different disciplines.

Adolescence is a distinct life phase between childhood and adulthood, which encompasses elements of biological change (including hormonal and physical changes) as well as major social role transitions (Sawyer et al., 2018). Susan Sawyer and her colleagues propose that a definition of 10-24 years corresponds more closely

to these changes than the framing which takes 18 years old as a cut-off point between childhood and adulthood (*ibid*). This poses a major challenge for reviewing literature about adolescence, since 10-24 blurs the lines between childhood and adulthood, and sufficiently disaggregated data by age is rarely available. Hence, whilst we know that 40% of the world's 79.5 million displaced people are children (UNHCR, 2022), the actual scale of adolescent displacement is not known.

Literature on displacement tends to refer to people who have been physically displaced (internal and cross-border) due to war, conflict, and persecution (Lubkemann, 2008). However, displacement can be used to refer to a diverse set of experiences of 'un-homing' (Elliott-Cooper, Hubbard & Lees, 2020), which can include severely reduced feelings of belonging in the place one lives and feeling as though one might have to move home because of economic, social, or political changes or major redevelopment projects (Atkinson, 2015; Elliot-Cooper, 2020; Yiftachel, 2020). Scholars working in HICs and LMICs have been pushing the boundaries of what ought to be recognized as displacement, including physical movement from one place to another, and emotional or 'affective' displacements in place (Nixon, 2011). We apply a broad definition of displacement, to include any experience of being 'un-homed', through forced physical relocation and displacement-in-place.

In this review, we understand mental health to include the absence of clinical disorders, and a state of wellbeing, capacity to realise abilities, cope with stress, and contribute to communities (WHO, 2013). Displacement has been linked to increased likelihood of clinical disorders, and to reduced states of wellbeing (Siriwardhana & Stewart, 2013). In the literature on displacement as an experience of 'un-homing', anxiety about losing one's home are pivotal to understanding when people are in the process of being displaced, or have been displaced in place (Atkinson, 2015). In this sense, mental health and ill-health can become the mode through which we understand displacement to be happening.

Implications of previous work

Adolescent mental health in contexts of displacement is not a new field. This review follows on from Reed et al. (2012)'s review of risk and protective factors to displaced children and adolescents' mental health in LMIC in 27 studies. The authors use their findings to adapt Bronfenbrenner's ecological model for human development. This model [Fig. 1] illustrates the migration journey (pre-, peri- and post-migration) and the factors which affect migration (individual, family, community, society). Reed et al. recognize that adolescents who are displaced experience a 'double disruption to developmental and cultural continuity'; associated with forging important developmental trajectories whilst burdened with certain challenges related to displacement.

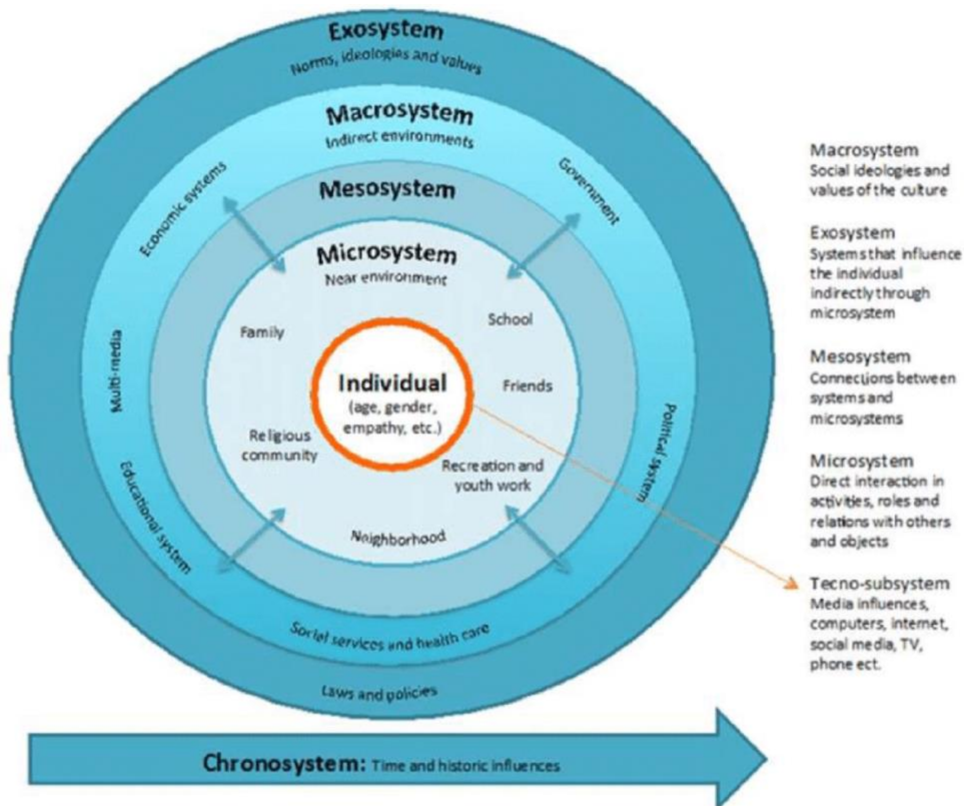

Figure 1. Bronfenbrenner's ecological model of human development. (Currie & Morgan (2020))

In the same year that Reed et al. published their review, two foundational papers were published on adolescent health. For the purposes of this review, we have drawn on the framework Sawyer et al. (2012) propose [Fig. 2], and adapt it using Viner et al. (2012)'s social determinants of adolescent health.

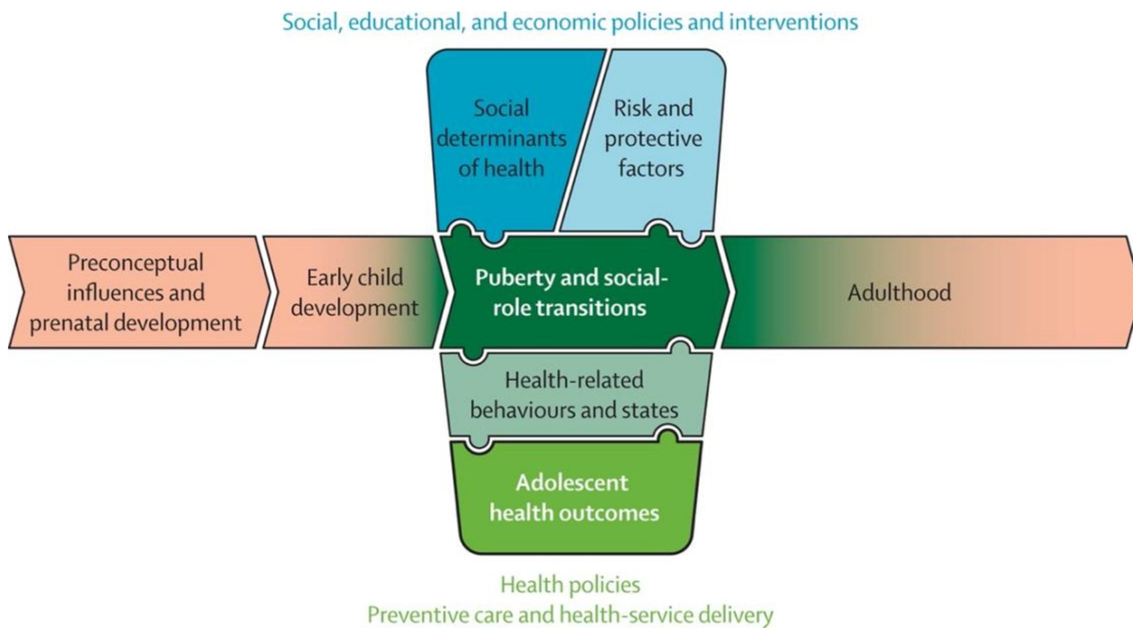

Figure 2. Sawyer et al. (2012). Conceptual framework for adolescent health

Sawyer et al.'s framework provides more detail about the impacts of health-related behaviors on health outcomes. This recognises that adolescents respond to societal, community, and family factors, and that these responses are capable of changing health-related outcomes. It also includes earlier childhood or adolescent experiences, and therefore accounts for events or contexts which have an ongoing effect on adolescent health. Viner et al. (2012)'s framework examines the social determinants of health and divides these determinants into two different levels, structural determinants and proximal determinants.

We've used Sawyer et al., (2012) and Viner et al. (2012)'s adolescent health frameworks to categorise the factors of displacement identified in the review into five dimensions:

1. Structural determinants of health (the broad circumstances in which people live i.e. the economic, political, social, environmental and cultural conditions that affect the health of these individuals e.g. income inequality, employment opportunities, war and conflict);
2. Social stratification (status inequalities between individuals within a social system)
3. Proximal conditions (the circumstances of daily life, from the quality of family environment and peer relationships, through availability of food, housing, and recreation, to access to education);
4. Health-impacting behaviours (e.g. sexual risk, substance misuse, coping, withdrawal); (Viner et al. (2012) place this underneath 'proximal conditions').
5. Earlier childhood or adolescent experiences (informed by Sawyer et al. 2012's model of adolescent health)

In the following section, we outline the review questions, scope of the review and methodology. In the findings section, we provide a summary of scholars' definitions of displacement and of the study population. We provide a summary of cross-cutting themes. We then provide more in-depth review of the displacement factors which affect adolescent mental health, which are structured by the five dimensions of adolescent mental health. We summarise gaps in the conceptual framework, and identify potential areas of interest for further research.

REVIEW QUESTIONS

To meet the overall aim of the review we identified literature to answer the following review questions:

RQ1: What is the nature and extent of literature on the impact of forced displacement from, within and between low- and middle-income countries on adolescent mental health?

RQ2: Which factors related to forced displacement from, within and between low- and middle-income countries are thought to impact adolescent mental health?

REVIEW SEARCH

Searching for studies to answer the review questions involved a broad and sensitive search strategy. Drawing on our previous experience of conducting reviews on mental health and young people in low- and middle-income countries (Bangpan et al. 2018) we

developed comprehensive search strings for each database using combinations of the three key concepts in the review: displacement, mental health and adolescents. Our searches used different free text and controlled vocabulary terms for each of these concepts, linked by the boolean operator OR before being combined into a final search string using the Boolean operator "AND". The following databases were searched by team members in March 2020: ASSIA (Applied Social Science Index and Abstracts); CINAHL (Cumulative Index to Nursing & Allied Health); EMBASE (Excerpta Medica dataBASE); PsychInfo; Scopus; Medline. Searches were restricted by language (English only), date (1980) and type of publication (e.g. excluding thesis and dissertations).

Review scope

The review exclusion criteria were:

- Publication date: published before 2010
- Language: Not in the English language
- Location: Sample populations not originating in LMICs
- Topic: Not about displacement and mental health or psychosocial wellbeing
- Population: Not aged between 10-24
- Type of publication: dissertations or policy papers (we recognise the immense value in knowledge generated by students and by researchers working in policy. However, we decided not to include these in this review because finish)

SCREENING AND CODING

Search results were imported into systematic review software, EPPI-Reviewer (Thomas et al., 2010). We piloted the inclusion criteria by comparing decisions by two reviewers using an inclusion worksheet with guidance notes. Differences were resolved through discussion. Each reference was screened on titles and abstract. Full reports were obtained for those references judged as meeting the inclusion criteria or where there is insufficient information from the title and abstract to assess the relevance. After completing this process, we included 37 studies in the review.

The reviewers extracted data from the included studies using a data extraction tool developed for this review. Again, the data extraction tool was piloted by reviewers on a set of the studies included in the review. Key descriptive information was extracted from all included studies to provide an overview of the field e.g.: bibliographic details (date, type of publication) geographical location, population details, types of mental health outcomes measured), before further review-specific coding tools, involving the extraction of more detailed characteristics (e.g. study design, definitions of displacement, findings) were developed for the final analysis.

SYNTHESIS

To answer RQ1 we coded and described studies to generate an overview of the nature and extent of research in the field. This evidence mapping was used to locate and synthesize studies to answer RQ2 on the possible factors contributing to, and the impact of, forced displacement on adolescent mental health. This was achieved by producing a narrative account of the complex interplay between the process of displacement, including the various ways being 'un-homed' is conceptualised in the literature, and mental health and psychosocial wellbeing. We drew on both theoretical

(e.g., conceptual arguments) and empirical data to generate and substantiate our claims. We tested and refined our narrative synthesis via a stakeholder consultation exercise before finalizing and developing it further. Stakeholders included academics working on AMH, forced migration, and AMH in low- and middle-income contexts

RESULTS

FINDINGS 1: RESEARCHERS' DEFINITIONS

Definitions of displacement from the literature

Displacement is framed as a 'decision to leave' which was 'generally only undertaken after an extreme event catalysed a need to protect family members from death, rape, imprisonment and/or torture' (Boswall, 2015). The UN definition of forced displacement was also used: fleeing home due to 'persecution, conflict, violence, human rights violations or events seriously disturbing public order', 'dislocations' due to war in the homeland or (urban) economic hardship (Chen, 2012, Panter-Brick, 2014).

In Massad (2017), the study population was forcibly relocated to provide space for Israeli settlement growth, military firing zones and newly declared nature reserves. This study moves closer to a broader understanding of displacement, which could encompass displacement due to war, but also, possibly, urban planning projects determined by the logics of settler colonialism.

There was variation in how displaced adolescents are referred to, and some of these studies use more than one term. Displaced adolescents are mainly referred to as 'refugees', even though in some cases they are not legally recognized as refugees by the host governments e.g. in Lebanon[1]. One study refers to adolescents as immigrants or migrants, which seemed to reflect the legal processes where the study was conducted. 'Refugee unaccompanied children' was used interchangeably with 'refugee'/'unaccompanied children'. 6 studies (Badri (2012); Makhoul (2011); Maksimovic (2011); Massad (2017); Mels (2010); Sakhelashvili (2016)) referred to internally displaced adolescents. Although internally displaced adolescents represent a larger proportion of displaced adolescents, they are underrepresented in this literature (60% of displaced people are internally displaced (UNHCR, 2020). Notably, none of the studies discussed displacement as a feeling of 'un-homing', but all of the studies focused on forced physical relocation either within a country or between countries.

[1] 'Refugee' is an internationally-acknowledged term which is associated with a series of obligations for host countries (Nassar & Stel, 2019), and some governments have avoided using the term in order 'to avoid undertaking obligations such a designation demands' (ibid).

Table 1 Population: displacement

Displacement	Number of studies
Refugees	29
Forcibly displaced	5
Internally displaced	5
Immigrants/migrants	1

Definitions of study population age
In our inclusion/exclusion criteria, we follow Sawyer et al.'s range of 10-24. These studies looked at age ranges which cross these age groups and cross early/mid/late adolescence. We didn't find a study which looked at this entire group.

Table 2 Population: Age

Age range	Number of studies
Age: Adolescents Only	N=24
Age: 10-25 (or falls in this range)	N=22

FINDINGS 2: CROSS-CUTTING THEMES

Age and mental health outcomes
Adolescents are particularly sensitive to the adverse effects of exposure to highly negative social experiences, such as war (Mirabolfathi, 2020). However, such 'negative social experiences' are not limited to displaced adolescents (Mirabolfathi 2020) nor do they affect adolescent populations to the same extent (Massad, 2017). Findings are equivocal about older age being a risk or protective factor. Younger adolescents have stronger reactions to traumatic experiences than older children (Oppedal et al., 2018). They are also slightly more likely to report PTSD symptoms (Mels, 2010), and have worse mental health (Massad, 2017). Effects may be particularly pronounced in adolescents whose working memory capacity is still developing (Mirabolfathi, 2020). More highly developed cognitive abilities in older adolescents facilitated adaptive coping (Barenbaum 2004, Betancourt & Khan, 2008) (in Mels, 2010). However, older age was significantly associated with incidence of anxiety-related disorders (Gormez, 2018).

Gender and mental health outcomes
10 studies explicitly compare mental health outcomes across genders. Studies mainly assess the following clinical disorders: depression (n=7), PTSD (n=5), anxiety (n=4). We note that eating disorders were not identified, nor did risk of suicide. Female gender was associated with all mental health problems, despite boys reporting more traumatic experiences (Eruyer, 2018, Kandemir, 2018). However, we note that most studies assess depression and anxiety, which are both internalising symptoms that are more typically associated with female gender: ‘girls tend to express high rates of stress by internalising symptoms while boys tend to express it with externalising symptoms’. (Kandemir, 2018). Kandemir (2018) argues that gender can play a moderating role but it

does not determine mental health outcomes. This study observed differences in outcomes within genders in different refugee camps in Turkey. Environmental factors – particularly adolescents' mobility around their neighbourhood or camp – play a moderating role, which intersects with gender: girls' mobility is restricted and therefore less likely to build potential support networks outside of the home (Betancourt, 2012, also noted as a potential mental health factor by DeJong, 2017).

FINDINGS 3: MENTAL HEALTH FACTORS

Social stratification

The only theme under social stratification included: 'feeling discriminated against and feeling marginalized by host communities.' This included poor treatment at school, threats of violence, experiences of violence and stigmatization from host communities. Mental health outcomes linked to discrimination and marginalisation included depression (Betancourt, 2012; DeJong, 2017), self-harm (DeJong, 2017), emotional problems (Stark, 2015), behavioural problems (*ibid*) and decreased self-esteem (*ibid*). Whilst discrimination and marginalization are the only explicit themes of social stratification identified in this review, we suggest that structural determinants and proximal factors are related to collective experiences of social stratification, particularly with regards to inequitable access to goods and services experienced by forcibly displaced people.

Structural determinants

This review identified 11 structural determinants of health that caused or exacerbated mental health disorders. These determinants were:

- Experience of or exposure to violence
- Inability to go to school
- Lack of food or water
- Indirect exposure to violence
- Change or loss of culture (including acculturative stress)
- No shelter/ poor living conditions
- Restriction of movement
- Exposure to unhygienic conditions
- No access to medical care
- Poverty
- Undertreatment of mental health disorders

Out of these structural determinants, 'experience of or exposure to violence' was the most common finding reported to influence the mental health of displaced adolescents, coded for in a total 14 academic papers out of and cited 38 times in the findings for 15 out of the 28 mental health outcomes we identified in this review.

War-related traumatic events include witnessing clashes, blasts, or death/injury of someone, and could have a lifelong impact on the psychosocial development of children and adolescents (Ceri et al., 2018). This code most frequently associated with depression and PTSD symptoms in the articles reviewed. It was noted that differentiating between the types of violence experienced is important to understand

the different impacts of mental health outcomes (Meyer et al., 2017a); but that this may be a difficult task due to the high rates of war-related traumatic events (Kandemir et al., 2018). It may also be important to study the timings of violent experiences or exposures. All studies agree that war-related traumatic events have a substantial, lifelong impact on child development. However, while many reference the traumatic impact of violence, this category groups together the experience during the ‘conflict or fleeing period’, and the ‘post migration’ period, despite the differing types of violence and effects on mental health outcomes. This can be seen in the analysis of depression and PTSD. Similar types of violent experiences have been reported during the ‘conflict or fleeing conflict’ period, such as seeing dead or severely wounded people, the violent death of a familiar person and witnessing gun fights, explosions and fighting for both conditions. However, in the post-migratory period, experience of or exposure to household violence leads to depression but not to PTSD. Therefore, when looking at the mental health outcomes of displaced adolescents, not distinguishing between types of violence could lead to inaccurate conclusions and affect possible interventions that do not take these differing forms of violence into account.

Exposure to more than one type of violence was associated with higher rates of anxiety (Meyer et al., 2017a). However, the experience of violence is not always war-related. Household violence also affects refugee adolescents, with high exposure associated with high incidence of anxiety, and low exposure associated with depression (Mirabolfathi et al., 2020). This type of violence is not defined in the literature but seemingly refers to witnessing household violence, and experiencing verbal abuse, physical violence or sexual violence. Meyer (2017) categorises household violence into 3 classes: class 1 being high levels of exposure to violence, class 2 being low levels of exposure and class 3 being no exposure. Perpetrators of this violence according to the studies are adults and witnessing household violence refers to witnessing adults shout/punch/kick/etc. each other. There little data for sibling/sibling or peer/peer abuse: for example, older brothers restricting the movement of their younger sisters through violence, in response to acculturative stress (DeJong, 2017). As only 2 papers out of 14 focused on this type of violence in a refugee context, further study is needed to assess the overlapping effect of this type of violence (which might be coded under ‘proximal conditions’), war-related violence and the influence of other structural determinants on refugee adolescents.

Inability to go to school was the second most common finding, with a total of 7 papers cited 16 times for 13 mental health outcomes. Education was found to be both a trigger and a protective factor for poor mental health outcomes. While schools are sources of social support and provide problem-solving skills and coping skills to mediate the effects of stress on children and adolescents (Kandemir et al., 2018) (in this review, we have ascribed this positive factor to the proximal condition, 'social support'), refugee status was often an access barrier to schooling. Other barriers included cost, language, poor quality of education and social exclusion or mistreatment due to ‘otherness’. Adolescents valued education and are often concerned by perceived shortfalls in their education (DeJong et al., 2017). It is worth noting that many of the papers used a study population of children in school; therefore, the results they present do not accurately represent children that are unable to go to school.

Proximal conditions

27 studies looked at one or more factors belonging to adolescents' proximal conditions. The factors identified under proximal conditions included:

- Difficulties adjusting to new country/society
- Being separated from family/communities
- Loss/death of family
- Loss of material possessions
- Living in a formal camp
- Feeling (un)safe
- Sexual abuse or assault
- Change in relationship with parents/parental stress
- Lack of social support
- Parental/caregiver depression (or other caregiver MH condition)
- Family conflicts
- Intimate partner violence

This section focuses on three most common factors: loss/separation from family, social support, and living in formal camps.

Loss/separation from family

12 papers looked at loss or death of family and ten papers looked at separation from families/communities. Loss or death of family or other important people in adolescent's lives was a common occurrence. Eruyar (2018) found 52.3% had lost someone they really cared about. Gormez (2018) found 56.2% had lost someone important to them. Kandemir (2018) found 71.9% had witnessed the violent death of a familiar person.

Separation from family and communities was also common. Loss of family members or other important people was almost always associated with worse mental health outcomes, most frequently depression (Meyer, 2017), PTSD (Badri, 2012; Gormez, 2018) and other anxiety disorders (Gormez, 2018; Meyer, 2017). There was some variability to this though; one study (Oppedal 2018) found that family separation and death were not significantly associated with symptoms of depression, but significant changes in family over the last year, as perceived by adolescents, was significantly associated with symptoms of depression. Mels (2010) found that adolescents who had experienced the death of their father had slightly reduced risk of externalizing problems, and Oppedal (2018) found that adolescents who had experienced separation from and loss of family members was not linked to depression (though 'drastic changes in the family' was). Loss or separation from family was often included with war-related traumatic experiences, so there's some overlap here with structural determinants discussed above. Betancourt (2012) speculated that forced separation from family and loved ones can explain some of the mental health impacts of some specific traumatic experiences such as abduction.

Social support

Six studies looked at the role of social support. Social support was often not explicitly

defined in the papers, but was generally understood to come from family, friends, community members and schools, with support from schools and families particularly important for wellbeing. It was widely understood that social support was a protective factor for the development of mental health conditions, but there were mixed findings on the availability of social support networks like family, and the actual offer of support. The social support available from family members is impacted by parent and carer mental health (Stark et al., 2015; Massed, Khammash & Shute, 2017; Meyer et al. 2017; Panter-Brick, 2014) and contrasted with household violence (Mayer et al., 2019).

While there were many barriers to accessing social support and many adolescents had inadequate social support, Oppedal, Özer & Sirin (2018) found that adolescents who had experienced more traumatic events had a greater perception of the social support they had available, and this greater availability of social support was associated with fewer depressive symptoms. In this study, children had been recruited from makeshift voluntary schools in formal camps, so it is likely that this environment created opportunities for social support.

Living in a refugee camp
Life in a refugee camp was examined by six papers. While studies often took place in camps, these didn't always explicitly examine the role of camps in mental health outcomes. There's some discordance in the studies on camps. While the previously mentioned study (Oppedal, 2018) looking at social support suggested that a makeshift school in the camp may have improved social support for adolescents, the studies looking at the role of camps in mental health outcomes often focused on violence in camps. Iyakaremye (2016) linked lack of parental authority (due to loss or separation, changes in relationships or family conflicts) to sexual violence in camps. Meyer (2017) compared mental health outcomes and violence in two different countries, in a camp verses a non-camp setting, and found higher levels of violence and worse mental health outcomes in camps. This study linked higher levels of violence to host country policy on integration, emphasizing the role of structural determinants in the production of proximal conditions. Violence may not be limited to camps themselves. O'Donnell (2015) found that urban settings with a refugee presence were associated with higher levels of violence than urban settings without a refugee presence.

In summary, proximal conditions impacting adolescent mental health are intricately related to each other and to broader structural determinants of health. The literature's presentation of many of these conditions was quite variable, and it's likely that proximal conditions are highly contextually dependent.

Mental health-impacting behaviours
Only three studies examined the impact of adolescents' behavioural responses to conditions of displacement on adolescent mental health. The main theme in this dimension was 'maturing quickly', which denoted adolescents exhibiting behaviours which were deemed 'adult'. In the studies, declarations about age-appropriate behaviours and responsibilities were made by adolescents, family members, and sometimes the researchers themselves. Makhoul (2011) linked the prioritization of family and household concerns over 'liv[ing] their lives as adolescents' and making

friends, with ‘feeling low’. Boswall (2015) suggested that young refugee women who married early might be at risk of isolation and that isolation had been linked with suicidal thoughts.

Experiences in early childhood, and earlier adolescence
11 studies mentioned early childhood and earlier adolescent experiences. The most common themes were ‘history of abduction’ and ‘early marriage.’ PTSD was the most common mental health outcome discussed in relation to early childhood and earlier adolescent experiences (Mels, 2010). Internally displaced adolescents who had experienced abduction and violence reported higher PTSD scores than adolescents who had not been displaced, even though this group had been exposed to ‘traumatic events’ (Mels, 2010). There is considerable overlap between this dimension and proximal conditions, particularly factors such as ‘being separated from family/communities, ‘loss/death of family’ and ‘sexual abuse and assault’.

DISCUSSION

Overview of the studies
In summary, valuable knowledge is being generated about and from LMICs about adolescent mental health and displacement, and this is continuing to address a major paucity of studies. There is a helpful body of literature which identifies factors that link displacement with adolescent mental health outcomes. However, it is still difficult to say how factors affect adolescent mental health i.e. the mechanisms which link them, from these studies. In terms of the factors which are discussed, there is a lot of emphasis on structural determinants and proximal factors, especially about camp environments, but less on other dimensions. In general, mental health-impacting behaviours and early childhood/earlier adolescent experiences were significantly less coded for than structural and proximal factors. This might be because they are less significant than those dimensions, because they are somehow accounted for in the structural or proximal factors, or because they are under-studied.

In terms of the studies themselves, the majority of studies included in this review were stand-alone case studies which utilized mixed methods (primary interviews and focus groups, as well as adapted quantitative measures of mental health) to describe mental health issues and contributing factors. These studies tended to focus on a specific sub-group of adolescents defined by age. There are few studies which compare adolescents of different ages (Gormez, 2018; Massad, 2017; Mels, 2010; Stark, 2015), and no longitudinal studies to understand how factors affect an individual at different stages of development. The absence of longitudinal studies probably reflects the lack of resources researchers have to conduct these important studies. There were no studies about neuro-diverse or differently-abled adolescents, which is a significant lacuna given the relatively high number of displaced people who are differently-abled (Pisani, 2016) and the additional challenges to their mental health, which this might group face.

Reviewed conceptual map with findings from the review

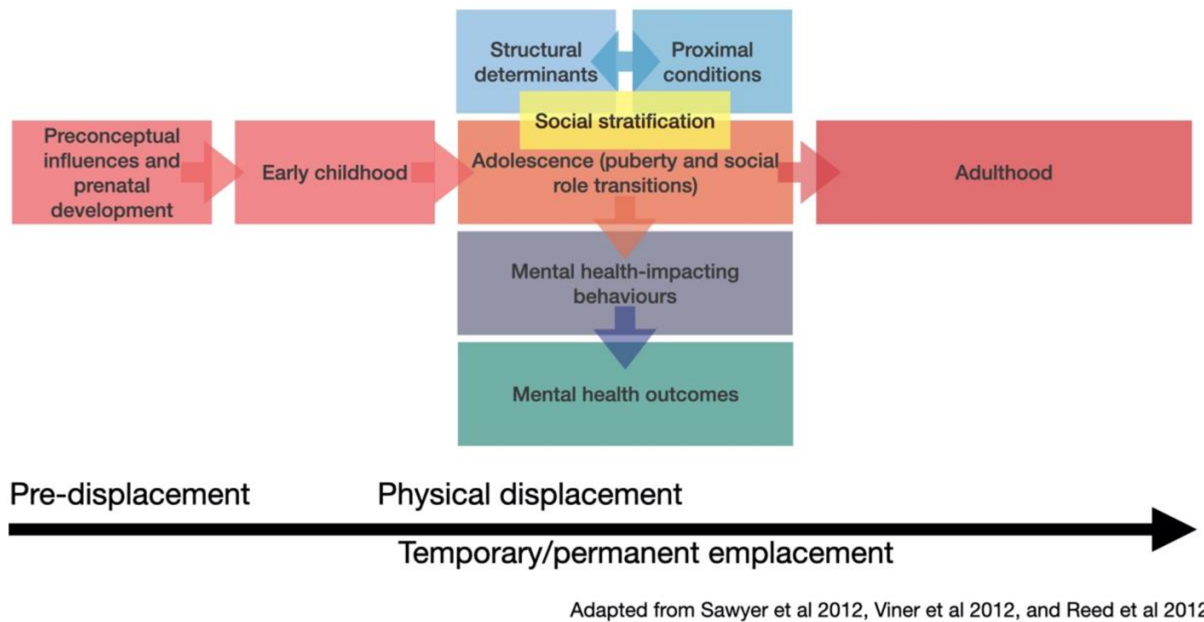

Figure 3. Dimensions of adolescent mental health in displacement

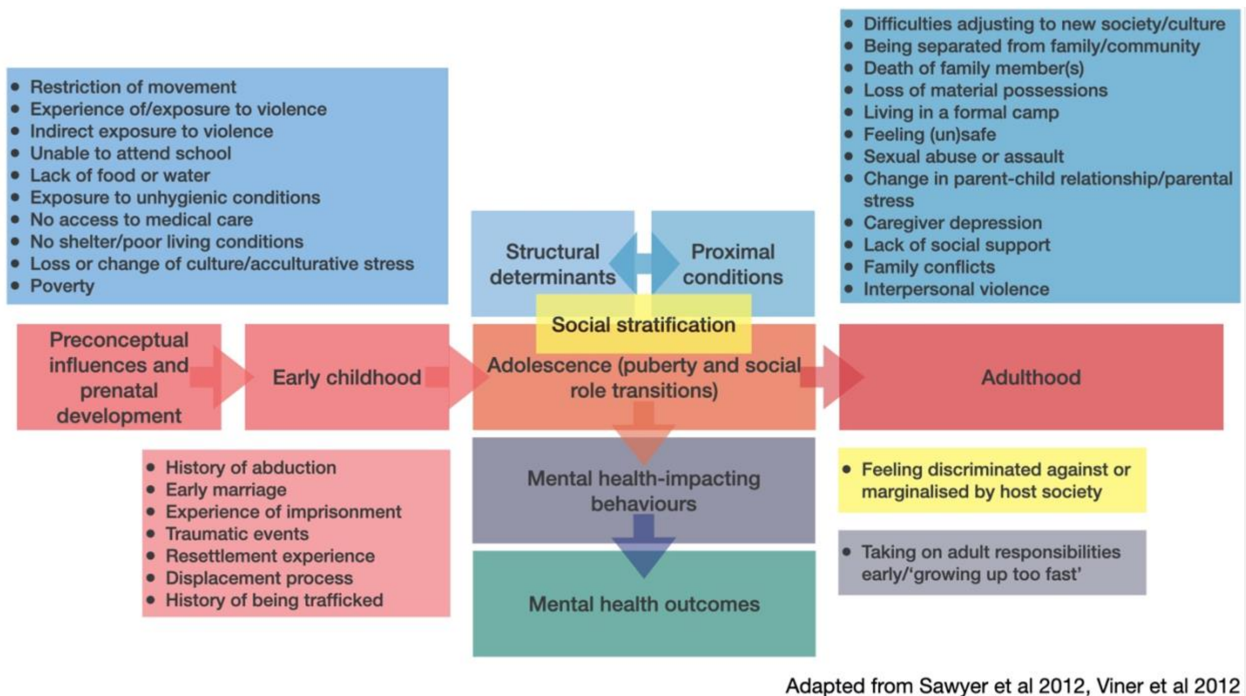

Figure 4. Dimensions and factors of adolescent mental health in displacement

Review of the review
This review was expansive in its attempts to work with a broad definition of displacement, which included forced migration across international borders, internal displacement and displacement-in-place. This was motivated by a belief that the categories of displacement, though helpful in some instances, has made invisible some experiences of displacement (ie. internal displacement and displacement-in-place) and has led to a tendency to present forced migration across international borders as the dominant experience of displacement. The majority of studies (31) looked at forced migration across international borders.

It was also expansive in its attempts to include adolescents from 10-24 years old, and not a smaller age range. This age range is a relatively new definition of adolescence, which is defined by a period of cognitive and hormonal changes, as well as social role changes. However, adolescence looks different between the ages of 10 to 24, and studies which look at adolescents understandably focus on a smaller age range, often overlapping with childhood and adulthood studies on either end. However, we suggest that our understandings of the impact of displacement on adolescents would benefit from an adolescent-specific perspective, which considers the adolescent brain and adolescent life experience as different from childhood and adulthood.

The review did show that displaced adolescents are susceptible to poor mental health outcomes which are linked to experiences of displacement. It is not clear from the reviewed literature whether they are more/less affected than children or adults, and how factors might differently affect mental health of different ages of adolescents, or how affects might change over time.

Finally, the review included clinical and psychosocial mental health outcomes. This was done to demonstrate the variety of ways in which scholars are linking displacement with mental health. The fact that we included both clinical and psychosocial outcomes meant that our review encompasses a broad range of methodological approaches to describing the link between displacement and adolescent mental health. We are responding to a demand to push beyond clinical, and often Western-derived, understandings and measures of mental (ill-)health to incorporate locally-specific understandings of mental health. This is particularly appropriate given the focus on studies conducted in LMICs, with adolescents from LMICs, on which Western-derived measures have often been imposed. However, we do note that studies exploring clinical outcomes often used adapted measures for country-specific settings (e.g. Betancourt, 2012).

LIMITATIONS
This study was limited by a focus on studies conducted in LMICs, of populations displaced from LMICs. This meant that a large number of studies of displaced adolescents from South and Central America were excluded, since many were conducted in the United States. Due to the time period chosen for the review, the majority of studies focused on displacement from Syria. The review did not examine methodologies in detail. However, we noted that methodologies were often described in limited detail, and were not always clearly linked to definitions of/approaches to

mental health. The review also excludes intervention studies, which may have helpful insights to offer in terms of the mechanisms which link displacement factors with adolescent mental health.

CONCLUSION

This review has shown that there is evidence that adolescents who have been displaced are at high risk of having poor mental health. The scholarship has shown that displacement is a multidimensional event, which can be associated with different dimensions and factors that affect mental health, across the displacement trajectory.

Mechanisms which connect specific experiences of displacement with worse mental health outcomes are still poorly understood. Whilst all of the papers included in this review focused on adolescents, few compared mental health outcomes between age groups. Limitations of research findings might be partially due to difficulties conducting research with adolescents who have been displaced. However, few papers discussed methodologies and research contexts in detail, and therefore it is difficult to say what factors influenced research design. As mental health research is increasingly becoming focused on mechanisms, displaced adolescents living in LMICs must be included in developing understandings of mental health.

We note that the majority of studies which make use of measurements of mental ill-health, including depression scores, do not make any attempt to explore their suitability in their papers. This might be because scholars have chosen not to write about their investigation of these measurements, but we suggest it would be appropriate to discuss the decision-making processes which informed their use. In addition, there were no papers included in this review, which considered displacement outside of forced migration across borders. We suggest that scholars of displacement and adolescent mental health might productively focus on situations of 'displacement-in-place', and that this is particularly pertinent in a time when international border regimes are reducing opportunities for migration. To support this research agenda, future research would benefit from increased interdisciplinary work on adolescent mental health, to inform research activities which are at once critical of Western tools and narrow conceptualisations of displacement, and which are actionable, so able to contribute to the reduction of mental ill-health among adolescents.

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APPENDIX

1. Coding tool

Question	Code
Aim of the study	Not stated Stated (add details)
How does the study frame displacement?	Not stated Stated (add details)
Sample number	Not stated Stated (add details)
Sample Age	Not stated/Unclear Stated (add details)
Data collection methods	Standardised Tools/Assessments Survey/Questionnaire Interviews (e.g. semi or unstructured) Focus groups Observation Randomized control trial Drawings Photo elicitation Secondary data analysis Data aggregation Film-making Tasks/games
Data Analysis	Statistical analysis Grounded theory Thematic analysis Ethnography Phenomenology Constant comparative method
Findings	Constant insecurity Gender differences Social stratification Feeling discriminated or marginalised by host countries Structural determinants of health Restriction of movement Experience / Exposure to violence (e.g. war / combat etc) Indirect experience of violence Not in school or unable to go to school Lack of food or water Exposed to unhygenic conditions No access to medical care No shelter/ poor living conditions Change/ loss of culture or ability to adhere to cultural norms/ acculturative stress Poverty Undertreatment of mental health disorders Proximal conditions

Question	Code
	Difficulties in adjusting to new country/society Being separated from family/communities Loss/death of family Loss of material possessions Living in a formal camp Feeling (un)safe Sexual Abuse or Assault Change in relationship with parents/ parental stress Lack of social support Parental/caregiver depression (or other caregiver MH condition) Family conflicts Intimate partner violence Health-impacting behaviours Maturing quicker/ 'growing up too fast'/ assuming responsibilities Earlier childhood or adolescent experiences History of abduction Early marriage Experience of imprisonment Traumatic events Resettlement experience Displacement Process Trafficking Age Mental health outcome Anxiety Hyperactivity Depression Self-harm PTSD Psychological distress Emotional Problems Behavioural problems Regular crying Suicidal ideation Disturbed sleeping Conversion disorder Enuresis Dissociative disorders Hyperarousal Internalisation Externalisation Post-traumatic growth Self-esteem Phobias Negative impact on cognitive function Separation anxiety Working memory Neuroticism

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