Journal of Refugee Studies Vol. 00, No. 0 © The Author(s) 2021. Published by Oxford University Press.
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doi:10.1093/jrs/feaa113

Refugee Children and Families During the COVID-19 Crisis: A Resilience Framework for Mental Health

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MS received April 2020; revised MS received October 2020

Children and families are undergoing unprecedented stress as a result of the COVID-19 pandemic, in part, due to the disruption of daily life arising from mandated social distancing protocols. As such, the purpose of the present report is to raise awareness surrounding resilience-challenging and resilience-promoting factors for refugee children and families during the COVID-19 crisis. Issues surrounding family life, parenting, and potential for family conflict are described. Also, cultural and linguistic factors are discussed, which may limit access to information about the pandemic and, accordingly, uptake of public health recommendations. Throughout our analysis, a trauma-informed framework is utilized, whereby potential for pandemic-related disruption in triggering previous traumatic stress is considered. Furthermore, using a developmental resilience framework and building upon the inherent strengths of families and children, suggestions for developing evidence-based programming and policy are reviewed. Responses should be: (1) multilevel, (2) trauma informed, (3) family focused, (4) culturally and linguistically sensitive, and (5) access oriented. The present analysis can serve as a timely guide for informing program design and policy in the context of public health, social services, mental health, health care, resettlement services, and other refugee-serving organizations.

Keywords: COVID-19, refugees, children, family, resilience, trauma-informed care, culture, language, parenting

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As the coronavirus pandemic accelerates, those at greatest risk include some 26 million children, women, and men forced to seek refuge as a result of war and persecution, half of whom are children below 18 years of age [The United Nations High Commissioner for Refugees (UNHCR) 2018]. In their joint press release on 31 March 2020, UN agencies observed that '[i]n the face of the COVID-19 crisis, we are all vulnerable. The virus has shown that it does not discriminate – but many refugees, those forcibly displaced, the stateless and migrants are at heightened risk' [World Health Organization (WHO) 2020a]. Thus, it is important that national and regional responses to COVID-19 consider the particular needs and vulnerabilities of refugee newcomers. Refugees are more likely to live in households with multiple generations and more people than the average household in the West. This, coupled with challenges upholding measures of physical distancing as well as the increased rates of trauma and mental health difficulties, makes the COVID-19 crisis especially problematic for refugee children and families. That being said, asylum-seeking, undocumented, and refugee children and families, as well as those fleeing violence and persecution in their home countries with recourse to non-refugee legal avenues, are resilient, possessing unique coping styles and characteristics that can mitigate the effects of adversity and stress. The current report highlights the unique factors that challenge and promote resilience in children and families from refugee backgrounds in high-income receiving countries (i.e. government-assistant/resettled refugees as well as asylum seekers/refugee claimants), with a particular focus on mental health, for the purpose of providing a guiding framework for scholars, policy makers, and refugee-serving organizations during COVID-19.

A Resilience Framework

Drawing upon Beiser's (2006) seminal refugee resettlement model, in addition to systemic organizing principles in child and family psychology (Browne *et al.* 2015; Lerner and Damon 2006), our analysis and recommendations are embedded in a dynamic framework highlighting the putative consequences of COVID-19 on family well-being and individual mental health. We posit a cascade (see Figure 1), whereby COVID-19 influences family well-being and, relatedly, mental health for children and other family members via massive social disruption that has emerged in the pandemic fall-out. For our purposes, family well-being is broadly defined as a general relational style and means of self-organizing, composed of communicative processes, organizational elements, and belief systems (Walsh 2015). Moreover, a holistic and culturally sensitive view of mental health is utilized, comprised not only of symptoms vis-à-vis western taxonomic psychiatric systems, or even bio-psycho-social frameworks in systemic psychology, but also cultural and spiritual views that encompass the individual's relation to the physical and metaphysical world (Manson 2003; Pickren 2014). COVID-19, as a biomedical disease and societal event, is viewed to influence family well-being and

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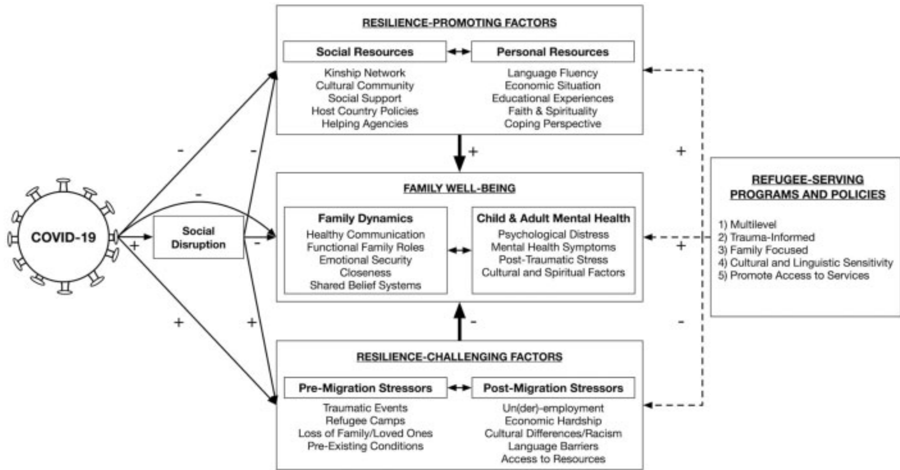

Figure 1.

The Cascade Model Displays How COVID-19 Influences Child and Family Outcomes for Refugee Newcomers via Social Disruption and Highlights Areas of Need for Programming and Intervention Recommendations

child mental health by increasing resilience-challenging factors (risk factors) for resettlement stress both pre- and post-migration (depending on where a family is in their journey), while simultaneously reducing the resilience-promoting factors (protective factors) that promote health and mitigate risk, including social and personal resources. Lastly, mirroring this framework that explicates the origins of family well-being and mental health in the context of COVID-19, recommendations for interventions and public health programmes by refugee-serving organizations are mapped onto this multilevel cascade, highlighting the multiple targets for evidence-based programming (Duan and Zhu 2020).

From a systemic perspective, resilience is a process through which children respond to (and experience positive adaptation in spite of) exposure to significant adversity that is facilitated or impeded by the complex, multilevel interaction of resilience-challenging and resilience-promoting factors over time (Luthar *et al.* 2000; Khanlou and Wray 2014; Pickren 2014). While family well-being and mental health provide the organizing framework for the present discussion, it is worth noting that positive mental health and resilience do not necessarily have a linear and unidirectional relationship (e.g. it is possible for a resilient individual to develop a mental health issue and also possible for someone with a mental health issue to be resilient) (Khanlou and Wray 2014). Nevertheless, the two are highly linked and we argue that, in the context of COVID-19, children's resilience is compromised via increased risks at multiple levels of analysis via the cascading effects of major social disruptions, which are filtered down through the family system to the individual level.

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COVID-19 and the Augmentation of Child and Family Challenges

In March of 2020, billions of families around the world experienced a monumental influx of stress and challenge as a result of the COVID-19 contagion reaching pandemic levels [World Health Organization (WHO) 2020a]. For all families, including those of refugee backgrounds, adaptation in light of this challenge will depend, in part, on pre- and post-migration stressors (see Figure 1; Beiser 2006). Amongst families with high levels of resources, increased frequency and duration of contact with parents during the shutdown may be beneficial for children, as they receive heightened levels of attention, with the possibility of coping and engaging in ways previously impossible due to the time restrictions of regular life. However, if families do not have the emotional, social, and economic resources that support harmonious interactions and human development, the home could become an area where distress manifests (Wang *et al.* 2020). For many, in addition to mandated restrictions on daily activities, requiring families to stay at home together for protracted durations, this includes the challenge of having to suddenly fulfil the full-time role of childcare and educator for children no longer in school or day-care (Heymann and Shindo 2020). What is more, many refugee parents in high-income countries are underemployed, working low-wage and low-skill jobs (Wilkinson *et al.* 2015), many of which are deemed to be 'essential service' jobs in the context of COVID-19, which presents the added burden of choosing between earning income and leaving children unsupervised. Consistent with family stress models of children's mental health difficulties, this stress increases susceptibility to relational conflict and (in extreme cases) family violence (Masarik and Conger 2017; Thompson and Rasmussen 2020). There are growing concerns about the anticipated rise in rates of domestic violence and child maltreatment during the COVID-19 crisis [Ending Violence Against Children 2020; World Health Organization (WHO) 2020a], though high-quality data are still forthcoming.

Pre-Migration Stressors

The mental health of refugees has garnered a substantial amount of attention in literature (Browne *et al.* 2017; Lustig *et al.* 2004). Refugees have often experienced numerous traumas, including events from their countries of origin (e.g. war, conflict, incarceration, and torture) and forced displacement from their homes, families, and social supports. Previous epidemiological research looking at the prevalence of Post-Traumatic Stress Disorder (PTSD) and depression in adult refugee populations across the world has found rates ranging from 9% to 30% and 5% to 50%, respectively (Silove *et al.* 2017). These upper-bounds are well above the population average prevalence. For example, the PTSD prevalence is substantially higher than non-refugee populations (Karam *et al.* 2014; Silove *et al.* 2017). In addition to considering exposure to traumatic events and related symptoms in adults, refugee children may have experienced many of the same pre-migration traumas as their caregivers, resulting in higher rates of paediatric

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mental health issues. For example, a recent meta-analysis of the prevalence of diagnosed mental illness in refugee and asylum seeker children and adolescents found rates of PTSD, depression, and anxiety disorders to be 22.71% (95% CI = 12.79–32.64), 13.81% (95% CI = 5.96–21.67), and 15.77% (95% CI = 8.04–23.50), respectively (Reavell and Fazil 2017). These existing mental health concerns of refugee newcomers make them particularly vulnerable during the COVID-19 crisis. Specifically, the conditions and emergency policies of COVID-19 (i.e. the 'pandemic state') may pose risk of retraumatization, given their phenomenological mimicry of disaster in host countries (Júnior *et al.* 2020).

Caregiver and child mental health (especially in the context of trauma) are inextricably linked, highlighting the importance of a developmental and family systems framework when considering refugees' response to COVID-19. For example, the relational model of PTSD, first developed by Scheeringa and Zeanah (2001), describes the complex ways through which traumatic events and associated stress emanate across generations. In response to acute or chronic trauma, psychological well-being of caregivers and children are connected, in part, via relationship dynamics, which may include impaired caregiver sensitivity and responsiveness, disrupted caregiver-child attachments, and exacerbated reactivity and negativity in both children and parents (Alink *et al.* 2019; Browne *et al.* 2020; Bryant *et al.* 2018). Thus, difficulties in family interactions, prompted by pre-migration trauma, may convey susceptibility to exacerbation by COVID-19 disaster state. In the case of families who have resettled or are in the process of resettling in a new country, pre-existing mental health challenges may be compounded by massive social upheavals, coming just as newcomers are getting adjusted into a new way of life. Furthermore, the most vulnerable families are likely those who are still in the process of migration and living in refugee camps, where conditions and the risk of both infection and psychological distress may be particularly dire, thereby posing a major humanitarian concern (Iacobucci 2020).

Post-Migration Stressors

In keeping with the relational model of PTSD and refugee resettlement frameworks (Beiser 2006), COVID-19 may potentiate the myriad post-migration stressors refugees encounter upon arriving in host countries (e.g. language barriers, racism, administrative challenges throughout the claimant process, loss of social support networks, neighbourhood factors, socio-economic hardships), thereby disrupting family well-being and children's mental health through interpersonal stressors (Browne *et al.* 2015). Much research has connected these challenges to poorer mental health and disrupted family dynamics throughout resettlement (LeBrun *et al.* 2015; Rossiter *et al.* 2018). Furthermore, in the context of COVID-19 disease contagion, per se, there are growing concerns that these post-migration factors will limit refugees' access to the quality of information about the pandemic, which could result in misinformation, mistrust, increased

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risk of infection, and potential violation of policies resulting in undue penalty (Refugee International 2020).

Post-migration barriers to services, institutions, and various forms of capital have likely been exacerbated in the wake of COVID-19, potentially creating greater distress for caregivers, which can spill over into the family system and influence children's emotional well-being (Browne *et al*. 2015). First and foremost, many refugee families experience barriers to accessing healthcare (Morris *et al*. 2009), which will only be compounded by the unprecedented healthcare strain due to COVID-19, particularly in regard to critical care (Moghadas *et al*. 2020), but also preventative care and mental health services (Liu *et al*. 2020). In addition, barriers to healthcare include a lack of knowledge about availability of services, eligibility requirements, means of access, transportation, lack of culturally and linguistically appropriate care, and low socioeconomic status (Hadgkiss and Renzaho 2014; Immigration Partnership of Waterloo Region 2019; Mangrio and Forss 2017; McKeary and Newbold, 2010; Morris *et al*. 2009). Another barrier to healthcare that is particularly relevant in the context of COVID-19 is the potentially limited access to appropriate technology for videoconferencing with healthcare providers.

Resilience-Promoting Factors during COVID-19

As we have seen, numerous factors can compromise family well-being, mental health, and resilience. However, these factors are not deterministic—whether one exhibits a pattern of resilience is influenced by the complex interaction of resilience-challenging and resilience-promoting factors. Some of the specific factors that have been found support the psychological well-being of adolescent refugees include financial means to provide for necessities, host language proficiency, social support networks, maintenance of cultural links, educational support, and faith or religious involvement (Weine *et al*. 2014). Unfortunately, many refugee families and children struggle to achieve the resilience-promoting factors outlined by Weine and colleagues, due to social, financial, emotional, and language difficulties. In the context of the COVID-19 crisis, the emergency measures being implemented by governments further limit their ability to foster these factors. That being said, it is important to note that resilience-promoting factors do not simply reflect 'an absence of risk,' and rather represent positively valenced characteristics of the bio-psycho-social developmental and family system, which may offset or modify the consequences of adversity in a number of qualitatively distinct patterns, depending on the type of stressor experienced and the outcome in consideration (Luthar *et al*. 2000).

In regard to the present discussion of resilience-promoting factors for refugee children and families in the face of COVID-19, it is important to consider the timing of these effects (before, during, or after particular trauma or stress exposures) in addition to their level of organization (in our framework, either *personal* or *social resources*, which can be further characterized; see Hostinar and Miller 2019 for a comprehensive review). For example, all refugee children and families

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will likely possess *inoculating factors*, including family narratives and experiences around successful prior coping in light of adversities before the pandemic, while *buffering factors* would include resources and protection that concurrently operate to offset adversity, such as positive family support at home during the quarantine period. *Repair factors* include health-promoting practices and styles of supporting one another immediately after the shutdown, while *compensatory factors* refer to the sociocultural resources, including religiosity, spirituality, and other cultural practices that are independent of the stressors and mobilized after repair is complete. *Promotive factors* are variables that promote health regardless of COVID-19 or other risk and may include a nation's strong refugee policy, social safety net, and universal health care, while *windows of opportunity* describe major life changes and formalized support services (e.g. psychotherapy) that may operate to change the trajectories for children and families for the better, downstream of adversity. Collectively, this conceptualization illustrates how the resilience-challenging and resilience-promoting factors for family well-being and children's mental health are multifaceted, dynamic and will continue to influence outcomes long after the immediate resolution of the pandemic.

Recommendations for Refugee-Serving Programmes

COVID-19 has elucidated the numerous ways in which contemporary social, political, economic, and civic systems fail to meet the needs of the most vulnerable, including refugee children and families (Bhopal 2020). Nevertheless, there are presently numerous refugee-serving organizations around the world (and other social justice groups serving diverse under-resourced communities) mobilizing resources and policy with remarkable capacity. From these outstanding examples and stories, our review taps the optimism, hope, and perseverance inherent within the family resilience perspective (Walsh 2015). Notwithstanding the tremendous grief, loss, and disruption emerging from this disaster, our analysis leverages this opportunity to focus on helping initiatives that are working, along with existing gaps, where programmes and policy can be strengthened. In guiding programmes and policies that serve to support and cultivate resilience in children and families who are refugee newcomers, we recommend initiatives that are (1) multilevel, (2) trauma informed, (3) family focused, (4) culturally and linguistically tailored, and (5) access-to-services oriented.

As explicated by our model (see Figure 1), the social determinants of health, including the resilience-challenging and resilience-promoting factors that contribute to family well-being and children's mental health in the context of COVID-19, are *multilevel*, spanning ecological layers of organization, social locations, and levels of the developmental and family context (Browne *et al.* 2015). Accordingly, it would not follow to simply target recommendations, policies, and programmes directly at family psychosocial outcomes and, relatedly, children's mental health. While targeted services (such as family supports, culturally sensitive family therapy, and psychotherapy) will certainly make up a part of the response, it is also necessary to move 'upstream' in the cascade leading to family stress, thereby

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addressing root causes, consistent with the well-articulated principle of prevention in public health (Fazel and Betancourt 2018).

Fortunately, there are growing calls for such efforts to be *trauma informed*, especially in the case of health care for refugee newcomers (Wylie *et al.* 2018). The principles of trauma-informed care with refugee newcomers have been extensively reviewed and are currently being synthesized in a Cochrane review of systematic reviews (Uphoff *et al.* 2020). Briefly, this paradigm fundamentally acknowledges the presence of trauma and hardship in the lives of children and families and seeks to support healing through the optimization of services and situations of living that promote individual and family safety, choice, collaboration, trust, and empowerment. This programme and policy ethos is often captured via the suggested shift from asking 'what is wrong with this person/family?' to 'what has happened to this person/family?'.

Given the multilevel and trauma-informed precepts, it follows that programmes aimed at promoting mental health amongst refugee newcomer children be *family focused*, including sensitive and non-blaming discussion of the role of parenting in children's mental health and socioemotional functioning (Morawska *et al.* 2012). In light of the challenges presented to caregivers and children by COVID-19, the World Health Organization (WHO) (2020b) has released helpful materials with clear-cut parenting strategies to implement during the pandemic, including guidelines for planning one-on-one time, promoting positivity, creating a daily routine, responding constructively to misbehaviour, managing stress, and talking about COVID-19. Of course, conversations around parenting and family dynamics in the cultivation of resilience must include cultural considerations, including differences in family values and the meaning of certain behaviours, bearing in mind the pandemic state.

Knowledge dissemination and mobilization will play a vital role in health promotion throughout the shutdown and in the mitigation of future waves of the novel coronavirus. That being said, outreach initiatives that *promote availability, access to, and uptake of services* are necessary for the optimization of health and social services. For example, in the case of crisis telephone lines and the telehealth movement (both of which have seen a remarkable mobilization of resources), it is imperative that support is available in appropriate languages. It is also important, in the case of telehealth services, that families have access to appropriate technologies (e.g. distribution of laptop computers for home use, access to a safe physical site from which they can log onto meetings). In certain jurisdictions, an influx of funds from government and private donorship has supported these efforts as the need for virtual services has increased dramatically. However, one of the major barriers for refugees related to accessing health services is a lack of awareness of their rights to health care and what services are available to them (Beiser *et al.* 2006; Norredam *et al.* 2006; Satinsky *et al.* 2019). Thus, beyond making the services themselves applicable to refugees, resources should be allocated to increasing awareness of what services are available and how they can be accessed.

The aforementioned recommendations are all necessary to cultivate resilience in refugee populations, though they are not a completely exhaustive list of relevant

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factors that may formally support family well-being and children's mental health (see Pickren 2014). A tremendous literature has highlighted the effects of income, poverty, and access to employment for refugee families in terms of caregiver mental health, psychosocial family processes (e.g. parenting, sensitivity within relationships), access to development-enhancing materials and experiences for children, and early childhood socioemotional development (Browne *et al.* 2017, 2018). Thus, programmes and policies supporting refugee family well-being and children's mental health should aim to integrate the recommendations listed above, while also advocating and lobbying elected officials to address the enduring and systemic socioeconomic factors that enable families to meet their most basic human needs.

Conclusion

The COVID-19 pandemic, and the social disruption therein, influences family well-being and children's mental health through a dynamic and multilevel cascade, spanning levels of the child and family ecology. Our framework has been exposited based on decades of theory and research, though empirical (quantitative) validation is warranted, and will be forthcoming as the social science process catches up to the speed of the pandemic. Nevertheless, available frameworks and data, upon which our model was carefully developed, suggest that COVID-19 directly and indirectly (via social disruption) increases resettlement stress, both pre- and post-migration, while simultaneously reducing the socio-contextual and individual resources that promote health.

Refugees have unique qualities that support their resilience. That being said, the disproportionate levels of stress refugee families experience warrant a targeted policy agenda that supports multilevel interventions. In addition to considering multiple levels of analysis, from individual to societal, and from preventative to responsive interventions, refugee-serving programmes and policies are recommended to maintain considerations of trauma, family systems, and cultural and linguistic sensitivity. Furthermore, interventions and policies should promote access to resources, thereby further fostering the child and family resilience process. Taken together, the model and literature outlined in this article provide a brief framework to guide public servants in health, mental health, and social service sectors as they engage in the laudable calling to support children and families of refugee background during this unprecedented time.

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