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UNIVERSITY OF TURKU

MENTAL HEALTH OF ASYLUM-SEEKING AND IMMIGRANT-BACKGROUND CHILDREN

Psychosocial Development in Relational and Spatial Contexts

Heidi Parviainen

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The originality of this publication has been checked in accordance with the University of Turku quality assurance system using the Turnitin OriginalityCheck service.

Cover Image: Zakaria Achkir Hamdaoua

ISBN 978-951-29-9117-4 (PRINT)
ISBN 978-951-29-9118-1 (PDF)
ISSN 0355-9483 (Print)
ISSN 2343-3213 (Online)
Painosalama, Turku, Finland 2022

To children and parents forced to leave their familiar places

UNIVERSITY OF TURKU
Faculty of Medicine
Department of Clinical Medicine
Public Health Science
HEIDI PARVIAINEN: Mental health of asylum-seeking and immigrant-background children – Psychosocial development in relational and spatial contexts
Doctoral Dissertation, 125 pp.
Doctoral Programme in Clinical Research
December 2022

ABSTRACT

This study explored the significance of the contexts for the mental health and psychosocial development of asylum-seeking and immigrant-background children. The relational contexts were parenting and parental mental health; spatial contexts were the reception center and school. The study's time points were the beginning of the migration in the reception center or later at school.

The interdisciplinary study combines the approaches of psychiatry and human geography. The first study addressed the mental health of accompanied asylum-seeking children within the relational context of parental mental health. The second explored the opportunities for parenting in the spatial context of the reception center. The third examined the emotional school engagement and mental health of immigrant-background children within the spatial context of school. The data consisted of interview and questionnaire data.

Accompanied asylum-seeking children had a high prevalence of psychiatric symptoms, as reported by their parents. The reception center's locale was essential to providing and impeding caregiving opportunities. The emotional engagement was hampered for parents and children in the reception center. In the school context, emotional engagement was lower among immigrant-background children than among natives. Teachers did not report any significant differences between the mental health of immigrant-background and native children. However, as their parents reported, immigrant-background children had more emotional symptoms and peer problems than natives.

The results highlight contextual approaches to strengthen the mental health of children with immigrant backgrounds. The increased dialogue between the professionals of mental health, human geography, education, and migration management would support child mental health and reduce risks of migration.

KEYWORDS: mental health, asylum-seeking, immigrant-background, child, psychosocial development, spatial, relational, context, emotional engagement, human geography

TURUN YLIOPISTO
Lääketieteellinen tiedekunta
Kliininen laitos
Kansanterveystiede
HEIDI PARVIAINEN: Turvapaikkaa hakevien ja ulkomaalaistaustaisten lasten mielenterveys – Psykososiaalinen kehitys vuorovaikutuksen ja tilan konteksteissa
Väitöskirja, 125 s.
Turun kliininen tohtoriohjelma
Joulukuu 2022

TIIVISTELMÄ

Tutkimus tarkasteli kontekstin merkitystä turvapaikkaa hakevien ja ulkomaalaistaustaisten lasten mielenterveydelle ja psykososiaaliselle kehitykselle. Vanhemmuus ja vanhempien mielenterveys toimivat vuorovaikutuksellisina konteksteina sekä vastaanottokeskus ja koulu tilallisina konteksteina. Tutkimuksen ajankohtana oli maahanmuuton alku vastaanottokeskuksessa tai myöhempi kouluympäristö.

Monitieteinen tutkimus yhdisti psykiatrian ja ihmismaantieteen näkökulmia. Ensimmäinen osatyö tutki turvapaikkaa hakevien lasten mielenterveyttä vanhempien mielenterveyden kontekstissa. Toinen osatyö selvitti, millaisia vanhemmuuden mahdollisuuksia vastaanottokeskuksen tilat tarjoavat. Kolmas osatyö tarkasteli ulkomaalaistaustaisten lasten emotionaalista kiinnittymistä ja mielenterveyttä kouluympäristössä. Aineistoina olivat haastattelu- ja kyselyaineistot.

Turvapaikkaa hakevilla lapsilla oli vanhempien mukaan paljon psykiatrisia oireita. Vastaanottokeskus tilana tarjosi sekä vanhemmuutta mahdollistavia että estäviä tekijöitä. Vanhempien ja lasten emotionaalinen kiinnittyminen oli vastaanottokeskuksessa vaikeutunut. Koulussa emotionaalinen kiinnittyminen oli heikompaa ulkomaalais- kuin suomalaistaustaisilla. Opettajat eivät raportoineet eroja ulkomaalais- ja suomalaistaustaisten lasten mielenterveydessä, mutta vanhempien arvioimana ulkomaalaistaustaisilla oli enemmän emotionaalisia oireita ja kaverisuhteiden ongelmia.

Tulokset korostavat vuorovaikutuksellisten ja tilallisten kontekstien merkitystä maahanmuuttotaustaisten lasten mielenterveyden tukemisessa. Dialogin lisääminen mielenterveyden, ihmismaantieteen ja opetusalan ammattilaisten sekä maahanmuuttoviranomaisten välillä tukisi lasten mielenterveyttä ja vähentäisi maahanmuuton riskejä.

AVAINSANAT: mielenterveys, turvapaikanhakija, ulkomaalaistaustainen, lapsi, psykososiaalinen kehitys, tila, vuorovaikutus, konteksti, emotionaalinen kiinnittyminen, ihmismaantiede

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Abbreviations

CFS	Child Friendly Spaces
CI	Confidence interval
ECEC	Early childhood education and care
HSCL-25	Hopkins Symptom Checklist-25
HUS	Helsinki and Uusimaa Hospital District
IOM	International Organization for Migration
OECD	Organisation for Economic Co-operation and Development
OR	Odds ratio
PROTECT	Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment
PTSD	Post-traumatic stress disorder
SDQ	Strengths and Difficulties Questionnaire
SE	Standard error
SPSS	Statistical Package for the Social Sciences
TERTTU	Asylum Seekers Health and Wellbeing Survey
THL	Finnish Institute for Health and Welfare
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization

List of Original Publications

This dissertation is based on the following original publications, referred to in the text by their Roman numerals:

I Parviainen H, Kiviruusu O, Lämsä R, Skogberg N, Castaneda AE, Santalahti P. Psychiatric symptoms and the association with parents' psychiatric symptoms among recently arrived asylum-seeking children in Finland. *Child Psychiatry Hum Dev*, 2022. doi: 10.1007/s10578-022-01371-2.

II Parviainen H, Lämsä R, Kiviruusu O, Santalahti P. Parenting in place: The reception centre as the spatial context for laying the foundations for asylum-seeking children's healthy development. *Health Place*, 2022; 76: 102823. doi: 10.1016/j.healthplace.2022.102823.

III Parviainen H, Santalahti P, Kiviruusu O. Emotional School Engagement and Psychiatric Symptoms among 6–9-Year-old Children with an Immigrant Background in the First Years of School in Finland. *Child Psychiatry Hum Dev*, 2021; 52(6): 1071–1081. doi: 10.1007/s10578-020-01086-2.

1 Introduction

More than ever, children and their parents are on the move, fleeing from one country to another. In 2020, European countries received over 420 000 new asylum seekers; nearly a third were children (UNHCR et al., 2020). On a societal level, this crisis related to migration is suggested to be the new normal—an adaptation strategy to the changing climate—fueled by digital technologies and globalization (Balsari et al., 2020). As migration represents a key challenge of our times, new solutions are needed for societies and geographical regions to support receiving asylum seekers for varying periods instead of restrictive migration policies (Simonsen & Skjulhaug, 2019). On an individual level, increasing numbers of parents face the most difficult decision of their lives when trying to predict which decision is in their child's best interests: fleeing into the unknown and leaving familiar contexts behind or staying in often dangerous and unsafe but familiar surroundings.

In asylum-seeking children's home countries, children have often experienced multiple traumas, such as fleeing their homes due to war, witnessing violence, and losing family or friends. The journey to the country of asylum can take months and pose life-threatening dangers. The temporal context of the asylum-seeking journey can thus be divided into preflight, flight, and resettlement experiences (Fazel & Stein, 2002); here, the focus is on the last stage. For many, resettlement is part of the continuation of their forced displacement, often characterized by waiting in liminal spaces and losing freedom regarding place. The different stages of forced migration considerably threaten children's psychosocial development and mental health (Kadir et al., 2019).

Children's psychosocial development happens in their relational and spatial contexts, and asylum-seeking children cannot be seen in isolation from the contexts in which they grow up (Zeanah, 2018). Early childhood experiences in these contexts, especially in the relational context of parenting, shape brain architecture and cognitive and psychosocial development, further influencing a child's future physical and mental health (Black et al., 2016; Cantor et al., 2018). The spatial contexts affect the children, their parents, parenting, and parental mental health, as Bronfenbrenner's (1979) ecological framework described: Parenting interacts with the environment of children and parents. Therefore, a spatial lens is needed to

understand how children's psychosocial development unfolds in a dynamic interplay among children, parents, and the spaces in which families live. Human geography examines how things exist in space, how features of the social world change across spaces, and the difference that places make to the nature of human existence (Jones, 2012).

Although understanding the traumas behind displacement is important to support mental health, recognizing the ongoing process of forced replacement in resettlement and engagement in this new environment is also crucial (Sampson & Gifford, 2010). Indeed, asylum-seeking children have experienced disruption in the contexts relevant to psychosocial development and disruption to the emotions engaging them in those contexts. Emotional engagement in a spatial context, also referred to as *a sense of place*, is associated with better psychosocial well-being in adults and children (Lewicka, 2011b; Scannell & Gifford, 2017). Particularly, during the loss associated with migration, a sense of place related to one's homeland or new neighborhood can enhance feelings of security and comfort (Juang et al., 2018). Similarly, emotional engagement at school can be particularly crucial for asylum-seeking and immigrant-background children, as children with positive feelings towards school are more likely to succeed in sociocultural adaptation and coping with negative emotions (Blum et al., 2002; Fang et al., 2016). School engagement appears to be a promotive factor for school success (Motti-Stefanidi & Masten, 2013). With its relationship to later work success and fewer socioeconomic disadvantages, school success can be described as an indicator of immigrant children's current and future adaptive success (Motti-Stefanidi & Masten, 2013).

In many cases, problems relating to poorer mental health, school success, and later socioeconomic status originate in the preadolescent years (Costello & Maughan, 2015; Ladd et al., 2000). The mental health outcomes of these children can be improved by enhancements in the contexts of psychosocial development (Lieberman & Ghosh Ippen, 2010). Consequently, improving mental health as early as possible to avoid possible negative outcomes is vital. However, previous work among asylum seekers and immigrants has largely failed to address the early childhood perspective and the surrounding relational and spatial contexts, even though these are intrinsic to development (Frounfelker et al., 2020; Gershoff et al., 2013; Merry et al., 2017; Sameroff, 2010).

2 Review of the Literature

2.1 Accompanied asylum-seeking children and immigrant-background children

2.1.1 Accompanied asylum-seeking children

Globally, the number of persons living outside their country was 281 million in 2020; children younger than 18 accounted for 35.5 million of them, and an estimated 13 million were refugees and asylum seekers (UNICEF, 2021). In 2020, Finland received 3209 applications for asylum, with 11% of the applications concerning accompanied minors (Finnish Immigration Service, 2021). In countries with individualized asylum-seeking procedures, an asylum seeker is "someone whose claim has not yet been finally decided on by the country in which he or she has submitted it" (UNHCR et al., 2006). An accompanied asylum-seeking child is a child in the company of an adult who, by law or custom, is responsible for accompanying the child (e.g., the child's parents, guardians, or primary caregivers).

Asylum-seeking children and their families form an especially vulnerable population (Calam, 2017). Before arrival in the country of asylum, in addition to the traumas many children and their families have already suffered, they experience poverty, violence, and dangerous journeys, as well as a lack of security, adequate housing, health care, and education (Harkensee & Andrew, 2021). These contributors have far-reaching implications for the psychosocial development and the future mental health of children and their families (Hanes et al., 2017; Opaas & Varvin, 2015). Moreover, children's right to mental health is critical in and of itself (Convention on the Rights of the Child, 1989). Much is known about unaccompanied children and their health needs (von Werthern et al., 2019), but less is understood about accompanied asylum-seeking children. White and colleagues (2011) pointed out there is a tendency to focus on categories of migrant children who are perceived as particularly exposed while overlooking other groups.

2.1.2 Immigrant-background children in Finland

Finland has a relatively short history as an immigrant-receiving country, and the number of immigrants remains small (OECD, 2017); in 2020, there were 444 000 individuals (8.0% of Finland's population) for whom both parents or the only known parent had been born abroad (Statistics Finland, 2021). While the numbers remain small on international and Scandinavian levels, migration's short history has led to poor labor market outcomes, especially for the children of immigrants (OECD, 2017). An immigrant is commonly defined as a foreign citizen who has moved to Finland and intends to live there for a longer time; sometimes, persons born in Finland but whose parent or parents had moved to Finland are called immigrants (Ministry of Social Affairs and Health, 2021). In the present study, the term *immigrant-background child* refers to all children who have at least one parent with a foreign native language. Finnish and Swedish are Finland's domestic languages.

Finland is one of the countries where immigrant-background adolescents are at particular risk of failing to achieve basic academic proficiency: Compared with adolescents without an immigrant background, they are more than twice as likely to fail if they have a personal migration experience (OECD, 2018). The adaptation and success of these immigrant generations are essential for the country's development and future (Motti-Stefanidi & Masten, 2013; OECD, 2018).

2.1.3 The mental health of asylum-seeking and immigrant-background children

Asylum-seeking and refugee children have a higher prevalence of psychiatric symptoms than non-refugee populations (Blackmore et al., 2019; Eruyar et al., 2018); high rates of trauma symptoms, depression, and anxiety; and heightened levels of externalizing problem behavior, such as aggression and hyperactivity (Blackmore et al., 2019; Henley & Robinson, 2011). Most studies exploring the mental health of asylum-seeking and refugee children have focused on vulnerable unaccompanied adolescents (those migrating without a parent or guardian); when accompanied children have been addressed, the children have mainly been school-aged (Curtis et al., 2018; Kien et al., 2018). Further, the mental health of migrants has often been addressed with epidemiological, quantitative, and trauma-focused approaches (Silove et al., 2017). Little discussion exists on the mental health of accompanied children, who are primarily younger than unaccompanied children; particularly, the early childhood experiences, attached parenting, and mental health of younger than school-aged children have been neglected (Frounfelker et al., 2020; Kien et al., 2018; Merry et al., 2017; UNHCR et al., 2020).

The age of the asylum-seeking children and the phase of the asylum-seeking journey and its duration influence the exhibition of psychiatric symptoms among

asylum-seeking children. Emotional and trauma symptoms have higher rates of occurrence in children who have recently arrived in a country of asylum compared to the rates among children who have been displaced for a long time; conversely, hyperactivity is higher among those displaced for more than two years (Blackmore et al., 2019). Moreover, asylum-seeking children enter their destination countries at different ages. Usually, studies among refugee children have found an increasing prevalence of mental health problems with age, similarly as in the general population, although it could be argued that investigation of mental health problems in very young children is challenging and a neglected area of research (Eruyar et al., 2018; Dalsgaard et al., 2019; Vasileva et al., 2020). Among refugees, this is suggested to be associated with older children experiencing both more and more severe traumatic events as they have a greater cognitive capacity to process their impact (Bean et al., 2007; Goldin et al., 2001).

In 2016, van Os and colleagues (2016) presented a systematic review of the existing knowledge of refugee children who had recently arrived in a host country. Table 1 (van Os et al., 2016) presents the six studies on the mental health symptoms of accompanied children, of which only two (Ekblad, 1993; Almqvist & Brandell-Forsberg, 1997) specifically addressed younger than school-aged children. While the reviewed studies reported high traumatic stress levels, emotional symptoms (Almqvist & Brandell-Forsberg, 1997; Ekblad, 1993), or post-traumatic stress disorder (PTSD) (Almqvist & Brandell-Forsberg, 1997; Rothe et al., 2002), based on the review, evident gaps seem to exist in the literature as the studies of accompanied children typically focused on certain ethnic groups; moreover, the most recent study was published two decades ago. A more recent nationwide register-based study presenting the health status of asylum-seeking minors newly arrived in Denmark found that over 40% of the 0–17-year-old children, based on the nurses' subjective evaluation, needed psychosocial support and further assessment; however, comparing the symptoms of younger and older children or unaccompanied and accompanied children was impossible (Eiset et al., 2020).

When considering immigrant children and adolescents, the previous literature on their mental health status gives mixed results. They have been reported to display more psychiatric symptoms than the general population (Alonso-Fernández et al., 2017; Atzaba-Poria et al., 2004; Belhadj Kouider et al., 2014; Hölling et al., 2008) and fewer psychiatric symptoms (Stevens et al., 2003; Vaage et al., 2009; Vollebergh et al., 2005). These two perspectives are called *migration morbidity* and *the immigrant paradox*, respectively. From the migration morbidity perspective, immigrants display lower mental health and overall adjustment (including school success) compared to natives. From the immigrant paradox perspective, immigrants display more positive outcomes than natives (Dimitrova et al., 2016). These contradictory results are considered to be associated with differences in migration

background, ethnic minority position, cultural background, age, the host population, and informants (IOM, 2017; Stevens et al., 2008). A recent meta-analysis combining the results of 51 studies reporting internalizing, externalizing, and academic outcomes among immigrant children and adolescents in Europe found that migration morbidity was better supported than the immigrant paradox (Dimitrova et al., 2016). In sum, immigrant children and adolescents seem to have poorer mental health than natives (Alonso-Fernández et al., 2017; Belhadj Kouider et al., 2014; Curtis et al., 2018; Stevens et al., 2015).

Table 1. Studies on the mental health of accompanied asylum-seeking children and adolescents who recently arrived in a country of asylum.

ARTICLE	AUTHOR, PUBLICATION YEAR	STUDY COUNTRY	COUNTRY OF ORIGIN	*N*	AGE, YEARS (*M*)	MONTHS SINCE ARRIVAL (*M*)	MEASURES	MENTAL HEALTH OUTCOME
Psychosocial adaptation of children while housed in a Swedish refugee camp: Aftermath of the collapse of Yugoslavia	Ekblad,1993	Sweden	Former Yugoslavia	66	5–15	(5)	Structured interviews with children and parents	58% homesick; 45% depression; 41% somatic symptoms; 39% nightmares; 28% fear
Refugee children in Sweden: Post-traumatic stress disorder in Iranian preschool children exposed to organized violence	Almqvist and Brandell-Forsberg, 1997	Sweden	Iran	50	3–8 (5.10)	12	Parental interviews; children's assessment: observations, structured tasks, and questions; the Lowenfeld World Technique	68% behavioral symptoms; 48% overdependency and anxiety; 44% re-experiencing; 18% PTSD; 26% post-traumatic stress symptoms
Refugee children from the Middle East	Montgomery, 1998	Denmark	Middle East: Iran (32); Iraq (168); Lebanon (22); Syria (13); stateless Palestinians (75); Turkey (1)	311	3–15 (7.5)	<1 (7 days)	Structured interview with parents	67% clinically anxious

ARTICLE	AUTHOR, PUBLICATION YEAR	STUDY COUNTRY	COUNTRY OF ORIGIN	*N*	AGE, YEARS (*M*)	MONTHS SINCE ARRIVAL (*M*)	MEASURES	MENTAL HEALTH OUTCOME
War trauma experience and behavioral screening of Bosnian refugee children resettled in Massachusetts	Geltman, 2000	USA	Bosnia	31	2–17 (10.7)	<3	Bosnia War Trauma Questionnaire	77% behavioral symptoms; 72% repetitive talking about violence; 52% nightmares; 40% acting out; 40% avoidance of exposure to memories
A nationwide screening survey of refugee children from Kosovo	Abdallah and Elklit, 2001	Denmark	Kosovo	1224	0–18 (8.2)	<1 (1 week)	Trauma and Symptom Form (Danish Red Cross)	20% emotional symptoms; 24% psychosomatic disturbances
Posttraumatic stress disorder among Cuban children and adolescents after release from a refugee camp	Rothe et al., 2002	USA	Cuba	87	6–17 (14.9)	4–6	Post-Traumatic Stress Disorder Reactive Index; Child Behavior Checklist—Teacher Report Form	57% PTSD; 67% avoidance; 60% re-experiences; 52% somatic symptoms; 51% hyperarousal

Table modified from Van Os et al., 2016

2.2 The contexts for psychosocial development

Children's psychosocial development cannot be understood without paying adequate attention to the multiple and overlapping contexts within which it occurs (Gershoff et al., 2013; Sameroff, 2010). *Contexts* are often understood as physical environments that children experience (Evans & Wachs, 2010; Gershoff et al., 2013); however, contexts can also be conceived more broadly and seen to include social, cultural, and political environments determining the interactions and experiences relating to children's development (Gershoff et al., 2013). Urie Bronfenbrenner's (1979) ecological approach to child development reflects this broad conceptualization of contexts. Paat (2013) suggested that, due to immigrant children's experiences in different ecological systems, Bronfenbrenner's theory is beneficial for understanding those experiences. Bronfenbrenner proposed that human development happens in a complex interplay of the various contextual layers of the surrounding environment and innate individual characteristics. This interplay between context and biology and the effect on child development is one of the central questions in early child development (Barlow, 2019; Boyce, 2010). Despite the varying emphases on the nature and nurture fields, researchers generally acknowledge that contexts are possible points of intervention for children at risk: Child developmental outcomes can be improved by enhancing the contexts of psychosocial development (Lieberman & Ghosh Ippen, 2010).

Abundant evidence shows that during childhood, the brain is highly vulnerable to contextual influences (Cantor et al., 2018). Early experiences in various contexts of childhood modify the brain structure via epigenetic modifications (Miguel et al., 2019). Adverse childhood experiences are associated with several mental and somatic disorders later in adulthood (Herzog & Schmahl, 2018). However, within the contexts of childhood, the phenomena of resilience suggests that the influence of protective factors overruling the risk formed by adverse childhood experiences can lead to a more positive outcome than expected (Stainton et al., 2019).

The present study's overarching contexts are (1) the relational contexts of parenting and parental mental health and (2) the spatial contexts of reception centers and schools.

2.2.1 The relational contexts of parenting and parental mental health

The relational context refers to the role of developmentally important relationships fundamental for children's healthy development, along with supportive spatial contexts (Baumeister & Leary, 2007; National Academies of Sciences, Engineering, and Medicine, 2016). Relationships between children and parents are the primary contexts through which biological and spatial factors influence and mutually

reinforce each other (Osher et al., 2018). Parents' capacity to accurately respond to a child's mental state is essential for developing shared experiences, emotions, and self-regulation (Bornstein & Leventhal, 2015; Siegel, 2012). Thus, these developmental relationships build the child's capacity to regulate emotions, behavior, and cognition; self-regulation is the foundation for lifelong functioning, affecting factors such as mental health, school success, health, and socioeconomic success (Murray et al., 2014; Sroufe, 1997).

Parenting

Parenting's multifaceted nature has been operationalized in several ways (Hoghughi, 2012). However, parents are generally acknowledged as influencing their infants via genes, beliefs, and behavior while indirectly influencing them through their interactions and the varying diverse contexts in which they live (Bornstein, 2002). Children actively try to keep their parents close and ensure they are being cared for, while parents instinctively seek out interaction with their children (Esposito et al., 2017). This interaction generates the parent–child attachment shaping the neural pathways involved in cognitive and psychosocial development and socio-emotional regulation (Esposito et al., 2017). These patterns of socio-emotional regulation are thought to remain relatively stable during one's lifetime, forming important links between early parent–child attachment, health-related physiological processes, and vulnerability to risk factors (Esposito et al., 2017). The early attachment relationships also constitute a secure base from which a child can explore the surrounding environment and a safe haven to which the child can return in times of distress; these are fundamental for learning and development (Ainsworth & Bowlby, 1991; Cassidy et al., 2013). A secure base means children can explore their environment freely as they can trust their parents' availability and sensitive responsiveness.

Bornstein (2002) argued that a critical step to fully understanding parenting is to evaluate the forces initially shaping it. The origins of individual variation in caregiving are complex, but some factors seem to have specific importance: the characteristics of children, biological determinants, personality, and contextual influences (including social situational factors, socioeconomic status, and culture). The present study focuses on the contextual influences affecting caregiving because these influences can often be altered to improve child outcomes.

Regarding parenting, parental cognitions are commonly thought to shape caregiving; in turn, caregiving is thought to shape child development. Parental cognitions are widely acknowledged as shaped by context (for example, culture) and the characteristics of children (Bornstein et al., 2018). However, contextual factors play a role in directly shaping caregiving and, thus, the whole ecology of childhood

(Bornstein, 2002). In the present study, Bornstein's (2002) central domains of caregiving are used:

1. *Nurturant caregiving* refers to the biological, physical, and health requirements of children.
2. *Material caregiving* includes how parents arrange the child's physical environment.
3. *Social caregiving* means the behaviors parents use to engage children emotionally and manage their interpersonal exchanges.
4. *Didactic caregiving* includes parental strategies for stimulating children to engage in and understand the world.

Parental mental health

Parental mental health influences all caregiving aspects: Parents must be emotionally, financially, and socially secure to optimally fulfil their parenting tasks (WHO et al., 2018). Parental mental health problems are often associated with caregiving difficulties (Arnold et al., 1997; Kaslow et al., 1994; Leinonen et al., 2003). For example, parents' trauma symptoms contribute to harsh caregiving and, onwards, to the poorer mental health outcomes of children (Bryant et al., 2018); parents' depression is associated with parents' negative and inadequate responses to children's efforts to engage with them (Downey & Coyne, 1990; Whitbeck et al., 1991). The association between parental and child mental health is well-established (Pietikäinen et al., 2020). Also, caregiving stress (the difficulty experienced in the caregiving role because the associated demands exceed the resources available to meet those demands) is a significant source of parental stress (Abidin, 1992). Because of the detrimental effects of caregiving stress on the quality of caregiving and children's well-being, identifying the sources of the stress is important (Bornstein, 2002). Previous studies have addressed the contexts surrounding parents and children as significant sources of caregiving stress, as well as parent and child characteristics (Deater-Deckard, 2004; Nomaguchi & House, 2013).

Among asylum-seeking children, parental mental health significantly impacts the children's mental health. A strong association exists between the mental health problems of refugee parents and their children; good parental mental health is an important protective factor (Fazel et al., 2012). Asylum-seeking parents often have their own distressing experiences and stressors, which can negatively affect their parenting skills (van Es et al., 2019). Thus, the parent's capacity to meet their child's changing needs can be compromised due to the parent's trauma, loss of support networks, and unsupportive living conditions (Lietaert et al., 2019; Mares & Powrie,

2014). However, helping parents cope with contextual stressors, for example, with the help of informal social support, is possible (Moran et al., 2019).

2.2.2 The spatial context of place

The spatial contexts that children and their parents experience greatly impact the children's psychosocial development (Ferguson et al., 2013). Drawing from human geography, everything in human life must happen somewhere, and that somewhere matters regarding what actually happens (Jones, 2012). In the present study, reception centers and schools are scrutinized as spatial contexts for children's psychosocial development utilizing the concept of place. People interact with their environment subconsciously in everyday routines, extracting from abstract space a meaningful place (Gieryn, 2000). A place is thus created by human experiences, in contrast to space, which has no social connections for a human being (Tuan, 1989).

Globalization and the increasing flows of migrants have increased geographical mobility, but this has not diminished the importance of place (Jack, 2015). It has been proposed that in modern societies filled with uncertainty, personal identities are continuously under construction through the continuous everyday interactions between individuals and their environments (Giddens, 1991; Jack, 2015). Moreover, despite the diminished time spent in one geographical place, feelings of belonging, security, and personal identity seem to be more closely attached to the places people come from than ever before (Entrikin, 1991; Jack, 2015; Lewicka, 2011b). Moreover, research among a refugee population has shown that these connections to places of origin seem to have an emphasized meaning, especially when families are placed in the temporal contexts of the asylum-seeking process and under continuous threat of being sent back (Menjívar, 2012).

As the Introduction stated, the early childhood years are a critical developmental period for children because the foundations for psychosocial well-being, mental health, and life success are laid (Hertzman & Williams, 2009). The influence of place on young children's development is not well understood (Brooks-Gunn et al., 1993; Leventhal & Brooks-Gunn, 2000; Ling Hin, 2009), albeit the ecological model of development dictates that children's development should be studied within the contexts in which they live (Bronfenbrenner, 1979). The significance of place becomes even more prominent when considering children whose psychosocial development and parenting are entangled with the changing places of their childhood.

Appadurai (1996) has suggested that all social phenomena comprise location, materiality, and meaning. In agreement with John Agnew's (1987) theory, the analysis utilizes his division of place into three dimensions: *location*, a point in

space; *locale*, the broader context of social relations for individual locations; and *a sense of place*, the subjective feelings associated with a particular location.

Location

The significance of a change of location in the refugee experience cannot be underestimated (Sampson & Gifford, 2010). Said (2001) described the displacement as an "unhealable rift forced between a human being and a native place, between the self and its true home: its essential sadness can never be surmounted."

Due to modern transportation and communication technologies, the distance between locations is less of a limitation than before. Within forced displacement, this modernization and deterritorialization of people and place mean that transnational connections to the place of origin are often an important part of everyday life (Madianou & Miller, 2012; Ferguson & Mansbach, 2012). Migration studies describe the "transnationalism" connecting people to two or more locations as "a process by which migrants, through their daily life activities, create social fields that cross national boundaries" (Basch et al., 1994). Thus, locations remain important as sources of meaning for mobile subjects (Moskal, 2015).

Locale

Locale can be understood as a place where individuals participate and express themselves in everyday life, anchored in their homes or other site-specific relations (Simonsen & Skjulhaug, 2019). The material environment impacts health outcomes due to natural features (such as water, parks, and forests) or aspects of the built environment (Jack, 2015). This environment enables different types of behavior, daily activities, and social interaction; it also influences well-being, identity, and mental health (Hauge et al., 2017). For example, children in noisy or chaotic locales report more anxiety and difficulty concentrating (Ferguson et al., 2013). Regarding parenting in crowded settings, individuals socially withdraw to cope with the overwhelming social stimulation, which can lead to unresponsive parenting and diminished social support (Ferguson et al., 2013).

The family home—or the temporary accommodations of an asylum-seeking family—is the most proximal locale influencing a young child's development. Many studies have shown that poor or overcrowded housing conditions negatively impact a child's health (Gifford, 2007; Harker, 2007). Moreover, the possibility to play is a vital prerequisite for psychosocial development. Play is essential for learning, cognitive and psychosocial development (Golinkoff et al., 2006), and developing a sense of oneself and others (Fonagy & Target, 2007). Reduced opportunities for children to play negatively influence their psychosocial development (Christian et

al., 2015; Ginsburg et al., 2007; Pellegrini, 2009). Senda (1992) has proposed that a place to play is one of the four required elements for creating a child's play environment, along with time to play, friends to play with, and what the child does when playing.

Outside the immediate home environment, the surrounding locale's characteristics can hinder or promote early childhood development (Dunn, 2012). Suggested developmentally critical physical characteristics of the locale are access to local services and the quality of those services, recreational opportunities, public transportation, the physical quality of child-related care, and educational and healthcare facilities (Center on the Developing Child at Harvard University, 2010; Christian et al., 2015; Goldfeld et al., 2015). Neighborhood deprivation affects parents' parenting approaches (Roosa et al., 2003; Simons et al., 1996). In deprived neighborhoods, parents are described as restricting their children's autonomy and mobility, further influencing children's possibilities for social interaction and their chances to develop independency (Pain, 2006; Valentine & McKendrick, 1997).

The locale's situation related to the surrounding environment is also significant. In urban studies, the term *peri-urban* has received considerable attention. It can be understood as a condition between the urban and the rural, in the rural–urban fringe (Qviström, 2013). Studies claim that peri-urban areas suffer from a lack of political interest and public transportation and easily become subjected to unplanned interventions and temporary uses (Sieverts, 2003).

Sense of place: emotional engagement with place

The multidimensional concept of a sense of place has been defined and applied in many ways in various disciplines (Nelson et al., 2020). Different theoretical traditions use various place-related concepts—such as place attachment, place identity, rootedness, a sense of place, place dependence, place satisfaction, or place engagement—in alternating and often incompatible ways (Hernández et al., 2007; Jorgensen & Stedman, 2006; Knez, 2005; Lewicka, 2011b; Pretty et al., 2003). A sense of place is the emotional engagement between individuals and their meaningful environments (Giuliani, 2003; Altman & Low, 1992). Thus, the concepts of a sense of place and emotional school engagement seem to entail aspects of the same phenomena. *A sense of place* is a concept often used in the human geography field, whereas *emotional school engagement* is especially used in the educational psychology field. In the present study, feelings of belonging and everyday routines are studied as components of a sense of place, aligning with the theory of a human geographer and phenomenologist, Seamon (2015), who put forward the theory of "time-space routines" or "body-ballet." He suggested that a sense of place is created through a set of automatized everyday activities performed in a place, contributing

to the "place-ballet," producing belonging within the rhythm of life in a place (Lewicka, 2011b). Hence, the meanings attributed to places help people to situate themselves in the world and feel a sense of belonging, with routines offering the opportunity to repeat experiences and strengthen feelings of belonging (Gordon, 2010; Vanclay, 2008). Given the lack of coherence in the terminology described above, in the present study, a sense of place and emotional school engagement are referred to as *emotional engagement*.

Little is known about how a sense of place develops (Lewicka, 2011b). Lewicka (2011b) proposed that important socio-demographic predictors for a sense of place are the length of residence, home ownership, social predictors of community ties, and a sense of security. Of the physical predictors, Lewicka highlighted the importance of access to nature, housing and neighborhood quality, size of building and type of housing, municipal services, and household density.

For children, repeated experiences of places—with the social meaning they attach to them—influence the development of a sense of place (Gordon, 2010). Moreover, a parent's sense of place plays a central role in developing their child's sense of place because the emotional qualities of the relationship between parent and child mold the child's experience (Chawla, 2007). Psychoanalytic theory describes how cognition about places is incorporated into the self, creating internalized objects serving as sources of security in times of stress (Gordon, 2010; Greenberg & Mitchell, 1983). In other words, the meanings attributed to places provide a framework for constructing personal identity (Cuba & Hummon, 1993; Hay, 1998). Morgan (2010) explained the formation of a sense of place with the help of the Circle of Security model (Marvin et al., 2002), based on Bowlby's (1978) attachment theory. In the Circle of Security model (Marvin et al., 2002), the child moves circularly between the attachment figure and the environment: The child seeks physical and psychological attachment to the caregiver, especially when distressed. By providing comfort and emotional regulation when the child needs it, the attachment figure can act as a secure base for the child, enabling their child's exploration. Frequent repetition of this exploration–attachment cycle between the attachment figure and child results in patterns of behavior and emotions and the emergence of an unconscious working model of the attachment relationship—the foundation of identity development (Siegel, 2012). However, in the original model, the environment's characteristics play no role. Morgan (2010) argued that place is a "fascinating presence that draws in the child" and that a child's sense of place develops because of this repeating cycle.

Research among children and young people has revealed the close connections between place, identity, and well-being (Altman & Low, 1992; Gordon, 2010; Irwin et al., 2007; Twigger-Ross & Uzzell, 1996). Some studies have explored the psychological processes that attach well-being to places. For example, Korpela

(1989) proposed that one's environment plays a role in self-regulation: It helps to restore the balance of pleasure and pain, and to maintain both the coherent image of oneself and high self-esteem. Lewicka (2011a) found that place-attached persons, compared with unattached persons, had a higher sense of coherence, were more satisfied with their life, had a stronger bonding social capital and neighborhood ties, trusted people more, and were less egocentric. These findings highlight the significance of place in supporting health and well-being (Sampson & Gifford, 2010).

2.2.2.1 Locale and emotional engagement within reception centers

Studies analyzing the spatial contexts of reception centers often address the political power relations intrinsic to a reception center and conceptualize reception centers as spatial formations in the struggles over territories, borders, and identities (Agamben, 1998; Puggioni, 2006; Puumala et al., 2011; Ramadan, 2013). Moreover, attention is paid to the different discourses on living in reception centers. For example, the reception centers are often in peri-urban areas; some asylum seekers experience these areas as difficult and traumatic (Simonsen & Skjulhaug, 2019). Further, symbolic and physical marginalization (othering) was described as having spatial ramifications regarding "popular and often toxic notions of who belongs where" and the power structures built into the architecture of cities. However, despite the lack of status, limited resources, and reduced mobility, the temporal and spatial in-betweenness are suggested to create opportunities for reflection and provide possibilities for new existential meanings (Ghorashi et al., 2018; Manjikian, 2010). In Ramadan's article on spatializing the refugee camp (2013), the space of the camp or center is described as more than just a humanitarian space of physical welfare or a space of exception and intensified biopolitical exile: "It is an assemblage of buildings, homes, people, institutions, social relations and practices."

In Finland, 19 reception centers for adults and families were operating in November 2021 (Finnish Immigration Service, 2022). A maximum processing time of six months was applied to applications submitted on or after July 20, 2018; however, this waiting time may be longer under certain conditions and is often further prolonged by appeals and new applications (Owal Group, 2019). The basic services a reception center provides are accommodations, social and health services, a reception allowance and spending money, interpretation, work and study activities, and voluntary return services (Finnish Immigration Service, 2022). Asylum seekers usually stay in a transit center initially; after an asylum interview, they are transferred to another reception center to await a decision (Finnish Immigration Service, 2022). Furthermore, it is noteworthy that in sparsely populated Finland, many reception

centers are in peri-urban locations with restricted connections to city centers and services.

Little research exists on the reception center locales and their implications for parenting (Merry et al., 2017). Ogbu and colleagues (2014) focused on the spatiality of Irish reception centers. They addressed the fact that parents felt unable to fulfill the basic roles of parenting, concluding that reception centers could damage children's well-being. Lietaert and colleagues (2019) found that various organizational aspects of reception centers restrict the opportunities for parenting, and insufficient attention is paid to an asylum seeker's parental role in reception facilities. The constricted parental possibilities regarding children's spaces and activities and the simultaneous emphasis on parents' responsibility for caregiving reflected by the parents' beliefs and the reception center's policies create a discrepancy causing parental stress (Lietaert et al., 2019). Ni´ Raghallaigh and colleagues (2020) highlighted that structural causes, such as institutional-type accommodations, compel staff to take an unreasonable regulatory role over parenting, often without adequate competencies, resulting in negative consequences.

Regarding asylum-seeking children, Finland's reception centers typically have different kinds of activities for children, mainly created by volunteers. Save the Children Finland first set up Child Friendly Spaces (CFS) in the Finnish reception center context in 2015, specifically to provide children with opportunities to develop and play to regain a sense of normalcy and support parents in providing a safe and nurturing environment (Häikiö et al., 2017). However, the last CFS closed at the end of 2019. In spring 2022, CFSs reopened in a few reception centers. The CFS is widely utilized in humanitarian emergencies to effectively address the protection and psychosocial needs of young children and support their developmental assets (Hermosilla et al., 2019). These aims also apply to reception centers, where asylum seekers spend prolonged periods. A previous study in Finland from two decades ago indicated that, despite the country's high level of social security, adequate living conditions for asylum-seeking children were not ensured (Sourander, 1998). However, despite this, more recent studies in Finland and other Nordic countries show that the spatial situations of asylum-seeking children continue to contradict the Nordic childhood ideology (Lähteenmäki, 2013; UNICEF, 2018) even though asylum-seeking children are at particular risk of adverse psychosocial outcomes (Fazel et al., 2012). In White's (2012) study on childhoods in an Irish asylum center, he argued that the exclusion and marginalization the children experience are significant; however, the children were also active subjects in creating their social and cultural identities. White (2012) argued that ultimately the decisions made about children's lives by authorities and their parents played a key role in determining the level of the children's access to developmental opportunities.

Hauge and colleagues (2015) listed a series of requirements for asylum seekers' well-being that directly link to the locale's geographical situation: seeing other people, short distances to public transportation, and easy access to activities and central areas (including having schools, doctors, and groceries in walking distance). However, reception centers are often in peri-urban areas. Asylum seekers can be seen (physically and symbolically) as "matter out of place," with this geographical location emphasizing their status as society's others (Douglas, 2003; Simonsen & Skjulhaug, 2019). Further, poor housing quality has been suggested to symbolize outsiderness regarding asylum seekers (Hauge et al., 2017).

The significance of an emotional engagement within a reception center becomes understandable if the disruption of a sense of place caused by forced migration is considered in the light of disrupting Seamon's theory of time-space routines or body-ballet (Fullilove, 1996; Seamon, 2015). Families not only lose their familiar locale, including their social contacts, but their routines and adaptations while being forced to try creating new ones. Migration studies have highlighted this recreating process through practices such as "recreating a home" and "recreating sense of belonging" (Cory, 2020; Fozdar & Hartley, 2014). However, the related literature often explores home through the experiences of adults (Moskal, 2015). Van der Horst (2004) pointed out that the government policy focuses on providing shelter rather than a home, whereas asylum seekers use concepts of home when describing their lives in the reception center. She concluded that the contradiction leads to dissatisfaction among asylum seekers when the basic requirements for a home are unmet. The involuntary loss of familiar places by forced migration can be extremely stressful (Giuliani, 2003; Gordon, 2010). Brown and Perkins (1992) suggested that losing normal attachments to places creates a stressful period of disruption, followed by a post-disruption phase of coping with lost attachments and creating new ones. Disturbances of a sense of place in early childhood are suggested as possibly creating fragmented narrative memories, affecting identity development and further perceptions of socio-spatial ties (Brown & Perkins, 1992; Kuusisto-Arponen, 2011).

2.2.2.2 Emotional engagement within school

In the present study, emotional engagement within school is conceptualized through the children's perceptions of the classroom atmosphere, their relationship with the teacher, the educational achievement, the sense of belonging at school, and bullying.

School engagement is a broad concept that has been analyzed in several ways (Fredricks et al., 2004). One approach is to divide it into emotional, behavioral, and cognitive engagement (Fredricks et al., 2004; Lam et al., 2014): *Emotional engagement* describes the extent of children's positive and negative reactions to the school, teacher, and activities. *Behavioral engagement* encompasses participation in

academic activities and conduct. *Cognitive engagement* generally refers to the motivation to master learning tasks. Emotional school engagement is less studied among young immigrant children, but immigrant adolescents have a weaker emotional engagement than natives (Chiu et al., 2012). Recent evidence from the Organisation for Economic Co-operation and Development (OECD) Reviews of Migrant Education shows that immigrant adolescents are at risk of poor school success (OECD, 2018). For refugee children particularly, support from teachers and a positive school climate promote a stronger sense of school belonging and, ultimately, better academic adjustment (Suárez-Orozco et al., 2009; Tyrer & Fazel, 2014). School engagement could be a potential means with which to improve educational outcomes because it encompasses processes promoting learning and can be nurtured in students (Ladd & Dinella, 2009).

Schools affect children's psychosocial development through organizational, social, and instructional processes (Eccles & Roeser, 2009). Children spend most of their day in school to develop their cognitive and social skills for their future in the adult world; thus, schools play a key role in their psychological well-being. Ellis (2005) suggested that the emotional significance of school develops over time through children's experiences of familiar routines building their confidence as they learn to know and become known by others, acquire intimate local knowledge, and learn the culture's norms. She adds that, according to Hay (1992) and Tuan (1989), if the classroom is a good place, it will be a source of security, belonging, meaningful relationships, and identity. During childhood, when school plays a major role in children's everyday lives, school may become central to the sense of self (Voelkl, 1997). Children recreate these identities and acquire new roles and values through actions in everyday life (Eyles, 1989). This identity development can be supported by trying to ensure these experiences are enjoyable and successful (Ellis, 2005).

School engagement correlates favorably with mental health outcomes and school success (Voelkl, 1997). Emotional school engagement inversely relates to emotional problems (Li & Lerner, 2011). Emotionally engaged adolescents are considered protected from emotional problems by supportive relationships with teachers and peers (Li & Lerner, 2011; Whitlock, 2006). School engagement is generally described as declining during adolescence (Li & Lerner, 2011; Wang & Eccles, 2012), yet most adolescents follow stable trajectories from moderate school engagement to very high engagement (Janosz et al., 2008). Immigrant adolescents seem to be at particular risk for a declining pattern of school engagement (Li & Lerner, 2011; Motti-Stefanidi & Masten, 2013). It has been suggested that immigrant adolescents disengage from school to protect themselves from failures in school success (Motti-Stefanidi et al., 2015). A lack of a sense of belonging can lead to adverse mental health outcomes, such as anxiety, depression, anger, sadness, and loneliness (Carpiano & Hystad, 2011).

3 Aims

The general aim of this study was to explore the mental health of accompanied asylum-seeking children and immigrant-background children and the contexts shaping their psychosocial development. The study addressed the relational contexts of parenting, parental mental health, and the spatial contexts of reception centers and schools.

Specifically, the study questions were as follows:

1. What is the mental health status of accompanied asylum-seeking children at arrival in the country of asylum within the relational context of parental mental health? (Study I)
2. What are the opportunities for parenting in the reception center's spatial context? (Study II)
3. What is the level of emotional school engagement reported by children and the mental health status as assessed by teachers and parents among immigrant-background children in the spatial context of school? (Study III)

4 Materials and Methods

4.1 Study designs and participants

4.1.1 Recently arrived asylum-seeking children (Study I)

4.1.1.1 Study design

The data of Study I were derived from the Asylum Seekers Health and Wellbeing (TERTTU) Survey carried out by the Finnish Institute for Health and Welfare (THL) in collaboration with the Finnish Immigration Service in 2018 (Skogberg et al., 2019). A sample of all first-time asylum applicants was drawn from the Finnish Immigration Services' electronic asylum database based on the registration of their first asylum application falling between February 19 and November 11, 2018 (Skogberg et al., 2018). All asylum applicants had applied for international protection in Finland in fear of persecution, war, or other types of insecurity.

The data collection of the TERTTU Survey consisted of a standardized health examination, questionnaire, and face-to-face interviews, including questions on living conditions, health, physical and social functional capacity, quality of life, experiences of traumatic and violent events, lifestyle habits, and service use (Skogberg et al., 2019). Questions on early childhood and development were applied concerning children (Skogberg et al., 2019). The study material, including the information letter, consent forms, and interviews, was compiled for each of the four age groups: under school-age (0–6 years); school-aged (7–12 years); adolescents (13–17 years), and adults (18 years and older) (Skogberg et al., 2018). For most (79%) of the participants, data collection was arranged within the first 30 days from the abovementioned registration and 14% within the second 30 days from the registration (Skogberg et al., 2018). A research assistant from the multilingual team of assistants conducted most of the interviews (62%) directly. A professional interpreter was used in the rest of the cases. Trauma-related symptoms were interviewed, whereas data on mental health symptoms was primarily collected with self-administered questionnaires. When the participant was illiterate, had difficulties

completing the questionnaire, or the questionnaire was unavailable in the participant's language, the research assistant interviewed them. Parents answered the questionnaire and the interview questions regarding children aged 12 years old or younger; the children in these age groups only participated in the health examination (Skogberg et al., 2019). The participation rate for adults was 79%; for accompanied children, it was 78% (Skogberg et al., 2018).

4.1.1.2 Participants

The participants of Study I were a subsample of the TERTTU Survey, consisting of 184 accompanied children aged 2–12 years old and their parents, comprising 68 fathers and 110 mothers. There were 93 children in the 2–6-year-old age group and 91 in the 7–12-year-old age group. Among 2–6-year-old and 7–12-year-old children, over 70% of mothers (79.5% and 74.2%) and about 90% of fathers (91.1% and 89.2%) had an educational level of at least secondary education. Among 2–6-year-old children, the most frequent region of origin was North Africa and the Middle East (57.0%), followed by Russia and the Former Soviet Union (30.1%). Among 7–12-year-old children, the most frequent region of origin was Russia and the Former Soviet Union (40.7%), followed by North Africa and the Middle East (35.2%). Information was gathered from 119 families, including 78 families with 2–6-year-old children and 71 families with 7–12-year-old children. Of these 119 families, 59 had both parents, 29 had both parents in Finland but only one parent in the study, and 31 families had only one parent: a mother. In the latter group of mothers who came alone with their children, fathers were reported as deceased, residing in another country, missing, or absent. Further, 46 of the families had one child, 46 had two children, 20 had three children, and 7 had more than three children, based on the number of children participating in the TERTTU Survey. In 51 families, more than one child was included in the study sample.

4.1.2 The asylum-seeking parents of children under school age in reception centers (Study II)

4.1.2.1 Study design

The analysis was based on semi-structured qualitative interviews ($n = 26$) among the parents living in three reception centers, of which two were transit centers and one was for waiting for asylum decisions. One of these transit centers had a CFS on the premises. In one reception center, participants were recruited through the information sessions the reception center's social workers held for each new asylum-seeking family. The researcher or a Save the Children Finland project worker did the

recruitment in the other two reception centers. Potential participants were given written information (in their native language) about the study's objectives, its voluntary and confidential nature, and the topics it would cover. Forty-seven families received the information; of those, 30 (64%) participated in the study.

The data was collected in the reception centers with the assistance of interpreters between November 2018 and February 2020. An interview was conducted if the family was still in the reception center approximately two months after the beginning of the study or after the family's arrival at the reception center. Of the 30 families agreeing to participate in the study, 26 families were still in the reception center, while four had moved out. The researcher conducted the interviews (n = 26) with one parent (n = 23) or both parents (n = 3). Altogether, 29 parents were interviewed.

The study was part of an intervention study investigating how reception centers support the psychosocial development of 2–6-year-old children and parenting by comparing children who have a CFS at their reception center with children who do not. Also, the aim was to assess the feasibility of the CFS and the experiences of parents, reception center staff, CFS project worker, and volunteers. However, the intended number of participants for quantitative analysis was not reached due to CFS activities ending at the end of 2019 and the decreased number of asylum seekers.

4.1.2.2 Participants

The participants of Study II were 29 asylum-seeking parents living in three reception centers in Finland. The asylum-seeking parents of 2–6-year-old children who met the following criteria were recruited: (1) they lived in one of the three reception centers in which the study was conducted, (2) their native language was Arabic, Dari, English, Farsi, Pashto, Somali, Sorani, Turkish, or Russian (this selection being based on the main countries of origin for asylum seekers in Finland), and (3) they were literate. Of all participants, 22 were female, and seven were male. Almost half the participants (n=14) had educational level of post-secondary education. Of the 26 families of the participants, 21 families had the whole family in the reception center. Eight families had one child, 12 had two children, and six had more than two children.

4.1.3 Immigrant-background children in their first years of school and native comparisons (Study III)

4.1.3.1 Study design

The data used in Study III were from a cluster randomized controlled trial of Together at School intervention program on children's socio-emotional skills

conducted by the Finnish Institute for Health and Welfare (THL) during 2013–2014 (Kiviruusu et al., 2016). The Together at School trial was designed to assess the intervention's effectiveness on children's socio-emotional skills and mental health. The informants consisted of children, parents, teachers, and principals. All Finnish primary schools were invited to participate in the study on the condition that the school had a minimum of two teachers who taught the first, second, or third grades and agreed to participate for the whole study period of two school years. The data were obtained via electronic questionnaires (for the teachers and parents) and computer-based tasks and questions (for the children) (Björklund et al., 2014). A paper version was also available for the parents. The data includes 79 Finnish primary schools and 3704 children (Kiviruusu et al., 2016). In 2013, there were 2370 primary schools in Finland (Statistics Finland, 2013).

4.1.3.2 Participants

The participants of Study III were 2610 children with their parents who participated in a cluster randomized controlled trial of the Together at School intervention program. The data from the participants at the baseline in the fall of 2013 were analyzed. The parents of 2610 children participated at the baseline; of these, 2578 provided information on their native language. An immigrant-background child was defined as one who had at least one parent with a foreign native language (Finland's domestic languages are Finnish and Swedish). Of the 2578 children, 113 (4.4%) had one parent with a foreign native language, and 35 (1.4%) had two parents with a foreign native language. Both parents of 2430 (94.3%) children had Finnish or Swedish as their native language.

There were 974 children (37.8% of the children) in the first grade, 999 children (38.8% of the children) in the second, and 605 children (23.5% of the children) in the third. In Finland, first- to third-grade beginners typically cover children ages six to nine (Ministry of Education and Culture, Finnish National Agency of Education, 2018). There were fewer nuclear families in the immigrant background group (55.4%) than natives (76.7%). Parents' unemployment or inability to work was more common in the immigrant background group among fathers (11.5%) and mothers (17.6%) compared to natives (5.4% and 6.4%, respectively). Family's subjective difficulty in covering expenses was greater in the immigrant background group (38.5%) than the native background group (23.3%).

4.2 Measures

4.2.1 Demographic characteristics

4.2.1.1 Study I

The socio-demographic factors of accompanied asylum-seeking children used in the analyses were the children's gender, parents' educational level, and family type. The parent's educational level was composed of eight categories: not known, none, basic education of three years or less, basic education of 4–6 years, basic education of 7–9 years, secondary school, vocational training, and post-secondary. The parent's educational level was divided into two categories: (1) basic education of nine years or less and (2) secondary school, vocational training, or higher. The parent's educational level was further organized into a dichotomous variable according to the highest educational level of both parents or the only parent in the study. The family types comprised (1) families with two parents, both in the study or one participating in the study and the other living in Finland but not participating in the study and (2) families with one parent and the other not living in Finland or absent.

4.2.1.2 Study III

The socio-demographic factors of the immigrant-background children and their native comparisons used in the analyses were gender, school grade, family structure, mother's basic educational level, parents' employment status, and family's self-reported economic situation. The family structure comprised four categories: nuclear, single-parent, blended, and other. Family structure was divided into two categories: nuclear family and other. Mother's basic education comprised three categories: lower than primary school, primary school, and upper secondary school. The mother's basic education was grouped into primary school or less and upper secondary school. Parents' employment status comprised seven categories: employed, entrepreneur, unemployed, disabled, stay-at-home parent, maternity or nursing leave, and student. Parents' employment status was grouped into two categories: unemployed or disabled and other. Parents reported the family's economic situation and estimated how easy or difficult it was to cover their living expenses with their income on a six-point scale. The family's economic situation was grouped into two categories: satisfactory and difficult.

4.2.2 Children's mental health (Studies I and III)

Children's mental health was assessed in both studies using the children's Strengths and Difficulties Questionnaire (SDQ), consisting of 25 items in the following five subscales: emotional symptoms, conduct problems, hyperactivity, problems with peers, and prosocial behavior. Each subscale consists of five items; participants evaluate how well the item fits the child's behavior on a 3-point scale (Not true, Somewhat true, or Certainly true). The scoring of the items is done on a scale from 0 to 2; after summing the 5 items for each of the 5 scales, the score ranges from 0 to 10. The total difficulties score is formed by adding the scores from all the scales except the prosocial scale. The SDQ is widely used internationally, has been validated in various research and community settings, and has been shown to have adequate psychometric properties (Achenbach et al., 2008; Kersten et al., 2016; Stone et al., 2010). Further, the Finnish language version of the SDQ has shown adequate psychometric properties (Borg et al., 2014).

For Study I, the psychiatric symptoms of the accompanied asylum-seeking children were assessed with the SDQ the parents completed. The analyses used all the subscales except the prosocial behavior subscale because the focus was on a selected population's problem behavior. In the version for 2–4-year-old children, three of 25 statements have different wording. The British normative scoring bands were used instead of the Finnish norms due to the children's non-Finnish ethnicity. The British normative scoring bands were utilized to divide 80% of the children into a *normal* category, 10% into a *borderline* category, and 10% into an *abnormal* category, while considering different cut-off scores for 2–4-year-old children and older children (Youthimind, 2021; Goodman, 1997). The *borderline* and *abnormal* categories were combined into one category. In this study, the internal consistency of the total difficulties score was satisfactory: Cronbach's α=.82. The subscales had moderate internal consistencies: emotional symptoms α=.76, conduct problems α=.62, hyperactivity α=.64; for some reason, the problems with peers subscale had an unacceptably low internal consistency of α=.31.

For Study III, the psychiatric symptoms of the immigrant-background children and their native comparisons were evaluated with all five subscales of the SDQ (Goodman, 1997; Stone et al., 2010). Teachers and parents completed separate questionnaires. In the SDQ teachers completed, the internal consistency of the total difficulties score was satisfactory, α= .87, and the subscales had satisfactory internal consistencies: emotional symptoms α=.74, conduct problems α=.77, hyperactivity α=.88, problems with peers α=.70, and prosocial behavior α=.82. In the SDQ parents reported, the internal consistency of the total difficulties score was satisfactory, α=.82, and the subscales had moderate internal consistencies: emotional symptoms α=.58, conduct problems α=.63, hyperactivity α=.80, problems with peers α=.58, and prosocial behavior α=.68.

4.2.3 Parental mental health (Study I)

The parents' anxiety and depression symptoms were assessed with the Hopkins Symptom Checklist-25 (HSCL-25). It has been widely used in refugee populations to evaluate for symptoms of anxiety and depression (Steel et al., 2009; Wind et al., 2017). Each item is answered on a 4-point scale (Not at all, A little, Quite a bit, Extremely). The item's scoring is done on a scale from 1 to 4. The total score is the average of all 25 items; the cut-off score of 1.75 was used (Nettelbladt et al., 1993). The internal consistency of the total score variable was α=.95 for mothers and α=.95 for fathers.

Parents' trauma symptoms were interviewed using the Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment (PROTECT) questionnaire (Dimitrova et al., 2012), which evaluates the likelihood of the respondent having had traumatic experiences based on trauma symptoms. This questionnaire is designed to be a fast screening tool for non-health professionals; thus, it does not screen for a potentially traumatic event that would presuppose a specific context regarding time, trust, and expertise (Mewes et al., 2018). The PROTECT questionnaire consists of ten yes-or-no questions; counting the "yes" answers together establishes the sum score. A total sum variable was constructed for mothers (mean 3.90, standard deviation 2.99) and fathers (mean 3.18, standard deviation 2.83). For mothers, the internal consistency was α=.83, and for fathers, α=.83. The result is categorized into three categories: low risk, medium risk, and high risk. The sum score of three or less reflects low risk, from 4 to 7 indicates medium risk and 8 or more is considered high risk. The medium-risk and high-risk categories were combined in the analyses due to the small number of cases in the high-risk category (among the younger children, mothers n=4 and fathers n=2; among the older children, mothers n=9 and fathers n=3).

Parents' psychiatric symptoms were organized into dichotomized categories: both parents or the only parent in the study had an HSCL-25 result in the clinical range (yes/no); both parents or the only parent in the study had a PROTECT result in the medium- or high-risk categories (yes/no). Parents' psychiatric symptoms were organized based on the known presence of at least one healthy parent in the family. Thus, by organizing the parents' dichotomized measures this way, the opposite category consisted of those families where the only parent in Finland was healthy or at least one of the two parents in Finland was healthy (and the other parent healthy or with psychiatric symptoms in the clinical range or not participating in the study). The presence of at least one healthy parent in the family was considered a protective factor for the child.

4.2.4 Parenting (Study II)

The relational context of parenting was assessed qualitatively with semi-structured interviews exploring the following subject categories: parenting amid the asylum-seeking process and in the reception center environment, the support available for the child and parenting, parenting barriers, changes in the child's behavior or parenting after leaving the home country, and views on possible changes to make the reception center more supportive of the child's development. Moreover, parents' views on CFSs were discussed if they had a CFS at their reception center. Interviews were audio-recorded and transcribed, resulting in 102 pages of text (font: Times New Roman; font size: 10; spacing: 1). The average duration of all 26 interviews was 45 minutes (range: 25–62 minutes). Interviews were qualitatively analyzed as described in Subsection 4.3.2, Study II. Parenting was assessed using Bornstein's (2002) central domains of caregiving: nurturant caregiving, material caregiving, social caregiving, and didactic caregiving.

4.2.5 Emotional engagement (Study III)

For Study III, emotional engagement at school was measured with a questionnaire developed explicitly for the Together at School trial to explore the different aspects of emotional school engagement in a way that is comprehensible for small children. The questionnaire's statements were created based on face validity while including the most widely applied aspects of emotional school engagement (Finn, 1989; Fredricks & McColskey, 2012; Voelkl, 1997). The children were asked to answer 14 statements regarding school on a three-point scale (Agree, Neither agree nor disagree, Disagree). The statements were also presented in audio format to enable small illiterate children to answer. The statements measured emotional school engagement, covering the child's perceptions of the classroom atmosphere, their relationship with their teacher, educational achievements, sense of belonging at school, and bullying (see Table 4, pp. 52–53).

4.2.6 Translation of the measures

For Study I, the data collection of the accompanied asylum-seeking children was mainly conducted by a team of multilingual research assistants, including members speaking Somali, Arabic, Dari, Persian, Kurdish/Sorani, Portuguese, French, or Russian, as well as Finnish and English. All the study material was translated into Somali, Arabic, Persian, Kurdish/Sorani, Russian, and English. The measures this study used were readily available in these languages for those who designed the original questionnaires and from previous studies conducted in these languages among migrant populations. Additionally, the information letter and consent form

were translated into Turkish. When the questionnaire was unavailable in the participant's language, the research nurse interviewed them. When the participant's language differed from those of the multilingual research assistants, professional interpreters from accredited companies facilitated administering the interviews and questionnaires.

For Study II, the data of the asylum-seeking parents were collected in English without an interpreter (n = 2) or with a qualified interpreter using over-the-phone interpreting (n = 8) or in-person interpreting (n = 16).

For Study III, the SDQ and the background information form were available in Finnish, Swedish, and the most spoken foreign languages in Finland: Albanian, Arabic, Chinese, English, Estonian, Russian, and Somali (Kiviruusu et al., 2016).

4.3 Data analysis

4.3.1 Study I

The psychiatric symptoms of asylum-seeking children were separately reported in frequencies for the two age groups, and bootstrapping was used to determine 95% confidence intervals (CI). As Subsection 4.2.2 described, the psychiatric symptoms were considered to include the borderline and abnormal categories of the SDQ. The associations of asylum-seeking children's SDQ outcomes in these age groups with the parents' psychiatric symptoms were analyzed using generalized linear mixed models. Mixed modeling accounts for nested sources of variability, meaning involving units at a lower level (e.g., individuals) nested within units at a higher level (e.g., families). Analyses were first conducted with only the parents' anxiety and depression symptoms or the parents' trauma symptoms as the independent variable (univariate analysis), followed by adjusting for socio-demographic factors (multivariate analysis), including the child's gender, parents' educational level, and family type. The associations of parents' psychiatric symptoms, SDQ subscales, and total difficulties have been presented as the odds ratios and 95% confidence intervals obtained from generalized linear mixed models.

All statistical analyses were performed using SPSS software version 27.

4.3.2 Study II

The qualitative analysis was performed using both inductive and deductive content analysis methods. First, open line-by-line coding was performed to inductively (from empirical observations to theorizing) generate codes and subcategories. Open codes were discussed among the authors to identify reappearing themes. Through this process, a concept of place was applied, with the analysis moving between data and

theory. In the second stage of analysis, focused line-by-line coding was performed to organize and transform codes deductively (from theory to empirical observations) according to spatial categories. Codes were further developed and organized according to thematic groups (location, locale, and an emotional engagement with place) in discussion with the authors, resulting in 97 open codes, 60 subcategories, and 23 main categories. The results consist of the central themes regarding the locale and emotional engagement with place developed in this process. In the text, the quotes are numbered according to the numbers of the participating parents.

All analyses were performed using Atlas.ti 7 for qualitative analysis of the transcribed interviews.

4.3.3 Study III

The associations between an immigrant background and emotional school engagement were analyzed using generalized linear mixed models. Emotional school engagement was separately reported in frequencies for the two groups, and comparisons were tested using the Pearson chi-square statistic. Multilevel (mixed) models were used to analyze associations between an immigrant background and emotional school engagement due to the clustering of the data (within classes and schools). School level was excluded from the consecutive analysis due to the nonsignificant variance component. Analyses were first only conducted with the immigrant background as the independent variable (univariate analysis), followed by adjusting for socio-demographic background variables (multivariate analysis), including gender, school grade, family structure, the mother's basic education, father's employment status, mother's employment status, and the family's economic situation. The associations of an immigrant background and emotional school engagement are presented as the odds ratios and 95% confidence intervals obtained from generalized linear mixed models.

The associations between an immigrant background and SDQ outcomes were analyzed using linear mixed models. As the data used were clustered within schools and school-class levels, multilevel (mixed) models were used to analyze associations between an immigrant background and the outcome variables. The variance component in the outcomes due to the school level was shown to be nonsignificant; therefore, the school level was excluded from the consecutive analysis. Analyses were first conducted with only the immigrant background as the independent variable (univariate analysis), followed by adjusting for the abovementioned socio-demographic background variables (multivariate analysis). Analyses of the teacher- and parent-reported SDQ data were done using linear mixed models from which the estimated marginal means, their 95% confidence intervals, and fixed effects estimates for an immigrant background were reported. Regarding the linear mixed

models of the parent-reported SDQ, three (of 12) analyses had problems in estimation; these (indicated in Table 5, p. 55) were analyzed using analysis of variance (i.e., not considering the clustering of the data).

All statistical analyses were performed using SPSS software version 25.

4.4 Ethical considerations

Regarding Study I, the Coordinating Ethics Committee of the Helsinki and Uusimaa Hospital District (HUS/3330/2017) approved the study plan for collecting the data of accompanied asylum-seeking children. All the adult participants provided written informed consent. The guardians of children and adolescents aged 17 years old and younger provided written informed consent for the child's participation in the study. Children aged seven years old and older provided their own informed written consent.

For Study II, the Ethics Committee of the Hospital District of Southwest Finland (May 25, 2018) approved the study plan for gathering data on asylum-seeking parents living in reception centers. All the participants gave written consent for their participation.

For Study III, the Ethics Committee of the THL in Helsinki, Finland (September 27, 2012) approved the study plan of the Together at School intervention program for the data of immigrant background children and their native comparisons (Kiviruusu et al., 2016). The informants consisted of children, parents, teachers, and principals. All the parents received an information letter regarding the intervention program and the study's aims. The parents were informed about the voluntary nature of their participation in the data collection, and a consent form for data collection was included in the information letter. The teachers and principals consented by agreement.

5 Results

5.1 The mental health of accompanied asylum-seeking children at arrival within the context of parental mental health

The first aim was to explore the mental health of accompanied asylum-seeking children at arrival in the country of asylum within the context of parental mental health. Table 2 shows the prevalence of the SDQ's total difficulties and their 95% confidence intervals in the two age groups. The prevalence here refers to borderline and abnormal categories of the SDQ. Among 2–6-year-old children, the prevalence was 34.9%; among 7–12-year-old children, it was 29.6%. The most common psychiatric symptoms among 2–6-year-old children were peer problems (40.7%), followed by conduct problems (38.4%). Among 7–12-year-old children, the most common psychiatric symptoms were peer problems (40.7%), followed by emotional symptoms (39.5%). Hyperactivity was the least common symptom in both groups (25.6% of 2–6-year-olds and 16.0% of 7–12-year-olds). Regarding the conduct problems of 2–6-year-old children, over half (51.3%) the boys had symptoms above the normal score; these symptoms were the only ones in the analyses with a significant gender difference (27.7% of the girls had symptoms above the normal score).

Table 2. The prevalence of psychiatric symptoms based on the SDQ above the British 80th percentile cut-off among asylum-seeking children, displayed by age group and gender.

	CHILD, 2–6 YEARS OLD, % (95% CI)				CHILD, 7–12 YEARS OLD, % (95% CI)			
	All *n* = 86	Male *n* = 39	Female *n* = 47	p*	All *n* = 81	Male *n* = 44	Female *n* = 37	*p**
TOTAL DIFFICULTIES	34.9 (24.4–44.8)	38.5 (23.1–56.2)	31.9 (17.9–45.8)	0.526	29.6 (19.5–39.7)	31.8 (18.9–46.9)	27.0 (12.8–41.9)	0.638
EMOTIONAL SYMPTOMS	33.7 (23.8–43.5)	30.8 (17.1–46.9)	36.2 (22.9–50.0)	0.598	39.5 (28.6–50.0)	36.4 (22.4–51.1)	43.2 (26.7–60.7)	0.528
CONDUCT PROBLEMS	38.4 (28.0–48.8)	51.3 (34.4–66.7)	27.7 (14.6–41.2)	0.025	27.2 (17.1–37.7)	25.0 (13.2–38.5)	29.7 (14.3–46.1)	0.634
HYPERACTIVITY	25.6 (15.9–34.5)	33.3 (20.0–48.7)	19.1 (8.2–31.6)	0.133	16.0 (8.3–25.0)	15.9 (5.6–27.7)	16.2 (5.3–29.0)	0.970
PEER PROBLEMS	40.7 (30.5–50.6)	43.6 (28.2–59.4)	38.3 (23.8–52.3)	0.619	40.7 (30.1–51.2)	43.2 (29.2–58.5)	37.8 (23.1–53.8)	0.626

*the *p*-value for the difference between boys and girls, Chi-square

5.1.1 The association between child mental health and parental mental health

Table 3 shows that according to the odds ratios from the unadjusted generalized linear mixed model for 2–6-year-old children, the parents' anxiety and depression were associated with the child's SDQ total difficulties, emotional symptoms, conduct problems, and peer problems; parents' trauma symptoms were associated with their child's SDQ total difficulties, emotional symptoms, and conduct problems. These associations remained significant in the adjusted models except for the parents' anxiety and depression and the child's conduct problems. Further, in the unadjusted generalized linear mixed model for 7–12-year-old children, the parents' anxiety and depression were associated with their child's emotional symptoms, and the parents' trauma symptoms were associated with their child's emotional symptoms, conduct problems, and peer problems. These associations remained significant in the adjusted models.

Table 3. Odds ratios (ORs) and their 95% confidence intervals (95% CIs) for parents' anxiety and depression, as well as trauma symptoms predicting a child's psychiatric symptoms based on the SDQ.

FIXED EFFECTS	PARENTS' ANXIETY AND DEPRESSION *OR* (95% CI)[B]		PARENTS' TRAUMA SYMPTOMS *OR*[A] (95% CI)[C]	
	Unadjusted	**Adjusted[A]**	**Unadjusted**	**Adjusted[A]**
CHILD, 2–6 YEARS OLD				
TOTAL DIFFICULTIES	4.32 (1.31–14.27)*	4.04 (1.12–14.57)*	3.09 (1.07–8.96)*	3.40 (1.03–11.17)*
EMOTIONAL SYMPTOMS	6.12 (1.94–19.26)**	6.11 (1.75–21.32)**	5.39 (1.84–15.78)**	9.70 (2.25–41.79)**
CONDUCT PROBLEMS	3.16 (1.05–9.57)*	2.99 (0.86–10.36)	3.62 (1.36–9.67)*	3.59 (1.15–11.19)*
HYPERACTIVITY	1.49 (0.52–4.27)	1.48 (0.41–5.26)	1.84 (0.68–4.98)	1.74 (0.54–5.67)
PEER PROBLEMS	3.74 (1.25–11.19)*	3.52 (1.04–11.92)*	2.14 (0.83–5.50)	2.04 (0.65–6.40)
CHILD, 7–12 YEARS OLD				
TOTAL DIFFICULTIES	3.19 (0.89–11.37)	3.07 (0.80–11.83)	3.21 (1.00–10.34)	3.07 (0.75–12.57)
EMOTIONAL SYMPTOMS	10.21 (2.60–40.09)**	7.89 (2.11–29.54)**	5.40 (1.65–17.65)**	5.17 (1.42–18.73)*
CONDUCT PROBLEMS	2.01 (0.64–6.32)	1.85 (0.47–7.33)	4.13 (1.38–12.34)*	4.29 (1.01–18.30)*
HYPERACTIVITY	0.86 (0.20–3.67)	0.95 (0.16–5.79)	1.40 (0.41–4.77)	1.91 (0.40–9.11)
PEER PROBLEMS	1.76 (0.58–5.29)	1.82 (0.55–6.05)	3.60 (1.31–9.86)*	3.66 (1.06–12.64)*

[A] Adjusted for the child's gender, family type (one vs. two parents), and parents' education (lower vs. higher).

[B] Both parents or the only parent in the study HSCL-25 ≥ 1.75.

[C] Both parents or the only parent in the study assessed with PROTECT in the medium- or high-risk category.

*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$.

5.2 The opportunities for parenting in the spatial context of the reception center

The second aim was to unveil the opportunities for parenting in the spatial context of reception center. The interplay among the contexts of parenting, spatial locale, and emotional engagement was scrutinized. Figure 1 presents the central themes of the interplay among the contexts of parenting, spatial locale, and emotional engagement with place.

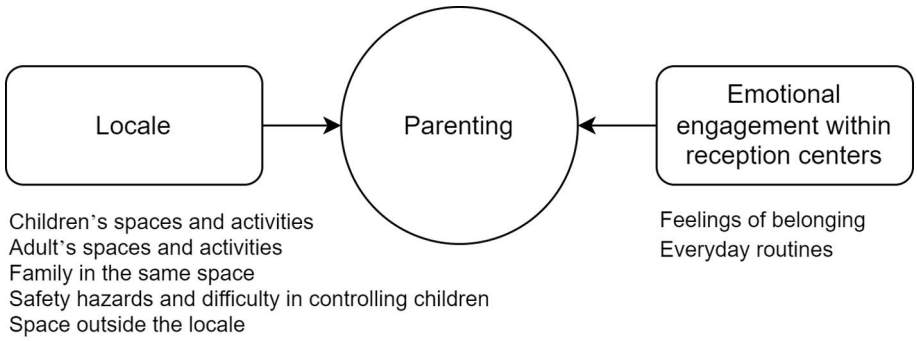

Figure 1. The interplay among the contexts of parenting, spatial locale, and emotional engagement within reception centers.

5.2.1 The children's spaces and activities: Valuable, but insufficient

Although gravely insufficient, children's spaces and organized activities aided parents in successfully implementing all four of Bornstein's categories of nurturant, material, social, and didactic caregiving. Children's spaces and organized activities were reportedly essential for restoring parenting capacities and partially decreased parents' constant pressure to organize activities for their children.

All the parents said that children's spaces and activities alleviated the burden of parenting. Children's spaces and activities reportedly implemented nurturant caregiving, offering a stimulating atmosphere with essential space and opportunities for safe play to keep up with age-appropriate development as part of material caregiving and providing parents opportunities to rest. Moreover, children could "get their thoughts away from problems to doing something" (Mother 26). Many parents emphasized the benefits related to didactic caregiving: the possibility for their children to develop their social and fine motor skills and creativity.

However, the children's spaces and activities were described as insufficient. Some respondents said there was hardly anything for children to do in the reception center and no possibilities to "use the energy." Almost all the parents highlighted, as part of material and didactic caregiving, the urgent need for adequate children's spaces and activities concerning an area, open hours, organized activities, or the possibility of attending early childhood education. This perceived impossibility of implementing caregiving as before was a source of significant parental stress.

The unavailability of spaces and activities meant many children spent their days in a confined family room playing on mobile phones or running in the corridors, which was seen to increase agitation and arguments among the children, further complicating social and didactic caregiving. As the narrative below illustrates, a general concern existed among parents over mobile phone usage among the children:

> They play hide-and-seek the whole day and run around the office. Unfortunately, there is one angry employee who becomes disturbed because of the noise, but they are children, you can't ban them completely. […] Here, we have to satisfy them all the time so that they won't spend the whole day again with the phone. It's more difficult to entertain them here. (Mother 16)

The parents acknowledged the unavailability of any space reserved for children; some parents tried to reserve segments of the family room for children as part of material caregiving. Many parents tried organizing activities themselves due to the lack thereof; however, a dearth of information on hobbies and insufficient public transport often hindered this endeavor.

As well as the above results concerning children's spaces and activities in general, parents regarded the CFS activities as advantageous, highlighting caregiving's social and didactic aspects, such as the possibility to engage in learning processes and the social aspects attached to group engagement. These social aspects were reflected in several positive changes in children's behavior and the emotional significance of being with other children. Regarding snack time at the CFS, one parent commented: "Eating together with friends makes them happy" (Mother 31). Further, some parents noted the supportive relationship formed between CFS volunteers and children.

5.2.2 Adults' spaces and activities: Restorative but unachievable

Adults' spaces and activities were critical in supporting parental mental health, but single parenthood and mental health problems presented barriers to attending them. Single parents often could not attend due to a lack of childcare possibilities.

Almost all the parents stated there were activities helping them regain parenting capacities, have time to themselves, or create social support networks. However, small children and mental health problems that parents experienced were often barriers to attendance. Single parents predominantly had no possibilities for childcare, as reflected in this single parent's reply to a question about her possibility for alone time:

> I can't attend anything because I have a small child, and I can't have any time on my own ever. And sometimes, I have thought that where is my place then? When can I be myself sometimes? I have to be with the child when she can't get to daycare. I have to be in an isolated place with a child … (Mother 3)

5.2.3 A family in the same space: Appreciation of the possibility to spend more time with one's children

For many of the parents, having one's family in the same space affected material caregiving, meaning an enhanced possibility for social and didactic caregiving. However, negative consequences were also reported.

The families spent more time together in the same localities, often in one shared room. Conversely, in their home countries, these families had often been more apart due to parents' long working hours, a prison sentence, or because they were hiding, among other scenarios. The parents expressed they had better possibilities to teach skills and play—enhancing the parent–child relationship—and protect their child from the negative influences of the asylum-seeking process:

> I was an entrepreneur, and from the early morning, I was working, during daytime, I only came home to eat and not until ten o'clock in the evening I was home. So, I didn't have much time with my child. But now, here, when I have had more time, I have spent more time with my child. She's growing up and needs a close relationship, and I think it's my obligation to support her more. (Father 4)

However, the increased proximity also resulted in negative consequences for parenting regarding diminished possibilities for parents to rest, children's increased lack of independency, and negative reactions from the children as they had both parents at home at all times.

5.2.4 Safety hazards and difficulties in controlling children

The spatial organization was regarded as negatively affecting caregiving in all four of Bornstein's categories of nurturant, material, social and didactic caregiving due to the lack of privacy, problems in adapting to living with others, and children's social interactions. However, positive aspects were also mentioned.

The most noticeable impact on parenting was the lack of privacy due to shared accommodations: The privacy of an apartment was seen as a prerequisite for implementing adequate parenting. For example, shared kitchens, bathrooms, and toilets raised multiple issues regarding health and safety as part of nurturant caregiving. Regarding social and didactic caregiving, the crowds of children in confined and public spaces led to fights and the children imitating bad behavior. This environment also made it difficult for parents to get their children to adhere to the rules of the family. This difficulty was seen as negatively affecting the parent–child relationship. Some parents also articulated positive aspects of the spatial organization regarding access to medical services, occasional assistance in childcare

for a few parents, and children's interactions (also seen as offering opportunities to explore different cultures).

5.2.5 Space outside the locale is often hard to access

The reception center was generally described as an isolated and closed space with limited public transport to the outside world, influencing material caregiving. In response to isolation, regular visits to the outside world were described as supporting parents' mental health, but concurrently, there were hardly any places to go to when parents lacked social relationships outside the center and had no knowledge of local activities: "Here, sadly, when we don't have the language, so we would like to be better informed of what is happening in the city so that we could participate more." (Mother 16)

5.2.6 Emotional engagement within reception centers

The feeling of belonging to a place was often hampered in the reception centers for adults and children, with the parents trying to support their children's sense of belonging. However, for some, the reception center was a place of security to receive care and support. On the temporal aspects of everyday life concerning opportunities to repeat experiences and strengthen feelings of belonging, almost all the parents stated that routines were hard or impossible to create.

Feelings of belonging

Among the parents was a general awareness of the difficulties of feeling a sense of belonging to a place for adults and children; many parents tried overcoming this in diverse ways. The parents' awareness was voiced in their descriptions of the problems of getting accustomed to the place, feeling at home and belonging, and grieving for the atmosphere of one's home country. A once self-evident aspect of life was now missing, as a mother explains in the following extract: "I really had a perfect life. I had a big apartment, many things to do, and many possibilities. Suddenly, coming here to a different environment, different situation, and to such a small space has been the most difficult thing" (Mother 15). A further barrier to belonging was connected to a change for the worse in living conditions, such as isolation ("worse than prison," Father 11) and small rooms. For children, the multiple changes made it hard to belong:

> He couldn't feel belonging anywhere because the apartment was changing, the surroundings were changing, the people around us changed so that in at the age

> of three, he had changed residences seven times. When we had an appointment with the social worker here in the morning and we were preparing us for that, I said that "Okay, we have an appointment with the social worker, let's go there." I noticed that he took his jacket and started to put his toys in the pockets. I said that you don't have to take toys because the social worker has toys in the room. He said that, "Yeah, but all my toys in the previous city were left there, so that I want to take these with me if we can't come back." So you notice that he's home nowhere, he can't say that this is my home, I live here and belong here." (Mother 24)

The parents tried supporting their children's sense of belonging by familiarizing them with their surroundings and organizing activities. Further, the parents tried illustrating their placelessness to their children in some way, as the examples below describe:

> At the beginning of the journey, because children understand things through play, we told the children that this is a sort of a race. And then, at the end, a prize awaits us. (Mother 31)

> Yes, because when I came here, she was like: "Why are we with so many people? Why are we not on our own?" And I was like: "They are looking for our house." (Mother 33)

For a few parents, the reception center was a place of security and a place for receiving care and support in the form of being looked after, where the staff invested in listening to them and attempted to help (regardless of success), and a place where they could get health services. One parent commented on the organized children's activities: "It brings us joy. For example, when the child is there for couple of hours, so the burden is a little lighter. The circumstances are so that we are being looked after—it makes us happy" (Mother 29). The positive emotional engagement in the place was seen to be reflected in caregiving and the child's well-being.

Everyday routines

Families' lack of routines was a significant concern for the parents, especially regarding their children. Almost all the parents explained that routines were hard or impossible to create. The lack of routines also applied long term:

> Here we have the unawareness that we don't know what happens next and where we are after a month or two months. In the home country, the children knew that

> after first class is second class next, there was routine and everything was logical, but here nothing happens in order so that we can't say what happens next. (Mother 19)

The parents, however, sought to create routines through mealtime and bedtime rituals. The regular children's activities were generally experienced to support routine-making, illustrated as important temporal signposts for the children. Other sources of support in creating routines were church activities and preschool for six-year-olds. In the parents' view, these regular routines were vital for their children's well-being: "But you know when before she felt sadness all the time, depression, but when they go to school, it's completely different. Because they are feeling: 'Okay, we are normal, go to school like other children'. Like that" (Mother 14). Some of the parents explained that their struggle to create routines was so exhausting that such did not leave much energy for other things.

5.3 The emotional engagement and the mental health of immigrant-background children in their first years of school

5.3.1 Emotional school engagement

Lastly, the first part of the third study's aim was to explore how the immigrant-background children experienced emotional engagement in the spatial context of school. Table 4 presents the frequencies of responses to the statements of emotional school engagement among immigrant-background and native children, and the results from the generalized linear mixed models that analyzed the associations between the groups. In the unadjusted model, children with an immigrant background had significantly less courage to voice their thoughts in class, felt lonely more often, had at least one friend in the class less often, and they had bullied someone in their class more often. These associations remained significant apart from "I have at least one friend in the class," even when adjusting for socio-demographic factors. Additionally, in the adjusted model, children with an immigrant background had more often seen someone in their class being bullied.

Table 4. The self-reported emotional school engagement of immigrant-background and native children, and the odds ratios (ORs) and confidence intervals (95% CIs) of an immigrant background for statements on emotional school engagement from two-level generalized linear mixed models adjusted with socio-demographic factors.

STATEMENTS		IMMIGRANT BACKGROUND CHILDREN (*N* = 133) %	NATIVE CHILDREN (*N* = 2220) %	UNADJUSTED *OR* (95% CI)	ADJUSTED *OR*[A] (95% CI)
CLASSROOM ATMOSPHERE					
IT IS PEACEFUL TO WORK IN THE CLASS	Agree	36.8	36.6	ref	ref
	Neither	51.1	48.6	1.08 (0.73-1.61)	1.10 (0.72–1.66)
	Disagree	12.0	14.9	0.80 (0.44-1.45)	0.88 (0.48–1.61)
THERE IS GOOD ATMOSPHERE AND ENVIRONMENT IN THE CLASS	Agree	62.4	62.7	ref	ref
	Neither	30.8	31.7	0.99 (0.67-1.48)	0.95 (0.62–1.43)
	Disagree	6.8	5.6	1.28 (0.62–2.64)	1.17 (0.56–2.45)
I HAVE THE COURAGE TO TALK ABOUT MY THOUGHTS IN THE CLASS	Agree	32.3	44.8	ref	ref
	Neither	41.4	34.2	1.73 (1.13–2.63)*	1.80 (1.17–2.78)**
	Disagree	26.3	21.0	1.76 (1.10–2.82)*	1.56 (0.96–2.55)
WE HAVE FUN IN THE CLASS	Agree	78.9	78.2	ref	ref
	Neither	15.8	17.8	0.87 (0.53-1.42)	0.81 (0.48–1.37)
	Disagree	5.3	4.0	1.35 (0.60–3.01)	1.32 (0.58–3.03)
RELATIONSHIP WITH TEACHER					
MY TEACHER LISTENS AND UNDERSTANDS ME	Agree	79.7	83.3	ref	ref
	Neither	17.3	13.9	1.33 (0.83-2.12)	1.33 (0.82–2.17)
	Disagree	3.0	2.8	1.12 (0.40–3.20)	0.95 (0.33–2.74)
I TRUST MY TEACHER AND I CAN TELL HIM ABOUT MY THINGS	Agree	72.9	73.3	ref	ref
	Neither	24.1	21.9	1.12 (0.74–1.70)	1.13 (0.73–1.76)
	Disagree	3.0	4.8	0.64 (0.23–1.79)	0.64 (0.23–1.82)
SENSE OF BELONGING AT SCHOOL					
I FEEL LONELY	Agree	27.8	16.1	ref	ref
	Neither	18.0	17.2	0.63 (0.37–1.07)	0.52 (0.29–0.93)*
	Disagree	54.1	66.7	0.48 (0.31–0.73)**	0.48 (0.31–0.74)**

STATEMENTS		IMMIGRANT BACKGROUND CHILDREN (*N* = 133) %	NATIVE CHILDREN (*N* = 2220) %	UNADJUSTED *OR* (95% CI)	ADJUSTED *OR*[A] (95% CI)
I HAVE AT LEAST ONE FRIEND IN THE CLASS	Agree	68.4	76.3	ref	ref
	Neither	5.3	5.3	1.14 (0.52–2.52)	1.24 (0.55–2.77)
	Disagree	26.3	18.4	1.53 (1.01–2.33)*	1.51 (0.97–2.33)
I MAKE FRIENDS EASILY	Agree	63.9	68.2	ref	ref
	Neither	30.1	25.7	1.24 (0.83–1.84)	1.26 (0.83–1.92)
	Disagree	6.0	6.1	1.06 (0.50–2.23)	1.07 (0.50–2.29)
I GET ON WELL AT SCHOOL	Agree	79.7	75.1	ref	ref
	Neither	18.0	19.7	0.89 (0.56–1.41)	0.85 (0.52–1.39)
	Disagree	2.3	5.2	0.42 (0.13–1.35)	0.44 (0.14–1.44)
EDUCATIONAL ACHIEVEMENT					
I DO WELL AT SCHOOL	Agree	76.7	81.2	ref	ref
	Neither	21.8	17.4	1.33 (0.86–2.06)	1.36 (0.87–2.13)
	Disagree	1.5	1.4	1.10 (0.26–4.72)	0.44 (0.06–3.33)
BULLYING					
SOMEONE IN MY CLASS HAS BULLIED ME THIS AUTUMN	Agree	36.8	30.7	ref	ref
	Neither	12.0	17.5	0.58 (0.33–1.04)	0.59 (0.32–1.09)
	Disagree	51.1	51.8	0.83 (0.56–1.23)	0.88 (0.58–1.33)
I HAVE SEEN THAT SOMEONE IN MY CLASS HAS BEEN BULLIED THIS AUTUMN	Agree	47.4	46.0	ref	ref
	Neither	25.6	17.6	1.41 (0.92–2.18)	1.59 (1.00–2.51)*
	Disagree	27.1	36.4	0.78 (0.50–1.22)	0.91 (0.58–1.43)
I HAVE BULLIED SOMEONE IN MY CLASS THIS AUTUMN	Agree	17.3	8.2	ref	ref
	Neither	9.8	9.7	0.48 (0.24–0.98)*	0.48 (0.23–1.02)
	Disagree	72.9	82.1	0.43 (0.27–0.71)**	0.45 (0.26–0.75)**

*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$

ref = reference category in the analysis

[A] Adjusting for gender, school grade, family structure, mother's basic education, father's employment status, mother's employment status, and family's economic situation

5.3.2 The mental health of immigrant-background children within the school context

Finally, the last part of the third study aim was to examine the mental health status of immigrant-background children in their first years at school within the context of school. Table 5 shows the associations between an immigrant background and psychiatric symptoms from the linear mixed models based on data reported by teachers and parents. The teachers reported no significant differences in psychiatric symptoms between the groups. The parents in the immigrant-background children group reported significantly more emotional symptoms and peer problems in their children than those in the native children group. Additionally, the parents in the immigrant-background children group reported higher scores for their children's SDQ total difficulties than those in the comparison group. In the adjusted models, these associations remained significant except for SDQ total difficulties.

Table 5. Estimated marginal means (M) and fixed effect estimates from linear mixed models of an immigrant background on psychiatric symptoms based on SDQ reported by teachers and parents.

	ESTIMATED MARGINAL MEANS		UNADJUSTED		ADJUSTED	
	Immigrant background *M* (95% CI)	Native *M* (95% CI)	Fixed effect estimate (*SE*)	*p*	Fixed effect estimate (*SE*)[A]	*p*
TEACHERS	(*n* = 129)	(*n* = 2247)				
TOTAL DIFFICULTIES	6.3 (5.3–7.2)	6.0 (5.6–6.3)	0.29 (0.50)	0.560	−0.29 (0.49)	0.558
EMOTIONAL SYMPTOMS	0.8 (0.6–1.1)	0.9 (0.8–1.0)	−0.07 (0.13)	0.615	−0.20 (0.13)	0.139
CONDUCT PROBLEMS	1.0 (0.7–1.3)	0.9 (0.8–1.0)	0.06 (0.14)	0.690	−0.07 (0.14)	0.583
HYPERACTIVITY	2.6 (2.1–3.1)	2.6 (2.4–2.7)	0.02 (0.25)	0.927	−0.12 (0.24)	0.620
PEER PROBLEMS	1.8 (1.5–2.1)	1.5 (1.4–1.6)	0.28 (0.15)	0.064	0.11 (0.15)	0.480
PROSOCIAL BEHAVIOR	6.0 (5.6–6.4)	6.3 (6.1–6.4)	−0.30 (0.20)	0.146	−0.28 (0.20)	0.152
PARENTS	(*n* = 148)	(*n* = 2430)				
TOTAL DIFFICULTIES	8.6 (7.8–9.4)	7.2 (7.0–7.4)	1.32 (0.42)	0.002	0.73 (0.43)	0.088
EMOTIONAL SYMPTOMS[C]	1.8 (1.5–2.0)	1.2 (1.2–1.3)	0.50 (0.12)	<0.001	0.35 (0.13)	0.008
CONDUCT PROBLEMS[B]	1.8 (1.5–2.0)	1.7 (1.6–1.7)	0.08 (0.13)	0.526	0.02 (0.14)	0.842
HYPERACTIVITY	3.0 (2.7–3.4)	2.7 (2.6–2.8)	0.29 (0.19)	0.133	0.06 (0.20)	0.766
PEER PROBLEMS	2.0 (1.8–2.3)	1.6 (1.5–1.6)	0.45 (0.13)	0.001	0.30 (0.13)	0.026
PROSOCIAL BEHAVIOR[B]	7.3 (7.0–7.6)	7.0 (6.9–7.1)	0.30 (0.16)	0.058	0.23 (0.16)	0.152

[A] Adjusting for gender, school grade, family structure, mother's basic education, father's employment status, mother's employment status, and family's economic situation

[B] Not estimable in the unadjusted linear mixed model. The values are from an analysis of variance without the clustering effect of school class.

[C] Not estimable in the unadjusted and adjusted linear mixed models. The values are from an analysis of variance without the clustering effect of school class.

6 Discussion

6.1 Summary of the results

This study examined the mental health of accompanied asylum-seeking children at arrival in the country of asylum within the context of parental mental health as a starting point. The study then explored the opportunities for parenting in the spatial context of the reception center. Lastly, the study addressed the emotional engagement and mental health of immigrant-background children within the context of school.

In the context of parental mental health, approximately one-third of the recently arrived asylum-seeking children in both age groups studied had psychiatric symptoms above the normal range as assessed by their parents. The most common symptoms in both age groups were peer problems, followed by conduct problems among 2–6-year-old children and emotional symptoms among 7–12-year-old children. Among the youngest group of children, over half the boys had conduct problems scoring above the normal score. In both age groups, the children's emotional symptoms were associated with their parents' anxiety and depression, and the parents' trauma symptoms, but the children's conduct problems were only associated with their parents' trauma symptoms.

Regarding the opportunities for parenting in the spatial context of the reception center, the spatial locale challenged or supported parenting in all four of Bornstein's categories of nurturant, material, social, and didactic caregiving. Although children's spaces and organized activities were gravely insufficient, they aided parents by successfully implementing caregiving, posing as essential for restoring parenting capacities. Adults' spaces and activities were vital in supporting parental mental health, but they were unavailable and inaccessible for some. For many of the parents, having one's family in the same space meant an enhanced possibility for social and didactic caregiving, but negative consequences were also reported. The spatial organization of the reception center impeded caregiving via lack of privacy, problems adapting to living with others, and children's social interactions. The reception center was described as an isolated and closed space with limited public transport to the outside, affecting parents' mental well-being.

Regarding emotional engagement, the parents considered the emotional engagement in the spatial context of a reception center to be hampered for parents and children. A sense of belonging to a place was often impeded for adults and children, with parents trying to support their children's sense of belonging; for some, the reception center was a place of security where they received care and support. Concerning the temporal aspects of everyday life related to opportunities to repeat experiences and strengthen feelings of belonging, almost all the parents reported that routines were hard or impossible to create.

In the school context, the immigrant-background children had lower self-reported emotional school engagement than the native children, as they had less courage to voice their thoughts in class; they also felt lonely more often. Further, they reported having more often been bullies and seen bullying in class. Teachers did not report any significant differences between the mental health of immigrant-background and native children. However, immigrant-background children had more emotional symptoms and peer problems, as their parents reported, than native children.

6.2 The mental health of asylum-seeking children at arrival and of immigrant-background children

6.2.1 The context of parental mental health

The findings regarding the high prevalence of psychiatric symptoms in both age groups of asylum-seeking children align with previous studies often comprising of school-aged or unaccompanied children (Blackmore et al., 2019; Kien et al., 2018; Lustig et al., 2004) and asylum-seeking children who recently arrived in a country of asylum (Montgomery, 2011; van Os et al., 2016). The parents estimated the prevalence of psychiatric symptoms above the normal range (34.9% in 2–6-year-olds and 29.6% in 7–12-year-olds) to be more than twice as high as the worldwide pooled prevalence of mental disorders in children and adolescents (13.4%) (Polanczyk et al., 2015).

Regarding the high prevalence of conduct problems at arrival in the country of asylum, especially in young boys, noting that childhood conduct problems are associated with multiple adverse outcomes in adulthood, such as psychiatric and somatic diseases, psychosocial difficulties, and unemployment, is critical (Sourander et al., 2005). In the present study, the children's conduct problems were associated with the parents' trauma symptoms in both age groups, supporting the literature showing that parental trauma increases children's behavioral problems and other mental health problems, even if the child is not exposed to the traumatic event (Back Nielsen et al., 2019; Bryant et al., 2018). Van Ee and colleagues (2016) showed that

the parental symptoms of PTSD among traumatized asylum-seeking and refugee parents directly related to children's insecure and disorganized attachment. Harsh parenting and insecure attachment are risk factors for conduct problems (Fearon et al., 2010; Murray & Farrington, 2010). Moreover, it has been proposed that parents may respond to threatening situations with emotional disengagement and distancing (Christian et al., 2010).

In both age groups, the children had a high prevalence of emotional symptoms associated with their parents' anxiety and depression, and the parents' trauma symptoms. Parental psychopathology is widely acknowledged as possibly relating to lower emotional availability and increased parenting stress, which may be a particularly notable factor regarding asylum-seeking children who have often lost the support network of a larger family (Fazel & Stein, 2002; Trapolini et al., 2008). Maternal and paternal psychopathology are associated with negative consequences for children's development, including internalizing problems (Connell & Goodman, 2002; Goodman et al., 2011). A parent's capacity for emotional engagement with their child is crucial to their child's psychosocial development (Christian et al., 2010). The qualities of this parent-child relationship form an integral part of the complex web of the child's relational experience (Rosenblum et al., 2006).

Numerous studies have documented that living in a refugee camp, multiple relocations, prolonged asylum processes, and a lack of child-friendly immigration procedures are all associated with poor mental health outcomes in refugee children (Kadir et al., 2019; Vossoughi et al., 2016). Early recognition of children's psychiatric problems is widely acknowledged as possible and able to support the children's development and mental health (Bayer et al., 2011; Durlak & Wells, 1997). After arrival in the country of asylum, post-arrival factors have been shown to moderate mental health outcomes for asylum seekers (Porter & Haslam, 2005), suggesting that much can be done after arrival to improve children's mental health despite their adverse pre-arrival experiences (Hadfield et al., 2017).

Asylum-seeking children's psychosocial development cannot be considered separately from the relational context. Parents must often cope with their own stressors and losses. Due to these stressors, parents can be less emotionally available, less structuring, and less supportive of their children (van Es et al., 2019). However, previous literature (Fazel & Betancourt, 2018; van Es et al., 2019) has suggested that these stressors' negative impacts on parenting could be prevented by focusing on social support to help families adapt to stressful experiences. In addition to developing mental health services targeted at these children and parents, asylum policies must consider the effect of asylum process stressors on existing psychiatric symptoms. This demand particularly applies to young children, considering asylum policies have been criticized for only encompassing children when they reach school

age or, if they are unaccompanied, ignoring the youngest of children (Vandekerckhove & Aarssen, 2020).

6.2.2 The school context

The finding that the teacher reports found no differences in the groups' psychiatric symptoms is in concordance with previous studies reporting that teachers do not report differences in psychiatric symptoms between native and immigrant-background children or report fewer emotional symptoms in immigrant-background children than what parents do (Crijnen et al., 2000; Jäkel et al., 2015; Vollebergh et al., 2005). However, the immigrant-background children had a higher prevalence of emotional symptoms and peer problems than the native children, as their parents reported, thus supporting the migration morbidity perspective (i.e., immigrants display lower mental health and adjustment than natives). The findings seem to imply that teachers report fewer psychiatric symptoms than immigrant-background parents for immigrant-background children and adolescents, especially concerning internalizing symptoms. Interestingly, in a Dutch study, teachers reported no differences in mental health between Turkish immigrant and native children and adolescents; however, Turkish immigrant teachers reported higher total and internalizing problems for immigrant children and adolescents than Dutch teachers (Crijnen et al., 2000). Thus, the language and cultural background differences between teachers and immigrant-background children possibly complicate children's ability to express emotional symptoms and teachers' perceptions of those symptoms. It may be argued that teachers detect immigrant-background children's and adolescents' academic and adaptive problems more easily than their psychiatric problems (Margari et al., 2013). Furthermore, one possible explanation for the differences in the findings of parent and teacher reports regarding emotional symptoms and peer problems could be that immigrant-background children might exhibit problems differently at home than at school compared to children with a native background.

6.3 The opportunities for children's psychosocial development between parenting and children's spaces

In the present study, the insufficiency of children's spaces and activities left children without meaningful ways to develop their capacities. Children were perceived to spend their days in the corridors with an uncontrollable mélange of children providing negative role models or on their mobile phones in the close quarters of a family room. This finding aligns with research conducted in deprived

neighborhoods, highlighting the higher likelihood of encountering negative peer role models (as perceived by parents), causing parents to worry over their children's psychosocial development, further influencing their parenting (e.g., the autonomy parents give their children) (Pinkster & Fortuijn, 2009). Thus, parental perceptions of a locale's safety are associated with young children's psychosocial development (Christian et al., 2015). The parents had succeeded in bringing their children to safety but could not fulfill their children's basic needs, such as play and education. The parents significantly suffered from the spatial impossibility of fulfilling their roles as parents. The parents in this study felt pressure to organize activities for children, which was experienced as strenuous in the absence of appropriate facilities, as also stated by the previous literature (Lietaert et al., 2019).

According to Article 31 of the UN Convention on the Rights of the Child, every child has the right "to rest and leisure, to engage in play and recreational activities" (Convention on the Rights of the Child, 1989). Participation in high-quality early childhood education and care (ECEC) is positively associated with children's cognitive and psychosocial development, with disadvantaged children benefitting significantly from high-quality settings (OECD, 2012). In Finland, all children under school age have a subjective right to ECEC (Finnish National Agency for Education, 2020). However, forming an exception, ECEC only must be organized for asylum-seeking children in "urgent cases, or when the circumstances otherwise so require" (Publications of the Ministry of Education and Culture, 2016), even though children with an immigrant background tend to have lower school readiness than those with a native background (De Feyter & Winsler, 2009) and are thus in particular need of ECEC. Several Finnish communities recently decided to offer ECEC to asylum-seeking children; however, ECEC is still not a subjective right guaranteed by legislation (Junttila et al., 2020). A child-centered approach is required to ensure asylum-seeking families receive appropriate advice on local possibilities for ECEC. The spaces of children and the meanings given those places highlight the value of childhood in a particular society. Regarding asylum-seeking children, it is not only a question of the value of childhood but of asylum-seekers and migration management (Seeberg et al., 2009). Migration management has been criticized for a clear tendency to give migration law precedence over the Convention on the Rights of the Child (UNICEF, 2018).

Without ECEC in the studied centers, the CFS appeared to succeed in providing opportunities for development, learning, and play; the CFS also supported parents in caregiving tasks. However, the activities were perceived as too infrequent. Also noteworthy is that the last CFS in a reception center in Finland closed at the end of 2019. During spring 2022, CFSs opened again in some reception centers. This lack of CFSs is an important argument regarding the value of childhood in society in the

present study discussing the insufficiency of children's spaces and activities in reception centers.

6.4 Strengthening emotional engagement in the spatial contexts of reception centers and schools

The related literature demonstrates that children develop a sense of self within the relationship with their parents (Fonagy et al., 2007; Rosenblum et al., 2006). However, the literature often fails to explicitly mention place as part of the shaping of self and identity (Spencer, 2005). Aligning with the theory of McCreanor and colleagues (2006), the meanings attributed to different spatial contexts are suggested as possibly being powerful enough to become central to one's identity. This emotional engagement could be the glue linking spatial context and identity, as identity involves emotions embedded in the spatial contexts.

The concept of belonging is addressed through daily routines of everyday life in relation to place and through the political-level positioning of asylum seekers and immigrants as "others." Marco Antonsich usefully distinguished between these aspects using the terms "place-belongingness" and the "politics of belonging" (Antonsich, 2010). He defined the former term as describing something intimate—the feeling of being "at home" in a place—and the latter as describing a discursive resource constructing or resisting forms of socio-spatial inclusion or exclusion.

6.4.1 The reception center context

The asylum-seeking parents used various ways to describe the loss of an emotional engagement with a place—for them and their children—and made conscious efforts to support the place attachment process through routines and activities. However, routines were hard to create. According to Weisner (2010), engaged participation in a community's daily routines and the emerging psychological experiences are constituent parts of well-being. Chaotic environments, like reception centers, do not provide opportunities for these processes, thus posing a risk to well-being.

Nonetheless, for some asylum-seeking parents, the reception center was a source of security and a place for social support and care from the reception center's personnel and the authorities. Social support is central in preventing parenting stress (McConnell et al., 2011). According to the findings of McConnell and colleagues (2011), higher levels of parental social support are associated with lower levels of parenting stress, ineffective parenting, and child difficulties. Taylor and colleagues (2015) found that perceived maternal social support contributes to children's social competence due to its positive relationship to maternal monitoring. In the reception

center context, social support and an intact marriage have been proposed to moderate adults' risk of developing depressive symptoms by enhancing their sense of identity and belonging (Beiser et al., 1989). The review by Merry and colleagues (2017) acknowledged the importance of positive interactions with the community and institutions as the interactions that enhance the migrant family's sense of belonging.

Not only do durable relationships convey social support, but brief contacts with unfamiliar people can also be sources of social support and generate belonging (Sarason & Sarason, 2009). These social relationships can serve as "anchoring points," strengthening belonging even when one's life situation is uncertain (Verdasco, 2019). Some asylum-seeking parents involved in responding to this study stated that the mere emotional investment of personnel and offers to help (regardless of success) were important. The critical factor in social support is not the actual amount of support received but the feeling of being supported (Ghate & Hazel, 2002). Thus, parenting and child psychosocial development are inextricably linked with parental social support. Abundant literature exists on parent training, but far less research has been done on strengthening parents' social relationships (McConnell et al., 2011).

Regarding the politics of belonging, the peri-urban locations of reception centers have been found to enforce experiences of not belonging (Simonsen & Skjulhaug, 2019). Children's need for an environment where they can develop a strong sense of identity and sense of belonging is not always prioritized in the policy decisions to assist children in their adaptation (Ebbeck et al., 2010).

Moreover, the influence of parents' weak sense of place regarding parenting can be interpreted in light of Morgan's (2010) developmental theory of place attachment (see p. 25 in the dissertation). Previous literature shows that parents consider that children need protection in excluding environments; in inclusive surroundings, they are seen as more independent (Spicer, 2008), implying that the exploration-attachment system is partially regulated by parents' courage and willingness to let their children explore. This courage essentially relates to the parents' emotional engagement with a place, their sense of place. This approach may help one understand the connection between the formation of attachment relationship and place: If a parent's emotional engagement with place influences the exploration-attachment cycle, then a parent's emotional engagement with place would also be connected to forming their child's attachment relationship and identity development.

6.4.2 The school context

The results generated by addressing emotional engagement within the school context (regarding the lower emotional school engagement of immigrant-background children in respect of the classroom atmosphere and a sense of belonging) are

consistent with previous studies on the school engagement of immigrant adolescents. An extensive review analyzing the emotional and cognitive school engagement of immigrant adolescents in 41 countries (Chiu et al., 2012) found that immigrant adolescents had weaker emotional school engagement but greater cognitive engagement than native adolescents. Adolescents with better teacher support or a better classroom climate often had a greater sense of belonging at school and better attitudes towards school than other adolescents. In an OECD review (OECD, 2018), immigrant adolescents had a weaker sense of belonging at school, influenced by cultural and linguistic differences between the country of origin and the host country. The adolescent's sense of belonging at school inversely relates to the linguistic distance between the language spoken at home and that spoken at school (OECD, 2018). A high sense of belonging to a school and high emotional school engagement relate to enhanced mental health outcomes (Li & Jiang, 2018; Li & Lerner, 2011).

Peer and teacher support positively affects school engagement in younger elementary school children, whereas later in school life, only teacher support positively affects school engagement (Demir & Leyendecker, 2018). A Finnish study by Säävälä (2012) examined school welfare personnel and parents' conceptions of the well-being of immigrant children and adolescents; Säävälä found that personnel and parents stressed different factors as risks and resources. In the school welfare personnel's views, being an immigrant does not compose any substantial risk for well-being, whereas immigrant parents and native language teachers fear negative attitudes toward ethnic or racial groups constitute a substantial risk for the well-being of immigrant children and adolescents. Teachers' beliefs and the normative climate in schools have been suggested as seemingly promising points for intervention and may be easier to change than the school context's structural aspects (Schachner et al., 2018).

6.5 Strengths and limitations

The strengths of the present study include the population-based total sampling design and high participation rate regarding the accompanied asylum-seeking children and their parents at arrival in the country of asylum. A further strength is a widely used and validated SDQ instrument for screening psychiatric symptoms among children. It has also been suggested to be suitable for screening refugee children who recently arrived in a country of asylum (Green et al., 2020). This study only relies on the parental assessment of asylum-seeking children's psychiatric symptoms in the absence of other informants shortly after arrival in the country of asylum. However, parental and teacher assessments are used among immigrant-background schoolchildren. Nevertheless, some of the SDQ's subscales had low reliability concerning Cronbach's α. This was especially true regarding the peer problems

subscale in Study I (α=.31), where the scale items formed no more an internally consistent measure but a sum index of the five quite separate items. Results of this scale should be interpreted very cautiously. Also, in Study III, some SDQ subscales had an α just below the .60 level, again warranting caution when interpreting the results.

The qualitative design used in the interviews among asylum-seeking parents allowed the parents to raise the issues they perceived as integral to parenting in a reception center, enabling exploring the possible causes behind the detrimental effects of the asylum-seeking process on small children.

In the present study, multiple ethnically diverse groups were involved with different immigrant and asylum-seeking backgrounds—a further strength of the study. However, the relatively low number of asylum-seeking and immigrant-background children does not allow further analysis of migration-related factors. Varying unknown reasons exist behind migration and the type and timing of a parent's or child's migration and ethnic background, which all influence the child's mental health outcome (Belhadj Kouider et al., 2014; Silwal et al., 2019).

The use of a non-validated questionnaire to assess emotional school engagement can be regarded as a further limitation of the study. However, using recorded statements concerning emotional school engagement enabling the self-reports of small children lacking literacy can be considered a strength of the study.

Among asylum-seeking parents, the use of interpreters can lead to excluding some potentially relevant information. Consequently, the qualitative analysis did not analyze nuances of language and nonverbal communication. However, multilingual research assistants conducted most of the interviews among recently arrived asylum seekers.

The HSCL and PROTECT questionnaire are broadly used in refugee populations; the HSCL is validated in this context, whereas research on the psychometric properties of the PROTECT questionnaire is still largely lacking (Hollifield et al., 2002; Wulfes et al., 2019). These remarks on the measures used should be remembered when interpreting the results. Nevertheless, all the measures behaved consistently and predictably, and the results are meaningful in the context of previous literature.

Applying an interdisciplinary approach to address the question of psychosocial development can be seen as a strength of the study. Childhood and issues related to children are multifaceted and inherently interdisciplinary; many ways exist to understand and conceptualize this complexity. Interdisciplinary studies integrate information, data, methods, perspectives, concepts, or theories from two or more disciplines to address problems that a single discipline cannot solve. With an interdisciplinary approach, overcoming analytic reductions generate a holistic understanding, often at a cost for researchers: Researchers must move between the

disciplines and integrate their different aspects. This study employed interdisciplinarity by combining concepts from psychiatry and human geography. For example, challenges regarding similar concepts of sense of place and emotional engagement were overcome by crossing disciplinary borders and gradually combining the concepts.

6.6 Implications and future directions

In this study, asylum-seeking children within the context of parental mental health and immigrant-background children within the school context had more mental health problems than the general population (as assessed by their parents). In light of the current knowledge on the significance of early childhood development and childhood mental health for later outcomes in adulthood (Black et al., 2016; Cantor et al., 2018; Costello & Maughan, 2015), strengthening the psychosocial resilience of these children should be prioritized in policy, research, and clinical practice. The spatial and relational contexts surrounding these children must offer available and accessible opportunities for psychosocial development and resilience, and their emotional engagement within these contexts must be strengthened to succeed in this task.

What this study implies regarding mental health symptoms is that multiple assessments are recommended when identifying immigrant-background children's psychiatric symptoms. Concerning the asylum-seeking children, the findings indicate the mental health of asylum-seeking parents and the family context must be adequately addressed to support asylum-seeking children's mental health. Further, regarding the spatial context of a reception center and as an extension to the Western-based psychiatric approach, an ecological, culturally sensitive approach considering the mental health, living conditions, and environmental concerns of children and parents is suggested to increase understanding of asylum-seeking children's psychiatric symptoms (Betancourt & Khan, 2008; Villanueva et al., 2017).

The findings concerning parenting and the reception center locale imply that policymakers should consider the spatial context of parenting in reception centers, particularly by securing adequate children's spaces and activities (especially regarding opportunities for early learning) and ensuring the privacy of families. These improvements would have far-reaching beneficial implications for asylum-seeking children's healthy development and future mental health. Moreover, if the spatial locale undermines the parental role, it leaves parents impotent and children without comfort in already unpredictable surroundings where the basic needs for safe play and education are unmet, putting the children at high risk of developmental psychopathology (Mares et al., 2002). Psychiatrists have a role in advocating for the appropriate treatment of these parents and children (Mares et al., 2002). Moreover,

the expertise of mental health professionals related to psychosocial well-being and the risks associated with migration could be employed more efficiently when organizing the spatial and relational contexts of asylum seekers by migration authorities.

Policies must recognize the double role of asylum-seeking children to promote their psychosocial development: Primarily, in the migration management field, these children must be seen as children and only after that as asylum seekers (UNICEF, 2018). The prerequisites for asylum-seeking parents to fulfill their parenting tasks in the spatial context of a reception center are lacking, contrasting with the high priority generally given to parenting and childhood in Finland. The rights of children that Finland ratified in the Convention on the Rights of the Child cannot be realized without the determination to guarantee adequate possibilities for parenting for every parent. Second, asylum-seeking children can be described as "double excluded": They do not have their own place in a reception center, and on a societal level, they can be seen as isolated and in a liminal state in which they cannot yet belong to Finnish society (Seeberg et al., 2009).

Parents must be given adequate social support to be emotionally and socially secure enough to fulfill their caregiving tasks and to enable emotional engagement within the spatial contexts of reception centers (WHO et al., 2018). Social support is a substantial form of parental support for parents' well-being and a buffer against stress (Geens & Vandenbroeck, 2013)—vital for the parents of young children (Witten et al., 2009). Moreover, difficulty in creating routines can thwart the efforts of parents and children to achieve emotional engagement and psychosocial well-being (Weisner, 2010). Thus, offering spatial possibilities for meaningful, sustainable routines in everyday life could support the psychosocial development of asylum-seeking children.

The present study provides information on immigrant-background children's emotional school engagement in their first years of school. School engagement during these years is critical, given its association with academic proficiency later in school life. The findings seemingly highlight the need to establish school-based methods to support immigrant-background children's emotional school engagement and mental health in their first years of school.

In the 21st century, important questions about health and disease cannot be solved by means of one discipline (Yazdani et al., 2020). Studies across and on the disciplinary boundaries are essential to inform researchers and policymakers on how to use the resources to improve children's mental health outcomes. This study illustrated how a combined approach employing disciplines of psychiatry and geography could lead to an increased understanding of the mental health of asylum-seeking and immigrant-background children and the process of psychosocial development. The interdisciplinarity does not mean the epistemological differences

between the life and social sciences should be diminished; instead, the differences could be used to create the research designs (Krabbendam et al., 2020), encouraging geographers to include the biological aspects of mental health and neuroscientists to regard the environment as actively constructed phenomena (Söderström, 2019; Krabbendam et al., 2020). An interdisciplinary approach will be crucial in future research to shape policy on how to create spatial and relational contexts supporting these children's mental health and psychosocial development.

7 Conclusions

It is widely acknowledged that early recognition of children's psychiatric problems is possible and can support their development and mental health (Bayer et al., 2011; Durlak & Wells, 1997). These children's mental health outcomes depend on the capacity of the surrounding relational and spatial contexts to provide the resources required to achieve psychological well-being amid adversity (Ungar, 2012). Hence, the current study sheds light on asylum-seeking and immigrant-background children's mental health and the opportunities for psychosocial development within their relational and spatial contexts. Moreover, emotional engagement in the spatial contexts of reception centers and schools was explored to understand how these contexts provide opportunities for psychosocial development that children and parents can engage with. The findings of this study contribute to understanding how to strengthen psychosocial development within the everyday contexts of children.

The findings seem to highlight contextual approaches to the mental health problems of asylum-seeking and immigrant-background children. The support for parental mental health and the implementation of school-based methods supporting the mental health of immigrant-background children in the first years of school seems crucial.

Policymakers should consider the opportunities for children's psychosocial development in a reception center that the interplay of parenting and spatial locale makes (or does not make) available and accessible. Securing adequate children's spaces and activities is particularly important, especially regarding opportunities for early learning and ensuring the privacy of families.

To support the emotional engagement and to promote opportunities for psychosocial development within these contexts, parents need appropriate social support and possibilities to establish everyday routines in the reception center context. In school, peer and teacher support seems crucial for emotional engagement.

Migration policies must consider the effect of migration process stressors on under school-aged children, as early childhood experiences are crucial for cognitive and psychosocial development. Young children's developmental needs are frequently unnoticed by the service system because parents are often still coping with their young children's problems within the family. Thus, the neglected young

children's contextual developmental needs should be prioritized, and focus should be given to listening to the voices of young children and their parents.

An interdisciplinary approach is needed in future research and practice. The collaborative research designs between the life and social sciences would generate new knowledge. Similarly, increased dialogue among mental health professionals, geographers, migration officials, and educational professionals would benefit psychosocial well-being and migration-associated risks. This cooperation could be employed when organizing children's spatial and relational contexts in ECEC, schools, and migration processes.

Acknowledgements

This study was conducted at the Department of Public Health, University of Turku, Faculty of Medicine, in collaboration with the Department of Public Health and Welfare, Finnish Institute for Health and Welfare (THL), between 2018 and 2022. I wish to thank Professor Sari Stenholm and Professor Emeritus Jussi Vahtera at the Department of Public Health at the University of Turku and Jaana Suvisaari, Research Professor and head of the Mental health team in THL, for providing the research facilities making my work possible. I am very grateful for the data and excellent supervising provided by THL. The Alli Paasikivi Foundation and Tiukula Foundation financially supported this study.

This study would have been impossible without the study participants. I owe my gratitude to all the committed study participants of Terttu and Together at School and the parents I interviewed in the reception centers. Your contribution made this study possible. I am touched by the level of trust you gave by sharing your personal experiences in often trying situations. I also acknowledge all individuals who contributed to collecting the data.

I am forever grateful to my supervisors, Päivi Santalahti, Olli Kiviruusu, and Riikka Lämsä. Thank you, Päivi, for having the courage and enthusiasm to believe in and guide me into my PhD journey. This enthusiasm has continued to sparkle and keep my belief in the research work alive throughout this journey's highs and lows. Thank you, Olli, for your endless patience, kindness, and meticulousness in answering my queries. Thank you, Riikka, for your innovative ideas and scientific inspiration. Päivi, Olli, and Riikka—I have always felt you have all the time in the world to guide me, even though you must have had plenty of other tasks accumulating. I am awed by your intelligence, pedagogical and social brilliance, and inspirational skills. Working with you all has truly been a privilege.

In addition, I would like to thank the individuals and their organizations that made this study possible by sharing their time and experience: Olli Snellman, Päivi Hieta, Sirpa Rönkkömäki, and Kaisa Kantola from Migri; Jaana Sikiö, Heimo Nurmi, Marita Nikander, and Elina Petrelius from the Finnish Red Cross; Hanna Markkula-Kivisilta, Eveliina Viitanen, Jenni Häikiö, and Matti Karjalainen from

Save the Children. I would also like to thank Eero Lilja from THL and Tero Vahlberg from the University of Turku for your statistical advice.

I want to thank my co-authors, Docent Anu M. Castaneda and PhD Natalia Skogberg, for their energetic and infectious attitude to research. I am extremely grateful for your insightful comments and suggestions on the manuscript and for using the unique Terttu data.

I am thankful to the members of my follow-up committee: Professor Sari Stenholm and Docent Venla Lehti. Thank you, Sari, for taking me under your wing to the Department of Public Health, showing the way to the world of research, and introducing me to the wonderful people in the Department of Public Health. Thank you, Venla, for your goodheartedness in donating your time for my PhD work and recruiting me to conferences and book clubs. Sari and Venla, your official assignment ensured the progress of my thesis work, but more importantly, your trust in my work has given me extra strength to believe in myself, even in the valleys of the journey.

I am grateful for the pre-examiners of this thesis: Professor Mirjam Kalland and Docent Mirjami Mäntymaa. Thank you for your valuable comments and insights that helped me progress with the thesis. I express my sincere gratitude to Professor Kaija Puura for kindly agreeing to act as my opponent in the public defense of my thesis.

I am incredibly thankful to the whole staff at the Department of Public Health for warmly welcoming me—a child psychiatrist from outside the research groups. I especially thank my fellow PhD candidates, some already PhD holders: Kristin, Saana, Miina and Sanna. Due to the pandemic, we were forced to end the physical coffee breaks that made research so much lighter. However, the warm memories of those moments and discussions have carried me far on this journey.

Thank you to my colleagues in my clinical work, Tyks Child Psychiatry. Your sincere encouragement enormously affected my stress management. When the Covid pandemic moved my research work into my living room, the weekly visits to clinical work became my social lifeline: The break room during lunch hour became my weekly opportunity to mingle and laugh. Special thanks to chiefs Taina Juvén and Elina Tiiri, my colleagues Anniina, Essi, Marketta, Cecilia, Mirjami, Paula and all the lovely people at the Child Psychiatry Outpatient Clinic, Kaarina.

I am lucky to still have friends outside of research and clinical work: thanks to the members of my beloved “Tyttökerho” who have walked with me through all the ups and downs for decades. Special thanks to my neighbors Liisa and Anders for their mutual childcare services and for letting us use their sauna, among many other things! The surrounding neighborhood and the winding stairs of our old house became my fountain of security while the world became chaotic due to the Covid pandemic.

Words cannot express my gratitude and love for my family: my parents, Leena and Sakari, my sister Marika with her family, my partner Kalle, and the wonderful children: Heimo, Tarmo, Petja, and Miska. For me, research is an attempt to understand the world and try to make it a better and more just place for all. My pursuit of understanding started early: the social and spatial contexts have shaped me. Since childhood, my parents encouraged me to explore multiple enriching and developing contexts; thus, I have had the courage and luck to have the possibilities to do so later in life in different environments. Thank you to my superb mother, Leena, for always being there, and to my father, Sakari, for his endless support and sense of security. My lovely children keep me down-to-earth every day. Finally, I am forever grateful to Kalle. With you, I cannot forget what matters most. In this journey's dark moments, the remedy sometimes was that you just smiled and held my hand by the laptop (when the cats as bysitters didn't help enough!).

Finally, all the encounters with different people in different places of the world, whether encounters short or long, have impacted my thinking. Therefore, I express my sincerest gratitude to these many people who might have only quickly passed through my life or are still making the journey with me: I often return to these encounters in my thoughts. I feel privileged to have met you and honored that you chose to open your minds to me. Thanks to these encounters, I have always tried to understand the contexts around me, I have learned to wonder and question.

Thank you,

18 November 2022
Heidi Parviainen

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TURUN
YLIOPISTO
UNIVERSITY
OF TURKU

Painosalama, Turku, Finland 2022

ISBN 978-951-29-9117-4 (PRINT)
ISBN 978-951-29-9118-1 (PDF)
ISSN 0355-9483 (Print)
ISSN 2343-3213 (Online)