

## MIGRATION AND ACCULTURATION: WHAT WE CAN EXPECT IN THE FUTURE

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### SUMMARY

*The use of violence and aggression on civilians during the war has become one of the most prominent military events of the 20<sup>th</sup> and 21<sup>st</sup> centuries, resulting in an increasing number of refugees and displaced persons in the midst of regional and tribal conflicts. We are witnessing a daily increase in the number of migrants when people are fleeing from their homes because of human rights violations, persecution, poverty, and conflict. When found in "host" countries, they often encounter bad conditions, with uncertainty and instability. Many come to Europe in search of economic and personal opportunities for progress, where they face different types of process of acculturation. 'Place loss', acute and chronic trauma, family disorders, and family reunification issues became more and more important issues.*

*Refugees, asylum seekers and irregular migrants have a higher risk for certain mental health disorders, including posttraumatic stress, depression and psychosis. In addition to being exposed to various risk factors for mental disorders, migrants often face barriers to access to adequate health care to address these issues. Some of the biggest challenges for migrant populations within "host" countries include: lack of knowledge of health care rights and health systems; poor knowledge of the language; different belief systems and cultural expectations of health care; and the general lack of trust in experts and in government. The rates of depressive and anxiety disorders usually increase over time, and poor mental health is associated with poor socioeconomic conditions - particularly with social isolation and unemployment.*

*Acculturative stress often implies a high discrepancy in the acculturation between parents and their children. This dislocation of families in new conditions has been caused by the different degrees of acceptance of "new culture" by children and parents, which causes serious difficulties, especially in bilingual terms.*

**Key words:** migration - progress - acculturation - asylum - country of "host"

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### INTRODUCTION

The use of violence and aggression against civilians in wartime has become one of the most prominent forms of military action in the 20<sup>th</sup> and 21<sup>st</sup> centuries, and has resulted in increasing numbers of refugees and displaced people as a result of regional and tribal conflicts (Agius & Glaurdić 2012). Many refugees are displaced to different European countries, where they have to face various forms of acculturation processes (Hasanović et al. 2005). "Loss of place", acute and chronic trauma, family disruption and problems reuniting families have become increasingly important questions (Agius et al. 2012).

Refugees, asylum seekers and irregular, illegal migrants are at greater risk of certain mental health disorders, including post-traumatic stress, depression and psychosis. Since 2015, more than 1.3 million refugees and migrants have arrived in European countries. The European migrant crisis, also known as the refugee crisis, is designated as the period beginning in 2015, characterised by a large number of people arriving in the European Union (EU) over the Mediterranean Sea, or overland through South-East Europe, after the migrant crisis in Turkey (WHO 2017). According to

Eurostat, in 2015 members of the EU received more than 1.2 million applications for asylum, which is more than double the number in the previous year. Before 2014, the number of applications for asylum in the EU reached its peak in 1992 (672,000), in 2001 (424,000) and 2013 (431,000), and in 2014 the number was again very high, 626,000 (Anonymous 2016, Marozzi 2015).

About 33 million people born outside the EU were resident in the EU in 2014, or 7% of the population of the 28 EU countries (which have a total of more than 500 million people). For the sake of comparison, the population born outside the host country amounts to 7.7% in Russia, 13% in the USA, 20% in Canada, 27% in Australia and 1.63% in Japan (Anonymous 2019).

According to the UNHCR, the number of forcibly displaced people around the world during the refugee crisis reached 59.5 million at the end of 2014, the highest level since the Second World War. Of those 59.5 million, 19.5 million were refugees (14.4 million under the mandate of the UNHCR, plus 5.1 million Palestinian refugees under the mandate of the UNRWA) and 1.8 million were asylum seekers. The remaining people were displaced within their own state (internally displaced people) (Anonymous 2015).

Developing countries hosted the largest number of refugees (86 per cent by the end of 2014, the largest number in two decades); the least developed countries gave asylum to 25 per cent of refugees around the world. In Turkey alone, there are almost three million Syrian refugees (Anonymous 2018).

The numbers rise even more when people flee from their homes due to human rights violations, persecution, poverty and conflict. Many come to Europe in the search for economic and personal opportunities in life. When they find themselves in these "host" countries, they often encounter poor conditions, lack of security and instability. The result of this kind of life is a growing trend of mental health disorders and attempted suicide amongst these populations, whose members are hoping to avoid from new risky situations.

As a response to evidence indicating an increasing rate of mental distress amongst refugees and migrants, the European region of the World Health Organization (WHO) states in its Strategy and Action Plan for Refugee and Migrant Health, that its priority is improving the mental health of refugees and migrants. There is an increased risk of mental difficulties, especially among women, the elderly and those who have previously experienced trauma. The risk increases due to the lack of social support and the higher levels of stress following migration.

As well as being exposed to various risk factors for mental disorders, migrants often encounter obstacles in access to the appropriate health care to solve these problems. Some of the greatest challenges for the migrant population within their "host" countries include: a lack of knowledge about their right to health care and health care systems; poor command of the language; different belief and cultural systems and expectations from health care, and a general lack of trust in experts and authorities.

The rates of depressive and anxiety disorders usually increase over time, and poor mental health is linked to poor socio-economic conditions - especially social isolation and unemployment.

## MIGRATION AND CHILDREN

The number of refugee, expelled and displaced people has been progressively rising over recent decades on the world demographic stage. More than 20 million displaced persons were registered on 31<sup>st</sup> December 1990 within the borders of their own countries. One hundred thousand refugee and displaced persons requested international protection and asylum throughout Europe and the United States of America (Anonymous 1991).

According to the UNHCR, the number of forcibly displaced persons around the world reached 65,600,000 at the end of 2016 - the highest level since the Second World War, with an increase of 40% since 2011.

The problems of a mental nature which occur during the process of social mobility, whether horizontal (when a person moves from one place to another) or vertical (when an individual moves from one social class to another), were the subject of scientific research in the second half of the 20<sup>th</sup> century (Tyhurst 1951).

The effect of contemporary warfare on children is a problem about which very little is known. Together with adults, many children have witnessed and been exposed to almost all, and some all war-related experiences (Goldstein et al. 1997, Hasanović et al. 2005). The majority faced separations from family, bereavement, close contact with war and combat, and extreme deprivation (Goldstein et al. 1997). Their traumatic experience has far-reaching consequences for their personality. This is particularly significant for teenagers, who are only beginning to deal with their own identity issues (Brennen et al. 2010, Kravić et al. 2013). Young adults who were children aged 5 to 12 years when they migrated, have the most difficult time in adapting to post-war life. Their condition is the result of growing up in an environment that did not provide a feeling of security and safety, e.g. they were not able to play outside and were frequently limited in their life inside (Bull 2004).

Contemporary wars destroy entire social networks, leaving survivors without a natural social support system in the place where they live. The traumatic events experienced by thousands of people during a conflict can have very long-term consequences on the mental health of entire countries who go through such events, and children and young people are particularly vulnerable (Hasanović 2011, 2012a,b, Brennen et al. 2010).

## ACCULTURATION

The term "acculturation" is defined as the cultural changes that occur within the constant and direct contact between two different cultural groups (Redfield et al. 1936). Originally the phenomenon of acculturation was understood on the group level, however, today it is recognized as a phenomenon on the individual level and the expression "psychological acculturation" is used (Graves 1967).

Acculturation is a fundamental part of the adaptation prompted by migration to new socio-cultural circumstances; it is the process by which immigrants change their behaviour and attitudes in contact with the different culture of the social community in which they find themselves. The notable rise in international migration is accompanied by a rapid increase in research literature on acculturation (Rogler et al. 1991).

In contemporary scientific circles, the term "acculturation" is used in various disciplines. The psychologically defined concept of acculturation means taking on and accepting the culture of the setting as one's own,

by a foreign individual or a small or larger social group. It relates to the psychological changes in individuals (internal and behavioural characteristics), whose cultural group is experiencing acculturation collectively. Berry (1987) points out that there are five general and partially overlapping categories that result from acculturation:

- First, there may be physical changes: a new place of residence, a new type of household, an increase in population density, more ecological pollution etc.
- Second, biological changes may occur: a new nutritional status, new illnesses (frequently forced devastation), and populations of mixed-race children are common (mestizo, mulatto etc.)
- Third, cultural changes necessarily take place, which are the heart of the definition: original political, economic, technical, linguistic, religious and social institutions undergo change or are replaced by completely new ones.
- Fourth: new sets of social relations, whether in a group or outside the group, where dominant forms may be established.
- And finally fifth: for individuals there are psychological changes, changes in behaviour, and changes in mental health, as the constant state of individuals trying to adapt to their new setting.

## **ACCULTURATION AND ACCULTURATIVE STRESS**

The experiences of migrants moving towards a social and cultural system that is different from their own have provided researchers with the opportunity to study the basic processes of adaptation. The current growth in international migration has further increased these opportunities. A significant amount of research has focused on various host countries, such as Canada (Berri et al. 1987), Australia (Taft 1983), Sweden (Magiste 1985), England (Bourhis et al. 1973) and Japan (Partridge 1987). One of the main focuses of the research is the relationship between migration and stress, because every form of migration is accompanied by changes which can be considered as the structural characteristics of this process (Shuval 1982). Gil et al. (1994) differentiate acculturation (cultural changes) from acculturative stress (the stress that stems from this process). Some forms of stress may be endemic in the acculturation process, as the result of communication problems, differences in cultural values, and discrimination. Acculturative stress often implies a major discrepancy in acculturation between parents and their children. This layering of families in new conditions is caused by the different degrees of adoption of the new culture by children and their parents (Scapocznik 1986), which exacerbates the difficulties that arise, especially in bilingual situations.

## **THE ADVERSE ATTITUDE OF THE HOST TOWARDS NEWCOMERS**

Since acculturation is a fundamental part of adaptation to new social and cultural circumstances, induced by migration, it is the process by which migrants change their behaviour and attitudes in contact with the different culture of the social community in which they find themselves.

The parents of immigrant children have come to a foreign country with a certain economic goal and a set perspective, which strengthened their willingness to accept the hardships of their "temporary" stay, and they often endure even obvious discrimination.

Their descendants, without a professional and economic perspective, react more sensitively and aggressively to the setting in which they want to be included (for them it is not foreign), but which, however, will not accept them completely as equals.

This can lead these young people to greater introversion and isolation within their own ethnic group, or in contrast, some of them will endeavour to integrate into groups of local youth, rejecting their old customs and values, and creating their own hybrid culture.

All this can very easily lead to asocial and criminal behaviour, and life at the very bottom of the society of the "wealthy host".

The crime statistics relating to young people of the so-called "second generation" differ from country to country, and also within individual immigration countries from region to region. The impression that they are often also tendentiously fabricated and twisted to serve campaigns against immigrants and their children, because some receiving countries are less friendly "hosts". There are many examples supporting this assertion in current world politics.

The administration of the President of the USA passed a law in 2018 on "zero tolerance" towards illegal migration, which caused the forced separation of more than 2000 children and adolescents from their parents, and their incarceration in detention centres. It is hard for us to imagine the scale of the drama of these young people and the consequences on emotional, cognitive, somatic and social levels as they grow up and later.

## **CHILDREN AND PARENTS IN MIGRATION**

If a migrant child completely embraces a different culture, consciously or unconsciously, because they experience it as more prestigious and dominant, or they deem it to be opportune, this leads to a breakdown in the relationship with their parents and conflict, or at the very least it disturbs the harmonious family structure.

In a home where the roles of the family members are precisely defined, and where the father is usually the

authoritative figure, traditionally the model of behaviour and an example to the younger members, the parents often find it difficult to accept the transformation of their own child into a young foreigner, with superior or completely alien behaviour.

It is paradoxical that even the host society does not accept this "mongrel" completely as its own (their stigma and social handicaps are the cost of their different ethical and cultural origins).

Therefore we can talk about a subculture of migrant youth, because the mark of "foreigner" is also stamped on even the best integrated of them.

The other extreme possibility is that the child feels completely rejected by their host society - their school, which, apart from its primary function, also includes an important socialization factor - and does not manage to achieve even basic affirmation in their new setting (due to poor knowledge of the language, differences in school systems, the social and economic status of the migrant family, and xenophobia and prejudice in the "hosts" which the child feels on their own skin), and they may experience a serious identity crisis.

This kind of crisis is characterised by powerful emotional tension, the maladjustment of a "person frustrated in their need for love and security," which may be manifested in strong aggression, or even regressive and immature behaviour, mutism, various phobias etc.

The feeling that the school is ignoring and marginalizing them drives children to behave in an unacceptable and negative manner. This also affects their academic performance in school. If they get into a vicious circle, consisting of a combination of inter-related elements (social and economic, psychological, educational, linguistic, political etc.), children will find it hard to get out of it.

Since they are "unable to fit in" and they have become "chronic re-offenders", the school will probably pronounce them to be "retarded" or send them to a special school, or they will have to repeat years until they reach the age when they are no longer obliged to go to school. After that, having not acquired any qualifications and without any practical experience, their problems with employment begin.

## **UNACCOMPANIED IMMIGRANT CHILDREN**

According to the European Commission, almost 90,000 unaccompanied children filed applications for asylum in European Union countries in 2015.

The figures of UNICEF show that in 2016, 25,800 unaccompanied children or separated persons came over the sea to Italy alone, more than twice as many as the 12,360 children that came the previous year.

Since many are unaccompanied as they migrate, many migrants who reach Europe, both boys and girls,

suffer from sexual and physical abuse. These crimes have a permanent effect, which should be a cause for concern for the administration of the countries where their status is finally resolved.

## **POSSIBLE SOLUTIONS TO IMPROVE THE MENTAL STATUS OF IMMIGRANTS**

WHO/Europe identified the urgent need to develop good practices for provision of care for mental health, and provision of support to member states to deal with the mental health needs of migrants.

In a report with a synthesis of evidence on health care, the WHO/Europe defined a series of good practices, which include:

- promote social integration through education, housing and employment;
- provision of services on the ground to ease access to PROTECTION,
- coordination of different services in the health care system to ensure integration of physical and mental health CARE and appropriate PROTECTION
- provision of information on PROTECTION rights and services available to migrants and health workers;
- training of health care experts to ensure they are open to groups of migrants, aware of their obstacles in access to protection, and interaction with health services, and skills in overcoming linguistic difficulties.

WHO/Europe is launching new initiatives to support member states in their efforts to improve care for migrants, and to integrate them into the local culture.

Recently the Knowledge Hub on Health and Migration was established with the aim of providing a forum for promotion of exchanges of knowledge, information and good practice related to the priority aspects of the health of migrants, with special focus on mental health.

In cooperation with the European Commission, WHO/Europe will offer material technical guidelines, interactive on-line seminars and health care tools for migrants, on the subject of mental health.

This can help bridge the existing gap between science, politics and practice in the field of migration and health, in order to meet the needs of countries on the front line of the massive influx of migrants and refugees (WHO 2017).

## **WHAT RESEARCHES TELL US**

In the world there is currently the largest number of refugees and asylum seekers living outside their country of origin due to war, political disturbances, violence and various other causes, at any time since the Second World War. This crisis affects all social services providing services in countries that have become hosts to

refugees. Most research has focused on the needs of young refugees and woman, and has neglected older individuals and their particular vulnerability (Hameed & Katona 2019).

Cultural identity related to mental health is of increasing interest in the field of transcultural psychiatry. However, there is a need to explain the concept of cultural identity for it to be useful in clinical practice. Groen et al. (2018) reveal the complexity and many layers of cultural identity, and assess the connection between stress and acculturation with (changes to) cultural identity. As part of a wider study of cultural identity, trauma and mental health, 85 patients from Afghanistan and Iraq, being treated for disorders related to trauma, were interviewed in a Short Cultural Interview. The analysis revealed three realms of cultural identity: personal identity, ethnic identity, and social identity. Within each realm, the relationships between stress and acculturation were established. The results provide an insight into the intensity of changes in cultural identity caused by stressors before and after migration and in the process of acculturation. On the basis of the results of the research, recommendations were drawn up to improve the cultural competence of mental health experts (Groen et al. 2018).

There is limited data on the connection between previous education and psychological and developmental outcomes in refugee children who have moved to Western Australia. Children of refugees have diverse migration, traumatic and educational backgrounds, which affect their health and psychological outcomes. Mace et al. (2014) in their research on 332 young refugees (average age  $9.58 \pm$  standard deviation 3.43 years) acquired the detailed information available about the education of 205 children. They found that the previous education of the child subjects was limited. 64.9% of subjects had experienced schooling interruption, and 55.8% received education in their primary language. Language development concerns were significantly associated with previous education in a second language. Other severe developmental and schooling issues were uncommon at presentation, with few correlations to prior education. In contrast, several migration factors, including separation from their family and mandatory detention that they had had to go through, were significantly correlated with psychological comorbidities, such as post-traumatic stress disorder. In order to monitor this population better, the authors recommend taking an in-depth multidisciplinary history, including previous education and psychosocial questions. They point out that partnership with educational institutions seems to play an effective, multifaceted role in helping resettlement; however there is a need for longitudinal research (Mace et al. 2014). Betancourt et al. (2012) point out that there is an increasing need to provide effective mental health services to children and adolescents amongst refugees

throughout the United States; the evidence base, necessary to manage the design and provision of services, is nascent. The authors investigated trauma history profiles, psychopathology, and associated behavioural and functional indicators among war-affected refugee children presenting for psychological treatment.

Clinical assessments indicate high rates of probable post-traumatic stress disorder (30.4%), generalized anxiety (26.8%), somatization (26.8%), traumatic grief (21.4%), and general behavioural problems (21.4%). Exposure to war or political violence frequently co-occurred with forced displacement, traumatic loss, bereavement or separation, exposure to community violence, and exposure to domestic violence. Academic problems and behavioural difficulties were prevalent (53.6% and 44.6%, respectively). However, criminal activity, alcohol/drug use, and self-harm were rare (all  $<5.45\%$ ). These findings highlight the complex trauma profiles, comorbid conditions, and functional problems that are important to consider in providing mental health interventions for refugee children and adolescents. Given the difficulties associated with access to mental health services for refugees, both preventive and community-based interventions within family, school, and peer systems hold particular promise (Betancourt et al. 2012).

Most services for mental health in children and adolescents previously exposed to traumas, were not originally developed for refugees, and information is needed to help clinicians design services to resolve the consequences of trauma in the refugee population. Betancourt et al. (2017) compared trauma exposure, psychological distress, and mental health service use among children and adolescents of refugee-origin, immigrant-origin, and U.S.-origin. On average, there were significantly more types of trauma exposure among refugee youth than either U.S.-origin youth or immigrant youth. Compared with U.S.-origin youth, refugee youth had higher rates of community violence exposure, dissociative symptoms, traumatic grief, somatization, and phobic disorders. In contrast, the refugee group had comparably lower rates of substance abuse and oppositional defiant disorder. The clinic-referred sample of refugee-origin youth presented with distinct patterns of trauma exposure, distress symptoms, and service needs that merit consideration in service planning (Betancourt et al. 2017).

Among adults there is strong evidence about peritraumatic dissociation (PD) predicting post-traumatic stress disorder (PTSD), yet evidence among children is very limited. It has been suggested that disturbances in memory functioning might explain the association between PD and PTSD, but this has not yet been empirically tested. In the desire to test the hypotheses that greater PD would be associated with more post-traumatic stress disorder (PTSD) symptoms, and that some of this association would be mediated by disorganized and non-verbal memories about the traumatic event,

Peltonen et al. (2017) conducted research amongst 197 Palestinian children living in the Gaza Strip. This provided empirical evidence that, among war-affected children, greater PD during traumatic events was linked with higher levels of PTSD symptoms several months later, even when accounting for their personal exposure to war trauma. Further, the study supported the idea that the detrimental effects of dissociation during a traumatic event may be due to dysfunctional memories characterized by disorganization and the lack of a verbal and coherent approach. Further tests of these hypotheses with larger samples and more points of measurement are called for (Peltonen et al. 2017).

In their study, Yalin Sapmaz et al. (2017) assessed early onset psychiatric disorders and factors related to these disorders in a group of refugee children from Syria, Iraq, Afghanistan and Iran, after they had immigrated to Turkey due to war. Clinical interviews were conducted with 89 children and their families. The mean age of cases was  $9.96 \pm 3.98$  years. A psychiatric disorder was found in 49.4% of the children. A total of 26 children were diagnosed with anxiety disorders, 12 with depressive disorders, 8 with trauma and related disorders, 5 with elimination disorders, 4 with attention deficit/hyperactivity disorder, and three with intellectual disabilities. It was found that seeing a dead or injured person during war/emigration, and the father's unemployment increased the risk of psychopathology. In the context of war and emigration, these children were trying to cope with the negative circumstances they had experienced before migration, as well as the despair they saw their parents experience (Yalin Sapmaz et al. 2017, Hasanović et al. 2005).

Goldin et al. (2008) compared independent clinical assessments of parents, children and teachers of 48 Bosnian refugee children in Sweden in 1994-1995 using a semi-structured interview. In an interview with a doctor, almost half the children (48%) were identified as having one or more mental health problems, "demanding further attention". Depressiveness was the single most prevalent symptom (31%); followed by post-traumatic stress (23%), and anxiety-regressiveness (15%). At the same time, 75% of the children were rated by teachers as "quite competent" in school. Parent, child and clinician appraisals of primary school children showed broad similarities. Teachers reported a similar prevalence of child distress, but identified different symptoms and different children demanding attention. Evaluation of teenage youths showed greater disparity: teenagers labelled their own symptoms more often as post-traumatic stress reactions, and teachers identified fewer youths in need of attention. The inter-relatedness between the parent, child and clinician appraisals supports the robustness of the semi-structured interview. At the same time, the distinctiveness of the teachers' reports underscores the need to incorporate an outside-world vantage point in the process of risk

assessment. Also, a more concrete presentation of post-traumatic stress reactions and a higher "further attention" threshold for inward emotional problems seem called for (Goldin et al. 2008).

Since the number of North Korean adolescents entering South Korea is increasing, Kim et al. (2014) tested the health behaviour, including behaviour related to mental health and factors connected with depression, of North Korean adolescents who had defected from their homeland and were living in South Korea. A total of 206 North Korean adolescents who had defected were selected, and the control group consisted of 618 matched South Korean adolescents. The analysis showed that North Korean adolescents had a higher rate of smoking cigarettes and current consumption of alcohol and drugs than adolescents from South Korea. The factors associated with depression in North Korean adolescents were: current smoking, lifetime drinking experience, and perceived stress. Therefore, to promote proper health behaviour and adaptation to South Korean society, a specialized approach is necessary for North Korean adolescents (Kim et al. 2014).

Several studies that have researched acculturation and self-management suggest that increased participation in the host culture (or adjustment to it) is linked with better health and disease control. Since there was a lack of research into the connection between acculturation strategies (attachment to Dutch and Turkish culture) and a wider capacity for self-management in the elderly population in The Netherlands, Cramm and Nieboer (2019) examined this relationship in that population. A total of 680 people completed their questionnaire (the response rate was 32%). The average age of the subjects was 72.90 years (standard deviation = 5.02; range, 66-95), and women comprised 47.6% of the sample. Most (80.3%) of the subjects had a low level of education.

Women, singles, more poorly educated subjects, and those with multi-morbidities experienced a lower level of attachment to Dutch culture, and reported a weaker capacity for self-management. Slightly stronger relationships were found between self-management and attachment to the Dutch culture than attachment to the Turkish culture. Multi-morbidity negatively affected the self-management abilities of older Turkish people living in The Netherlands. Given the high prevalence of multi-morbidity in this population, investment in their self-management abilities is expected to be beneficial. Special attention is needed for women, single individuals, less-educated people, and those with multi-morbidities. Interventions aiming to integrate these groups better into Dutch society are also expected to be beneficial for their self-management abilities (Cramm & Nieboer 2019).

Every year, about 60,000 refugee children move to western countries. Kaplan et al. (2015) analysed the effect of refugee status on cognitive functioning. The results of their study indicate that the distinctive in-

fluences for these children include exposure to traumatic events and the need to acquire a new language, which are factors that need to be considered to avoid over-diagnosis of learning disorders and inappropriate educational placements. Pre-arrival trauma, psychological sequelae of traumatic events, the developmental impact of trauma, and the quality of family functioning, have been found to influence cognitive functioning, learning, and academic performance. In addition, the refugee child may be semi-proficient in several languages, but proficient in none, whilst also trying to learn a new language. The influence that the child's limited English proficiency, literacy, and school experience may have on academic and test performance is demonstrated by drawing on research into refugees' English language acquisition, as well as the more extensive literature on bilingual English language learners. Implications for interventions are drawn at the level of government policy, schools, and the individual. The paper concludes with the observation that there is a major need for longitudinal research into refugee children's learning and academic performance, and interventions that will close the academic gap, thereby enabling refugee children to reach their educational potential (Kaplan et al. 2015).

Displaced refugee children, especially girls, showed limitations in play before migration, with higher levels of engagement in play after moving. The provision of opportunities for various forms of play may enhance the positive results of moving for children and their parents. Larger longitudinal studies are needed, examining the play of refugee children and its connection with physical, developmental and psychological well-being (MacMillan et al. 2015).

Buhmann (2014) points out that treatment of traumatized refugees is traditionally aimed at PTSD, but his research shows that patients suffer from numerous psychiatric and somatic comorbidities. Almost all patients, in addition to PTSD many also had depression, pain and untreated somatic complaints. Further, 58% of them had physical problems for which they had received treatment, 16% of patients had psychotic symptoms, mainly related to their trauma, 27% had permanent personality changes after catastrophic events according to ICD-10, and 46% reported traumatic brain injury. Patients reporting chronic pain had higher symptom scores on the Hopkins Check List of depression and anxiety symptoms, or the Harvard Trauma Questionnaire (HTQ), and patients with psychotic symptoms scored higher for all symptom clusters on HTQ. At pre-treatment assessment, the patients' level of functioning and quality of life were very low. The majority of patients lived on public subsidies, their education levels were low, and most patients had a limited social network. There was less improvement in PTSD when patients were receiving public subsidies, and less improvement of depression when patients re-

ported pain in the upper extremities. A positive association was found between systematic use of CBT methods and improvement in patient condition. In the end, they point out that the comprehensiveness of PTSD in explaining the symptoms of traumatized refugees is questionable (Buhman 2014).

After immigration, out-patient psychiatric patients are often exposed to various potentially traumatizing post-immigration events, with many negative consequences for their mental health and quality of life. However, some patients also report positive personal changes, post-traumatic growth, related to these potentially traumatic events. In their study, Teodorescu et al. (2012) describe post-traumatic growth, symptoms of post-traumatic stress, depressive syndrome, post-migration stressors, and their connections with the quality of life of out-patient psychiatric populations of refugee origin in Norway.

Post-migration stressors, such as unemployment, a weak social network and poor social integration, were moderately negatively correlated with post-traumatic growth and quality of life, and positively correlated with psychopathological symptoms. Multi-traumatized refugees in outpatient clinics reported symptoms of psychopathologies and post-traumatic growth after they were exposed to a large number of traumatic events. Post-traumatic growth was positively correlated with quality of life, and negatively related to post-migration stressors (Teodorescu et al. 2012).

Asian Americans are the faster growing population group in the United States. At the same time, evidence exists that problematic levels of drinking are rising amongst adult Asian Americans. Social and cultural factors, such as acculturation and the birth rate, may also help explain the drinking patterns in this group. The literature suggests that there are major and significant differences within the group of Asian Americans, so that individuals who were born in the United States and/or are more acculturated are exposed to a higher risk of alcohol abuse and the problems related to it (Hahm et al. 2003). Asian Americans with a high level of depressive symptoms, psychological disorders and more perceived discrimination have an increased risk of alcohol abuse (Iwamoto et al. 2011, Nishimura et al. 2005, Yoo et al. 2010). Most research on this population has used samples from colleges; therefore it is important to examine samples from the community, including young adults from the United States who do not attend college, and older adults in the Asian American population (Iwamoto et al. 2016).

## **WAR IN BOSNIA AND HERZEGOVINA**

With the onset of war in Bosnia and Herzegovina (BH) in 1992, new demographic movements occurred, which varied in intensity and in terms of their main characteristics over the course of the war. Groups of

displaced people and refugees appeared both inside the borders of BH and beyond it, in Europe and throughout other continents too. Today, after more than 24 years since the Dayton Agreement was signed, migrations of the population of BH continue, both from BH and European states to third countries, and a significant number of these people has returned to their homeland after many years living in foreign cultures.

The return home is referred to as the repatriation process. The need arises for integration of research into acculturation and the mental health status of Bosnian and Herzegovinian displaced persons and refugees during their temporary stay in other countries, and also upon their return, whether it was voluntary or forced. It is especially necessary to pay attention to psychological and behavioural consequences that are long-term in nature, in view of the past two and a half decades of constant political and economic uncertainty, which is not improving today. It is necessary to identify points of convergence and new guidelines for scientific research. Very little has been done in this regard so far (Avdibegović et al. 1998, Hasanović et al. 1999, 2005, 2017, Hasanović 2012a,b).

The open question remains of future research into the acculturation of all those who have permanently left BH, and who are still doing so, from the point of view of the times to come, which will bring the growth of the initial problems that occur with this type of threat to mental health balance.

## CONCLUSION

The process of mental change in people who leave their own country for any reason and move to another, is present in different age groups, occupations, in both sexes, and in different nationalities. They have all survived the drama of leaving their home, and life in settings with different cultures. Many have had the additional trauma of the suffering or death of close family members, or experiencing an illness for which they have had to seek medical help in a country where they are unable to express themselves well about the difficulties they are having. In many cases, their family has been decimated due to the fact that some family members have remained in the country from which they came to their new "homeland". In their new "homeland" they do not have the possibility of employment, their social drama deepens, and it is accompanied by mental crises which develop into severe forms of depression, delusional disorders, perceptive illusions, paranoid disorders etc. For professionals dealing with mental health, both in our country and in the world, this is a new practical challenge, which we can only face by taking a scientific research stance, so that from the outset we are able to research in detail the characteristics of this psycho-social phenomenon, so that we have clear epidemiological, clinical, therapeutic and other parameters

drawn up in an objectively well-established research process. One of the aims is to help those responsible in the socially functioning hierarchy to reorganize the existing material and human resources, so that we may respond adequately to the demands of the time, the events and the people who are our contemporaries.

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### Contribution of individual authors:

Mevludin Hasanović: conception and design of the manuscript, collection and interpretation of data, literature searches and analyses, manuscript preparation and writing the paper;

Dina Šmigalović: made substantial contributions to conception and design, collection of data, participated in revising the article and gave final approval of the version to be submitted.

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