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Migration background in Austria – potential risk for mental health?

Predstavlja migracijsko poreklo v Avstriji tveganje za duševno motnjo?

Povzetek

Avstrija je zaradi globalizacije in vojne v islamskih državah postala večkulturna država s 16% migrantov. Ta etnična raznolikost ne zagotavlja le dragocenih virov in priložnosti, temveč tudi izzive. Številne študije kažejo, da je med migranti povečana razširjenost duševnih motenj. Cilj študije je ugotoviti, ali migrantski otroci in mladostniki v Avstriji pomenijo tveganje ali dejavnik virov ter ali k razvoju duševnih motenj prispevajo tudi drugi dejavniki.

Podatki so vzeti iz dveh ambulant za otroke Univerze Sigmunda Freuda (SFU) na Dunaju. Vsebujejo biografske podatke in diagnozo ICD-10 pri 3222 otrocih in mladostnikih, starih od 3 do 17 let. V vzorcu ima 796 oseb migracijsko ozadje. Napovedovalci, vključeni v model logistične regresije, so: starost, spol, materin jezik, očetov jezik, jezik, ki se govori v družini in ozadje družine. Na duševne motnje sta vplivala spol in starost, ki sta vplivala na glavno diagnozo ICD-10. Rezultati kažejo, da je pri deklicah pogosteje postavljena diagnoza F4, pri fantih pa F9. Študija je tudi pokazala, da imajo turški otroci večji delež diagnoze F9 kot pa otroci iz Bosne, Hrvaške, Srbije, Avstrije ali Nemčije. Poleg tega je turški materin jezik dejavnik tveganja za postavitev diagnose F9. Analiza nakazuje, da v Avstriji otroci in mladostniki z migracijskim poreklom nimajo slabšega duševnega zdravja kot otroci brez migracijskega porekla. Za razumevanje vpliva migracije in migracijskega porekla na glavno diagnozo ICD-10 bo potrebno še več raziskav. Po vednosti avtorice je pričujoča študija prvi raziskovalni projekt za oceno vpliva migracijskega porekla otrok in mladostnikov na razvoj duševne motnje izveden v ambulanti za otroke in mladostnike na Dunaju .

Ključne besede: migranti, migracijsko ozadje, diagnoza ICD-10, otroci in mladostniki, dejavniki tveganja

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Abstract

As a result of globalization and war in Islamic countries Austria has become a multicultural country in which approximately 16% of the population are migrants. This ethnic diversity not only provides valuable resources and opportunities, but also challenges. Many studies indicate that there is an increased prevalence of mental disorders among migrants.

The aim of the present study is to determine whether the migration background of children and adolescents in Austria is seen as a risk or a resource or if other factors contribute significantly to the development of mental disorders.

The data is extracted from the two Sigmund Freud University (SFU) Children and Adolescent Outpatient Clinics in Vienna. It contains not only information about biographic backgrounds but also the ICD-10 diagnosis of 3,222 children and adolescents aged 3-17 years. Out of this sample, 796 persons have a migration background. Predictors included in a logistic regression model are age, sex, mother tongue, father tongue, language spoken in family and family background.

Mental disorders were influenced by gender and age and had an impact on the main ICD-10 diagnosis. Results show that girls are more likely to be diagnosed with an F4 diagnosis and boys with F9. The study also revealed that Turkish children showed higher risk of an F9 diagnosis than children from Bosnia, Croatia, Serbia, Austria or Germany. Furthermore, a Turkish mother tongue revealed another risk factor leading to an F9 diagnosis.

The analysis suggests that children and adolescents with a migration background in Austria are no worse off in terms of their mental health than children with no migration background.

More work needs to be carried out on understanding the impact of migration and a migration background on the main ICD-10 diagnosis.

To the author's knowledge, the present study is the first research project in Vienna conducted in an Outpatient Clinic for Children and Adolescents to estimate the impact of children's and adolescents'migration background on developing a mental disorder.

Keywords: migrants, migration background, ICD-10 diagnosis, children and adolescents, risk factors

Introduction

Migration and migration background

In general, migration refers to a movement of people between different countries. The most important characteristic seems to be the change from one society to another (Schenk, Ellert, & Neuhauser , 2007).

According to the microcensus of Statistik Austria, the term "migration background" covers all persons whose parents were born abroad, irrespective of the child's own nationality. Furthermore, the population with a migrant background can be sub-divided into two groups, namely the first generation and the second. The first generation refers to those who were born abroad and subsequently moved to Austria. Their children being born in Austria of parents who were born abroad are referred to as the second generation of immigrants. A »third generation« is not recorded separately in the statistical surveys, since they have parents who were born in Austria and thus no longer belong to the population with a migration background (Anzenberger, Bodenwinkler, & Breyer, 2015;Statistik Austria, 2019).

Trends in the demographic development of migration in Austria

Austrian history displays numerous facets and diversities of migration. Since a description of the entire historical migration process would go beyond the scope of this article, a focus is deliberately placed on the last few decades.

Since the beginning of the 1960's, Austria's population has increased by around 1,264,000 as a result of immigration. In the 57 years between 1961 and 2017, there were almost 1.602 million more foreigners moving to Austria than Austrians moving abroad. (Blasge, 2014; Statistik Austria, 2018) On average in 2017, about 1.,97 million people with a migration background lived in Austria - 72,400 more than in 2016.

In relation to the total population in private households, this corresponded to a share of 23%. About 1.47 million people belong to the »first generation«, since they themselves were born abroad. The remaining 501,000 people with a migrant background were born in Austria of parents who were born in a foreign country (»second generation«)(Statistik Austria, 2018).

According to a statistic carried out at the beginning of 2019, there are about 1.4 million foreigners living in Austria. This corresponds to about 16.2% of the population. Both of these numbers have been rising continuously for a number of years. The largest group of foreigners living in Austria are the Germans with approximately 192,000 persons, closely followed by the Serbs (approx. 121,000)

and then the Turks (approx. 117,000). If people with a migration background (first and second generation) are included, around 2 million people were recorded in 2018 (Statista, 2019).

Migration is a biographical process and can change/transform community and society, especially when several cultures meet. This process of adaptation is called psychological acculturation (Berry, Phinney, Sam, & Vedder, 2006; Sluzki, 2010).

In Austria, almost a quarter (23.93%) of all children and adolescents suffer from mental problems. The migration background is seen as a potential social risk factor, but in the first epidemiological study for the whole of Austria it did not turn out to be the decisive factor for a mental disorder (Bundesministerium für Gesundheit, 2016).The following study was conducted with the aim of investigating the current psychiatric and psychotherapeutic treatment of children and adolescents with a migration background.

Current state of research

In recent years, there have been repeated studies on the extent to which the migration background or the fact that someone migrates influences and changes the persons concerned.

The fact that migration is a critical life event and that the persons concerned feel a high pressure to adapt due to reorientation in a new culture were shown in studies by many authors (Akkaya-Kalayci, Popow, Waldhör, Winkler &Özlü--Erikilic, 2017; Berry et al., 2006; Bhui et al., 2005;Brettschneider, Hölling, Schlack, & Ellert, 2015; Kirkcaldy, Wittig, Furnham, Merbach, & Siefen, 2006). This high pressure to adapt causes psychosocial stress, which can be accompanied by health issues.

According to Berry et al.(2006), these burdens do not necessarily have a negative impact on the health situation. The effects of migration depend rather on the extent to which personal and social skills and resources are available to cope with the demands. Only the lack of resources leads to unfavourable effects on health, which leads to acculturation stress (Behrens &Calliess, 2008; Haasen, et al., 2007).

Migration can therefore have a negative impact on mental health and is considered to be a general risk factor for mental disorders (Aragona, et al., 2011; Leeuwen, Rodgers, Regner, &Chabrol, 2010; Noymer & Lee, 2012). Acculturative stress is seen by many authors (Berry et al., 2006; Bhugra, 2003; Czubinska, 2017) as a proximal factor of acculturation when explaining mental stress in people

with a migration background, because it induces stress during the acculturation process. Family stressors are often passed on over generations. Migrant children in particular often experience generational conflicts and a divergence between their family values and the norms of the social environment in which they are now living (Ceri, et al., 2017; Portes & Rumbaut, 2005; Walker, Wingate, Obasi, & Joiner, 2008)

Among the mental disorders frequently associated with migration are depression, psychosomatic complaints, somatisation and post-traumatic stress disorders (Idge, Heinz, Schouler-Ocak, & Rössler, 2019; Vogelgesang, 2011). Some studies (Agorastos, Haasen& Huber, 2012; Aragona et al., 2011; Assion, Stompe, Aichberger&Calliess, 2011; Bermejo, Mayninger, Kriston&Härter, 2010; Brandl, et al., 2018) point to an increased prevalence especially in depression and somatoform disorders. Other studies were unable to identify a generally higher risk of mental illness than among people without migration background (Glaesmer, Wittig, Brähle, Martin, Mewes&Rief, 2009;Waxenegger, Mayerl, Rasky, Stolz&Freidl, 2017; Waxenegger, Mayerl, Stolz, Rasky&Freidl, 2018;).This high prevalence was associated with difficulties in acculturation (Walker et al., 2008). Especially for young people, the process of acculturation can be stressful because they are members of both the new culture and heirs of the culture they brought with them. They have to explore both the old and the new and learn to engage with two potentially opposing cultures. Women of Turkish origin in Germany for instance suffer more from intercultural value divergences and show a higher acculturative stress assessment (Idge et al., 2019).

Methods

For the statistical analysis, the data of the children and adolescents aged 3 – 17 attending the two Sigmund Freud University (SFU) Children and Adolescents Outpatient Clinics in Vienna was used (n= 3222 cases in total). This data was collected for the period from April 2014 to October 2018. Out of 3,222 cases 796 are labelled as having a migration background.

Data collection Patients arrive at the outpatient clinic with a medical report and a referral for psychotherapy. They may have been referred by a school, paediatrician, family doctor, psychiatrist or by themselves. When they arrive at the outpatient clinic, they undergo a registration interview. A trained staff member fills out a master data sheet that records socio-demographic characteristics such as gender, age, address, etc. This is followed by an anamnestic questionnaire to

explore the biographical background of the patient. Following this the child or adolescent may undergo a psychological test. The next step is an initial consultation with a registered therapist who makes a preliminary diagnosis. The child or adolescent then works with a therapist under supervision. The therapist also has to fill in a medical history sheet, which he or she should complete within the first few sessions and which provides further in-depth anamnesis details and a deeper insight into the patients' backgroundwhich contributes to making a definitive diagnosis. This data is collected in an SPSS system file.

In Austria in total around 250 different languages are spoken. In addition to German, the most commonly spoken languages are Turkish, Serbian/Croatian/Bosnian (Source: Statistics Austria). These languages (German, Turkish and Bosnian/Croatian/Serbian/Croatian) were considered for the statistical evaluation in this study.

Statistical analysis The descriptive and inferential statistical analyses were performed with the IBM SPSS® 25 statistics programme. The significance level was determined in advance with $p \leq = 5\%$, corresponding to the probability of error (first type error), so that a result within the context of hypothesis testing with $p \leq .05$ is described as significant.

In order to gain an overview, the relationship between gender, migration background and diagnoses according to International Classification of Diseases – 10 (ICD-10) was examined. From this it was evident that three main diagnoses, F3 (*mood [affective] disorders*), F4 (*neurotic, stress related and somatoform disorders*) and F9 (*behavioural and emotional disorders*), stand out and should be investigated in more detail. Thus, various calculations regarding the age at migration, the first language of the parents and the spoken language in the family were considered.

Inferential statistical methods Interrelations between two nominally scaled variables with at least two levels (categories) were analysed on the basis of contingency tables using Chi-square tests (goodness of fit). For a given association between two variables, the test variable x^2 can be used to assess whether the levels of the dependent variable have a distribution difference with respect to the independent variable. Using the standardized residuals ($|>1.96|$), it can be shown in this case where the empirical distribution deviates from the theoretically expected one. If the expected value was <5 in more than 20% of the cells, the correction was necessary by applying an exact Fisher (c.F.) test.

Binary logistic regression is used as a model test to predict the probability of occurrence of the level of a dichotomous criterion. The advantage of this method is that both metric and dichotomous predictors can be used and that multi-category predictors can also be incorporated using dummy coding.

The Hosmer Lemeshow test examines the model fit; the test size forest is distributed Chi-square; the recording of the predictors can be done by the Enter method, whichwas the method used for the purposes of this study. The declared variance share of the criterion covered by the predictors is expressed by the coefficient of determination NagelkerkeR2.

Results

Looking at the total sample size of 3,222 cases the data shows the following gender and migration background demographics.

Table 1
gender demographics

gender	n
male	1946
female	1272
transgender	1
no data provided	3
total	**3,222**

Table 2
age demographics

age	n
0-2 yrs.	17
3-6 yrs.	398
7-10 yrs.	1077
11-14 yrs.	1073
15-18 yrs	638
no data provided	19
total	**3,222**

These tables were examined for relevant variables and whether there is a connection with the main diagnosis. In particular, those variables were analysed that are related to the migration status of the child or adolescent.

There is a significant connection for gender and the main diagnosis (x^2 (5) = 117.13, $p < .001$), whereby a distribution difference of the diagnosis categories with respect to gender can be assumed.

Table 3

Frequencies and proportions (column percentages) of the main diagnoses concerning gender (n=2166 valid cases)

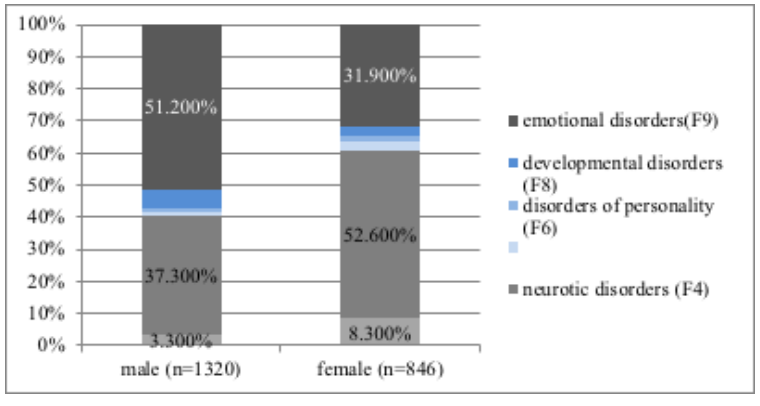
	Gender					
	male		female		total	
Diagnosis	n	percent	n	percent	n	percent
Affective disorders (F3)	44	3.3%	70	8.3%	114	5.3%
Neurotic disorders (F4)	492	37.3%	445	52.6%	937	43.3%
Behavioural syndromes (F5)	9	0.7%	20	2.4%	29	1.3%
Disorders of personality (F6)	18	1.4%	15	1.8%	33	1.5%
Developmental disorders (F8)	81	6.1%	26	3.1%	107	4.9%
Emotional disorders (F9)	676	51.2%	270	31.9%	946	43.7%
Total	1,320	100.0%	846	100.0%	2,166	100,0%

Taking the standardized residuals |>1.96| into account, it was observed that the proportions for female patients were increased in the diagnosis categories F3, F4 and F5 and for male patients in F8 and F9. As can be read from the table, for example, the proportion of boys with the main group F9 (behavioural and emotional disorders with onset in childhood and adolescence) is significantly higher than that of girls who are much more frequently diagnosed with the main group F4 (neurotic, stress and somatoform disorders).

The distribution of diagnoses according to gender is shown in figure 1.

Figure 1

Proportional values of the main diagnoses with regard to the sex of the patients



The connection between the main diagnosis and the migration background was examined. No statistically significant result between the two characteristics ($x^2(5) = 3.07$, $p = .690$) was found.

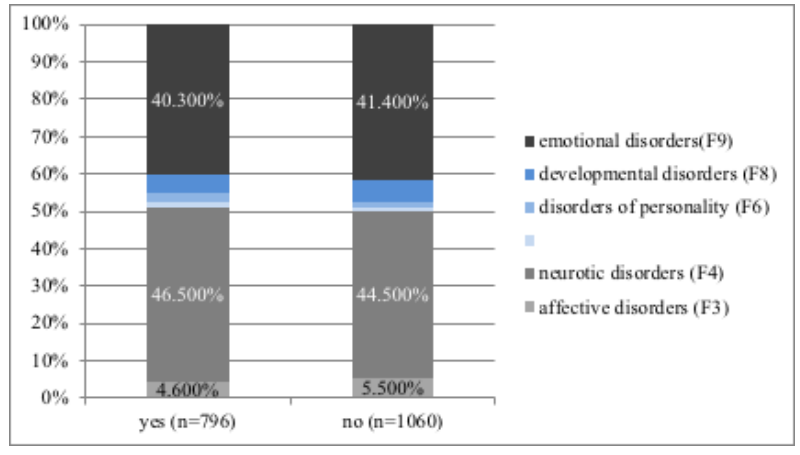
Table 4

Frequencies and proportions (column percentages) of the main diagnoses with regard to the migration background of the patients (n=1856 valid cases)

	migrationbackground					
	yes		no		total	
diagnosis	n	percent	n	percent	n	percent
Affective disorders (F3)	37	4.6%	58	5.5%	95	5.1%
Neurotic disorders (F4)	370	46.5%	472	44.5%	842	45.4%
Behavioural syndromes (F5)	13	1.6%	13	1.2%	26	1.4%
Disorders of personality (F6)	16	2.0%	16	1.5%	32	1.7%
Developmental disorders (F8)	39	4.9%	62	5.8%	101	5.4%
Emotional disorders (F9)	321	40.3%	439	41.4%	760	40.9%
total	796	100.0%	1.060	100.0%	1.856	100.0%

Figure 2

Proportional values of the main diagnoses with regard to the patients' migration status



As a consequence, the extent of fit between the main diagnosis and the age at the time of migration (four age groups) was also investigated. The number of main diagnoses was subsequently reduced to the three largest groups, those

with a correspondingly large population. There was an insignificant distributional difference between the three diagnostic groups with regard to the four age groups (x^2(c.F.)=8.90, p=.145).

Table 5

Proportional values of the main diagnosis with regard to the patients'age (n=72 valid cases)

	Age at migration							
	3 - 6 yrs.		7 - 10 yrs.		11 - 14 yrs.		15-18 yrs.	
diagnosis	n	percent	n	percent	n	percent	n	percent
Affective disorders (F3)	2	7.1%	5	22.7%	1	7.1%	1	12.5%
Neurotic disorders (F4)	16	57.1%	10	45.5%	11	78.6%	7	87.5%
Emotional disorders (F9)	10	35.7%	7	31.8%	2	14.3%	0	0.0%
total	28	100.0%	22	100.0%	14	100.0%	8	100.0%

It was then of interest to examine to what extent there was a connection between the main diagnosis and the language of the mother or of the father or the language spoken in the family as an indicator for a migration background.

Table 6

Frequencies and proportional values (line percentages) diagnosis groups for mothers' mother tongue (n=882 valid cases)

	diagnosis					
	Affective disorders (F3)		Neurotic disorders (F4)		Emotional disorders (F9)	
Mother tongue (mother)	n	percent	n	percent	n	percent
German	43	6.4%	337	50.5%	287	43.0%
Turkish	4	3.7%	41	37.6%	64	58.7%
Bosnian/Croatian/Serbian	4	3.8%	56	52.8%	46	43.4%
total	51	5.8%	434	49.2%	397	45.0%

A significant result (x^2(4)=10.78, p=.029) was noted for a distribution difference of certain diagnoses with reference to the most frequently represented languages of the mothers. Taking the standardized residuals |>1.96| into consideration, a higher proportion of children with mothers of Turkish first language for the diagnosis F9 could be observed compared to the other groups.

Table 7

Frequencies and proportional values (line percentages) diagnosis groups for fathers' mother tongue (n=894 valid cases)

	diagnosis					
	Affective disorders (F3)		Neurotic disorders (F4)		Emotional disorders (F9)	
Mother tongue (father)	n	percent	n	percent	n	percent
German	39	5.9%	326	48.9%	301	45.2%
Turkish	5	4.4%	47	41.2%	62	54.4%
Bosnian/ Croation/ Serbian	5	4.4%	57	50.0%	52	45.6%
total	49	5.5%	430	48.1%	415	46.4%

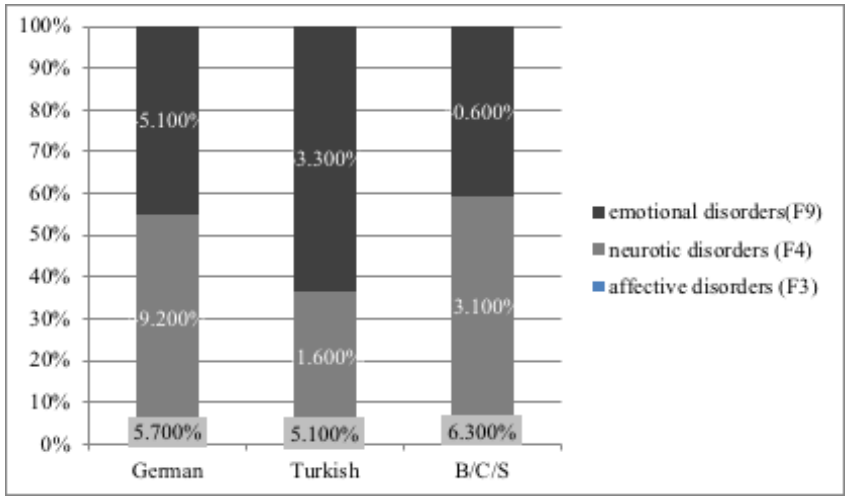
A significant result (x^2(4) = 3.76, p =.439)was not found for a distribution difference of certain diagnoses with regard to the most frequently represented fathers' mother tongue.

Table 8

Connection between language spoken in the family and main diagnosis

	diagnosis					
	Affective disorders (F3)		Neurotic disorders (F4)		Emotional disorders (F9)	
Language spoken in family	n	percent	n	percent	n	percent
German	48	5.7%	414	49.2%	379	45.1%
Turkish	4	5.1%	25	31.6%	50	63.3%
Bosnian/ Croatian/ Serbian	4	6.3%	34	53.1%	26	40.6%
total	56	5.7%	473	48.1%	455	46.2%

Figure 3
Connection between language spoken in the family and main diagnosis



With regard to the family language, on the other hand, the connection with the main diagnosis was statistically significant (χ^2(c.F.)=10.802, p=.025)). Due to the standardized residuals |>1.96|, it was observed that the diagnoses of group F9 were elevated in familes where Turkish is the family language.

In addition to the bivariate analyses, it was subsequently examined whether and to what extent the type of most frequent diagnoses (F3, F4 and F9) was influenced by certain indicators. Within the context of model tests through binary logistic regression, it was analyzed which characteristics have the strongest influence. For this purpose, the diagnoses F3 vs. F9 and F4 vs. F9 were taken as dichotomous criteria (diagnosis) and the influence of several independent variables (predictors, covariates) was evaluated.

The following predictors were applied: gender (dichotomous, male/female), age at registration (metric), migration background (dichotomous, yes/no), sibling position (dense, single/sibling), age at migration (categorical), family language (categorical) and age at separation of parents (categorical).

Dummy coding was implemented for categorical predictors, with »last« (BCS) as the reference category for migration age (>15 years) and family language and »first« as the reference category for »no separation« for age when parents separated. The model adaptation was assessed using the Hosmer Lemeshow test; the non-significant results (p's > .05) indicated the model fit of the analyses. The analyses were performed using the enter method, with all variables simultaneously subjected to model testing.

The results for model testing F3 vs. F9 are summarized in the following table.

Table 9
Coefficients of predictors in model F3 vs. F9 (n=451 valid cases)

							95% CI	
predictor	**B**	**SE**	**Wald (χ2)**	***df***	***p***	**OR**	**LL**	**UL**
Gender	-.819	.389	4.437	1	.035*	.441	.206	.945
Age	-.501	.075	45.009	1	<.001**	.606	.523	.701
Sibling position	-.001	.560	.000	1	.998	.999	.334	2.991
Migration background	.125	.512	.060	1	.807	1.133	.416	3.089
Age at migration			.202	4	.995			
Language spoken in family			.497	2	.780			
Age at parents' separation			4.295	7	.745			
constant	27.394	28403.793	.000	1	.999	-		

** significant at p < .005; *significant at p < .05; ° tendency

The gender (p = .035) and the children's age (p<.001) proved to be significant predictors with explanatory value for the prognosis of F9 behavioural abnormality in comparison with F3.

The male sex and lower age is to be interpreted as a risk factor with F9, while the other predictors did not provide significant explanatory values. The declared share of variance based on the coefficient of determination R2 according to Nagelkerke reached 43.7%.

The results for model testing F4 vs. F9 are summarized in the following table.

Table 10
Coefficients of predictors in model F4 vs. F9 (n=808 valid cases)

							95% CI	
		B	**SE**	**Wald**	**df**	**p**	**OR**	**UL**
Gender	-.700	.157	19.992	1	<.001**	.496	.365	.675
Age	-.144	.023	39.964	1	<.001**	.866	.828	.905

** significant at p < .005; *significant at p < .05; ° tendency

							95% CI	
		B	SE	Wald	df	p	OR	UL
Sibling position	.147	.191	.590	1	.443	1.158	.796	1.684
Migration background	-.176	.190	.856	1	.355	.839	.578	1.217
Age at migration			1.883	5	.865			
Language spoken in family			6.987	2	.030*			
(1) Ger. vs. BCS	.234	.336	.485	1	.486	1.263	.654	2.440
(2) Turk vs.BCS	.998	.413	5.838	1	.016*	2.712	1.207	6.093
Age at parents' separation			13.626	7	.058°			
(1) prenatal. vs. none	-.051	.298	.030	1	.863	.950	.530	1.702
(2) 1 yr. vs. none	-.290	.344	.714	1	.398	.748	.381	1.467
(3) 1-3 yrs. vs. none	-.082	.239	.119	1	.730	.921	.576	1.472
(4) 4-6 yrs. vs. none	-.321	.232	1.908	1	.167	.725	.460	1.144
(5) 7-10 yrs. vs. none	-.685	.250	7.480	1	.006*	.504	.309	.824
(6) 11-14 yrs. vs. none	-1.241	.577	4.628	1	.031*	.289	.093	.896
(7) 15+ yrs. vs. none	.691	.740	.872	1	.350	1.996	.468	8.510
constant	-18.403	40193.020	.000	1	1.000	.000		

** significant at p < .005; *significant at p < .05; ° tendency

Gender ($p < .001$), age of children ($p < .001$) and family language ($p = .030$) proved to be significant predictors with explanatory value for the prognosis of F9 behavioural abnormality in comparison with F4, as well as parents' separation between the childrens' ages of 7 and 14 could be proven as a risk factor for an F9 diagnosis.

The male sex and lower age are therefore to be seen as risk factors for F9. In addition, families with Turkish as their mother tongue were more likely to be diagnosed with F9 than families with BCS. The declared share of variance based on the coefficient of determination R2 according to Nagelkerke reached 17.8%.

The other predictors did not provide significant explanatory values. Thus, sibling status, migration background, age at migration and German vs. BCS as family language in both models (F3 vs. F9 and F4 vs. F9) did not achieve a significant explanatory value for the occurrence of either diagnosis.

Discussion/interpretation

The outcome of the present study shows that it is mainly gender and age that have an influence on developing a mental disorder.Similar results can be found with Wagner et al. (2017), where the prevalence of internal disorders was higher in girls, while impulse control and conduct disorders were more likely to be found in boys. The hypothesis that a migrant background would influence the development of mental disorders did not reach statistical significance (Glaesmer et al., 2009).

The slight significance regarding the language spoken in the family can be explained by previous studies. For example, Turkish-speaking migrants seem to have lower life satisfaction regarding their health than people who have no migration background. Life satisfaction decreases the older they get (Ete, 2000; Özlü-Erkilic, Winkler, Popow, Zesch, & Akkaya-Kalayci, 2015). It was also discovered that Turkish speaking children and adolescents tend to have a higher probability of developing depressive and anxiety symptoms whereas peers who have no migration background show more frequently externalizing problems (Guttmann, Aysel, Özlü-Erkilic, Popow, & Akkaya-Kalayci, 2019).In addition, it could be observed that in Austria Turkish patients have the highest suicidal tendency compared to Bosnians/Croatians/Serbians and Austrians. Bosnians/Croatians/Serbians and Austrians tend more towards acute stress disorders (Akkaya-Kalayci et al., 2017).

Not to be underestimated is the acculturation process and the ability of adaptation. (Berry et al., 2006; Haasen, et al., 2007).Cultural identity, such as integrated friendship choices, have an impact on mental health, as these can reduce suffering by developing coping strategies (Bhui, et al., 2005). Factors like ethnicity, socio-economic status, intercultural consultation as well as communication skills are of great relevance and show the complexity of the impact on the health-related services and on the conception of illness and health (Brandes, Gerken, & Walter, 2009; Koch, Hartkamp, Siefen, & Schouler-Ocak, 2008; Sturm & Moro, 2010). One aspect that could explain the result is anchored

in the fact that young Turkish migrants have a more negative attitude towards psychotherapy than people with no migration background. This is attributed to culture-specific factors (Calliess, Schmidt-Ott, Akguel, Jäger, & Zeigenbein, 2007; Freidl, Waxenegger, Stolz, Mayerl, & Rásky, 2017).

In general, the non-significant difference in whether a person has a migration background regarding the development of a mental disorder should be emphasized (Glaesmer, et al., 2009; Waxenegger et al., 2018) It is considered that more detailed studies and research are needed.

Limitations and conclusions

This study bears some limitations that should be acknowledged. First of all, it was conducted in Vienna's two Outpatient Clinics for Children and Adolescents, therefore the results might not be generalizable to other regions of Austria or Europe. Secondly, it must be considered that the migration of these sample families has led them into a more beneficial country, Austria. Austria is not only known as a welfare country, but its capital Vienna is the most liveable city in the world (The Economist Group, 2019).

The present study does not reveal any statistical significance regarding the influence of a migration background on mental health. Based on the results, there are other factors (like age and gender) that are more crucial in determining the risk of developing a mental disorder, while a migration background alone did not have any significant influence. Although a migration background turned out not to be crucial for developing mental disorders in children and adolescent boys and girls, important findings were found when considering spoken language. These replicate previous studies and suggest that in Turkish speaking families children have more emotional problems and may develop disorders, which might be due to acculturation stress and a lower ability for adaptation. Since this turns out to be a vulnerable population with more negative attitudes towards psychotherapy, it raises the question which therapeutic techniques would be most useful for stimulating healthy development and wellbeing.

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