“A Study of Psychological Well-being among Women Forced Migrants in Bosnia and Herzegovina”

Final project report for the research project “Engendering forced migration, socio-political transition, and mental health in BiH, Serbia, and Kosovo"

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Abstract

The aim of this study was to examine the mental health of war-displaced persons and returnees in Bosnia and Herzegovina, 20 years after the end of war, and to explore socio-demographic and health factors that contribute to the psychosocial well-being of these particular groups. The psychosocial health factors included an investigation into prevailing positive and protective (salutogenic) and negative (pathogenic) health factors, in order to uncover the complex patterns of well-being in the targeted population.

Leading research questions in this psychometric study were: How does the experience of inter-ethnic violence, large-scale war-displacement, and protracted socio-economic transitioning affect the psychosocial health of women forced migrants in each of the three environments, and what is the state of their psychosocial well-being, including both distress and resilience factors in these challenging social environments?

This cross-sectional study was implemented in 12 towns in Bosnia and Herzegovina. A total number of 230 participants (250, including the pilot study) were included in the study. All participants belong to one of three targeted populations: returnees (107), internally displaced persons - IDPs (114), and refugees (9). Data were collected during face-to-face interviews using 12 instruments presented to the participants in the following order: Socio-demographic questionnaire, Quality of life questionnaire, Stress inventory, Anxiety questionnaire, Self-esteem questionnaire, Loneliness inventory, Optimism-pessimism inventory, Scale for measuring coherence of life, Social support questionnaire, Time management questionnaire, the List of stressful events inventory, and the Questionnaire for specific health issues and appropriate support services (QHI).

The results show that our participants obtained high scores on the instruments measuring positive health, and low scores on those instruments measuring distress, which means that we generally deal with a psychologically healthy population.

Among salutogenic health factors, we found the following protective factors: age (younger participants feel better), being married, improvement in social status, regular sources of income, and the factor of residence in terms of living in own house or in a family-owned house. Factors that belong to risk health factors are: gender (women have a higher perception of stress), being an IDP (a population that indicates higher number of stressful events), disability in the family, unresolved housing issues (living in collective centres or in social housing), financial dependence (dependence on the social welfare or a family member, and/or other person's financial support), residence change (repeated change of residence), war-related human losses (experience of losing a family member), having a physical injury, having severe mental health problems and receiving treatment for them (experience of psychological conditions that required professional treatment), and having been a consumer of medical therapies of any type (including mental health issues).

Women are more prone to distress than men and demonstrate higher scores on the stress scale, which implies a higher level of stress. Moreover, female participants who have been diagnosed with any type of mental disease demonstrate lower self-esteem, lower perception of friend and family
support, lower time management perception, and higher stress and anxiety levels. Having received medical treatment or psychological support, and having visited a psychotherapist are important factors for women's self-esteem, coherence of life, time management, perception of stress, anxiety and loneliness, while these factors have no significance for the psychological health of men.

On the other hand, married male participants show higher level of perceived social support from family, while there is no such tendency observed in female participants. Moreover, having regular income is an important salutogenic factor for male, but not for female participants.

**Introduction to war-displacement and the return of displaced women in Bosnia and Herzegovina**

Displacement is rising across the world and it is becoming a global issue in terms of international public health. It is estimated that there are around 45.2 million forced migrants globally (Siriwadhana et al., 2014), and that the number of internally and externally displaced persons is growing exponentially in many global regions (Siriwadhana, 2015).

A number of studies have indicated that migration is to be considered a traumatic experience. Refugees and IDPs suffer significantly higher levels of mental health impairment than other groups (Porter & Haslam, 2001). They are more vulnerable to mental disturbances due to the experience of migration itself, since migration requires cultural adaptation and severe changes in socioeconomic position (Gulsen et al., 2010).

Transitions are challenging processes in people's lives, and they can contribute to social marginalization, loss of social networks, health care issues, and adverse health consequences including depression and anxiety (Shishehgar et al., 2015). Forced migration caused by war is challenging for a person's physical and mental health as it involves emotional distress connected to personal and collective loses. Moreover, the combination of loss and movement intensifies an individual's sense of threat and loss of control, and is thus considered to constitute a specific traumatic experience (Nuttman-Shwartz et al., 2011). Dohrenwend et al. (2006, cited in Nuttman-Shwartz et al., 2011: p. 487), state that exposure to traumatic events can lead to pathological responses and negative consequences such as anxiety, fear, depression, and post-traumatic symptoms. According to Good (1996), displaced persons are at a special risk for depression, anxiety disorders, and somatization disorders. Also, they have a tendency to develop “cultural bereavement” (Eisenbruch, 1992, cited in Good, 1996), a process of grieving for their lost home and culture that is as painful as the grief for someone who has died. That puts displaced persons under a risk for developing various mental health problems ranging from delinquency, alcohol and drug abuse, to the most severe mental health issues.

According to Thomas & Thomas (2004), the most common psychological reactions found in refugee and displaced people groups have included PTSD (as a reaction to violence and/or torture), depression (a reaction to loss), somatization and existential dilemmas (where belief patterns have been challenged). Siriwadhana et al. (2014) state that both externally and internally displaced forced migrants have an increased prevalence of depression, post-traumatic stress disorder, anxiety,
somatization, and other mental disorders, while resilience is related to protective and mediating factors like higher socioeconomic status, younger age, and social support.

Although all types of displaced persons are under risk, some research findings show that there are some differences and that internally displaced persons are under higher risk than refugees and returnees. IDPs are not protected by international refugee laws and, therefore, cannot access international aid and services (Siriwadhana et al., 2014). In comparison to IDPs, refugees might be positively influenced by greater protection and discontinuation of exposure to violence (Erol et al., cited in Mels et al., 2010), yet negatively affected by cultural bereavement. The third group are the returnees who have regained residential stability. Porter and Haslam (2005, cited in Mels et al., 2010) concluded that IDPs had the worst outcomes for mental health, followed by returnees, and finally refugees. IDPs are found to be a high-risk group for mental health disorders, and they score lower on mental health indices than refugees (Salah et al., 2012: p. 782).

Most of the previous research on mental health of displaced persons has focused on post-traumatic stress disorders (PTSD) and depressions. However, displacement experiences can generate both pathological and resilient responses in the affected persons (Porobić, 2012).

There are studies that imply that traumatic experiences can also evoke positive changes and growth (Tedeschi et al., 1998; Nuttman-Shwartz et al., 2011). Findings regarding whether trauma might cause impairment or growth are underdeveloped, but most point to the fact that, should the trauma exceed a certain level of severity, it becomes devastating (Powell et al., 2003; Mahdi et al., 2014; Dekel et al., 2012).

Nearly 80% of refugees and IDPs are women and children, and they are particularly vulnerable to physical and mental health difficulties and have unique health care needs (Thomas & Thomas, 2004). Many displaced children continue to function normally; however, they can still develop a whole range of symptoms, such as PTSD, depression, anxiety disorders, and behaviour problems (Mels et al., 2010).

When it comes to women, studies reveal that many displaced women suffer serious mental health problems as a result of migration process, such as depression, schizophrenia, posttraumatic stress disorder, suicide, and psychosis (Beiser, 2015; Bhui et al., 2003; Grisaru et al., 2003 cited in Donnelly et al., 2011). Those women have difficulties meeting their mental health care needs (Donnelly, 2004; Morrow and Chappell, 1999; all cited in Donnelly et al., 2011). Among the factors that contribute to low levels of mental health of women refugees, Donnelly et al. (2011) mention low socioeconomic status, unemployment and underemployment, marginalization, discrimination, gender issues, language barriers, cultural differences, social stigma, and lack of knowledge regarding available mental health services. Barenbaum et al. (2004, cited in Mels, 2010) state that female gender is an important factor which negatively influences psychological well-being, which means that women tend to show lower resilience during and after traumatic events.

The war in Bosnia and Herzegovina (1992-1995) was characterized by a high level of destruction, but also devastation on a demographic level with 100,000 dead, and around 31,500 missing.1 More than 60% of the population of Bosnia and Herzegovina was severely affected by war-induced

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1 According to International Commission for Missing Person and Missing Person Institute in Bosnia and Herzegovina, http://www.icmp.int/where-we-work/europe/western-balkans/bosnia-and-herzegovina/
displacement. More than 2.3 million people had to flee their homes; around 1.3 million of them left the country and found protection abroad, and around 1 million were displaced within the BiH borders (Porobić & Mameledžija, 2014, referring to MHRR and UNHCR statistical overviews).

The war ended with the Dayton Peace Agreement in 1995, and one part of this Agreement (Annex VII) refers to the right-based return of all persons displaced as the result of the war. Since then, significant efforts were made by national and international organizations regarding the provisions for successful return of displaced persons, especially through legal regulation of property restitution. However, after regaining their property, many of the war-displaced did not fully return to their pre-war homes. Rather, they migrated to areas where their ethnic group is in majority, or have re-emigrated, permanently leaving the country. Most of the support programs aimed at returning the refugees and IDPs to their homes did not have a significant impact on full integration of returnees, mainly because of the lack of security, lack of economic opportunities, and insufficient social services (Fagan, 2011; Porobić & Mameledžija 2014; Porobić, 2016).

During the 1992-1995 war in BiH, in addition to the male population involved in warfare, the civilian population was exposed to severe violence and suffering. Many women were subjected to torture involving gender-based violence, imprisonment, and deportation. Therefore, psychosocial help to refugees and IDPs was made available, and was particularly aimed at women and children as the most vulnerable groups within these populations, both during the war, and in the period after the war.

Various domestic and international institutions provided adaptive support to women in Bosnia and Herzegovina, and were mainly focused on providing a helpful coping climate involving social and cultural resources (Petrović, 2010; Porobić, 2012) that could lead to meaningful and positive amelioration of war adversities, including making sense of stressful experiences, and integrating grief, anger, or anxiety through intense personal and socially mediated processes (Porobić, 2012).

At first, this psychosocial support, provided by foreign and international non-governmental organizations in partnership with local ones, focused on providing the basic needs: food, shelter, medical treatment, and acute psychological help. During the two decades of post-war reconstruction, they expanded their field of activities to include the returnees as well.

After the war, aided by international organizations like UNHCR, UNDP, UNICEF, WFP, OSCE, CRS, Medica Mondiale, and American Embassy, among others, numerous NGOs provided economical and psychological help to women refugees, or otherwise displaced women. The projects involved donations of funds to start their own business. Some of those organizations provided psychological help to women victims of sexual violence (Medica Zenica, Žena BiH Mostar, Women’s Association Derventa, etc.). The returnees became a new vulnerable category, and they needed psychosocial help. This help was provided through legal counselling regarding the return of property, and access to basic human rights such as health, employment, and education. Numerous projects were realized in order to provide economic empowerment to this population.
In summary, the work on improving mental health in post-war Bosnia and Herzegovina involved many different stakeholders and various target groups, although it has still not been integrated into the state-run mechanisms of service provision (Porobić, 2015).

**Research questions**

Questions of mental health are particularly salient in the countries of the Western Balkans (WB) that face prolonged processes of social and economic transition and protracted forced migrations, such as Bosnia and Herzegovina (BiH), Serbia, and Kosovo. These three countries, which have been severely affected by war-induced displacement during the 1990s dissolution of the former Yugoslavia, when around 4 million people became uprooted and/or forced to flee their homes, still face a number of issues regarding the full protection of the rights of displaced persons, including the right to return to their domicile and full access to socio-economic rights, such as education, health, social protection, and employment. According to UNHCR's regional profile for South-East Europe in 2014, there are still 366,000 war-displaced persons in the WB region who are in need of a 'durable solution.' Apart from the acute forced migration issues still being tackled, the overall socio-demographic situation in these countries is heavily reshaped by both war-induced displacement and post-war socio-political instability, infused by severe economic deprivation, causing further emigration. It is important to note that the number of persons with mental health difficulties in these countries is higher than the EU average, with causes related to two decades of war, ethnic tensions, poverty, and lack of organization in the mental health sector.

The project addresses the following research questions (of which the first two directly relate to the psychometric study):

- How does the experience of inter-ethnic violence, large-scale war-displacement, and protracted socio-economic transitioning affect the psychosocial health of women forced migrants in each of the three environments?
- What is the state of their psychosocial well-being, including both distress and resilience factors in these challenging social environments?
- What is the nature of psychosocial support (governmental and non-governmental, and formal and informal) provided to this population?
- What should be done to address the psychosocial needs identified among this population, and to fill the gaps in the existing programmes and policies?
- Which good practices (if any) could authorities and different national, regional, and international stakeholders implement, in order to improve the practice of providing psychosocial services and their accessibility to women forced migrants in these three countries?

**Methodology**

**Sample**

The sample for this study consisted of 230 participants (117 male, 113 female), from 11 towns (14 municipalities) in Bosnia and Herzegovina.
The criteria for recruiting participants were as follows:

- Gender: equal number of female and male participants;
- Status: persons officially registered or unofficially belonging to the category of refugees, internally displaced persons, or returnees in BiH;
- Age: older than 38 years;
- Housing: participants living in collective accommodation should constitute no more than 10% of the total sample;
- Stratified population: diversity in ethno-religious background, education, socio-economic status, employment status, and other common socio-demographic diversities.

When it comes to the sampling technique, we used a convenient sample, targeting the population of the displaced, returnees, and refugees across the country, in locations where the largest percentage of this population is statistically registered by the UNHCR and by the Ministry for Human Rights and Refugees (MHRR). Data was collected in 14 municipalities with the highest rates of returnees, IDPs, and refugees registered among the total population. UNHCR Office in BiH provided us with registries of collective centres in BiH, which were then checked and reconfirmed by the MHRR, which issued a letter of support for the fieldwork and informant recruitment, and thus enabled the access to the collective centres with IDPs across the country. Participants were recruited on site by contact persons in Centres for Social Care, the Mental Health Centres, and NGOs working with target populations in each municipality.

Figure 1 shows the map of sampling areas in Bosnia and Herzegovina. The number of selected locations reflects the variation along the lines of urban/rural, local majority ethnic group (Bosniak/Croat/Serb), and the political organization of the country. Based on all above mentioned criteria, the municipalities in which data collection took place were: Bosanski Petrovac (pilot study), Bugojno, Mostar, Sarajevo, Srebrenik (Federation of BiH), Banja Luka, Doboj, Istočno Novo Sarajevo, Prijedor, Trebinje, Derventa (Republic of Srpska), and Brčko (Brčko District).
Figure 2. Sample structure according to gender

Figure 3. Sample structure according to category (displaced/returnees/refugees)
**Procedure**

In order to check the applicability of instruments, a pilot study was conducted. For this purpose, we used 20 participants from Bosanski Petrovac (10 male and 10 female). This data is not included in our study, nor was it further analyzed since some of the instruments used were subsequently replaced, or were excluded from further research.

Fieldwork lasted three months and involved data collection that started in January 2015, and was finalized in March 2015. Data was collected through face-to-face interviews by two trained and qualified survey administrators, using structured questionnaires. The survey administrators underwent an intensive training program for successful administration of the 12 questionnaires used in this research.

Participation in the research was voluntary, and after completion, participants received an incentive in the amount of 20 BAM (10 Euros). The participants signed an informed consent, as well as a confirmation for receipt of payment for participating in the study. The research applied ethical guidelines from the UNHCR Code of Conduct (2004).

**Instruments**

The set of instruments applied in this research consists of 174 items in total, contained in 12 questionnaires. Two questionnaires were especially designed for the purpose of this study in order to respond to specific research demands, but also taking into account the target population. These questionnaires are: the Questionnaire for gathering socio-demographic data (SD), which was presented to participants as the first one in the set, and the Questionnaire for specific health issues and support services (QSS), which was filled out at the end.

A total of ten instruments were applied for measuring psychological characteristics: life satisfaction, psychological stress, anxiousness level, self-respect, loneliness, optimism, sense of coherence, level of social support, time management, and stressful life situations. The description of each of the mentioned instruments follows the same order in which they were used in the surveys.

1. **SD Questionnaire** is a questionnaire constructed by the researchers with an aim to obtain data about age, gender, nationality (ethnicity), family structure, marital status, residence information, residence conditions, level of education, sources of income, and information about the category of returnee, refugee, or IDP. These categories had a temporal distinction (prior to the war and today), as we aimed to elicit data on demographic differences which occurred due to war and displacement, and in the post-war period.

2. **Manchester Short Assessment of Quality of Life – MANSA** (Priebe et al., 1999) measures an individual’s perception of their quality of life. The scale consists of 16 statements on a Likert scale of 7 degrees. Twelve items are divided into 3 sections: general satisfaction (financial situation, work, educational process, and current occupation), quality of free time (friendships), while the third section explores the assessment of satisfaction with personal security, sexual life, close relationships, and the assessment of personal health. The total score is calculated as a linear combination of the sums of answers on questions 1-3, 6-8, and 11-16. Theoretically, the score can range between 12 and 84. A higher score indicates a higher level of
satisfaction. Participants with a score above 48 possess a fairly good life satisfaction (Priebe et al., 1999). The scale has satisfying metric characteristics (Priebe et al., 1999).

3. **Kessler Psychological Distress Scale – SR1 (Kessler, 1992)** measures the self-assessment of psychological stress based on a certain set of emotions an individual feels in the time span of four weeks. It consists of 14 items, which are divided into two sections. In the first section, the participants need to assess, on a five-point grading scale, how often the mentioned emotions are experienced in the time period of four weeks. The second part consists of four objective questions which relate to the extent (measured in days) to which these feelings affected some important life aspects in the previous period, such as: work, studying, or daily activities, and whether the participants felt the need to seek expert help (from a healthcare worker) because of these emotions (Kessler & Mroczek, 1994). The total score is a linear combination of answers to 10 questions. Theoretically, the score can range between 10 and 50. The interpretation of scores is provided by authors (Andrews & Slade, 2001), and suggests the following framework:
- below 20 – good psychological condition and a lack of stress;
- from 20 to 24 – mildly elevated psychological stress;
- from 25 to 29 – clearly elevated psychological stress;
- above 30 – highly elevated psychological stress.

4. **GAD 7** measures Generalized Anxiety Disorder. It consists of 7 items. The problems stated in the questionnaire are related to the feelings of anxiety, inability of control and relaxation, concern, irritability, and constant fear. The participants need to provide an estimate on a four-point grading scale on how frequently they were bothered by each of the aforementioned problems in the period of last two weeks. At the end of the questionnaire, the participants who highlighted at least one of the problems as relevant in their lives were asked to assess to what degree that particular problem interfered with everyday activities, ranging from none to extremely high degree (Spitzer et al., 2006). The scale has good metric characteristics (Spitzer et al., 2006). The total score is a linear combination of 7 answers. Theoretically, scores can range from 0 to 21. Results higher than 10 – indicate a possible diagnosis of Generalized Anxiety Disorder, which should be verified by further evaluation; The interpretations of scores provided by the authors range within the following framework:
- higher than 5 - indicates mild anxiousness;
- higher than 10 - indicates an increased level of anxiousness;
- higher than 15 - indicates a high level of anxiousness.

5. **Rosenberg Self-Esteem Scale – RSS (Rosenberg, 1965)** measures a general feeling of self-esteem. The scale consists of 10 statements and the participants need to assess their self-satisfaction, feeling of pride, worth, success in task-based activities, and their position in society compared to other people. Five statements are formulated negatively, and five are formulated in a positive manner. The participants can respond to each question by assessing to what degree they agree with a claim, on a four-point Likert scale. The scale has good metric characteristics (Frank et al., 2008). The total score is calculated as the sum of all answers, after reversing the statements 1, 3, 4, 7, and 10. The total score can range from 10 to 40. In general, every score above 30 is regarded as indicative of a high level of self-esteem, while scores below 20 reflect a damaged or seriously affected self-esteem level.

6. **The short version of UCLA loneliness scale (Lacković-Grgin et al., 2002)** examines global loneliness, defined as an uncomfortable emotional and motivational state caused by an inability to satisfy the needs for intimacy, love, belonging, closeness, and relationships (Lacković-Grgin et al., 2002). It consists of 7 items and the participants need to estimate, on a
five-point Likert scale, the frequency with which the mentioned mental states occur in their lives. This scale also has satisfying metric characteristics (Lacković-Grgin et al., 2002). The total score is expressed as the average value of all items; theoretically, values of the results range from 1 to 5 (Lacković-Grgin et al., 2002).

7. **Life Orientation Test – LOT-R (Scheier et al., 1994)** - The optimism/pessimism scale is designed for assessing the position of an individual within the optimism/pessimism dimension (Scheier et al., 1994). The questions are related to the participant’s assessment of hope and outcomes concerning uncertain situations, personal stance regarding the future, and the participant’s hopes for positive future outcomes. The participants answer questions using a five-point Likert scale. Metric characteristics are satisfying (Scheier et al., 1994). Questions 2, 5, 6, and 8 are fillers, and reverse items are 3, 7, and 9. The total score is a linear combination of questions 1, 3, 4, 7, 9, and 10. Theoretically, scores can range from 6 to 30, where higher scores reflect higher level of optimism, and vice versa.

8. **The short version of Sense of coherence scale – SOC (Lacković-Grgin et al., 2002)** measures the participant’s perception of the world as understandable and meaningful place (Lacković-Grgin et al., 2002), combined in the feeling of coherence. The scale consists of 23 questions related to: the participants' feelings of understanding other people, the degree of meaningfulness of their current jobs, their life experience, methods for managing problems, reactions to unpleasant situations in the past, and plans for solving problems in the future. Furthermore, the questions cover a whole continuum of outlooks for the future, and plans for resolving future issues. Participants respond to questions by providing answers on a seven-point Likert scale. It has good metric characteristics (Lacković-Grgin et al., 2002). Reversed items are 1-3, 6, 8, 9, 11, 14, 17, and 21-23, and the total score is a linear combination of all answers. Theoretically, scores range from 23 to 161, and a higher score reflects a higher level of coherence.

9. **The Social Support Appraisal Scale – SS-A (Vaux et al., 1986)** measures social support and consists of two facets: friends support and family support (Cournoyer, 2011; Vaux et al., 1986). It contains 21 items. The content of items is concerned with support from friends which is examined by the participant’s evaluation of respect they receive from friends, their support and care for well-being, and mutual respect. The content of items that cover the area of family support is concerned with the assessment of how much their family members care for the well-being of the participant, to what degree the sense of belonging and connection is felt within the family, and how reliable are the members of the family. For assessing the answers to these questions, the participants use a four-point Likert scale. The scale has satisfactory metric characteristics (Monahan and Hooker, 1995). Reversed items are 3, 10, 19, and 20. The total score is a linear combination of all items, and can range from 21 to 84 for friend support. For family support, the total score is a linear combination of items 2, 4, 7, 9, 11, 16, and 20, and can range from 7 to 28. The score for friend support is obtained when items 1, 6, 10, 13, 14, 17, and 21 are summarized, and that score ranges from 7 to 28. It is believed that a lower score equals to a higher level of social support.

10. **TSQ (Time structure questionnaire)** measures the level of the participant’s structured and practical time usage. This questionnaire consists of 26 items that cover the aspects of the meaning of life, self-respect, assessment of the present, positive outlook on the future, type A behaviour, efficacy of work habits, persistence in achieving goals, efficacy of organization, etc. (Bond & Feather, 1988). Participants respond by using a seven-point grading scale. It has good
metric characteristics (Helsten, 2012). Reversed items are 3, 7, 9, 15-17, 19, 20, and 22 (Bond & Feather, 1988), and the total score is a linear combination of 26 items. Theoretically, the score ranges from 26 to 182, where a higher score reflects a higher level of structured use of time.

11. The List of Stressful Life Events – LSZD (Opačić et al., 2005) measures the level of exposure to stressful events (Opačić et al., 2005). A list of 20 questions was used, related to heavily stressful situations experienced by the participant. If the answer is positive, the participants were asked to state when the situation took place and whether it was related to the war or to normal life experiences. This list was given in the form of an interview. There are no data related to psychometric characteristics; the scale has more of a descriptive form (Opačić et al., 2005). There are two scales: one score could be a summary of positive answers, while the other could be a summary of answers related to war circumstances (Opačić et al., 2005).

12. QHI – The Questionnaire for specific health issues and appropriate support services was specifically designed for the purpose of this research study, and the questions are mainly related to the individual experiences of psycho-social, psychological, and psychiatric services. The questions in the first part of the questionnaire are related to physical injuries, head traumas, visits to a psychiatrist, psychologist, or a neurologist, whether a diagnosis was established, and if so, was there use of medications, and for how long. The second part of this instrument is concerned with the reasons for (not) participating in some type of psychiatric therapy, psychotherapy, or any type of counselling in general. At the end, two questions were given where the participants needed to express their opinion on establishing a regional educational centre for various psychosocial services provided to returnees, refugees, and displaced persons.

It is important to mention that instruments 2 to 11 are all standardized based on the population that constituted our sample. All instruments have satisfactory metric characteristics, which were cross-checked in our study. By choosing these instruments, we attempted to purposefully cover two complementing sides of mental health: salutogenic and pathogenic health factors (Antonovsky, 1984 and 1996). The results below are presented in reference to the above.