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Mental Health Consequences of War and Post-Conflict Development: A Case Study on Bosnia and Herzegovina

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ABSTRACT

This study reviews contemporary literature on the overall state of mental health in the context of international development. It identifies the need to prioritize mental health in the field of international development and to create informed policies and programs through the use of case-study examples of countries that have witnessed much involvement in this domain. Societies undergoing or recovering from a conflict are identified as especially vulnerable to a range of mental health problems such as high levels of Post Traumatic Stress Disorder (PTSD), post-conflict anxiety and depression. The psychological effects of the 1992-1995 war in Bosnia and Herzegovina and the various ways in which these have manifested themselves in a ten-year post-conflict period are examined. The mental health consequences of the war affect the whole society, with women and children, rural populations, refugees, internally displaced persons and war veterans being the most vulnerable population sub-groups. An analysis of the post-conflict psychosocial programs and subsequently health and mental health reforms ensues. Psychosocial programs are identified as overall effective in addressing post-war mental health problems and critiqued in terms of their cultural adaptability and success at achieving desired sustainable results. Mental health reform is a complex process dependent on a range of contextual political, social and economic factors. Recommendations for further research and action include establishing countrywide evaluation measures, improving research facilities and addressing political fragmentation at the national level and lack of international coordination at the global level.

Keywords: mental health, psychological consequences of conflict, international development, Bosnia and Herzegovina, post-conflict society, psychosocial

PART I

Abbreviations

APA: American Psychological Association

DALY: Disability-Adjusted Life Year

DSM IV: Diagnostic and Statistical Manual of Mental Disorders

EC: European Commission

Federation of BiH: Federation of Bosnia and Herzegovina

ICD-10: International Classification of Diseases

MDGs : Millennium Development Goals

NGO: Non-Governmental Organization

OHR: Office of the High Representative

PTSD: Post-Traumatic Stress Disorder

RS: Republic of Srpska

UN: United Nations

UNDP: United Nations Development Program

WHO : World Health Organization

WB: World Bank

Introduction

This study presents the current state of mental health on a global level, identifying the key issues and priorities for the mental health field to address. It identifies these needs in terms of how they can be addressed in international development and why addressing them is crucial to the overall development of societies. The study will discuss the state of mental health in developing countries in general, with a particular emphasis on post-conflict societies. An in-depth examination of the country of Bosnia and Herzegovina is made. The country is analyzed in terms of the mental health consequences most commonly suffered by its population due to the war and with particular emphasis on the reforms and post-conflict development initiatives that have attempted to address these. The main research question examined by this study asks how can internationally implemented mental health initiatives best address the mental health consequences of war. In order to address this question holistically, the study addressed wartime psychological consequences and post-conflict development, asking the following sub-questions: what are the major mental health determinants of war and to what extent do these affect post-conflict reconstruction. The overall argument advanced is that mental health needs to be a priority in international development because addressing mental health problems is crucial in order to achieve overall social and economic reconstruction of countries that have experienced a war or conflict. The role of mental health initiatives in overall development should be to specifically cater to the identification and proper treatment of the mental health problems that resulted out of the war as well as be conscious, sensitive and adaptable to the cultural and contextual factors present in the society in question. Detailed analyses of what the mental health problems consequences

of war are as well as what impact the post-conflict environment has on the course of development for individuals and societies are presented and provide empirical support for the conclusions and observations made in the study.

Justification and Scientific Contribution of the Topic:

The concept of mental health itself is underdeveloped in international development (Das, 2007; Patel, Saraceno, Kleinman, 2006) but is extremely important because it is implicated in all levels of a person's ability to function in society. Mental health is crucial because it has been found that the failure to address the mental health and psychosocial disorders that affect 'populations that have experienced mass violence and trauma caused by conflict will impede the efforts to enhance social capital, promote human development and reduce poverty' (World Bank, 2005). An increased understanding of mental health consequences of war and conflict and the creation of effective, specifically targeted interventions to deal with mental health issues have been shown to be a key variable in implementing successful post-conflict reconciliation and reconstruction programs (Das, 2007). Giving enough attention to mental health in post-conflict societies is therefore important because it addresses not only specific individual mental health problems, but also the negative consequences that mental health problems may have the social and economic functioning of entire communities and countries. The particularly difficult circumstances implicated in mental health and the functioning of wartime and post conflict societies create a further need to include mental health as a research variable when studying post-conflict societies.

The country of Bosnia and Herzegovina was chosen as the subject of the case study because the effects of its devastating internal war, which occurred between 1992

and 1995 (Boyd, 1998) can serve as a template in gaining an understanding of what types of psychological and psychosocial problems war and conflict produce, the consequences that these problems have on the overall social and economical functioning of society, and in turn the solutions that have been adopted to address them. Because it has now been over a decade since the war officially ended, the country is chosen as a subject of comprehensive examination because it provides a rich body of war-related psychological experiences and a number of different initiatives and programs that have been implemented over a ten year period (starting from early international intervention during the war until presently). It is a beneficial case study because it serves as a strong reference point for the importance of addressing post-war mental health consequences and the limitations and opportunities that countries are faced with when re-building their societies.

While there exists a range of literature on post-conflict development and separately on the medical or theoretical understanding of war-related psychological symptoms, there is little literature that addresses the relationship between both these variables. This means that there is a need for research on the way that mental health problems have been addressed through development initiatives in post-conflict countries. The present study will therefore aim to provide a comprehensive understanding on this topic, in addition to building on the existing knowledge on the topics addressed in the literature review.

Methodology:

The methodology employed for this study includes a theoretical analysis on the topic of mental health in developing countries, with a particular emphasis on the mental

health consequences caused by conflict. A critical, qualitative desk review of the existing literature and documentation on the implemented programs will be performed in order to provide a comprehensive analysis of the mental health needs of post-conflict societies and how these are addressed in the international development field. This will be done through an examination of the literature on mental health problems globally as well as a case study about the country of Bosnia and Herzegovina. Operational definitions of the main psychological concepts will be provided as well as a discussion on the study's interpretation of what mental health entails. For the purpose of the theoretical analysis, a psychosocial theoretical framework will be adopted. What the psychosocial perspective entails and the justification for its use will be discussed in detail.

In terms of the case study, the psychological effects of the 1992-1995 war that occurred in Bosnia and Herzegovina and the various ways in which these have manifested themselves since will be examined. A range of initiatives that have been implemented by various international donor agencies, national and international, governmental and non-governmental actors during the post-war period will be presented and discussed. Their approach to mental health problems, their activities and long-term benefits of the initiatives will be qualitatively assessed. The scope of the study is a holistic approach of the way in which the entire population has been affected by the war, with specific focus on groups known to be especially vulnerable to the negative effects of war: children, rural populations, displaced persons and refugees, combatants, the physically disabled. The impact of the plethora of initiatives implemented in the country, including the mental health reforms that have occurred at a national level will be discussed. A concluding chapter will critically examine the body of work presented,

highlighting further needs in the overall mental health field internationally, with an emphasis on the important particularities that are to be addressed in post-conflict mental health intervention.

The collection of data will come primarily from online search strategies of scientific journals and publications and hand-searches of printed scientific journals and books. Data collection will also consist of consulting online databases, project archives and various relevant actors' websites in order to document projects that have been implemented as well as their reports on the progress, desirable goals and overall results of these projects. This will entail examining initiatives implemented by actors such as the World Bank (WB), the United Nations (UN), various non-governmental organizations (NGOs) and governments. Databases and publications by the World Health Organization (WHO) and its affiliated activities in the field of mental health will be heavily consulted because they offer a rich body of practical and academic information on the relationships between socioeconomic factors, war-related experiences and general and mental health functioning and also because they reflect the standard global perspective that is adopted by the international actors when addressing mental health needs around the world. The primary goals, the approaches taken and overall results reached by the implementation of their programs will be identified and discussed collectively in order to provide a framework for reference to studies and programs that attempt to address mental health functioning in post-conflict societies.

PART II: THEORETICAL ANALYSIS

The State of Mental Health in International Development

Defining Mental Health:

In order to provide a theoretical framework for an understanding of the impacts of mental health on overall societal functioning, this section will define and distinguish between some of the key concepts discussed, including mental health, mental disorders and mental health problems. While the term *mental health problem* and the term *mental health disorder* will be narrowly defined in a way that demonstrates the distinction between them and thereby attests to the severity of the problem, the terms mental health/psychological health and mental/psychological well-being will be used interchangeably. Subsequent sections will also provide operational definitions used in the fields of psychology and psychiatry to refer to the conditions being discussed, including disorders such as Post-Traumatic Stress Disorder and depression, and other medical or psychological terminology.

Before providing some existing definitions of the concept of mental health, it should be noted that the definition adopted for this study includes societal and environmental factors as well as individual and emotional considerations. Similar to the U.S. Surgeon's General (1999) perspective on mental health, the concept is viewed here not as stable or rigidly defined but as a fluid continuum that evolves during one's lifetime.

Mental Health has been defined by some as a state of successful mental functioning, resulting in productive activities, fulfilling relationships with other people and the ability to adapt, change and cope with adversity (U.S. Surgeon General, 1999). Mental health is defined by the World Health Organization (from hereon referred to as WHO) as 'not merely the absence of disease or infirmity, but rather a state of complete physical, mental and social well being" (WHO 2001). While WHO's definition may be

somewhat idealistic in terms of aiming for a complete state of overall health, without any problems, the intention here is not to present an ideal of mental health that must be achieved by all before they can be considered mentally healthy, but to emphasize the need to include mental health in international development, without the need for extreme conditions of mental disorders to be present. Another valuable aspect of this broad and inclusive understanding of mental health is that it incorporates the importance of overall functioning and implies an interrelationship between mental, physical and social health (U.S. Surgeon General, 1999). As a concept, mental health has gained increasing attention worldwide and is considered to be indispensable to personal well being, family and interpersonal relationships and contribution to community or society (U.S. Surgeon General, 1999). Mental health is as important as physical health is to the overall well-being of individuals, societies and countries (WHO, 2001) although this may not always be evident in widespread attitudes toward it or in the proportion of investment in mental health services and programs, as will be evidenced later. Psychological health can also be conceptualized as resting on a continuum of psychological well-being (De Jong & Kleber, 2007) where this continuum ranges from psychological health to suffering from major psychological disorders. Psychological disorders and illnesses are defined next.

The term mental disorder (or mental illness) refers collectively to all diagnosable mental disorders (WHO, 2001). A mental disorder is a recognized, medically diagnosable illness that results in the significant impairment of an individual's cognitive, affective or relational abilities (U.S. Surgeon General Report, 1999). Mental disorders are health conditions that are characterized by alterations in thinking, mood or behaviour or some combination thereof, interfering with the abilities of individuals to learn and to

function socially (Ibid). Mental disorders result from biological, developmental and/or psychosocial factors (Ristock, 1995). Although what constitutes 'normal' or appropriate behaviour may depend on cultural norms and values (De Jong & Kleber, 2007), a condition is deemed to be a mental disorder when it causes such levels of impaired functioning or disability that extends beyond what is considered socially and culturally appropriate and results in behaviour that is vastly different from the statistical norm and that prevents individuals from functioning and participating in society (WHO, 2001). Diagnosis and classification of mental disorders are done using the internationally recognized Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) produced by the American Psychiatric Association (APA) and the International Classification of Diseases (ICD-10) created by WHO (WHO, 2001).

In-between a mentally healthy person and one suffering from a mental illness is a large portion of the population who may be experiencing, have at some point in their life experienced or are at risk for developing problems with their mental health and everyday functioning. Between the two extremes of mental health and mental illness lies a large 'middle category' of psychosocial problems and a large section of the population which is non-symptomatic, that is, not demonstrating symptoms sufficient to be classified as mental disorders, but still suffering from various problems (DeJong & Kleber, 2007). These mental health problems can be conceptualized as responses resulting from the disruption of effective interaction of individual, group and environmental factors, due to physical illness or inadequate coping skills or other external causes such as unjust social structures and family tensions (Ristock, 1995). Mental health problems can therefore be defined as signs and symptoms of insufficient intensity or duration to meet the criteria for

any mental disorder (U.S. Surgeon General, 1999). For this reason early intervention is needed in order to address mental health problems before they become potentially life-threatening, because people who suffer from mental health problems are at a greater risk for developing mental disorders (Ristock, 1995). Therefore, mental health does not only mean an absence of mental disorders and freedom from psychiatric symptoms (Ibid) but also takes into account the importance of fostering overall well-being and working on addressing lesser psychological problems that do not necessarily meet diagnostic or clinical criteria. This perspective is also useful when designing and implementing international initiatives because it emphasizes that not only those exhibiting extreme symptoms should be targeted for intervention, but societies overall, especially if these societies have suffered collective traumas or tragedies such as natural disasters and wars (Webb, 2004). Again, it is important to recognize that meanings of ill health are as much socially constructed as they are physically experienced and that the meaning and management of physical or mental health is shaped by social and cultural understandings (Adok, Arias, Castelli, Cluver, Coulter, Denov, Heeren, Jareg, Lukenam, Oudwin, Robinson, Smith, Wessels, 2008).

Another important concept that is discussed at length throughout the paper is the psychiatric condition of Post-Traumatic Stress Disorder. In order to avoid misunderstanding and confusion about the meaning of this term, a brief definition and explanation of this disorder is provided here. Other psychological terminology will be briefly defined throughout the text. Post Traumatic Stress Disorder (from hereon referred to as PTSD) occurs after experiencing or witnessing a 'traumatic stresssor' which is the psychological term for a severely threatening, uncontrollable event that instills a sense of

fear, helplessness or horror (Myers, 2001). Responses typical of someone who is diagnosed with PTSD include but are not limited to: intense fear in response to the event, helplessness or horror and disorganized or agitated behavior (Ursano & Norwood, 2003). Overall, PTSD can be said to consist of symptoms of arousal, avoidance and intrusion (Dybdahl, 2006) which can take the form of persistent haunting memories and nightmares, numbed social withdrawal, depression, increased arousal or anxiety, avoidance of stimuli associated with the trauma and general numbing of responsiveness (Myers, 2001; Ursano, Fullerton, Norwood 2003). To test for the presence of PTSD symptoms researchers and clinicians conduct surveys that ask how often respondents experience things such as: irritability or anger, reminders of the traumatic event, waves of strong feelings related to the event, dreaming about the event and physical reactions to it like shaking, sweating, trouble concentrating and falling asleep, intrusive thoughts and recurring mental images (De Jong & Kleber, 2007)[1]. Research confirms what can intuitively be implied, that longer periods of exposure to traumatic events and the more extreme the nature of the violence witnessed or experienced is, the more intense and persistent the PTSD symptoms are (Schmidt, Kravick Ehlert, 2007). PTSD was first identified as a psychological disorder following the return from battle of World War II veterans. Since then, various conflicts throughout the world have spurred the research on PTSD, and many psychosocial interventions are prioritized on the prevalence of trauma and PTSD symptoms in the affected populations (Jaganjac, 2004; Myers, 2001).

A psychological understanding of 'violence' is also provided in order to equip the reader with a conceptual understanding of violence that allows for the link between

[1] For a detailed diagnostic criteria for PTSD please see: American Psychiatric Association (APA). (1994). *DSM-IV Source Book, Volume 1.* New York: American Psychiatric Publishing Inc.

mental health consequences of violent actions to be made with ease. WHO's *World Report on Violence and Health* (De Jong & Kleber, 2007) defines violence as the intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, disrupted development or deprivation. Exposure to repeated and intense violence is associated with future levels of aggression in children (Yakin & Mc Mahon, 2003), psychological problems such anxiety disorders and substance misuse (De Vries, 2006; Horowitz, Weine & Jekel, 1995), overall stress and nervousness (Martinez & Richters, 1993), somatization disorder and suicidal behaviour (Njenga, Nguithi, Kang'ethe, 2006) and feelings of hatred and extremely high levels of hopelessness and despair that affect individual and social functioning (International Congress of Ministries for Mental Health and Post-Conflict Recovery [ICMH], 2004).

Mental Health and Development:

Mental health and behavioural disorders are very prevalent in the world, carrying devastating economic and social impacts on the lives of individuals and societies. WHO estimates that more than 25% of the world's population will have been affected by a mental or behavioural disorder at some point during their lives (Kastrup & Baez-Ramos, 2007). Until recently the burden of mental illness on health and productivity has been profoundly underestimated around the world (U.S. Surgeon General, 1999). A contemporary perspective, the *burden of disease* approach has had an important effect on the way that mental health is viewed. Initiated in the 1990s through the Global Burden of Disease Study, the overall state of the world's health was measured

by creating a common metric to estimate the health loss associated with morbidity and mortality (Baingana & Bannon, 2004). The study's aim was to provide a comprehensive assessment of the burden of 107 diseases and injuries to select ten major risk factors for eight major regions in the world (Ibid). The study attempted to qualify global and regional patterns of health, identifying the effects of various diseases, injuries and risk factors on overall population health. The burden of disease approach yielded important evidence on the impact of mental health disorders and problems on overall health of populations. Using the Disability-Adjusted Life Year (DALY) as a measure to assess the burden of disease, depression was identified to be a leading cause of disability worldwide (Jaganjac, 2004). The DALY is a time-based measure that combines years of life lost due to premature mortality and years of life lost due to time lived in ill health (World Bank, 2005). There are an estimated 450 million people worldwide who have in some way suffered from mental or behavioural disorders (Jaganjac, 2004). Using the global burden of disease approach, mental disorders rank 4th among the ten leading cause of disability globally (Jaganjac, 2004). This means, that together with diseases such as coronary heart disease which accounts for 60% of the global burden of disease, HIV/AIDS and stroke, mental disorders are among the leading global causes of disease burden (Ibid). Depression alone contributes to 12% of the overall global burden of diseases (Ustun, Avus-Mateos, Chatterji, Mathers, Murray, 2004). Depression, or major depressive disorder (as it is diagnostically classified) is a mental disorder defined as a state of sadness, despair loss of interest in daily life (Sims, 2005). The burden of depression worldwide is a major public health problem affecting patients and societies (Utsun et al., 2004). Depression highly interferes with functioning and has an early age of onset,

increasingly affecting children and adolescents, thereby not being only an adult disease as it is commonly perceived (Ibid).

Many mental health illnesses are more prevalent in developing countries, including various cognitive disorders such as learning disabilities being more common in some developing countries (Sims, 2004), increasing levels of depression in a number of developing and post-conflict countries such as Sri-Lanka (Patel, 2007), a significant rise of suicide among farmers in India and indigenous peoples in Latin America as a result of various economic and agricultural reforms that have taken place (Robinson, 2006) and deaths induced by dependency on drugs and alcohol among men in post-communist Eastern Europe due to low economic growth and unstable regime and institutional changes that have led to elevated stress in the populations (Patel et al., 2006; Jenkins, 2007). In a study of 1,283 displaced women in Western Sudan, one third met the criteria for major depressive disorder and experienced extreme suicidal thoughts due to largely unaddressed mental health problems (UN Office for the Coordination of Humanitarian Affairs, 2006). At the same time, despite being exposed to high levels of mental health problems, residents of developing countries experience a serious shortage of access to mental health treatment, which will be discussed shortly.

Comorbidity is also very common among different mental health problems and disorders. The term comorbidity refers to the presence of one or more disorders or diseases in addition to a primary disease (First, 2005). In the psychiatry, psychology and counseling fields, comorbidity refers to the presence of more than one diagnosis occurring in an individual at the same time (Ibid). Comorbidity sometimes creates a challenge for diagnosis because it is very prevalent among psychiatric and psychological

disorders. For example, anxiety and depressive disorders often go hand in hand, meaning that most people who suffer from a major depressive disorder also tend to exhibit anxiety symptoms (Ustun et al., 2004). Comorbidity is also prevalent in post-conflict populations. PTSD is highly comorbid with depression and with psychotic disorders, meaning that the majority of those suffering from PTSD also suffer from depression, and an estimated 18% of PTSD patients also have psychotic symptoms. (Klaric, Klaric, Stevanovic, Grkovic, Jonovska, 2007).

Another reason why mental health is critical in international development is because it is directly related to physical health. As was mentioned previously, mental health and mental illness are influenced by a combination of biological, psychological and social factors. Since mental and physical health are inseparable (U.S. Surgeon General, 1999), poor mental health also contributes to poor physical health and vice versa (Moodie & Jenkins, 2005). For example, mental health problems are closely associated with poor physical health, such as HIV/AIDS and poor maternal and child health (Miranda & Patel, 2005). Physical and mental health directly influence one another through two pathways (WHO, 2001). They impact each other directly through physiological systems such as neuroendocrine and immune functioning systems and also through health behaviour which refers to the wide range of activities that humans have such as choosing to eat healthy and exercise, avoiding smoking and engaging in safe sexual practices (WHO, 2001). These pathways show us that poor mental health can both directly and indirectly be traced to diminished physical health.

Despite the fact that populations in underdeveloped countries have the highest needs for mental health care, they also have the lowest access to it (Saxena, Thornicroft,

Knapp, Whiteford, 2007). There is an enormous gap between mental health needs and services in developing countries (Patel et al., 2006). Mental health resources are unevenly distributed and scarce for many countries and they are also inequitably distributed between countries, between regions and within communities (Saxena et al., 2007). Studies show that mental health disorders have been largely ignored or neglected in developing countries, where budgets for mental health services constitute less than 1% of many developing countries' overall health expenditure (Patel, 2007). Furthermore, the poorest of the world's countries are spending proportionally the lowest percentage of their overall budgets on mental health (Saxena et al., 2007). The quality of services for mental health patients is also less than impressive. In a number of developing countries, those in need of mental health services do not receive any evidence-based care, which leads to chronicity of the problem, increased suffering and thereby increased costs of care (Saxena et al., 2007). In a WHO global study it was found that more than 40% of countries in the world have no mental health policy and over 30% have no mental health programs (WHO, 2001). Over 90% have no policy that includes children and adolescents (Ibid), both of whom are particularly vulnerable populations. In terms of healthcare coverage, many countries do not cover mental and behavioural disorders to the same extent as they cover other illnesses, making it difficult for people to afford medications that could be very beneficial in eliminating their symptoms and treating them (WHO, 2001). Therefore, the present mental health global situation is that there is an increasing burden of mental disorders and yet a widening 'treatment gap' (Marmot, Friel, Bell, Houweling, Taylor, 2008) where mental disorders are rarely regarded with the same importance as physical health in a large number of

countries. The need for strengthening overall care and services for people with mental disorders is a global priority (Patel, 2007) and better action to increase mental health awareness is needed at all levels of the health system.

It is also becoming increasingly important to promote the concept of mental health, rather than just mental illness/disorders (Hasanovic, Sinanovic, Pajevic, Avdibegovic, Sutovic, 2006). The earlier definition adopted by this study demonstrates the distinction between mental health and mental disorders and the above discussions show the importance of focusing on the concept of mental health in order to promote well being before problems develop into chronic and debilitating disorders. Mental health promotion can be defined as the process of enhancing individuals' capacity to take control of their lives and improve their mental health, empowering people and communities to interact with their environment in ways that enhance emotional and spiritual health (Hasanovic et al., 2006). Mental health promotion also contributes to the reduction of risk behaviours such as tobacco, alcohol and drug misuse, unsafe sex and social and economic problems such as crime rates, absenteeism from school and work, partner violence etc. (Ibid). Mental health promotion is important because it fosters the resilience and empowers individuals to strengthen their coping skills and personal efficacy, allowing for earlier detection of mental health problems (Schmidt et al., 2008).

People who suffer from mental illnesses are often subjects of discrimination. Another reason for focusing on adequate treatment of those who suffer from mental issues is a widely documented history of human rights abuses of persons who suffer from mental illness (Patel et al., 2006). These abuses often occur due to misperception about mental illness which can lead to the mentally ill being perceived as dangerous or a social

threat to others (Appelbaum, 2006) especially when referring to the severely mentally ill, whose behaviour might at times be unconventional and erratic. Such sentiments are demonstrative of the widespread stigmatization and stereotyped perception of the mentally ill, which is also an important issue to be considered in mental health initiatives. It is argued that stigma is a problem even in developed countries, and it is an excuse for inaction and discrimination since it sways public opinion and leads to a non desire to invest in mental health programming (U.S. Surgeon General Report, 1999).

Stigma fosters an unscientific understanding of mental illness and deprives people of their dignity, interfering with their full participation in society (United States Surgeon General, 1999). Stigmatization and stereotyping are not only related to poor scientific explanations for the etiologies of mental orders, but also to the mistaken belief that symptoms are caused by a sort of moral taint or a lack of willpower and subsequent shame and fear which prevents individuals from seeking much needed treatment (Ibid). Stigmatization and stereotyping can also be reflected in poor attendance and adherence to medication regimens and lack of support from family members (Medscape, 2006). Such a perspective serves as a cultural 'excuse' for inaction because it erodes confidence that mental disorders or problems are valid, treatable conditions (US Surgeon General, 1999). The presence of stigma as a cultural perception diminishes the public's willingness to pay for social and mental health services, reducing the availability of treatment to those who need it and thereby continuing cycles of low self-esteem, isolation and hopelessness among the stigmatized (WHO, 2001).

Economic Development and Mental Health:

Mental health is also an important variable to consider in overall economic development. Findings from developed countries show that the relationship between low socioeconomic status and psychiatric morbidity is strong and significant (Sollie, 1971). Studies from developed countries also show that there are direct correlational links between poverty and poor mental health, where common mental disorders are significantly more frequent in socially disadvantaged populations (Fyers, Melzer, Jenkins, 2003). Studies in Western non-traumatized industrialized societies have founed a clear link between the impact of mental illness on the market by measuring variables such as job performance and productivity (ICMH, 2004). Factors such as unemployment, low income and material standard of living as well as presence of social problems such as violence in the society were positively correlated with the prevalence of mental disorders in a number of developed and developing countries (Fyers et al., 2003; Wyshak, 2000; Aidoo & Harpham, 2001). Economic well being has been seen to directly influence health, where higher wages and material conditions are correlated with better health and better productivity (WHO, 2006). Simply put, healthy bodies and minds are necessary for productive labour-forces and economic growth (WHO, 2006).

'Poverty' as a concept includes phenomena that extend far beyond the material measures of income. As Joseph Stiglitz states, 'the deprivations of poverty go beyond a lack of money' (Stiglitz, 2007, p.11). Poverty can be understood in a more comprehensive manner, as an overall state of having insufficient means, including the lack of social or educational resources (WHO, 2001). Addressing mental health problems was introduced as an integral part of health system interventions overall which aim to achieve some of the key Millennium Development Goals (MDGs) (Miranda & Patel,

2005). The MDGs are a collection of global goals set during the 2000 United Nations Millennium Summit and aimed at battling poverty by addressing the many social dimensions that are implicated in it, such as income levels, diseases, adequate shelter and gender equality, (Millennium Project, 2006). The goals foster a global partnership between countries, where all work together to eliminate poverty by working on the eight goals of eradicating extreme hunger and poverty, achieving universal primary education, promoting gender equality, reducing child mortality, improving maternal health, combating diseases such as AIDS/HIV and malaria, ensuring environmental sustainability and developing a global partnership for development[2] (Millennium Project, 2006). Mental health is closely related to reaching the MDG of eradicating extreme poverty and hunger since poor and marginalized people are at a greater risk of suffering from mental disorders and receiving worse treatment due to high costs of care and lower employment opportunities (Miranda & Patel, 2005). Addressing their mental health conditions and providing treatment for them would improve their chances of being more productive and rising out of poverty.

The consequences and impacts of poverty are therefore extensive but not always easy to measure and quantify and are wide-ranging and long lasting (WHO, 2001). In the World Bank (WB) study 'Voices of the Poor' where over 60,000 economically disadvantaged men from sixty countries were interviewed about their views on their situation, the men expressed a concern not only for insufficient earnings, but also strong feelings of insecurity and powerlessness, and those without jobs stressed that they felt marginalized and shunned out of their societies (WHO, 2001). Therefore, in addition to

[2] For a detailed discussion of the Millennium Development Goals (MDGs) please see the United Nations Development Program (UNDP) Millennium Project Archives. Available at http://www.unmillenniumproject.org/goals/index.htm

creating unfavourable living conditions, poor economic standing can have negative effects on the emotional and psychological well being of individuals. High levels of hopelessness and despair which in some countries affect 40% of their citizens have major negative effects on entire societies' social and economic development (ICMH, 2004). Poor economic functioning is therefore linked with poor mental health and also with worse physical health, demonstrating that health and mental health are not just matters for the health sector, but are socially determined and must therefore be addressed by a collaboration between various sectors of society (Marmot et al., 2008). Inequality, poverty and health and mental health, therefore, need to be battled in a holistic manner because they are all interrelated.

The relationship between poverty and mental health illness is therefore a mutually reinforcing one. The two are connected through a 'vicious cycle' and a two-way street, where poverty might lead to mental health disorders through pathways such as stress or deprivation and lower likelihood of poor individuals to receive effective treatment, and at the same time mental health can impoverish people through lower employment and higher health costs and spending (Fryers et al., 2003). A higher socioeconomic position in society also predisposes individuals to a wider availability of social and psychological resources providing them with an advantageous position when coping with adverse events (WHO, 2006). The course of a mental disorder (meaning the further development and worsening of the disorder) is also affected by the socioeconomic status of the individual (WHO, 2001), where variables such as poverty, low education, social exclusion, conflicts and disasters are the major social determinants of mental disorders (Patel, 2007). The inadequate social support and few resources being allocated to mental

health care characteristic of many developing countries is a path to worsening of the mental health condition and a downward spiral into poverty. The onset and worsening of mental health problems may play out in different ways. For example there may be a lack of overall mental health services in a country, or there may exist many barriers to accessing care by a poor population even in countries that do provide it. The treatment gap is high even in rich countries, where their poor populations often do not have access to mental health coverage due to unemployment or minority status (Jenkins et al., 2003). For the poor in developing countries, the treatment gap is thereby even higher.

Countries that have experienced a war have a hightened concern related to economic development and mental health. Wars leave countries economically destroyed, they re-structure organizational systems and deplete social resources. This leaves war-torn countries even more susceptible to the cycle of economic struggle and mental health problems. Wars lead to adverse mental and physical health, which are related to limited productivity, deceased engagement in social activities and the imposition of care-giving burdens on social networks and services (Galea & Wortman, 2006).

Mental Health and Conflict:

We have so far touched on the importance of including mental health in international development by examining the burden of disease that mental health problems such as depression cause and by emphasizing the social and economic aspects as they pertain to issues of mental health. The next section examines the role of mental well-being and promotion thereof in countries that have experienced wars and conflicts. The major impacts of conflict on mental health are discussed as is the role that mental health may play in post-conflict reconstruction. The section demonstrates how supporting

mental health initiatives in conflict-affected societies can also make an important contribution to meeting the MDGs (WHO, 2001). This can be achieved by recognizing the effect that healing war-related trauma can have on the overall social and economic advancement of societies and by acting on research findings which show that addressing psychological consequences of conflict at the individual level can lead to treatment of society as a whole, allowing to achieve the collective goals of social justice, reconciliation and prevention of future violence (ICMH, 2004). It is argued that mental health must be incorporated into designing policy, training and interventions since it facilitates understanding of the difficulties faced by the victims of the war (Medeiros, 2007). It should also be treated as an essential component of overall post-conflict development and populations in conflict situations should receive mental health care as part of the total relief, rehabilitation and reconstruction process (Murthy, & Lakshminaranayana, 2006). Furthermore the need for 'traumatized' persons and communities to receive basic mental health care is consistent with the UN Declaration of Human Rights, Article 25 Item 1, which states that everyone has the right to a standard of living that adequately provides for the health and well-being of himself and his family, including food, housing, medical care and social services (ICMH, 2004).

Despite our improved understanding of their devastating effects, wars are a common occurrence worldwide. In the Middle East region alone 80% of their population is in a conflict situation or has experienced a conflict situation in the last quarter century (Murthy & Lakshminarayana, 2006). Numerous conflicts have occurred in the past two decades or are ongoing presently including the Balkans, Rwanda, Afghanistan , Iraq and the Israel-Palestine conflict to name a few. Both inter-nation and more limited low-

intensity internal conflict are associated with poor mental health in the short and long runs (Galea & Wortman, 2006). It is estimated that by the year 2020 war will be one of the top 10 causes of disability and death (Vass, 2001). Despite the pressing need to include mental health in post-conflict development, it has been a largely neglected domain in post-conflict reconstruction initiatives and policy designs (Medeiros, 2007). There are also problems with the way they are being carried out when they are included. Trauma approaches to mental health of war-affected populations have been the most commonly used approaches and they involve assessment using clinical rating scales to count trauma symptoms and the provision of short-term programs (Jones, Rustemi, Shahini, 2003). However, due to the fact that these kinds of programs are often implemented according to standards and needs assessments conducted by external humanitarian agencies, they are usually done independent of existing medical and social structures and services (Ibid). This concern will be further examined in the Bosnia and Herzegovina case. The physical consequences of wars and conflicts are widely recognized, visible and reported, while the mental health consequences are less so, despite the fact that the mental health effects of extreme violence can be chronic disabling and can develop into serious physical health problems (ICMH, 2004). Human loss in wars and conflicts is often expressed in depersonalized and anonymous numbers and statistics (De Jong & Kleber, 2007). However, if these statistics are broken down into a percentage of people who have lost a loved one divided we see that the personal losses are substantial and that, in many situations, at least 50% of people lose someone they knew closely (Ibid). The devastating effects that such losses have on the mental health of

their citizens constitute a major factor that hinders the post-conflict development of these societies (Jaganjac, 2004).

Economic difficulties caused by wars place additional constraints on countries and hinder efforts at offering and developing efficient programs. Some ways in which the economic war-related problems are reflected in the healthcare system include severe budget constraints being faced by hospitals that can lead to poor quality of care, low staff morale and inadequate sources for even the most basic necessities (Jaganjac, 2004). Poverty and wars both put populations at an increased risk of exposure to environmental hazards and health problems, demonstrating the clear links between the destruction of infrastructures, overall health and mental health (Dybdahl, 2006). Overall, it has been noted that conflict situations cause more mortality and disability than any major disease (Murthy & Lakshminarayana, 2006). Wars cause an overall deterioration of existing social structures, by destroying communities, families and overall social and economic fabric of nations, exposing populations to stress and trauma, limiting their access to preventive and curative health and resulting in elevated rates of psychopathology and physical morbidity in both combatants and non-combatants (Galea & Wortman, 2006). Survivors of extremely traumatic events are at a high risk of developing a range of psychiatric disorders and psychological problems including depression, complicated grief, suicide, generalized anxiety disorders, substance abuse and PTSD (Dybdahl, 2006). Research done by WHO shows that 10% of people who have experienced traumatic events will have serious mental health problems and another 10% will develop behaviour that will hinder their ability to function effectively (WHO, 2001).

In terms of specific psychological diagnosis in response to experiencing a conflict, a wide range of symptoms and syndromes in the populations of conflict areas has been documented through research and practice (Murthy & Lakshminaranayana, 2006). The most widely documented war-related psychological problems are depression and PTSD (Ibid). With global levels of depression being already very high, since it is the 4th leading cause of disability, it is notable that recent large-scale epidemiological surveys show even higher levels of depression in traumatized populations, where depression is up to seven-fold higher than baseline levels in non-traumatized societies, and PTSD is up to ten-fold higher (Jaganjac, 2004).

PTSD [recall definition on p. 14] is directly related to experiencing a trauma, trauma in its broadest meaning referring to a life-threatening or frightening event (Sims, 2005) which leads to psychological distress (Begic & Mc Donald, 2006). The most commonly used form of evaluating the trauma experienced by a community has been the collection of statistics about the number of traumatic events experienced by a community (Strang & Ager, 2008). In addition to PTSD and trauma-related problems, high rates of disability and premature death associated with chronic medical illnesses such as cardiovascular disease are also associated with psychiatric morbidity (the proportion of psychiatric illness in a given geographic area) in traumatized populations (Jaganjac, 2004; Murthy & Lakshminaranayana, 2006). Research done in the 1990s on veterans returning from the Gulf Wars showed that a majority of them reported general health complaints such as severe fatigue (De Vries, 2005). Such health concerns are typically experienced by general non-war traumatized populations, but they were proportionally much more prominent in those who experienced war in some form (Ibid). Also, the range

of visible war-related psychological consequences exhibited by conflict populations may not always deal with trauma-related symptoms, but may be related to cultural and social factors that are not always easily identified in traditional diagnostic manuals. For example, many patients receiving mental health services related to the Kosovo war demonstrated a complex mix of social and psychological difficulties that did not always fit conventional diagnostic categories (Jones et al., 2003). These included feelings of identity confusion, adjustment problems and concerns over everyday living, finding employment and providing for one's family (Ibid).

Examinations of war populations have shown prevalence of PTSD in a number of different countries. In the conflict of Kosovo a significant linear decrease in mental health status and social functioning was associated with increasing exposure to traumatic events in those aged 65 and over, while 17.1% of the general population aged fifteen or older reported symptoms of PTSD (Murthy & Lakshminaranayana, 2006). Similarly, 24.8% of people who experienced the Rwandan conflict have met the symptom criteria for PTSD (Ibid). Studies have also shown that those who exhibit these PTSD symptoms have a higher tendency of exhibiting negative attitudes toward the Rwandan war-crime trials, strongly pointing to the fact that trauma is a factor that plays a role in people's ability to move past the terrible things that happened to them during the war and that it needs to be addressed if attempts at reconciliation are to succeed (Gourevitch, 1999).

Additional knowledge that supports the need to include traumatic experience and mental health in post-conflict reconciliation is the widely documented finding that trauma-related symptoms, and symptoms of PTSD have long-term effects, remaining significant many years after the conflict, or re-occurring after having disappeared for

several years (Jaganjac, 2004; Murthy & Lakshminaranayana, 2006). The level of exposure to traumatic events is usually positively correlated to PTSD symptoms persisting long after the end of the war (Hasanovic, Sinanovic, Pavlovic, 2005). A study addressing the effects of trauma on Cambodian children who had been exposed to armed fighting showed that PTSD was still prevalent in 48% of the children and depression was also highly prevalent, affecting 41% of them, even three years following an original evaluation (Kinzie, Sack & Angell, 1989). Bosnian adolescents who had been exposed to severe psychological war trauma still had high level of trauma more than three years after the end of war.(Hasanovic et al., 2005).

It can therefore be argued that a war does not end once a peace agreement is signed or armed conflict ceases. Researchers have also found that social disturbances often occur after a war-related trauma has been experienced, disrupting the recovery process of entire nations. For example, there is likely to be an increase in both criminal and domestic violence which can affect at least the next two generations (Dybdahl, 2006). In a longitudinal follow-up study of survivors of the Cambodian civil war in the 60s, it was noted that survivors had high levels of psychiatric symptomatology even ten years following the conflict (Mollica, McInnes, Pole, 1998) and that cumulative trauma (defined as trauma that occurs due to ongoing social and personal traumatic or stressful events) enhanced persistence of psychiatric symptoms ten years after the experience of the original traumatic event, the war (Ibid). Some recent evidence shows that the traumatic experiences of war may have an effect that extends even beyond the generations who lived through the war, demonstrating the pattern of inter-generational transmission of psychological trauma (Galea & Wortman, 2006). Effects of continued

violence also trickle down from one generation to the next (Hernandez & Romero, 1993). Therefore if the war-related mental health problems are not addressed in the short run and immediately following conflict they can become visible or carry their effects over to many years following the war, causing much damage and inhibiting the overall ability of societies to move forward.

The Post-Conflict Context and Psychosocial Functioning

The Psychosocial Perspective:

As has been demonstrated thus far, war leaves undeniable social, economic and psychological consequences on whole societies. In order to address adverse effects in a holistic manner and to reinforce the belief that improvement of mental health and psychological functioning benefits overall development, a holistic approach must be adopted. With this said, is not enough to look at each of the variables mentioned earlier, the economic, social or psychological separately, but at the interplay between them and the influence they have on one another. For this reason the theoretical framework adopted by the present study is a psychosocial one. Psychosocial theories encompass both internal psychological and external social factors in their study of human behaviour (Myers, 2001). They emphasize the idea that important issues concerning individual personality and behaviour can best be understood by studying how humans interact, influence and relate to one another socially (Ibid).

The psychosocial perspective has been applied in projects and programs that have attempted to deal with the wide range of social and mental health consequences of conflicts around the world. Many such programs were implemented in Bosnia and

Herzegovina and will be discussed later in terms of how they have contributed to post-conflict progress.

Adopting a psychosocial theoretical framework enables to address the range of societal determinants of mental health, as they pertain to the post-conflict environment. This is done by theoretically accounting for the relationships that exist between internal psychological well being of individuals and their successful coexistence as members of social and economic units. Defining what constitutes a psychosocial perspective and outlining what function a psychosocial program is intended to fulfill, however, is not a straightforward task. It can be hard to define what falls under a 'psychosocial' initiative because the concept is quite broad and many different objectives and aims may be classified as addressing psychosocial needs (Strang & Alastair, 2008). This difficulty in defining and outlining what types of programs fall under the category 'psychosocial' has led to a wide diversity of approaches, initiatives and programs to be labeled as such. Overall, psychosocial initiatives cover a wide range of issues and objectives and their actions greatly vary in the types of resources, methods and expertise that they employ (Strang & Ager, 2008). Different psychosocial perspectives vary from one another in the nature of the problems that they address and also in terms of the specific methods they adopt to address these problems (Ibid). They look not only at the individual level, but see individuals as part of bigger social units, such as families and communities and acknowledges the social resources that these groups can offer in the recovery process (The Psychosocial Working Group, 2000). It follows that as much as genetics and personality play a role, human behaviour is equally shaped through interactions with the natural or social environment (WHO 2001). This interaction between the individual and

his environment is an important element of the coping process (De Jong & Kleber, 2007) and programs that address the psychological consequences of violence have to recognize and enhance this process.

Adopting a psychosocial perspective is also consistent with the present study's perspective of mental health, which is essentially a psychosocial one since it includes societal and environmental factors. This understanding acknowledges the individual experiencing mental health problems (irrelevant to how severe they are), the health care system and social system within which the individual exists in a multi-faceted and holistic manner. It supports the premise that neither the individual experiencing mental health problems nor the health service system exists in isolation. As such, it follows that the solutions to mental health problems also need to be broadly-based and multi-sectoral, because in addition to the health service sector, other domains of society such as social services, education, employment and the environment are all correlated with mental health (Ristock, 1995).

While attempting to outline what a psychosocial perspective or model is, it is also useful to conceptually distinguish between a psychosocial and other models such as the medical model. Distinguishing between the characteristics that make up a strictly medical and a psychosocial model allows us to identify the factors that the medical model may undermine and that the psychosocial perspective attempts to account for. By addressing the difference in perspective, it becomes possible to outline the types of solutions and programs that proponents of each perspective would employ in the field. While medical approaches define psychological problems as illnesses or dysfunctions that need healing by the application of treatment (Losi, 2000), psychosocial perspectives present suffering

and mental disorders not in medical terms, but in community-oriented terms that address even those who may appear free of medical or trauma symptoms (Ghosh, Mohit, Murthy, 2004). In addition to addressing the interplay of external and social factors on individual and group functioning, psychosocial perspectives can also be conceptualized as 'treating' psychosocial disorders or problems. A psychosocial disorder is made up of any interrelationship of psychological and social problems that together constitute the disorder (World Bank, 2005). Therefore, establishing objective diagnostic criteria for when to implement psychosocial initiatives can be done by identifying a prevalence of psychological symptoms, a social disruption and a problem in the relationship between the two. The previous section has shown that the prevalence of such a disruption is high in countries that have experienced a conflict. While it does specifically deal with mental health disturbances, the psychosocial approach also differs from a strictly psychological approach because it does not only aim to alleviate individual suffering by solely addressing a particular mental health problem, but includes both the psychological component and the social element, facilitating action that emphasizes the importance of reintegrating individuals into their environments (De Jong & Kleber, 2007). When applied in a post-conflict context they underline the idea that focusing too narrowly on 'traumatization' or identification of trauma symptoms may be simplistic (Summerfield, 2002) and does not address the wide scope of war-related issues. The approach also views society to be a dynamic form, constantly adjusting and changing in response to events and circumstances (Strang & Ager, 2008).

It follows that psychosocial programs which aim to promote the ideals of the psychosocial perspective provide psychological services and social services (DeJong &

Kleber, 2007).). Psychological services include counseling and emotional support based on therapy principles, workshops that provide people with education, skill training, advice and advocacy (Ibid). The social services they may provide include practical support such as water, sanitation and other necessary physical supports, community education and community mobilization to strengthen social cohesion (DeJong & Kleber, 2007). They facilitate individual development, giving people the skills to reconnect with their societies, while at the same time facilitating the improvement of these societies overall, in order to create the optimal circumstances for reintegration (Ibid). Projects described as psychosocial emphasize ethical, cultural and social issues on all levels of care and promote the idea that care needs to be made available and communicated broadly to all of society (Graben, 2006). Psychosocial initiatives address a community as a whole (Strang & Ager, 2008) particularly a community that has been impacted immediately and long-term by a major event such as a conflict or natural disaster (Ibid). This comprehension of the psychosocial perspective is relevant to the present study because it emphasizes the current, post-conflict context of the society and its potential for recovery and development. The post-conflict context, as it pertains to the society, is the focus of the psychosocial initiative.

Technically speaking, psychosocial programs work by strategies that enhance the existing psychosocial protective factors and decrease the psychosocial stressors and negative factors at different levels of intervention (Agger, Vuk & Mimica, 1995). This means that they provide services that are necessary but currently lacking in the society in question and they work in a way that aims to enhance existing positive factors. They can also be perceived in terms of improving the resiliency of societies. Resilience refers to a

sense of flexibility and ability to re-establish one's own balance and essential feeling of being in control of oneself and oneself in relation to the external world (Hasanovic, Sinanovic, Selimbasic, Pajevic, Avdibegovic, 2006). Resilience can be described as the ability to perform successfully in life despite adversity (Yakin & Mc Mahon, 2003). It may be determined by individual or personal variables such as self-esteem and personal conceptualization of life events as well as by external factors such as availability of community and social network supports (Ibid). There is much contradictory evidence on the question of resilience. Some researchers claim that prior experience of highly traumatic events predisposes humans to more severe symptoms following a subsequent traumatic experience (Hernandez & Romero, 2003). Others argue that past exposure to stressful and traumatic events may actually increase resilience (De Vries, 2005). Such research suggests that having survived a highly traumatic experience at some point in life makes people better prepared and able to cope well with future stressful or traumatic events that they may come across in their lives.

The research on resilience is therefore complex and at times contradictory. Women for example, are a group that is highly vulnerable to the psychological consequences of war, but at the same time their resilience to stress and the way that this helps them in sustaining their families has also been strongly recognized (Murthy & Lakshminaranayana, 2006). This means that while women as a group can be particularly vulnerable to mental health problems, they also demonstrate high levels of re-adjustment following a traumatic event, demonstrating a kind of strength and resilience to the adversity that they face. It can be argued that because the majority of a population that experiences war does not develop extreme symptoms such as PTSD, people are naturally

resilient to the negative effects of trauma and can 'bounce back' with little intervention (De Vries, 2003). Overall, there is a need in research to better understand resilience and how it is affected by personal and contextual factors (Yakin & Mc Mahon, 2003). Despite the inconsistencies in research and need for further study on this matter, one generally agreed-upon notion is that, regardless of the strength of resilience factors in the recovering society, researchers and practitioners must stay away from over-emphasizing resilience as this carries the risk of overshadowing the serious effects of traumatic events (Adok et al, 2008). Without getting into an extensive empirical search for evidence on the most more reliable findings regarding resilience, we can view psychosocial programs as being implemented in order to cater to and boost the level of resilience that already exists in the societies at question.

Externally funded psychosocial programs, implemented by foreign organizations and development agencies, are the most common psychosocial initiatives present in developing or post-conflict countries (Ingleby, 2005). The need for external intervention can be explained in terms of boosting the society's natural resilience abilities and supplementing the psychosocial services that are necessary for recovery, but at that time, lacking in the particular society. Theoretically speaking, the intervention by an external agent is usually employed based on the calculation or perception that the affected community does not have the sufficient overall resources to overcome the effects of the major catastrophe that it has experienced (Strang & Ager, 2008). In the context of the present study, this may be perceived as a society that is experiencing an insufficient resiliency, requiring additional support, hence, the involvement of the external humanitarian or development community.

While it is useful to view psychosocial initiatives as agents that are filling a needed service gap and inducing the existing resilience factors in societies, this also demonstrates the complexities associated with designing and implementing psychosocial initiatives since resilience factors, priorities, needs, contextual and cultural factors all differ from country to country. The 'social' component of psychosocial initiatives is that they also attempt to take into account the cultural differences. By recognizing the important role that contextual and social factors make, it should be understood that culture can also have important implications in the way that trauma is experienced and perceived by different societies. Adok et al. (2008) argue that the cultural context influences how stress and trauma reactions are expressed, how they are interpreted and the level of meaning or importance that symptoms are given by individuals and their communities. This means that standards of 'normality' are subjective and may differ culturally, affecting the extent to which certain societies may perceive some behaviours and psychological disturbances as problematic or to what extent these actually interfere in their everyday functioning. With this focus on culture and societal context also comes the idea that the practices and programs should be used to complement rather than replace existing social and cultural healing mechanisms that are already in place (Adok et al., 2008).

Whereas initially, aid programs for war-affected regions focused primarily on physical health, there has been a significant increase in the provision of psychosocial aid in the past decade (Dybdahl, 2006). The conceptual move has been made in international development, where the main actors such as WHO, WB, and various international relief agencies no longer advocate the identification of extreme trauma or medical symptoms as

the starting reference point on which they base their intervention or assistance (Adok et al., 2008). For example, the globally active medical organization 'Doctors Without Borders' has begun to spread the message that all medical interventions need to have psychological and social components (De Jong & Kleber, 2007). This comes out of the recognition that the role of doctors is not simply to provide technical solutions, but to play an emotional role as well, in order to provide support to traumatized populations and to give overall comprehensive treatment (DeJong & Kleber, 2007). WHO has created a manual on mental health and psychosocial support in emergency settings in which it emphasizes that protecting and promoting mental health and psychosocial well-being should be the responsibility of all humanitarian agencies and workers (WHO, 2001). In terms of post-conflict development, healing and reconciliation programs are necessary in order to prevent recurrence of collective violence and to break the cycles of continued violence and animosity (Staub, 2000) and mental health concepts should be incorporated into these reconciliation programs (WHO, 2001). Overall there has been an increase in the international concern for and funding allocated to psychosocial programming, and in the scope and scale of programs that are designed and implemented to address the psychological and social needs of war-affected populations (Strang & Alastair, 2008).

While evaluations and critical examinations are taking place, it is argued that a fundamental issue in the assessment of psychosocial programs is that things such as program evaluations still need to be examined through systematic research (De Jong & Kleber, 2007). Lack of long-term research and evaluation may point to the fact that it is difficult to ensure that they are achieving sustainability. While the present study does not aim to conduct a systematic or quantitative evaluation of the performance of psychosocial

programs, it does examine them qualitatively in terms of the way they have been implemented in Bosnia and Herzegovina and to a lesser extent, overall in the world. This may provide a reference point for examining the way in which these programs are implemented, the principles they are based on and the objectives they attempt to achieve. By looking at a country that has had over ten years of experience as the place where a large number of psychosocial programs have been implemented (Hasanovic et al., 2005) a qualitative assessment regarding the extent to which psychosocial programs address relevant mental health issues in post-conflict societies and what type of impact they may exercise on societies is offered

Understanding the Post-Conflict Context:

Contemporary research in psychology, sociology and international development fields has only recently begun to include a holistic and multi-faceted approach to the understanding of overall societal well being and opportunities for healthy living after experiencing extreme violence. Research on the long-term effects of war-related psychological malfunctioning has been relatively scarce (Kastrup, 2005). The research that has been generated thus far emphasizes the need to prioritize the problem of mental health in economically underdeveloped societies and countries transitioning from war into peace (Patel, 2007). Additionally, an emphasis is made on the collaboration between various levels of political and institutional decision-making and the need for perspectives that examine the relationships between psychological, social and overall economic functioning (Kucukalic, Dzubur-Kulenovic, Ceric, Jacobson, Bravo-Mehmedbasic, Priebe, 2005). What must also be examined further is the actual society in which the post-

conflict reconstruction is taking place. The importance that the contextual characteristics of a society have on opportunities for development and rehabilitation is discussed here.

In a widely influential study by Murthy and Lakshminaryana (2005) a comprehensive analysis of the mental health consequences of war within a number of countries that have experienced war in recent years, including Afghanistan, the Balkans, Cambodia, Iraq and Rwanda was performed. A wide range of consequences was identified including PTSD, anxiety, depression, increased mortality and disability, various other long-term physical and psychological harms as well as a reduction in material and human capital . However, in addition to these symptoms being caused by war-time traumatic experiences, factors conducive to the period following the war, played a significant role in the manifestation and course of these psychological problems (Murthy and Lakshminaryana, 2005). Subsequent life events and their association with the occurrence of psychiatric problems were found to have important implications for the rehabilitation and minimization of the ill effects of the conflict situations (Ibid). Similarly, De Vries (2005) has stressed that the majority of war-affected individuals do not develop extreme symptoms and disorders such as PTSD, and that our perception of what healthy mental health functioning entails in a post-conflict society needs to be broadened. He stresses the need for psychosocial care and provision of services that have a long-term perspective rather than simply dealing with immediate symptom alleviation. Additionally, much research is needed on the experiences and course of psychopathology in the post-war, or post-trauma context (Ibid). Therefore, recent research emphasizes a need to focus on expanding our understanding of mental health problems to include a vast range of psychosocial conditions and to include the context and implications of post-war

experience on the development of mental health problems as an important variable to consider. For this reason, a more holistic and multi-faceted approach is necessary. This section advances the argument that the conditions that characterize the society after the war play a crucial role in the post-conflict recovery process. It follows with other contemporary research in the field which has demonstrated that the focus and treatment of solely the trauma-related and immediate war symptoms is simply not enough for overall societal development or for the ability of individuals to overcome the effects of a war (Galea & Wortman, 2006; Murthy & Lakshminaryana, 2005).

The impacts of a war, and especially the psychological and societal impacts of wars persist far beyond the end of the war itself. The previous discussion of the long-term effects of PTSD has demonstrated that the psychological and physical pathology can persist for many years after a war has ended (Galea & Wortman, 2006). The time frame following the war is very complex and our full understanding of it is limited (Ibid). The post-conflict society undergoes many changes in its overall political system, the country needs full re-structuring of its damaged economy and its physical and institutional structures. Therefore, the post-conflict period does not only refer to a peaceful period that ensues once armed combat has officially ended, but to a complex period of social changes and various struggles to overcome the negative effects brought on by the war.

Cross-cultural research and psychological research on refugees and displaced persons has shed light onto the importance that the environment in which the 'recovery' is taking place has in fostering this recovery. Findings of such studies have much insight to share when it comes to developing post-conflict initiatives because they have traced,

through experimentally controlled studies, the effects of different types of environments on the psychological well-being of war-traumatized populations.

The ongoing experience of post-conflict stressors such as continual displacement or traumas prolongs the persistence of psychological problems and delays recovery (Galea & Wortman, 2006). Simply put, post-war social stressors make recovery more difficult (Klaric et al., 2007). Everyday postwar stressors such as chronic unemployment are associated with persistence of psychological disturbances and PTSD symptoms (Ibid). Continued frequency and intensity of these stressors, such as worsening economic conditions, changing social structures, family breakdowns or stressful behaviour of family members such as drug and alcohol abuse intensify the symptoms. This is because they exhaust the few coping mechanisms that are left after the war, diminishing the availability and feeling of social support (Klaric et al., 2007). Refugee studies have found that the prevalence of depression in refugee populations was significantly correlated with experiencing social isolation and low activity levels in a new society that contributed to ongoing and disabling persistence of depression (Miller, Weine, Ramic, Brkic, Djuric-Bjedic, Smajkic, Boskailo, Worthington, 2002).

Positive experiences and availability of social supports, on the other hand, can aid in psychological post-conflict recovery. A study performed on a group of Bosnian refugees who had experienced highly traumatic events during the war and had re-settled in the United States found that various post-migration circumstances had led to a significant decrease in the prevalence of PTSD symptomatology in this group (Miller et al., 2002). It was found that the ability to stabilize their lives, to become acculturated to the American society, and have the opportunity to communicate their memories through

participating in testimony, led to a decrease in the diagnosis of PTSD in this population (Ibid). A study on the experiences of Bosnian refugees living in Australia found that social and economic opportunities such as the ability to find meaningful employment that utilizes the skills of the refugees had important implications in the willingness of these populations to participate in their new society and to identify themselves as contributing members of this society (Colic-Peisker & Walker, 2003).

Even resiliency can be viewed as a mobile concept and not a fixed capacity for individuals to respond positively to adversity since it also depends on other contextual factors (Adok et al., 2008). For example, a study on child soldiers have found that those who are re-integrated into supportive contexts which provide them with opportunities to advance and make economic and educational opportunities available for them are more resilient to the trauma experienced during fighting and better respond to trauma and post-conflict stressors (Adok et al., 2008). On the other hand, those who found themselves in unsupportive contexts with little chance in improving their educational or economic prospects were more vulnerable to further exploitation and re-recruitment (Ibid).

The situation is complicated further because it is not always easy to state what exact factors will be helpful and what is detrimental to post-conflict recovery. For example, it is generally agreed that healthy social relationships are beneficial for mental health (De Vries & Van Hecke, 1994; Young, 2001). However, the situation becomes very complex when the society as a whole has experienced a shock to the system. Social integration of various kinds can also be detrimental to psychological well-being (Kunovich & Hodson, 2005). After a collective trauma such as a war is experienced, the community ceases to exist as an effective source of support (Ibid). Sometimes, social

supports such as friends and family can actually aggrevate feelings of loss and suffering, by reminding each other of the losses and continually talking about the war (Ibid). Therefore, while participation in social activities and social interaction is overall beneficial to mental health (Young, 2001), not all types of social involvement are always beneficial to mental health (Kunovic & Hodson, 2005).

The above studies were presented as examples of the rich field of refugee and immigrant studies, which have examined acculturation and adaptation of immigrants to new societies. Such studies should be acknowledged in international development because they provide a body of knowledge about matters that are very important in international development in general and should be applied in post-conflict development initiatives. They also provide an empirical cause for hope because they demonstrate that recovery from extreme traumatic experiences can be obtained through nurturing environments that provide the opportunity for meaningful social and economic involvement. They demonstrate that the post-conflict climate and the conditions that international agencies and countries they create for their citizens can have important implications in the overall personal and societal progress of their people.

This notion of the importance of the overall social context within which people are living and developing has begun to appear in the doctrines of international organizations such as the World Health Organization. WHO has stated that a nurturing and caring environment filled with positive and nurturing relationships is crucial for healthy development of children (WHO, 2001) and for the overall successful treatment of those suffering from mental health problems. WHO recognizes that the context in which programs and treatments of any kind are being implemented is a crucial factor in the

success of these programs. Sometimes, less so than even factors such as poverty itself and than levels of exposure to traumatic events, the changes in life circumstances brought on by war may have a greater impact on mental health (Do, Friedman, McKenzie, Scott, 2007).

In conclusion, programs that attempt to implement a psychosocial perspective and to account for and adjust to the complexities of the post-conflict context have been implemented more widely in contemporary post-conflict development initiatives (WHO, 2001). They are advocated because they strive to incorporate the social and structural causes of conflicts through an inclusive and multi-disciplinary approach (DeJong & Kleber, 2007). A multi-disciplinary approach is more effective since it leads to the creation of initiatives that are more attuned to the mental healthy needs of war-affected communities and their potential for recovery (Miller, Kuklarni, Kushner, 2006). For this reason it should be widely recognized that mental health care cannot and should not be implemented without careful assessment and adaptation to local situations (Ventenovel & Kortman, 2004) and, most importantly, in a way that is best suited to address the characteristics of the post-conflict context.

PART III: CASE STUDY

Mental Health Consequences of War and Post-Conflict Development in Bosnia and Herzegovina

The Bosnian Context:

From the period immediately following World War II until its independence in 1992, Bosnia and Herzegovina existed as republic of the Socialist Federation of Yugoslavia together with five other republics, Slovenia, Croatia, Serbia, Montenegro and

Macedonia (Cohen, 1995). Shortly following its turbulent 1992 independence war broke out in the country and lasted until the signing of the Dayton Peace Agreement in 1995 (Ibid). While the SocialistYugoslavia existed ethnic and cultural tolerance was deemed important and respected as a part of the country's historic legacy (Topic, 2008). Despite the pre-war multicultural and multiethnic environment, ethnic and religious identity were played on by political and military leaders and they had an important influence in the war (Ibid). Without getting into a detailed analysis of the ethnic and political explanations behind the war, the country experienced a change in regimes from one-party communist rule to the rise of nationalist parties in the democratic period of the late 80s and early 90s, which erupted into a war between its three major ethnic groups, the Serbs, Croats and Muslims. The Muslim ethnic groups is referred to as Bosniaks in contemporary literature (Mesko, Fallshore, Muratbegovic, Fields, 2008; Stubbs, 1998), but referred in this study as Muslim in order to avoid confusion with the term Bosnian, which denotes a member of any ethnic group, but living in Bosnia and Herzegovina, and therefore of Bosnian nationality.

The war in Bosnia and Herzegovina is best described in the context of the overall collapse of Yugoslavia, having broken out shortly after Slovenia and Croatia asked for and were granted independence (Rusmir, 1999). Following Croatia's independence, war broke out in the country and close to 250,000 people were displaced and forced out of their homes into collective units in the process of ethnic homogenization (Kozaric-Kovacic et al., 2002). Shortly after, Bosnia and Herzegovina requested that they be recognized as an independent state, leading into an even more devastating and destructive war that lasted close to five years. The war was fought between three armies, each army

was made up primarily of Serbs, Croats and Muslim soldiers, who were fighting for ethnic dominance. Backed by ethnonationalistic ideology and principles of ethnoterritorialism, where groups attempt to create geographic units of land that are populated by a single ethnic group (Tuathail & Dahlman, 2004), military action reached extreme levels of aggression and violence. The goal of creating ethnically 'pure' territories was achieved through the use of murder, systematic rape of women, violent displacement of people out of their homes by fear tactics and forced emigration (Tuathail & Dahlman, 2004; Mesko et al., 2008). This process came to be known as ethnic cleansing, because it literally involved 'cleansing' territories of unwanted ethnic groups. The large-scale military ethnic cleansing is documented as having been initiated by the Serb army in an attempt to gain a large unit of land that belonged to and was populated only by Serbs, and was counter-acted by reactive ethnic cleansing by the other two armies (Tuathail & Dahkman, 2004). This means that across the country, members of all the three ethnic groups witnessed and experienced extreme levels of violence and aggression.

While statistics on the numbers of people killed during the war vary in different documents and are said to be politically charged, it is estimated that of the prewar population of 4.4 million 250,000 people were killed, approximately 240,000 wounded and 25,000 permanently disabled (Rechel, Schwalbe, Mc Kee, 2004). More than 2 million lost their homes or fled (Ibid). The war did not discriminate against civilians and soldiers, and it is estimated that 90% of those who were killed or wounded in the war were civilians (Dybdahl, 2001). The millions of people who lived through the war, even when not directly affected, were in some way witness to the death and destruction going

on around them. Combining the large statistics on numbers of casualties and the purposefully psychologically scarring practices that were employed during the war including ethnic cleansing and military use of mass rapes, it is understandable why a discussion of the mental health consequences of this war is a very important topic to write about.

The Republic of Bosnia and Herzegovina, as it is now formally called, is made up of 51, 129 square kilometers and has just over 4 million inhabitants (Mesko et al., 2008). The country borders Croatia, Serbia and Montenegro, is a part of the South-Eastern European region (WHO, 2006) and has a population of just over 4 million (Mesko et al., 2008). The country is still made up of a Serb, Muslim and Croat ethnic population, although the population is not heterogeneously dispersed across the country as it was prior to the war (Topic, 2008). In 2000 it was estimated that the overall ethnic composition was Croat for 14.3 % of the population, 37.1% were Serb, 48% Muslim and 0.6% other (Rechel et al., 2004). The ethnic dispersion is presently centered around the single ethnic group-dominated entities (Boyd, 1998; Belloni, 2001). [See Appendix A, Map 2 and Map 3 for a graphic representation of the ethnic composition of the country before and after the war].

Bosnia as the state it is now was created out of the Dayton Peace Agreement. The Dayton Peace Agreement was a peace treaty signed in 1995 under the supervision of an estimated 60,000 US and coalition troops, therefore in the midst of international presence (Boyd, 1998; Caspersen, 2004). The peace accord is often referred as having simply put a 'freeze' on the fighting (Topic, 2008). The agreements reached in the peace accord allowed for the formation of two distinct entities, the majority ethnically Serb Republic of

Srpska covering about 49% of geographic territory and the Federation of Bosnia and Herzegovina (Federation of BiH), a predominantly Muslim and minority Croat population covering about 51% of the country's territory (Boyd, 1998). For clarification purposes, the country which is the subject of this case study is called Bosnia and Herzegovina, and is divided into two political units or entities, one is named the Federation of Bosnia and Herzegovina (from hereon referred to as the Federation of BiH) and other is the Republic of Srpska (RS). The entities enjoy almost full autonomy in all aspects of political governance (Boyd, 1998). In addition to the two separate entities, there exists a third independent region called the District of Brcko, which again enjoys governing autonomy (Ibid) [See Appendix A, Map 1 for a basic geographic division of the country]. At the national level, the country is led by a tripartite presidency rotated between a Serb, Croatian and Muslim leader. Additionally, there exists an Office of the High Representative (OHR) position, filled by a foreign national representing the EU and the countries that were present during the fabrication of the Dayton Peace Agreement (Belloni, 2001). The role of the OHR was initially to oversee the successful implementation of the objectives and conditions of the Dayton Peace Agreement by national officials, and his powers include imposing laws and making administrative edicts (International Crisis Group, 2003). The role of the OHR is under review and the decision to ultimately close this position is currently being debated (OHR Press Release, 2008).

It is often argued that the Dayton agreement essentially created a nation where no common sense of national community existed (Boyd, 1998). The entities have autonomous jurisdiction over most matters (Belloni, 2001) and separate Ministries for all domains of social and political life. Governing the country is further complicated because

the entities are again divided into relatively autonomous governing municipal and cantonal bodies. The Federation of BiH is divided into ten cantons, which are headed by a premiere and again enjoy significant independence from one another and from the entity or nation-level government in their decision-making (Boyd, 1998). The cantons are divided further into local-level municipalities (Ibid). The Republic of Srpska has a more centralized entity-level government, which is divided directly into municipalities (Boyd, 1998). Overall the country is governed by a plethora of governments, international organizations and nongovernmental organizations, 'with no single leader who has the authority to require compliance from anyone on anything' (Boyd, 1998, p.45), and dependent on cooperation from the three parties, with little interest from each to see a powerful and working central governing body (Boyd, 1998). Bluntly stated, it can be concluded that partition characterizes the country overall as the ethnic groups are divided along every level of social and political existence (Ibid).

At this point it is important to have outlined and identified the basic political and ethnic divisions in terms of the way the country is governed. However, attempting a further discussion into the validity and functionality of the political and governmental systems extends beyond the scope of this paper. While the differences in governance and in the way the health system and mental health systems are due to this overall structure of the country's system, the present study nonetheless addresses the country as a whole. This means that the overall population of the country is addressed as being vulnerable to post-conflict consequences, not particular regions. Distinctions are made between the types of psychological effects that the war has on different population sub-groups, such as women and children, but the distinction is not outlined between ethnic populations or

specific geographic regions. This level of analysis was chosen for the purpose of understanding overall impacts of violence on human beings.

The war had long-term and devastating effects on all sectors of society, from the economy to the social fabric of local communities, paralyzing state infrastructure and the health and education systems (Walsh, 2000). In terms of its overall institutional functioning and its economic situation, Bosnia is classified as a 'country in transition' (Mesko et al., 2008). The term 'transitioning' describes a process of transition from the so-called socialist system to a new political economic system (Ljubic & Hrabac, 1998), mainly a democratic political system and more open, capitalist economy. The country's economy has suffered vastly due to the war. The region of south-eastern Europe has an overall gross domestic product (GDP) per capita that is significantly lower compared to Western European countries (WHO, 2006). Furthermore, although it has experienced a slow and steady increase in economic growth since the late 1990s, Bosnia and Herzegovina continues to have one of the lowest levels of GDP even in comparison to other countries in South Eastern Europe and especially in comparison to Western European countries (WHO, 2006). For example, in comparison to other countries in South-Eastern Europe, some some 'high GDP' South-Eastern European countries such as Croatia and Romania have GDPs of U.S. $7789 and U.S.$ 3377, lower-end countries such as Albania and Bosnia have GDPs of U.S. $2372 and U.S.$ 2158 respectively (WHO, 2006). The official unemployment rate in the country is cited at 44%, but a large grey economy exists and people are making earnings in other ways but are not formally registered employees, estimating that unemployment rates can be moved down to 20% (Mesko et al., 2008; Subotica & Wildman, 2003). Unemployment is high among all

labour-force aged groups, but affects some groups even further. It is said to be highest among displaced persons and demobilized soldiers (Subotica & Wildman, 2003). A World Bank labour-market survey has demonstrated that youth are also profoundly affected by high unemployment, citing youth unemployment levels as twice the national averages (Fares & Tiongson, 2007). This has negative effects on the long-term economic participation for youth, since initial unemployment has lasting effects on earning, showing that youth take longer and are less likely to transition out of the jobless phases and into productivity (Ibid). Poverty figures in the country are also very high, as a 2000 survey showed, even after accounting for the benefits of the grey economy, about 15% of people in the Federation of BiH were living below the poverty line, and about 24% of people in the Republic of Srpska were (Subotica & Wildman, 2003). Regional differences also prevailed, with Croat dominated areas enjoying the highest standards of living in comparison to the Serb and Muslim dominated areas (Ibid).

Health and mental health are priorities in all of South-Eastern European region (WHO, 2006). The overall burden of disease in central European, former socialist countries is estimated at 17.2% of DALY's, which is statistically the second highest ranking after established market economies (25.1%) and significantly higher than the world average (12.3%) (Jaganjac, 2004). It is important to address the health and mental health system of the country because it is lagging behind world standards and to stress the importance of investing in the health system, in order to improve mental health and overall social and economic development of the country. When comparing the health policies of the Central and Eastern Europe region and Western countries such as West European Union members, North America, Australia, New Zealand and Japan, significant

differences in quality of healthcare have been noted. For example, while the health sector appears to be a leading public priority in the West (followed by defense and social security), where most Western countries spend between 7% of their GDP and 4% of GDP on health, the East and Central European countries are spending significantly less (Oreskovic, 1998). Overall, the conflicts, population movements and socio-economic changes have made the inhabitants of this region increasingly vulnerable to diseases and mental health problems (Levett, 2001). There has been an overall disparity in terms of decreased social well-being, growing susceptibility to diseases and a disparity in health status and spending between Western Europe and East and Central European countries (Levett, 2001).

The Bosnian context has been chosen as the focus of this study for many reasons. It is an example of the finding that the nature of contemporary conflicts has changed in recent years, where protracted violence is more often than not aimed at innocent civilians and children (Corkalo-Biruski, Jerkovic, Zotovic, Krnectic, 2007). As a result of this, the direct and indirect effects of trauma on individuals and communities have been evidenced and hard to ignore. The Bosnian conflict also demonstrates the concerns that have been discussed thus far, mainly the idea that war leaves undeniable mental health consequences and that the process of rebuilding and fostering an environment of peace and social, mental, economic development is a complex process. For this reason paying close attention to the post-war, contextual characteristics of a society recovering from war is crucial in any development attempt. The country also provides a rich body of precedence about the types of involvements that the international community engages in post-conflict countries, since the Bosnian conflict is known to have received great media

attention and an influx of humanitarian aid and assistance during and following the war (Dybdahl, 2006).

Vulnerable Groups

Although the present study adopts a wide approach of the mental health consequences of conflict and recognizes that they have affected the Bosnian society overall, research has shown that sub-groups within the population have been affected by the conflict to varying degrees and in different ways. Some common post-conflict reactions such as PTSD and depression are similarly prevalent across all demographic groups, while others such as continued exposure to violence and prevalence of health risks are experienced to varying extents by different population sub-groups. Studies done early in the post-conflict phase showed definite signs of mental health problems and disorders, with a significant appearance of approximately two thirds of the general population being 'new patients', that is, patients seeking treatment for disturbances that were related to experience of war stressors (Loga & Ceric, 1997). Each year there is an increasing number of documented mental disorders, usually related to either war experiences or to subsequent difficult life conditions (Hasanovic et al., 2006). In a comprehensive study of a randomly selected 1,574 primary healthcare patients, patients were asked to answer questionnaires about symptoms and signs of depression, anxiety, somatization disorder, eating disorders, and alcoholism (Broers, Hodgetts, Batic-Mujanovic, Petrovic, Hasanagic, Godwin, 2006). The results of this representative study showed that at least one type of mental or social disorder was found in 26% of the respondents, and 12% had more than one disorder (Ibid). Somatization disorder, major depression syndrome, and panic syndrome were experienced by 16%, 10%, and 14% of

respondents, respectively, while 5% or less were suffering from eating disorders or alcohol abuse (Ibid). This study showed that very high levels of the population (almost more than ¼ of the total population of adults who attended family medicine centers) reported at least one type of mental or social disturbance (Ibid).

Overall, the social and economic underdevelopment that characterizes post-war Bosnia and Herzegovina places its population at a vulnerable position in terms of physical and psychological health (Levett, 2001). The following section identifies and separately examines how the war has affected the most vulnerable groups in society, reflecting previous research which has identified that more socially and economically vulnerable groups such as women, children and refugees are more susceptible to the mental health consequences of war (Galea & Wortman, 2006). Finally, this section also examines stigma and ethnicity, two concepts that have had a large influence on the mental health functioning of people in this country.

Gender: the Way Women Have Been Used In and Affected by the War in Bosnia and Herzegovina:

Women have considerable mental-health needs in many developing countries as well as in developed countries (UN Office for the Coordination of Humanitarian Affairs, 2006). Women are especially affected by depression and high levels of suicide (WHO, 2001) and are more commonly prescribed psychotropic medications than their male counterparts (Horowitz et al., 1995). Depression among mothers affects women worldwide and is significantly correlated with maternal health and mortality in both developed and developing countries (Ibid). Women's increased vulnerability to psychological consequences of conflict has been widely documented, as has the

relationship between gender-based violence and the prevalence of common mental health disorders (Murthy & Lakshminaranayana, 2006). In conflict situations, women are exposed to different types of war-related trauma than men and in this sense exhibit different psychological problems (Kastrup, 2006). For example, clinical research on the effects of traumatic experiences shows that women in Bosnia exhibited somatization disorder, panic syndrome, and binge eating disorders more often than men (Broers et al., 2006) while substance abuse and increased violent and criminal behaviour were more prevalent in males (Broers et al.; Loga & Ceric, 1997). Wide epidemiological research on groups of Bosnian women who had lived in the country during the war and experienced traumatic events either directly as victims of targeted violence or indirectly through witnessing the death of loved ones, found that women had noticeably poorer mental health than the rest of the population (Klaric et al., 2007).

In the Bosnian war, women did not only passively experience war-related violence, but were an actively targeted group. Widespread violence against women was exercised as a war strategy. The Western media brought attention to the organized rape of women as a weapon of war, and as a part of the greater attempt at ethnic cleansing of entire populations (Allen, 1996). Rapes were done systematically and at a large scale in at least 30 documented rape camps (Ibid). It is estimated that between 20,000 and 50,000 women in total were raped during the war (Rechel et al., 2004). Apart from being a viscous physical attack on the female body, militarized war-rape was used as a potent psychological tactic to intimidate, degrade and humiliate women, shaming them in front of their families and communities (Wietsman, 2008).

Through deliberate strategies such as ethnic cleansing and systematic rape, women were continually exposed to violent and traumatic events, not only as 'accidental' casualties of war, but as a specifically targeted group. For this reason it is not surprising that women have suffered profound and long-term psychological consequences of this violence. These consequences include the prevalence of PTSD as well as an additional number of emotional and social problems (Klaric et al., 2007; Rechel at al.,2004). PTSD remains a frequent but not the only post-war psychological disorder within the country, and women who were directly exposed to long-term and extreme war trauma have exhibited serious post-traumatic and general psychological problems even over 10 years after the war (Klaric et al., 2007).

Due to the multiple roles that women play in societies, such as being mothers and nurturers as well as a crucial part of the labour force, they have overall been found at an increased risk of experiencing mental and behavioural disorders in their lifetime (UN Office for the Coordination of Humanitarian Affairs, 2006). In the Bosnian context, the war has had profound impact on the position and types of roles that women have adopted. Some researchers argue that the overall status of women in Bosnia has diminished since the war (Malesevic, 2006). With the post-war refusal of all ideologies and principles followed under socialism, equality being one of them, gender equality has also been rejected. Religious influences have impacted a societal opinion of the role of women, where Muslim fundamentalism has resulted in a return to the traditional role of women as instruments for biological reproduction and nurturers of family and cultural values, and the increased nationalism and partiarchism in the growingly influential Catholic and Orthodox churches has had similar influences on society's attitudes (Malesevic, 2006). In

a survey examining the level of importance that women attribute to different life roles, domestic and family roles such as role of mother, sister and wife placed first in order of importance, ethnic identity came second, while work-related identities were less important and placed further down on the scale (Walsh, 2000). It is hypothesized that the importance placed on domestic and ethnic identity may reinforce one another, and demonstrate how nationality and ethno-nationalist idealization of masculinity and femininity may reinforce gender identity (Walsh, 2000). This is consistent with other research on gender and identity in the country which has found that heightened nationalism and the increasing role and power of religious institutions in the everyday lives of its citizens as well as growing conservatism and traditionalism at the national level have eroded the status of women in Bosnia and Herzegovina (Kunovich & Hodson, 2005). Conflict creates a confusing and contradictory dynamic for the formation of tender identities (Walsh, 2000). While in some conflict contexts around the world wars change the roles of women by forcing them to enter the workforce and take on economic roles that were previously reserved for men, in Bosnia a different pattern took place. The role of women moved from the idealized working woman of socialist rhetoric to the idealized 'mother of the nation' (Malesevic, 2006; Walsh, 2000). Diminished status in society has been found to have negative consequences on mental health of individuals across developed and developing countries (Fryers et al., 2003; Jenkins et al., 2004; Sims, 2003). In Bosnia, for example, a study of displaced, unemployed women showed that lack of participation in society and economy was associated with lower self-esteem, low scores on measures of self-worth and higher levels of depression (Klaric et al., 2007).

In addition to the pressures they face due to these 'expanding and often conflicting roles' women continue to face sexual discrimination and domestic and sexual violence (WHO, p.15). Women are more likely than men to be adversely affected by the escalating rates of substance abuse and by high levels of domestic and sexual violence (UN Office for the Coordination of Humanitarian Affairs, 2006). Studies in developing and developed countries have demonstrated significant prevalence of poor mental health in victims of domestic violence (Ristock, 1995). In post-conflict situations, domestic violence increases further (Loga & Ceric, 1999), rendering the women living in these societies especially vulnerable to mental health problems. These findings have been demonstrated in Bosnia where criminal records show abuse and violence by men has increased (Loga & Coric, 1999). High unemployment and inability by Bosnian men to provide for their families has been reflected in abusive and violent behavior against their spouses (Walsh,2000). Alarming numbers of women across the country are being abused physically or psychologically by their husbands or sons, many of whom are unemployed or demobilized soldiers (ibid). Women also tend to explain violent behaviour of their partners as a post-conflict phenomenon, an unfortunate post-traumatic symptom, excused by unemployment and alcoholism (Walsh, 2000). Due to such rationalizations of their partners' behaviour, they are likely to stay in abusive relationships for long periods (Ibid). Social inequalities and inadequate access to necessary services such as healthcare may also contribute to a higher likelihood of women staying in abusive relationships. As a subsequent section will show, healthcare coverage in the country is an important issue in terms of inequality in accessibility to coverage and inadequate coverage for those in need. This has particularly affected women by diminishing their accessibility to

reproductive healthcare (Walsh, 2000). In a 1998 study of health concerns, contraceptive use, sexually transmitted diseases (STDs) and breast and cervical cancer were the most noted health concerns in women (Ibid). Inadequate access to contraceptives has increased the abortion rate to three times the pre-war levels (Rechel et al., 2004) while at the same time new charges for health services such as check-ups, STD tests and abortions have been introduced but are not covered by most basic health insurances (Walsh, 2000). In addition to the low levels of coverage, it was found that about 30 % of women relied on their husbands' employers for health coverage, 6 % paid for their own costs and 25% of women (mainly from rural areas) received no healthcare coverage (Ibid).

High levels of comorbidity between two or more mental health disorders or problems are also prevalent in various female populations, including internally displaced, non-displaced and refugee women, meaning that they often experience more than one mental health symptom at a time. In other words, war-related traumas and unfavourable post-conflict living conditions that often expose women to an ongoing experience of unfavourable or further traumatic experiences have impacted women in various ways, leading to feelings of anxiety and powerlessness and a sense of lack of control over their lives (Dybdahl, 2006; Schmidt et al., 2008). Additional consequences of war-time trauma or difficult post-conflict living conditions include diminished self-esteem and self-image which often correlates with poor social functioning (Kastrup, 2005). Therefore, inequality in access to necessary services and violence against women has had devastating effects on women in Bosnia and Herzegovina, affecting them across all sectors of society such as health care, mental health and overall status of women.

Children:

Children are often described as the most vulnerable group in conflict settings, due to the fact that their neurological system is still sensitive to external influences and they are more susceptible to shocks in their development process (Baingana & Bannon, 2004). They may be susceptible to a combination of psychological problems as a result of exposure to violent and traumatic events as well as to the indirect effects of conflict, such as malnutrition, which leads to stunting in growth and cognitive impairment (Ibid).

The war in Bosnia and Herzegovina did not discriminate among its targets and was characterized by violence not only at the battlefield but also against civilians, women and children. Studies have shown very high levels of exposure to traumatic events and losses among children in areas of the country that experienced intense conflict (Stuvland, Durakovic-Belko, Kutlaca, 2001). Many children survived for almost four years of living under constant shelling and sniping activities and it is estimated that of the over 200, 000 people killed in the war 16,000 were children (Ibid). Children that scored highly in PTSD levels in studies immediately following the war continued to show high levels of PTSD and psychiatric disability in a three year follow up study (Schmidt et al., 2008). This is consistent with other studies that have shown that PTSD is chronic and long-lasting (Medeiros, 2007; Webb, 2004). A study on children and adolescents who had experienced traumatic events during the Bosnian war found a relationship between PTSD and self-concept, where high levels of PTSD were correlated with poor self-concept (Schmidt et al., 2008). This is because intense prevalence of PTSD interfered with cognitive functioning and affected the children's development process leading them to develop a poor self-concept and inhibiting their ability to develop a valued image of

themselves (Ibid). Children suffered direct trauma experiences such as shelling and seeing dead and wounded people but also indirectly through trauma suffered by their parents or from loss of everyday life, evidenced by poor schooling or decreased material conditions (Dybdahl, 2001). Post-war conditions have also contributed negatively to overall child physical and emotional development due to inequality in health coverage and in other social services (Rechel et al., 2004). Similarly, some prevalent physical health and cognitive problems have been identified as recurrent in war-traumatized children in Bosnia and Herzegovina including non-organic enuresis and learning disabilities as the most common diagnoses (Jones et al., 2003). In a comparative study of school-aged children in Bosnia and in the country of Kosovo, it was demonstrated that children who had experienced severe violence during the war-period also exhibited more behavioural problems exhibited through socially disruptive behaviour in school settings (Mc Evoy-Levi, 2006), irritability, difficulty concentrating and poorer grades up to five years following the war (EPPI-Centre, 2008; Hasanovic et al., 2005) Similar studies of young children across cities in Bosnia demonstrated that while the most commonly examined disturbances such as stress-reactions did affect one fifth of the child population (Jones et al., 2003), other problems were more prevalent and had more impact on children's ability to function. Main problems included a mix of social and psychological difficulties that are not accounted for in traditional trauma diagnoses.

The well-being of children is also very closely dependent on the physical and mental health of their mothers. Studies have shown that depression in mothers can be linked with childhood mortality, childhood failure to thrive and stunted growth due to malnutrition (Baingana & Bannon, 2004). Babies born of mothers that were depressed

during pregnancy and in the postnatal period had a risk more than five times greater of being underweight and stunted than babies of non-depressed mothers, even after other confounding factors such as mother socioeconomic status were accounted for (Miranda & Patel, 2005). Mothers in post-conflict societies often express a concern over their ability to care for their children under difficult living circumstances, especially if they were subjected to torture or sexual violence (Dybdahl, 2006). The combination of susceptibility of children and women relates to the experience of depression or PTSD by mothers, rendering them unable to provide quality care and stimulation that could enhance their children's growth. Additionally, various environmental stressors in and following the conflict situation such as depressed economic situation, inability to find employment and low satisfaction and quality of life can manifest themselves as increased violence in the home, once again negatively affecting the children and women who are exposed to or witnessing it (Baingana & Bannon, 2004).

Studies of post-conflict societies of the former Yugoslavia have estimated that there is a significant number of children who are in need of mental health services. Many health centers around the former Yugoslav countries report seeing an average of two or three children with serious psychological difficulties each day (Jones et al., 2003). However, despite the pressing need for mental health services for children, local health and psychological centers are not always equipped with the best approaches and methods for dealing with the complex issues that their patients exhibit (Ibid). There is also a cultural perspective on mental health that may be very problematic for the efficient treatment of children's mental health problems. Many mental health problems such as behavioural disturbances, when exhibited by children, have traditionally been regarded as

related to poor upbringing and a primary concern of the family, not of mental health professionals (Jones et al., 2003). This cultural attitude has resulted in the underassessment and lack of treatment for neurodevelopmental problems (Ibid). The practice has often been that only children with severe disorders are taken to general practitioners or pediatricians, and in many rural communities religious teachers rather than trained mental health professionals are engaged in addressing the problems, by charging a fee to say prayers and engaging in superstitious acts (Bougarel, 2007).

Overall it is also argued that much more knowledge and scientific research is needed on the psychosocial functioning and needs of children who are living through or suffering the aftermath of ethnic and political wars (Dybdahl, 2001) in order to fully understand the complexity of the effects of conflict on children and to be able to implement the optimal treatment programs and policies that will ensure that these children are comprehensively and adequately cared for.

Rural Populations:

Global patterns show that mental health centers are usually located within larger metropolitan areas (WHO, 2001; Mollica et al., 1998), leaving limited options to rural inhabitants due to problems in finding transportation and limited educational resources and information about existing options. Examples of mental health discrepancies between rural and urban populations include higher suicide rates among Chinese rural populations (WHO, 2001) and depression rates among rural African women being twice as high as in the general population (Njenga et al., 2006). The widespread rape of women in the Bosnian war, mentioned earlier, was also most prominent in the rural areas and villages (Allen, 1996).

The war in Bosnia and Herzegovina forced upheavals of large numbers of rural populations, leading many to relocate in cities and towns, and leaving them without their traditional networks of support and few resources to turn to (Jones et al., 2003). The rural areas of Bosnia and Herzegovina are characterized by traditional and collectivist values (Belloni, 2001), dependent on a large extended family and a community way of life. Larger family and village social support systems can lower the risk of developing mental health disorders and help insulate individuals against poverty should they develop a disorder (Das, 2007). This effect is in psychology referred to as *psychological support* and pertains to socio-psychological assistance that is not administered by mental health professionals (Simons, Ingerski, Janicke, 2007). These social ties are argued to provide a level of support that can insulate individuals from mental illnesses and problems. With a disintegration in traditional systems and dispersion of rural populations to different cities, such social 'insulators' have been lost, leaving the rural displaced population at an increased risk for mental health problems. Increases in violence among displaced rural populations have been attributed to a breakdown for traditional mechanisms for resolving conflicts and inter-generational struggles between rural elderly and their younger children or grandchildren (Walsh, 2000). Many of the rural people used to traditional farming ways of life have also found themselves without necessary professional skills to find employment and earn a living in the cities (Walsh, 2000). Therefore, the rural populations face a double obstacle for treatment of mental health problems: an overall lack of formal mental health services at the level of the villages as well as a diminished social capacity to care for those suffering from mental health problems in other, traditional ways. The cultural difference between rural and urban populations has also resulted in prejudice and

discrimination against rural populations, where the influx of people from the villages is perceived as the reason for many ills that plague the cities including the increased spread of communicable diseases and increases in pollution (Walsh, 2000).

Displaced Persons and Refugees:

Migration and relocation to a different country or to different regions of the same country bring a complex need for personal adaptation and acculturation to a new way of life. When this migration is not a voluntary decision, but is a result of a war which forces people out of their homes and their societies, it can impose heavy tolls on the psychological well being of people. The involuntary and traumatic nature of refugees' migration has been found to have important implications on their mental health (Miller et al, 2002, Colic-Peisker & Walker, 2003).

Migration often brings with itself increased stressors and adverse life events such as reduced social supports, possible poverty, dependence on a cash economy, unemployment or increased social stressors which may place these populations at an increased risk for mental disorders (WHO, 2001). This means that in addition to having experienced war-time traumas, refugees and internally displaced persons continue to experience an ongoing accumulation of stressors and pressures of adjustment during their exile (Martin, 1994). Migration and displacement lead to lives forever being changed and to people's notions of normality being completely upturned, leaving long-lasting effects on their psychological well being (Berman, Giron, Marroquin, 2006). The mental health consequences of war seem to be even more prominent in displaced and refugee populations, with high rates of PTSD found among refugee populations across different

host or 're-settlement' countries (Schmidt et al., 2008). Mental health impairment and prevalence of PTSD symptoms is common in refugee and internally displaced populations due to the fact that they face accumulating stressors and pressures related to adjusting to their new environment (Timotijevic & Breakwell, 2000; De Vries & Van Heck, 1994).

It is estimated that over a million (conservative estimates say just over a million to other ones saying it is 2 million) out of the 4.4 million pre-war Bosnia and Herzegovina population people have been driven out of their homes (Miller et al., Rechel et al., 2004). It is estimated that about 1 million have been internally displaced, meaning that they have relocated out of their homes-towns into different regions across Bosnia, and another 1 million have sought refuge in other countries (Franz, 2003; Walsh, 2000). In a 2001 study it was estimated that out of the whole population, about 14% of the people living in Bosnia and Herzegovina were internally displaced (Subotica & Wildman, 2003). In a study comparing Bosnian refugees living in the United States and non-displaced populations still living in Bosnia, Begic and Mc Donald (2006) found that the refugees reported significantly higher levels of PTSD than the group living in Bosnia. Additionally, there is also a distinction between Bosnian refugees living in other countries and those who are internally displaced and living in new cities throughout Bosnia. Studies comparing internally displaced persons and refugees have found a distinction between these two groups, showing that refugees who resettled into new countries demonstrate slightly better mental health on measures such as competence and self esteem than internally displaced populations (Schmidt et al., 2008). This again demonstrates the importance of the post-conflict context and the impacts that the

conditions for life, including social and economic options, have on healthy mental development. Internally displaced persons are living in a post-conflict society and continue to experience economic and political instability whereas refugees who emigrate elsewhere are living in a stable environment, which facilitates psychological recovery, thus their higher scores on mental health measures (Schmidt et al., 2008).

Studies have also identified that 'returnees', or individuals who had left during the war but returned to the country after the fighting ended, faced acculturation problems upon return to Bosnia after having lived in a different country for a number of years (Hasanovic et al., 2005). The United Nations High Commissioner for Refugees (UNHCR) estimates that 1 million refugees have been returned to their pre-war homes, having lived elsewhere during the war (Touthail & Dahlman, 2004). Those returnees who had adapted to the culture in the exile country had difficulties in adapting back to the culture in Bosnia (Hasanovic et al., 2005). Returnees also have a difficult time in finding equal employment opportunities and social benefits, especially if they are a minority returning to a town dominated by a different ethnic group. Studies show that very few ethnic minority returnees find employment and less than 10% are given access to adequate healthcare (Topic, 2008).

Therefore, immigration and refugee studies have demonstrated that persons who have been internally displaced or forced to relocate to other countries are at an increased risk for poor mental health due to the fact that in addition to having experienced wartime traumas they also have a range of psychological stressors and issues to face in their new, relocated environments.

Veterans/the Physically Injured

Veterans and innocent civilians throughout the country were physical victims of the fighting and subsequent landmines. The post-war climate has also witnessed an increase in injuries and violence due the presence of landmines and large number of weapons in circulation due to weak arms controls (Rechel et al., 2004). Overall, more than 200,000 people were wounded in the war, an estimated 13,000 were soldiers disabled in battle, and living with permanent disabilities (Walsh, 2000). It is estimated that in the total war-time and immediate post-war period more than 30,000 people were disabled in some manner, either permanently or are living with amputations (Rechel et al., 2004; Ljubic & Hrabac, 1998).). For war veterans, a loss of activity and ability to provide for their families erodes self-image and may compound war-related trauma (Walsh, 2000). Soldiers were also in continual contact with high levels of death and violence. It is argued that there has been a disproportionate amount of psychosocial programming geared at women, as the soldiers are often seen as aggressors, the women as victims, and it is easier to deal with the victims than the aggressors (Walsh, 2000). Disabled war veterans do, however, receive the highest proportionate economic assistance, in comparison to other affected groups. Although they have separate systems that provide services in the country's two entities, both entities divide disability benefits based on type of disability on three levels, war veterans, civilian victims and those with disabilities that are unconnected to the war (Walsh, 2000). War veterans receive the most generous benefits and are the priority of many post-conflict reconstruction programs including first priority for suitable housing, training and employment programs (Ibid). This again creates inequality in access of services because most veterans are adult males, with the vulnerable groups of women and children with physical or mental disabilities

and women who care for family members with these disabilities receiving less support (Ibid). However, keeping he previous finding that funding for psychosocial programming has been distributed more to programs that provide services for women, it is interesting to note that there clearly exists a difference in the types of programs that are deemed suitable for men and women. Additionally, keeping in mind the poor economic performance of the country, neither group receives benefits that are substantial to cover their costs of living (Walsh, 2000).

Mental Health of Service Providers:

It has been noted that in cases of conflict, healthcare personnel often work with minimal support and assume great responsibility, often dealing with cases and emergencies for which they have not been previously trained (Jaganjac, 2004). Mental health professionals working in Bosnia during the war worked long hours under extreme situations, were often traumatized themselves by the things that they have witnessed and often went unpaid and with little food and security for themselves (Ibid).

When external mental health personnel enter a developing country the theoretical premise is that there is a deficiency of existing trained mental health professionals. To recall, psychosocial intervention occurs when it is perceived that the existing resources within the affected community are not sufficient, and involvement of the international aid community is thereby necessary (Strang & Ager, 2008). Some statistics support this approach, showing that many countries have less than one trained psychiatrist per one million population, and none or very few trained community mental health nurses, clinical psychologists or social workers, who are often professionally isolated and unsupported by formal monetary assistance (Sims, 2003). In Bosnia, for example, the

practice of psychology itself is a relatively new profession. The first University Department of Psychology opened at the Philosophy Faculty of Sarajevo University in 1989 (Corkalo-Biruski et al., 2007). Shortly after, psychology departments opened in Banja Luka and East Sarajevo and in 2005 in the city of Mostar. Before this the only psychology training that existed in the country was a joint pedagogy/psychology Bachelor within the Pedagogy Faculty (Ibid). Real development of Bosnian psychology, therefore started only in the 1990s where war followed and the professionals were immersed in intense clinical work with acutely traumatized refugees, victims of atrocities and other war-related PTSD (Corkalo-Biruski et al., 2007). The overall health system suffered a fate that is common to developing countries, especially countries that are experiencing a war, the exodus of highly skilled professionals. Known in the international development field as 'brain drain', this phenomenon refers to a loss of intellectual capital, where highly skilled and educated professionals leave their countries of origin to pursue better living and employment opportunities in other, more economically advanced countries (Stiglitz, 2007). The war in Bosnia and Herzegovina led to a significant loss of health and mental health professionals, where the total number of people employed in the health sector dropped from an estimated 19,3000 pre-war, to an estimated 11, 857 by the year 1996 (Simunovic, 2007). The ones that were left were themselves living under war conditions and were left with the task of addressing the large numbers of war-related psychological problems in their patients. In response to this, a large number of initiatives were introduced to assist mental health professionals, including overall reform of the mental health system and other projects such as staff training in trauma management, which will be discussed in the section on reforms.

Although research findings show the need for assistance in training and external support to be extended to mental health professionals dealing with extreme emergencies such as wars (Knapp, Funk, Curran, Prince, Grigg, McDaid, 2006; Simunovic et al., 2007), the belief that mental health professionals are themselves traumatized and ill-equipped has become widely contested and critiqued in recent years. It is argued that this perspective leads to a depreciation and under-evaluation of local capacities, that it overlooks existing cultural structures and services and that it aggregates the abilities and knowledge of the 'Western' foreigner. Specifically, this school of thought argues from the premise that even the initial assumption that populations are 'traumatized' leads to an imperialistic type of professional expertise and importation of Western therapeutic models which are implemented in a way that undermines other cultures' existing norms and practices of dealing with psychological distress (Pupavac, 2002). Essentially, the argument is that people are being 'colonized' through the use of Western psychological knowledge and treatment standards (Ibid). This perspective critically questions the assumption that post-conflict societies should automatically be classified as 'traumatized' because, as is known in psychology, humans naturally exhibit a range of stress reactions in situations of extreme external shocks such as wars (Pupavac, 2000).

The general culture-based arguments about the overall professional fields of international development and psychology can be extended to pertain to the Bosnian example to some extent. The dominance of external psychological and development-based approaches has been witnessed in the initiatives that have been designed and created internationally and then brought into the country. Also, the entire process of reform and implementation of psychosocial programs, even when entrusted to the local

practitioners has not occurred without an extensive focus on training, 're-training' and educational components for mental health professionals and para-professionals (Kucukalic et al., 2003). This character of post-war development in Bosnia and Herzegovina can be used to pertain to the cultural integrity argument because by having a 'teaching' component, these initiatives can undermine the professional abilities and knowledge of the local professionals.

The strength of such arguments is that they emphasize the need for further research to validate the cross-cultural and fully universal adaptability of psychological diagnoses. It is important to always validate psychological diagnostic measures and existing knowledge when implementing them in contexts where they have not been utilized or implemented before (Knapp et al., 2006). They also promote awareness about making post-conflict initiatives sensitive to particular local contexts, which should undeniably be an important variable in post-conflict psychosocial programs or, for that matter, in any international development initiative. However, despite the need for programs to be sensitive to local contexts and designed and implemented in ways that enhance human capacities and their recovery from adverse situations rather than overlook existing methods and practices of coping, the psychological effects of such extreme situations as wars and the accompanying experience of violence and witnessing of emotionally disturbing acts cannot be overlooked as natural human responses that will, essentially, pass on their own. As was stated earlier in the discussion on resilience, making the distinction between human capacity to naturally overcome, or be resilient to certain adverse situations in their life, and recognizing areas that need to be enhanced through the use of psychological intervention in order for individuals to recover and

function is crucial. Although not all people who experience a war will suffer traumatic and completely debilitating consequences or PTSD (Hasanovic et al., 2005), they most likely will be affected by at least one of the many problems discussed throughout this study, so having an adequate source of mental health services to turn to when they do experience a psychological problem should be something that they are entitled to. If, due to a lack of community or national capacity to provide these services, assistance comes in the form of external aid, it does not necessarily follow that the recipients of these services are being negatively culturally 'colonized' by Western professionals. The alternative - failure to treat mental health disorders - will carry more detrimental individual and social consequences on long-term functioning than being 'exposed' to an international mental health service will. Examples of just some of the ways in which untreated traumas can be manifested either directly or indirectly even years following a war include documented instances of a increased number of chronic mental disorders, suicides and substance abuse disorders such as an increased rate of post-war drug use, especially among adolescents (Ljubic &Hrabac, 1998). What this sheds light on is the idea that the question of addressing the mental health of service providers themselves can also be conceptualized in terms of resiliency factors. For example, societies may have existing models and methods for dealing with psychological distress. However, certain extreme conditions such as the eruption of violent and destructive wars, can either destroy the institutional infrastructures that are responsible for providing such services (Simunovic, 2007), they may lead to a loss of professionals working in the field, or may leave these professionals with the unrealistic burden of addressing the large volume and extent of needs that their population suddenly has.

Rather than questioning the theoretical power dynamics that characterize the world we live in, emphasis should be made on communicating with the mental health professionals that are working in conflict-ridden countries, acknowledging the needs that they themselves identify as priorities and providing the funding and best known options for therapy, counseling and services. It would not be appropriate to openly and purposefully withhold known medical cures for physical illnesses, and along that same logic it should not be acceptable to withhold therapies and treatments that are known to be effective in addressing psychological illnesses and problems. Additionally, acknowledging the fact that there might be a need to address the mental health concerns of professionals in post-conflict societies themselves does not necessarily imply that their professional abilities are being undermined, but attempts to ensure that they have resources to turn to themselves. It is common for mental health professionals as well as other professionals to consult with colleagues when working on difficult cases, and is also widely accepted even within the 'Western' world that mental health professionals themselves may have suffered from mental health problems at some point in their lives, or that there might be times when they will seek the help from other mental health professionals when they are faced with emotionally difficult situations.

Stigmatization and Discrimination Toward Mental Health Problems:

World-wide studies of the attitudes and treatment by various societies toward their mentally ill populations have prompted researchers to identify stigmatization and stereotyping as a priority that must be addressed in international development programs that work to improve the living conditions of persons suffering from mental illnesses. A wide body of research, as well as much popular media has shown that many cultures

continue to stigmatize against mental disorders (Weiss, Jadhav, Raguram, Vounatsou, & Littlewood, 2001). In turn, stigma and misconceptions about mental problems lead to unfavourable and harmful treatment of those exhibiting them. The theories of stigmatization and its negative effects on the willingness of societies to invest in mental health services for those who need it were discussed earlier. Within Bosnia and Herzegovina stigma regarding mental health issues is still very pervasive in many communities (Hasanovic et al., 2006). The influx of international initiatives and mental health programs has had some positive effects on the integration and overall acceptance of those suffering from general mental illnesses and more severe mental disorders (Multicultural Disability Advocacy Association of NSW, 2008). However, despite some progress, many local and international NGOs continue to emphasize the need for further and better integration into society of persons with known mental health problems. Such action, it is argued, should take the form of equal opportunities for employment and for the rights of mentally ill to be protected within the legal framework (Association 'Svitanje', 2007).

Ethnic Belonging:

An extensive review of the existing literature on the topics of religion, identity formation and conflict demonstrates that ethnic and religious identity have played a significant role in contemporary conflicts (Armakalos, 2001; Shenk, 2006).The war in Bosnia and Herzegovina is most commonly described as an ethnic war (Belloni, 2001; Cohen, 1995) as it was fought between the three major ethnic groups. Religious and ethnic identity are often considered as the most significant basis for national homogenization and identification in the Bosnian conflict (Velikonja, 2001).Even the

wartime rape of women by soldiers of opposing ethnic groups has been theorized as a form of 'erasing' an ethnic identity. Feminist theorists view the forced impregnation of women with the other group's offspring as a strategic attempt to erase the victim's cultural and ethnic identity (Allen, 1996) because if a child is produced out of the act of rape, the child takes on the ethnic identity of the father, therefore of the other group. Designed as an intentional and strategic act of brutality (Walsh, 2000), war-rape also carried the purpose of demoralizing community belonging and identity (Ibid). It did so by running the risk of producing children who will not carry the ethnic identity of that community, and by shaming the women in the eyes of their communities. The psychological and social consequences of such rapes and violence have been discussed earlier and are undeniable, many of the victims still having difficulty being re-integrated into their societies (Walsh, 2000).

Due to the division of borders within the country along ethnic lines implemented by the Dayton Peace Agreement, ethnic identification and division along ethnic lines continues to characterize contemporary Bosnian society (Mirescu, 2005). The Dayton created a state which does not provide balanced nor equal rights for groups or individuals across the entire country (Topic, 2008). An understanding of ethnicity and its implications in the conflict and in contemporary Bosnian society is an important component that needs to be addressed in any post-conflict reconstruction program, mental health initiatives included. Because of the segregated nature of Bosnian societies across different entities and municipalities, psychosocial and mental health initiatives need to address the contextual differences within the cities they are being implemented. In order to include optimal involvement of existing mental health professionals and services,

mental health initiatives need to pay attention to local particularities and to creatively enhance an overall national messages of coexistence (Kunovic & Hodson, 2005).

While participation in ethnically-based or religious groups may have its benefits in terms of offering social support and mechanisms for coping with traumatic experiences it may also have negative impacts by promoting war-time ideals of exclusion and preferential treatment of the majority group (Kunovic & Hodson, 2005). Bosnian minority groups living in cities that are dominated by a different ethnic group have been known to experience a range of discriminatory situations, from unequal employment opportunities to outward violence and hate crimes. Studies show that discrimination thrives at all levels of political governance and there are some areas in which there is not a single member of a minority group employed at public administration, institutions or companies (Topic, 2008). Experience of discrimination has been found to moderate individual and minority groups' tendency to identify and participate more fully with the majority culture (Pak, Dion & Dion, 1991). In a study examining sociocultural variables on acculturation (Sodowsky, Lai, & Plake, 1991) an increased perception of racial discrimination and prejudice was reflected in less acculturation and participation in the dominant culture. Discriminatory behaviours and exclusion of minority groups diminishes their available social support and can lead to a form of 'identity crisis' and feelings of lack of belonging (Burg & Shoup, 1999) causing them to be socially isolated and withdrawn. Therefore, the mental health consequences of discrimination against minorities have been shown to be significant in psychological research, and since the Bosnian society is very strongly characterized by geographic and political divisions along

ethnic lines, the psychological dimensions of ethnic belonging and ethnic identity need to be taken into account in initiatives that address the well being of the society.

Mental Health Reforms

The way in which the different mental health effects of the war have been addressed within the country are discussed next by examining the health and mental health reforms that have taken place on an ongoing basis through the influence of many different national and international actors. The discussion on country reforms demonstrates the changes, progress and further needs that are characteristic of the post-conflict mental health situation in the country. This section also exemplifies the ways in which certain rhetoric from the international development field have been applied in mental health reform within the Bosnian context, what types of initiatives have been implemented and how mental health concerns are generally perceived and addressed in the country.

Theoretical Framework for Understanding the Reforms:

In order to frame the changes that have taken place in the country within a global context, the theoretical framework for the analysis of the following section has been made in reference to a number of the leading documents on health and mental health reforms. Two main documents that have influenced health and mental health reform implementation on a global scale are *Mental Health: New Understanding, New Hope* (WHO, 2001) and WHO's report on *Health and Economic Development in South-Eastern Europe* (WHO, 2006). These documents provide a broad understanding of the leading international organizations' perspectives on mental health and how to go by establishing

the necessary institutions and services to address it. The main principles of these influential documents provide a theoretical understanding of what mental health reform overall entails and aims to achieve. A brief discussion of the principal messages and suggestions made in the documents is provided next. The influence of their ideals and approaches can be directly traced in an examination of the changes that have taken place in the Bosnia and Herzegovina example, from immediately post-war, to the present. Overall, these initiatives are examined within a ten-year period, from their early introduction in 1995 to a decade later.

WHO is, to put it simply, 'hopeful' about the prospects of the international community to adequately address and deal with the widespread problems related to mental health functioning (WHO, 2001). The organization emphasizes that we have at our disposal the knowledge and power to significantly reduce the burden of mental and behavioural disorders (WHO, 2001). The message portrayed is that the numerous mental health disorders faced by developing countries are not only treatable, but can be addressed with cost-effective, locally feasible programs (Patel et al., 2006) and with assistance and participation of large international agencies. Furthermore, it is argued that these goals of successful treatment of problems can be achieved through the provision of an integrated public health method (WHO, 2006). A public health model is characterized by concern for the health of a population in its entirety and by awareness of the linkage between health and the physical and psychosocial environment (WHO, 2001; U.S. Surgeon General Report, 1999). This approach offers a very broad view of health and illness, as it focuses not only on traditional areas of diagnosis, treatment and etiology but also on epidemiologic surveillance of the health of the population at large, health

promotion, disease prevention and access to and evaluation of services (U.S. Surgeon General Report, 1999). In order to achieve these systems of healthcare many countries will require extensive reforms. These reforms have been widely advocated and supported in international development initiatives of WHO, the WB and many others (WHO, 2001; WHO, 2006).

The premise of these reforms is a widely held belief that successful mental health services need to be de-institutionalized and moved into the community and primary care sectors. The de-institutionalization of mental health services refers to the process of re-focusing treatment of persons with mental disorders away from long-term hospitalization in socially secluded hospitals or asylums, toward community-based services that allow those suffering from mental health disorders to participate in society to their maximum capacity (Stubbs, 1998). The process of de-institutionalization of mental health services was begun in many Western European countries and the U.S. in the 1940s and 1950s due to pressure from Psychologist's Associations to their governments to create better policies and programs for their mentally ill populations (Ibid). The argument was that in order to address the high burden of mental issues, mental health care needed to be fully integrated into primary care services and to be fully covered by insurance policies (Ustun et al., 2004). Internationally, backed by the research and advocacy of various institutional bodies, the message today is clear and it emphasizes that in places where mental asylums exist, their purpose must be minimized to treating cases of the most extreme mental disorders or altogether replaced with psychiatric wards in general hospitals and with well-organized community-based and outpatient care (WHO, 2001). The empirical relationship between traumatic exposure to wars and poor health further suggests

intensifying the collaboration between primary and specialty medical care (DeJong & Kleber, 2007). It is argued that because medical professionals such as community health workers, nurses and doctors are in regular intimate contact with the emotional and psychological worlds of their clients, their role rarely exclusively entails the provision of medical support (Ibid). Instead, they are often required to indirectly address problems related to the mental well being of their patients. For such reasons, the goal to fully integrate mental health services into the general health system has been prioritized in international mental health reform initiatives (Utsun et al., 2004). This goal, it is argued, can be achieved by providing general health workers with basic training in mental health in order to enable them to identify common mental health disorders and to enable them to refer cases to higher levels of care in a timely manner as well as to initiate the provision of appropriate interventions at the community level such as offering psychosocial support and listening skills to their patients (WHO, 2006). Also, it is generally agreed that programs must be science or research based, cost-efficient and culturally adaptable to different settings (ICMH, 2004).

Reforms in Bosnia and Herzegovina:

The implementation of various internationally headed projects and programs throughout the country has led to major reforms in the healthcare and mental health systems in Bosnia and Herzegovina. It has been argued that the crisis of the war provided an opportunity for a wide change in the overall system to unfold in the shape of extensive reforms (Kucukalic et al., 2005). In order to understand the mental health system and to contextualize the different initiatives and projects that have been implemented throughout Bosnia and Herzegovina, it is necessary to discuss the overall health system in the

country. This is because mental health service provision takes place within the broader context of general health systems and the successful implementation of mental health policies and reforms relies on a strong overall health system (Miranda & Patel, 2005; WHO, 2001). Bosnia and Herzegovina's overall functioning as a country is in a transition phase and the healthcare reforms are reflective of this process of transition (Ljubic & Hrabac, 1998). Different sectors of society are experiencing transitions, the country is moving from one overall system to a new, it is undergoing major judicial reforms, its public spending and financing methods are changing and is in the midst of an overall administrative transition from a highly centralized to completely federal-decentralized system of governance (Ibid), in addition to generally having evolved from a war-time into a post-war system. The health and mental health systems before the war, the reforms undertaken since the war and various health and mental health projects that have been implemented are discussed next.

Healthcare Systems Before and After the War:

Before the war, the Bosnian health system shared many characteristics with other former communist countries in the region. The health system in many Eastern European countries was centralized, 'top heavy' and hierarchical (Jenkins, Klein, Parker, 2005). The pre-war Bosnian health system was centralized at the level of the Republic of Bosnia and Herzegovina, where a single body, the Ministry of Health, held centralized control over health matters (Cain, Duran, Fortis, Jakubowski, 2002). The system was financed through 'nongovernment affiliated institutions' called 'self-managed communities of interest', which provided health insurance, social security and disability insurance to employees and their families (Cain et al., 2002) ensuring that literally everybody had

complete health coverage and protection (Simunovic, 2007). There were three sectors of healthcare, divided into primary care offered in general and regional hospitals, secondary healthcare which was provided in specialized centers and tertiary level care which took place in clinical hospital centers that were usually attached to research centers and university medical schools (Ljubic & Hrabac, 1998). Contrary to this centralized system, healthcare governance in Bosnia can presently be described as completely decentralized and uncoordinated (Cain et al., 2002). The decentralization of health systems was advocated immediately following the war, through the influence of internationally funded projects in the country, many of which included the goal of healthcare policy reform and restructuring as a pre-condition to project implementation (Medscape, 2006). The mental health reform principles advocated by WHO were reflected in the activities of many of the international NGOs and donor agencies, as they encouraged local actors such as governments and local NGOs to satisfy requirements of reform and include these as goals in their project proposals (Hasanovic et al., 2006).

At the national level there is no single body with any authority to make decisions for the whole country (Cain et al., 2002). Furthermore, the healthcare systems in the two political entities, the Republic of Srpska and the Federation of BiH, differ from one another. All healthcare matters such as finance, management, organization and provision of care are entirely the responsibility of each individual entity (Cain et al., 2002). The following is a brief description of the organization of the healthcare system.

At the level of the Federation of BiH there is a total of eleven Ministries of Health, one weak and powerless Federation-level Ministry located in the capital of Sarajevo and ten additional ministries, one for each canton. The Federal-level ministry

has no authority over the cantonal operations and the cantonal Ministries are autonomous and function independently of one another (Cain et al., 2002; WHO, 2006). Each cantonal Ministry operates its own health insurance fund and health care services through facilities such as hospitals (clinical centers, cantonal hospitals and general hospitals), *Dom Zdravljas* (health centers) and *ambulantas* (health posts) (Cain et al., 2002). At the level of the Republic of Srpska, the system is centralized at the entity level, with one Ministry of Health and Social Welfare, located in the city of Banja Luka being responsible for health matters for all of its cities and inhabitants.

Therefore, no national, country-level mandate for health care provision, management or financing exists (Cain et al., 2002). Various policy analysts agree that this uncoordinated feature of the health system alone demonstrates functional repercussions in attempts to make coordinated decisions (Cain et al., 2002). There is also little communication between entities and at the federation level between municipalities, further leading to lack of coordination of health policy (Ibid). This is symptomatic of the country as a whole, with little consultation between entities taking place in virtually all sectors of governance (Topic, 2008). This has led to widespread duplication of services and sometimes duplication of funding for the same programs by foreign donors (Cain et al., 2002). The transition from specialized institutions to community care is also hampered by the complicated Ministries of Health who have a negative attitude toward de-institutionalization (Jaganjac, 20004). Lack of Ministerial support for community services reduces their willingness to cooperate across different levels and to successfully implement reform policies at the practical level.

As mentioned earlier, the pre-war system was financed through 'non-government affiliated institutions' that provided health insurance to employees and their families (Cain et al., 2002) The system is presently still funded through this 'collection' system to some extent (Ibid) and through additional mechanisms that have evolved since. During the war financial assistance came from state budgets, assistance from financial aid and donations and out-of-pocket expenditures (Cain et al., 2002) and it still continues to unevenly depend on these. Another effect that the war had on the health system was drastically decreasing healthcare expenditure from the prewar level of 6.5% of GDP to 1.25% during and immediately following the war (Ljubic & Hrabac, 1998). Therefore, the system today is financed through a mixture of the pre-war method and also through new means that have been designed during and after the war. In 2002, it was found that the major sources of funding for the health system were budget payments from the Federal Ministry of Health, funds channeled through cantons, municipalities and cities, private out-of-pocket payments by individuals and fee-for-service payments in both the public and private sectors and international actors (multilateral, bilateral and non-governmental organizations) (Subotica & Wildman, 2003). Insurance funds also exist at each entity level, the Federation of BiH Insurance Fund and the Health Insurance Fund of Republika Srpska (Ibid). However, they face problems with allocation of funds, problems that are mainly related to the fact that the economy is performing very poorly and that the state cannot establish effective tax enforcement systems, making it difficult for the government to obtain adequate funds (Cain et al., 2002). Post-war and present healthcare has also shifted greatly to households an individuals. Individuals are expected to pay for a share of their treatments and medications, which has led to inequalities in access to care,

since the unemployed are not exempted from having to contribute certain payments (Subotica & Wildman, 2003). Studies in 2000 showed that 62% of households could not cover the basic costs of health care on their own (Rechel, Schwalbe, McKee, 2004). Studies on the quality of care throughout the country show that informal payment to physicians by the minority who could afford it remains the best way to receive quality services (Subotica & Wildman, 2003; Rechel, Schwalbe, McKee, 2004). Therefore, the war did not only have negative economic effects on the funding of the health system, it also impacted the quality of services being provided. About 30% of the country's health facilities were physically destroyed in the war and about 30% of its best professionals lost to either death or emigration (Cain et al., 2002). A pattern of employment that emerged in the disorganized and corrupt war period was the appointment of professionals to high positions such as Ministers of Health and heads of Clinical and Research department based on political and nationalistic affiliation, regardless of the fact that many of these individuals did not have the professional or medical credentials to serve these functions (Simunovic, 2007). Individuals without proper training and accreditation were appointed to high-level positions such as Ministers of Health and hospital directors due to their political affiliations (Simunovic. 2007). Even when the doctors were competent, it was not easy to be faced with the large numbers of war-wounded during the war, and many left the country if given the opportunity to do so. The number of those employed in the health sector dropped from around 19,300 in 1991 to 11, 857 in 1996 (Simunovic, 2007). Apart from affecting the availability and quality of physicians the war created an overwhelming need for doctors to deal with the injured, with the communicable diseases,

outbreaks of infectious diseases and lack of ability to reach the sick in time leading to high levels of death and disability (Response International, 2005).

Due to the fact that the entities are almost completely ethnically homogenous [see Appendix A, Map 3], it also follows that health care services are, like many other sectors of social life in Bosnia and Herzegovina, highly segregated along ethnic lines. With no central national-level body to exert influence and pass health policy that affects the entire country, there is little incentive to address ethnic issues or promote multi-ethnicity in health planning. With the continual responsibility of healthcare resting within cantonal or entity-level governance, each Ministry is only concerned with its own people, the ethnic group that inhabits its region. This ensures that little is done to address inequitable access to healthcare between the ethnic groups. This also applies at a geographical level, where the creation of borders has resulted in a distribution of hospitals, which does not ensure optimal and equitable access to health services for all people (Cain et al., 2002). The hospitals are mainly staffed by majority-population ethnic groups, with displaced persons and ethnic minorities finding it more difficult to find employment (Cain et al., 2002). This has also been mirrored in other ex-Yugoslav countries, where segregation along ethnic lines remains a prevailing feature of the health systems in Kosovo and Serbia, with ethnic minorities fearful of working and seeking treatment in majority-dominated health facilities (Bloom, Hoxha, Sambunjak, Sondorp, 2007). The discussion on the health and mental health reforms demonstrates the complex range of effects that wars have on societies, in terms of creating unfavourable political, economic and social contexts in which it is difficult to provide stable government and quality services for the majority of the country's population. The disorganized and fragmented nature of the overall

governance system is mimicked in the division of social and health services, leading to shortcomings in the quality and availability of services. The poor treatment of mental health problems, in turn, creates unfavourable conditions for future prospects of economic and social development.

Overall, even though reforms are continually implemented and supported by international donor organizations, many practitioners and researchers agree that the outcome of the reforms has not been very efficient (Cain et al., 2002; Topic, 2008). Some have described Bosnia as a classic example of premature decentralization (Cain et al., 20020), due to the fact that the prewar institutions which are unready for change are still functioning and performing the same functions as they did before the war without reorganizing themselves, while newly created facilities lack the capacity to operate efficiently and find themselves in novel administrative and managerial structures governed by foreign principles (Ibid). Additionally, recent studies have shown, that as investment from foreign donors to the country is decreasing, studies of the financing of the health system have shown that the reduced inflow of aid is not being offset by other capital inflows, meaning that there is as of yet insufficient financing from within the country to take the place of the contributions that were being made by the international donors (WHO, 2006). This is an example of negative influences of globalization on the country.

Despite the drawbacks in healthcare reform implementation, it is argued that the reforms in the health sector have been more advanced than in other social sectors in the country (Cain et al., 2002). The reforms started occurring immediately following the war

and continue to take place. Major actors in the reforms have been WHO, the World Bank (WB), the European Commission (EC), UN Children's Fund, U.S. Agency for International Development, Canadian International Development Agency, U.K. Department for International Development and many others(Atun et al., 2007; Subotica & Wildman, 2003; WHO, 2006). Various health care centers have been set out across the country by the Swedish, British, German, Italian and Dutch governments, who have had an influential presence in the country's healthcare reforms for over ten years (Kucukalic et al., 2005). Overall it is harder to list what international organization, agency or NGO did not somehow contribute to the country's health reforms through funding or project implementation. The World Bank has invested a total of US $1.1 billion into a total of fifty-one development projects throughout the country. About 47 million is estimated to have gone to support war victims through health and psychological programs including basic reconstruction of health facilities, development of family medicine, strengthening of Public Health Institutes and technical assistance for strengthening insurance systems (Kucukalic et al., 2005). In 2005 the World Bank invested USD 17 million into a new Health Sector Enhancement Project to continue support for the health sector in the country (World Bank, 2005). This is their fifth major healthcare related project in the country since their earliest involvements in 1996 (Ibid). This most recent project aims to target policy-making by strengthening systems for monitoring and evaluating performance (ibid). A program that has contributed to reform implementation is the creation of an effective family doctor system, which has had a smooth incorporation at the community level and ensures adequate primary care is accessible by the population (Cain et al., 2002). This program followed the principles of health reform advocated

internationally by WHO, promoting the idea of community care and strengthened the role of family medicine in the country. Similar projects have provided training and re-training to general practitioners, nurses and health center mangers in the field of professional Family Medicine and health care management in the cities of Zenica, Sarajevo (Federation of BiH) and Doboj (Republic of Srpska) as well as equipped centers throughout the cities according to International Family Medicine standards. Major actors in family medicine programs have been the WB and WHO and international governmental agencies such as the Swiss Agency for Development and Cooperation (SDC) together with various local agencies such as NGOs, Ministries of Health and Physicians Associations (SDC, 1998).

Since the onset of the war international humanitarian organizations have also sent supplies and medical equipment to hospitals around the country. The Friends of Bosnia organization, for example, prides itself on sending thousands of dollars worth of supplies such as antibiotics, incubators, surgical gloves, canes, wheelchairs, fetal heart monitors (Friends of Bosnia, 1998). Likewise, the International Rescue Committee (IRC) sent provision of airlifted medical supplies and food, physical reconstruction of hospitals and psychosocial support programs for severely traumatized populations and refugees throughout and following the war (International Rescue Committee, 2006). Much of the equipment sent by these 'well-meaning' humanitarian agencies proved to be useless and not needed because supplies were sent without consulting with hospitals and getting lists on what they actually needed (Simunovic, 2007). Some of these organizations have expanded their involvement from preliminary sending of supplies and emergency psychosocial assistance to more elaborate and encompassing projects. The International

Rescue Committee has, for example, expanded to reconstruction in roads, hospitals, water systems, microenterprises and community-based health projects including skills-training for mentally and physically disabled (Ibid), becoming one of the largest international NGOs in Bosnia and Herzegovina, with offices in the cities of Sarajevo, Gorazde, Mostar, Bihac, Tuzla and funding and implementing projects from 1992-2006 (International Rescue Committee, 2006). Such examples of international involvement have led to further reform in the mental health sector.

Other examples of health projects include the promotion of WHO's anti-smoking ideals and policies, whereby millions of dollars have been spent by the European Commission and WHO on non-smoking campaigns throughout the country (Simunovic, 2007). Some have argued that such programs have had little positive impact on the population since smoking remains among the main public health problems in the country and Bosnia's inhabitants are statistically the leading cigarette consumers in Europe (Subotica & Wildman, 2003). Further arguments show that such programs are an example of how international programs and initiatives can be dissociated from the actual health programming needs of the country they are being implemented in (Simunovic, 2007).

Overall, even though reforms are continually implemented and supported by international donor organizations, many practitioners and researchers agree that the outcome of the reforms has not been very efficient (Cain et al., 2002; Topic, 2008). Some have described Bosnia as a classic example of premature decentralization (Cain et al., 20020), due to the fact that the prewar institutions which are unready for change are still functioning and performing the same functions as they did before the war without

reorganizing themselves, while newly created facilities lack the capacity to operate efficiently and find themselves in novel administrative and managerial structures governed by foreign principles (Ibid). Additionally, recent studies have shown, that as investment from foreign donors to the country is decreasing, studies of the financing of the health system have shown that the reduced inflow of aid is not being offset by other capital inflows, meaning that there is as of yet insufficient financing from within the country to take the place of the contributions that were being made by the international donors (WHO, 2006).

Mental Health Reforms:

In addition to general health reforms, major mental health reforms have taken place since the war ended and the country is considered by the international community to be a leader in mental health reforms in the Southeastern Europe Region' (Nemgar, 2008). The reforms that have been reached in Bosnia have been said to be exemplary to the region, and they continue to be deepened and followed up on through the collaboration with other Eastern European countries (Kucukalic et al., 2005). The country has committed to continue building on the successes achieved so far in the mental health field by collaborating with other Eastern European countries in order to ensure sustainability, self-growth and international cooperation and also has formally agreed to maintain mental health as a priority in its public policy agenda (Stein, 2007). However, despite the fact that it has made much progress in introducing changes in mental health policies and approaches, the levels of care in proportion to the prevalence of mental health disorders and problems remain low in comparison to Western European and overall world standards (WHO, 2006). Despite the activities of NGOs and the recognized

mental health impacts of the conflict, mental health maintained a low-priority topic for policy makers during much of the post-conflict reconstruction and rebuilding period (Rechel et al., 2004).

Obstacles to successful mental health policy implementation are inherent in the overall health system, preventing them from being implemented to the benefit of all those who truly need it. The primary health care system of a number of post-communist countries in the region is structured in a way does not easily allow it to detect common mental health disorders (Jaganjac, 2004). The mental health system inherited from the pre-war Yugoslav system offered psychiatric services that were concentrated on a biological and institutional approach to mental disorders primarily in adults (Jones et al., 2003). This means that it was not easy to identify mental health problems in the general population, and only those with sever psychological, intellectual or behavioural problems were treated by professionals in specialized institutions and asylums. General mental health problems are not easily detectable by professionals in the pre-war primary services (Jaganhac, 2004). This often led to the over-institutionalization and hospitalization of people with mental health problem (Jenkins et al., 2005). Mental health policies, if they did exist, often did not include strategies for developing social support such as job opportunities and safety nets (Jaganjac, 2004).

Therefore, mental health, as a concept that encompasses not only the absence of major psychological disorders (WHO, 2001) but includes a range of psychological and emotional well-being, is a relatively new concept in the country (Rechel et al., 2004). Even psychology as an independent discipline did not start in Bosnia until the 1990s,

which is when the war broke out and professionals were faced with the huge crisis of clinical work with acutely traumatized refugees, victims of atrocities and other war-related problems (Corkalo et al., 2007). Therefore the majority of their work has been influenced by the presence of foreign nationals and experts. Challenges faced by psychologists include regulation of practicing psychologists poses a serious issue due to legislative queues in new states, lack of previous ties between specialism of practice and specialism of training and degree of human need in the post-war climate (Ibid). The system leaves few opportunities for much needed intersectoral collaboration between systems for health, social care, housing, employment and social justice (Jenkins et al., 2005). In terms of financing of the mental health system, the same difficulties exist as those discussed for the overall health system. Furthermore, mental health is not seen as a priority for insurance policies and health insurance schemes do little to address mental health, since health benefits continue to be linked to solely biomedical health services (Kucukalic et al., 2005). The war deteriorated even the specialized psychological services that did exist due to the destruction of institutions, decrease in the number of qualified professionals and additionally eroded informal sources of psychological support such as family and community systems by destroying the existing social fabric (Kucukalic et al., 2005).

The present division of mental health services follows the municipal and entity-level divisions of the general health system. The post-war decision was made not to re-build the damaged specialized institutions but to embark in an ambitions and comprehensive reform of the entire system (Kucukalic et al., 2005). The aim of the reforms was to shift services from the hospitals to the communities (Ibid). The idea was

that services such as mental health promotion, prevention, treatment and rehabilitation for patients with even the most severe mental illnesses should be situated close to where the people live, which was very different from the previous medical approach to the treatment of the mentally ill that was based on hospitalization and seclusion into specialized institutions (Kucukalic et al., 2005). This new system required a multidisciplinary approach that closely linked mental health professionals with professionals in other services such as psychiatric wards and government and NGOs (Ibid). In their review of some of the mental health reforms that have taken place in Bosnia and Herzegovina, Hasanovic and his colleagues (2004) demonstrate and point out that the programs have tended to use a 'modern mental health promotion approach based on European programs (Hasanovic et al., 2004, p.77). This approach works around the concepts of personal resilience and empowerment as the key elements in promoting self esteem and personal efficacy and strengthening life and coping skills and was promoted throughout the country through the use of public media and education and awareness programs (Ibid). The approach and examples of its use in the country closely follows the guidelines and general principles set out by WHO and discussed earlier.

Mental Health Projects:

In self-evaluations of their reform-related mental health programs, many international agencies state that requirement to shift from institutional to community-level care in the country has overall largely been met (Health Net TPO, 2008; WHO, 2008). There are currently over 39 multidisciplinary community mental health centers that are linked to primary care and can adequately address mental health disorders (Kucukalic et al., 2005). The geographic, political and ethnic distribution of the country's

population dictates that these communities and community centers largely serve only a single, majority ethnic group. Mental health reform projects within the framework of psychosocial programs began to be implemented immediately following the war. In 1996 the Ministry of Health and the World Health Organization initiated a National Program for Mental Health Reform in order to address the recognized mental health problems after the war. The reform was based on the establishment of first-line care and the decentralization of the treatment of people with psychological problems (HealthNet TPO, 2008).

International medical and psychosocial assistance started to pour into the country as early as 1992, when the war in Bosnia gained media popularity in world media stations (Smith, Perrin, Yule, Rabe-Hesketh, 2003). The early projects, implemented while the war was still going on, focused on 'emergency psychosocial assistance', the approach was community based and looked to satisfy the immediate needs of the population such as providing food, medication and clothes and crisis psychological interventions (Kozaric-Kovacic, Kocijan-Hercigonja, Jamorosic, 2002). In the post-war reconstruction period the interventions continued to emphasize the community element, and they started focusing on non-specific psychological and community social help (Kozaric-Kovacic et al., 2002) The post-war period, from 1995 till approximately 2006 has been described as being flooded with international assistance (Simunovic, 2007).).

As the widespread rape and traumatization of women during the war became apparent, human rights groups started to implement programs to offer assistance to the victims. A project funded by *The Advocates of Human Rights* and carried out by the local NGO Medica Zenica (National Violence Against Women Monitor Program, 1993). The

center provided services such as shelter for women and girls who were victims of violence including rape and trafficking, psychosocial support and therapeutic counseling (Ibid). The project took a holistic approach to post-war development and later extended their services into an SOS . telephone helpline to all victims of violence, gynecologic assistance, outreach work to remote rural areas, vocational trainings, psychosocial training for professionals working in the mental health field and training for non-violent conflict transformation and reconciliation (Ibid). The local partner Medica Zenica has also gone on to develop a Therapy Center and an Information and Documentation Center (ibid). The services reached the city of Zenica and surrounding municipalities and villages. The organization Vive Zene (Women's Center for Therapy and Rehabilitation) was started in 1994 with support from the German International Association for Maternal and Neonatal Health, the EU, and OHCHR (Vive Zene, 2006). The organization initially provided assistance to traumatized women, most often rape victims, and according to its own databases, it simply carried out models proposed by their foreign funders. Since, the organization has evolved and is managed almost entirely by national personnel, making decisions based on its direction and approaches (Ibid). It offers psychotherapeutic treatment to a wider population women including victims of abuse and economically disadvantaged women, and anyone in crisis, offering services such as a women's helpline, coping skills and professional skill training. As part of the first wave of reform-based programs, the 1996 project by UNICEF in collaboration with the national Ministry of Health and the World Health Organization started the 'Child Friendly Hospitals' program, targeted at women and children providing training for mental health workers in curricula that meet the European standard of psychological care (HealthNet TPO, 2008).

This has included involving the local population in the medical decisions of their children and introducing child-friendly facilities into hospitals such as playrooms and other recreational opportunities (Ibid). Since 1998 until 2005 War Child has contributed 101.668 Million EURO to psychosocial and education programs for children in Bosnia and Herzegovina. Their approach, an emphasis on multi-ethnic cooperation from an early stage was advocated in projects throughout the country in partnership with local schools, daycare centers and Mental hospitals (War Child, 2005). It works through the education of children with mental and physical handicaps, enhancing coping skills and encouraging multi-ethnic contact and cooperation among children and young people as well as pedagogical training for teachers in dealing with children with learning and physical disabilities (Ibid).

An example of a specific mental health reform program was initiated by the Tuzla Canton Psychiatry Association and based on model programs used elsewhere in Europe (Hasanovic et al., 2006). Since 1996 psychiatry residents from Tuzla University have been completing the Harvard Program in Refugee Trauma seminars about mental health care for refugees and other war victims (Ibid) and the Canton of Tuzla is working on integrating psychological training into primary health care through the implementation of the 'Pedagogy of Trauma' training for family physicians and several other disciplines that work with traumatized persons. Community associations such as the association of Tuzla Canton War Veterans, the association of parents and friends of drug abusers, both actively working to educate the population and destigmatize mental health disorders (Hasanovic et al., 2006). The project *Psychosocial Trauma Therapy for Orphans* was implemented in the orphanages of the Federation of BiH's cities Sarajevo and Tuzla

(Islamic Relief Worldwide, 2007). The aim of this project is to identify children with emotional and behavioural problems. The project is ongoing and implemented by the Islamic Relief Worldwide foundation in collaboration with the local NGO Amica Educa. Services such as an SOS-Helpline, painting groups for children, teenagers and adults under the supervision of specialists, massage therapy, and self-help groups are provided within the framework of the project. (Islamic Relief Worldwide, 2007). The project is self-monitored, with Islamic Relief staff assessing the orphans' progress and response to the project (Ibid). The very active Landmine Survivors Network (LSN) provides psychosocial assistance to landmine survivors, links them t health care and rehabilitation services and involves them in economic reintegration programs (Landmine Survivors Network, 2007). The organization sends local and foreign outreach workers who provide psychosocial assistance and education as well as direct assistance such as prosthetic/orthopedic devices that assist in mobility and improve living conditions and opportunities (Ibid). The organization operates in over 80 municipalities in both the Federation and Republic and claims to have provided some form of assistance to over 2,200 beneficiaries, including employing landmine survivors/amputees in their organization (Ibid).

In the Republic of Srpska a lot of projects assisting landmine and war survivors have been implemented as well as programs to try and include the Muslim and Croat minorities who may have been victims of witnessed ethnic cleansing by Serb army forces during the war (Response International, 2005). A project titled *Medical and Psychosocial support and Sustainable Health Services for Victims of Torture/Ethnic Cleansing During the Balkan Conflict* was carried out from 2004 to 2006. It offered psychosocial support to

those undergoing searches for missing persons including counseling, liaisoning them with social services, advocacy on their behalf, legal and welfare relatives and provides medical services such as mother and child health promotion, environmental health assessments and health education (Ibid). The organization also presently works in collaboration with the Ministry of Health, offering such medical and psychosocial services for internally displaced persons within the Republic of Srpska and refugees. It receives funding from the United Nations Voluntary Fund for Victims of Torture (UNVFVT) and the Norwegian Government and Ajahma Trust (UK) (Response, International, 2005).

Aspects of the successful implementation of mental health reforms that are yet to be met in the country include further research to be generated in the country and better mechanisms for evaluation and monitoring of progress. A recent project by INCO and Universiy of Sarajevo Medical Centre, Department of Psychiatry has demonstrated that improving psychological research facilities in the country's academic institutions is a priority in advancement of mental health knowledge in the country (Nemgar, 2008). These further needs and shortages in mental health reform progress will be discussed next. The question of declining aid investment in the country not being met by sufficient flows from within the country (WHO, 2006) will be discussed in the final section.

In terms of examining whether the psychosocial programs and projects that have been implemented have targeted the prevalent psychological disorders and problems, it can be concluded that they have addressed the main concerns that have been identified as crucial. For example, in the discussion of needs for women and children's programs to address mass trauma, exposure to sexual and other forms of violence, the need for social services and programs for the economically disadvantaged, internally displaced and those

who are discriminated against, programs have existed to target specific war-related consequences. Overall, the multitude of programs and projects implemented by numerous international actors have had an influential role in pushing for reforms of overall health and mental health systems throughout the country. Through the emphasis on local capacity building and community care in international programs the shift in health care has been made from highly centralized to diffused forms of health governance in the country. Consequently, shifts from highly institutionalized psychiatric care to community-based mental health services have also been advocated by international donor organizations and NGOs and have led to the creation of numerous centers for counseling and community social services. Local attitudes, however, and allocation of funds in healthcare insurance systems and overall national reconstruction programs remain a lesser priority for policy makers, despite progress in mental health awareness and despite formal agreement to the WHO principle that governments should be as responsible for the mental health of their citizens as much as for their physical health and economic well-being (WHO, 2001). Despite the fact that poor health directly negatively affects various labour market outcomes in Bosnia and Herzegovina, and in general in much of the South Eastern Europe region and the fact that its economy has much to gain from improved public health, (WHO, 2006), the overall health and mental health status of citizens in this region of the world is improving at low rates and there still exists a large gap between this region and EU countries.

Progress, Critiques and Recommendations

Although the mental health reforms and the overall provision and availability of psychosocial services in the country has often been cited as successful (WHO, 2006) and

the country as an exemplary pioneer of mental health reform in the Eastern Europe region, it has been demonstrated that the complex context within which these reforms have taken place has led to less than ideal outcomes and that many difficulties in implementation still remain. The conclusion that the mental health condition in the country is in need of further development stems not only from the fact that the war has had long lasting negative effects on large segments of the population, but can also be contributed to the unfavourable post-conflict conditions that continue to characterize the country. This refers to the overall political and economic difficulties faced by all, but also to some general drawbacks in the way the health and mental health systems are organized, and in the manner in which the multitude of programs and initiatives have been designed and implemented. A general critique can be made regarding the way that the programs have been implemented and to what extent they have reached a sustainable level. A further critique is made with regard to how successful psychosocial initiatives have the potential to be in terms of achieving long-term results and determining methods for the creation of evaluation measure of the true success of this elaborate country wide and global collection of existing and past programs, services and reforms.

It has been widely quoted that the amount of western media attention given to the Bosnian conflict has been vast (Dybdahl, 2006) and that the willingness to provide aid and recognize the psychological consequences of the war resulted in an unprecedented influx of internationally funded mental health professionals, programs and initiatives (Mooren, Jong, Kleber, Ruvic, 2003). While the present study did not aim to provide a completely exhaustive account of all the mental health initiatives implemented during and following the war, it has shown many examples which attest that such claims are

accurate and that international involvement in addressing the mental health consequences of the war in Bosnia and Herzegovina has been significant. However, the availability of large quantities of programs and funds does not necessarily result in improved systems and quality of care. The following paragraphs underline the situations in which an abundance of resources did not necessarily produce lasting and widespread benefits and the importance of addressing the specific and highly complex contextual issues that need to be addressed before a willingness to act and an abundance of funds can truly be translated into long-term benefits for the large majority of the psychologically affected population.

Inconsistency and Lack of Cooperation at the National and International Levels:

Two general difficulties in implementing mental health programs and reforms are of primary concern, the internal complex situation of how the health system is governed and a general lack of coordination between the externally funded programs. These conditions are identified as problematic because they impede the goal of reaching sustainability, a goal that should be a priority in international development initiatives.

A message underlying the entire mental health reform process has strongly advocated the view that every individual has mental health needs which underpin all areas of functioning including physical health and economic functioning (Hasanovic et al., 2006). The review of the existing research and examination of implemented initiatives has found that this aspect of reform implementation, has had much progress in emphasizing the relevance and importance of the concept of mental health in Bosnia and Herzegovina and that progress has been made in the professional field, and to some extent in the society overall (Hasanovic et al., 2005). However, despite visible

improvement in the literature and practices of some mental health centers, the prevalence of stigmatization, stereotyping and discrimination in social and employment practices still characterize much of the society (Atun et al., 2007). This shows that the acceptance of mental health as an open topic and acceptance of mental health problems as a normal aspect of individual and social life needs further improvement. Mental health needs to be further integrated and recognized as a key aspect of societal functioning, discrimination and stigma regarding views on mental health need to continually be addressed. Furthermore, those suffering from mental health problems or intellectual disabilities need to be incorporated into social and economic spheres more effectively and more visibly.

In order to ensure widespread benefit and continual, sustained use of programs, it is often necessary that certain pre-conditions of functionality are met. Among the need for the programs to be well designed, properly researched, suitable and adapted to the community they serve, it is also necessary that a level of collaboration exist among the relevant organizational and institutional structures, both at the national and international levels (Hasanovic et al., 2006; Hosman & Engels, 1999; Nemgar, 2008). The previous discussion of the fragmentation and division of health and other social services at the cantonal, municipal and national-level demonstrates the fact that this precondition is difficult, and in the current Bosnia and Herzegovina context, almost impossible to achieve. WHO's position on mental health reform in developing countries strongly advocates the idea that the Ministries of Health in post conflict countries should take on the great responsibility of designing and implementing national mental health recovery plans and coordination of all mental health activities by local and international non-governmental organizations and international donors (ICMH, 2004). In Bosnia and

Herzegovina, this becomes problematic due to the complex institutional and legislative system, the autonomy that different municipalities, ministries and institutions have and the lack of coordination between these different levels of governance. The nature of mental health and psychosocial care also requires a multi-disciplinary approach and thereby a working relation and collaboration between primary and medical care workers (DeJong &Kleber, 2007). This has not been achieved in Bosnia and Herzegovina, and the system is characterized by little collaboration across sectors, across entities and cantons and also with little collaboration among mental health services and the different professional disciplines providing them (Cain, Duran, Fortis, Jakubowski, 2002; Kucukalic et al., 2005). It has been evidenced that due to the structure and autonomy of various institutions and municipalities, there is an overall lack of consensus and complete dichotomy of opinions on the same issues held by ruling political parties in Bosnia and Herzegovina. Some have attributed this lack of collaboration to a lack of modern information technologies and appropriate forms of networking (Kucukalic et al., 2005). However, since this issue of division along lines of political jurisdiction characterizes other domains of social and political life, it is presumable that a lack of proper communication technologies is not the primary cause of uncooperative behaviour. The general uncooperativeness across sectors, entities and political units and its effects on overall productivity needs to be emphasized more strongly in academic literature and in practice, in order to develop theories and models about how to implement mental health care in a society in which war-related traumas are abundant, a society that is divided along war induced ethnic and political lines in virtually all aspects of existence. In other words, externally designed and funded health and mental healthcare needs to be

implemented in such as way that while it should be free of political or ethnic association, it also recognizes the political and social context in which it is being implemented in order to avoid becoming another addition to the ineffective system that already exists. This is the only way to ensure that the functionality and benefits of attempted initiatives are not short-lived, but that they are sustained over the long-term and beneficial to large numbers of users.

Apart from the lack of coordination and collaboration between national actors, a similar pattern can be observed externally, at the level of the implementing international agencies. Comparative and comprehensive studies of many projects worldwide, including the present one, have shown that international and national efforts are often uncoordinated, leading to duplication and the development of parallel systems that can undermine the existing treatment systems and undermine local capacity (ICHM, 2004; Simunovic, 2007). 'The coordination of health and mental health activities in post-conflict countries is often characterized by anarchy' (ICHM, 2004). Patterns of funding foster dichotomous rather than integrated field practice, where NGOs work to address different aspects of the psychosocial recovery process, without communicating or coordinating activities between themselves, creating gaps in coverage and lack of proportionality to the different needs (Adok et al., 2008). This pattern has been mirrored directly in Bosnia and Herzegovina, where large amounts of international funding have, due to their uncoordinated and non-standardized nature, had negative side effects. The discussion on funding of the healthcare in the country (see p.88-89) has shown that a large proportion of it comes from external funding. When a country is overly reliant on external 'solutions' and funding from external donors, this can prevent it from moving

forward in establishing self-sustaining methods of governance and financing. Some researchers warn about the overwhelming foreign aid dependency among politicians and professionals in the country, who have been documented to misuse the system of international aid (Cain et al., 2000). Evidence exists where donor agencies have paid several times for the creation of the same document or project (Cain et al., 2000), meaning that it is difficult to trace what exactly some of the projects produced. This demonstrates a clear duplication of services and unwillingness to progress but to simply accumulate short-term funds to meet particular needs, and it is questionable to what extent these needs are those that are most relevant to the majority of people or to the few who are designing the funding proposals. The project archives and the few academic studies documenting a statistical/quantitative evaluation of certain projects that were consulted for the purpose of this study all focused on one particular project, or on several initiatives implemented by a single organization or donor agency. These patterns signal the need for coordination and guidance at the international level, regarding the best means of providing a wide range of necessary services, without duplicating programs or failing to address certain needs. Little documentation on the levels of communication between different international actors who are or were at some point active in the country (with exception of documented presence at national and international conferences) and no scientific research studies comparing the results achieved through programs implemented by different agencies have been identified. Individual evaluations of particular projects have been statistically quantified and published in books or scientific journals and have been presented throughout this study, but a comparative or cross-analysis at a wider scale has not been available. This study attempts to provide a qualitative description of the

situation in order to present a comprehensive analysis of the countrywide situation and recommends that future studies continue to address this issue and to established accurate, quantitative analyses.

A common representation of this problem of a lack of coordination is the widely recognized fact that there is no standardized global approach to the mental and physical healing of traumatized populations (ICHM, 2004). The response of international institutions has been that this lack of standardization can best be addressed by coordinating and clarifying the role of international organizations such as the WB, WHO and other relevant agents, due to the fact that such institutions have been the key actors in post-conflict psychosocial development (WHO, 2001; WHO 2006). This standardization of evaluating mental health initiatives has been identified as a priority on a global scale, with WHO specifying that an international classification of health interventions needs to exist (WHO website). A country wide evaluation of reforms in Bosnia and Herzegovina could serve as a first step in providing an example and ground work for establishing international classification and evaluation systems and guidelines. While standardization and a globally accepted set of norms and best psychosocial practices is needed and beneficial, such a standardization of practices needs to leave enough openness that will not undermine existing infrastructures and services that exist in developing countries and that they will still be designed in a way that leaves key decision-making about program design to be determined by local actors.

Discussing 'The Psychosocial Program':

This section underlines two main critiques related to psychosocial programs. One is related to the assumptions underlying the initiatives, mainly the theoretical goal of

addressing internal as well as external social and contextual factors of recovery and the extent to which programs are actually designed to address both. The second is related to the implementation of programs on-site and mainly the ease with which they might fall into the trap of undermining local customs and undermining professional credibility of national and local health and mental health professionals.

Upon examination of the psychosocial projects in Bosnia and Herzegovina, researchers have criticized them for being too dominated by concept of post-traumatic stress disorder (Agger et al., 1995) and have pointed out that greater attention should have been placed on the sociopolitical aspects of the psychosocial projects (Dybdahl, 2006). Over the years following the war, some organizations have evolved to provide services that cater to the current and proportional needs of the populations, while other programs and the organizations that once existed and implemented initiatives are distant memories. The ability of programs to evolve in a way that addresses the needs of the population as they present themselves, either focusing more heavily on the trauma-related or the social aspects, remains a challenge. At this point it should be noted that even within the field of psychosocial interventions both variations in practice and dichotomous thinking still persist (Adok et al., 2008). The earlier discussion on the psychosocial perspective was provided precisely in order to address the many critiques that have been expressed in the international literature regarding the efficacy and validity of psychosocial initiatives. The range of programs that are described as psychosocial and that have been implemented in Bosnia demonstrate that not all programs are made to follow all the ideals of the psychosocial perspective, and that some might focus more heavily on certain aspects such as trauma symptoms, than on other concerns that may

also be relevant. This should not be seen as a necessarily detrimental aspect of the psychosocial approach, but can be utilized to make initiatives more flexible, provided that the domains most heavily focused on are identified through an analysis of the true needs and priorities of a population. This becomes difficult when initiatives are designed internationally, and should signal the imperative need for in-field, contextual assessment prior to design or implementation of initiatives.

Psychosocial programs that take place in the community should also incorporate both political and social elements (Adok et al., 2008). It is visible in the Bosnian situation is that there is very little attention given to the political and ethnic climate (Ibid). While mental health interventions should be free of ethnic discrimination, it is important for the implementers of the programs to be acutely sensitive to and aware of the political climate and the realities of ethnic tensions and divisions which shape social interactions and are a reality that is inseparable from the everyday functioning of the society in which they are working. In other words, the argument here is that an inadequate attention to local context can easily be identified in the literature examined throughout the study. Studies examining ethnic tension and overall post-conflict reconciliation in Bosnia and Herzegovina have been widely conducted, but they have been done separately from any discussion of mental health reform or psychosocial intervention. Including the ethnic factor in an examination about the post-conflict mental health recovery of a population would not only be interesting but should be necessary because ethnic identity and ethnic belonging play important roles on the development of individual identity and mental health (Bougarel, 2007; Bowen, 1996; Eriksen, 2001) and thereby on the opportunity of achieving reconciliation and sustained peace and stability.

Deeply entrenched in any discussion of the successful implementation of psychosocial programs is the question of culture, as it pertains to the perception of mental health priorities, the types of treatment available by the mental health systems and types of treatment sought or deemed appropriate by the population. The previous discussion on the types of programs implemented during the war and especially during the post-war reform period in Bosnia and Herzegovina has recognized that stigmatization against those suffering from mental health illnesses and/or problems prevails in the society, and that some population sub-groups, such as male ex-soldiers are less likely to seek treatment for their psychological symptoms due to this perception (Walsh, 2005). This demonstrates that there exist differences in perception and attitude toward mental health between different cultures and also among different demographic and population sub-groups within a single country or culture. Such discrepancies are prevalent in the field of psychology and are ongoing issues that are being raised and addressed in developing as well as developed countries. The cultural question in the present discussion combines the overall need for sensitivity of cultural contexts to be exercised by any international agent or organization with the issue of cross-cultural validity of psychological concepts such as PTSD which are widely criticized for being overly dependent on a western world of the view (Hasanovic et al., 2003) and a western understanding about what entails healthy mental functioning. The present study recognizes that cultural interpretations of mental problems and cultural constructs of violence and what the thresholds for acceptable levels of violence are, differ around the world (Berman, 1999), but also recognizes that even with variations in cultural norms, violence has powerful negative effects on the mental health of human beings and these should not be left unaddressed.

A humanitarian agency providing support in a complex emergency will inevitably do so in such a way as to protect the integrity of its own organizational values (Strang & Ager, 2008) at the same time they are entering a community with its own set of values. Interventions and programs evolve through an 'interaction between the affected community and the external community' (Strang & Ager, 2008). Therefore, the main critiques to the implementation of psychosocial programs are that they might run a high risk of undermining local culture and professional integrity. In a transitioning country such as Bosnia, introducing a psychosocial initiative, whether during the fighting, or at the post-conflict phase is not simply a question of introducing a method of treatment for mental illness but a part of the entire process of transition and it may carry implications that extend beyond the provision of services. Because they play such a crucial role on the overall perceptions and practices that go on in any developing country, international organizations need to be constantly self-critical of the role they play. To prevent them from undermining local practices and understanding their own direct and indirect role, the cultural values of the implementing international agent need to be self-assessed, openly recognized and presented to the local culture they are going to be working in, in order for an open communication to exist. In this manner, by identifying the values of the external agency's cultural or organizational values as well as outlining the main values of the society where their projects are being implemented, incompatible values that may impede the initiative can be identified and dealt with, and the program practices can be best adapted to suit the already existing practices.

Therefore the cultural component of the argument advanced by this study has been more of a pragmatic one. It has emphasized that rather than framing the

international assistance to mental health professionals through the provision of personal resources that they may rely on and material and educational assistance to help them carry out their work in an optimal manner as a question of cultural power struggles, it is a matter of providing resources that enhance and assist the work of these professionals, increasing their overall personal and professional ability to help their patients. On a theoretical level, the mental health needs of mental health professionals should be conceptualized as an integral part of the overall battling of stereotypes about mental illness, making it truly acceptable for all who need mental health services to feel comfortable in seeking them, regardless of social status, education levels or profession, including the mental health profession. The theoretical perspective of the present study is also not one that questions the validity of mental health problems or that undermines the universal applicability of psychological intervention and its ideological principles because this would lead to inaction and unaddressed concerns. Instead, the emphasis is made on the importance of acknowledging the true needs of societies, understanding the contextual features of the places where mental health initiatives are being implemented in order to avoid creating programs that do not address the true needs of the societies and thereby do little to improve the situation.

Further, an unexplored issue is the effect of the philosophies of the psychosocial initiatives and their overall effects on the culture and attitudes of local populations, or of certain segments of the population has important implications in the overall transition process. While the country is studied in-depth as a politically, judicially or economically transitioning society, little research exists on the psychological transition that undeniably transcends all levels of functioning. This means that the psychosocial initiatives should

not only be examined in terms of their ability to achieve pre-determined treatment goals, but in the extent to which they negatively or positively influence the society overall. In other words, their effects should be taken in consideration with the overall transitional context in which they may have unanticipated effects. A brief example of a negative effect is the creation of the 'NGO elite', a group of internationally trained nationals who have benefited from the professional development provided by the international community (Belloni, 2001). This can be translated into mental health professionals who are very familiar with the requirements of their donor organizations, or more simply put, their employers, and who may design initiatives based on these organizational requirements, without necessarily recognizing or meeting the true needs of the populations they are working with. This is but one example, and other effects of the psychosocial movement on society overall should be identified as a research variable and further studied.

The psychosocial perspective also claims to recognize that long-term restoration of the community and sense of self-efficacy is essential in sustaining and ensuring long-term effects of the psychosocial intervention (Adok et al., 2008). However, while this is a desirable and necessary goal, its realization is based on a comprehensive understanding of what the long-term needs of a post-conflict society are and how societies are affected by transitional or post-conflict periods over the long term. This is a lesser understood phenomenon since little longitudinal data exists about the long-term effects of the transition period, including the effects of unemployment and all the labour market adjustments and public policies (Fares & Tiongson, 2007). Similarly, little longitudinal data exists on the successes and effects of mental health programs and reforms in

developing countries. For this reason, a country with over a decade of experience in mental health reform and psychosocial program implementation should be more widely recognized in the literature, as a potential starting point for the systematic longitudinal assessment of conflict-related psychological needs and consequences. Acquired knowledge and experiences should be shared globally (DeJong & Kleber, 2007).

In order to avoid implementing programs that do little to improve the overall conditions of mental health because they are externally designed and do not address the true and most pressing needs of the societies they are attempting to help, it is important to acknowledge and appropriate certain critiques that have arisen in response to the widespread implementation of psychosocial programs worldwide. While these were identified in the section on mental health of mental health professionals in Bosnia and Herzegovina, it was stressed that it is not necessary to undermine the overall need for psychological initiatives, or to disregard the existence of important psychological problems and disorders by claiming that their conceptualization is too rooted in Western psychological knowledge. On the other hand, it is important to understand that some concepts such as psychology over all and the disorder of PTSD did originate in 'the West', and that cultural variations in the way people experience and relate to traumatic events do exist. Overall, however, the discussion on the psychosocial perspective has shown that psychosocial perspectives are quite effective especially in comparison to other types of models, such as overly economic approaches to post-conflict development, or overly medical psychological ones. For this reason, their benefits and potentials should not be disregarded, instead they should be implemented where needed, in a way that respects contextual variations, practices and existing means of dealing with adversity.

Further Needs: Improving Research and Evaluation Measures:

Overall, researchers point out that we need to further improve our understanding of the longitudinal and developmental effects of exposure to war in order to improve our ability to target interventions (Stein & Tanielian, 2006). Researchers and practitioners in the fields of international psychology agree that there is an incredible need for research to be generated, of empirical data to be collected regarding the efficacy of programs and for this research to be used to guide clinicians and policymakers when deciding what the optimal content of interventions should be and to whom it needs to be administered (Ibid). As pertaining to the Bosnian context, the question of research is an important and critical one. While reforms, programs and initiatives have sprung up throughout the country, psychology university departments have done little in comparison. The country can be considered a leader in mental health reform in the region, but these services need to be underpinned by high quality research facilities at universities and within organizations (Nemgar, 2008).

While the goal of this paper was to include a vast literature on the country originating from national scholars, this has not been easily doable. The majority of the work discussed in this paper has collected data either from international organizations' databases, or from international medical, psychological and political journals. Although many of the research studies were conducted by national academics, researchers or practitioners, almost all of the studies discussed throughout this paper were published by international, mainly European or American academic journals. The neighbouring country of Croatia has produced much empirical and academic research specifically on the vast influence of international psychosocial initiatives and the national policies and

institutions that have been established as extensions of these international programs. Much research used in this study was found in the Croatian Medical Journal, but journals originating from Bosnia and Herzegovina have not been accessible. The next priority in the psychology of the country should be to establish quality research journals and create an outlet for research and academic knowledge and experiences of the country's professionals, many of whom have been directly involved in many of the programs and in the overall reform process.

This question of research can be traced back to the above argument about examination of mental health problems independently of war-related variables. The overall field of psychology in the country needs to further its research. It is understandable that the priority has been on war-related factors, since psychology and its institutions and services in this country did flourish following the war and in immediate relation to the effects of the war. However, with wars going on all around the world, it is difficult to justify the need for further services, especially if they are unrelated to trauma or PTSD, since the priorities of international donors and organizations often switch to other regions of the world in which imminent conflict-related needs are more apparent. International donor organizations have shifted large amounts of funding and program initiatives into countries with more recent conflicts such as Kosovo and Afghanistan, and (Tuathail & Dahlman, 2004) because these are perceived as more in need of psychosocial assistance than 'old' conflicts are. With falling investment and lack of interest in the region, certain goals set out in psychosocial programs are not being met, such as the need for ongoing coaching, learning and evaluation of practitioners and long-term sustainability of psychosocial goals (DeJong &Kleber, 2007). The argument here is that

caution needs to be exercised in order to avoid allocating large amounts of funds and programs that address the immediate effects of the war, without establishing long-lasting benefits. A continual involvement in post conflict of transitioning countries such as Bosnia and Herzegovina could provide insight into how to best allocate funds that address the imminent effects of the war, as well as how to maintain a result-yielding, continual and evolving involvement, which ensures that the long-term struggles are addressed.

The question here becomes how existing programs and research facilities can reflect current psychological needs of the population, that is needs that arise many years following the conflict. Little research has been identified that isolates the war element of psychological wellbeing. Without risking a contradiction to the very relevant argument that war-related psychological consequences are long-lasting and can transcend generations (Hernandez & Romero, 2003), it should also be noted that there is a range of other influences such as overall economic hardship, cultural influences of globalization, questions of self-esteem in youth who did not have traumatic experiences and many other psychological topics need to be identified and addressed. The war could have direct or indirect effects on these, but the war should not be the sole identification and reference to mental health problems in the country as it has most commonly been presented, especially in international literature and the activities of international organizations. Again, this stresses the need for overall further research in many areas of the field of psychology, both on war-related problems and on other social and psychological phenomena that pertain to the country. Because it is still a very economically

disadvantaged country, these evolving psychological needs should not be overlooked by the international development field just because there are no immediate traumatic threats.

As was stated earlier, numerous community projects have been implemented but these often do not translate into a coherent national policy (Jenkins et al., 2005), and where policy does exist it is not always being coordinated with the level of training available to the professionals and thereby to the work that is being carried out at the community based level. The argument, however is that this can successfully happen, that this is precisely what has happened in Western countries which have integrated national policies with community initiatives, and that this can be done (Jenkins et al.,2005; WH0, 2004). While programs have been widely implemented, completed and often rated as successful, standardized and large-scale evaluation of the true extent of benefit and success of the programs on a national and long-term scale are simply lacking in the country. Researchers have identified that this is a priority at the current state of reform, identifying the need for further research and establishing evaluation criteria to evaluate the successes and benefits of these programs to individuals and communities as a priority need (Hasanovic et al., 2006). While some organizations such as the WB, Canadian International Development Agency and WHO do provide an overviews of the amounts of funds allocated to mental health initiatives in the country, all of which claim to have undergone internal, organizational program monitoring and evaluation, it was difficult to find empirical studies quantifying the overall benefits of these programs or wide-scale surveys on societal attitudes about the benefits or usefulness of these programs. This difficulty has been echoed by other researchers who have noted that structured and systematic evaluations of the true merits of psychosocial programs on the country as a

whole are a rare practice (Mooren et al., 2003). While some evaluation studies focusing on particular programs and citing general recommendations for program improvement have been found, few systematic evaluations of the overall effects of this widely implemented, internationally guided mental health movement in the country exist. There is an absence of outcome data and uniform information systems for monitoring and evaluating service delivery are still to be developed (Kucukalic et al., 2005) and clear-cut criteria for evaluation are lacking (Hasanovic et al., 2006). This needs to be the next priority in the mental health reform process in the country. The experiences and knowledge gained from such an evaluation tool can then be used as a point of reference for ongoing mental health programs and reforms throughout the world because similar ideologies and principles, those advocated by the main international such as WHO, are used in their global implementation.

CONCLUSION

In conclusion, it has been shown that mental health concerns need to be prioritized in international development, especially pertaining to countries that have experienced violent conflicts. Post-conflict societies such as Bosnia and Herzegovina demonstrate that mental health is a crucial variable in overall post-conflict reconstruction. This is because a failure to meet basic mental health needs of a population restricts this population's ability to perform socially and economically and deteriorates its physical health, diminishing the overall capacity of the society to thrive and develop. Post-conflict countries have heightened mental health needs due to the range of mental health consequences that limit their citizens' capacities in addition to widespread war-related economic and social problems. For these reasons, mental health must be addressed if

overall development and reconstruction is to take place. Additionally, examination of cultural, political and post-conflict contextual variables is crucial in any reform implementation, because, as this case study has shown, transitioning or post-conflict countries have extremely complex internal systems of governance and functioning that need to be well-understood and reviewed before the introduction of new programs or reforms can take place. Extensive reforms and numerous psychosocial programs are being implemented throughout the world and the pool of examples of successes and failures from Bosnia and Herzegovina should serve as a rich empirical body of knowledge and reference in this process.

In terms of general conclusions pertaining to the post-conflict mental health development in Bosnia and Herzegovina, the study has demonstrated that many of the conflict-related psychological problems that have been identified are similar to the problems faced by developing countries and post-conflict societies all around the world. Wars affect entire populations and although different population sub-groups may exhibit slightly different reactions to extreme violence and some groups are particularly vulnerable to its effects, it is impossible to find a group that is completely unaffected or psychologically resistant to the negative consequences of conflicts, regardless of nationality, ethnicity and demographic variables. The significant presence of international involvement in the country has led to a number of programs and reforms to be implemented and the conclusion has been reached that these have had some positive impact on the overall advancement of mental health as a social priority and that psychosocial initiatives have addressed the main concerns of the war-affected population by targeting cultural stigmatization and experiences of trauma as experienced by the

vulnerable groups. They do, however, need to be further elaborated to incorporate the range of post-war factors that continually affect mental health and to avoid the risk of withdrawing funding and programming prior to achieving sustainable results. This further elaboration should also include design and implementation of systematic country wide evaluation measures and improved research facilities throughout the country. Overall, mental health needs to be continually addressed in public policy and international initiatives and not disregarded as something that has already been addressed based on the fact that large amounts of programs have targeted it. Because mental health evolves and changes throughout the human life span, so must the initiatives and programs that are designed to enhance and address it.

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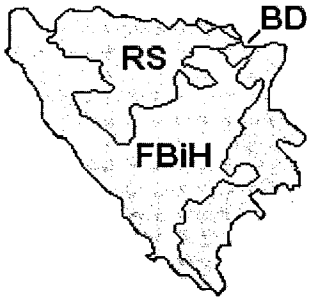
APPENDIX A

Map #1

Pictoral Map Outlining the Geographic Division of Entities[3]*:*



RS = Republic of Srpska

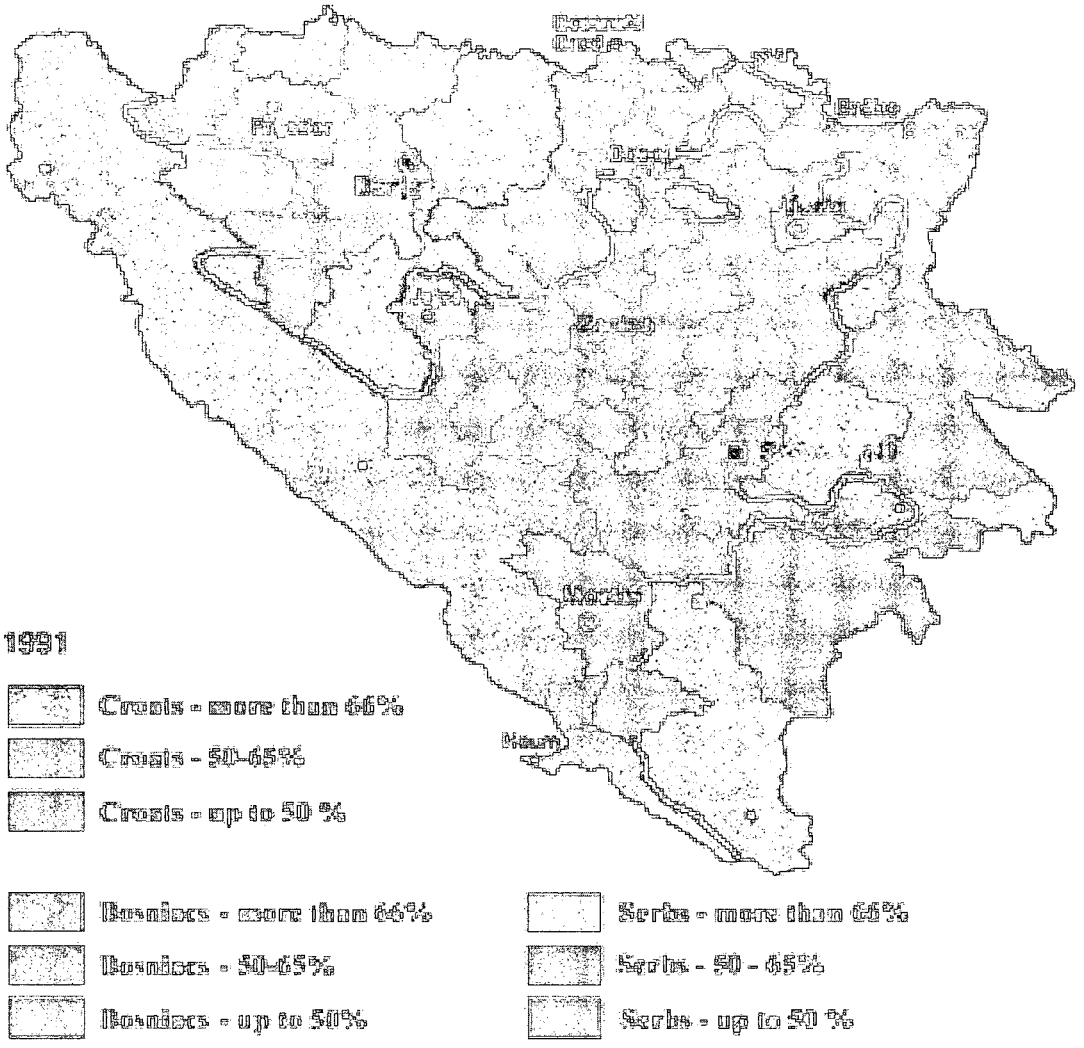
FBiH = Federation of Bosnia and Herzegovina

BD = Brcko District

[3] Map Source: *Map of Bosnia and Herzegovina.* Accessed May 2009 from the World Wide Web: http://upload.wikimedia.org/wikipedia/commons/5/5c/Bosniadivisions1.PNG

Map # 2

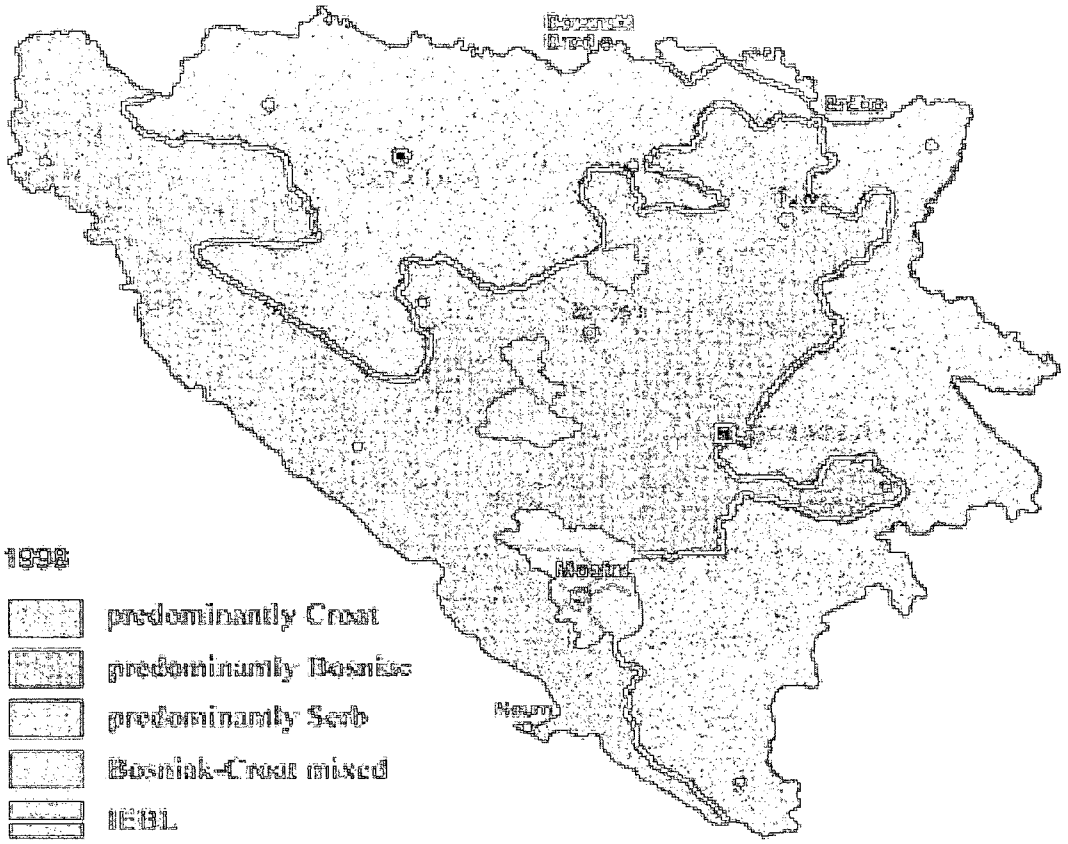
Ethnic Composition of Bosnia and Herzegovina immediately pre-war in 1991[4]*:*



[4] Map Source: Office of the High Representative (OHR). (2009). *Office of the High Representative and EU Special Representative.* Accessed May 2009 from OHR Maps Online: http://www.ohr.int/ohr-info/maps/

Map # 3:

Graphic Representation of Ethnic Composition After the War (1998)[5]*:*



[5] [5] Map Source: Office of the High Representative (OHR). (2009). *Office of the High Representative and EU Special Representative.* Accessed May 2009 from OHR Maps Online: http://www.ohr.int/ohr-info/maps/