REFUGEES AND MENTAL HEALTH - IMPLICATIONS FOR THE PROCESSES OF REPATRIATION AND INTEGRATION

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INTRODUCTION

Persons who go to exile leave their homes, jobs, familiar social environments, friends, cousins or even the closest family members. They do so in order to avoid a life risk, in the conditions that are threatening either because of a direct danger or because of the proximity of armed conflicts. By the time they find a refuge in a new environment, these individuals have most often already been exposed to various stressors and have either witnessed the suffering of other persons or experienced threats for their own or the lives of their close ones. All of this can lead to various psychological difficulties in some individuals, and even to the development of psychiatric disorders that hinder adjustment to the new environment and prevent continuation of life in posttraumatic conditions, which, in that case, calls for assistance and therapy.

However, we have to bear in mind that the term "refugees" denotes a very heterogeneous group of individuals who significantly vary in their primary characteristics, personal stressful experiences and subjective reactions to them. Although a considerable number of individuals in exile can manifest certain characteristics of posttraumatic disorders, it is by no means all who develop stress-related disorders. Furthermore, the conditions in which these people live demand a continuous and often long humanitarian assistance that has to be well planned and must include various aspects. Finally, exile in itself represents a temporary experience, which means that both refugees and the host environment live under

the imperative of a "durable solution" that, most often, implies integration in the new environment, repatriation, or emigration to a third country.

This work purports to demonstrate the results of a research of some basic factors that might have influenced the decision on repatriation or local integration. These factors include: 1) the kinds of the traumatic war events our respondents have been exposed to, 2) their general psychological difficulties and posttraumatic psychopathology, 3) their personality characteristics or dimensions, and 4) their self-concept. But before we present our results, we will offer a brief review of some of the basic methodological problems of understanding of mental disorders in refugees. We will also offer some key elements of the understanding of the refugee context in the former Yugoslavia.

In the last few decades, psychological problems of refugees have attracted considerable attention, which means that we dispose now of important experience gathered through psychological research in emergencies. Our work relies on three basic sources: 1) findings about mental disorders of refugees in other regions of the world which were affected by the crises that triggered mass refugee movement, 2) findings about the ex-Yugoslav refugees who emigrated to third countries, and 3) results of the studies effectuated in the resettlement countries of the former Yugoslavia (primarily Bosnia & Herzegovina, Croatia and Serbia & Montenegro).

Methodological problems and the refugee context in the territory of the former Yugoslavia

The majority of studies of refugees were effectuated in developed resettlement countries. Although their results contain a plenty of valuable information, we have to bear in mind that more than 70% of refugees live in low-income countries, as well as in environments which face them with existential problems and even with the deprivation of essential needs and further political insecurity. All this has direct implications for the methods of psychological investigation (Pernice, 1994; Jacobsen and Landau, 2003).

However, the differences in relation to the studies of refugees in the developed western countries are not exclusively limited to the problem of existential vulnerability. We have to bear in mind that some of the refugees in Serbia & Montenegro still live in collective shelters (for more than ten years now), which means that their living conditions (and especially the conditions of family life and upbringing of children) are significantly different, quite simply, more difficult than other, "normal" conditions. Furthermore, a number of the refugees experienced exile several times, as in the case of the refugees from Croatia and B&H who had found a temporary safe haven in Kosovo only to be exiled again in 1999. Furthermore, the refugees in S&M were also exposed to the NATO bombing campaign in 1999, as well as to the turbulent political changes that occurred thereafter. (Lečić-Toševski and Draganić-Gajić, 2004). Nevertheless, even the

persons who found refuge in a third country faced stressful experiences, such as the problems of residence permission, change of habitation, unemployment, discrimination and social isolation (Silove, 2002; Papadopoulos et al. 2004; Kivling-Bodén and Sundbom, 2002; Pernice and Brook, 1996).

On the other hand, we think that the refugees who found refuge in one of the three countries created after the breakup of Yugoslavia – B&H, Croatia, S&M – were not exposed to such acute problems of acculturation as were the refugees who emigrated to the EU countries, the USA, Australia or Canada, if we consider some measurable ingredients of «culture» (such as language, behavior, names, clothing, food and religion). Or, in other words, they did not have to deal with the perception of an *other* culture, followed by a negative or a positive attitude, preferences, attachments, identification or other psychological states (Williams and Berry, 1991; Rudmin, 2003). However, during the Yugoslav conflicts of the 1990s, the question of cultural differences between the former Yugoslav ethnic groups was given a special, political, meaning and was used in a way that accentuated the differences, usually using them as an argument for the assessment of "higher" or "lower" level of development. This kind of argument, often used to instigate nationalistic passions, was sometimes backed by scientific, psychiatric and psychological circles (Kecmanović, 1999). Simultaneously, the speed of change that during the last few decades characterized globalization and the development of communications systems, transport and free market precluded any possibility of definition of a stable, unchangeable "culture" and thus placed all individuals (migrants or not) under the requirements of "acculturation" (Rudmin, 2003). In a more specific, psychiatric sense, there occurred a reinforcement of the assumption that the basic pathology is universal, that the prevalence of major disorders in various cultures is identical and that cultural differences are contained only in the differences of manifestation of disorders (Cheng, 2001).

Traumatic events experienced by refugees

Experiences of refugees can differ significantly, but the kinds of traumatic events usually vary strongly and include various stressors, such as active participation in combat, accidental exposure to danger, captivity, torture, witnessing of murder or torture, personal injury and incapacitation. Diversity of traumatic events is especially characteristic of civil wars, because the frontline between the warring parties is often volatile and violence against civilians very frequent. This kind of situation was also present in the Yugoslav wars of the 1990s. In some of our earlier works, we have described the methodological problems of the measurement of war-related stressors (Jović et al. 2002), and of torture especially (Jović and Opačić, 2004).

There was a number of studies that demonstrated the existence of a relationship between wartime traumatic events and psychiatric disorders, especially

PTSD, and this relationship is especially important in the refugees who underwent torture or some form of violence (Jaranson et al. 2004; Mollica et al. 1998b; Mollica et al. 1998a; Miller et al. 2002; Bhui et al. 2003). Still, the correlations between stressors and the consequent psychopathology were relatively weak so that sometimes the "dose dependence" could not have been established (Yehuda and McFarlane, 1995). Therefore, when reflecting on the studies that failed to demonstrate this relationship (Kivling-Bodén and Sundbom, 2003; Weine et al. 1995), we have to, first of all, ask ourselves about their methods, and especially about their instruments of assessment of war stressors.

Mental disorders in refugees

The prevalence of psychiatric disorders

Studies of the mental status of refugees from various regions of the world demonstrate very high rates of prevalence of mental disorders, especially posttraumatic stress disorder (PTSD), depression, and other anxiety disorder. De Jong et al. have found that the rate of the prevalence of "serious mental health problems" in Rwandan and Burundese refugee camps was 50% (de Jong et al. 2000), but the measured rate of psychiatric disorders could go up to 90% (Kinzie et al. 1990). In fact, the rates of the prevalence of psychiatric disorders in refugees varied in various studies, depending on the applied assessment method. The most frequent way of assessment was by short self-assessment instruments, but in principle the prevalences remained high even when some more reliable instruments were used. Thus, the rates of life prevalence in the refugees from Butan examined by the Composite International Diagnostic Interview (CIDI), for any psychiatric disorder amounted to 56,1% (for the non-tortured refugees) and 88,3% (for the tortured refugees) (Van Ommeren et al. 2001). The life prevalence of PTSD was 14,5% for the first, and 73,7% for the second group. PTSD in refugee psychiatric patients had the highest prevalence rates – up to 46,6% (Lavik et al. 1996). Epidemiological population surveys in "post conflict, low-income countries", demonstrated that the PTSD prevalence continued to be several times higher than the supposed prevalence rate of the general population in the developed western countries. The established prevalence rates were 37,4% (for Algeria), 28,4% (for Cambodia), 15,8% (for Ethiopia) and 17,8% (for the Gaza strip) (de Jong et al. 2001). There was a certain, relatively low, number of refugees who could manifest trauma-related psychiatric disorders several years after the experience of exile (Steel et al. 2002-).

We know of no reliable data on the prevalence of psychiatric disorders in the refugees from the former Yugoslavia, either those who have emigrated to a third country or those who have found refuge in the region. Various results obtained in studies conducted in developed countries signal the existence of a high

prevalence of PTSD (even up to 74%) (Weine et al. 1998). For instance, a recent study has established a prevalence rate of 60.5% for the "probable presence of PTSD" in refugee Kosovo Albanians (Ai et al. 2002). A research on 81 refugees and internally-displaced persons in Croatia has reveled a much more modest PTSD prevalence of 20% (Marušić et al. 1998). A study of 47 Croatian war veterans demonstrated that 34% of the respondents (i.e. 16 individuals) manifested current PTSD (Kozarić-Kovačić et al. 1998). A study of refugees in Serbia, carried out by the Institute for mental health, found that 29,2% of the examined had PTSD (Lečić-Toševski et al. 1999). When only a selected sample of male torture survivors had been examined (N=60), diagnosis of stress-related disorders was set in 79,9% of cases (Ilić et al. 1998). A study of torture victims, carried out by International Aid Network, discovered the actual PTSD prevalence rate of 63.8%, but also established a 20.2% prevalence rate of lifetime PTSD, which, when summed, represents 84% of the PTSD life prevalence in this population (Špirić and Knežević, 2004).

The meaning of these numbers is a practical question. A short report by de Jong and Komproe (de Jong and Komproe, 2002-) pointed out a need to define the clinical importance of posttraumatic disorders, in order to define therapeutic needs and organize corresponding services. The authors referred to an earlier analysis of Narrow et al. (Narrow et al. 2002), where the prevalence of psychiatric disorders had been reduced by the significant 20%, when disability associated with morbidity had been assessed (measured by help seeking, life interference or use of medication associated with morbidity). A realistic assessments of the prevalence could help the planning of adequate strategies of assistance in complex crisis situations (Mollica et al. 2004).

Categories of psychiatric disorders in refugees

Although the majority of studies of psychopathology in refugees focused on PTSD, one should bear in mind that this population has high prevalences of other disorders as well, and especially the prevalences of depression, persistent somatoform pain disorder and dissociative disorders (amnesia and conversion) (Van Ommeren et al. 2001). One has to count with this fact when analyzing the reports where the prevalence of disorders was measured only by PTSD-specific instruments.

Exile and war imply many psychological problems that cannot be subsumed under the diagnosis of PTSD, and these are sorrow or grief, alienation and loneliness, loss of self-esteem, depression, anxiety, somatization, guilt and substance abuse (Arredondo-Dowd, 1981; Espin, 1987; Garcia-Peltoniemi, 1991; Rebhun, 1998). The very introduction of PTSD diagnosis into the DSM III classification (in 1980) inspired research that aimed to: a) ascertain alternative criteria for PTSD diagnosis, b) reexamine the validity of symptoms through various

kinds of stressors, c) reexamine the adequacy of the tripartite division of symptoms, and d) reexamine the minimum of symptoms necessary for diagnosis (Courtois, 2004)**.**

An additional goal of these studies was to elucidate the constellation of the trauma-related symptoms that were not included into PTSD diagnosis. These syndromes were variously labeled, as "*Complex PTSD"* (CP), or "*Complicated PTSD*". At the beginning of the 1990s, Roth et al. (Roth et al. 1997) have attempted to construct a standardized diagnostic interview for the verification of the *Disorders of Extreme Stress not Otherwise Specified* (DESNOS) concept.

Prospective studies with war veterans (Ford, 1999; Newman et al. 1995), children victims of violence (Ford and Kidd, 1998), and abused women (Pelcovitz and Kaplan, 1995), have confirmed the clinical validity of the CP concept. The field research, carried out in 1991 and 1992, demonstrated that these disorders were trauma-related and that there was a high comorbidity with PTSD (Roth et al. 1997). Although a comorbidity between PTSD and DESNOS existed in 92% of cases (Ford, 1999), the authors believed that there are fundamental differences between the two diagnoses and that the symptoms of DESNOS can be found in situations when the PTSD criteria are not met, especially in childhood abuse cases (Roth et al. 1997). In the Tenth version of The International classification of diseases (ICD-10), a special place was given to the category of „Permanent personality change after catastrophic experience" (F62.0) (World Health Organization, 1992), which can serve as a basis for the understanding of the complex picture of chronic disorders described in the picture of DESNOS or CP.

The CP/DESNOS concept includes seven distinct areas of change frequently related to early trauma (Herman, 1992b; Herman, 1992a): 1) changes of regulation of affective impulses, 2) amnesia, depersonalization and other dissociative phenomena, 3) changes of self-perception (Courtois, 2004; Pearlman, 2001), 4) changes of the perception of the perpetrator, 5) changes of relations with others – lack of trust and impossibility of intimate attachment, 6) somatization and other medical problems, and 7) changes of the value system. In this section, we will deal more closely with changes of the perception of the self, i.e. changes of self-concept.

Before leaving the theme of diversity of mental disorders in refugees, we have to remark that wartime stressors and subsequent exile can deteriorate the general status, conditions of therapy and protection of human rights of the chronically mentally-ill, who in crises situations usually represent a neglected population category (Silove et al. 2000). Moreover, exile indirectly affects development of mental disorders by intensifying factors such as poor antenatal health and nutrition, suboptimum perinatal care, increased risk of birth injuries, infantile malnutrition, early separation from care givers, neglect and understimulation of children, exposure to chronic communicable diseases that

affect the brain, the risk of traumatic epilepsy and exposure to extreme and repeated stress (Silove et al. 2000).

Longitudinal development of mental disorders, and adjustment in exile

A considerable number of refugees suffer from PTSD-related symptoms, which is related to the destructive influences that traumatic events and the conditions of life in exile had on their mental health (de Jong et al. 2000; Lavik et al. 1996). These persons can be especially sensitive to negative events in exile such as existential and housing problems, not only because of their individual characteristics but also because of their situation. Posttraumatic pathology (which reduces adaptation abilities) and poor social conditions in exile create a sort of "vicious circle", given the fact that a higher posttraumatic symptom level at follow-up was associated with a pattern of negative living conditions such as open unemployment, social isolation, and a high dependence on social welfare (Kivling-Bodén and Sundbom, 2002). A study of Kosovo refugees in Sweden revealed that the PTSD prevalence in exile, measured in two time points, grew from 45% (in the first measurement) to 78% (in the second measurement, after 18 months) (Silove and Ekblad, 2002). A second Swedish study identified the factors of the risk of aggravation of posttraumatic psychopathology as "severe life-threatening trauma and present life in exile with unemployment and unresolved family reunion" (Lie, 2002). This is in accord with our earlier studies of internally-displaced persons from the Prizren area, which have demonstrated that in two time points (with two years of distance), within the same population (but, unfortunately, not with the same examinees), the levels of psychopathology in exile had significantly increased (Tenjović et al. 2004; Tenjović et al. 2001).

A study of the Bosnian refugees settled in collective shelters in Croatia, carried out in two time points (1996 and 1999), demonstrated that the persons who had initially met depression or PTSD diagnostic criteria (45% of the sample) did so after three years as well, while 16% of the initially asymptomatic respondents developed one or both of the disorders in the meantime (Mollica et al. 2001-).

Mental disorders and somatic health

Stress-related disorders, and especially PTSD, differ from other psychiatric disorders by their strong potential to cause poor somatic health. This is facilitated by some psychological and physiological specificities such as adrenergic stimulation, sympathic hyper reactivity, endocrinological abnormalities, opioid disregulation and probable disorders of the immune system, as well as by some specific psychological or psychopathological characteristics such as hostility, depression, alcohol/drug abuse and malnutrition – which can all have serious additional consequences for somatic health (Friedman and Schnurr, 1995).

As for the assessment of the effects of mental disorders on the general mental and somatic functioning, it has been demonstrated that PTSD had the same impact on the general mental functioning as major depressive disorder, but that PTSD was related to much more severe somatic damage than major depressive disorder, panic disorder and generalized anxiety disorder. This effect, as demonstrated by canonical regression analysis, was unique to PTSD and was not related to age, gender or some other comorbid anxiety disorder. This means that an efficient therapy of PTSD can directly affect corporal health as well (Zayfert et al. 2002).

Personality characteristics and stress-related disorders

Until the 1990s, the relevant scientific literature was dominated by a firm belief that PTSD is "a normal reaction to abnormal events". When repeated empirical evidence revealed that trauma alone cannot explain the appearance of PTSD and that individual differences in reaction to traumatic events are significant, there appeared an interest for risk factors or any other vulnerability indicators. In fact, this represented a shift of interest towards more complex, multivariate etiological studies. Simultaneously, the interest was imposed by practical reasons. Since the majority of traumatic situations (wars and civil, peacetime disasters) affect considerable numbers of individuals, it became highly important to identify the persons in high risk and thus reduce the number of persons receiving unnecessary assistance (Roy-Byrne et al. 2004). There appeared a number of studies that contained the so-called "meta-analyses" of the risk factors of development of PTSD (Brewin et al. 2000; Ozer et al. 2003), as well as studies that used a more complex methodology for the determination of the factors that predicted development of PTSD (King et al. 1998; King et al. 1996; King et al. 2000; King et al. 1999; Shalev et al. 1997; Shalev et al. 1996). In view of the requirements of our present work, we will limit ourselves to a brief review of personality characteristics measured by personality inventories (instruments for the assessment of personality characteristics or dimensions), leaving aside "the fixed markers" (gender, age, race), or the factors of premorbid adjustment.

The most frequent finding of the studies that made use of the instruments measuring the characteristics comparable with the dimensions of the Big-five model,[59] was that the persons who had developed PTSD had higher neuroticism than the persons without PTSD (Casella and Motta, 1990; Chung et al. 2003; Cox et al. 2004; Holeva and Tarrier, 2001; Jaycox et al. 2003; Lauterbach and Vrana, 2001; Lawrence and Fauerbach, 2003; Lee et al. 1995; McFarlane, 1996), or that they were higher on neuroticism and introversion (negative extraversion) (Bunce et al. 1995; Fauerbach et al. 2000; Fauerbach et al. 1996), which can mean that

[59] Most frequently Eysenck's EPQ or some of the previously mentioned instruments with the five-structure, and much less frequently some measure of neuroticism.

these personality dimensions can have a predictive value for the development of PTSD. We have found only one study that has discovered a significant relationship between PTSD and one additional personality dimension: agreeableness (A) (with N and E) (Talbert et al. 1993). However, the relationship between neuroticism and PTSD does not have to be so simple, since it is always possible to conclude that these studies "measured the consequences rather than the causes of PTSD" (Bramsen et al. 2000).

In two genuinely prospective studies on war veterans, increased values in the MMPI (Minnesota Multiphasic Personality Inventory) were predictive for the development of PTSD in Vietnam War veterans (Schnurr et al. 1993), while the pre-combat neuroticism was predictive for the development of PTSD in Second World War veterans (Lee et al. 1995). A study of the Dutch soldiers who had participated in peace-making missions in the former Yugoslavia matched their profiles in the Dutch version of the MMPI with posttraumatic pathology (Bramsen et al. 2000). The results have demonstrated that posttraumatic pathology had the highest correlations with the total number of stressors[60], personality characteristics (namely, "Negativism" and "Psychopathology"),[61] and respondent age.

A prospective study carried out in our country, on a sample of students from the Belgrade university, before and after the NATO bombing campaign, represents one of the few prospective studies that made use of the NEO PI-R on the civilian (albeit selected) population in several time points – before the trauma, immediately after the trauma and a year later (Knežević et al. 2005). The survey is a consequence of a good practice of regular psychological testing of students at the Department of psychology, while the unfortunate circumstances of 1999 served as an experimental context for prospective studies. Some findings of this study deserve attention for several reasons. First of all, *Neuroticism* (N) before the trauma (the bombing) had statistically significant (although low) correlations only with intrusion (from the Impact of events scale - IES), in both time points, but not with avoidance. No other dimension correlated with the IES measures, except *Openness* (O) that revealed a correlation with intrusion after the first year. This was a seemingly unexpected result, since it was logical to conclude that openness to experience (which, in theory, represents an increased capacity of processing of the most diverse kinds of experience) also facilitates the processing of unwanted, traumatic events. Nevertheless, the authors have offered some possible explanations of this phenomenon, from which we shall here stress the fact that O was high in the whole sample, which means that high levels of O perhaps acquire a predictive value. In their conclusion, the authors stated that it was "possible to

[60] Measured by a simple list of 13 items, without psychometric verification, except the test-retest reliability.
[61] The names of the scales come from the Dutch version of the MMPI.

speculate whether studies that measure posttraumatic personality tend to overestimate the relationship between personality traits and posttraumatic stress because of posttraumatic changes of personality or partiality that affects all the assessments effectuated in the same time" (Knežević et al. 2005).

Self- concept and exile

The problem of self-concept (and especially the problem of self-esteem) of refugees and immigrants has been discussed in a series of works (Ben-Porath, 1991; Espin, 1987; Hovey and Magaña, 2000; Hovey and Magaña, 2002; Finch et al. 2000; Noh et al. 1999; Liebkind and Jasinskaja-Lahti, 2000; Koomen and Frankel, 1992; Westermeyer et al. 2000). Most frequently, it turned out that refugees had a weak self-esteem. This finding is ascribed to different reasons, such as loss of social position (downward social mobility), since many refugees had to accept the jobs for which they were overqualified, i.e. the jobs much inferior to the ones they had in their home country (Ben-Porath, 1991). The situation resembles to the one we have in our country. For instance, many BBAs, MAs, PhDs or engineers work in the flea market.

A second possible reason is change of gender roles. Namely, it happens frequently that women find jobs before men (Ben-Porath, 1991; Espin, 1987), which in many cases threatens the traditional role of men as breadwinners, which, in turn, enfeebles their self-esteem. A third possible reason is maladjustment to the new culture and drift to the minority position, frequently followed by a rejective attitude of the domicile population (Espin, 1987; Finch et al. 2000; Noh et al. 1999; Liebkind and Jasinskaja-Lahti, 2000; Koomen and Frankel, 1992). The so-called "acculturative stress", low self-esteem, inefficient social support, lack of control over personal choices (i.e. impossibility of choice) and shift from the rural to the urban way of life are some of the factors significantly related to anxiety and depression disorders (Smith et al. 2002; Papageorgiou et al. 2000; Hovey and Magaña, 2000; Hovey and Magaña, 2002).

In spite of the existence of very strong stressors, it is by no means all refugees and emigrants who develop psychological disorders. On the other hand, the majority of these individuals experience in exile more or less difficulties that could hardly be labeled as pathological. In difference with the majority of other findings, Slodnjak et al. (Slodnjak et al. 2002) have in their study of 265 adolescent refugees from Bosnia found that they were less depressed and had higher self-esteem than their 195 Slovenian peers. Except that they expressed more sorrow and more concern about the future, the refugees did not manifest more behavioral problems or poorer school achievement. The authors concluded that interpretation of the relationship between depression and exile trauma has also to take into account cultural factors.

Some personal resources that might facilitate the overcoming of difficulties, such as resilience, experience of coping with adversity, imagination, internal locus of control, general self-esteem and impression of personal competence also play a prominent role (Beiser, 1990; Nicassio, 1985; van der Veer, 1998; Ahearn F., 2000).

Opačić (Opačić, 1995) has demonstrated that the system of self-evaluation plays a direct or indirect role in the following processes:

1. maintenance of a positive balance of well-being in time perspective;
2. maintenance of consistency through various roles in the regulation of aspirations, expectations and values (the choice of motives and their duration and intensity);
3. prediction of the effects of one's own and other people's behavior;
4. interpretation of the consequences of one's own and other people's behavior (locus of control);
5. choice of partners, friends and role-models (evaluation of others);

Opačić's statements are corroborated by some additional findings about the relationship between self-esteem, on the one hand, and locus of control (Elbedour et al. 1993; Knoff, 1986), hostility (general negative attitude toward others) and general satisfaction with life, on the other hand (Kaplan, 1982; Rosenberg, 1985). Results have demonstrated that the persons with a lower self-esteem are more likely to have a negative locus of control, a more negative attitude toward others and a lower general satisfaction with life.

RESULTS OF THE PRESENT STUDY

In this work, which bears the title of a preliminary report, we have decided to offer a review of the part of our research that refers to the differences between examined groups of refugees and returnees, leaving aside the complex relations with the domicile population, ethnic divisions or some more complex analyses of the significance of predictive factors. Our goal, therefore, was to discover the possible differences between refugees and returnees and ascertain whether these differences could be interpreted as an important psychological factor that affects the decision on repatriation or local integration.

The method and the procedures of investigation, the description of the sample and the instruments used in this study are described elsewhere in the monograph.

War stressors in refugees and returnees

Insight into the frequency of the traumatic events that our respondents had been exposed to and group differences, demonstrated in Table 1, offer some very valuable information:

1) there is a relatively important number of respondents from all three groups who had been exposed to some war-related stressful event(s);
2) all inter-group differences are significant, with the difference between refugees and returnees existing in 11 of the 20 enlisted categories of stressful events;
3) high percentages in the domicile population reveal a high exposure of this population category to war-related stressful events.

If we take the cumulative value of the frequency of exposure to all categories of stressors, all intergroup differences are statistically significant ($F_{tot}(2,1499)= 29,664$; $p=0,000$), and the same goes for the refugee-returnee differences ($F_{tot}(2,1499)= 26,751$; $p=0,000$). Quite simply: returnees had generally been exposed to a lesser number of various traumatic events than were the actual refugees.

If we analyze the categories of stressors on which refugees' and returnees' frequencies differ, assuming that the *kind* of war experience could also influence the decision on repatriation, we reach some very interesting conclusions. First of all, there are no statistically significant differences of the frequency of exposure to direct assault on the respondent (categories 3-6), serious injury in the course of war, "kidnapping or abduction" or "imprisonment". On the contrary, there are some very clear differences of the frequency of combat participation (No. 14), torture (No. 17), lack of food, water or shelter (No. 10 and 12), and injury or loss of a close person (No. 9, 15 and 16).

Table 1: *War stressors in refugees and returnees*

		P% N=527	I% N=501	D% N=463	Tot% N=1501	$F_{tot}(2,1499)$	P=	F_{ip} (1027,1)	P=
1.	Serious accident in the course of war	7,99	12,57	7,99	9,52	4,084	,017	5,969	,015
2.	Natural disaster in the course of war	0,37	2,40	0,22	1,00	7,505	,001	8,037	,005
3.	Non-sexual assault by known person	3,72	5,79	2,16	3,93	4,263	,014	2,477	,116
4.	Non-sexual assault by unknown person	11,52	10,18	7,13	9,72	2,836	,059	,483	,487
5.	Sexual assault by known person	0,19	0,20	0,22	0,20	,006	,994	,003	,960
6.	Sexual assault by unknown person	0,37	1,20	0	0,53	3,471	,031	2,316	,128
7.	Imprisonment	10,41	8,58	4,97	8,12	5,067	,006	1,003	,317
8.	Life-threatening disease	4,83	7,39	1,08	4,53	11,302	,000	2,970	,085
9.	Sudden death of a close person	8,74	15,17	6,48	10,19	11,033	,000	10,371	,001
10.	Lack of food or water	24,72	32,93	19,65	25,90	11,510	,000	8,609	,003
11.	Disease without possibility of getting therapy	10,04	9,78	4,10	8,12	7,310	,001	,019	,890
12.	Lack of shelter	24,91	41,92	11,45	26,43	62,660	,000	34,964	,000
13.	Serious injury	8,74	10,78	3,89	7,92	8,285	,000	1,232	,267
14.	Combat or shelling	61,15	70,26	61,34	64,25	5,951	,003	9,597	,002
15.	Knowledge of murder or violent death of a close person	36,62	45,31	28,73	37,08	14,466	,000	8,163	,004
16.	Disappearance or kidnapping of a friend or family member	28,62	33,93	12,31	25,37	33,421	,000	3,410	,065
17.	Torture	7,62	11,58	3,46	7,66	11,371	,000	4,722	,030
18.	Kidnapping, abduction	9,11	9,18	2,38	7,06	11,329	,000	,002	,967
19.	Other life-threatening war experience	35,32	32,53	24,84	31,16	5,264	,005	,893	,345
20.	Feeling of fear or peril because of witnessing to a war-related event	10,41	14,37	7,34	10,79	6,277	,002	3,777	,052

P=returnees; I=refugees; D=domicile population

These findings partially coincide with our earlier (still unpublished), seemingly paradoxical results that distress provoked by personal injury is relatively less important than distress caused by war-provoked deprivation, exactly like the experiences from the categories 10 and 12. The experience of torture,[62] in perfect accord with the results of earlier studies, was correlated with very high levels of posttraumatic pathology, and it is therefore by no means surprising that torture survivors are more frequent among those who have decided to remain in exile.

[62] We are quite aware that it was not identical with the experience of imprisonment

Moreover, there is a surprisingly high number of returnees who underwent torture, although they are statistically significantly less numerous when compared to refugees. This result is to be taken as especially important since it corroborates the idea that even the most traumatized individuals - who underwent the most severe forms of abuse at the hands of the opposite side - are to some extent, although in presently unclear circumstances, ready to return to their pre-war homes. We say "unclear circumstances", simply because we have not yet elucidated all the factors that conjointly affect the decision on repatriation.

Still, in our opinion, the most remarkable difference is the one of injury or loss of a closed person, given the fact that there is a higher number of people who had that experience among refugees. Unfortunately, the question that defines the category 14 ("shelling or participation in combat"), does not enable us to discriminate between the persons who actively participated in combat (as members of regular or irregular forces) and the civilians who had been exposed to combat by sheer coincidence (for instance, because being unable to leave a location under attack). A better discrimination between the two groups would have informed us if the persons who underwent these experiences were more reluctant to repatriate because they feared persecution, arrest or condemnation.

If we are to venture to portray, on the basis of these scant data, the kind of war-related experience that a typical refugee or returnee underwent, we might say that a typical refugee is a person who was more likely to have combat exposure or combat participation, and who, because of war, had experienced hunger, unprotected escape, frequent torture and loss of close persons. On the other hand, a typical returnee is a person who had equally been assaulted, arrested (and perhaps injured), but underwent less frequently these previously enlisted experiences.

Posttraumatic psychopathology in refugees and returnees

Table 2 contains the average values and standard deviations on three distinct IES-R scales, as well as the total values on this instrument, for all of the three groups under scrutiny. The table also contains the values obtained in the SRD-10, as well as the significances of all intergroup differences, and between refugees and repatriates especially.

Table 2: *Posttraumatic symptomatology in refugees and returnees, measured by the IES-R and SRD-10*

	M_p	SD_p	M_i	SD_i	M_d	SD_d	M_{tot}	SD_{tot}	F_{tot} (1074,2)	P=	F_{ip} (767,1)	P=
INTRU	1,6936	1,10903	1,7506	1,15888	1,6178	1,16192	1,6896	1,13993	1,091	,336	,481	,488
AVOID	1,7625	,93036	1,6705	1,02168	1,5809	,95968	1,6821	,96972	3,213	,041	1,696	,193
HYPER	1,5102	1,07268	1,5828	1,18832	1,3705	1,05208	1,4927	1,10617	3,051	,048	,786	,376
IES-R	5,0639	2,88056	5,3164	3,10964	4,7206	3,00841	5,0497	2,99877	3,895	,021	1,665	,197
SRD-10	1,0510	,91468	1,1710	1,06441	,8472	,84174	1,0298	,95177	9,597	,000	2,818	,094

INTRU=Intrusion subscale; AVOID=Avoidance subscale; HYPER=Hyperirritability subscale; IES-R= Total IES-R score; SRD-10=Total SRD-10 value; M=Mean value, SD=Standard deviation; P=Returnees; I=Refugees; D=Domicile population

We have to remark that the differences of the IES-R values of these two groups are not statistically significant, either on the subscales or on the instrument as a whole. There is, however, a small, mildly significant difference between the groups on the SRD-10. On the other hand, *all groups* reveal mutual differences on the avoidance and hyper-irritability subscales, as well as in the total IES-R values and there is also a clear, statistically very significant difference on the SRD-10.

The next question we tried to answer was whether we could assess the frequency of clinically important stress-related disorders in the respondent sample on the basis of the measured values. The instrument we used to measure posttraumatic simptomatology (the IES-R) does not make possible diagnosing of PTSD. However, it is possible to use the IES-R as a screening instrument that can identify the individuals with clinically important symptom levels. These persons very likely have PTSD and can be subsequently diagnosed by additional methods and clinical interview. An earlier, much more common version of this instrument was frequently used for this purpose (Sundin and Horowitz, 2002).

All our previous experience with the use of the "cut-off score" on the IES for diagnosing of PTSD reveals that this instrument does not have a good balance between sensitivity (the number of those who have a diagnosis and were detected as such) and specificity (the number of those who have not the diagnosis and were detected as having it). If the border value is set too high, sensitivity becomes insufficient (i.e. a large proportion of those with PTSD are not diagnosed), while, if the value is set too low, the proportion of the persons with PTSD diagnosis becomes hypertrophied.

In difference with the classical calculation of the border value, canonical discriminant analysis, among other things, makes possible prediction of group membership. This is obtained by the use of Fisher's classification coefficients. The bigger the number of the variables that serve as the basis of classification, the better the obtained classification. A major shortcoming of this procedure is that the

establishment of the regression equation demands a previously established accurate definition of diagnostic categories.

In order to calculate classification coefficients, we used the already existing data on 145 beneficiaries of the IAN Centre for rehabilitation of torture victims, for whom, aside from the data on the IES-R, we also had information from clinical interview, as well as the values on the *Clinician Administered PTSD Scale* (CAPS).[63] On the basis of the CAPS results, we have defined two groups: 1) the group with current PTSD and 2) the group without PTSD. Items from the IES-R were used as predictors for the establishment of group membership. In this way, we have obtained a canonical correlation of 0,628, significant at the 1‰ level[64]. On the basis of this function, 75.9% of cases were correctly classified (sensitivity 81%, specificity 69.5%), which represents the best possible linear classification this instrument can yield. Obtained in this manner, Fisher's classification coefficients were then used in our sample of 1502 respondents. That is how we used the IES-R items to assess the number of persons with PTSD in our sample.

Table 3 demonstrates the percentages of respondents classified on the basis of this procedure

Table 3: *Presence of posttraumatic pathology in respondents – classification according to the IES-R border value*

	Current PTSD	Without current PTSD	Total
Returnees	192 (35,7%)	346 (64,3%)	538 (100,0%)
Refugees	177 (35,3%)	324 (64,7%)	501 (100,0%)
Domicile population	127 (27,4%)	336 (72,6%)	463 (100,0%)
Total	496 33,0%	1006 67,0%	1502 100,0%

Table 3 makes possible to see the percentages of the examined groups that might correspond to the stress-related prevalence or, at least, serve as a rough estimate of the real prevalence. Relatedly, we have to remark that: a) there is a repeated finding of high values of the indicators of existence of posttraumatic psychopathology in all groups; 2) although intergroup differences do exist, returnee-refugee differences are not significant. The importance of these findings will be discussed later on.

The values obtained on the SCL-90-R and the significance of all intergroup differences (and especially the significance between refugees and returnees) are

[63] A structured interview for the assessment of PTSD symptoms which represents the "golden standard" in PTSD diagnosing

[64] These results will be demonstated elsewhere in the monograph.

demonstrated in Tables 4 and 5. Although all intergroup differences are significant for the majority of the questionnaire scales, refugees and returnees vary significantly on only two scales: *Hostility* (HOS) and *Psychoticism* (PSY). This becomes clearer if we consult the original interpretation of the meaning of these scales (Derogatis, 1994). The *Hostility* dimension refers to "thoughts, feelings or actions that are characteristic of the negative affect state of anger". It reflects the qualities such as aggression, rage, irritability and resentment. The *Psychoticism* dimension is constructed in a way so as to represent a continuous dimension of human experiences "from mild interpersonal alienation to dramatic psychosis".

Table 4: *Psychiatric symptomatology in refugees and returnees, measured by the SCL-90-R*

	M_p	SD_p	M_i	SD_i	M_d	SD_d	M_{tot}	SD_{tot}	F_{tot} (2,1166)	P=	F_{ip} (1,792)	P=
SOM	49.88	10,185	50.67	12,150	48.71	10,370	48,961	10,934	4.327	.013	2,378	,123
O-C	45.19	8,186	45.57	8,933	44.22	8,384	44,128	8,510	3.488	.031	,261	,610
I-S	48.42	8,060	49.38	9,058	47.81	8,081	47,743	8,408	2.618	.073	,908	,341
DEP	46.25	7,561	46.58	8,568	44.93	8,454	45,259	8,205	4.485	.011	,179	,672
ANX	46.58	9,092	47.89	10,259	45.61	8,890	45,700	9,446	4.732	.009	2,147	,143
HOS	50.35	8,232	51.94	9,837	51.34	9,393	50,540	9,149	2.251	.106	4,542	,033
PHOB	49.89	7,204	50.91	8,349	48.54	7,863	48,994	7,843	8.528	.000	1,946	,163
PAR	50.69	8,891	51.07	9,965	49.29	9,462	49,561	9,441	2.947	.053	,311	,577
PSY	44.70	8,704	46.33	9,825	44.34	9,164	44,283	9,246	4.464	.012	4,430	,036
ADD	48.15	8,553	49.06	10,430	47.14	9,306	47,031	9,447	4.074	.017	1,110	,292

SOM=Somatization; O-C=Obsession-compulsion; I-S=Interpersonal sensitivity; DEP=Depression; ANX=Anxiety; HOS=Hostility; PHOB=Phobic anxiety; PAR=Paranoid ideation; PSY=Psychoticism; ADD=Additional items; M=Mean value, SD=Standard deviation; P=returnees; I=refugees; D=domicile population

Table 5 contains the values and significance of differences between refugees and returnees on the SCL-90-R indexes. The significance of differences between refugees and returnees on the PST (*Positive Symptom Total*) and GSI (*Global Severity Index*) indexes, with the first group scoring significantly higher than the second one, on both indexes, means that refugees reported more symptoms than returnees and revealed a higher symptom severity level[65].

[65] The PST is a mesure of the number of symptoms assesed as positive by the respondent, while the GSI represents the sum of all values divided by the numer of questions (N = 90).

Table 5: *Values and differences in the SCL-90-R indexes*

	M_p	SD_p	M_i	SD_i	M_d	SD_d	M_{tot}	SD_{tot}	F_{tot} (2,1137)	P=	F_{ip} (1, 768)	P=
GSI	,8419	,62296	,9854	,80179	,7729	,66828	,8643	,70211	8,741	,000	7,812	,005
PST	41,0913	23,2913	43,6930	25,7429	37,1165	24,2832	40,6149	24,5182	6,699	,001	2,169	,141
PSDI	1,7289	,53431	1,8283	,66006	1,7192	,54778	1,7567	,58199	3,949	,020	5,341	,021

GSI=Global severity index; PST=Positive symptoms suffering index; PSDI=Positive symptoms total; M=Mean value, SD=Standard deviation; P=returnees; I=refugees; D=domicile population

Personality characteristics of refugees and returnees

As Table 6 demonstrates, although there are some intergroup differences on the *Neuroticism* (N) and *Openness* (O) scales, there are no significant differences between refugees and returnees. However, differences again became significant when the domicile population group was taken into analysis. If we compare the values of the domicile population and refugees only, the difference on these two scales becomes much clearer (*Neuroticism*: $F_{i\ d}(1,760)= 5,203$, $p=0,023$; *Openness*: $F_{i\ d}(1,760)= 6,134$, $p=0,013$). As the latest finding will not be comment here, we only have to remark that we have not established significant differences between returnees and refugees in the personality characteristics measured by the given instrument.

Table 6: *Values of the NEO FFI domains and significances of intergroup differences*

	M_p	SD_p	M_i	SD_i	M_d	SD_d	M_{tot}	SD_{tot}	F_{tot} (2,1160)	P=	F_{ip} (1,777)	P=
N	31,968	6,846	32,532	8,326	31,125	8,692	31,873	7,991	3,005	,050	1,072	,301
E	38,708	5,954	38,950	5,734	39,073	6,577	38,907	6,095	,364	,695	,332	,565
O	36,175	4,724	36,251	4,788	37,128	4,975	36,514	4,844	4,650	,010	,051	,822
A	39,708	4,182	40,026	4,290	39,820	4,676	39,849	4,383	,524	,592	1,099	,295
C	44,419	5,964	44,971	6,324	45,193	6,610	44,854	6,303	1,576	,207	1,572	,210

N=Neuroticism; E=Extraversion; O=Openness; A=Agreeableness; C= Conscientiousness M=Mean values, SD=Standard deviation; P=Returnees; I=Refugees; D=Domicile population

Self-concept in refugees and returnees

Bearing in mind the previously exposed results, one could assume that refugees, returnees and the domicile population, taken as groups, will vary in their general image of the self (*self-image*), impression of general competence (*self-efficacy*), degree of disenchantment with human nature (*misanthropy*), impression of control over one's own life (*locus of control*) and general satisfaction with one's own life (*well-being*). Excepting the results obtained by Slodnjak et al. (Slodnjak et

al. 2002), we can expect that the domicile population will have a higher self-esteem, a stronger feeling of personal competence, a stronger impression of control over one's own life, less hostility and a globally stronger general satisfaction with one's own life. It can equally be assumed that returnees (when compared to refugees) will have a stronger feeling of personal competence and a more internal locus of control.

The results exposed in Table 7 partially confirm these assumptions.

Table 7: *Values of the self-concept dimensions and significances of intergroup differences*

	M_p	SD_p	M_i	SD_i	M_d	SD_d	M_{tot}	SD_{tot}	F_{tot} (2,1035)	P=	F_{ip} (1,777)	P=
Self-image	3,348	,571	3,421	,553	3,394	,625	3,386	,583	2,044	,130	4,268	,039
General competence	3,479	,606	3,388	,724	3,625	,698	3,494	,682	14,989	,000	4,799	,029
Externality	3,204	,613	3,328	,656	3,140	,681	3,225	,653	10,599	,000	10,028	,002
Misanthropy	3,254	,673	3,293	,725	3,194	,776	3,248	,724	2,251	,106	,794	,373
Quality of life	4,198	,772	4,229	,767	4,463	,728	4,290	,766	17,657	,000	,432	,511

M=Mean value, SD=Standard deviation; P=Returnees; I=Refugees; D=Domicile population

Although the expected tendency was present, we could not affirm that the three groups under scrutiny significantly varied in their general attitude toward others. All that we could conclude on the basis of arithmetic means was that all the three groups have a negative image of human nature. Similarly, we could not discover any difference in their general self-image. On the other hand, there were some differences in the global impression of personal competence, perception of control over one's own life and general assessment of life quality. In this respect, the lowest results were found in refugees, followed by returnees and then by the domicile population, with the exception of assessment of the general quality of life, estimated as being poorest in returnees and not in refugees.

Differences between refugees and returnees are of more interest to us. Our assumptions about the general competence and locus of control have been confirmed. The difference in the perceived quality of life has disappeared, which means that that the general difference between these three groups can be ascribed to the difference between refugees and returnees, on the one hand, and the domicile population, on the other hand.

Although it is methodologically questionable to analyze partial differences when the global ones are absent, it is remarkable that, when compared to returnees, refugees have a significantly better self-image, and this is something worth analyzing. Refugees, therefore, are those who more often have a positive opinion about their welcome in the host environment and their personal appearance, strength and intelligence, but simultaneously feel that they are not able to achieve much and make significant changes in their lives. This gap between the global self-

esteem and the global competence is bridged through externalization of the reasons that caused their actual situation. Although their attributions of reasons are largely correct, we cannot but remark that the same reasons existed with returnees as well. It seems that this self-impression of refugees represents a reflection of their defense position ("I am good, but the world is bad"). It is, therefore, an inauthentic self-image that we have here – an image not founded on personal successes and achievements but defenses and devaluation.

Subjective assessment of psychological state and help seeking

Table 8 summarizes answers to the questions from the General questionnaire about psychological status, help seeking and needs for assistance, before the war and in the moment of study. These data basically speak about a dramatic difference between the pre-war assistance needs and the assistance needs in the moment of study. Graphs 1 and 2 offer a visual presentation of this change.[66] The results do not call for an additional explanation and their importance will be discussed soon.

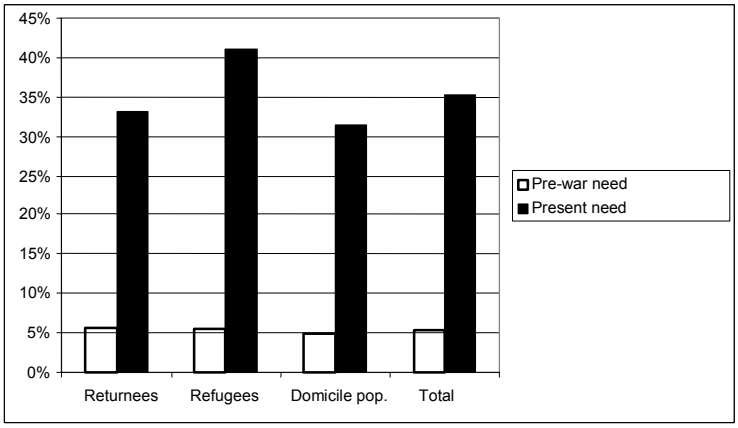
Table 8: *Subjective assessment of psychological state, and data on help seeking*

QUESTION		P	I	D	Total
1. Before the war/exile, did you feel a need to consult a doctor because of your psychological problems?	yes	5,6%	5,4%	4,8%	5,3%
	no	94,4%	94,6%	95,2%	94,7%
2. Before the war/exile, did you consult a doctor because of your psychological problems?	yes	3,9%	4,6%	3,3%	4,0%
	no	96,1%	95,4%	96,7%	96,0%
3. Used you to take tranquilizers before the war/exile?	yes	7,5%	8,4%	6,4%	7,5%
	no	92,5%	91,6%	93,4%	92,5%
4. Do you feel a need to talk with an expert about your present psychological state?	yes, a great need	8,9%	11,1%	6,6%	8,9%
	yes, but not such a great need	24,3%	30,0%	24,8%	26,4%
	don't know	15,1%	13,6%	13,6%	14,1%
	no	51,8%	45,3%	54,9%	50,6%
5. Do you take tranquilizers now?	yes	29,2%	29,8%	27,0%	28,7%
	no	70,8%	70,0%	73,0%	71,2%
6. When compared with the pre war/exile period, your present psychological state is:	much worse	18,1%	22,0%	13,1%	18,1%
	somewhat worse	41,1%	43,9%	37,6%	41,1%
	the same	33,6%	30,1%	44,8%	35,4%
	somewhat better	5,4%	3,8%	3,6%	4,4%
	much better	1,7%	,2%	,8%	,9%
7. When compared with the pre war/exile period, you feel that your present life situation is:	much worse	52,6%	48,0%	34,8%	45,6%
	somewhat better	30,9%	36,7%	41,1%	36,0%
	the same	11,0%	11,2%	18,4%	13,4%
	somewhat better	4,7%	4,0%	4,6%	4,4%
	much better	,7%		1,1%	,6%

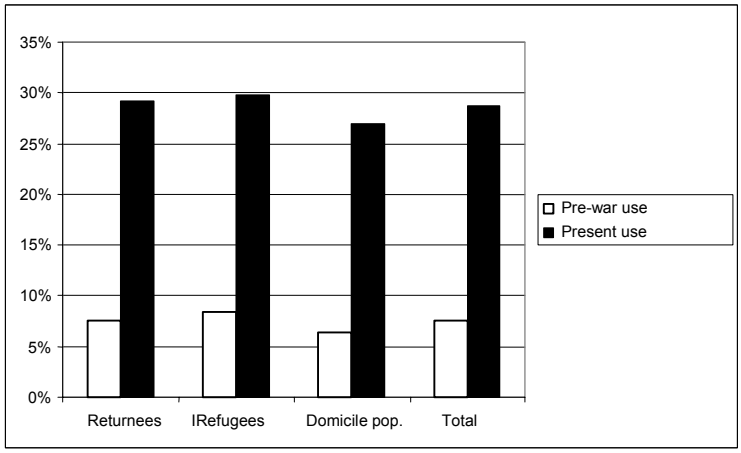
P=Returnees; I=Refugees; D=Domicile population

[66] We summed all the positive answers (in various degrees) to the question No. 4 ("Do you feel a need to talk with an expert about your present psiychological state?")

Graph 1: *Subjective impression of the need for psychological help*



Graph 2: *Use of psychotropic medication*



DISCUSSION

Before we start discussing particular results, and before we offer their tentative synthetic interpretation, we have to express a general impression that we had in the whole course of the study – impression of a persistent poignancy of war events and of disastrous effects of the psychological consequences of war, years after experiencing trauma. This study, which is, we believe, methodologically solid and sufficiently comprehensive to represent, at least partially, the picture of the psychological reality of the posttraumatic condition of the former Yugoslavia, offers insight into the scope of human suffering and ordeal that took place in the Yugoslav wars of the 1990s. Two thirds of our respondents (64,25%) were, in their

own words, exposed to combat or shelling, while huge percentages of the respondents reported "murder or violent death of a close person" (37,08%), or "disappearance or abduction of a friend or family member" (25,37%). Even the most extreme forms of trauma, such as imprisonment and torture, were expressed in significant percentages (7,66% and 8,12%). A third of the respondents precisely (33%) reported the symptoms of PTSD, the severity of which could be classified as current PTSD. In other words, it can roughly be stated that these individuals suffer from stress-related disorders! Almost a third of the respondents (28,7%) use tranquilizers, while a saddening minority experiences their situation as the same (13,4%) or somewhat better than their pre-war situation (4,4%). Therefore, we have to conclude again that the real psychological consequences of war experiences should be understood as a permanent aggravating factor in the processes of reconciliation, repatriation and adjustment in the posttraumatic period – a factor that can maintain its destructive influence even decades after the original traumatic experience. As so many times before, we are faced with the fact that war suffering cannot be "forgotten" or denied politically, socially or medically. After immensely destructive experiences of the Yugoslav wars of the 1990s, only real and comprehensive insight into various aspects of the posttraumatic life of the population and skillfully designed programs of social assistance, empowering, prevention and rehabilitation can lead to a genuine healing.

In the psychiatric/psychological sense, we do not have relevant epidemiological data for the assessment of real needs. Namely, we lack data on the most frequent comorbidity disorders (depression; substance abuse), as well as data on chronic, particularly disabling disorders such as schizophrenia and bipolar disorder. Besides, our study did not include children and the young and our research and sample design could suggest that perhaps some other high-risk groups have been omitted as well. Our attempt to ascertain the rates that would serve as indexes of the prevalence of stress-related disorders can serve as a rough orientation. Still, if we compare our data on drug intake (table 8, item 5) with the percentage of the respondents classified by this method into the group with current PTSD (table 3), we can see that deviations are reduced to few percents (4% in the whole sample). This can speak in favor of the validity of the chosen method of assessment and its practical value in the process of screening in similar research situations. But, much more important, these results reveal huge percentages of the population exposed to psychological suffering. Strategically, the findings represent yet another proof of the necessity of realization of serious epidemiological studies that would ascertain the real psychological/psychiatric consequences of the Yugoslav wars in the posttraumatic period. We also have to make one critical remark: the absence of similar studies in the three countries where we have effectuated our survey cannot be justified by the lack of financial or human resources since, as far as we know, these have generously been used for programs of often unclear practical value and utility. Ideally, the real data on the human

consequences of the Yugoslav wars could reveal yet another part of the real price of the political projects of the 1990s, paid by thousands of the dead and permanently disabled.

Our results reveal that the persons who remained in exile vary in the kind and number of traumatic experiences but not in posttraumatic pathology. Differences on the *Hostility* and *Psychoticism* scales of the SCL-90-R point out to possible differences in impression and management of aggressive impulses, as well as to differences in social withdrawal and isolation. Although these characteristics can also bee seen in the PTSD picture, they correspond much more to chronic, permanent personality changes, described within the complex PTSD or DESNOS constructs. This opinion is substantiated by a mild (but still significant) difference in stress-related dissociative symptomatology, measured by the SRD-10 scale. If, therefore, we were to issue a judgment on the kind of psychopathology that could, at least partially, influence the decision on repatriation, we would have to divert our attention from PTSD in its clinically defined form (as measured by the IES-R) to some more complex patterns of permanent post-catastrophic personality change. Correspondingly, our NEO-FFI findings reveal that there are no significant differences between refugees and returnees on personality dimensions, which are innate, as it is assumed.

When these results are supplemented with data on self-concept (and this concept is one of the possibly most important indicators of permanent post-catastrophic personality change), intergroup differences become much more visible. The complex interaction of impression of personal competence, self-esteem and locus of control, which we have obtained here, suggests that, in the course of time, the actual exile can become the *psychological* exile. In other words, passivity, impossibility of active participation in the creation of one's own life and dependence on external (usually adverse) circumstances can lead to a "vicious circle", the exit from which is sought not in the transformation of the actual condition but in the quest of an another support and rationalization of passivity. Although this picture is set deeply in the social field (and its causes are perhaps unbreakably related to other vital circumstances that affect personal decisions, including the one on repatriation), our results suggest that psychological factors must not be neglected.

CONCLUSION AND RECOMMENDATIONS

In short, we can say that there are significant psychological differences between returnees and the persons who decided not to repatriate. These differences lie in the domain of traumatic experiences, as well as in the domain of psychopathology that in all probability belongs to the area of permanent post-catastrophic personality change. Besides, our results make possible to form a clearer picture of the magnitude of the problem. They also call attention to the need

to investigate the psychological/psychiatric consequences of war sufferings through serious epidemiological studies. Moreover, it seems that the totality of our results offers a rather clear picture of the directions that future psychosocial programs for refugees should take. The priorities reside in an active confrontment with posttraumatic sequelae and development of long-term goals for the establishment of internal locus of control, which implies assumption of the responsibility for the development of one's own potentials and enhancement of global competence through development and realization of a life plan that would consist of small steps and clearly operationalized goals.

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