BOSNIAN REFUGEES IN CANADA:
TRAUMA, RESETTLEMENT AND HEALTH IN TEMPORAL PERSPECTIVE

by

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A thesis submitted in conformity with the requirements for the degree of Master of Science, Graduate Department of Community Health, Department of Public Health Sciences, in the University of Toronto

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ABSTRACT

It has been assumed by many investigators of refugee health that refugees, due to stresses associated with trauma and resettlement, experience more pathology and resulting poor health than host populations. However, because contradictory findings have emerged from some of these studies, a clear connection between the experiences of trauma, resettlement and their influences on refugee health remain ambiguous. The goal of this study was to put aside initial assumptions pertaining to the health of Bosnian refugees. Rather, health was largely defined by participants through personal perceptions, accounts and descriptions of their experiences pertaining to trauma and resettlement and how these experiences influenced their health over time. A snowball sample of ten Bosnian refugees was selected according to age, gender and period of time spent in Canada. Each participant was visited on three separate occasions over a 9-week period, in order to collect information and data pertaining to their health. The methodology was primarily qualitative with informal, unstructured, indepth interviews. However, investigator observations as well as formal, structured health and demographic data were also gathered in order to augment and validate the interview information.

This research has shown that the participants in this study faced suffering, adversity, and resettlement challenges that posed risks to their health over time, yet all verbalized and were observed to be experiencing adequate health and function. That is, all participants were independently performing the activities of daily living, working and/or upgrading their skills, caring for themselves and/or their families, establishing new social supports, making realistic plans for the future and using the health care system sparingly. The positive health experienced by participants in this study appeared to be largely due to interactions between personal, psychosocial, and cultural characteristics with life events over time. These interactions modified the health risks associated with trauma and forced resettlement and contributed positively to the health and function of the participants in this study.
ACKNOWLEDGEMENTS

This thesis began as a straightforward task. In the beginning I was sure of my destination. However, after encountering many unanticipated deviations, twisting and turning paths, and some very rough waters, my journey ended in quite a different place.

My thanks go to Professor Joan Eakin, and in particular to my supervisor, Professor David Coburn who assisted me in thesis development and completion.

My thanks also to my best buddy, MB, for his ongoing practical advice and assistance.

And finally, to my children who supported me all through this odyssey with their quiet, unquestioning and unfailing support.
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CHAPTER 1

INTRODUCTION

This study focusses on the health of Bosnian refugees and their experiences of trauma, uprooting and forced resettlement. Bosnian refugees are victims of a war characterized by ethnic cleansing and genocide. Since they are recent arrivals to Canada, it is important to begin to build an understanding pertaining to how past trauma and the stresses of forced resettlement might have affected the health of this group. The findings may also be relevant for similar groups of refugees from other countries. For the purposes of this study, health was defined as the ability to successfully engage in the activities of daily living, to set realistic personal, professional, and social goals and to engage in behaviours that focussed on meeting these goals.

Most of the past literature pertaining to refugee health has demonstrated that refugees have higher rates of poor health than their host populations (Ajdukovic and Ljubotina, 1995; Mollica, et al, 1992; Allodi, 1990; Mollica, Wyshak, and Lavalle, 1987; Allodi, 1982, 1980). While the literature is replete with analyses of refugee experiences that lead to stress and illness, there is little understanding of the exact relationship between trauma and health. Most investigators have made a number of questionable a priori assumptions pertaining to study outcomes by: a) emphasizing negative health outcomes, b) failing to explicate all of the potential components unique to the experiences of trauma and resettlement and their influences on health, and c) failing to account for adequate coping and positive health. A further limitation of existing research pertaining to refugee health, is that most studies used static and/or standardized outcome measures such as clinical morbidity and health function. This presents a problem because outcome measures or indicators alone do not elucidate the process by which refugee health is composed but merely documents a relationship. Consequently, the dynamics that might reveal how trauma and forced resettlement could influence refugee health remain ambiguous.

The assumption that most refugees suffer poor health is at
best, overly simplistic and at worse, biases analyses towards a pessimistic view of refugees (Scrignor, 1984). Consistent with some recent findings, it can no longer be assumed that trauma and resettlement have deleterious consequences on the health of all refugees (Edwards and Beiser, 1994; Weeks and Rumbaut, 1991). Consequently, an alternative approach might be to speculate on the possibility that trauma and resettlement can present both opportunities and risks that might result in differing levels of health for some refugees or refugee groups. However, in order to investigate this possibility, the context of individual experiences, their meanings, as well as factors related to health and coping over time ought to be established (Moos and Schaffer, 1986; Moos, 1985, 1984). For example, it could be that the meaning of phenomena change over time and these changes in turn enable some refugees to overcome challenges that initially posed risks to their health. Hence, in order to understand the process whereby some refugees can transform and transcend disastrous life experiences and still maintain positive health, it is crucial to link the differential levels of health with life experiences and associated meanings over time.

1.1 STATEMENT OF THE PROBLEM

Although many investigators have assumed that refugees have higher rates of ill-health than their host populations, there is enough contradictory evidence to warrant further investigation. Rather than simply conceptualizing refugee health as a static state characterized by pathology, it might be more pertinent to perceive health as a multidimensional process. This process might consist of shifting health patterns over time that includes interactions between changing experiences, associated meanings, and personal and sociocultural characteristics. Determining the interactions amongst these factors might point to the role such interactions play in modifying health in positive and/or negative ways. This type of investigation could be carried out by gathering information pertaining to subjective, indepth, individual reports of past, present, and anticipated future experiences (ongoing life events, tasks and situations), the meanings participants attached to these experiences, and pertinent objective data such as questions and
observations pertaining to personal, psychosocial, and cultural characteristics. The subjective information and objective data when combined, could reveal health patterns that might provide insight into the processual relationship between health and modifying influences over time. That is, since the present is influenced by the past and anticipated future, individual health has to be viewed in relation to these particular contexts. Identifying contextual patterns would reveal information pertaining to specific life experiences and events that influence health over time.

The thrust of this study is to investigate the nature of health as a process in relation to Bosnian refugees who have been forcefully uprooted from their country of origin and who have resettled in Canada. In addition, study of this particular group of (previously) middle class refugees may give us a better understanding of how some groups of refugees differ from others. That is, most research has been carried out on refugees from far less developed areas of the world, whereas, the refugees in this study came from a relatively advanced country in Central Europe. Simply describing the experiences and reactions of such a group will be a useful addition to the literature.

1.2 PURPOSE OF THE STUDY

The purpose of this study is to:

a) Describe the experiences and reactions of refugees from a 'developed' country.

b) Reach an understanding, through personal descriptions and objective data, of the ways in which the experiences of trauma and forced resettlement might influence the health of Bosnian refugees over time.

1.3 REFUGEE DEFINED

The mandate of the Office of the United Nations High Commissioner for Refugees (UNHCR) established in 1951, focussed on the protection of refugees. Initially, a refugee was defined as an individual who had been forced to leave her/his country of origin due to a well-founded fear of persecution related to race, religion, nationality, membership in a particular group, or holding certain political opinions (Vernez, 1991). However, it became apparent that this definition failed to encompass group movements in response to
generalized violence in the third world and developing countries. Consequently, in 1967, the UNHCR revised and expanded on their original mandate to include individual or groups of refugees who were victims of forced displacements outside of European boundaries (UNHCR, 1970).

This study has used the United Nations definition, which has been largely adopted by Employment and Immigration Canada (1989). That is, a refugee is defined as an individual who has been persecuted psychologically and/or physically and, as a result, was forced to leave her/his country of origin for her/his own safety or that of her/his family. Since persecution of an individual can lead to physical and/or psychological trauma, conceptually, the term "refugee," includes an assumption of cruelty and/or threatened cruelty. The Bosnian refugees in this study indeed did experience and/or were physically and psychologically threatened through ethnic cleansing (physical violence, arbitrary imprisonment, systematic torture, rape, forced uprooting, deportation, psychological suffering) and genocide (attempts of deliberate extermination). These experiences compelled them to leave their loved ones, homes and country for their own safety or that of their families.

1.4 Significance of the Study

Since the recent disintegration of the former Soviet Union and the rapid breakdown of Communist society, territorial conflicts such as that experienced by Bosnians have the potential to occur between other ethnic groups in developed countries in Eastern Europe and elsewhere. Given that so many Bosnian refugees have resettled in Canada since 1992, in order for Canada to form realistic and effective health and social policies, information on the health of this population is essential.

Despite the many studies that have assumed pathology in refugees, serendipitous findings warrant further investigation into the possibility of good health as well. The results from a study of this nature might be three-fold. Firstly, policies aimed at specific, self-identified strengths, difficulties and needs might avoid assuming ill-health and result in considerable savings to the health care system. Instead of assuming that all Bosnian refugees are prone to poor health and/or dysfunction and tailoring policies
accordingly, it would be more cost-effective to elicit the opinions of individual refugees pertaining to what they perceive to be their strengths, difficulties and needs. Secondly, by focussing policies on individual self-reported health and function, individuals would be active participants in their resettlement strategy leading to empowerment and easing somewhat, specific difficulties faced in this period. Thirdly, placing an emphasis on strengths, good health and function would present Bosnian refugees in a positive light within Canadian society and help to counter existing negative attitudes towards refugees.

Summary

Research pertaining to refugee health is not abundant, and that applicable to Bosnian refugees is almost non-existent. Even so, there are major problems in the assumption underlying these studies and the interpretation of their findings. For example, adopting a beginning assumption that trauma and forced resettlement inevitably leads to poor health, and the portrayal of health as a fixed entity frozen in time, narrows and limits investigations. Since it has been shown that refugees can share the same experiences, but that these experiences can lead to varying levels of positive and negative health, the following question arises, "How can these contradictory findings be explained?"

Since the environment is everchanging, so too are individual life experiences, associated meanings, and personal and sociocultural characteristics. That is, since present realities are simultaneously affected by memories of the past and anticipations of the future, what needs to be clarified is the process of ongoing interactions between experience, associated meaning, personal and sociocultural characteristics and health over time. Consequently, in order to reach an understanding of the specific influences of trauma and forced resettlement on the health of refugees, health must be portrayed as a process.
CHAPTER 2

LITERATURE REVIEW

In order to provide a foundation for this investigation of refugee health, a discussion of the literature pertaining to trauma, forced resettlement and the concepts of health, temporality and meaning will be discussed in this chapter.

2.1 CONCEPTUALIZATIONS OF HEALTH

a) Sources and Models

Almost fifty years ago the World Health Organization defined positive health as, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (1947). This conceptualization emphasized the multi-dimensional nature of health but was so encompassing that it made it difficult to separate health from other phenomena (Callahan in Wondolowski and Davis, 1991). Thirty-seven years later, this definition was modified to emphasize health as a resource. Health was described as, "the extent to which an individual or group is able, on one hand, to realize aspirations and satisfy needs; and on the other hand, to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living; it is a positive concept emphasizing social and personal resources, as well as physical capacity" (WHO, 1984). This definition identified particular aspects of individual and community health, quality of life and empowerment, but was still general in its scope. That is, the definition of individual and group health as a positive resource was clearly stated, but little was said about how to attain it.

The conceptualization of health in Canada initially grew out of the traditional WHO definition in which health was seen simply as the absence of disease, to one in which individuals are enabled to control, and improve their health. In his report, "A New Perspective on the Health of Canadians", Lalonde (1974) defined health as an individual right and a part of everyday living that enhanced the quality of life. From this perspective, health was seen not merely as a result of curing illness, but as a fluid and dynamic daily force influenced by individual values, beliefs, culture, circumstance and environment (physical, social and economic). The Ottawa Charter (1986) enhanced LaLonde's
conceptualization to include specific health pre-requisites for individuals and groups, such as peace, shelter, education, food, income, stable eco-system, sustainable resources, social justice and equity.

There are many other perspectives, sources and models of health. For example, Fylkesnes (1992) believed that health had physical, psychological and social dimensions and was related to lifestyle. Parse (1991, 1989) argued that health was co-created through relationship patterns with individuals and the environment, was a personal commitment, and a synthesis of values. Bergner (1985) believed that health was comprised of five interdependent dimensions (genetic, biochemical, functional, mental state and health potential). Phillips (1989) felt that there were no universal health norms but rather that health was reflected in how individuals perceived and actualized their potentials through actions and decisions that were based on individual values.

While most of the above perspectives of health grew out of or were elaborations of the original WHO definition of 1947, all shared a common trait, that of understanding and defining health. This task often led to an objective cataloguing and description of the conditions within as well as outside of the individual that were believed to influence health. Only rarely was there an effort to elicit subjective components of health through personal descriptions of experiences and associated meanings. Further, this approach often consisted of evaluating health at one point in time and rarely considered health as an evolving, dynamic and changing process. Yet, if health is in constant flux in relation to changing environments and experiences, to portray health as a static state produces a very narrow understanding of its dynamic, comprehensive, and multidimensional nature.

2.2 INVESTIGATIONS OF REFUGEE HEALTH

Refugee health has been investigated by many experts in the psychological, medical and social sciences. The thrust in psychological and medical research has been on mental and physiological function and behaviour (Beiser, Johnson, and Turner, 1993; Beiser, Turner, and Gonesan, 1989; Allodi, 1990, 1989; Kolk, van der, 1987; Mollica, Wyshak, and Lavalle, 1987; Young,
Sociological investigations have examined refugee groups and their organization (Williams & Berry, 1991; Desantis, 1990; Hull, 1979). These disciplines have contributed valuable knowledge that has led to an understanding of the difficulties that refugees experience and how these difficulties negatively influenced their health. A common theme was that refugees suffered adjustment problems and challenges that resulted in physical, social, and/or psychic ill-health and/or dysfunction. For example, it was established that former victims of persecution and trauma suffered psychological disability, sleep disturbances, poor health and dysfunction that resulted in pathologic anxiety and an inability to perform simple, daily tasks (Ajdukovic & Ljubotina, 1995; Mollica, et al, 1992, 1990; Mollica, Wyshak, de Marneffe, Khouon, and Lavalle, 1987; Allodi, 1986; Allodi & Rojas, 1985; Eitinger, 1985; Scrigner, 1984). The major assumption of these and many other investigators was that refugees, due to the nature of their traumatic and resettlement experiences, were susceptible to developing some form of ill-health and dysfunction that required treatment.

While many studies pertaining to refugee health have primarily assumed ill-health and dysfunction, serendipitous outcomes have at times, emerged. For example, it was found that certain new arrivals were able to cope as well as they had before migrating; infants born to Indochinese refugee women, children of European newcomers, and many Southeast Asian refugee youth experienced good health, adapted and prospered; there was a lower mortality rate among newcomers of three ethnic groups then among resident populations; some refugees who survived persecution, suffering and hardship were found to have experienced increased emotional maturation, and were able to carry on a normal life once resettled (Edwards and Beiser, 1994; Weeks and Rumbaut, 1991; Young, 1987; Eitinger, 1985; Moos 1985, 1984; Ziegler and Kelner, 1981; Hull 1979). While these surprising and unexpected outcomes were contrary to the investigators' initial assumptions, they provided evidence that some refugees, despite having been exposed to severe trauma and the stresses of forced resettlement experienced good health and function.
A growing number of researchers have recognized difficulties with an approach that primarily focuses on ill-health and dysfunction in refugee populations and instead, have concentrated on identifying good health and function. For example, Nann and Dean (1977) cautioned about the drawbacks of research which delved only into the negative aspects of refugee health and pointed to the positive gains from refugee resettlement, such as their contributions to host countries. Other investigators found that surviving human cruelty, being forceably uprooted and resettled, although traumatic and stressful, did not necessarily result in illness (Beiser in Williams and Berry, 1991; Ochberg, 1988; Kuo & Tsai, 1986; Rose, 1983). These investigators claimed that in spite of suffering trauma and the hardships and stresses of forced resettlement, many refugees experienced adequate health and function, were motivated to improve their situations, and to take advantage of the opportunities a new country had to offer them by successfully rebuilding a new life.

To focus investigation primarily on the discovery of either negative or positive health and function, presents a unidimensional and overly simplistic view of refugee health. Since refugees most likely possess some combination of positive and negative health, studies that do not explore both fail to recognize that the influences of refugee experiences on health represents a multidimensional, complex process that unfolds over time. This process consists of past, present, and anticipated life events that can present opportunities and risks, and to assume one at the expense of the other fails to recognize health as a fluid, dynamic, fluctuating and evolving process with many dimensions.

In my past experience as a community nurse I noted that while the refugees I visited had endured a great deal of suffering, most quickly found employment and housing, learned English, determined what health and social benefits were available to them, were well-nourished, used the healthcare system sparingly, and possessed a hopeful outlook for the future. Further, their children established friendships with their Canadian peers, and performed well at school. In listening to the stories of these refugees from different countries, it became apparent to me that while all were struggling
to come to terms with past trauma as well as the ongoing stresses associated with forced resettlement, many verbalized and appeared to be experiencing positive health and function and rapidly adapting to life in a new country. However, while most refugees coped well and experienced positive health and function, others did not. Indeed, even among those who either coped well or did not, there were different degrees of health and function. This observation caused me to reflect on whether certain personal, psychosocial and cultural characteristics might be capable of modifying the deleterious effects of traumatic and stressful experiences. If this were the case, then it would be important to determine what these characteristics were and how they interacted with life experience to produce differing interpretations of events and health outcomes.

As noted in Figure 1, the components that constitute a contextual health pattern (experience, characteristics, meaning and health) are in constant flux in relation to ongoing events and life experiences, hence, these patterns are fluid, evolving, and ever-changing. For example, while individuals can experience the same event, how this event is experienced could depend on the meaning attributed to it. The attributed meaning in turn, could be largely influenced by individual characteristics. It is these dynamics that could influence and modify health between, as well as within individuals, in either positive or negative ways.

Since experience, meaning, and personal, psychosocial and cultural characteristics can change over time, the contextual pattern of an individual’s health might also change. For example, trauma and forced resettlement represent abrupt life changes. The meaning of these life changes, through interaction with individual characteristics might be altered and in turn, increase or decrease the threats posed to health. If this were the case, then it would be important to determine the contextual patterns of refugees’ health over time in order to understand the significant interactions between experience, meaning and characteristics, that influence health and function. For example, different contextual patterns might be evident before and during the experience of trauma, and upon resettlement. These patterns might be further influenced by each individual’s anticipated future. If this were the case, then
Possible Influences on Health

Contextual

Experiences

Personal, Psychosocial & Cultural Characteristics

Meaning

Pattern

HEALTH
health is a process that can only be fully understood within the ongoing contexts of life experience.

In sum, while many studies have focussed on identifying ill-health and dysfunction in refugees, some investigators have found evidence that refugees, in spite of the many difficulties and challenges faced, have experienced adequate health and function. However, whether studies have advanced assumptions of positive or negative health in refugees, the focus on only one or the other has unnecessarily restricted the findings. While most refugees likely possess different degrees of positive and negative health and function, little is known about how some are able to transform traumatic and stressful life events into experiences that do not pose serious threats to health. It could be that some refugees with particular characteristics, when faced with new and challenging life situations and events over time, might somehow interpret these experiences more positively and cope better. Hence, identifying a series of contextual health patterns could provide an understanding of how some refugees are able to transform and transcend traumatic life events and the stresses of forced resettlement, and still maintain positive health.

2.3 INVESTIGATOR’S CONCEPTUALIZATION OF REFUGEE HEALTH

It is my belief that in order to reach a comprehensive understanding of refugee health, it is important to identify and link shifting contextual health patterns formed by the interactions between personal, psychosocial and cultural characteristics, changing experience and associated meanings. The personal description, explanation and interpretation of individual experiences, (their importance, significance and value) and their interactions with certain characteristics over time, might reveal the nature of refugee health as well as how it is maintained. For example, these dynamics are portrayed in a narrative by a survivor of a concentration camp in Bosnia (Ali and Lifschultz, 1993). This prisoner described the overcrowding in inadequately ventilated buildings, lack of fresh water and very little food that led to extremely poor hygiene and health. Most prisoners lost up to 30 kg. of weight in a very short period of time, experienced repeated bouts of dysentery, and became infested with lice. Regular, systematic,
and brutal beatings in which men were often beaten to death were commonplace. Injuries produced by beatings and torture resulted in cuts, abrasions, fractures and amputations of body parts for which there was little or no medical attention. Inmates experienced overwhelming stress as they never knew when their next beating might occur or whether or not they would survive it. Bosnevic, who used a pseudonym in order to protect relatives still living in Bosnia wrote,

All the time my only thought was how to survive, assuming I had the good fortune not to be killed outright. I am convinced that it was only some inner stability that saved me. I created this island of stability by singing, by keeping my sense of humor, and by thinking of my family. In the end, a man needs to realize that he is alone in the world and that the only one who can help him is himself......we had to create a calmness within ourselves, for in the end everything came down to individual experience. Our fear was our own, our beatings were our own, our physical endurance was our own, only our suffering was shared. (pp. 112)

While Bosnevic tells us that the experiences of trauma that induced physical and mental suffering were similar in all prisoners, the above illustrates how he struggled to reconstruct his inner self in order to cope and survive. The meaning of these experiences to Bosnevic was his realization that in the end he was responsible for his survival. The stability and inner calm he achieved were largely due to personal, psychosocial and cultural strategies. That is, in drawing on past and present experiences, knowledge and behaviours (fear, beatings, realizing he was alone, singing, sense of humor) and future hopes (thinking of his family) he was able to remain functional and to survive.

The next section will discuss temporality and its role in health.

2.4 TEMPORALITY AND HEALTH

Many studies of refugee health have not taken into account its evolving nature, that is, many questions have been confined to the present, i.e., have taken a cross-sectional perspective. However, because life is transitory, it entails movement, dynamism, and often emphasizes change, concepts that are difficult to describe within a cross-sectional study.

...the fullness of existence embodies an overwhelming, intricate balance of defined, ill-defined, undefined, moving, stopping, dancing, falling, singing, coughing, growing, dying, timeless and time-bound molecules...and the spaces inbetween. So complex is this
structure (that) a linear wrench will not turn a spiral bolt.
(Tom Robbins, 1991, p.138)

Reality always occurs in the present but is partly interpreted through memories and anticipations. Hence, recollection, anticipation and present perceptions occur simultaneously and individuals rarely speak of conscious experience outside of its temporal nature. Similarly, health is experienced in its immediacy but within an ongoing flow of lived time, that is, health is grounded in a present sense of self and of body but is tied to conceptions of past events and anticipated futures. Through coalescing the past and anticipated future health into immediate experience, the conceptualization of health can move beyond a simple linear or fixed perspective (Saltonstall, 1993; Trombs, 1992; Green, 1984; Hartcoltis, 1983).

In sum, in order to provide an accurate representation of refugee health, a focus is needed on what experiences occurred over time, anticipations of future health, and how these experiences and anticipations influence health.

The next section will discuss the significance of meaning to health.

2.5 MEANING AND HEALTH

Carlson (1988) noted that meaning is an "elusive and slippery" word to define but that generally, most experts agreed that it referred to the significance and importance in the ordering of things. For example, Aroian (1988) defined meaning as the process whereby the external and internal environments are experienced, interpreted, and responded to. The Kreitlers (as cited in Carlson, 1976, p. 18) believed that meaning was tied to referents (object, word, sentence, abstraction, event, process, activity, theme) and since discovering meaning included encountering, examining and restructuring of a referent, a new reality was often the result. Hence, according to these definitions, the meaning of health can be depicted as a dynamic, evolving process consisting of subjective and objective experiences which are used and revised as guides or references for action (Maines, 1991).

The part that meaning plays in understanding health can be determined in two ways. The first constitutes an objective
perspective in which factors such as social class, gender, ethnicity, etc., are identified, examined and grouped. The second perspective constitutes a subjective one in which individual patterns of meaning and significance pertaining to experience are explored. The objective environment consists of events and circumstances external to and independent of the individual's control, while the subjective environment consists of inner, conscious, evaluations of these events and circumstances. Hence, meaning is the mechanism whereby an individual combines, reconstructs, and projects arrangements of the the subjective and objective environments, blended with recollections and anticipations.

Groupings of objective data, while providing important background information, do not capture individual variations in meanings and thus do not convincingly account for health change. Conversely, while subjective evaluation through self-report provides the closest link to health change, it often does not always accurately capture the crucial influence of the objective environment. Consequently, in order to discover how and why health might be modified through interactions between experience, meaning and personal, psychosocial and cultural characteristics over time, contextual health patterns that include both subjective and objective information, must be determined. The next section will enlarge on this theme.

2.6 OBJECTIVE INFORMATION AND PERSONAL MEANING

The findings of most studies that have focussed on refugee health, have been based on data obtained through surveys or questionnaires. However, adopting this perspective in health research restrains and circumscribes the constantly changing and evolving health of the individual (Ots, 1990). Recently there has been a growing interest in eliciting personal meanings of health through narrative. Similarly, although still small, an increasing number of investigators believe that to combine subjective narrative and objective data will lead to a fuller understanding of health. Antonovsky (1987, 1979) suggested that health researchers expand their view to recognize a perspective that would include how people related to their environments. Pender (1989) believed that health
was best understood by blending empirical (objective) and personal (subjective) meanings in research in order to produce an integrated understanding. McKinlay (1992) recommended that the combination of both quantitative (objective) and qualitative (subjective) methods would lead to enriched research results. He wrote:

...rigid adherence to one [approach] at the expense or to the exclusion of the other is destructively parochial and results in often incomplete or even inaccurate explanations and, by extension, misfocused research and misplaced policies. (p. 111)

Description and prediction are important aspects of research but equally so is understanding how individuals regard, explain, and interpret health and illness first hand. Quantitative research methods are often unable to capture inner meaning, while qualitative methods often miss the importance of the objective information pertaining to health. Thus, in attempting to reach a comprehensive understanding of refugee health, external realities cannot be regarded as mutually exclusive from personal interpretations. While each perspective adequately deals with one reality, in order to reach a comprehensive understanding of refugee health, interactions between the two must be discovered.

This study will consider both objective and subjective information in the investigation of the health of Bosnian refugees, in order to establish findings that are comprehensive in their scope. It is my belief that by combining both sources of information, a more accurate, broader, deeper and richer meaning of health would emerge.

2.7 REFUGEE TRAUMA

Essentially refugee trauma is defined by the United Nations as cruel physical and/or psychological intentions and/or actions directed at an individual (Chapter 1, page 5), and most researchers have either adopted this definition or some modification thereof. However, since trauma can differ in severity and length of time, not every refugee suffers the same experience, alternatively, if the experience is the same, it could be interpreted quite differently. Thus, the way in which trauma affects health could be dependent both on the experience and individual interpretation.
a) **Refugee Trauma and Health Effects**

Most researchers agree on a definition of trauma but there are many contradictory ideas about how trauma affects health, the links are still disputed and unclear, and it has become increasingly apparent that they are quite complex. However, it has been noted that those individuals who possessed a strong self-concept, a sense of purpose, a feeling of satisfaction with previous success and achievements, a full and rich life and good health pre-trauma, experienced the best health outcomes after being exposed to war and trauma. It was these individuals who were the most resilient in that they were able to readily recover from setbacks and respond to stress and adversity while still maintaining overall positive health (Sluzski as cited in Curran, 1985). Consequently, in order to understand trauma and health in Bosnian refugees, noting the interactions over time between individual experiences, meanings, and characteristics (such as self-esteem and past achievements) might point to factors that are capable of reducing the negative impact of trauma on health.

The following section will discuss the common assumptions that many investigators have made regarding trauma and its effects on the health of refugees. There are three approaches to the study of refugee health and trauma; a) trauma causes ill-health and dysfunction, b) health can be maintained in spite of trauma and, c) certain modifiers possessed by the individual and/or within the environment can influence the interaction between trauma and health.

b) **Refugee Trauma, Negative Health and Dysfunction**

The investigations that focus on trauma as a cause of negative health in refugees form the largest body of literature. These investigations are based on the assumption that the experience of trauma functions as a catalyst that propels individuals into a state of stress that leads to negative health and/or dysfunction, mentally, socially and/or physiologically. Although the conceptualization of stress lacks uniformity, most investigators would define stress as a generalized physiological or psychological state necessitating reduction through the process of coping until adaptation occurs (Berry, Kim, Minde, and Mok, 1987). Stress can be caused by any difficulty in the environment that causes distress,
such as an individual's response to the environment, or a particular interaction between the individual and the environment. It is assumed that stress is a precursor to poor health, disease, and dysfunction. However, in most research, this finding has not always been clearly or consistently borne out and has been clouded in ambiguity (Beiser, 1993; Kopinak, 1985; Cooley and Keesey, 1981).

The following studies provide only a few of the many investigations in which a link between trauma, stress and ill-health was found. For example, many investigators described the symptoms of post-traumatic stress disorder as it related to trauma. This disorder consists of any of the following; sleeplessness, nightmares, tremors, sweating, irritability, psychosomatic disorders, low self-esteem, anxiety, depression, psychosis, physical disabilities and social dysfunction (Ajdulovic and Ljubotina, 1995; Engdahl, Speed, Eberly, and Schwartz, 1991; Mollica, 1988; Scrigner, 1984). Other findings included persistent dysfunctional psychological and biological coping; alterations in the immune system; accelerated stress and more illness in those individuals who had been victimized by ethnic cleansing (Weine, et al, 1995; Dekaris, et al, 1993; Kolk van der, 1987; Alodi, 1986; Stover and Nightingale, 1985). Lastly, Ajdukovic and Ljubotina (1995) concluded that those Bosnian refugees who possessed the most hope and health in the initial post-trauma period, were subject to developing more depression over time.

Studies that focus on stress as a cause of poor health in refugees often list certain situations that are unique to refugees, with an assumption that these are stressful (Marsella, Bounemann, Ekblad, and Orely, 1994; Berry, Kim, Minde, and Mok, 1987). Although it may be true that stress in refugees can be caused by traumas, such as forced upheaval, life change, overwhelming demands and distress, etc., not enough attention has been paid to the interactions between these trauma experiences, associated meanings, and possible modifiers, such as pre trauma, migration, and resettlement conditions. Since the interaction of these factors might influence health in either a positive or negative fashion, failure to consider them have caused some investigators to draw simplistic assumptions about the inevitability of ill-health in
refugees. Further, many studies employed clinical cases from which to draw their conclusions thus ignoring those refugees who might have been experiencing positive health and function.

c) Refugee Trauma, Positive Health and Function

A smaller body of literature has emerged with the finding that although the effects of trauma could be stressful to refugees, ill-health was not always the result. For example, some investigators have found that the initial crises faced by refugees did not always predict future dysfunction, and that many refugees coped successfully by facing challenges, resolving traumatic experiences and moving on to lead productive lives. Some refugees even experienced new growth and maturity, such as increased psychic strength and insight that enabled them to successfully overcome the trauma they had suffered (Bauer and Prieke, 1994; Edwards and Beiser, 1994; Baker in Basoglu, 1992; Moos and Schaefer, 1986; Eitinger, Krell, and Rieck, 1985). Other findings pointed to the resiliency that some refugees exhibited that enabled them to more easily solve problems encountered which subsequently relieved their discomfort and resulted in positive health (Ajdukovic in Stern, Love, and McDevitt, 1994; Mueke, 1992).

While this approach represented a distinct shift from the many studies that assumed pathology was an inevitable result of trauma, it is most likely that refugees, as do all people, possess a combination of both positive and negative health and function at any given point in time. Thus, the primary question is not whether refugee trauma leads to either positive or negative health and function, but on balance, what and how certain experiences influence health in primarily positive or negative ways over time. By determining how the balance of health shifts in response to experiences over time, a more accurate picture of refugee health will be revealed.

d) Refugee Trauma, Modifiers and Health

Investigators that adopted this perspective focussed on the role that modifiers played in relation to trauma and health. For example, Helman (1984) found that age, weight, build, genetics, previous health, social support and language acquisition were important factors that influenced the response to stress and illness
in refugees. Allodi, Hefey, and Moldofsky (1985) discovered that nightmare frequency was related to how a refugee experienced persecution and trauma rather than to its objective severity. Stern, Love, and McDevitt (1994) found that resiliency in refugees was influenced by the interpretation of past and present experiences and choice. Marsella (1994) found that resiliency was developed through an individual ability to balance risks and achieve mastery over hardship. Figley (1985) discovered that a belief in one’s invulnerability, perceptions of the world, and view of oneself, were the best predictors of how trauma would be resolved. These and other researchers looked for modifiers that would help explain why some refugees were adversely affected by trauma while others were not. While many of these investigations also assumed that experiences of trauma would lead to negative health and function in refugees, the approach was to move beyond trauma as a direct link to negative health and to identify those factors that were believed to influence the degree of negative health experienced.

While this study approach sometimes led to the finding of correlations between experience, certain modifiers, and health, it often consisted of an a priori "cataloguing" of experiences that investigators believed might be harmful to health, rather than eliciting the personal experiences and interpretations of participants in their studies. Further, while this approach moved beyond simply establishing a direct link between trauma and health and considered the possible influences of certain modifiers, conclusions were often restricted to the current and not the evolving situation. For example, the same modifiers might influence health in very different ways at different points in time. Consequently, in order to determine the precise role of modifiers on refugee health, studies must move beyond a cross-sectional view to a more process-oriented view of health.

2.8 REFUGEE RESETTLEMENT

For the purposes of this study, resettlement is defined as the act of seeking asylum after being displaced from a country of origin. There are two types of displacement, voluntary and forced, and important distinctions separate the two. Voluntary displacement represents a choice to leave one’s country of origin and usually is
a carefully planned process whereas forced displacement occurs suddenly and against one's will. In the former case, the individual or family has time to discuss and plan a move, to bid farewell to loved ones, to assemble resources, and to put into place any supports that may be necessary in order to successfully migrate and start life in a new country. Further, voluntary displacement is usually a straight forward move from one country to another. In forced displacement, uprooting is involuntary, often sudden and acute, there is no time to plan a course of action as victimization, violence and/or impending death are very real threats, and frequently, all is lost (tangibles and intangibles) when one is forced to flee (Sluzki, in Curran, 1985). Most refugees who have been forcefully uprooted may initially become internal refugees, that is, they may be driven out of their homes, but become refugees within their own country. Those who successfully cross a border into a neighbouring country in order to seek asylum become external refugees. Neighbouring countries are often hostile to external refugees and frequently encourage them to quickly move on to another country.

Consequently, most refugees choose, if at all possible, to migrate to a host country of second asylum where they will be granted immigrant status and eventually be able to apply for citizenship. However, planning to immigrate a second time, after suffering trauma and an unwelcome sojourn in a country of first asylum, requires emotional and practical resources, such as time, patience, a relatively stable emotional state, and some financial capital. For example, immigrating requires the filling up of many documents, successfully passing numerous immigration interviews, a medical examination, and payment of a fee. In the end, most governments who accept refugees are highly selective and many refugees who have expended a great deal of energy and time to fulfil the application criteria are ultimately refused entry.

a) Refugee Resettlement and Health
Stein (1980) stressed the importance of defining the refugee experience and suggested that future research should not only be increased but should concentrate on identifying consistencies or patterns that describe this experience. Ten years later, Noshpitz
and Coddington (1990) pointed out that the literature pertaining to displacement was still too little and often methodologically flawed. That is, because each group of refugees was quite unrepresentative of any other group, generalizing findings from other studies often led to the erroneous conclusion that most refugees should be considered at serious risk to develop health problems. Despite the fact that these and other experts in the field of refugee resettlement pointed to shortcomings in the study of refugee health, what does emerge quite consistently from existing literature is that most refugees experience a massive amount of guilt about leaving family, friends and country behind, often without the opportunity of even bidding farewell. Further, the daunting tasks pertaining to resettlement are added to the enormous losses, material and psychological, that refugees have experienced due to forced uprooting from their country of origin. It was presumed that due to these experiences, both physical and mental health were either negatively affected or at great risk of being affected.

In sum, while the amount of research relating to refugee resettlement and health has been increasing, there is still too little and, not enough attention has been paid to identifying subjective accounts of personal experiences and their interactions with characteristics that might influence and modify health over time. It is through the identification of these factors, within health patterns, that a better understanding of the effects of resettlement on refugee health might be discovered.

**Synthesis**

The review of the literature in this chapter has pointed to ambiguities with regard to understanding the health of refugees. These ambiguities have primarily been a result of a priori assumptions pertaining to outcome, a lack of attention to the roles of meaning and temporality, the use of clinical cases, overly generalizing findings from one refugee group to another, and an overwhelming focus on negative health outcomes.

While most existing literature has contributed greatly to knowledge about how trauma and forced resettlement adversely affects the health of refugees, this perspective is unidimensional and narrow in scope. By failing to look beyond pathology, the
conclusion that refugees will suffer some form of negative health and function is brought into question. Conversely, those few investigators who have stressed positive health and function in the refugee have been as intent on identifying good health and coping as others have been on identifying ill-health and dysfunction. Since it is likely that refugees experience a combination of positive and negative health, both assumptions circumscribe and narrow the possibility of discovering an adequate picture of health. Consequently, rather than focussing on one health outcome, equal consideration should be given to identifying those factors, processes or interactions that could influence health in either positive or negative ways.

In this study, there will be an inductive exploration of the interrelationship between trauma, forced resettlement, and refugee health. An attempt will be made to discover the nature of the refugee experience, as well as factors that may transform and modify health. Participants in the study will be considered as the best sources from which to obtain information pertaining to the subjective aspects of their experiences, meaning and health. However, this information will be combined with objective observations and questionnaire data in order to compile a deeper and broader understanding of the health of participants in this study. The next chapter will outline in detail, the methods and methodology that will be employed in order to elicit the aforementioned information and data.
CHAPTER 3

METHODOLOGY

3.1 STUDY DESIGN

Qualitative interviewing was the major method of information gathering in this study. Since the goal of this investigation was to obtain in-depth accounts of the experiences of trauma and forced resettlement, informal, qualitative interviews were identified as the best vehicle for capturing participants’ viewpoints pertaining to descriptions and details about experiences, situations, behaviours, beliefs, values, attitudes, and meanings (Aroian and Potsdaughert, 1989; Bryman, 1988).

Data from quantitative measures such as formal demographic and health questionnaires and participant and investigator observations, will be employed as an adjunct to the informal interview information. The combining (triangulation) of all data and information derived from the interviews, the demographic and health questionnaires, and observations, will result in an enriched understanding of the implications of trauma and forced resettlement on the health of participants in this study (Cowman, S, 1992).

Triangulation is the combination of multiple approaches to study the same phenomenon and is based on the premise that weaknesses in a single approach will be compensated for by strengths in another. Some investigators believe that the combination of qualitative and quantitative methods will elicit deeper and richer health knowledge but only if the design and method chosen are consistent with the researcher’s intent (Packard and Polifroni, 1990; Clarke and Yaros, 1988). Other investigators are dubious about the results derived from triangulating quantitative and qualitative paradigms.¹

While this study will be driven by a qualitative paradigm it is my intent that the design will capture and combine information and

¹Eakin and Maclean (1993) have expressed scepticism regarding triangulation at the paradigm level. They believed that there were too many differences between quantatative and qualitative investigation to fruitfully combine these. Although Eakin and Maclean were critical of and doubted the feasibility or desirability of triangulating findings at the paradigm level, combining findings at a methodological level is another matter completely.
data from different methods in order to explore and describe the phenomena. Consequently, the narrative information will be complemented, augmented, and strengthened by numerical data and observations (Fig. 2). It is my belief that by combining these methods, different health realities will be illuminated, complement each other, and provide a fuller, broader and deeper understanding of refugee health.

The primary benefits in choosing different methods to measure each of the phenomenon are, a) the investigator increases the accuracy of the findings through counterbalancing the flaws of and/or weaknesses in one method with the strengths of another and, b) comparisons of responses between the informal interviews, the questionnaire data and observations will clarify ambiguous and/or vague responses, thereby increasing confidence in the findings.

In sum, since there is a conspicuous lack of research pertaining to refugee health, and a notion that much past research, due to methodologies employed, is often inaccurate or biased (chapters 1 and 2) there is a need to explore the phenomenon in more depth in order to develop a full and accurate understanding. While there is much controversy surrounding triangulation, there are also a number of existing examples demonstrating that a linkage between qualitative and quantitative methods is not only possible but also useful (Jenkins and Howard, 1992; Dressler, 1991). What is important is that in research, methodologies ought to be selected primarily to facilitate a better understanding of phenomena being studied.

3.2 PARTICIPANT SELECTION AND CRITERIA

Resettlement, community and religious centres were initially contacted in order to meet prospective participants. Such settings were accessed with the permission of directors, teachers, and participants. Participants for the study were recruited via a referential, snowball sampling procedure whereby a letter of introduction was distributed to mosques, churches, community centres, schools, and apartment buildings (Appendices 1 and 1a). This letter was available in Bosnian and English and was printed on brightly coloured paper so that it would attract attention when posted on bulletin boards in community centres, places of worship
Methodological Triangulation

Ethnographic Information
Observations

HEALTH

Health Information

Demographic Information

Fig. II
and/or elevators in buildings where large numbers of Bosnian refugees had settled. The content of the letter of introduction included an explanation of the nature of the study as well as the name, address and telephone number of the investigator.

Bosnian refugees who had been in Canada for no less than 3 and no more than 7 months were asked to participate in the study. This period of time ensured that participants were past the initial settling period yet were still steeped in the Bosnian culture. Other inclusion criteria were that each participant be 19 years of age or over and be able to read, speak and understand English. While this latter criteria excluded many Bosnians, its adoption was due largely to limitations in time and research funds. Most importantly, each participant and the investigator were able to engage in a dialogue on a one-to-one basis without the intrusion of a third person. This reduced participants’ inhibitions which might have disrupted a free-flowing dialogue, and enabled the interviewer and participants to form a closer bond over three interviews. The names of potential participants were collected by the investigator and entered on a roster. Volunteers who had agreed to participate in the study were chosen after a telephone and/or face-to-face contact had occurred. The final group studied numbered 10 (five females and five males).

In sum, Bosnian refugees fitting the criteria as outlined, were approached either by the investigator or the investigator’s contacts in the Bosnian community. Each contact led to further introductions or referrals to other refugees. This process yielded potential participants who expressed interest in taking part in this study. Hence, participants were chosen according to the inclusion criteria above and their ability to converse in English and to understand and respond to questions posed to them on the questionnaires.

3.3 PROTECTION OF PARTICIPANTS

No risk, stress or discomfort to participants was anticipated by taking part in this study, however, the safety and rights of each participant were ensured in the following ways.

The letter of introduction in both Bosnian and English (Appendices 1, 1a) conveyed important information pertaining to the investigator, outlined the purpose of the study, the eligibility
criteria, and what would be required of each participant.

A consent form was also provided in both Bosnian and English (Appendices 2 and 2a). Since participants were new to Canada and unfamiliar with Canadian culture, the consent form was very detailed and precise. Included was information that clearly outlined the nature of and time required for each interview, and details informing the participant that (s)he could refuse to answer and/or terminate the interview or withdraw from the study at any time. Ample time was set aside to answer questions in order to ensure that each participant understood the purpose of the study, as well as the expectations required of her/him.

Written consent was obtained from each individual who agreed to participate in the study prior to beginning the first interview. Whether or not it was requested, a copy of the consent form was left with each participant after the first visit.

3.4 ETHICAL CONSIDERATIONS

1. The procedure for recruitment, informed consent and handling of any discomfort experienced by participants was outlined and submitted to the Human Subject Review Committee, University of Toronto, Toronto, Ontario, Canada. The Committee approved these procedures in December, 1994 (Appendix 3).

2. Permission to enter community facilities in order to meet new refugees was obtained by approaching leaders or directors of such facilities.

3. Informed consent was sought and obtained from all participants prior to the initiation of the first interview (Appendix 2 and 2a).

4. The safety and confidentiality of each participant was assured by the following:
   a) The same investigator conducted all interviews with each participant.
   b) One investigator was responsible for the safekeeping of all information obtained.
   c) Confidentiality and anonymity was assured through each participant being assigned a number. Names were not used on the transcripts or questionnaires.
   d) All data are to be destroyed once the study is completed.
3.5 ADAPTATION AND PILOTING OF MEASURES

Modifications pertaining to the proposed methods for this study were carried out after testing the methodology on two consenting Bosnian acquaintances, prior to beginning the study. For example, three interview questions were reduced to one opening probe, the demographic and health questionnaires were shortened, and some of the questions were rephrased in order to enhance participants' understanding.

Since this study included interviewing participants whose first language was not English, as well as triangulating qualitative and quantitative information and data, piloting the measures before beginning the study added to investigator confidence and comfort. There was no attempt to draw assumptions or conclusions about the health of the Bosnian refugees who agreed to participate in the primary investigation based on the information obtained in the pilot study.

3.6 INFORMATION COLLECTION PROCEDURES

The procedures employed to procure health information and data were informal interview, observation, and health and demographic questionnaires (Fig. 2).

The purpose of the first informal interview was to establish a free-flowing dialogue through which each participant would be able to comfortably share their experiences. The purpose of the second interview was to gather demographic and health data based on written questions answered by participants. The data obtained from these questions was used as an adjunct to the qualitative, informal interview information. The purpose of the third interview was to compare and validate the investigator's perceptions and conclusions pertaining to participants' experiences and health with each participant.

In sum, there were three separate participant and investigator interactions for a total of approximately 5 hours. The purposes of the interviews were to collect information pertaining to participants' experiences, background and health, and to compare and validate the investigator's conclusions with those of each participant. Since the health of participants was believed to be part of an ongoing process, consideration of experience and health
over time was primary in all information and data gathering methods. Each of these methods are described in further detail in the following sections.

A) DEMOGRAPHIC QUESTIONNAIRE

The purpose of obtaining demographic data was to provide a framework within which the interview information, health questionnaire responses, and observations could be interpreted. The 31 demographic questions were adapted from a study of Polish immigrants in the United States (Aroian, 1988) (Appendix 4). While the demographic questionnaire had to be modified in order to reflect questions relating to refugees in Canada, it was chosen because it focussed on recent arrivals in a country, their families, and religious and ethnic backgrounds. These areas were important in this study, as participants had been in Canada for less than one year, family relationships had been disrupted, and participants were victims of a war marked by ethnic cleansing. Other questions consisted of simple, nominal inquiries which targeted background variables such as birthdate, gender, marital status, employment, occupation, education, language, date of arrival in Canada, date the refugee left her/his country and whether or not (s)he intended to apply for citizenship. This questionnaire required approximately 30 minutes to complete.

B) HEALTH QUESTIONNAIRE

The primary purpose of this questionnaire was to elicit data pertaining to the biopsychosocial health of participants through answers to structured questions which were taken from Canada’s Health Promotion Survey (Ministry of Supply and Services, 1988) and the Ontario Health Survey (Ministry of Health, 1990) (Appendix 5). Questions numbered 37 and inquiries pertaining to social support, psychological function, and physical health formed three separate sections on the health questionnaire. Physical attributes such as height and weight were recorded with the use of an ordinary tape measure (centimetres), and a calibrated bathroom scale (kilograms). Questions that focussed on weight, exercise, substance use, safety practices, social relationships, nutrition, mental health, etc. were modified in order to make them more applicable to a refugee population. For example, asking what the weight was during the war
and before arriving in Canada contributed information on the current well-being of each participant. The number of possible responses to some questions were reduced in order clarify and simplify understanding, and questions were revised to reflect health in three time perspectives (past, present and anticipated future). Present health referred to each participant’s current health at the time the questionnaire was completed, while the past and future represented prominent memories and anticipations as defined by each participant. This questionnaire included nominal responses to forced answer, closed-ended questions and required one hour to complete.

C) INTERVIEW SCHEDULE (FIRST AND THIRD INTERVIEWS)

a) Informal Interview

The first interaction between the investigator and each participant occurred either in a community setting or as a telephone contact. The primary purpose of this interaction was to introduce the researcher and participant. Questions and/or any concerns that the participant had regarding the study were answered at this time. In addition, a time and place for the first interview was discussed.

The day before the appointed interview, the investigator prepared a file marked with the number assigned to the participant as well as consent forms in Bosnian and English. Other information included in this pre-interview file related to initial impressions that the investigator had gathered either through telephone or face-to-face contact with the participant such as, gender, dress, facial expressions, language skills, etc. A natural setting had been pre-arranged, where comfortable discussion and disclosure could take place, in all cases, the participant’s home. Being welcomed into the homes of participants indicated a level of trust, and also enabled the investigator to observe the environment.

An attempt was made to suspend any a priori assumptions, interpretations, labels and/or ideas that might have contributed to pre-formed biases or opinions, prior to beginning the interview. This interview was audiotaped, and any necessary notes and jottings pertaining to the interviewer’s perceptions and observations were made during or immediately after the interview. Discussion with each participant was approached in an informal and friendly way, explanations about the disclosure process and the recording were
offered, and questions were answered. A comfortable interaction between the investigator and participant was insured by pacing the interview in order that the participant had adequate time to understand and respond, and a beverage and/or light snack were shared during the course of the interview.

The investigator began the interview with the following general statement, "I would like to discuss your health with you. Perhaps we could start the discussion with the following question: When you think of your health, or hear the word 'health', what feelings or thoughts come to your mind?" (Appendix 6). This opening statement provided a general direction for the interviews while encouraging spontaneity by allowing participants to choose beginning comments and to colour their ongoing dialogue in positive, negative or neutral tones (Burns, 1989). Additional questions were posed only to encourage further elaboration in order to add understanding, or to pursue the development of pertinent topics that participants introduced. Inquiries or statements were rephrased if participants appeared to be having difficulty understanding or answering spontaneously. The time allotted for this interaction was 2 hours of which 1.5 hours were audiotaped. The remaining half hour was intended to allow the participant and investigator to initially settle in before the interview began and to formally terminate the disclosure process.

Spradley (1979) noted that ethnography uncovers the realities and meanings of others' lives through discovery and description, consequently, the use of language is paramount. While the purpose of this interview was to observe and listen to narratives about refugee experiences and associated health meanings, interviewing people whose first language is not English can pose some special challenges. It has been noted that qualitative research sometimes does not address the issue of the attribution of different meanings in language. Further, when speaking within the context of another culture the accuracy of interpretation and hence the validity and reliability of information can be seriously threatened (Clarke, 1992; Headley, 1992). Consequently, the investigator took precautions in order to ensure that meanings were understood. One of the techniques the investigator used to ensure an accurate understanding was probing. However, this scrutiny needed to be
carried out in an open-ended and non-threatening manner in order to avoid instilling a priori ideas and/or feelings of intimidation. For example, a participant might say, "Sometimes I feel badly". The investigator might say, "Can you help me to understand what this means?" After clarification by the participant, the investigator might then add, "When you say "sometimes", can you tell me when those times are?" These probes uncovered deeper meanings than the original sentence conveyed and also ensured a mutual understanding by both the investigator and the participant.

While the temporal aspect of health was often implicit in participants' narratives, the investigator's references to different time frames were sometimes difficult concepts for some participants to grasp. Since these were very important concepts in this study, the investigator had to ensure that participants understood the precise meaning of each. Consequently, the investigator would often add an explanation or use an illustration to add clarification. For example, the investigator might say, "You said that you lost 20 kilograms during the war. How many kilograms did you weigh before the war?" After the participant had responded to this question, the investigator might add, "You lost 20 kilograms during the war, how much do you weigh today?" Using one frame of reference in order to elicit past and current health information contributed to an accurate and mutual understanding. Lastly, repeating or restating what had been said (using the participant's terms) when the participant seemed stalled or unsure of how to continue was also effective. This often happened when the participant was discussing distressing topics pertaining to their traumatic experiences.

b) Final Interview

Each audiotaped interview yielded an average of 28 pages of typed dialogue. This original dialogue was gradually reduced to prominent topics that represented each participant's recurrent lines of thought. These topics however, were based on the investigator's interpretation of each participant's perspectives. Consequently, the goal of the final interview was to provide a validity check for this interpretation by consulting with each participant regarding its accuracy. When necessary, this interview was also used to pose questions that might have arisen in the editing and analysis of the
questionnaires.

At the beginning of the visit, the investigator would review the purpose of the visit and answer any questions that the participant might raise. A pencil and a copy of the main topics derived from the original interview were given to the participant with the request that it be read. The investigator would inform the participant that (s)he could make notes and/or ask questions. While the investigator busied herself with watching television, playing with children (if present), talking to family, etc., the participant was given an opportunity to read, comment on or make notes pertaining to the written material. No time limit was imposed in which the participant was to accomplish this task. Rather the participant was instructed to take as much time as necessary to read and think about what was written, ask questions if necessary, and tell the investigator when (s)he had completed the task. Usually no more than 5 - 7 minutes was necessary for each participant to read the written material. The investigator then asked if there were specific comments or questions regarding what the participant had read. Regardless of whether or not there were questions or comments, the investigator would then discuss each point with the participant, bringing to recall the original dialogue from which the interpretation had sprung. This validity check enabled the investigator to assess her interpretation of the essence of each participant's original dialogue. Two copies of this document were brought to the interview and participants were asked if they would like to keep one. Since this interview represented the last interaction between the investigator and participant, one hour was allowed in which to fulfil the objectives as well as to formally terminate the partnership that had been formed.

D) OBSERVATIONS (PARTICIPANT AND INVESTIGATOR)

Participant observations represented participants' health and environment and included their interactions with family, friends and community, dress, surroundings, physical health and psycho-social function. These observations were carried out through interactions between the investigator and each participant in the study, over the course of three interviews as well as the initial meeting and/or telephone contact.
The investigator observations consisted of research activities pertaining to Bosnians and their culture including, reading relevant literature, engaging in discussions with Government officials (Immigration, Citizenship and Refugee) Bosnians in Canada, the United States and the former Yugoslavia, and attendance at cultural events. For example, prior to the initiation of this study, in order to reach a better understanding of the culture, the investigator visited the homes of Bosnian people who had resettled in Canada, attended community functions, such as cultural festivals and Bosnian schools for children, spoke to refugee and immigration government officials, and read newspaper accounts and books that described the culture and events leading up to the war. The investigator also spent four weeks in the former Yugoslavia (under the protection of the UNHCR and, a) met with refugees still within their country of origin, b) exchanged information with researchers at the University of Zagreb (Croatia) and with individuals working within humanitarian organizations such as Care Canada (Zagreb, Sarajevo, Bihac) the Red Cross (Split, Croatia) the UNHCR (Zagreb, Split, Sarajevo, Mostar) and military and paramilitary personnel in NATO and the UN forces, c) visited the Directors of the International Rescue Committee and Survivors (San Francisco) (the mandate of both organizations was to assist Bosnian refugees who sought asylum in the United States) and, d) visited with personnel at the San Francisco General Hospital where all Bosnian refugees resettling in that city underwent an initial medical investigation. These experiences enabled the investigator to learn more about the Bosnian culture, contributed to a feeling of familiarity and comfort, and strengthened the investigator's credibility.

3.7 INFORMATION AND DATA ANALYSIS

A) DEMOGRAPHIC QUESTIONNAIRE ANALYSIS

The data derived from the Demographic Questionnaire were edited by checking for errors to make sure the information obtained was clear and readable. These edited data provided the framework within which the ten participants could be described.

The responses to each question were aggregated in table form and the questions were grouped into similar topics. For example, one table contained responses to questions relating to birth data,
and arrival in the country while another dealt with issues related to ethnicity, marital status, religion and cultural organizations, etc.

B) HEALTH QUESTIONNAIRE ANALYSIS

Editing (checking for errors, making sure the data were clear and readable) was a first step in analyzing these data. The response to each question was aggregated and grouped in order to form similar topics (biological, changing health, consulting health professionals, health insurance, self-rated health, dental health, nutrition, health conditions, reproduction, lifestyle, safety and psychosocial issues) and illustrated on tables. Each table was divided into male and female responses and time frames.

C) CONTENT ANALYSIS OF INTERVIEW INFORMATION

Ethnographic analysis is the non-numerical organization and interpretation of information in order to discover patterns and themes (Luczun, 1988; Tesch, 1990). There are several different types of content analysis, and the one chosen often depends on the design of the study and the type of analysis chosen by the investigator. One method emphasizes searching for similar or dissimilar statements, behaviours or patterns of behaviour, and culminates in the formation of major themes and abstract theoretical formulations. Another method abstracts qualitative information into concepts and categories, discovers variations of the categories, then links the categories in a hierarchial fashion in order to make case comparisons (Leininger, 1990; Glasser, 1978). Since the primary focus of this study was to seek out commonalities through the discovery of individual meanings, these two models were influential in the development of the method of content analysis employed in this study. Consequently, the approach taken was to discover and identify concepts through assessment of evidence from the dialogues, in-depth analysis of individual cases, and comparison of cases. This task began with a five stage process which included transcribing and coding the interview, categorizing, forming themes and finally maxims, as described in more detail below.

i) Transcribing

Transcribing involved listening to the tape in its entirety and transcribing it within 24 hours of the first interview so that
nuances could still be accurately recalled and captured. Each typed version was re-read in order to edit as well as to grasp deeper meanings. Extraneous verbalizations and repetition of words which were not crucial to emphasize a point were edited out of the transcript. Impressions the investigator had gathered such as tone of voice, facial expressions, surroundings, dress, interactions with family and friends, and notes or jottings that had been made during or after the interview were integrated into the text. Consequently, the investigator formed initial impressions when first transcribing the information but upon subsequent readings and after including all other information, discovered new impressions and deeper meanings that went beyond the mere reading, transcription, editing and counting of verbal and observed information. Complex relationships which had not been obvious on first readings due to the dynamics of the actual interview process, information overload, and editing, began to emerge.

ii) Coding

Coding the transcript included assigning different letters to pertinent topics raised by the participant. These letters were organized in sequence to avoid inconsistency or overlapping. Coding pertinent topics continued until there were no new possibilities for codes to emerge from the original dialogues. Thus the transcript was broken into segments which could consist of a single noun, a clause, sentence or paragraph. Once the entire transcript had been coded, identical codes were aggregated into groups. When these steps were accomplished an unmarked transcript was recoded by the interviewer in order to ensure the validity of the initial coding scheme.

iii) Categorization

Forming categories involved assembling classes or divisions of information from the previously coded material. This process included combining similar codes in order to form a coherent category. That is, codes were refined, narrowed and combined until main categories were formed. Once this process was completed, participants' recurrent lines of thought were manifested and led to the emergence of patterns.
iv) **Theme Development**

Theme development included examining each category in its entirety and integrating the information to form concise, coherent themes. *Individual* themes were scrutinized and comparisons resulted in the discovery of similarities and dissimilarities that resulted in the emergence of *central themes* that were common to all participants. Each theme and its components represented both an integration and literal expression of the category, including its temporal aspects, and led to a comprehensive understanding of participants' experiences and associated meanings over time.

v) **Maxims**

Maxims were derived from the central themes and were the embodiment of participants' positive health beliefs and values. Each central theme was transformed so that it represented a positive health value or belief. Consequently, it could be said that the maxims were an abstract statement that represented what participants believed had or would lead to good health and function over time.

To sum up, content analysis proceeded in the following way: a) transcription and editing of the audiotape, b) adding observations and field notes, c) rereading of the transcript, d) coding transcript, e) rereading and recoding an unmarked transcript, f) categorizing codes, g) developing themes, h) transforming themes into maxims. In order to clarify the procedure used in this study, content analysis was presented as a linear progression. In actual fact, the phases described overlapped, in that the cognitive process often constituted a back and forth movement between inductive and deductive reasoning.

D) **VALIDATION OF INFORMATION DERIVED FROM INFORMAL INTERVIEW**

Each informal interview yielded an average of 28 pages of typed dialogue which was reduced to prominent topics that represented *individual* participant's recurrent lines of thought. Consequently, prominent topics would vary from person to person. The information derived from this interview served as a crucial evaluation tool in order to validate the investigator's interpretation of each dialogue and served as a stepping stone for the development of themes. Once the investigator's interpretation of the essence of each informal interview was discussed and approved by each participant, the
investigator was able to return to the task of further condensing the material to discover similarities and dissimilarities that would lead to central themes and subsequently to maxims.

This interview was also used to summarize the interactions that had taken place over three visits and to answer any questions the participant might have regarding the study. Thanking the participant for their input, offering a small gift, relaxing, discussing their future plans, and often sharing food and a beverage were all part of the termination process.

3.8 TRIANGULATION

All findings, viz a viz informal interview, observations, questionnaires, and validation interview were first analyzed separately as described in previous sections of this chapter. Following this activity, all information and data were combined in order to construct a multidimensional picture of health pertaining to the participants in the study.

3.9 CALENDAR OF EVENTS

The Calendar of Events is outlined in Appendix 7.

Summary

This chapter explained the methods and methodology used in this study including the study design, the research setting, participant and investigator observations, inclusion criteria, selection of participants, ethical considerations and adaptation and piloting of the proposed measures. Information and data collecting methods and analysis were outlined. Information on how triangulation was to be achieved was also outlined. The next three chapters will present the the findings from each measure, and the central components represented by themes.
CHAPTER 4

PRESENTATION AND ANALYSIS OF FINDINGS

The data originating from the demographic and health Questionnaires (Appendices 4 and 5) served as a chronology, supplement, and context for the interpretation of the major results in this investigation, obtained from the formal interviews and observations. Information from these sources were combined in order to reach an understanding of the relationship between trauma and forced resettlement, and how these experiences influenced the health of the participants in this study over time.

4.1 REASONS FOR AND CONDITIONS SURROUNDING REFUGEE TRAUMA AND RESETTLEMENT

Since all participants were exposed to trauma and involuntarily and forcibly uprooted from their homes and country, in order to begin to understand how these experiences might have influenced health, it is important to present some of the historical events that led up to the war in Bosnia.

The former Yugoslavia was part of the former Soviet Union and consisted of six republics, including Bosnia-Hercegovina, Serbia, Slovenia, Croatia, Macedonia and Montenegro (Softic, 1995; Immigration and Refugee Board, 1993) (Appendix 8). Modern Bosnia was the last of the Slav states to emerge in the fourteenth and fifteenth centuries and consisted of three main ethnic groups, Serbians, Muslims, and Croatians (Appendix 9). The religious beliefs and/or practices of these three main ethnic groups were Christian Orthodox, Islamic, and Roman Catholic. However, the country also was home to smaller populations of Jews, Ukrainians, Albanians, and Macedonians. These diverse ethnic groups and religions had co-existed peacefully together in Bosnia, since the end of the Second World War (Kurspahic, in Ali & Lifschultz, 1993).

As the former Soviet Union began to disintegrate, Yugoslavia was adversely affected. In 1991, Croatia, followed by Bosnia-Hercegovina, declared independence. Both of these actions were opposed by Serbia which desired Yugoslavia to remain intact and from April, 1992, until November, 1995, the people of Bosnia were traumatized as the country was embroiled in a civil war. Ethnic
cleansing and genocide were practiced, thousands of people were maimed or killed, and 2.4 million refugees were created as forcibly displaced people had to flee towns and cities which their families had inhabited for generations (Diego Arria and Hitchens, cited in Ali & Lifschultz, 1993). Large parts of the country were decimated, families were uprooted and separated, pre-existing social and political structures were destroyed, and children, women and men experienced violence and loss of life.

a) Leaving Bosnia

Regardless of the amount of time that participants spent in Bosnia during the war, interview information revealed that the decision to leave was made within a few hours, days or at the most 1 – 2 weeks. The first scenario, e.g., leaving in a few hours, was necessitated when a city or town would suddenly come under heavy shelling and troops would begin advancing. One participant said,

"I hear the guns, I see the guns. I couldn’t believe that this (war) could happen. Then I see that I have to go."

The second scenario, e.g., making a decision over a few days or weeks, was a process that was often kept secret and the departure would take place surreptitiously, under the cover of darkness, or on a pretense. These actions were necessary as the civil war turned neighbour against neighbour, consequently, danger to lives increased exponentially with the number of people who knew of the intended departure. One participant said,

"I no say I visit my wife in Canada, but in Croatia. (If) I say "my wife in Canada", I never get out. To get paper (military pass), its difficult, but one friend help me. When I had that paper I fast go out. I thinking maybe something, something change."

What was common to both of the above scenarios was that the departures were enacted under duress, and the only possessions taken were those that could be carried in a small bag. All escapes were dangerous due to landmines, shelling, and snipers. Those men caught attempting to desert the military or the country would have been maimed or killed immediately. Participants described feelings of unbearable fear and panic as they attempted to escape. Those who left by the last public transports out of Bosnia described the panic-stricken people who were fighting amongst themselves for a seat on a plane or bus. This is illustrated in the following story.
told by a participant who attempted to get his spouse and children out of the country,

"It was one mess, panic, mess. About 500, 1000 people in the bus station in__, very small bus station. And the majority of those try to catch this bus. It was all confusion. I decided to try for those ticket. Several times I fell down. It was really hard, you know."

The next section will present an overview of each participant’s story from their lives prior to and during the war to their arrival in Canada, and their hopes for a future in this country.

4.2 INTERVIEW PROFILES OF PARTICIPANTS

This section provides a brief description of each participant’s characteristics and experiences. Originally, eleven participants agreed to take part in the study but one, a 28 year-old male, dropped out after the first interview. The reason he gave was that he had commenced employment and did not have time to continue with the study. However, during the first interview I observed that he was very uncomfortable, often rising suddenly and pacing the room or leaving for short periods. He seemed very suspicious of me and although he insisted that the interview not focus on the political aspects of the war, he kept coming back to this topic again and again. His obvious discomfort with the interview process may have been another reason why he decided not to continue as a participant in the study.

The remaining interview profiles were assembled from each participant’s narrative and organized chronologically, along with observations made by the investigator, in order to portray how experiences and events unfolded for each participant over time.

While two hours had been allowed in order to complete this interview, with actual taping at 1.5 hours, in most cases, this was barely enough time. The homes of all participants were beehives of activity that contributed to frequent interruptions of the interview process including family members and/or friends present or dropping in, and telephones ringing frequently. Further, the initial process of settling in, interview preparations, sharing refreshments and terminating what was often an emotional interview at times, required more than the allotted time.

The interview profiles below illustrate how a common history
and culture can serve as a backdrop to each individual’s unique reality.

Participant #1 (N)
This 54 year-old Muslim woman appeared confident, made good eye contact, spoke frankly and exuded a great deal of warmth. She had been in Canada for three months. "N" was an architect and had spent the first two years of the war in Bosnia. During this period she had worried constantly about the lives of her son and spouse, the latter having been arrested, detained and tortured. She lost 35 kilograms, and due to her declining health, "N" was advised to leave the country under the protection of a humanitarian organization. Her spouse remained in Bosnia. "N" resided for a short period in Italy, before leaving for Canada.

At the time of the interview, "N" reported past health issues prior to the war as occasional mild digestive problems, varicosities in her legs and a back ailment. "N" had rarely sought the assistance of health professionals, preferring instead to self-treat any health discomforts experienced. Although "N" admitted that her physical and mental health had been compromised during the war, and worry for her spouse who remained in Bosnia caused her continual distress, she still considered herself to be in good health. "N’s" goals were to regain her strength, reunite her family and start a business in Canada.

Participant #2 ("A")
This 32 year-old Muslim woman appeared confident and communicated in a direct way. "A" had been in Canada for four months and lived with her two-year old daughter.

Prior to the war, "A" had earned a liberal arts degree in Bosnia, and worked as an editor. During the war, "A’s" mother had died, her brother and spouse were forced to join the military and she gave birth. As the war intensifed and the necessities of life became more difficult to obtain, the survival of her infant became a priority. With the help of friends, "A" escaped with her infant and resided in Croatia with relatives. This period was very stressful for her as she had been unable to locate her spouse in Bosnia for over six months. Further, as a refugee, she was prohibited from working, therefore, her relatives were attempting to
support her and her child as well as their own children. "A" felt her presence had become an imposition. Her options were to either go into a refugee camp or attempt to immigrate to Canada.

At the time of the interview "A" reported that aside from a skin allergy, chronic bronchitis, and some required dental care, she believed her health to be good. Although she worried daily about her spouse who was still in the military in Bosnia, she had developed a new appreciation for things she had once taken for granted, such as adequate food, and warm, clean lodgings. She was enrolled in ESL and computer classes. Her goals were to reunite her family, to find full-time work and to provide a stable home for her child.

Participant #3 ("C")
This 41 year-old Muslim woman was talkative and communicated easily. She had been in Canada for five months and lived with her two children.

"C" had earned a fine arts degree in Bosnia, and had been an artist prior to the war. "C" described her decision to leave Bosnia as a very difficult one, as she had wanted to stay in her country with her spouse. However, as shelling increased and the necessities of life became more difficult to obtain, for the sake of her children who were then 9 years and 2 months, she decided to leave. She was able to reach Austria and lived with family there. However, while in Austria "C" experienced ethnic discrimination. This began to affect family relationships and function, thus, she decided to immigrate to Canada.

At the time of the interview, "C" was attempting to control an eating disorder that she had developed as a teen. This eating disorder had been exacerbated by her responsibilities as a single parent and worry for her spouse who was in the military in Bosnia. Although she admitted to finding safety, comfort and friends in Canada, "C" was struggling with feelings of insecurity, worry, and unhappiness. Her goals were to reunite her family, to find full-time work and provide stability for her children.

Participant #4 ("G")
This 29 year-old Muslim male was very soft-spoken. He had been in Canada for six months and lived with his parents who had recently
joined him. "G" had received a nursing diploma in Bosnia and worked in a clinical setting prior to the war. He had spent the first two years of the war in Bosnia in the military and had participated in the care of many injured Bosnians of all ages. After his escape, "G" spent a short time in Croatia before immigrating to Canada.

At the time of the interview, "G" expressed constant worry about his brother, who had experienced life-threatening treatment in a concentration camp. Further, "G" was struggling with feelings of ambivalence, guilt and sadness about his past role in the military. He felt that his coping in Canada was compromised by his need to resolve his feelings, accept his losses, learn English, nurture friendships, feel accepted by Canadians, find work, and re-unite his family.

Health issues that "G" reported were psychological changes such as frequent sleeplessness and periods of extreme anxiety in which he would begin to sweat, shake and feel acute apprehension. Further, bronchitis and some mild respiratory allergies had been intermittent problems since childhood. In spite of these health issues, "G" believed that essentially, his health was and had always been good. He was enrolled in ESL classes and his goals were to find employment and re-unite his family.

Participant #5 ("M")

This 40 year-old Muslim male had earned a degree in economics and worked as a computer programmer prior to the war. He had been in Canada for six months and lived with Bosnian friends.

"M" had spent the first two years of the war in the military, however, when the opposing side had claimed victory and fighting ceased, "M's" ethnicity prevented him from working, he was arrested and detained in a prison camp and badly beaten by military personnel. He described his experiences in the military and prison camp as terrifying and confusing. The violence and brutality he witnessed and/or experienced, as well as severe deprivation, were accentuated as former trusted alliances crumbled due to ethnic tensions. Although "M" was eventually acquitted and released, he was in constant danger of being incarcerated again. His escape from Bosnia to Croatia was fraught with the danger of discovery. At the time of the interview, "M" stated that although he was
experiencing a physical problem that necessitated medical intervention, this was "a little problem" and overall, his health had always been good. He attributed his good health to his exercising and controlling his weight. He was taking ESL and computer classes and his future plans were to improve his English, to find a well-paying job, buy a vehicle, a larger residence and visit his friend in the States.

**Participant #6 ("J")**

This 38 year old Muslim woman communicated openly and confidently. She had been in Canada for five months and lived with her spouse and two children.

"J" had earned a degree in psychology and had worked in a clinical setting prior to the war. "J", her two children (10 and 7 years) and her spouse had escaped from Bosnia when the city in which they resided came under heavy shelling. The family had initially fled to Serbia but chose not to stay due to the possibility of "J's" spouse being conscripted. Consequently, they moved on to Slovenia to live with relatives. However, they were not allowed to work or collect social benefits and experienced discrimination there. After volunteering as a counsellor and interpreter at a refugee camp, "J" was eventually hired by the government. She found this work depressing and mentally exhausting but had little choice but to carry on, as her spouse remained unemployed. Further, "J’s" mother who had joined them a few months after their arrival had suddenly died of a heart attack. Although "J’s" physical and mental health had always been good she sunk into a depression. She slept poorly, worried constantly about her family in Bosnia, lost weight, and was overwhelmed by the duties of wife, mother and breadwinner. Finally, after waiting for almost two years, "J’s" family were accepted for resettlement in Canada.

At the time of the interview, "J" described her health as somewhat compromised by a respiratory condition which had originated in Slovenia. While "J" was struggling with worries about her family in Bosnia, grieving for the loss of loved ones, and a marital relationship that required a lot of readjustment, she was enrolled in ESL classes and worked as a volunteer interpreter. Her goals were to find work, successfully re-settle her children, regain her
health, re-establish a relationship with her spouse.

Participant #7 ("S")

This 42 year old Muslim woman spoke very quickly and moved about frequently during the interview. She had been in Canada for five months and lived with her two children (18 and 11 years). "S" had been educated and employed as an architect in Bosnia prior to the war. Leaving her spouse behind, she had narrowly escaped death while attempting to leave Bosnia with her children, sibling and parent. They resided with relatives in Slovenia but due to her refugee status, "S" had been prevented from working or obtaining social benefits there. Family relations soured after six months and she, her mother and children were forced to move. "S" began to take in laundry and combining her earnings with her mother’s resources they were able to afford a small apartment. Food and clothing were obtained mostly through humanitarian organizations. After volunteering her skills for many months, "S" was finally employed as an architect. However, seeing little future for herself or her family and discouraged by the discrimination she and her children were experiencing, she emigrated to Canada.

At the time of the interview, "S" reported her past health to be good except for hypertension which was controlled with medication. "S" reported health changes such as premature aging, memory impairment, poor dental health, depression, sadness, crying and loss of weight. She related all of these changes to her experiences of trauma and resettlement and to a marital relationship that was causing her a great deal of unhappiness. In spite of these difficulties, she insisted that her health was essentially good. "S" attended ESL and computer classes, delivered flyers in the evenings, and volunteered for a local art gallery. Her goals were to make more Canadian friends, find a full-time job, purchase a vehicle, obtain citizenship and travel Canada with her family.

Participant #8 ("D")

This 34 year old Croatian male had been a photographer in Bosnia before the war. "D" had been in Canada for six months and lived with his spouse and 3 year old child.

"D" had been forced to enlist in the military and was unable to leave Bosnia for 2.5 years. He described his experiences during
this period as "upsetting" and saw his survival as largely a matter of luck. Finally, while on military leave, "D" was able to escape from Bosnia. He spent a short time in Croatia before joining his family in Canada. He described this period as one of healing, as for the first time since the beginning of the war, he had enough to eat, drink and felt safe.

At the time of the interview, "D" was experiencing constant anxiety about the safety and well-being of his family remaining in Bosnia. He reported that his experiences during the war, and worry for his family negatively affected his psychological function. He experienced nightmares every 2-3 nights and certain sounds (loud and/or whistling) still caused him to start and to feel frightened momentarily. "D" was enrolled in ESL classes and worked part-time in the evenings as a janitor. His goals were to continue to heal, re-adjust to family life, find full-time work preferably in his area of expertise, attempt to help his family in Bosnia and establish a peaceful life.

**Participant #9 ("E")**

This 42 year old Serbian male was direct and appeared very confident. He had emigrated to Canada six months earlier and resided with his wife and two children (18 and 11 years).

"E" had earned a political science degree and worked as a journalist prior to and during the war in Bosnia. "E" remained in Bosnia after he assisted his spouse and children to escape. Due to the nature of political editorials he wrote during the war, his life had been threatened many times. Eventually he was able to escape Bosnia and for the next two years attempted to re-establish himself in three countries of asylum in Europe. Unsuccessful in his attempts, he joined his spouse and children in Canada.

At the time of the interview, "E" reported that during the war he had lost a total of 30 kilograms, his dental health deteriorated and for a period after leaving Bosnia, certain sounds would cause him to start and to feel frightened momentarily. However, "E" proudly reported that his health was good. Although he felt lucky to have survived the war, he was bitter about the loss of many friends and colleagues, his country and his career. "E" was enrolled in ESL classes and his goals were to find a full-time job,
preferably in journalism, and to attempt to rebuild a new life with his wife and children.

**Participant #10 ("B")**

This 39 year-old Serbian male appeared very intense and was very direct. "B" had been in Canada for six months and resided with his spouse and two children (11 and 4 years).

"B" had worked as an architect in Bosnia prior to the war. He had spent the first 2.5 years of the war in the military before escaping Bosnia. "B" described his survival during the war as a "miracle" and believed that it had been largely due to luck. During the war "B" had witnessed former friends adopt nationalist, ethnic views while others had used the war to further economic and/or political gains. These experiences, caused "B" feelings of anger and cynicism and problems related to trusting people, even in Canada.

At the time of the interview, although "B" believed that his physical and emotional health were good and would improve over time, he reported that he had lost around 27 kilograms during the war. He described his first months in Canada as "slightly disturbing", with vivid dreams about the war and momentary fear when he heard certain, loud noises. "B" worked part-time in construction but was hoping to find work in his area of expertise. His goals were to re-build a life with his family, assist his spouse to re-establish her career, and to lead a quiet and peaceful life.

**4.3 THEMES**

Participants' narratives of events and how these events were experienced and interpreted gave rise to four central themes including, war, survival, family and resettlement.

There were certain components associated with each theme, for example, the prominent components associated with the theme war were, life prior to and life during the war. When participants spoke of the trauma, suffering, persecution and forced displacement they suffered during the war, it was usually against a backdrop of what their lives had been like prior to the war, a contrast that engendered a great deal of emotional pain. Participants described the many tangible and intangible losses experienced with the advent of the war. A second theme that emerged from participant's
narratives was *survival*. Participants associated this theme with enduring the brutalities of war, in which genocide and ethnic cleansing played prominent roles, the dangers of escape, and thankfulness to be alive. The third theme to emerge from the participants’ narratives was *family*. Participants associated this theme with the disruption of close family relationships followed by separation, imminent loss and associated apprehension, and the hope of future re-unification. The fourth theme identified was *resettlement*. This theme was associated with participant’s experiences in a temporary, first country of asylum, as well as in Canada. Females’ experiences in a first country of asylum were more negative than those experienced by males. Resettlement in Canada for both genders, was associated with many tasks and challenges including learning the language, finding work, stabilizing (physically and emotionally), grieving, rebuilding, and setting future goals. Thus, the four central themes emerged in the dialogues, as temporal sequences. A more detailed assessment of these themes and their influences on health will be presented in Chapters 5, 6 and 7.

The next section will discuss the role of observations in rounding out an understanding of Bosnians and their culture.

4.4 OBSERVATIONS OF BOSNIANS AND THEIR CULTURE

The observations discussed in this section as well as those interspersed throughout the next chapters occurred at several different junctures and levels in the course of this study (see Chapter 3). These observations of participants and their environments, when combined (triangulated) with interview information and questionnaire data, added a crucial dimension that contributed to confidence in interpreting biological health, attitudes, behaviour, and psychosocial function.

Although none of the participants spoke fluent English, all were able to express their thoughts coherently. Participants seemed eager to share their story with me and expressed their feelings and opinions in a warm, open, confident, and uninhibited manner, whether they were discussing politics, health, traumas experienced or resettlement issues. Humour was evident in all stories told, even the saddest. Children were cherished, there was a lot of physical
contact between parents and their children, and while parents were very tolerant of their children's behaviour, they could also be firm if the situation warranted. The children were not shy but very openly curious and asked many questions. All apartments were sparsely decorated with second-hand furniture, but were orderly, well-kept and clean. Although many participants wore second-hand clothing, all were dressed fashionably, appropriately, and neatly, indications that they took pride in their appearances. Each participant and their families and/or friends appeared to have established relationships that were open and comfortable. For example, even though all participants had been in Canada a short time, friends often rang or visited during interviews, interactions were carried out in comfort, and guests were always welcomed. For example, I always received kind invitations to occupy the best chair, share a beverage and food, and during the winter interviews, a sweater and/or slippers were often offered for warmth. While the interview schedule was time-consuming (3 interviews, 5-6 hours) emotionally draining (subject matter) and all participants were busy from morning until night attending to the many tasks of resettlement, interviews were rarely rescheduled.

The next section will triangulate the responses from the demographic questionnaire with appropriate narratives from the interviews, and observations.

4.5 DEMOGRAPHIC PROFILE

The demographic findings when combined with pertinent interview information and observations resulted in a portrait that illuminated what life events were experienced by participants over time and how these experiences influenced their lives, attitudes, behaviours and health.

The ages of the ten participants spanned young adulthood to middle age, with a mean of 39 years (Table 1).

Half of the participants cited no religious preferences (Table 2). The remaining five identified Christian or Islamic religious beliefs but of these, three practised a religion. It has been noted that tolerance among all religions was exercised in the former Yugoslavia, even though there was an indifference toward its practice related to the pre-war socio-political environment
### DEMOGRAPHIC QUESTIONNAIRE RESPONSES

(Age and Sex)

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**TABLE 1**
### DEMOGRAPHIC PROFILE

#### SEX

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#### Religion

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#### Practices Religion

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#### Ethnicity

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#### Membership in Cultural Organization

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<td>5</td>
</tr>
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</table>

**TABLE 2**
Lovrenovic and Imamovic, 1992). One participant shrugging his shoulders commented,

"Church, synagogue or mosque are always close, side by side in my country. Peoples can go wherever they want, if they want, that is not a problem."

It was noted that it was primarily the elderly that actively participated in the practice of religion. For example, a participant reported,

"Mostly it is old people (who attend church). Village people...people from the hills."

Participants identified their ethnic groups as Muslim, Bosnian, Croatian or Serbian, and six of the eight marriages were between people of these different ethnic groups (Table 2). Since two out of three marriages in the former Yugoslavia were interethnic, (Ali & Lifschultz, 1993) interview information revealed that the war placed inter-ethnically married participants in a painfully impossible and dangerous situation that threatened the lives of their spouses and children in the ethnic polarization that occurred in Bosnia during the war. Leaving the country was the only way to preserve their family units. One participant angrily explained this situation as follows,

"How can I choose? He is Croat, I am Muslim. What our children then? Can we cut them in half and say, you go there and you there? It is impossible."

No participant was involved in a Bosnian cultural organization (Table 2). Interview information revealed that participants were saddened and traumatized by the ethnic divisions and atrocities that took place during the war. Consequently, mingling with Bosnian people in Canada was not only a reminder of the sadness and trauma suffered, but caused a pervasive sense of distrust toward former compatriots who may have committed crimes during the war. One participant stated abruptly, "Why I should go there? People only argue about the war. I had enough of that. I want to forget." Another participant said angrily, "I see some people there. I know what they did in the war. I don't want to talk to them." These feelings are in agreement with previous investigations that established that refugees in a country of second asylum were often suspicious about former compatriots and this attitude led to group factionalism and inhibited cohesiveness
Males spent an average of two months in a country of first asylum (Table 3). According to interview information, this short period of time was largely positive because it represented survival, a culmination of a successful escape from the military and Bosnia, and a first step toward a new life. Smiling broadly, one participant commented,

"It's another world. Electricity, water, much food, normal life, don't have police. For the first time in over 2 years, I was warm and saved."

The female experience in a temporary country of resettlement differed in that the average stay was 18 months. These participants endured constant worry pertaining to the lives of their spouses who remained in Bosnia, they experienced discrimination, and some were alienated by host families who had initially offered assistance. One woman sobbing, told the following story,

"The children fight and put him (son) into the mud and beat him because he is a Bosnian. He didn't tell me what's happen. But he was blue (bruised)."

Another woman quietly commented on how discrimination had affected her 10 year old son, "My son, he was shamed to speak Bosnian. He is very blonde and could pass for German, so he only speak German."

Another female tearfully expressed what it was like being rejected by family,

"And we were with them (family) a few months and they say, "Enough, we don't want you here anymore." I can't understand that, even now. That hurts."

One woman spoke of the daily anguish she experienced pertaining to the well-being of her spouse.

"I fear for the life of my husband. Over one year I didn't hear from him. I don't know if he alive or dead. Each time the phone rings I am under stress."

These women were not eligible to receive social benefits or to legally take employment. Consequently, they were forced to work illegally, at less than minimum wage, in order to avoid having to reside in a refugee camp. One woman sadly told the following story,

"I was in a refugee camp just once. I cried. I think for normal people it is impossible to live there. People who lives there because very depressed. I don't know what will happen with me and my children in that kind of camp (so) I was paid less for the same job but I did it so my family would not go to (a) refugee camp."
### DEMOGRAPHIC PROFILE

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<tr>
<td>1993 (Sarajevo)</td>
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<td>1</td>
</tr>
<tr>
<td>1994 (Livno, Sarajevo)</td>
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</tr>
<tr>
<td>1995 (Sarajevo)</td>
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<td>1</td>
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<tr>
<td>1995</td>
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<td>2</td>
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<tr>
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<td>Spouse</td>
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<td>Friends</td>
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**TABLE 3**
When it became evident that their spouses might not be able to join them for months and maybe years, these women made the decision to immigrate to Canada alone or with their children and to begin establishing a new life. Data describing arrival in Canada and sponsorship are outlined in Table 3. According to interview information, supports that church sponsors provided to four participants included financial aid, home and telephone visits, dinner invitations, housing, clothing and food as needed. Church sponsored participants were thankful for these supports but indicated that at times they found these intended kindesses intrusive. Since the church was providing financial aid and housing, participants felt an obligation to agree to other social overtures, even when they preferred not too. One participant said in a quietly angry voice,

"I don't like her, she just comes here and sits. I know she is kind but sometimes I just want to be alone."

Participants who were sponsored by a Government program did not report experiencing this discomfort.

Participants were either granted landed immigrant status before arriving in Canada or within a few months after arrival. Interview information revealed that receiving landed immigrant status enabled participants to be eligible for social benefits, work training programs and to legally seek employment.

All participants resided with or close to family members or friends in Canada. Interview information revealed that participants were able to communicate by telephone with family members in Bosnia, on the average of once every two weeks. Participants experienced constant anxiety about the safety of their families, were struggling to learn English, establish a stable home, attempting to come to grips with losses they had experienced, as well as to find employment. Those women who were single parents described this period as hectic and exhausting but also expressed pride at their accomplishments and ability to cope. One participant smiling proudly said,

"I knocked (on doors) everyday, I phone and try (a) hundred times and I find a job and I did my job and many other job that my family can live. I start to volunteer and deliver newspapers. I met people. How I can learn if I don't meet people?"
Previous investigators have found that women who experienced upheaval and losses learned how to handle these events better and developed stronger coping skills (Elder & Likert, 1982). One of the single males resided with friends and the other with parents in Canada, while the married males joined their spouses and children who had preceded them to Canada.

According to interview information, couples experienced difficulties re-integrating and re-establishing a relationship. These marital difficulties centred around issues such as, how time apart and differing experiences had changed the relationship, child-rearing, and an alteration in roles. These issues caused a great deal of tension within these relationships. For example, one female stated,

"Bosnian men doesn't know how to cook, to sew. They (are) not like Canadian men. They have to learn."

Another participant spoke seriously of the negative effects of change,

"We are quite different. We both have more experience in life. Ways in which we hadn't before. And we looking at life difference. I'm not the person which I was before but I have to live. He (spouse) change very much. Everything is different when everything is okay but when there is trouble, I think women are more strong than men."

Conversely, the female participant who had left Bosnia, resided in a temporary country and resettled in Canada with her family intact presented a very different perspective. She said,

"Before the war I had (a) marriage with sometimes trouble but I think now we (are) stronger. We now have problems but its qualitatively different."

Nine participants possessed a post-secondary education, and all participants had been engaged in full-time, professional occupations in Bosnia prior to the war (Table 4). Since arriving in Canada, four participants had found part-time employment, all were seeking full-time work, and eight were receiving assistance. Interview information revealed that although part-time employment was considered as temporary and unskilled, it enabled participants to feel useful and positive about their ability to find employment, to improve their English, and to put them into a position of realistically assessing the job market by establishing contact with Canadians. One participant stated,
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<td>Economist</td>
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<td>Editor</td>
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<td>Journalist</td>
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<td>Professional Course</td>
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TABLE 4
"I like to work my job (profession) but I know its impossible now. I like first learn English. If I stay in it will be difficult for my occupation, but I can change. Now I have job (part-time). I will try for full-time. But now I have good money and its a good job for me. Its okay."

It has been found that Bosnian people resettled in a country of second asylum are very motivated to achieve, but have difficulty reaching out to accept help from others as they would rather remain as independent as possible and solve problems on their own (personal communication, Don Climent, International Rescue Committee, San Francisco, California, January 4, 1996). To illustrate, one participant stated,

"I, in my life, want to succeed (at) everything. I'm happy that I succeed and stand on my (own). I feel good about that. I do not want to lose my independence. I want to work at something, to contribute. I have some ideas."

Considered crucial to obtaining full-time employment in the future were, upgrading skills, English, and education as necessary. One participant stated,

"I'm a university graduate. I will learn English then get a job at something I know."

Responses to questions about income, relatives in Canada, language of preference, and citizenship are illustrated in Table 5. Incomes from Government or church sources were augmented by 5 participants, or their spouses, with part-time occupations such as, clerking, custodian, selling art, construction and delivering flyers. No participant was receiving income from a source outside of the country. According to interview information, participants felt their incomes were adequate to provide the basics of life (food, clothing, shelter, etc.) but were worried about what would happen if they were unable to find employment once this support was terminated (usually one year). This impending situation created an increasing tension as time elapsed. It had been found that one of the primary tasks faced by refugees in a country of second asylum is finding employment, while the fear of an inability to provide for family caused stress in refugees of both genders (Kemp, 1993; Farias, 1991). One participant anxiously reported,

"In six months, the Government money is gone. I must learn better English, I must find a job."

Relatives residing in the country of origin consisted of close
## DEMOGRAPHIC PROFILE

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<td>$350. – $399. (1 adult, 2 children)</td>
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<tr>
<td>(2 adults)</td>
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<td>$400. – $449. (1 adult)</td>
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<tr>
<td>(2 adults, 1 child)</td>
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### Education of Person(s) Providing Income

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### Occupation of Person(s) Providing Income

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<td>Student, selling art</td>
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<tr>
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### Relatives in Country of Origin

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### Relatives in Area or Within 4-Hour Drive

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<tr>
<th>Relatives in Area or Within 4-Hour Drive</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

### Language of Preference

<table>
<thead>
<tr>
<th>Language of Preference</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Bosnian</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

### Hear About Study

<table>
<thead>
<tr>
<th>Hear About Study</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESL</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Friends/Relatives</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

### Apply for Citizenship

<table>
<thead>
<tr>
<th>Apply for Citizenship</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

**TABLE 5**
as well as extended family. Interview information revealed that participants worried daily about the fate of those left behind and looked forward to the next time they would be able to communicate with their families by telephone, sacrificing scarce financial resources in order to do so. One participant commented,

"It is expensive to call but all my family stay in Bosnia, you know. I miss my parents, my brothers and family from my brothers. I miss my family."

Watching and/or listening to the daily news for any information on how the war was progressing caused varying degrees of anxiety and guilt about leaving relatives behind. For example, another participant, fighting to hold back tears, stated,

"My parents and sister (are) in Sarajevo but I can't help them. When I watch tv news at night and see what's happening (Bosnia) I want to help them but I can't. I think about them everyday and everytime."

Five participants had cousins living within a 4-hour drive. Interview information revealed that due to distance, cost, lack of transportation and/or hectic schedules, telephone conversations were common while visits were rare.

Nine participants attended ESL and/or business courses. Four participants preferred to speak English while the remaining six preferred Bosnian. Interview information revealed that all participants had known a little English prior to coming to Canada. This had been acquired through studying English at schools in Bosnia, travelling to Western Europe or being in contact with tourists who visited Bosnia before the war. Those participants who preferred to speak Bosnian wanted to preserve their language in order that their offspring could retain some of the culture that had been lost. However, they did not want to sacrifice the acquisition of good English skills either. One participant said,

"They (children) must know English to do well at school and find a good job later. (But) also to know another language, the language of their country, is important."

All participants intended to apply for Canadian citizenship within three years of their date of arrival in Canada. Interview information revealed that participants were committed to establishing a life in Canada and consequently, had no desire to return to their country of origin to reside, even when the war ended. This finding is consistent with previous evidence in which
it was established that few Bosnian refugees who reached a country of second asylum intended to return to their homeland to re-establish residency (Ajdukovic and Ajdukovic, 1993; Kemp, 1993). Reasons given by participants for not returning were, that there was little future for their families in a country that had lost its infrastructure and where ethnic tensions ran high and, there would be little opportunity to build a meaningful life in Bosnia for many years to come as jobs and resources would be scarce and a new political agenda still had to be set. One participant angrily expressed the following,

"We saw weapons, (heard) the guns. We live before in peace. We didn’t know what happened. Why? For what would I go back? There is nothing there for me now."

Participants revealed feelings of shame, disappointment, anger and hurt over what had occurred in their country of origin. One participant tearfully expressed this as follows,

"I could never believe, even in a million years, that this could happen in my country. I was raised in peace, where all peoples accepted each other. I can’t understand how such a thing could happen, how people could allow it to happen."

Triangulation of the demographic data, interview information and observations provided knowledge and meaning about personal and family histories, cultural and religious attitudes and practices, and the psychosocial and political environments of participants. Discovering events as experienced by participants prior to and during the war, while escaping Bosnia and resettling, produced an understanding of the reactions to these events, and their influences on health over time. These influences will be explored in more detail in subsequent chapters.

The following section will combine (triangulate) the responses from the health questionnaire with appropriate narratives and observations.

4.6 HEALTH PROFILE

The health profile was constructed through combining the answers from the health questionnaire (Appendix 5, Tables 6 – 9) interview narratives, and observations. This profile served as a health chronology, supplementing and adding context to the preceding demographic and interview information, and providing another dimension for the interpretation of the experiences of refugee
trauma, forced resettlement and health.

Examination of participant's weights in Table 6 illustrates that there was very little weight fluctuation among those three females who were able to escape Bosnia within the first few months of the war. Those males who had been in the military reported losing between 2 and 13 kg. while the participants who remained in Bosnia as civilians, lost between 8 and 12 kg. of weight. Past reported weights of those participants who did not spend a long time in Bosnia during the war are most likely to be more accurate than those citizens and military personnel who spent longer periods there. Indeed, some interview information revealed that a few participants reported losing more weight, however, it was also revealed that the opportunity to observe and monitor weight was either not a priority or a possibility during the war. Nonetheless, the weight losses that seven participants experienced during the war caused by lack of adequate nutrition had largely been regained during their resettlement in Canada, and eight were within 5 kg. of their desired weight.

Civilians received less food then military personnel during the war, as the latter group were given priority when food was distributed. This situation caused male participants who served in the military to experience feelings of shame and guilt at seeing civilians, especially children, the elderly and women hungry and so severely malnourished. One participant commented,

"Most just get a little" (gestured with thumb and forefinger) "rice, beans. Soldier is not a lot (but) soldier have got some food (but) women, children, very bad."

Hunger motivated people, especially children to seek out military personnel in order to obtain food. Softic (1995) wrote,

_Hunger has leapt at our throats, crept into our homes. Hungry people are waiting for the (soldiers) to give them the leftovers of their dinner. The queue stretched out into the street, up to 200 metres long. People wait four or five hours. Children swarm around troop carriers and trucks, pampered city kids, who only eight months ago were hanging out at the corner stores, choosing from the candy counter their favourite treats._ (pp.77)

In the summer, in order to survive, participants ate whatever vegetation could be found including leaves, various weeds and grass. When humanitarian aid was available, participants received small portions of subsistence foods, such as rice, beans, and cooking oil.
## HEALTH PROFILE

<table>
<thead>
<tr>
<th>Future</th>
<th>Height cm*</th>
<th>Past</th>
<th>Present</th>
<th>Anticipated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>154</td>
<td>43</td>
<td>54</td>
<td>54</td>
</tr>
<tr>
<td>2</td>
<td>172</td>
<td>50</td>
<td>58</td>
<td>58</td>
</tr>
<tr>
<td>3</td>
<td>167</td>
<td>83</td>
<td>83</td>
<td>68</td>
</tr>
<tr>
<td>4</td>
<td>160</td>
<td>60</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>5</td>
<td>167</td>
<td>65</td>
<td>62</td>
<td>65</td>
</tr>
<tr>
<td>x</td>
<td>164</td>
<td>60</td>
<td>63</td>
<td>61</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Male</th>
<th>Height cm*</th>
<th>Weight Kg.*</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>192</td>
<td>80</td>
<td>85</td>
<td>80</td>
</tr>
<tr>
<td>2</td>
<td>169</td>
<td>70</td>
<td>75</td>
<td>70</td>
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<tr>
<td>3</td>
<td>183</td>
<td>80</td>
<td>82</td>
<td>82</td>
</tr>
<tr>
<td>4</td>
<td>181</td>
<td>85</td>
<td>97</td>
<td>115</td>
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<td>5</td>
<td>194</td>
<td>85</td>
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<td>98</td>
</tr>
<tr>
<td>x</td>
<td>184</td>
<td>80</td>
<td>87</td>
<td>89</td>
</tr>
</tbody>
</table>

* 1 kg. = 2.2 lbs.
1 cm. = 0.03281 ft.

**TABLE 6**
Meat, fruits, vegetables, milk products and grains were only intermittently available through the black market at exorbitant prices, consequently, these foods were not consumed for months at a time. Those participants who did not receive adequate nutrition experienced health problems such as damage to and loss of teeth and hair, lethargy, sleeplessness, and cessation of or erratic menstrual cycles in women. One participant reported,

"In that two-year period I fluctuate between 45-58 kilos. I was bleeding from the gums. My body it was stretched. I was in a panic and very, very afraid. I stop menstruating."

Lack of food and the survival of offspring were the primary reasons that some participants left Bosnia. One woman tearfully explained,

"I think, "Should I go or should I stay?" In summer I could grow some food but in November, the snow came, there was little food or water for anyone. I was scare that she (child) die."

Another woman related the following,

"We hadn’t any milk, we hadn’t bread and we have to wait in long line (for food) and the snipers shoot. I took my children from the war because I know that there they wouldn’t be healthy anymore."

Most of the health conditions identified in Table 7 did not indicate appreciable increases or decreases over time. That is, if a health condition had been identified in the past, it was also identified in the present and anticipated future. Interview information revealed that most of the health conditions identified were intermittent and were considered to be innocuous in that they did not affect daily function. One participant reported,

"My mother and me we have high blood pressure. I have this, maybe its family? (But) I haven’t anything wrong with my body."

Self-rated health was reported by participants as remaining consistent over time. Very few participants reported problems with eyesight or hearing (Table 7). According to interview information, the dysfunctional hearing identified by three males in the past had been due to temporary deafness (lasting 2 - 5 days) experienced after engaging in prolonged battles. One male said,

"Sometime if there is big battle, much shooting and shelling, I can’t hear for sometime hour, day after."

Past emergency room visits cited by participants had been made mostly in childhood and young adulthood for minor injuries and
HEALTH PROFILE

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Past</th>
<th>Present</th>
<th>Anticipated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Back pain</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Arthritis</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Asthma/Breathing</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Stomach/digestive</td>
<td>2*</td>
<td>2*</td>
<td>2*</td>
</tr>
<tr>
<td>Joint/bone</td>
<td>1+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td>1</td>
<td></td>
<td></td>
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</table>

2. SELF-RATED HEALTH

<table>
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<th></th>
<th>Past</th>
<th>Present</th>
<th>Anticipated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good near sight</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Good far sight</td>
<td>9</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Hear well in group</td>
<td>8</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Hear well 1:1</td>
<td>8</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Emergency room visits</td>
<td>6</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Use of medications</td>
<td>8</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

3. PROFESSIONALS VISITED

<table>
<thead>
<tr>
<th></th>
<th>Past</th>
<th>Present</th>
<th>Anticipated</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner</td>
<td>10</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Specialist</td>
<td>7</td>
<td>2*</td>
<td>5*</td>
</tr>
<tr>
<td>Dentist</td>
<td>10</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>4</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Optometrist</td>
<td>9</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td></td>
<td>2*</td>
<td></td>
</tr>
<tr>
<td>Chiropractor</td>
<td>1*</td>
<td></td>
<td>1*</td>
</tr>
<tr>
<td>Psychol/Social Worker</td>
<td>3</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Herbalist/Naturopath</td>
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<td></td>
<td>4</td>
</tr>
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</table>

4a) DENTAL CARE

<table>
<thead>
<tr>
<th></th>
<th>Past</th>
<th>Present</th>
<th>Anticipated</th>
</tr>
</thead>
<tbody>
<tr>
<td>No dentures</td>
<td>5</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Partial dentures</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Full dentures</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Regular visits</td>
<td>10</td>
<td></td>
<td>10</td>
</tr>
</tbody>
</table>

b) LAST DENTAL VISIT

<table>
<thead>
<tr>
<th></th>
<th>Past</th>
<th>Present</th>
<th>Anticipated</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 3 months</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 - 6 months</td>
<td>2</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>7 - 9 months</td>
<td>3</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>10 - 12 months</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over 1 year</td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

+= Male response only, *= female response only

TABLE 7
illnesses. The single emergency room visit in Canada had been for a child's respiratory infection. Some participants reported that the increased number of emergency room visits anticipated in the future would be related to their aging process and/or offspring. One participant explained this as follows,

"Maybe for my children or when I get older I will have more sickness."

The use of prescription and non-prescription medications varied little over time, however, females reported taking more (Table 7). According to interview information, most medications taken by both genders, consisted of across-the-counter types such as aspirin, aids for indigestion, and cold remedies. Generally, most participants indicated they chose not to take medication of any kind. For example, one participant stated emphatically,

"I don't take medication for this condition. I think I can make this better."

Females had or anticipated having twice the number of health consultations than the males over time (Table 7). Interview information revealed that if the advice of a health professional was deemed necessary, female participants had less difficulty than males in seeking this advice, either for themselves or their families. Consulting was seen by one woman as a preventive technique that would ensure existing good health. She stated,

"I check my body every six months, one year (so) I won't have trouble later."

Conversely, most male participants attempted to minimalize or deny any perceived or real health difficulty, thus, they had fewer consultations over time. For example, one male participant who had been experiencing a negative health condition intermittently over the course of two months stated,

"I have this little problem. I think that it doesn't very difficult problem and I think for my health...it will be excellent in the future."

The fewest number of consultations by both genders were reported since resettling in Canada. According to interview information, the primary reason was that participants did not experience health difficulties that necessitated a consultation or if they did, they chose to self-treat. One participant offered the following,

"I don't know how (it) is here, but in my country we use very much herbs for many things" (health conditions).
This point of view was shared by other participants as a consistent number identified herbs and/or vitamins as forms of self-treatment in the past, present, and anticipated future.

All participants had received regular dental care since childhood and until the start of the war in Bosnia. In Canada however, only three had seen a dentist, all for emergencies (Table 7). Interview information revealed that all participants needed this care as dental health had deteriorated since the war. Those who had spent prolonged periods in Bosnia during the war were most acutely in need of dental care. One participant stated,

"*I have bad tooth. My tooth was fine until war when not enough food and no time to take care of it.*"

Further, those who spent prolonged periods in a country of first asylum where they were not eligible for health and social benefits were also in acute need of dental care.

Interview information revealed that health coverage in Bosnia had included both dental and optical care. One participant explained,

"*Because its not private (health plan) you know, and all these things was in Government. In our country we have all...eyes, teeth, all is covered. (It) was a good organization.*"

All participants identified finding employment through which they could access extended health benefits as the answer to providing themselves and/or their families with the comprehensive health care they had been accustomed to.

Examination of the data in Table 8 illustrates that the primary way to change health identified by most participants was to increase exercise. A previous correlation between choosing exercise as a way to change health and higher education might also apply to the participants in this study (Ontario Health Survey 1990). Interview information revealed that participants were more interested in exercising in order to maintain their health than to lose weight. For example, one participant stated in a very confident manner,

"*In my country I liked exercise, sports, action. My fitness is a consequence of exercise.*"

Information on reproductive health is illustrated in Table 8. In the past, participants had employed a number of birth control methods including, the birth control pill, condoms, and the IUD.
HEALTH PROFILE

1) WAYS TO CHANGE HEALTH

<table>
<thead>
<tr>
<th>Activity</th>
<th>Past</th>
<th>Present</th>
<th>Anticipated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lose Weight</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
</tr>
<tr>
<td>Gain Weight</td>
<td>1+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change eating</td>
<td>2*</td>
<td>2*</td>
<td>3*</td>
</tr>
<tr>
<td>Stop Smoking</td>
<td>6</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Reduce medication</td>
<td>1*</td>
<td>2*</td>
<td>2*</td>
</tr>
<tr>
<td>Exercise more</td>
<td>4</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Nothing</td>
<td>1+</td>
<td></td>
<td>1+</td>
</tr>
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</table>

2) REPRODUCTIVE HEALTH

<table>
<thead>
<tr>
<th>Activity</th>
<th>Past</th>
<th>Present</th>
<th>Anticipated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of contraceptives</td>
<td>10</td>
<td>6</td>
<td>8</td>
</tr>
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</table>

3) LIFESTYLE AND SAFETY

<table>
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<th>Activity</th>
<th>Past</th>
<th>Present</th>
<th>Anticipated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoke cigarettes</td>
<td>8</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Drink alcohol</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Wear seatbelts</td>
<td>6</td>
<td>8</td>
<td>10</td>
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</table>

NUTRITION

<table>
<thead>
<tr>
<th>Activity</th>
<th>Past</th>
<th>Present</th>
<th>Anticipated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most important foods</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fruits &amp; vegetables</td>
<td>9</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Most important to limit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fat</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

* = female response
+ = male response

TABLE 8
The latter had been the preferred method of contraception used by women. Interview information revealed that there were various reasons for avoiding oral contraceptives, such as a belief that use would be detrimental to the health of women over time, side effects (weight gain, mood swings, bloating) or, the dislike and/or responsibility of taking a pill daily. One female who believed that most birth control methods could be detrimental to her health, had undergone four abortions, as abortion had been a legal procedure in the former Yugoslavia. At the time of the interview, those females whose spouses had not joined them had discontinued the use of birth control methods. In the future, nine participants intended to employ contraception, as long as pregnancy was a possibility. Interview information revealed that most of the married participants had completed their families. Only one woman, smiling shyly, openly stated her desire to have more children once she was re-united with her spouse, "You know, I'm not so young. I don't have too much time to make more babies."

Although eight participants had smoked cigarettes in the past, this number was halved in the present and three anticipated to be smoking in the future. Interview information included reasons why participants had begun to smoke tobacco. One reason was that smoking had been a way to impress peers and to feel "grown-up". One participant said,

"Actually, a lot of us smoke....everybody smoke. I smoke when I have 16 years, 17 years old."

In the former Yugoslavia, smoking was very common, quite acceptable and very cheap, while in Canada smoking was considered very expensive. One woman explained,

"I try not to smoke. It's very, very hard. At home, in our offices, everything smell. That's horrible. Everywhere, people don't smoke, not here. Nobody smoke. Now I see how this is bad and its very expensive."

One participant who intended to continue smoking rationalized this behaviour in the following way,

"I take not more than 5 cigarettes (then) I stop it. Sometimes if I'm in with people who smoke then I smoke. When I was in ... I was nervous. I smoke half box a day. My grandmother smoke two box in one day. She have 88 years when she died."

Eight participants reported drinking alcohol on a regular basis
and intended to continue to do so into the future. According to interview information, regular drinking was defined as only drinking alcohol on special occasions, or, drinking a few glasses of wine or bottles of beer per week.

Seatbelt use was identified more frequently in the present and anticipated future than in the past. Interview information indicated that prior to the war, seatbelt laws were not strictly enforced in many parts of the former Yugoslavia. Those participants who had begun to wear seatbelts in the past had been mostly married with families and had done so in order to ensure the safety of their children. The number of participants who had begun to wear seatbelts in Canada increased because not only was it the law, but the law was enforced.

Nine participants chose fruits and vegetables as the most important food group to consume while fat was identified by over half of this group as most important to avoid. Interview information revealed that all participants knew that foods from the four food groups had to be consumed regularly in order to maintain health (Ministry of Health, 1989) and the avoidance of fat became increasingly important as one aged. The interviewer noted that all homes had a bowl of fruit on the table and most children would choose fruit as a snack.

The data in Table 9 illustrates that over time, most participants reported no problems with their memories and those who reported a "little" forgetfulness also remained consistent. Only one participant reported amnesia in the past. Interview information revealed that after leaving Bosnia and while residing in a temporary country, this participant sometimes could not remember certain events that had occurred during the war. She explained,

"It's very hard if you have something in your life, in a normal life, and for one night you lose everything. In [ ] , sometimes at night, I wanted to remember, "Where is this book, or some nice things (I had)?" What happened I don't know. I can't remember now everything."

Most participants reported that their thinking had been clearer in the past then at the time of the interview. Interview information revealed that participants defined clear thinking as being able to prioritize and organize the overwhelming and
HEALTH PROFILE

1a) MEMORY

<table>
<thead>
<tr>
<th></th>
<th>Past</th>
<th>Present</th>
<th>Anticipated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can remember most...</td>
<td>6</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Forget a little...</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Unable to remember...</td>
<td>1*</td>
<td></td>
<td>1*</td>
</tr>
</tbody>
</table>

b) THINKING

<table>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Good...</td>
<td>9</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Little difficulty...</td>
<td>1</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Great difficulty...</td>
<td></td>
<td></td>
<td>1*</td>
</tr>
</tbody>
</table>

c) STRESS

<table>
<thead>
<tr>
<th></th>
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<th>Present</th>
<th>Anticipated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cope well...</td>
<td>8</td>
<td>6</td>
<td>10</td>
</tr>
</tbody>
</table>

2a) SUPPORT, FEELINGS

<table>
<thead>
<tr>
<th></th>
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<th>Present</th>
<th>Anticipated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can find support...</td>
<td>8</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Can express feelings...</td>
<td>7</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Can confide in...</td>
<td>9</td>
<td>8</td>
<td>10</td>
</tr>
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</table>

3. RELAXATION

<table>
<thead>
<tr>
<th></th>
<th>Past</th>
<th>Present</th>
<th>Anticipated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased exercise...</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Reading...</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Worry less...</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>See friends...</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
</tr>
<tr>
<td>Get out more...</td>
<td>4</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Time with family...</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Work or sleep...</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

4. LEISURE TIME

<table>
<thead>
<tr>
<th></th>
<th>Past</th>
<th>Present</th>
<th>Anticipated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost all by self...</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1/2 with others...</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Almost all with others</td>
<td>5</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

*female response only

TABLE 9
exhausting number of tasks that had to be accomplished each day, such as personal and child care, job hunting, shopping, etc. Sluzski (in Curran, 1986) found that the many tasks that had to be accomplished by newcomers in order to adjust and adapt often resulted in an ability to focus on immediate concerns, while the larger picture remained fuzzy and relegated to the background. At the time of the interview, fewer participants felt they were coping as well with stress as they had in the past, or hoped to in the future. Interview information revealed some of the problems related to coping, such as memories of trauma either witnessed or experienced in Bosnia. One participant recounted the following, "We know they (soldiers) would come back. We don't know what to do, where to go. We moved everyday and slept in elevators between floors at night. I was very afraid."

Another participant remembered the following incident. He spoke very quietly and avoided eye contact, "The soldier wants to kill me. I was beaten with a club. I almost die."

Ruminating about family members remaining in Bosnia and guilt about having left loved ones and country behind were identified as sources of stress that sometime hampered coping. One woman stated, "I wait for the moment when I can see my family. I will be better when I can see them."

Another participant said, "I want to stay, but I see this is impossible. Then my husband say, "You go out now", and we (participant and children) went out."

Worry about finding employment in Canada, and grief related to losses both tangible and intangible, were other sources of stress for participants. For example, one male said angrily, "I build so much in my life and now it is all destroyed. I must learn English then I must find (a) job."

The stresses experienced during resettlement in Canada impacted on participants and their health causing poor sleep patterns, nightmares, lowered concentration, digestive upsets, sudden shaking, sweating, and a feeling of undefined fear. For example, one participant related the following, "If I think too much of those times, I can't sleep."

Another participant said, "I have problem maybe with nerves. I usually have nightmare...bad
dreams. Sometimes I can't sleep. Bad memory. Sometimes I start to shake and sweat and can't stop. I thinking I again in the war and I have feeling for high frequency, loud sound. I jump and feel scared."

Over time, most participants said they had been able to find support, discuss feelings and confide in someone. However, most of these participants were either living with adult family members or had continued close friendships with Bosnians whom they had known in their country of origin. Interview information revealed that this was not the case with those participants who had not been able to forge close friendships with either Canadians or Bosnians or whose spouse was still in Bosnia. One of these participants said tearfully,

"I would like some Canadian friends (but) its much harder connecting to people here. I really make emotional investments in my friendships (but) it takes time."

Participants' abilities to find support and confide in others over time were quite consistent. It was only with regard to expressing feelings in the present, that more participants described experiencing difficulty.

Overall, except for exercise that showed a slight increase over time, all other methods of relaxation over time remained quite consistent (Table 9). Corresponding findings emerged when participants discussed ways in which they spent their leisure time. Further, most participants chose to spend almost all, or at least half of their time with others.

The next section will discuss the findings from the validation interview.

4.7 VALIDATION INTERVIEW

Each participant was given a copy of the investigator's interpretation of the informal interview (Appendix 10). One participant disagreed with part of the investigator's interpretation of the informal interview that referred to his feelings pertaining to his employment prior to the war. After discussing this matter in detail with the participant and referring back to the original interview, the investigator agreed that part of her interpretation had been incorrect and subsequent changes were made.

Since this interview represented the third of three visits that spanned a period of approximately three months, a rapport had been
established between the investigator and the participant and family. Further, all participants had trusted me with sensitive and painful information, tears had been shed, food shared, and I had met friends and family. Consequently, while representing a short period in time, the interactions had been intense and the time required often extended beyond that originally planned. It was for these reasons that part of this interview time was devoted to formally terminating a relationship that had been formed, not on longevity, but on sharing deep and intense emotions, tears, and laughter.

**Synthesis**

This chapter presented and integrated the findings from the ethnographic and validation interviews, observations, and the demographic and health questionnaires. Triangulating the information and data from these sources illuminated different dimensions of the phenomena under study, and resulted in the identification of four themes that represented the central experiences of participants.

Findings from the above multiple indicators demonstrated that while participants experienced stress related to trauma and resettling, none reported or was exhibiting overt signs of negative health or function. That is, participants generally appeared to be functioning adequately physically, socially, and psychologically. Positive health and function was evidenced by the abilities to problem solve realistically, cope with traumatic memories, establish new relationships, plan for the future and perform activities of daily living, such as caring for selves and/or others, budgeting, searching for employment, learning English, and freedom from physical limitations.

While the experiences of refugee trauma, forced resettlement, and their sequelae caused varying amounts of stress among participants, there were indications that over time, cumulative personal and socio-cultural characteristics contributed to participants being able to cope with the stress and hence, to positively transform negative experiences. Lastly, the part played by selection cannot be ignored. While many refugees sought humanitarian asylum in Canada, selection is generally based on those judged to have the best chance of succeeding (Young, 1991). The
next two chapters will examine the four themes in more depth in order to identify patterns, similarities and dissimilarities that will further explain the central aspects of refugee trauma, forced resettlement and health over time.
CHAPTER 5

WAR, SURVIVAL AND HEALTH

Four themes were identified in Chapter 4 that pertained to refugee trauma and resettlement. Discussion in this chapter will elaborate on and develop further two of these themes (war and survival). The third and fourth themes, namely resettlement and family, will be discussed in Chapter 6. Information in this chapter is primarily qualitative however, quantitative data from the health and demographic questionnaires and observations are included where pertinent.

The interview was initiated with an open-ended probe meant to elicit information about health and the experiences of trauma and resettlement. The investigator began the interview with the following statement,

"I would like to discuss your health with you. Perhaps we could start the discussion with the following question: When you think of your health, or hear the word ‘health’, what feelings or thoughts come to your mind?"

This probe did not label or connect trauma or resettlement to health in any way, nor was the issue of health over time identified thus participants were allowed to define and colour their own experiences. Participants' initial responses to this pivotal lead-off question are included in Appendix 11. It is noteworthy that four males and two females generally defined positive health as a balance between physical and mental health, while two others defined health in terms of activity. Other definitions referred to the importance of vitamins, fresh air, food, water, and friendship. While some of these initial responses were similar, the interviews revealed the uniqueness of each individual's health beliefs.

The information that emerged from the interviews contained remarkably consistent reports of experience, despite the differences in conditions noted in Chapter 4, (time spent in Bosnia, survival, escape, amount of loss and disruption, experiences in a first country of asylum, sponsors, and support). While participants described the experiences of trauma, forced resettlement and their sequelae as extremely stressful and in some cases, posing risks to health, participants' descriptions of their experiences were not all
negative. Discussions also included positive descriptions, such as: relief that they had survived the war and maintained good health; the opportunity to re-unite families; initiating new employment; finding peace and security in their host country. They all had hopes (rather than fears) for the future. Nonetheless, it was clear that resolving feelings associated with the trauma experienced, and coping with negotiating the many tasks and demands of resettlement, would have to be accomplished before a level of comfort could be reached and optimal health and future opportunities realized.

5.1 THEMES

Interview information, while providing an overview of the ways in which the experiences of trauma and forced resettlement affected refugee health and function, also revealed common themes that represented the main foci of discussion to which participants would come back time and again. As briefly noted in Chapter 4 these themes included: war and its impact on the lives of participants; survival within and escape from Bosnia; resettlement in first and second countries of asylum; and, the importance of family. These themes represented the central aspects of the experiences of refugee trauma and resettlement that had implications for participants' health. In this Chapter as well as Chapter 6, information pertaining to each theme or components of these themes, are linked specifically to participants' narratives.

1) WAR

Participants' struggles to find meaning in the suffering war had inflicted on them inevitably included contrasting descriptions of the nature of their lives during the war with the time of peace that preceded the conflict. Consequently, the odyssey into which participants were thrust began with a description of their lives before the war.

a) Life Prior to the War

Quality of Life

Participants described living in stable family environments within a tolerant, pluralistic, and peaceful country. As citizens of the former Yugoslavia, the advantages and opportunities that participants described included education, employment, housing, health and social benefits. The political regime was a benevolent
one in that citizens were free to pursue their chosen vocation, express their views, and to travel outside of the country. One man described his life and country as follows,

We were as any normal country in a society close to this. We have many things, very good life before. In general, people were very open-minded, full of spirit. The situation was better everyday. I'm born in '57. They are very good years for development of my country. I had everything in life I wanted, whenever I wanted. We have everything in our lives, and my kids too, up to the moment when the war started. I never thought about the war and fights and anything in my life. I'm very peaceful person, a family guy. I love my wife and kids, I like family, I like my profession, we had wonderful friends.

One woman confirmed the above description through recounting the nature of her life before the war and pride in her country.

If you see my city, my country before the war and in the Olympics, is beautiful. All countries come. (There were) flags, trees, flowers. I feel proud. And we have all, everything for us to help, education, job, eyes (optical)... all. We lived very well. All my family lived very well. We each had (a) big house, car. I bought everything I want and it was not hard. We have everything we want. I travelled very much.

The following narrative recounted by one female participant illustrates family stability and cohesiveness and confirms the above description pertaining to the ease with which former Yugoslavians were able to travel outside of the country.

One year I travelled between Libya (where her spouse worked) and Malta when my daughter was in school. We send (son) to school in London alone and he was so sad and lonely and having a hard time. Immediately we decided to go. We left everything, the house, the job, everything.

These comments, not only suggest that the former Yugoslavia was an orderly, advanced nation, but also that those interviewed were proud of their country of origin and amongst the relatively privileged within that nation. Comments pertaining to a feeling of national pride and the relative affluence of these participants were scattered throughout the interviews.

Health

While some participants discussed chronic conditions such as skin allergies, hypertension, bronchitis, digestive and back conditions, all described their pre-war health as good. That is, none reported suffering from serious illness or dysfunction prior to the war. They were proud of the good health they enjoyed in that period. The meaning of good health was defined as being able to carry out and enjoy the activities of daily living without suffering
severe dysfunction or ill-health. One woman explained,

"I have breathing problem sometime. We in the valley and sometime the air is heavy. But my mother take us to the seaside in the summer and I ski in the mountains in the winter."

A male participant recounted the following,

I had one disease before, when I was young. I had heart problems. Kind of, kind of, we call it some kind of noise on the heart (murmur). It disappeared during treatment of ten years. It disappeared completely. I got it when I was six years old and disappeared when I was sixteen. It disappeared with little medications, now everything, it is okay. But I have normal time when I was small, I do everything. And now I have the normal life.

Another woman discussed her health and that of her family, and pointed to what she considered was an important role played by the health system that was in place before the war.

When I was child, my health was pretty good. When I was small, I had many of those children's diseases but with no post effects. I was pretty healthy (and) I delivered two children. I have cards to show they (children) have all vaccine and everything when they was small. I care about that very much. That was important for me. Our government really care about that. They teach us that. It doesn't matter if you are working or not, you can go to the doctor. It was a good organization.

b) Life During the War

Events and Reactions

Participants admitted to eagerly following on television the escalating events that immediately preceded the war but continued to deny the reality of war until guns could be heard, casualties could be seen, their cities were shelled and/or they were forcibly displaced from their homes. One woman explained,

We didn't know (much) about war, about politic, about situation in Bosnia but I worked one short time with Yugoslav army. I think, when I work with these people I know will be war. These people speak very normal about war. For me its very strange but was signal that not okay. (At first) we didn't see nothing but we all the time listen. Because we hear how soldiers destroy all town. We go out of the house and we listen. Then we hear guns and the soldiers starting to come to my town. We was on the line and we Muslim. We didn't feel safety and we go out.

The beginning of the war was described as unexpected and sudden, resulting in multiple traumas associated with the total collapse of the culture as participants had known it. The civil war led to the rise of ethnic and religious intolerance, decimation of towns and cities, social and political disruptions, the scattering of families and friends, sniper fire, shellings, and severe deprivations (food, water shelter, etc). The multiple, simultaneous
losses that accompanied the chaos included possessions, careers, significant places and most importantly, loss of and/or separation from significant family and friends. When participants depicted their country falling into disarray and the effects on their personal lives, they described a montage of feelings, including shock, disbelief, confusion, disorientation, anger, fear and horror, anxiety, disappointment, sadness and deep regret.

Shock, disbelief, and anger that one’s country could be at war were common initial reactions. These feelings are illustrated in the following narrative by one male participant,

"It was my biggest mistake. (angrily) I don’t know how I couldn’t find out that it will be war. It was very stupid but it was very sudden, unexpected. She (friend) ask me if all was prepared for war. I answer, "Are you crazy? Which war? Who will fight against whom?" It was impossible for our style of living to understand. We have to fight with our neighbours, with our relatives who are not the same nationality.

A female participant described a similar reaction,

"I could not believe that this happen to my country. I have to see with my own eye, the soldiers and blood, hear with my ear, the gun before I could believe it.

A quickly escalating series of feelings pertaining to shelling, brutality and violence were portrayed by two male participants as they described their experiences at the beginning of and during the war. The first man recounted the following,

"The first day of the war when grenades started to fall, I was just like in the movies (laughs quietly). All my life I was (seeing) the movies and now I was just in it and it was much tougher and harder than the movie. In real, its more horrible then could ever make a picture. It was amazing, it was horrible. The things I passed through. I was still civilian then and we just staying home, try to hide in the cellar. I didn’t like to do that. Shells fell around my apartment. Then I realize they were deliberately shelling (the) apartments with tank grenade. Tank grenade is very precise and I realize they can hit anything, everybody they want. Here we are just ants, ants, rats (voice rising,). I was horrified. They were killing innocent people.

The second male participant recounted a similar experience and reaction to the horrors of the war,

"I had to stay in city now, because city was surrounded. It was impossible to go out. I find out that ____ shoot canons over the city. They burned houses, they destroy. And I told myself that first I didn’t believe it. It was not my comprehension of war, of relations between man. One is target, like rat. I was in a building in the city. I was on the first floor. I saw the walls, dancing. I saw pieces, faces of walls disappearing, people flying, doors. In the breaks (shelling) I look out of window. I saw houses burning. It was incredible, really."
Impacts of Social and Political Disruptions

The war in Bosnia was marked by widespread genocide and ethnic cleansing. That is, there were deliberate attempts to exterminate certain groups through rape, torture, arbitrary detention, forceable displacement and execution and no one, adult or child, civilian or soldier, female or male, was immune from these dangers. One male participant sadly described his experience,

I don’t like to talk much now of these scenes but people doesn’t have water, have to go to the well, the only well in the city and (wait) in the line. I realize that they (soldiers) are killing, killing (pauses and sighs deeply) not even people then (but) kids, kids (voice rises) especially kids. (Speaks quietly and looks at the floor) You know why (genocide).

Further descriptions of the ethnic intolerance that developed during the war, and its effects on civilians are evident in the following comments by two female participants. The first recalled the following which she recounted in an angry tone of voice,

For these people, one kind of people was the best, one kind of people is nothing. I was in this place and I wasn’t this nationality and I had to go out. I had to go out and we don’t have choice. All people who are in mixed marriage have to go out. Its crazy.

The second woman explained in a sad voice,

These people went into my town and killed and took everything. I am Muslim, I had to go out. We didn’t have choice.

Social and political disruptions caused by the war were so abrupt, all-encompassing, and brutal, that participants had little time to adjust to, analyze, or plan their actions in advance. Hence, in the beginning their actions were little more than confused reactions to each new event. The circumstances under which they were victimized were not only beyond their understanding but out of their control. These dynamics are illustrated in the following narrative by one male participant,

I was working when began fight and explosion on the city and town. Mayor of town call on the radio for many people to come to the military office and go in the front. I must go and I get the gun and clothing (uniform). There’s big confusion, without organization. I am Muslim and I was put in Croatian army and I be afraid, afraid that my own men shoot me. Many Muslim people in prison for many, many days and months. I was in prison because of my name. Soldier looking for me wrote my name on a list. I go in prison. That prison isn’t classic prison and many people was on a rooms. No fence, but soldiers, guards. People didn’t think anything. People didn’t eat anything. Time was very fast. You see your neighbour, soldier comes and bring him anywhere, I don’t know where, sometime he don’t come back. I feel the confusion. For me, this is very difficult and I want forget it.
Trauma, Uncertainty, and Stress

The war transformed all aspects of life. Not only were there severe deprivations but uncertainty and stress pertaining to personal safety became daily companions. One male explained,

Your home don't have electricity, water. You must go out and find bread or food or something....water for drinking for wash. And when you go out you're half dead man. You don't know where a shot comes from. Everyday is stress. When you wake up, you don't know what's going to happen today.

Participants experienced continual strain due to the constant dangers and threats to their lives and the lives of significant others. Lives could be ended at any moment with a bullet, a landmine, in a shelling, through ill-health (caused by lack of or contaminated food or water, inadequate shelter and clothing) or detention and torture by the enemy. In an anxious voice and speaking very quickly, one female described her experiences that led to feelings of terror,

I had such big fear, constant fear, terrible fear. If you go out, you don't know will you come home or finish dead or... All the battles were around us. Then one day, I looked through the window and saw the soldiers were coming in uniforms and with guns. And they said to my husband, "You have got to come with us." My husband asked, "Why? What have I done?" "Oh, you are member of party." I started to scream. Many were taken from the apartments. They were beaten and tortured. If men were young and released, their legs were shot first so they could not fight in another army. They took my husband and they beat him. It was a terrible night. We knew they would come back.

Loss

Since multiple, simultaneous losses experienced during the war occurred abruptly and unexpectedly, there was little time to prepare for these. Thus, homes and all possessions, the cumulative result of years of work, were hastily abandoned as participants fled their cities, towns or sections of the city to seek refuge elsewhere. The following comment by a female participant illustrates the sudden, total nature of loss,

I take only one suitcase, a few things. Everything else stay in my home. Everything. I didn't have one picture, documents, anything.

The biggest loss, threatened or real, was that of family and friends. However, due to the social, political and personal chaos the war had caused and each individual's struggle to survive, there was little time to dwell on these separations and losses when they were taking place. Sadness and deep regret pertaining to the
separation from and/or loss (real or threatened) of significant others and his inability to respond at the time, is evident in the following narrative of a male participant who spoke very quietly,

*My brother was interned in a camp. He almost died. I can’t find (out) for long time where he is. The Red Cross finally release him (long pause, then a deep sigh). I had lot of friends. I lost many friends. Where they now? Some is lost, some is perish, some is killed. In every massacre I had some killed friends. All my life is (gestures with a downward movement of hand). I had a girlfriend in Bosnia but when the war begin she move and I think she live. . . . I don’t know and I forget because I didn’t have time for these things then.

The implications of cumulative losses (tangible and intangible) and the profound and lasting effect these losses will have on lives in the future, are encapsulated in the following narrative by a woman who sadly and tearfully explained,

*We don’t forget this, never. We’ll live with this, but little empty, you know. I can have bigger house than this but it feel empty. I didn’t live empty (before) I live very open with much people, much things, and much event happen. This is a very strange situation and feeling for me. In one moment, we lost everything. In this situation, we lost friend, lost many, many friends. My friends killed. Some friends we didn’t found. We don’t know where they are, and I don’t feel the same for people.

**Synthesis**

The previous sections of this chapter have shown how war influenced the participants in this study. While information was primarily derived from the informal interviews, data from both the demographic and health questionnaires as well as observations were included when pertinent.

Participants’ retrospective descriptions of life experiences included life before and after the war had begun. Participants reported that before the war, they had enjoyed many personal and socio-political advantages that were a result of living in a country where tolerance, pluralism and peace were realities. Further, when participants described scenarios of their lives pre-war, they spoke of happy and loving family relationships, a beautiful country, affluence, and robust health. The country was described as providing an environment that was conducive to the actualization of individual potential and growth both professionally and personally.

While it would be easy to assume that the trauma of experiencing a brutal war would encourage an overly idealized memory of the way things were before the war, there is evidence to support the reports of participants. For example, it was pointed out in
Chapters 1 and 4 that the former Yugoslavia did represent a successful experiment in Socialism that included a humanist, multi-ethnic and pluralistic culture in which economic, social, and political advantages were numerous. Further, there was a reluctance on the part of participants to relocate either before or immediately after the war had begun. These pre-war descriptions were similar to those the investigator heard from people living in Bosnia.²

The genuine shock, disbelief, sadness and regret that participants expressed as their country became enmeshed in civil war, was echoed by Softic (1995) when she watched her city crumble around her,

"What happened to my, my Sarajevo? It used to be the most European city in the Balkans and among the "worldliest" in the world - because it accepts differences as a value, and ridicules prejudice and rigidity as so much nonsense. The question is whether this highly lauded "Sarajevo spirit" will be able to survive the death of so many Sarajevans, the stampede of such a herd of invaders, and the systematic annihilation of so many differences, that is, the annihilation of the "unity of diversity." (pp. 50)

While the findings from the health questionnaire as well as the informal interviews indicated that some participants reported chronic health conditions, most described their health as good in the pre-war period. They attributed their good health primarily to the benefits derived from living within a pre-war social system where all-encompassing health care was available to any citizen. However, data from the health questionnaire (Chapter 4) also indicated that many participants had practiced certain behaviours that they believed would help maintain good health, such as the use of herbs and vitamins, exercise, eating a nutritious diet, and limiting the use of substances such as tobacco and alcohol. In fact, they appeared to place more faith in these self-help methods than in regular medical treatment. One woman expressed the following,

I think that these people, health people, medical people.....maybe I am too unkind of these people, but I think if you (are) diagnosed, then you have everything. Its mistake and I think if you have a sickness and the sickness don't go out, you have to learn to

²These reports were confirmed by Bosnians I spoke to in the former Yugoslavia, who proudly commented on the beauty of their country before the war and the advantages they had possessed as citizens. However, countering these proud comments were the pain, anger, disappointment, and deep regret they felt about how the war had altered their country and their lives (1995).
Since participants had been raised and educated in a tolerant, pluralistic milieu in which social and political policies assured all citizens equal rights that were generally equitably applied, to be driven out of homes and cities, targeted as victims, exposed to severe and cruel deprivations and losses, brutally terrorized, and separated from significant others, were experiences that caused intense feelings of alienation and confusion. Participants experienced a shrinking existence in that their concerns as well as time horizons were significantly reduced. While the multiple traumas experienced during the war were devastating, there had been little time to dwell on the implications as participants' energy was invested in coping with the daily chaos and its immediate effects.

The health of participants remaining in Bosnia during the war rapidly deteriorated. Food was so scarce that civilians were driven to eat the local flora. Since water pipes were often damaged or the water supply was turned off by the enemy, the only water available for drinking and cooking was from contaminated wells or rivers. Thus, participants were forced to make daily trips to these sources, wait in line to fetch water, and then carry this back to their homes while dodging sniper bullets. The lack of basic sustenance plus ingestion of often contaminated food (due to improper storage and cooking) and water resulted in malnutrition, gum disease, severe digestive upsets and loss of weight. Medical sources in Bosnia (Medivac, Red Cross) confirmed this situation and also informed me that mortality among the very young and very old rose dramatically. Parents of young children were particularly worried about the future effects of the war on the health of children who were without proper

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3 Bosnians I spoke to in Bosnia recounted being abruptly thrust into a way of life that was totally alienating. Their days were spent foraging for food, fetching water, and trying to keep alive. Losses included family members and/or close friends, and most material possessions had been sold or confiscated. Looting was common and crime was rampant. People were loathe to leave their shelters for fear of theft or "squatters" (rural people driven into the cities). Since ethnic tensions ran high, often neighbours were a real threat to personal safety (1995).

4 Although while in Bosnia, I attempted to be very careful with regard to the ingestion of water and/or food, I too succumbed to a severe gastro-intestinal condition and became very ill (1995).
nutrition for up to three years. Beans, rice, flour, cooking oil, noodles and bread were often the only food available for months at a time. Intermittently available were tuna, corned beef and cheese, and rarely, fruit and vegetables (Meissner, 1994).  

The disintegration of social networks was a result of significant others scattering because they had been driven out of their homes or had been forced to seek safety elsewhere. Consequently, feelings of isolation plus the daily occurrences of witnessing death and destruction, obtaining daily sustenance, and ensuring personal safety, caused participants to experience a continuing state of stress.  

In spite of the profound suffering that encompassed the social, psychological and physical aspects of life in Bosnia during the war, many participants indicated that, in looking back, they realized that they had remained relatively healthy. However, their perception of health seemed to change from that of regarding health as a positive, holistic, individual state, to that of mere survival, primarily dependent on psychological manoeuvres. These dynamics are illustrated in the narrative of a male participant,  

You know, through my refugees experience I could say that our impressions about health are totally changed. We find out that (a) more important thing is to have a normal psychological life process. I think this produces a defence for the organism. We had not normal life from '92, from beginning of war. We were healthy without food, without water, without be clean. We had not water for 15 days for example, but we were able to survive all illnesses.  

The issue of the war and its potential effects on the health of participants is an important one to consider in order to understand how health and function might be affected upon resettlement. One limitation of many other studies that have investigated the effects

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5Humanitarian sources I spoke to in Bosnia confirmed that people received aid for months at a time. This aid consisted primarily of rationed cooking oil, beans, macaroni, flour, rice, bread and occasionally dairy products, meat, fruits and vegetables. The only other food available to people was sold at exorbitant prices on the black market. Thus, most civilians would not consume dairy products, fruits, vegetables or meat for months at a time (1995).

6During the period of time I spent in the former Yugoslavia (four weeks) I experienced intermittent feelings of depression due to the daily stress of being exposed to physical danger (snipers, shelling) witnessing physically and psychologically maimed women, men, and children, and the enormous destruction within the environment. Most distressing however, was the expression of those who had suffered so much hardship, best described as apathy, blankness, a look of absolute hopelessness (1995).
of war on health has been their static nature (Chapters 1 and 2). However, since this study focussed on the temporal aspects of health, the result was an evolving picture that clearly illustrated the ways in which war influenced and changed the health, attitudes, and behaviours of participants over time.

The next section of this chapter will explore the ways in which participants survived and managed to escape the war in Bosnia.

2) **SURVIVAL**

a) **Strategies Employed to Survive and Escape the War in Bosnia**

Participants described the necessity of learning new adaptive attitudes and behaviours that had been alien to them before the war, in order to survive in and escape Bosnia. These new strategies were then applied to specific circumstances that posed a threat to health and life, and enabled participants to maintain an emotional equilibrium in response to danger, and to make decisions in uncertain situations while under duress. For example, one male participant explained his 'restructured thinking' once Bosnia had been plunged into war and he faced a daily struggle for his survival,

> I then have to carefully rethink everything, everything in my whole life, everything I learn, I have to rethink. I tried to simplify three rules. I'm not allowed to touch anybody, anybody physically but I'm free to defend myself in the same way. I'm not allowed to touch anybody's property as a second rule. Third rule is, everything other is freedom (choosing) the kind of (life) you want, attitudes and everything else. I didn't have opportunity to check these things when it was peace before.

The following sections represent situations that posed severe threats to participants' health and survival, and the strategies employed to respond to these threats.

Deprivation and Persecution

Civilians in Bosnia during the war had to implement strategies with which to survive the severe hardships brought about by the lack of basic needs, such as food, water, shelter and warmth. Further, they were defenseless in the face of repeated shellings, sniper fire, and persecution. As pointed out in Chapter 4, while men in the military were exposed daily to direct and immediate danger in battle, they usually did not suffer such severe deprivation as civilians, and possessed weapons with which to protect themselves. Both of these scenarios will be discussed.
The following description by one female participant illustrated the desperate nature of her survival and of those around her as they attempted to meet their daily needs, such as acquiring food and fetching water. This participant pointed to the importance of learning strategies that enabled her to adjust to the harsh conditions and to change her behaviours in order to enhance her chances of survival,

People were going everywhere during the war. Running everywhere, searching for food, didn't care about grenades. All the time on the move. Going to pick up water, three kilometres, taking it on the back. And I was telling them, "It's better you adjust your life." We learn so much you know. Doing without water, how to use a small quantity. We learn to make some food just with some greens or foliage. We make some salads from grass or leaves or trees or anything we could find so we could live.

Since heat was often unavailable either because the enemy was withholding it, or through damage incurred in battles, surviving the cold was imperative. One woman described the new attitudes she adopted and behaviours she practiced,

When gas is off, we keep warm with jackets, blankets, curtains, anything. Big piles on us. We burn anything we could find. There is no trees left in the city. All gone. People go in the night and take to keep warm. Burn chair, furniture, anything. We learn clothes is good for heat. Certain clothes.\footnote{While in Bosnia during the war, I learned that people used small tin stoves that served a dual purpose. These stoves could be hooked up to the gas lines, but when gas was unavailable, to burn substances for heat and cooking. I was informed that when wood was unavailable, blue jeans were the preferred fuel as they burned for a long time and gave off a lot of heat (1995).}

Seeking a safe shelter after being driven out of one's home or in order to survive persecution, sniper fire, and shelling was common. One male participant recounted the following,

I was like a refugee in my own city. I had nothing. I haven't safe place. Sometime I sleep two hour, and you have nothing and you change places, places. Most of the time I slept in my office, but it wasn't safe. It was unbelievable.

Accepting the Possibility of Death

Deaths on the battlefield, in cities that were being shelled, and by snipers, were daily occurrences during the war and unless participants were able to find a way to counter these constant assaults that posed serious threats to health and to life, they would not have survived. In order to come to terms with the high possibility of death, participants, whether civilian or military,
found it necessary to develop attitudes and enact behaviours that would increase their chances of survival. One male participant explained how he believed he survived,

> If you have to fight for your life you say, "What can I do?" Nothing else. Then if I would be killed, okay, what can I do? But I'll do my best not to be killed, to fight as much as I can to survive and thats it. (pauses and smiles ruefully) Its very simple to say that or to see it on the movie, but to feel that, and no way out (pauses). Most of the people there have to fight or to die, thats something completely different. You say good-bye to your life first and, (pauses, sighs and lowers voice) if you 'miracly' survive, then you will meet yourself again. Thats exactly what happened to me. Thats how I survived actually. Maybe I jumped, I don't know, 300 times on the round and three times grenades fell but I was in the trench. I jump in and I survive. That saved me because I realized that I acted for a part of second sooner or before the others.

Participants adopted attitudes that enabled them to assimilate, rationalize and cope with witnessing daily, a constant barrage of bloodshed and death around them. One man who had served in the military, explained that one method of coping was through humour,

> The first time you see a dead body, it is horrible, but then, you get used to it, and sometime make joke. Sometime we don't have enough ambulance, but we have car. We see bodies, feet sticking out of window. When the car is drive slow, you know peoples is dead inside, when it drive fast, peoples is still alive.

Another male who had also served in the military cited denial of these experiences as the only way to cope and maintain an emotional equillibrium. He explained,

> We come to place where is battle. All destroy. Burned. One man say, "Hey, look. Here is a dog." We look and I see is body, all black (charred). I see the feet and I know its peoples. But all men come and say, "Yeah, its dog, its dog, its burned dog."

Accepting the reality of these traumatic situations could result in depression and profound sadness. One male participant spoke very slowly, quietly and avoided eye contact as he recounted the following,

> For one day, one day, I see 162 people dead. A whole village. Dead. Women, children, all, all is dead.

Compromising Principles

Participants described how their principles often had to be compromised in order to ensure their physical and emotional survival. This is illustrated in the following narrative recounted

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8While in Bosnia I received information from military, humanitarian personnel, and Bosnian people that pointed to the desperate acts of some married women engaging in prostitution in order to earn money or be given food to take
by a male participant who had served in the military, but before the war had been engaged in a profession devoted to saving lives,

*I was nurse and you must understand, in the front, all people is same...no soldier, no official, no nurse, because this is war.* (pauses and looks away) If some people shoot at me, I must shoot back. My profession does not matter. I didn't go to the front in a (nurse's) uniform, I wear army clothes and carry a gun.

Another participant, a male who had worked as a photographer before and at the beginning of the war (before being conscripted) recounted the following,

____ has many, many people, all in a ghetto. Some men is police, some in military but I'm stay in the newspaper for little pay. We improvise some dark room and we work. (Military) stories, placards. Its not my (kind) of job, photographing dead people you know. But I....sometime if I have camera, I take picture of dead people for the newspaper.

**The Importance of Support**

Social support was identified by many participants as playing an important role in their survival. One woman recalled the following,

*When bombing and shelling start, I went to my neighbours. Their flat was more secure. Sometimes we were sitting, maybe ten persons, keeping company. It was much easier for everyone to talk with these fears when you are together.*

Another participant, a male, explained the role that a neighbour had played in saving his life,

*The soldiers, they come to my apartment. They began to beat me with club. They beat me for a half hour. They want to kill me. My neighbour come out, he was shouting on them and telling them leave me alone. He was (different ethnic group) but a good man.*

One participant, a woman, explained the crucial difference that social support made to coping in Bosnia during the war when individuals shared their scarce resources, their losses, their fears, and their hopes for the future,

*Before war, see neighbour, only say hello or maybe nothing. Everybody come, go, too busy. (But) in war, peoples help each other, share whatever they have, food, clothes. At night when shelling and no light, we all in one place together with candles, trying to keep warm. We laugh, joke, somebody have food, he share. We talk about time before war, who (is) killed, and what happens when it end.*

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9While I was in Sarajevo during the war, I spent some nights with Bosnians. Huddling close together in order to keep warm, the sound of shelling and gunshots outside a chilling reminder of the war, the only light and warmth was from one or two candles and the occasional sporadic flash from shelling. Neighbours (adults, children, adolescents) would congregate in one apartment and speak of the past, their futures, and people killed in recent shellings or sniper fire.
Humour was another component that participants identified as important in maintaining their mental health and surviving the trauma of war. One male participant explained this as follows, "Surviving was uncertain when there was bombing, heavy fighting, but people made jokes (and) this gives a moral boost." Another participant, a female, chuckled frequently as she described the following experience,

And he (spouse) came running up the street pushing the wheelbarrow full of clean diapers, and the soldiers, they start to shoot and he jump and all...the whole clothes, clean clothes, just fall in the dirt. And I start to laugh and we have to go back to the river and start (wash) again.

Another participant, a male, described the importance of humour in his ability to face and survive extreme danger. He smiled broadly as he related his story,

She (spouse) and two kids left on the last civilian airplane from the airport. I wasn't allowed. That was stop for men. And when I saw how the airplane was going in the air, taking off, I was happiest person in my life, I laugh and I said, "You can shot me now, I don't care." (chuckles) I put my hands in my pockets and I was whistling and all along the road the sniper was shooting around me but I didn't care.

Chance

Another component of survival which many participants described as being important was luck. This component was mentioned several times when participants spoke of their survival in and escape from Bosnia. Participants would often go through all the rational explanations that they believed contributed to their survival and then chance would be included as a completely unexplainable, random act of fate that they believed played a crucial role. Chance was raised most frequently by participants who spent longer periods in Bosnia during the war, primarily the males. For example, one male participant described the following,

It was very risky, everyday. Bombarding, everyday, killing people. It was like you know, party poker. You had to chose (and) only one succeed through the darkest places when a thousand innocent people killed. Oh, I was lucky.

Another male participant described his escape from the military and Bosnia and the part he believed that chance played in his survival,

Whatever scarce food was available was pooled. At these times, no matter what the topic, there was always laughter in spite of the tragedies of war (1995).
I’m going through a tunnel, a long tunnel out of the city. It is very small and I have to bend over and run (rises and demonstrates a hunched over position). Then I’m going in the mountains and the usually shoot. I’m really scared, but I’m lucky, it’s foggy and I have luck, I’m okay.

Finally, a third male participant expressed the importance of luck in his survival,

*I think those night our building was hit by 72 grenades I see walls disappearing, people flying, (pauses and shakes head) but, if you are lucky, you are lucky.*

b) Escape From Bosnia

Even as their country collapsed around them and participants were exposed to the violence and horror of war, priorities pertaining to escape were identified and decisions made. For example, the evacuation of women and children was seen as a priority while males, often against their will, were conscripted into the military. One male participant explained grimly, "*Womens and children must go, mans must stay and fight.*"

Despite the suffering and hardships imposed by war, participants still exercised all of the few options available in order to remain in Bosnia and keep their families intact. Since men were strictly forbidden to leave the country (unless they had influential connections), women and children either had to stay and take their chances or leave without husbands and fathers. This was described as a very painful decision to make. One man explained,

"*It was hard for them (family) to leave, but it was impossible for me to leave because I was those age when I am military. I accept this reality.*"

One woman recounted the rationale she and her spouse employed in order to remain together as a family in Bosnia,

*I saw all the mans and women and children go from house at beginning of war. They suffer more than us. We didn’t plan to move from _____ in that time because we always thought, everyday, "It will calm down". It was why I stayed there until November, to see can we do something to stay together?*

Since most families remained together until the last possible minute in the hope that the war would end, decisions to separate families were described as forced, painful, rushed, poorly planned and dangerous. Departures were clouded with reluctance, ambivalence and confusion. This is evident in the following narrative in which one woman explained,
We worked this day (spouse and participant). And then, this day, I took only clothing for my children. It was a small bag, too small bag. I was in very confusion and I pick up very old things you know. Everything (else) stay.

One male participant had served for almost 2 years in the military, and his attempt to leave the country was filled with peril but he had been imprisoned once and his life was in danger. He told the following story about his escape,

I am Muslim and it is dangerous for me to remain. After the fighting, I find a way. It was difficult to leave Bosnia, to cross border. I was called off of the bus and called into the office. He (official) looking for a document which I didn't have. My friend was rich man and we give officer many Deutchmark. After that, the officer put us on the bus.

Protecting Children

The final decision made to separate families was based on the realization that the war was not going to end quickly and suffering and deaths were going to increase. To save the next generation became a major imperative. Over half of the participants left Bosnia in order to ensure the safety of their children. This is evident in the following narratives. However, one male participant still felt ambivalence pertaining to the decision to separate his family,

Maybe daughter don't live the winter (so) I like that (spouse and child) go out (Bosnia). I think its better but its confused in my mind. Sometime I think its better they go out but sometime I think maybe its better together.

The following two participants identified the well-being of their children as the primary reason why the family separated, but still felt compelled to rationalize that decision. The first, a woman, explained her situation,

I took my children from the war because I know that there they wouldn't be healthy anymore. We live in the basement and we saw the weapons. We was all scared very much. And then my son start with his eyes (demonstrates a blinking movement with eyes). I know we have to go.

The second participant, a male, recounted his experience,

We split up, thanks to (infant). She was only two months, a baby. If she were older, we would maybe rethink, "Let's wait a little more to see what we have and maybe it calm down everything." Fortunately, we couldn't wait. (There was) nothing, no food and stuff that babies need. There was rocketing of particular targets, skirmishes, but quite enough to persuade you to go out.

Finally, the pain involved in leaving one's country of origin and the guilt at having left significant others and fellow citizens
behind, is poignantly encapsulated in the following narrative of one female participant,

When I left I felt so full of poison inside. I cry and I cry. I felt really bad. I felt sad, helpless and I'm sure people still in Bosnia felt the same. Bosnia is my home. I still love my country. I miss my country. That nationality line was very, very strong in our education. And then I suffer for the people, not only for my husband you know (still in Bosnia).

Threats to Health

Attempting to survive and escape the war in Bosnia led to serious health risks. In this regard, participants described their environments as posing very real threats and dangers to their health including loss of weight, poor dental health, gastro-intestinal conditions, and stress-related symptoms, such as poor sleep patterns, chest pain, digestive problems, crying, and depression. The events that threatened the health of participants included inadequate and contaminated food and water, lack of heat, poor hygiene due to lack of water and soap, and stress-related conditions emanating from bearing witness to and attempting to survive the daily violence and persecution that surrounded them. Health professionals were unavailable as many were at the front or had left the country early in the war. Those few who were left could not adequately practice their craft, due to shortage of equipment and medications. Consequently, medications retrieved from medicine cabinets, humanitarian sources, or the military were passed hand-to-hand from relative to friend to neighbour.¹⁰

In spite of these many assaults on their health, participants still pointed to positive aspects in that period. For example, they were proud of having survived the hardships and suffering imposed by the war and felt relief at escaping its horrors while at the same time maintaining an operable level of physical and mental health. For example, one female participant who had spent two years in Bosnia during the war, described aspects of her health that

¹⁰ I was bedridden for 2 days with a severe gastro-intestinal infection in Sarajevo during the war. My host approached my bed and holding out a well-worn capsule said, "Take this, you will be better." Even in my weakened and feverish state, as a health professional I verbalized a cardinal rule, "I can't take medication without knowing what it is." My host looked me straight in the eye and said, "You are very, very ill. Now take this." I did. Within a few hours I started to feel better at which point I timidly asked if there might be another "pill" available (1995).
deteriorated but also pointed to her definition of positive health, 

I was under great stress that time. I was stressed all the time and lost a lot of weight. I lose two tooth and bleed from the gums. First I was afraid that I can lose them (son and spouse). Later when my son went out (escaped) I was in pain for my husband. Grenades were falling. I don’t know where he is. I was really in panic and very, very afraid. I had pain in the chest. If they start to shoot then I was trying to hide somewhere. (But) you know, that’s one thing. It was surprising how our health was good in that period. Oh, sometimes we would get some little cold or something, that’s all.

Synthesis

In the previous section, it has been shown how the efforts to survive the brutalities and deprivations of war influenced the health of the participants in this study. While information was primarily derived from the informal interviews, data from both the demographic and health questionnaires as well as observations were included when pertinent.

Participants regarded surviving the hazards of the war and escaping Bosnia primarily as a personal triumph which was largely accomplished through changing attitudes and behaviours from those that had been appropriate in peace, to those that would ensure survival during the war. Surviving the trauma of war as well as escape from Bosnia led to stresses in the forms of physical and psycho-social assaults that posed serious threats to the health of the participants in this study. Participants described the preservation of health and life as a series of psychological demands and challenges. They believed that if these demands and challenges could be satisfactorily met, then the chances of surviving the war and escaping from Bosnia unscathed, increased. New attitudes and behaviours that it was believed would ensure survival were described by participants as follows: the ability to be flexible and to adjust to hardship, suffering and persecution; to accept the possibility of one’s own demise; to develop coping mechanisms that would assist in coming to terms with the rampant death and destruction all around them; to reach out for support from others; to be willing to compromise principles; to maintain a sense of humour; to be willing to separate from significant family members.

There was one other aspect that participants regarded as crucial to their survival and that was being blessed by fate or luck. Adopting new strategies and chance were considered crucial to survival in the
face of the victimization, persecution, violence and brutality experienced during the war.

The decision to leave the country and disrupt significant family units was delayed for as long as possible in the hope that the war would end quickly and life would return to normal. However, when that hope faded, the inevitable decision to leave Bosnia that was made by those participants with offspring, was based on the desire to preserve the lives of their children. This desire to ensure the survival of at least one parent and progeny outweighed the pain and guilt of disrupting family units and became the main driving force behind the decision to leave. For those participants (2 males) who did not have children, the motivation behind their departures was sheer survival. Both came from a city where ethnic hatreds had reached a fever pitch, prison camps were a reality, and many lives had been lost. Both had fought in the military on the side that was eventually defeated and one had been imprisoned and severely beaten. Consequently, both had experienced physical and psychological persecution pertaining to their ethnicity as well as their past activities in the military. While they fled to save their lives, they also experienced pain and guilt about leaving significant others behind including, parents, a sibling (incarcerated in a prison camp) and a close relationship with a companion.

While the traumas of surviving the war compromised participants' biological, and psychosocial health, the conditions suffered were described as transient or not important. That is, health concerns decreased in importance in relation to a fight for survival, or, health priorities were drastically changed. Another explanation for participants' survival during the war was that they possessed certain characteristics that enabled them to be more resilient and thus cope more effectively with the trauma experienced. Characteristics (personal and social) which may have modified the influences of war on health and ensured survival will be examined in more detail in Chapter 7.
CHAPTER 6

RESETTLEMENT, FAMILY RELATIONSHIPS AND HEALTH

Resettlement and family, two of the four central themes identified by participants in this study, will be discussed in this chapter.

3) RESETTLEMENT

An obvious disparity between the genders emerged in the descriptions of the first resettlement. Consequently, the differing experiences of male and female participants are discussed in separate sections of this chapter.

A) First Country of Asylum

i) The Female Experience

The pain experienced by female participants as they fled Bosnia leaving behind spouses, families, friends, possessions, and country, was described in Chapters 4 and 5.

It was important to female participants, if at all possible, to seek asylum in countries that a) were accepting refugees, b) had not imposed restrictions on certain ethnic groups, c) contained relatives or friends and, d) was in close proximity to Bosnia so that spouses could more easily join their families. One woman explained,

"I know that (country) take Muslims. My mother is living there. I take my children and my brother's son and live with my mother. My husband can find me there."

Female participants described arriving with little money and one small suitcase. Children who accompanied their mothers were frightened and traumatized by their experiences in Bosnia, the sudden separation from fathers, and an awareness of their mother's anxious and uncertain state. One woman explained,

"When we came there everything left behind. (We have) only a little money. Kids, tired and they scared. I try to hide as much as possible. I never told (son) that I'm afraid for the life of his father. He doesn't like to see me cry and he miss his father but he never spoke in a way to upset me."

Female participants initially joined host families or friends who were citizens of the selected country. One woman explained,
"I go to (country) because is husband cousins there. I stay with them until he come out."

Another woman explained an important factor in her choice of a first country of asylum,

I worked in (country) ten years ago and I think maybe in this situation will be job for me. It was my idea. And we had some relatives we can go in their house and live.

**Difficulties Faced By Women in First Countries of Asylum**

The lives of the women who spent long periods of time in first countries as refugees were filled with difficulties. While it was initially expected that spouses would join their families in a relatively short period of time, only one male was able to escape from Bosnia within seven months. The remaining women spent up to two years waiting for their spouses.

Being unable to obtain immigrant status in these countries meant that female participants were restricted in finding employment, housing, and receiving social benefits. While assuming sole responsibility for the emotional and financial support of themselves and their children, they grappled with such issues as distress pertaining to their spouses and families remaining in Bosnia, discrimination directed at them and their families, alienation from hosts who had initially taken them in, struggling to avoid residing in a refugee centre, re-living trauma, and general uncertainty about their future. Each of these components related to the theme of resettlement in a first country of asylum, will be discussed in more detail below.

**Worry for Family in Bosnia**

Of all the difficulties encountered in adjusting to a new country so soon after being uprooted from their own, the one described by female participants as the most acute, was their continuing anxiety for the safety of their families in Bosnia. One woman tearfully recounted her experience,

When I came there I was in great pain and afraid for the life of my husband. I would cry when I watch tv. My father was there, my brother and sister-in-law. And I suffer for the people, not just my family.

Women who resided in first countries of asylum were often unable to locate their families in Bosnia for periods of up to one year as telephone and postal services had been intermittently disrupted
and/or non-existent during the war. Consequently, they often had no idea where their spouses and families were or whether they were still alive. One woman explained,

_In the beginning I didn’t have connection with husband, that he can call me or I call him. Over one year, I didn’t have connection. (Then) in the last 4 or 5 months, I find some connection. You know, a telephone bridge. Then I know he is alive._

**Experiencing Discrimination**

Discrimination directed against female participants and their families in first countries of asylum was common. Their descriptions of daily life were peppered with narratives pertaining to discrimination they or their families experienced and which contributed to strain in their daily lives. Although female participants did not note the occurrence of discrimination in the immediate settling-in period it quickly became evident when, as refugees, attempts were made to obtain work or secure accommodation. One woman described her experiences and the effects on her and her family,

_The discrimination came later when I’m wanting to work, when I wanted to find an apartment, then I felt that. I worked with designers that I was better than and I was only assistant. I saw that my son was ashamed to speak our language. And then there were so many other people there who said, “Oh your husband is …., your son has that name.” And there were people that I had to hide that my husband is in the ….. army. And my mother was working for the opposite (another ethnic group) man and we were fighting between…. (pauses) It was really a bad situation for me. Full of stress and maybe I didn’t have chance to relax._

One woman explained that experiencing discrimination was alienating, confusing, and painful because she had never been exposed to this in her country of origin. Her demand to be treated as an equal is demonstrated in the following narrative,

_I buy a bus ticket on one place in bus station and the man told me (sighs heavily) “You from south, you don’t know how to buy a ticket.” But I don’t care what he said. I sit down in the bus and I see that he read my second name and so he know (she is Bosnian) and he want to hurt me. I not used to that way in my country. But every month I go the same place and ask for my bus tickets because I know I have right and he can’t do to me anything. But my son, had bad experience. The children fight and beat him because he is a Bosnian._

Some participants attempted to understand and rationalize possible reasons for the discrimination that was directed at them and/or their families. Two women offered succinct analyses of their dilemmas as refugees, including explanations for and solutions they had employed in order to cope with ongoing inequities experienced.
The first woman recounted the following,

Its hard to be a refugee in one poor country. You know, people would like to understand you but they couldn't if they haven't job. But I couldn't have there any papers that I'm person, that I'm anybody because we are (pauses)...mixed marriage you know. Any country couldn't like my family because my husband, he's.... But I said, "I have to live, my children have to live." I take phone book and call all company and try, hundred times. And I knocked to every door where I know they work my job. And once I succeed. They told me, "We can't pay you, but we understand you." I told, "Okay, I will volunteer and I start like that."

The second woman recounted a similar story but ended with a heartrending question that clearly underlined her ambivalence about the treatment she received as a refugee,

You know, as refugee I couldn't work (for pay) in this country, that is law. They catch me work, it will be very bad for me. I worked 6 months as a volunteer and didn't have nothing, just volunteer. I hope that in time, they give me a job that pay. I know that was not a rich country. It was very crazy situation because we think we lost Bosnia in war, we will be safety when we go to another country and we in the same trouble. We thought, "Where is there that displacement people can live as people without prejudice?"

Alienation from Host Families

Estrangement from host families who had initially taken female participants in, was common. After the initial settling-in period and when the realities of being a refugee became clear to everyone (difficulty finding employment, the prolonged absence of spouses, discrimination, crowding in homes, etc.) host families quickly became disillusioned and began to rethink their original decision. While female participants were aware of why some host families reneged on their original commitment, the pain associated with being rejected was difficult to accept. More to the point however, was their immediate vulnerability once they left the host family as there were few options open to them. One woman explained,

We were with my family for a few months and they say, "Enough, we don’t want you anymore." (Voice falters and eyes fill with tears) Very hard things which I can't understand even now. I think, if I will be in their place, I couldn't do many things which they do and it hurt me more because this is my family.

Another woman explained her situation, outlining the manner in which alienation and disaffection both on her part and that of her host family set in, as time passed,

In the beginning it was good, but after six months I start to losing myself. I try to read a lot of books but I decide I want to work something, I want to make food. I thought I would go back to Bosnia but I saw that the war its going bad. The family did not have a lot of money and I didn't have a lot of money, and I can't work, and
they have a lot of bad feelings. I was nervous.

The Decision to Immigrate to Canada

While the initial subsistence needs of female participants and their families were met with the help of host families, as these sources dissipated, they had only their own resourcefulness to depend on. The most dreaded outcome of being unable to provide for themselves and/or their families was to be forced to reside in a refugee centre.\(^{11}\) Participants regarded this outcome with dread, not only because of the dependent lifestyle they would be forced to adopt but also because it often reduced the chance of being accepted for immigration to another country. One woman who had been estranged from her host family after a few months in a first country of asylum explained her reaction to a refugee camp she visited:

I go to the refugee camp just once and I go out. I cried through the street. I think for normal people it is impossible to live there. People who lives there and people whose work there became very depressed. I didn't know what would happen with me and my children in that kind of camp because people don't do anything there, just sit and wait what will happen. So I find apartment and start to take people's laundry. I'm engineer. I hate to do laundry, but I do so my children don't have to go to camp.

Once female participants realized that their spouses might not be able to join them for quite some time if, in fact, they survived the war, and that they would continue to be prevented from obtaining immigrant status in a first country of asylum, the decision to immigrate to another country was made. One woman described how she reached this decision,

I could go to some refugee centre but I would sit and just wait. I don't want that. I don't wait anymore. Then I decided to go away, really far away. I have opportunity to go to Canada or stay in (country) but the only option, a good option was Canada.

Another woman expressed her fear of having to reside in a refugee centre as primary in her decision to immigrate. However,

\(^{11}\) While in the former Yugoslavia, I observed the living situations in refugee camps. Laundry was hung on long lines outside of the buildings. Residents, including children, sat listlessly or wandered around the grounds which were enclosed with a high, steel fence. While meeting the basic needs of refugees, these camps were little more than 'holding pens' with long rows of wooden barricks, communal toilets and laundry facilities. Each family was allotted one room in which they slept, ate, and lived. Food was prepared on a hotplate and rooms often did not contain running water. Naked light bulbs lit up the long, narrow corridors, shoes were kept in rows outside of the doors, cardboard boxes of whatever the family possessed were piled along the walls in the rooms, and a feeling of hopelessness and helplessness pervaded the milieu (1995).
her explanation also illustrates her tenacity in persisting with immigration authorities, and the emotional and financial costs of doing so,

I listen too much, see too much and I know how this (refugee camp) is like. I don't like to be there. I listen (heard about) this program...Canadian Government. It was two and a half years to come to Canada. They have not embassy where I live in (country). I have to phone many times and travel there. It costs very much but they give me this chance and I'm happy with that.

A third woman who had finally been able to contact her spouse by telephone recounted the following,

I say I have chance to go to Canada and what I should do? He told me, "Do what you want, I can't help you here." So I decide to go and maybe he come after.

Loss and Trauma

Residence in a first country of asylum represented the place in which female participants began to face and to dwell on the reality and implications of the traumas and losses they had suffered in being forceably displaced from Bosnia. The emotional pain that was experienced by working out past trauma resulted in some difficulties with memory. One woman recalled,

For a long, long time I couldn't remember my home, the things what I had lost. We lost everything. Sometimes I stay awake at night and I try to think what's happened? But it's hard to remember then. And I try and try, but I can't. I didn't feel nothing for a long time...empty.

Another woman who had spent two years in the war zone in Bosnia described how she re-lived her experiences of trauma while residing in a first country of asylum,

"Sometime I wake up and I don't know where I am. I thinking again I in war and I jump and feel scared."

Health of Female Participants in First Country of Asylum

The difficulties experienced by female participants included their constant anxiety pertaining to family in Bosnia, re-living trauma, accepting losses, trying to support their families within a society where they were not treated as equals and exposed to inequities every day, influenced their health in a number of different ways. It was primarily these factors that negatively influenced health in some women. One woman described her symptoms pertaining to re-living trauma,

I slept a little better, but if I think too much of those times I can't sleep. I was full of stress, and I was in pain (digestive) and afraid.
Another woman described how the worry for family and social inequities she experienced as a refugee affected her health,

*I worry about my husband, I didn’t see him for two years. I see that people is always talking about our last name. (son) is having trouble with friends. I eat too much and have too much weight. I think about how I was before the war. I cry. I feel the stress all the time.*

A third woman who had been able to secure employment as an interpreter in a refugee camp, recounted how the trauma of separating from family as well as the difficulties faced in her first resettlement affected her health,

*I think that health is affected in the mind and body. I know that I will have trouble with my body because I don’t feel nothing. I was just ice. I work in the refugee camp, I work in house, I work with family and I didn’t think nothing. Everyday I listen to (others) trouble but I don’t think about me. Then one day I just have this big attack and I go to hospital. I can’t breathe and I’m very scared.*

In spite of experiencing difficulties that negatively influenced health, female participants were still able to manage their activities of daily living and to cope with and solve problems encountered. That is, they were able to find ways to remain out of the refugee camps, support themselves and their children, and to plan for the future in a realistic way. For example, when their spouses failed to join them and they were unable to obtain immigrant status in first countries of asylum, female participants made unilateral decisions to move on to a country where they would be accepted as immigrants and be able to start a new life. Given their circumstances, such as scarcity of financial and emotional resources female participants, in applying to immigrate to Canada, faced a task that involved a single-minded approach that necessitated innumerable telephone calls, travel expenses, as well as forms to complete and interviews to pass over a period of several months. Female participants accomplished all of these tasks alone while at the same time working to support themselves and their families. Hence, in spite of facing innumerable difficulties as single parents in a country where they were being treated inequitably, female participants were generally able to cope with these difficulties and to move on to another phase of their lives.

The question as to how these women were able to accomplish so much after experiencing such severe trauma and continuing stress and
difficulties, and still maintain adequate health and function, brings to mind the presence of certain characteristics that could have acted as modifiers. For example, Kohn, Nao, Schoenbach, Schooler, Slomczynski, and Slomczynski (1990) investigated class, education and success (in three cultures) and found that those who were more advantageously located in a class structure were likely to be more intellectually flexible and self-directed, and possessed better psychological functioning. It has already been shown in a previous chapter (Chapter 4) that these participants were well-educated, affluent and experienced good health prior to the war. The influences of these modifiers on health and function will be considered in more detail in subsequent sections of this Chapter as well as in Chapter 7.

ii) The Male Experience

The male experience in a first country of asylum was discussed very little in the informal interviews. Male participants would describe in great detail their past experiences in Bosnia, their escape, their current resettlement in Canada and their future plans, but the time spent in a first country of asylum was passed over very quickly. Even though the investigator probed, in order to obtain more information from this period, little was forthcoming. Consequently, findings tend to be primarily based on responses to questions on the questionnaires as well as observations and notes made by the interviewer.

The reasons for the lack of information volunteered by males probably related to the short period of time spent in a first country of asylum, on average 2 months. Further, for the male participants, escaping from Bosnia produced a great feeling of relief at having survived the war. And, a first country of asylum represented a stepping stone to a new future in Canada. However, because so much had to be accomplished in such a short period of time (beginning to adjust to a normal life, and making plans to immigrate to Canada) it could well be that this period became a blur of transitional tasks that focussed on terminating their war experience, combined with immigrating to a new country and a new life.

Three of the males had deserted the military while on leave
and/or day pass, while the other two had been in extreme danger because of their ethnicity and political views. Consequently, all males experienced relief upon arrival in a first country of asylum. One male participant described his feelings as follows,

Yeah, I'm relaxed. This place is on the seaside and I'm came in August. Its nice, nice weather. I can't believe it. Electricity, water, much food, normal life, don't have police, no checkpoints, and no one give me trouble.12

Since escapes from Bosnia were surreptitious, dangerous, and hasty, male participants arrived with little more than one small bag and little money. The two single males resided in rooming houses while the three married males were taken in by host families. One male explained, "I stay with my Auntie in one very big house in (country). I have room with cousin in the upstairs." Another male reported his experience, "My colleagues that I know from before is there and I stay with them."

The first priority of the married men, once they had reached safety, was to contact their families in Canada. One male explained, chuckling and smiling broadly, "I can't wait to call (spouse) and tell her I am out." Another male smiling, said, "I call (spouse) right away, tell her I am safe." None of the males remained in a first country of asylum for any length of time as all contacted the Canadian Embassy within days of their arrival. One participant explained, "As soon as I reach (country)I go to Canadian Embassy."

Since male participants quickly received approval to immigrate to Canada in order to join their families and/or begin a new life in another country, not only the time spent in a first country of asylum, but the nature of the male experience was significantly different from that of the female participants. That is, the males were not seeking employment, were only responsible for themselves, and intended to move on, hence, they did not experience the inequities or inequalities that the females had.

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12 I entered Bosnia from Split in southern Croatia. Split is a tourist city on the coast of the Adriatic Sea. There were checkpoints separating the two countries but, aside from an overwhelming military presence in Split, it might have been a different world. Although feeling some of the effects of the war, food was still quite abundant, and institutions were operating adequately. Some public transport and entertainment were available to humanitarian and military personnel as well as to citizens (1995).
Health of Male Participants in a First Country of Asylum

Since male participants placed very little emphasis on this short period from the past, there was little information from the informal interviews that pertained directly to health. However, according to information derived from the health questionnaire, in spite of the prolonged trauma and deprivations suffered in Bosnia, that led to a serious threats to health, most males proudly reported maintenance of adequate health in this period. Three males referred to experiencing sound sensitivities but all correctly assessed this phenomenon as transient and caused by their experiences in the war. One of these males described the following,

Only once, when I was in (country) one sound was similar to grenade you know. But I think those wheels which serve something fell down...fall down and I was sure (pauses and ponders). After that, no more.

B) Resettlement in Canada

Resettlement in Canada brings the narratives into the present and represents a period filled with ambivalence. On one hand participants were relieved and thankful to have reached a country where they could feel safe, secure and receive assistance in resettling but on the other, they were struggling daily with an overwhelming number of difficulties, tasks and adjustments. These tasks included, coping effectively with worry about family in Bosnia, stabilizing family relationships in Canada, upgrading English and job skills, finding employment, establishing new social supports, planning for the future, and coming to terms with trauma suffered. This situation was further complicated by participants' feelings of guilt, anxiety, and frustration pertaining to the safety and security they had found in Canada while their significant family members and country were still at war. These aspects of resettlement will be discussed in more detail below.

a) Resettlement Difficulties, Adjustments and Tasks

Family in Bosnia

A primary problem identified by participants, was separation from and worry about the safety of significant family members remaining in Bosnia that resulted in feelings of helplessness and guilt at not being able to assist them emotionally and/or financially, and for having left them behind. These feelings led to
obsessive thoughts pertaining to the welfare of family members which spilled over into everyday activity. The following narrative of one male participant illustrates this scenario,

*My parents and sister (are) in (city) but I can’t help them. It is a bad situation there and I think all the time, “what’s happen, what’s happen?” My problem now is my family. I think about them everyday and everyday*

Experiencing feelings of helplessness and guilt pertaining to family members and their safety prevented participants from fully enjoying the comfort and benefits offered to them in Canada (food, shelter, financial assistance, etc.) and the hope for future re-unification with close family members was described by participants over and over again. One woman explained,

*When we see too much food in the store, in the fridge, I feel very, very bad because I know that people (in Bosnia) don’t have nothing. We have here so much, and people in my country suffer. I miss my family and I live to see them again.*

Another participant, a male, described his feelings of frustration at not being able to help his sibling,

*My brother almost die. He want to come here, (and) I want to help him, but I don’t have money for sponsorship right now. I miss him*

**Family in Canada**

The re-establishment of a close relationship was a difficulty described by those participants who were re-united with their spouses after separations ranging from 2-2.5 years. It was not only the length of time per se but the enormous, traumatic life events that disrupted established relationship patterns, and led to role changes that created difficulties between spouses. This finding has been confirmed by investigators who discovered that new roles assumed within families in second countries of asylum, can produce a shift in power, create tension and lead to family dysfunction (Clinton-Davis and Fassill, 1992; Chan in Lumsden, 1984).

The following narratives pertain to participants’ descriptions of the problems encountered or anticipated in re-adjusting to their spouses. In discussing the imminent arrival of her spouse to Canada one woman chuckled as she explained what she anticipated would be one aspect of their adjustment,

*Bosnian men, they doesn’t know how to look after themselves. Always women look to them, mothers, sisters, wife. Now they learn, like Canadian men to do those other things they never do before.*

The second woman sadly explained the struggles she and her spouse
were encountering in their first months together,

_I don't know how to explain that but we was change very much. We didn't know each other even and I'm married eighteen years. Everything is different._ (pauses) _I don't know, we will see._

While female participants spoke more easily about their marital relationships, males did contribute some comments. In response to his spouse's description pertaining to changes she had noted, the ambivalence is evident in one male's explanation,

_She (spouse) think I'm different (but) I don't think I change so much. It's hard to me to know. We were apart long time, see, have different things. Maybe that's make difference._

The male participants who were married were struggling to catch up to their spouses and offspring, most of whom had spent a considerable period of time in a first country of asylum and whose arrival in Canada had predated their own. Males who had escaped the military and Bosnia only months earlier, were simultaneously attempting to adjust to changed family dynamics, and suffering the sequelae of the trauma they had witnessed and experienced while in Bosnia. This situation led to difficulties in attempting to re-establish comfortable relationships between spouses. Further, fathers also described experiencing some difficulties with re-establishing relationships with their offspring. One male who had only been in Canada for a few months was left in charge of his very active three-year old child. Until his arrival in Canada a few months earlier, he had last seen his child when she was six months old. He explained in an exasperated voice,

_You know, while I not here, (daughter) is so spoiled. (Spouse) doesn't know to control her. (Jumps up off the sofa and runs after the child who is racing toward the bedroom and screaming. He returns, holding the squirming child). She just doesn't listen (kisses child on the cheek). I try to tell (spouse) but (shakes his head and smiles) she doesn't listen too._

In another family which the father had recently rejoined, he noted his adaptation in Canada compared to his family, and also pointed out that his children often by-passed his efforts to parent and went directly to their mother. On one such occasion he appeared

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13 _While in the former Yugoslavia, I noted that most Bosnians were extremly patient, loving and benevolent toward their offspring. Consequently, most children and adolescents I met were extroverted and uninhibited in adult company. If they were gently chastised by their parents for some reason, they would often make a joke of it and both parent and child would end up laughing_ (1995).
sad and embarrassed as he explained,

They forget me (pauses). It will take some time. But I saw (that) my family, my wife, especially children, how they succeed to find themselves (in Canada) and I see myself how fast I succeed.

While re-adjusting to one’s spouse was described as difficult, many participants were anxious to work out the difficulties through co-operation and planning a future together. One male said,

I would like for (spouse) to work at her art. She is very good. I wouldn’t like her to stop. I could support her with construction work until I improve my English and find better job. I thinking maybe we move to (a larger city) where her work will be more exposed.

Another participant, a female whose spouse had been able to join her before immigrating to Canada explained that the adoption of necessary role changes had been difficult for her spouse to accept. However, she regarded their difficulties as ultimately strengthening their relationship. She explained,

I work because I know people from before (but) husband can’t work. He feel very bad and very depressed because he can’t find job. Its for him, we come to Canada. I think that before war I had marriage with sometimes trouble but its just imagining about what could happen. Now is real. I think now we (are) stronger. Each other support the other. I think it qualitatively different. Now is no time to imagine. Now we work together, learn English, find job, give kids good life first.

The two single male participants, not having to cope with re-establishing relationships with spouses and offspring, did not experience the same type of difficulties and their settling-in was less complex in this regard. Both had quickly established friendships with other Bosnian men shortly after arriving in the refugee centre. Plans were quickly made to share digs and expenses as well as to move to another city where work would be easier to find and accommodation would be less expensive. One male participant said,

I meet roommates in refugee centre. We make the friends. After some time, we think, "Maybe too expensive to live here (city)". We phone Immigration. They say, "Yes, you can move, just give new address." So we come here. Rent is cheap and maybe we find jobs easier.

The other single male explained,

In this building live seven Bosnian people, no family, single people. Sometime we go to mall, swim, play soccer. Sometime we go for beer. (Laughs).

Language and Employment

Participants emphasized the importance of improving their English, and regarded this achievement as directly proportional to
finding full-time, challenging employment in the future. One male participant explained,

I would like to learn very good English language first and after that I would like to work job, job which I know.

A female participant expressed a similar point of view,

You know I looking for a job now. Its very optimistic but (laughs) I talk with people who work the same job and I don't know how this looks like in this country, but I think we have to learn English. Its first one we need. After this, I don't know but I will work out something.

Participants also recognized the need to improve their English in order to meet instrumental, social and expressive purposes and overall integration into the host society. That is, improving English was considered crucial to the performance of the activities of daily living and resettlement, as well as filling psychological and social needs that hinged upon language ability. One man explained his difficulties when he first began to speak English,

I couldn't talk in English, I couldn't think on Bosnian Just like a robot, just stuck like a computer when he is between two decisions. I feel terrible when I try speak (to) someone, to ask question. But I'm better everyday.

Another man explained the importance of language in mastering the practical tasks of everyday living, but also the social tasks such as making friends,

Very little things is problem for me, Post, Bell, very little things, because language is problem. I have friends in my country but in Canada, no, because, well, language. I would like to have some Canadian friends. I would like to go out but no money, no car, no language.

A third man stressed the importance of language in order to feel accepted in social settings. He explained,

We have friends, Canadian friends and friends from our country. And we are usually together. Its good things for me and for family. Together. But I have one problem. I don't know too good English.

While participants described the difficulties of adjusting to a new culture (Canada) and the amount of information that had to be learned, e.g., how to take a bus, where to find stores, etc., these were relatively short-term problems and easily resolveable for most. However, the more complex cultural differences took much effort, time and energy. For example, participants expressed the need to upgrade work skills and to find employment. They described occupational challenges, such as differences in professional knowledge and skills and/or simply not knowing how to meet the
"right" people. One male participant explained,

*I am architect. I have good experience in my country. This is job I know and would like to find (here). But I don't know the right man and I have to take course to learn different computer program here.*

As a result of these differences, as noted in the demographic questionnaire, those participants who were employed experienced marked occupational status demotion. One man explained,

*I like to find work in my profession but maybe it is difficult. For now, janitor is okay. People is kind and I can earn some money.*

While participants received financial assistance for one year after their arrival in Canada, all were anxious to find paid, full-time employment before assistance was terminated. One male explained his situation in an anxious tone of voice,

*Government pay me for one year. I have six months left to learn English, find job. I must find job.*

**Establishing New Social Supports**

Clinton-Davis and Fassill (1992) discovered that the resolution of separation from, or loss of friends was one of the foremost tasks faced by refugees in the resettlement period. As noted in earlier sections of this chapter, grief over the loss of significant friendships either through death or forced displacement was experienced by all participants in this study. After the immediate resettling period in Canada and when participants had begun to establish a level of comfort, grieving for friends who had been killed in the war and attempts to locate those who had been dear to them before the war were made. One man explained,

*We have so many friends before the war, good friends. (But) now some is killed, some is split all over the world, some stayed in Bosnia by force, but very few still there. I tried to find some my friends (and) sometime we speak to each other. We are connected by the phone. (Sadly) I miss them. Maybe one day we will see them again. We are in touch with these people but because of that situation and that happenings, now I'm very careful of picking up the new friends which I'm getting to know everyday.*

The above participant as well as others, pointed out that building and developing an appreciation for new friendships in a new country was no easy task. Forging new social supports was sometime hampered by an ongoing resolution of the loss of old friends, lack of trust in new potential friendships or, as pointed out in the section pertaining to language, lack of adequate English skills and knowledge of social mores sometime presented barriers. One woman noted the differences in the nature of friendships in her country
and Canada that made new friendships difficult to form,

It is so much harder connecting to people here, friends and family and...its hard to explain because its the way people are going together here. But we used to have friends that we were always together to share everything. It was really different from here and its difficult when you lose that.

Another woman expressed the ambivalence she felt pertaining to her need to establish friendships as support systems, but being unable to "invest" fully in them because of unresolved grief pertaining to the loss of friends in her country of origin. She explained,

We met people from this church who were really kind. I invest in my friendships and I need these people now. They really act like friends except sometimes I feel that I really don't accept them. I think maybe it takes some time. Then I understood that I miss my friends, many friendships I made for years. And now, I can say maybe I have one or two. One night I'm dreaming (about) a friend of mine and when (begins to cry and is unable to finish, regains her composure and begins again) So I think, you can't forget it and put all. I just think about friends but I can't bring them here (cries again).

Although participants saw the practicality of forming friendships early in their resettlement period, they still had difficulty viewing these friendships as genuine. One woman explained,

I have protection from church and people who called me from church. They give me believing that I will have here protection, that somebody think about me, somebody can help me if (daughter) sick or I'm sick. I have enough friends who help me and I like how they have a relation with me but is one problem, they don't know about my family. I know their family but they doesn't know mine. I think it is important that people know (your) past and not just present time.

Some participants explained difficulties trusting and hence, forming relationships in Canada with both Canadian and Bosnian people. One male participant explained,

I could have many Canadian friends. Peoples want to be friend (but) how to explain whats happen to us? They could never understand that. And, I have to test the others (Bosnians) first. Where they was, what they do (in the war). I don't trust until I test them.

A similar attitude was shared by another participant, a female, who explained,

People in Canada don't know what happen in my country and they ask something very crazy, "Why you go out your country?" And I don't know how to explain. Now in Canada come people. These people went in my town and killed and now these people have the same station as me in Canada. Its very hard.

In sum, the loss of social supports whether temporary or permanent caused participants to experience a great deal of grief and difficulty in establishing, trusting and forming new social
supports. It appeared as through participants, in attempting to resolve past loss and grief often found the task of moving on in life through establishing new social support networks extremely difficult (Kemp, 1993).

**Resolving Trauma**

After the immediate settling-in period in Canada, participants had time to re-examine the trauma they had experienced and to try to understand and place these experiences in perspective. Participants described the pain involved in working through their past trauma that contributed to feelings of depression, including sadness, anger, decreased concentration, sudden fear, and various physiological reactions, such as sleeplessness, nightmares, sound sensitivities and indigestion. These emotional and physical reactions are illustrated in the following narrative of one male participant,

*I was full of stress, didn’t have chance to relax. I was in pain (digestive) and afraid. I see many people die. Since the war my psychological (health) is no same. Sometime I can’t sleep, bad memories. Sometime I start to shake and sweat and can’t stop.*

Another man described his war experiences and their sequelae in a way that highlighted his ambivalence,

*I have dreams. Many of them, they are not horrible...they are not horrible. They are very realistic, and...I just know that I’m dreaming? And I feel, I feel its not horrible to me because I passed too much horrible things then is in that dream. I knew, instantly, that its dream (and) I’m just reviewing the tape (points his forefinger to his temple and makes winding motion). I’m trying to be realistic. (Lowers voice and shifts body slightly toward me). First two months here I was too careful of some very low, very thin, very...ah...quiet noises, like whisper of the wind which is always alarming you that a grenade is coming. Not boom sounds. Not strong sounds. Very tiny noises.*

The following explanation was offered by a woman who described her attempts to resolve trauma related to losses she had experienced,

*Since I am in Canada, people ask me about (pauses, searching for words) "Well, you lost blood", but they don't really feel that and I don’t really have that barrier, that protection that I can say, "Oh, I’m fine thank you." I lost lot and left lot. I start to think about it and I usually cry.*

Another male participant expressed his frustration at having
lost everything, including his country, and being forced to begin again. His anger is evident in his comments relating to his escape, his current situation, as well as his views about the future of his former country. He explained,

I build so much in my life, I can't build again. I'm fed up to build, why? I give to another a chance to build, not to destroy. In escaping (Bosnia) I realized that there is no life there in the very far future because something generally is distressed in society there that unfortunately wouldn't be in alignment for a long time.

Finally, another component of resolving trauma during the resettlement period resided in attempts to find meaning in the violence, brutality and persecution that participants had experienced and that continued to impact on their lives. This is illustrated in the following narrative of one male participant,

Because I ask myself, "Why so many killings people, why?" But, you know, I find out that (it is) some shape of aggression. When you analyze all that you see, more and more things are senseless. (Becomes very quiet, looks at floor and pauses). I could fight for Bosnian side but what aim? Our aim is to defend Bosnia. They have aim to defend Serbia, they have aim to defend Croatia. What we are, in the war between each other? Its not war for me. Is disease, very bad disease, very hard kind of cancer.

Finding Comfort in Canada

Participants described varying reasons for, and different levels of comfort upon resettlement in Canada. For example, some participants identified a feeling of sustenance and safety that Canada had provided to them and/or their families. One woman explained,

I never know before what's mean to be hungry. This country give us, as family, so much. This country give us food. What we hadn't for two and one-half years. Everything is okay, this house, government pay, everything. We just have to work and live, that's all.

Another female regarded positively, the cultural aspects of life in Canada,

I like here everything. People they clean their house with what they don't need anymore. I like that. That's very, very clever. That's very good. I think it's okay that we come to Canada. I was very surprised when I see this place. I had in Bosnia, big house and we had everything but when we lost this, we have this. Its just like a present (laughs).

A male noted with surprise, how quickly he adjusted and noted similarities between his country and Canada,

At first I think I am stranger here in this country but now its not problem for me. Here is not big difference from my country. Housing is almost similar. Its maybe the same size or a little bit smaller than I have (Bosnia). But when I go to my friends and see that they have houses, that's something I didn't have there. I have small house but it is not like so big like people have here. The
climate is (pauses) I think, same.

There were participants who described how their initial dismay on arriving in Canada gradually developed into a feeling of ease as they were able to appreciate the kindness of people around them. One woman explained,

So when I came here, did I come to the end of the world? When we came here there were so many things I really didn’t like. I ask myself, “Why did I come here?” I didn’t see the reason. (But) people are so kind so I don’t have that kind of stress like I had in (first country of asylum). I feel that I’m coming down. My nerves are a little bit getting okay.

A male participant explained how at a superficial level, he had been able to find and interact with new friends but at a deeper level, still felt some alienation and ambivalence in Canada. He explained,

I can speak with people, normal conversation. I can go in dinner. I can sit and we have many Canadian friends. Its okay, but I have some social problem here. I think now I am stranger here in this country but maybe its not a big problem. Here is not big difference from my country.

Finally, one woman’s narrative illustrates the components that lent her a feeling of comfort and hope for the future,

We are different but we are healthy and we are lucky. This country give us, as a family, so much. When we came it was very cold but I feel comfortable....I don’t know how to explain that. Because it was nice. Now I feel very good. Even (though) it is hard, in my family I have to solve many problems but I have chance here.

The Future

Participants’ future aspirations and hopes focussed primarily on establishing a stable and peaceful life, finding rewarding employment, maintaining good health, re-uniting families, and obtaining citizenship. Consequently they were committed to building a future in Canada through resettlement and not returning to their country of origin. However, this decision was often made with a great deal of ambivalence and rationalization. For example, one male participant explained that in Bosnia,

There is the minimum of doctors, scientists and now is not the problem, but how (it) will be in future when peace come. It will take years to rebuild. I think its better we stay here.

One female participant expressed similar views,

We can’t go back. This war I believe, never stop and when stop my children couldn’t live there. Me, I can’t live there. And especially in a place where people think who they are. Serbian, Croatian, or Muslim, I don’t like to hear that, to live like that. For a few years I hope that I can get citizenship and my children can go to school. We always travel in Europe. Now, without car and
without money I can't do that, but I plan that. One day when I get job, buy car, we can travel and see all Canada.

Participants visualized a future in which they would improve their English, find rewarding employment and be able to establish a stable and peaceful life. One male explained,

I like to work my job but I know its impossible here now. I must first learn English. Thanks God, we are healthy. I don’t have some special problem. I don’t like to have some special swimming pool. I like normal life for my family. It will be like home.

As noted in previous sections of this Chapter as well as in Chapter 4, re-uniting family in Canada was a primary future goal of participants, both male and female. For example, female participants looked forward to being re-united with their spouses.

One female explained,

My husband will come out of Bosnia. Then he coming here. We will live with (daughter). Finally we will be together. I hopes to God this could happen.

Another participant, a male, recounted the following,

My sister is in ____. She could come out with children (but) she not to leave husband. They decide to come out together. I want they come here to Canada. We try to save money to sponsor. I want Mom and Dad come here but maybe they want to stay there (Bosnia).

One of the single male participants, since he had no dependents in Canada, was freer to consider alternatives in his future. However, he still expressed the wish for family re-unification. He explained,

I like bring mother here. She in danger everyday. She old and she don’t want to leave. But I ask. I stay in Canada probably many, many year in the future. I don’t know if be a situation better in my country. Maybe I will go back in my country. I don’t know. I hope in future when I begin work that it is better, that I can go to cinema, theatre, order, (pauses and thinks) pizza.

C) Health and Resettlement in Canada

As noted in chapter 4, as well as sections of this chapter, participants identified biological health conditions that pertained to the respiratory, skeletal, digestive, and cardiovascular systems as well as to dental health. However, only two participants, a male and a female, reported that their conditions were occasionally disruptive to their activities of daily living in Canada.

The issues that influenced the biopsychosocial health of participants in the resettlement period in Canada, pertained primarily to disrupted significant relationships, adaptation issues (language, social support, job skills) finding employment, and past
trauma. The sequelae related to past trauma experienced during the war included nightmares, flashbacks, grief pertaining to separation from significant others and other losses, sound sensitivities, and depressive symptoms (sleep patterns, sadness, crying, etc).

While participants spoke quite openly of any health difficulties they were experiencing, none reported, nor was it observed, that these difficulties seriously interfered with their activities of daily living, such as caring for themselves and/or their families, learning English, seeking work, and planning for the future. Further, as noted in this chapter participants were able to realistically and effectively analyze and counterbalance any difficulties they were experiencing with the gains they felt they had made in coming to Canada.

These findings of positive health and function in participants in the resettlement period are in accordance with other recent investigations. For example, Somach (1995) found that aside from the severe dental problems suffered by most Bosnian refugees as well as some isolated, mild chronic and emotional difficulties, overall, most refugees were experiencing adequate health in the resettlement period. The positive health experienced by the participants in this study, may be a result of past and present individual characteristics that influenced and modified health, such as age, socio-economic status, a satisfying occupation, self-esteem, language skill, cultural familiarity and similarity. These dynamics will be discussed in more detail in the next section as well as in chapter 7.

**Synthesis**

The male experience in a first country of asylum was short, transient, and was accompanied by feelings of relief and happiness associated with escape from the war, and anticipation at joining family and/or resettling in Canada. However, the female experience was shown to be much more difficult and stressful. This was due primarily to the length of time spent in countries that were hostile to them as refugees, and led to an uncertainty in their daily lives which made establishing a stable existence or planning for the future extremely difficult. Petaevi (1993) observed that female refugees experienced serious difficulties upon resettlement
pertaining to forced uprooting, deprivation of family and community support and/or cultural ties, an abrupt change in roles and status, and the absence of an adult male. Additional potential threats, such as expulsion, refoulement, harassment and different forms of exploitation were also encountered.

The letters are full of sadness and homesickness. They have a tiny apartment in a house. The kids are going to school. The people are pleasant, but only pleasant. Frankly, the are putting up with them. She doesn't yet have a work permit. She hasn't made any friends. She's homesick, she misses her husband. All the worries and problems that she used to share with (him) have now fallen on her shoulders alone. (Softic, 1995, pp. 117)

As pointed out in a previous section of this chapter, while female participants did indeed encounter many difficulties that at times influenced their health, these influences rarely interfered with their responsibilities toward their families, their ability to cope with daily difficulties, or to plan for the future.

It has been shown that all participants in this study were struggling with a number of difficult and stressful issues upon resettlement in Canada. However, by far the most distressing issue pertained to the separation from and worry about the safety of family remaining in Bosnia (Somach, 1995; Clinton-Davis and Fasill, 1991). Additional stresses included language, past trauma, stabilizing their lives and/or that of families, upgrading job skills, finding employment, establishing new social supports, and planning for the future. Consequently, the gains participants made by reaching a country that provided some measure of safety and certainty, were offset by the practical difficulties, adjustments and tasks associated with a second resettlement.

Some investigators have found that positive adjustment and the health of refugees were at increased risk in relation to the accumulation of stressful circumstances upon resettlement (Stern, Love, and McDevitt, 1994; Farias, 1991). However, Williams and Berry (1991) discovered that refugees who settled in a pluralistic country such as Canada, were well-educated, possessed some knowledge of the language and culture and a measure of self-esteem, exhibited more resiliency toward cumulative stresses and experienced more successful resettlements. Not only did the participants in this study consistently report overall positive health and function in
spite of the hardships imposed during the war and the difficulties of resettlement, but the investigator did not observe debilitating negative health or dysfunction over 5 - 6 hours of visiting. Positive health and function were exhibited in the attitudes and behaviours that underscored coping, adjustment and resiliency, such as appropriate affect and energy, friendliness and openness, a sense of humour, the ability to focus on the conversation in spite of a linguistic disadvantage, appropriate interactions with family, friends and the investigator, the ability to realistically problem-solve and plan for the future, and the absence of any obvious physical limitations or disabilities.

Certain factors such as education, positive health, the ability to problem-solve and actively confront difficult situations, may have enabled the participants in this study to survive, escape, and initiate a successful resettlement (Jablensky, Marsella, Ekblad, Jansson, Levi, and Bornemann, 1994; Figley, 1985; Kunz, 1981). While participants were challenged with a cumulative number of difficult resettlement issues that caused them to experience a great deal of stress, the financial resources provided by sponsors, plus positive personal and social characteristics enabled them to reflect on and examine these issues, and in turn, may have interacted with and positively influenced their health, function and resettlement (Edwards and Beiser, 1994; Baker in Basoglu, 1992). The personal characteristics that participants in this study possessed that may have influenced and modified health, leading to an initial successful resettlement included being older, of high socio-economic status with positive health, stable family backgrounds, higher education, and satisfying occupations. Supporting factors in Canada included financial and social support, cultural similarity, a familiarity with the language, and opportunities to seek employment and to engage in job training. Consequently, positive health and resettlement of participants were due to personal characteristics that enabled them to successfully integrate personal meaning with their past, present, and anticipated future life situations, in addition to resources made available to them in Canada.

In sum, it may have been individual characteristics that
contributed to the continuing positive health and function of the refugees in this study, enabling them to effectively cope with suffering, hardship and challenge, and to plan for a future built on hope.

The fourth theme, that of family, will be discussed in the next section.

4) FAMILY

As shown earlier in this chapter as well as in chapters 4 and 5, there was an abundance of information pertaining to the importance of family relationships to the participants in this study. This theme cut across the other three (war, survival, resettlement) and was shown to be a constant over time. The main components pertaining to this theme included, family relationships prior to the war, forced separation from significant family members, family relationships and resettlement in Canada, and influences on health pertaining to separation from and well-being of significant family members in Bosnia.

Family Relationships Prior to the War

The nature of family relationships in Bosnia, prior to the war, were portrayed as stable, loyal, close and loving (chapters 4 and 5). In fact, the importance of family in all phases of life seemed to be an ingrained cultural value. For example, Softic wrote (1995),

My whole life I’ve had it easy: a happy childhood in a happy family, parents who offered me, along with love, everything they had. Prohibitions didn’t exist for me, nor did any sort of compulsion; I was taught to be independent. (pp. 82)

In the informal interviews, family relationships were depicted as the rock upon which all else was built, whether these relationships were between parents and children, siblings, or spouses. While family support all through the life cycle was described by participants as their touchstone, the emphasis on offspring as the primary focus of family is illustrated in the following narratives by two female participants. The first said proudly,

We did everything for our kids. We wanted to give them a good education and everything. We love our kids and are so much attached to them.

The second woman echoed a similar viewpoint,
I travelled very much and spend lots of time in my job but all my free time, I spend with my children. If I didn't do that in my life, sometimes I think they wouldn't be so healthy.

Participants explained that as they grew up and reached their teenage and young adult years, parental tolerance and support (financial and emotional) remained constant. That is, living with parents at least until formal schooling had terminated and even after marriage was common. Married participants obtained their own residence, usually after beginning a family, often within the same city and within walking distance of parents. The geographic and emotional closeness of participants' family lives in the former Yugoslavia prior to the war, was described and contrasted to Canadian culture by one female participant,

We are not grown up like people from here. Mostly we are living with our parents even when we are married so we are much more involved. I was already 29 years (and pregnant) and my mother said to me, because you know, abortion is not forbidden in my country, "You decide what you want. If you want to make an abortion, or to marry or not, do what you want." (Laughs) When we got married we went to live with my mother-in-law and we were with her about two years and then we moved.14

Forced Separation From Significant Family Members

As illustrated in chapters 4, 5 and in the previous section of this chapter (resettlement) the war changed the nature of family relationships suddenly, acutely, and radically. While the multiple and traumatic losses that participants suffered during the war included material possessions, places, significant relationships, and country, participants described the forced separation from significant family members (spouse, children, parents, siblings) as the greatest and most painful loss. This pain was felt equally by both genders.

The disruption of family units in Bosnia was often initiated by female participants and their children making a hasty retreat for whatever border was closest to them and where their ethnicity

14 At the beginning of the war in Bosnia, many families sent their older children (who were attending the upper grades of high school or university) to join relatives or friends in Serbia, Slovenia, Croatia or other European countries, in order to complete their schooling. Some young people were able to attend universities in the US through special scholarships. These parents had not seen their children for three years and communications had been at best, sporadic. These separations had caused parents remaining in Bosnia extreme anxiety and worry about the manner in which their child was coping without family support (1995).
would not be a factor in crossing (chapter 5). The males' escapes were, due to conscription, later and surreptitious. Consequently, participants were unable to bid prolonged farewells or to grieve the potential separation from significant family when attempting to survive the war and escape. It was not until they had reached a country of asylum that they began to grieve for, worry about, and experience guilt for abandoning significant family. One woman discussed the ambivalence she felt at separating from her spouse and country,

_When I left husband, and plane took off from (airport) I felt like when you have a fruit, when its old you want to throw it away. It is grey (decaying). I lost a lot and left lot. I safe with children but I couldn't really say, "Now I'm happy because I'm safe with _my_ children." He's (spouse) in the army, in the special forces. I couldn't picture anything more terrifying._

While the women left their spouses and families in Bosnia in order to ensure the survival of their children (as noted in chapter 5) they suffered feelings of isolation, grief, and anxiety pertaining to the loss, safety and well-being of significant family members left behind. One woman recounted her experience,

_I didn't feel nothing after coming to ____. Children start to go to school, but it was not the same as Bosnia, not the same. I feel empty inside. All my family stay in Bosnia you know. I missed them and I didn't know how to help them._ (Begins to cry).

The male participants on the other hand, experienced family separation differently. Since they were conscripted and as a consequence unable to legally leave the country, the initial period of separation was filled with hope that the war would be short-lived, that they would manage to survive it, and would be re-united with their families. However, as noted in chapter 5, many males described the increasing agony they experienced after separation from significant family members and as the war dragged on. Male participants who were married, described feeling guilty at not being able assist their spouses who were often struggling to provide for children while at the same time experiencing discrimination in

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15 Young people that I spoke to who had been sent out of the country at the beginning of the war to attend school in Croatia and the United States admitted to experiencing intense feelings of isolation and fear for the well-being and safety of family members left behind in Bosnia. These feelings were so strong and had been present for such a prolonged period that some young people admitted to continuing depressions, anxiety, and difficulties with studies (1995, 1996).
temporary countries of asylum.

I know she (spouse) have hard time in (country) but I can’t do nothing. I must stay and fight.

Often unable to communicate with their families for months at a time, they worried about how their families were managing without a male breadwinner or if they would see them again. One male explained,

I worry how (spouse) is managing with kids in (country). I try to escape (military) but can’t. I don’t know when and if I will see them again.

Finally, escaping the military and Bosnia brought males closer to some significant family members but they were in turn, distanced from others remaining in their country of origin.

Family Relationships Upon Resettlement in Canada

As noted in chapter 5 and in an earlier section of this chapter, the nature of family relationships was radically altered as families were forcibly separated due to the the war. The resulting disruption held consequences for family function upon resettlement in Canada. For example, spouses had spent varying periods of time apart and the women had assumed the roles of breadwinner and sole support for offspring. When spouses were re-united, in spite of their happiness and relief, they experienced difficult adjustments such as, reconciling differing past experiences, and adjusting to new roles in a new culture. Since most women had become accustomed to the roles of breadwinner and primary decision-maker in some very difficult circumstances such as escape from Bosnia, resettlement in a first country of asylum, migration and resettlement in Canada, relinquishing and/or even sharing this role required a great deal of re-adjustment. One woman explained,

I do all there (first country of asylum). Then I do again here (Canada). It is difficult now to change when I do all before he (spouse) come here (Canada).

On the other hand, the males had just survived a brutal war in which bravery was paramount. Their perception of the role they would adopt on returning to their families was an extension of that assumed before the war (breadwinner, head of the family, protector). One male recounted his experience,

Everything change now. The family is change (pauses and looks away). We will see.

When males were re-united with their families they found that
their spouses were either working and/or attending job re-training, their families were well-advanced in language skills and acculturation, and their children regarded them with shyness, nonchalance, and/or anger. That is, either children seemed to regard their fathers as a threat to their relationships with their mothers and/or they simply treated them as non-entities. For example, on many occasions I noted that children would by-pass their fathers when seeking permission and would appeal to their mothers when their fathers attempted to discipline them. After one such incident, a female participant explained her perspective,

So much has happened to all (of) us. We have to know each other again. (Glancing at spouse and appearing embarrassed) Children have to know (their) father again.

While visiting homes where males had recently joined their families, I noted that the mothers and children were much more aggressive and confident in greeting and interacting with me, while the males lingered on the periphery. When I would reach out to shake their hands and introduce myself, often they would smile sheepishly, avoid eye contact and mumble that their English was very poor. One male noted,

I hope to quickly catch up to my wife and kids and adjust to Canada successfully as they (have).

While spouses struggled with re-establishing the relationships they had shared prior to their separations and most admitted to experiencing difficulty in doing so, they placed the needs of their offspring before their own. That is, establishing a stable family environment in which their children could flourish both in the present and the future was placed before all else. One man explained,

Now that we are here, most important is (the) kids. We must make (a) life for them, for their future.

Another participant, a woman said,

The first thing is the children. That they study at school, make something for themselves, that they be happy. The first thing is to make for them a happy life and future.

To sum up, the worry experienced by participants pertaining to the safety and well-being of significant family members in Bosnia, plus the adjustment and modifications of roles in a new culture, caused a great deal of strain and tension on family relationships in Canada. The next section will discuss the implications of family
separations, role changes and the safety of significant family members on the health of participants in this study.

The Influences of Family Disruptions on Health

Participants described ongoing feelings of anxiety and fear pertaining to the safety and well-being of significant family members remaining in Bosnia. These feelings are illustrated in the following narrative which was tearfully recounted by one female participant,

_I wait for the moment when I can see my family again. I don’t know when this (is) because they are closed in this area and they don’t go out. I feel afraid for them, and I think I will be better when I see them and can help them._

Another woman said,

_I miss my family. I want I should see them. I dream some time about them and I cry._

Participants attempted to allay their feelings of loss, sadness and anxiety, by contacting family members as often as was possible by telephone, often using their scarce financial resources in order to do so. One woman explained,

_We talk to them (siblings, parent, nephews) maybe once, twice (a) month. It is very expensive but I must (emphasis on this word) talk to them. Everytime, I try not to cry to upset them, but everytime I cry._

When participants spoke of the dangers their family members were exposed to in Bosnia, without exception, they described experiencing obsessive thoughts that led to constant stress related to their safety and well-being. One male said,

_I think about them all the time. I worry for them, if they be alive._

Another participant, a woman said,

_I pray to God everyday that he (is) safe and alive. Everyday I am feeling the stress._

The preoccupation with the well-being and safety of significant family members became a daily companion that was both emotionally and physically debilitating. In addition, as noted in the previous section, married participants were also challenged by the changes within their re-united families in Canada pertaining to disrupted roles and patterns of interaction between spouses and children. Not only were some symptoms of depression evident in behaviours at times (obsessive thoughts, fatigue, sadness, anxiety, weeping, etc.) but many participants made frequent reference to experiencing symptoms
as well as the specific reasons for doing so. These reasons included, the safety of family members and feelings of inadequacy related to an inability to assist them financially and/or emotionally; guilt pertaining to having left Bosnia and having secured safety and sustenance; an obsession with watching, listening to, reading or speaking about the war. However, these verbal reports and behaviours were tempered with some positive aspects as well. For example, participants pointed to realistic strategies and plans that focussed on re-uniting family members in Canada and verbalized a belief that successful resettlement would enable them to assist their family either within Bosnia and/or to leave the country. Consequently, future family-oriented strategies enabled participants to constructively focus on successful resettlement by instilling hope that enabled them to cope more effectively with some of the negative health and function that had been caused by family issues. One man explained,

*First I need language, then job, then I can help my family. I can sponsor them to come here. I feel better if I can do that.*

In sum, being separated from significant family members who were exposed to the hazards of war caused participants to experience distress and depression. However, these effects were partially offset by the realization that if certain resettlement strategies were enacted, re-unification with family could become a reality in the future. Until this goal could be reached, the hope was that loved ones would not become casualties in the war.

Similarly, the stress participants experienced pertaining to role changes brought about by family reunifications that had taken place in Canada, was partially offset by the shared goal of both parents to provide a stable and unified home for their children as well as a secure future. Hence, while negative health and function were caused by family disruptions, participants were still able to engage in constructive and realistic analysis, problem-solving and planning. The resulting strategies led to an alleviation of the stress experienced and to a resiliency that enabled them to achieve a balance by maintaining a measure of positive health and function.

**Synthesis**

Family was the theme that cut across all others and represented
the main driving force throughout each participant's life from childhood to adulthood, from peace to war to resettlement. Family relationships and supports were described as the crucial foundation upon which all other life events had and were being built. Participants described experiencing a stable environment in which they passed from childhood to adolescence to adulthood and within which they received ongoing financial and emotional support as they reached each milestone in their lives. Providing stability for their children was in turn, a priority for those participants who had offspring. Family disruptions and their sequelae incurred by the war (separations, anxiety regarding those family members remaining in Bosnia, and role changes) led to a great deal of anxiety, sadness and distress which in turn negatively influenced the health and function of participants. Depressive symptoms including obsessive thoughts, fatigue, weeping, poor sleep and appetite were common. Participants did not hesitate to discuss these aspects of negative health and function pertaining to family issues, and regarded these difficulties as transient and manageable. To illustrate, they were putting into place strategies to resolve family issues such as maintaining contact and planning reunification with significant family members, and struggling to re-establish family life in Canada by learning to cope with role changes that had taken place. More important, they were meeting these challenges while still adequately performing the activities of daily living.

The next chapter will contain a discussion and conclusions pertaining to the experiences of trauma, forced resettlement and health by presenting an overview of findings, discussing the role of pertinent characteristics in modifying health, the maxims that were derived from the central themes, an evaluation of the methodology, limitations of the study, and recommendations for future research.
CHAPTER 7

TRAUMA AND RESETTLEMENT AND THE HEALTH OF BOSNIAN REFUGEES

The purpose of this study was to investigate how the experiences of trauma and forced resettlement influenced the health of Bosnian refugees living in Canada. In this chapter, major findings are summarized and a model is presented that identifies the key components of the experiences of trauma and resettlement and the implications of these for health. Theoretical considerations, an evaluation of the methodology, limitations of this study and recommendations for future research, conclude this chapter.

DISCUSSION AND CONCLUSIONS

The focus of this study was to discover whether the experiences of trauma and forced resettlement influenced the health of Bosnian refugees in Canada and if so, to what extent. The goals of this focus were met through participants' descriptions of and their reactions to the experiences of war and resettlement. These descriptions were then analyzed in depth, in order to understand how, and to what extent, trauma and resettlement affected the health of these refugees. Health was defined in biopsychosocial terms and included subjective and objective perceptions and observations of life events and their influences on well-being, the ability to perform the activities of daily living, to problem-solve, and to set realistic goals for the future.

Since I regarded health as a process, in order to fully comprehend how the experiences of trauma and forced resettlement influenced participants' health, it was necessary to identify ongoing life events, as well individual evaluations of these events. Through combining these two forms of knowledge, it was possible to reach an understanding of how participants' life experiences and health were connected over time.

Past literature pertaining to refugee health has been primarily limited to clinical studies and to specific instances in time. Such approaches tended to ignore the interaction between the present, past memories, and anticipations of the future. Further, many investigations embarked on research with an a priori focus on pathology. Consequently, data and conclusions pertaining to refugee
health were almost exclusively negative in tone and often led to findings that were appreciably narrowed and circumscribed, focussing as they did largely on the health risks that refugees face. Though there is some evidence that refugees present an example of enormous human capacity to cope with assaults on identity and dignity, indications of positive health are largely absent from studies (Mueke, 1989). In order to avoid the above dilemmas, this study made few a priori assumptions that participants would be in poor health, participants were recruited from community settings, and the nature of health was examined through the subjective perceptions of participants, and objective observations of the investigator, within a framework of memories and anticipations. These strategies revealed a sequence of contextual health patterns that consisted of interactions between personal, psychosocial, and cultural characteristics, and experiences over time (Chapter 2).

The central issues identified by participants consisted of four themes: war, survival, resettlement and family. While these themes have been presented and discussed in chronological sequence (chapters 4, 5, and 6) they emerged in the interviews in a more random manner. That is, as participants told their stories they moved back and forth between time perspectives, emphasizing important issues through contrast and comparison. For example, participants would enhance or clarify the effects of war, by describing what their lives had been like before the war and how this experience had influenced their ongoing health and function. Consequently, each participant’s description of ongoing life events revealed a unique pattern that represented individual experiences, meanings, characteristics, and associated health. Each pattern possessed a definite beginning yet were incomplete in that the endings consisted of proposed plans and/or anticipations for the future. When comparisons were made, various participant accounts of their experiences and the effects of these experiences on their health, revealed certain unifying features. These features are discussed in more detail below.

7.1 DIFFERENCES, SIMILARITIES, AND PATTERNS

Since it has already been established in previous chapters (5,6) that the experience of war and resettlement were somewhat
different between the genders, these differences will be highlighted in the following sections, along with similarities and overall patterns of health.

a) Bosnia

There were few significant gender differences pertaining to health, education, socio-economic group, marital status, occupation, family stability and residence prior to the war. For example, participants had been raised in urban settings and within stable households, experienced a comfortable socio-economic environment, and described their health as robust. Further, most had acquired post-secondary educations, and all had held professional, well-paying jobs and travelled outside of their country of origin.

There were significant gender differences pertaining to how the war was experienced and interpreted. For example, the males were conscripted and prevented from leaving Bosnia, hence, most remained in the country up to 2.5 years. While their lives were in danger, they were given adequate sustenance (food, water, clothing, shelter), some financial remuneration and weapons for defence. In contrast, regardless of the period of time female participants remained in Bosnia, they experienced the war differently. For example, while their lives and those of their children were also in danger, in addition they endured daily severe deprivations, terror, persecution and brutalities, without any form of defense.

The complete upheaval of participants' lives and their struggle to survive the daily threats to health and safety, caused both females and males to experience a continual state of stress that resulted in poor health and function. Loss of weight, disrupted sleep, depression, anxiety, weeping, hypervigilance, sound sensitivities, and digestive and cardiac irregularities, were the primary symptoms described.

Participants survived the hazards of war and maintained their health, through adopting new attitudes and behaviours that underscored flexibility and resiliency such as: relinquishing peacetime behaviours and adopting those applicable to war, accepting the possibility of death, learning to cope with witnessing daily frequent and ongoing destruction, maintaining social supports, compromising principles, disrupting close personal attachments when
necessary, maintaining a sense of humour, and a belief in fate or chance. Health was re-defined, not in positive terms, but as sheer survival. Symptoms which might have indicated poor health in pre-war times were ignored or downplayed.

Escape from Bosnia was equally dangerous for both genders. Women and children could be killed by sniper fire, shelling or land mines, while the males, if caught attempting to leave Bosnia, would have been imprisoned, tortured, and/or killed. Regardless of participants' gender, the eventual decision to leave Bosnia was extremely painful, representing a permanent relinquishment of the multiple significant attachments that had formed the foundations of their lives. Attempting to preserve these significant attachments was the primary reason why participants were reluctant to leave the country. Still, continuing fear and guilt for those significant family and friends left behind persisted throughout their sojourn in a first country of asylum and upon resettlement in Canada.

b) First Country of Asylum

Significant gender differences pertained to forced resettlement in first countries of asylum. Women and children fled to countries that were close to the borders of Bosnia and where relatives and/or friends already resided. They expected that their spouses would join them in a short period of time or, that the war would end and they would be able to return home. Given these short-term expectations and the haste with which they had left their country, they arrived with few possessions, very little money, and initially resided with host families. However, after the initial settling-in period, the realities of being a refugee in an inhospitable country became manifest.

The unexpected challenges that females encountered included discrimination, threats of expulsion, harassment and different forms of exploitation, an abrupt change in role, poverty resulting in lowered self-esteem, and feelings of isolation from family, community, and culture. Compounding these challenges was a feeling of constant anxiety pertaining to the re-living of trauma and for the safety of significant family remaining in Bosnia. Further, after months of waiting, the patience of host families began to wear thin. Rejecting the option of residing in a refugee camp, the women
recognized that living independently and/or immigrating to another country required money. Thus, most opted for finding employment even though this action meant breaking the law and jeopardizing their residency. Those who were successful in finding employers to hire them surreptitiously, were financially exploited and in constant fear of being discovered by or reported to the authorities.

These resettlement challenges affected the health of female participants by inducing a constant state of stress that resulted in disrupted sleep patterns, breathing, eating, and digestive difficulties, increased smoking, anxiety, depression, weeping, anger, and denial of feelings. In spite of these difficulties, they reported adequate coping and function as illustrated by their ongoing emotional and financial support of their families. They all also made plans for a future that they realized might not involve their spouse. In short, when female participants recognized the impossibility of establishing a new life in an inhospitable country, the war continued unabated, and spouses did not join them, they made the decision to emigrate to Canada. In accordance with that decision, these women initiated, followed through and completed the immigration process even though it required a great deal of physical and emotional energy as well as financial input (innumerable phone calls, travel, filling up of forms, and interviews). Through successfully coping with an extremely difficult life situation and actually gaining entrance to Canada, they represented a somewhat select group in that they took specific actions to alleviate their multiple dilemmas.

The male experience stood in stark contrast to the experiences that females encountered. Firstly, fleeing to first countries after their successful escapes from Bosnia left them feeling elated, thankful, and relieved to still be alive and out of danger. Secondly, but most importantly, they had no intention of remaining in a first country for any length of time, thus they did not encounter the same problems that the females had. The families of the married males had already emigrated to Canada, consequently, these males intended to join them as quickly as possible. The two single males, recognizing how difficult it would be to secure landed immigrant status, quickly made the decision to immigrate as well.
All male participants were granted clearance by the Canadian authorities in a matter of months.

The health of male participants in this short period of time also differed from that of females in the same situation. While the female participants had suffered negative health related to ongoing stresses, male participants described this period as one of gradually improving health in which they gained weight, relaxed, and enjoyed luxuries that they had been deprived of for a long time. Hence, for the women, the time in the host country presented enormous challenges and an uncertain future, whereas for the men leaving Bosnia underscored their survival and the promise of a better future.

c) Resettlement in Canada

There were few gender differences pertaining to the tasks, adjustments and challenges faced in the resettlement period in Canada. What did differ however, were the skills that females acquired since leaving Bosnia that made it easier for them to cope with these tasks, adjustments and challenges. That is, these women had successfully and with minimal support, survived and escaped the war and resettled for an extended period of time in an unfriendly country. They had begun to resolve losses, coped as single parents, initiated and completed the immigration process, and faced the fact that their spouses and close family members might not survive a war that seemed to be neverending. While the last realization was a source of continuing distress, and adapting to a new culture constituted an enormous adjustment, their new hard-won skills and competencies enabled them to land squarely on their feet. They prioritized tasks and continued to plan for the future. At the same time they never gave up hope that their families would remain safe and their spouses would eventually join them in Canada.

The males on the other hand, did not have time to develop the same kind of strengths as the females had simply because the transition period from their country of origin to Canada, had been much shorter. They had little time to process or reflect on the quick succession of changes they had experienced. In this short period they had fought in the militia, survived battles and their escapes from Bosnia, spent an exhilarating but short period of time
in a first country, and departed for Canada.

Upon arrival in Canada, the married males found their families settled in furnished apartments and well on the way to adaptation. That is, spouses were engaged in part-time employment and/or activities, and had adopted the roles of provider and decision-maker for the family. The language skills of the children and spouse far surpassed that of male participants with the result that the men often had to turn to family members to ask the meaning of a word or for correct pronunciation. Children by-passed their fathers to seek their mother’s advice, and families had formed a new social group that initially did not include husband or father. All males had played an equal part in their family units prior to the war, hence their new and ambiguous role placed them in a disorienting and confusing position. Perhaps given more time to reflect on the changes that might have occurred within their families and themselves in the period of time that had passed, they might have been more prepared for the changes they experienced. Nonetheless, not only did they have to "catch-up" to their families, but simultaneously attempt to master the necessary skills in order to function adequately from day-to-day, to struggle to establish a new role in the family, and to deal with sequelae related to trauma experienced in Bosnia. This situation placed these males under tremendous pressure and in turn placed a strain on marital relationships and represented a serious hurdle to the successful reunification of families. Further, most marriages were between partners of different ethnic groups. During the war, males had often engaged in battle against the ethnic group to which his spouse belonged. Since there was so much tension between partners pertaining to reunification, it was difficult to sort out precisely what issues were causing the most difficulty in marriages.

The single males on the other hand, while also struggling with the same tasks, adjustments and challenges of resettlement exacerbated by the short time in transition, did not not have to cope with re-establishing marital or parental relationships. The advantages in this situation were that they did not have to adapt to role changes in relation to significant others, were free to pursue their own interests, and to move from one community to another in
order to take full advantage of opportunities available to them.

It has been established that all participants, regardless of gender, were challenged by resettlement issues including loss, resolution of grief, trauma and its sequelae, family disruption and reuniting, language, occupation, initiating and forming new social supports, and generally reaching a level of comfort in a new host country (chapter 6). The only difference was that females had begun dealing with most of these issues at an earlier stage than the males had, with the result that they were in the process of resolving some of these challenges. However, regardless of at what stage participants were in resolving resettlement challenges, each had to be mastered before they could capture a feeling of belonging. Their recent experience had begun as a total sense of loss and disruption of their prior life, followed by ongoing struggles, demands and more losses in first countries of asylum. In Canada, the primary task faced by participants was to begin to rebuild lives that had been shattered by the war. Former assets such as education and work experience, so important to rebuilding and establishing a feeling of competency and self-esteem were initially discounted in Canada, leading to work at menial jobs and subsequently, to lower status. Unfortunately, participants' limited language skills also represented barriers to secure and well-paying jobs. While diminished occupational status and marketability were issues that made re-building especially difficult, participants struggled to negotiate this challenge.

In sum, both female and male participants in this study managed to negotiate an unbelievable number of tasks in a short period of time in spite of limited resources. In doing so, their feelings of being at ease in Canada increased rapidly. They overcame monumental barriers in order to secure any kind of employment, regardless of their previous education or occupation, and were determined to rebuild their lives in the most comfortable way possible despite the disadvantages they faced. They often subordinated their own cultural values, relegating them to a "private" sphere (diet, language, etc.) and forced themselves to learn, accept, and derive comfort from their host culture. These initial coping strategies aimed at learning Canadian ways, limited and defused somewhat, the
overwhelming and adverse conditions of forced resettlement and trauma, imbued a sense of belonging, relieved the level of stress, and were reflected in positive health and function.

The next section will discuss the protective roles that certain characteristics appear to have played in positively influencing the health and function of participants in this study.

7.2 HEALTH MODIFIERS

Health modifiers consist of personal, psychosocial, or cultural characteristics that might be capable of influencing how experiences affect health (chapters 1 and 2).

While most of the literature pertaining to refugee health has been based on the assumption that these experiences inevitably led to health breakdown (chapter 2) this study revealed a more positive view of refugee health. What has been established in the past and in this study is that most refugees experience life situations and events that do pose a risk to health. These experiences include physical danger and deprivations, trauma, losses, family disruptions, isolation, unemployment and/or status demotion, learning new roles, language, and culture, and the challenges of an uncertain future (Ljubotina, 1995; Beiser, Johnson, & Turner, 1993; Clinton-Davis and Fassil, 1992; Fox, 1991). However, what has not been clearly established is why and how some refugees, such as the participants in this study, face the numerous physical, social, cultural and psychological demands, and at the same time maintain an adequate measure of positive health and function. For example, based upon participants' narratives and the investigator's observations (chapters 5 and 6) participants were functioning reasonably well, did accomplish daily tasks and put into place strategies with which to achieve short-term and plan realistic long-term goals. This is not to say that participants never experienced poor health related to past trauma and current resettlement challenges, but that in spite of these stresses, their health on balance, revealed a great number of strengths, human capabilities, and resilience. This raises the question as to whether the assumption of pathology so frequently adopted in previous studies have produced findings biased towards poor health (Williams & Berry, 1991).
The cumulative influence of personal, psychosocial and cultural characteristics such as being relatively young, possessing good health and advanced education, being married, occupation, urban orientation, stable families, and pride in their country of origin, enabled participants to cope with and survive the life-threatening traumas of war, the resulting forced displacements, losses, and family disruptions. For example, youth and good health enabled participants to endure the violence and deprivations of war. Higher education, urban dwelling, travel outside of the country, exposure to a flourishing tourist trade, and professional work experience, all contributed to the development of confidence, self-esteem, and flexibility that culminated in constructive problem-solving and coping during the war (Berry, Kim, Mindy, and Mok, 1987; Somach, 1995).

Finally, participants' intense kinship ties, pride in their country, and the hope that their lives, as they had been would be returned to them, were primary in the decisions to remain in Bosnia after the war had begun, as well as to survive assaults to their health during this period. It was these personal, social, psychological, and cultural values, beliefs, and behaviours, that contributed to participants' maintenance of health and function during the war. These characteristics, by interacting with life events, modified threats to health that may otherwise have required or demanded clinical attention before or upon resettlement in Canada.

A similar interaction of characteristics and life events enabled participants to survive the next stage of their enforced journeys. For example, females leapt hurdle after hurdle, and transformed a distressing life situation to their advantage by employing constructive problem solving skills in order to cope with living in an inhospitable country of first asylum. The knowledge, skills, confidence and self-esteem that each female had developed over their lives enabled them to confront a series of biopsychosocial assaults and to remain focussed on their goals. They emerged from the experience, not only with their health and function intact, but with increased strength, resiliency, confidence and pride. Thus, it appeared as though their past successful coping
with challenge enhanced their ability to face further threats.

In sum, all participants confronted the hardships and suffering in the war (and women in first countries of asylum) that posed ongoing risks to health, but when it appeared that hope for a better life was not within their grasp, they turned to behaviours that gave them a new purpose. That is, the women made the decisions to leave Bosnia and subsequently to immigrate to Canada, while the males planned and executed escapes from the hazards of war. Both of these behaviours, made possible by accumulated personal, psychosocial and cultural characteristics, enabled them, not only to survive the war, but to make active plans for the future.

The health risks that participants faced upon resettlement in Canada compounded those that already existed prior to immigrating. The increased losses and life disruptions, adoption of new roles, the novelty of a new culture, and acceptance of the reality that they had permanently left their country of origin, led to feelings of anxiety, sadness, difficulty trusting, and anger. At the same time, the need for acceptance and to integrate and reconstruct a new view of themselves, their families, and their futures became paramount. The sheer number of tasks, challenges, needs, and accompanying feelings, presented enormous risks to health. While these risks did influence health negatively at times, on balance, participants subjectively believed that they were experiencing adequate health and function, and the findings of this study concur with that view.

The same characteristics and dynamics that enabled participants to meet and successfully confront hardships encountered before arriving in Canada were only partly responsible for their positive health and function once they had resettled. That is, by the time participants reached Canada, they had experienced and successfully surmounted a series of hardships, suffering, and challenges that resulted in a depletion of existing health and function. Consequently, it is important to examine additional characteristics that acted as health modifiers to enable participants to continue to maintain adequate health and function upon facing additional resettlement challenges in Canada. For example one asset was the landed immigrant status that had been granted either before leaving
Europe, or shortly after arrival in Canada. Given this advantage, participants were eligible to receive health and social benefits, and could seek employment openly and without fear of retribution. These advantages contributed to feelings of empowerment, confidence, belonging, and hope for a new beginning.

Another health modifier pertained to marital status. For example, it might be concluded that the readjustments between spouses upon reunification, represented an additional threat to health (chapters 6 and 7). However, there was evidence that overall, the support received within marital relationships exerted a positive influence on health, relieving feelings of alienation and isolation common to refugees. Further, in spite of the spousal tensions upon reunification, the absence and/or loss of significant family and friends strengthened the emotional bonds between marital partners and within families (Fox, 1991; Ross, Mirowsky, and Goldstein, 1990). It is noteworthy that while all the males were confronted with tremendous resettlement stresses in Canada the two who were unmarried were exhibiting and verbalizing more emotional and physical difficulties than were the married men.

The losses in Canada differed from those described when participants left their country of origin. In Canada, participants were able to limit and/or recoup their losses somewhat by implementing strategies that assisted them to overcome some of the resettlement challenges. These strategies, made possible by different forms of material, financial, and emotional assistance led to employment, volunteering in the community, enrolling in ESL and re-training courses or, simply accessing malls, grocery stores, or coffee shops in order to interact with people. These strategies increased participants' financial certainty, decreased their social isolation, led to the forming of new friendships, enabled them to practice their language skills, and added to their knowledge of their new host culture. In turn, participants' levels of confidence, self-esteem, empowerment, and feelings of achievement were appreciably improved. Thus, diminished occupational status and marketability compounded the problems pertaining to rebuilding a new life. Yet these disadvantages were buffered somewhat, by past and present modifiers that led to an optimism pertaining to the
achievement of short-term goals such as studying and learning English, the initiating of financial stability, learning new work skills, and reaching a better understanding about the host culture.

The youth of participants was also an asset. That is, it has been shown that younger refugees encounter fewer problems adapting to a new host culture (Kunz, 1981). Further, the participants in this study noted that they were still young enough that a new start in life could be made and realistically realized.

A rudimentary knowledge of English was also an asset. Most participants had been exposed to the English language either while in school in their country, through tourists who visited their country, or through travel to other countries. Consequently, although no participant had mastery over the language, most possessed a familiarity, which made the task of mastering it much easier and relieved some of the stress pertaining to resettlement.

Participants pointed to the socio-cultural similarities and the geography of Canada, as providing a feeling of comfort in their new culture. However, it must also be kept in mind that as a group, participants did not constitute a visible minority and thus, were not subject to possible bias or discrimination. These characteristics exerted a positive influence on what could have led to magnified risks to health.

Lastly, it could be speculated that participants may have idealized their life before the war and that this process may have also served a protective function that resulted in better health (Chan, 1984). For example, thinking of their lives before the war may have transported participants to a happier time before the former Yugoslavia became engulfed in war, families were intact, and life was predictable. This idealized version of the past may have provided some relief from the overwhelming realities of resettlement that resulted in daily stress.

In sum, meeting short-term goals gave participants a measure of pride, decreased their level of stress, and contributed to an increased confidence, moving them closer to meeting the longer-term goals including family reunification, stable employment, increased occupational status, and grief and trauma resolution. However, many of the resettlement strategies described above would have been
difficult if not impossible to enact if participants had not possessed cumulative past characteristics, bolstered by the opportunities made available to them in Canada, that interacted with experience and positively influenced their health.

In actively confronting threats to health, it was necessary for participants to possess the abilities to cognitively and constructively differentiate and prioritize challenges, and the confidence and maturity to act and readily recover after each assault (Schaeffer & Moos, 1992). These cognitions, behaviours, and recoveries, were made possible, it appears, by the influence of cumulative personal, psychosocial, and cultural characteristics that decreased stress, defused danger and resulted in survival and positive health outcomes (Carpenter & Scott, 1992). While past characteristics contributed to participants' coping and health in Canada, it was also the various personal, social, and psychological supports received that enabled participants to meet their short-term goals, and to plan for their future in a new country. Thus, the positive implications of the re-building process transformed forced resettlement from a distressing experience to one of positive health and function evidenced by growth, increasing financial certainty, self-improvement, and hope for the future.

The next section will discuss the theoretical significance of the findings of this study.

7.3 THEORETICAL SIGNIFICANCE OF THE FINDINGS

This section addresses the health maxims that represent the four central themes identified by the participants, followed by an explanation of a model that illustrates the experiences of trauma, resettlement and health. Finally, the theoretical applicability of this study will be discussed.

a) HEALTH MAXIMS

The health maxims that are derived from the central themes identified by participants (chapters 4, 5, 6) symbolize their positive health values and beliefs. That is, these maxims depict the positive conditions considered necessary for the maintenance of health.

i) Health is Peace

War and its effects on life and health was a central theme
identified by participants. This theme included a description of life before the war and events and reactions when war broke out (Chapter 5).

The social, economic, political, and environmental disruptions that accompanied the onset of the war posed serious threats to the physical and mental health of participants (chapters 4 & 5). These threats included ethnic persecution, shelling, lack of subsistence, contaminated food and water, and the unrelenting fear for the lives of loved ones and oneself. The sequela of these traumas such as family separations, re-living and coming to terms with trauma suffered, and resettlement tasks, while not resulting in the need for clinical intervention, negatively influenced participants' health and function upon resettlement. Since participants considered a time of peace in Bosnia as fulfilling, happy, stable, and certain, it was this existence that they described as normal, healthy, and hoped to recapture in Canada. This hope is illustrated in the following quote of one woman participant,

> It is difficult for me to forget and speak about this things that happened in war. Its very hard. I want to forget everything and live a new life. This country give us a chance to live again, to work again in peace, as family. The children can grow up as normal people.

Since "peace" connotes serenity, tranquility, rest and reconciliation, this theme was represented by the positive health maxim, "Health is peace."

**ii) Health is Resiliency**

While both physical and mental health were threatened by the struggle to survive the war and its effects (chapters 4 and 5) participants survived the war trauma with evidence of positive health and function. They believed that survival had largely been possible due to adaptive psychological strategies that included the flexibility to adapt to a threatening environment by learning new attitudes and enacting new behaviours. Softic (1995) wrote,

> The war became a lifestyle. I adapted easily, I didn’t burden myself with unnecessary principles. Terror and helplessness engendered defiance, defiance awoke pride and pride became spite. (pp. 127)

The chance of surviving the war was enhanced by the life-sustaining abilities to adapt and rebound from suffering and ongoing dangers. The components of these abilities included flexibility,
hardiness, tenaciousness, and irrepresibility. Since resiliency best describes this process, survival is represented by the maxim, "Health is Resiliency."

**iii) Health is Belonging**

Resettlement for all participants, began as a forceable displacement and a severing of significant connections to their country of origin. The implications of this forceable displacement resulted in losses; anxiety pertaining to significant family remaining in Bosnia; the need to re-establish support networks, learn the language, find employment and acceptance; resolve trauma; and plan for the future. Coming to terms with all of these issues resulted in profound feelings of alienation, isolation, and detachment and in turn posed threats to health. Since the word "belonging" connotes adaptation, adjustment and connecting, the positive health maxim that most clearly represents this theme is "Health is Belonging."

**iv) Health is Unity**

Family issues including relationships prior to the war, forced separation during the war, relationships upon resettlement, and plans for reunification in the future, represented the salient concern of participants. Distress in relation to family issues, while not requiring clinical intervention, negatively influenced the health of participants in a number of ways (chapter 6). Participants believed that the only way in which their distress could be alleviated was to be able to ensure the safety and well-being of significant family members in Bosnia, and/or preferably, to bring about reunification in Canada. Since the word "unity" connotes solidarity, wholeness and harmony, this theme is represented by the positive health maxim, "Health is Unity."

In sum, the health maxims derived from the four central themes, when transformed in order to represent participants' positive health values and beliefs, revealed the factors over time, that were considered necessary for the maintenance of positive health and function in the face of war trauma and forced resettlement. Consequently, these maxims symbolize the significant beliefs of participants in this study, that are considered necessary for the maintenance of health in the present and in the future.
The next section will present and discuss the model that represents the central issues surrounding the experiences of trauma, resettlement and health

b) MODEL

This model illustrates the experiences of trauma, resettlement, and their risks to health, as well as the attributes that were considered necessary for the maintenance of positive health (Figure 3). Specifically, the model depicts increasing feelings of comfort (solace, contentment, calm, serenity) made possible by life in a peaceful society, a thankfulness at having survived the war, initial feelings of belonging, and the hope of unifying family in the future. The model also depicts movement over time with the present representing the central reality, but being influenced by past experiences and future goals.

The dotted lines and directional arrows indicate permeability and a processual perspective in which health through time, is subject to many kinds of influences and responds to these influences in specific ways. For example, while traumatic experiences posed health risks, the cumulative personal, psychosocial and cultural characteristics intervened, making it possible to enact strategies that modified these risks and resulted in maintenance of health. The maxims that emerged from this interaction represent positive conditions that are necessary for the maintenance of health. For example, resilience was a crucial characteristic that made it possible for participants to survive trauma, reach Canada, and maintain health. Consequently, while traumatic experiences pertaining to the war, and their sequelae, posed enormous risks to health, the presence of cumulative personal, psychosocial and cultural health characteristics modified and reduced these risks with the result that participants were able to maintain adequate health and function.

It is important to note that the experiences that increased risks to health and their interactions with personal, psychosocial, and cultural characteristics occurred at an uneven pace through time. That is, health risks associated with war predated survival which predated resettlement issues, while family remained a constant through time. Similarly, the conditions necessary for the
A Model Depicting The Central Issues
Of Refugee Trauma, Resettlement & Health

Fig. III
maintenance of health represented by the health maxims also proceeded at an uneven pace. This portrayal indicates that while participants were experiencing adequate health and function, reaching an optimal level was still hampered by the ongoing tasks and challenges associated with trauma and resettlement. Thus, the pattern of health was constantly changing and evolving in relation to past and present health risks, while simultaneously moving toward an increasing optimal level of health and function.

The next section of this chapter will discuss the generalizability of this model to other groups and situations.

c) GENERALIZABILITY OF MODEL

This model may be generalizable to other groups of refugees who are victims of persecution and war. That is, refugees, regardless of culture, are victims of trauma and forced displacement, consequently, all must face the challenges of resolving past traumas suffered as well as resettlement challenges. The issues of language, socio-economic status demotion, grief resolution, resolving past trauma, separation from or loss of significant persons, and adjusting to the novelty of a new host culture, all pose risks to health. Strategies to deal with these risks must be initiated and at least partially achieved before health risks can be reduced and comfort achieved in a new country.

This model might also be applicable to other situations in which individuals experience traumatic experiences that impact negatively on health. While some of the specific components of the experiences of trauma and forced resettlement may not be applicable to every type of victimization, surmounting the health influences pertaining to the event and its sequelae are a constant in any case.

In sum, while few life events would equal the magnitude of the unanticipated nature of war trauma that refugees experience, all refugees regardless of culture or host receptivity, have to cope with the sequelae of past trauma while simultaneously resolving resettlement issues in the present, and attempting to plan for an uncertain future. The generalizability of this model is illustrated in its depiction of the components that can either increase or decrease the health of refugees over time.
d) **THEORETICAL APPLICABILITY**

The theoretical conceptual perspective most evident in this study is that of symbolic interactionism. The assumptions of the symbolic interactionist approach can be summarized as follows: thought is shaped by social interaction; social interaction consists of thoughts, actions, interactions, learned meanings, and symbols; meanings and symbols can be modified on the basis of interpretation because individuals in part, self-interact, examine courses of action, and choose (Blumer, 1969). Since this theoretical approach primarily focuses on individual psychological states and their relationship to action or inaction, the strategy to theory-building in this perspective is through reaching an understanding of the *ongoing* symbolic processes of people in interaction with phenomena. Consequently, theory is attuned to the *processual* nature of the social world (Ritzer, 1988). That is, the components necessary to building this theory emphasize individual interpretive, evaluative, definitional, and mapping processes that are employed in relation to the environment and its shifting nature. Hence, the strategy to theory-building in the symbolic interactionist perspective is through reaching an understanding of the *ongoing* experiences of individuals in real interaction situations, or, theory is attuned to the *processual* nature of the social world.

Critics have asserted that while the symbolic interactionist approach can function as a supplement to macroanalysis by providing a framework, link, or a conceptual staircase to macro social levels, many believe that the theory has yet to demonstrate any potential for analyzing complex macro social patterns. Consequently, this perspective has often been accused of ignoring larger social structures by minimizing and denying facts that may significantly impact on society and behaviour (Turner, 1991).

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16 Gestures, artifacts, language, meanings, and socialization.

17 Assemblage (aggregation, population size, growth, and production); differentiation (competition, exchange, mobilization of power leading to subcategories, subcultures, and subranks); integration (reducing disintegrative pressures through structural co-ordination, symbolic unification, and political consolidation).
Critics have also charged that the symbolic interactionist approach has too easily sacrificed the tenets of conventional science and that concepts such as the mind and self are too confused, imprecise and prove difficult to serve as a theoretical study base or to operationalize. In response to these criticisms, it is important to recognize that the symbolic interactionist approach emphasizes obtaining knowledge about the real world through sensitizing concepts (such as the mind and the self); the rejection of scientific operations and mechanistic tools; viewing human action as unpredictable, and, concentrating on process. Therefore, this perspective is in complete opposition to the 'hard' scientific approach that sees human action as socially determined, has a need to discover antecedent causes of action, concentrates on static solutions, and stresses traditional scientific operations (variables, questionnaires, surveys, etc.) (Ritzer, 1988).

It is only recently, that the importance of settings, contexts, interpretation, interaction, understanding individual perspective, subjectivity, change, adaptation, and time have been recognized as not only being crucial to understanding human nature, but as having been woefully shortchanged in mainstream research (Jessor, Colby, Shweder, 1996). This has resulted in serious questions pertaining to the ability of the 'hard' scientific approaches in social theory to tell a full and coherent story with broad applicability and permanence (Blalock, 1984). Indeed, proponents of 'soft' scientific methods have counter-charged that; knowledge in the 'hard' sciences tends not to be situated or conceptually and empirically connected to the properties and texture of the social settings from which it has been obtained. Further, it has failed to accommodate human subjectivity in inquiry and to attend to the role of meaning in behaviour and social life, and, that the seemingly ingrained preference for large-sample research over detailed studies of development in individual cases and particular settings leads to a tenuous hold on the dynamics and course of individual, institutional, and societal change. It is these aspects of inquiry that tend to emphasize the shortcomings of quantitative research and might also account for the recent renewal of interest in symbolic interactionist methods (Jessor, Colby and Shweder, 1996).
The primary focus of this study, was to understand how participants were affected by the events occurring within the environment (phenomena) how these were processed and interpreted (experience and meaning) the action taken (behaviour) and the outcome. Hence, participants’ micro individual interpretive, evaluative, definitional, and mapping processes provided a conceptual staircase to the macro social levels. The conceptual staircase that was established between social structural phenomena (the socio-political aspects of war and the resulting forced dispersion of people) plus individual interactive processes that were initiated to cope with these phenomena, led to assertions about health. These assertions were then confirmed by carefully documented statements and other resources, about how larger external events and individual coping mechanisms interacted to create, sustain, and/or change varying patterns of health.

As noted in chapters 2 and 3, there does not have to be an antinomy between hard and soft, quantitative and qualitative science. Although often cast as irreconcilable, such contrasts can be inherently misleading. For example, as shown in this study, it is not only how information is collected but how it is used that determines its importance. Further, in this study, joint reliance on both applications captured information that is multi-dimensional and revealed a portrayal of the larger social events, individual reaction to these events, and the links that join the two. Consequently, the resulting findings are complementary, converging, and represent a powerful strategy for enriching research findings.

In sum, a continued reliance on the same methods of discovery in the social sciences must not hamper the pioneering of new methodologies that could lead to new knowledge. Indeed, this activity constitutes the core and the true nature of science. This theme will be further explored in the next section in which an evaluation of the methodology employed in this study will be discussed.

7.4 EVALUATION OF METHODOLOGY

Establishing and maintaining a calm and reassuring milieu during the interview is crucial in order to obtain useful information and requires specific skills such as the abilities to:
begin and formally terminate an interview; establish a rapport; refocus a discussion; appropriately restate, probe, and repeat; cope effectively with painful emotions, weeping, silence and/or family chaos; and, possess a working knowledge of health, social services and refugee policies. However, even with these skills, the initial interview is stressful and exhausting. That is, a shorter resettlement period equates with poorer language skills and a great deal of unresolved emotional pain on the part of the participant, making the interview a difficult task for both participant and the interviewer. However, counterbalancing these disadvantages is that participatory research helps reduce the power differentials that so often exist between researcher and participant and can often silence the authentic voice. That is, using this methodology leads to the development of a comradie and shared organization of ideas (intellectual, moral, and aesthetic) that renders redundant, the necessity of obtaining large numbers of participants in order to learn culturally dominant stories (Howard, 1991). Further, a shorter period of time in Canada can lend an authenticity to information that might be sacrificed given a more lengthy resettlement period. Consequently, while the audiotaped interview is time-consuming and arduous, and demands the participant’s and investigator’s full emotional involvement and attention to language, this mode of information gathering can prove very successful in eliciting an authentic, subjective perspective of experience and health. However, due to its arduous and complex nature, investigators who plan to use this methodology in future studies ought to recruit interviewers who possess the appropriate skills, experience, and expertise.

While the qualitative paradigm within which quantitative and qualitative methods are combined can be methodologically complex, triangulation permits comparisons between different sources of information. These comparisons clarify existing ambiguities and vagueness and increase the investigator’s confidence pertaining to the accuracy of the findings. This design increases interview time and often the need to train interviewers and leads to increased financial costs. However, it is still less expensive than conducting two separate studies (Floyd, J.A. 1993). It is also
important to note that since the methodology is controversial as well as complex, piloting the proposed study can add a great deal of confidence on the part of the investigator and can also point to important modifications that may have to be made in the design, prior to the initiation of the full study.

Providing letters of introduction and consent that are detailed and precise, offered in participants' native language, and printed on brightly coloured paper, is an excellent way in which to attract, recruit and inform participants while at the same time earning their trust. Information ought to be very detailed and precise, particularly if the participants' first language is not English. A new code of conduct for research in the social sciences and humanities has suggested that researchers ought to make more explicit the purpose and procedures they will be using in their investigations (Lewington, J., 1997).

The snowball referential sampling technique can be a practical way in which to recruit participants who are new to Canada. That is, all participants are referred to the study by someone they know. Without this technique, participants might be more difficult to locate and recruit, and establishing trust might also be a problem. However, this technique can hold implications for the final outcomes of the study, such as homogeneity pertaining to age, education, socio-economic background, similar experiences, and lack of information on non-responders. That is, how many potential participants will see the letter of introduction and/or hear about a study but decide not to volunteer, and why? These are issues that would be worthwhile considering in future studies. Choosing an equal number of females and males highlights differences between the genders related to experience, behaviour, characteristics, and health. For example, the phenomenon pertaining to the initial reluctance of males to participate might be worth further exploration in a future study.

The variability provided by residence in different communities can be an advantage in that the investigator can correlate participants' adjustments to different cities with the facilities and quality of assistance that were available to them. This information can be useful in the final analysis for drawing
comparisons.

While there can be some overlap between the interview information and responses to the questionnaires, ensuring that there is about 4-6 weeks between the first and second visits, can provide a solid base of comparison between the questionnaire responses and the first interview.

Using observations as validation tools for interview and questionnaire information is an added technique that leads to clarification and a better understanding when communicating with participants whose first language is not English.

Having participants confirm or disconfirm the investigator's interpretation of the prominent topics emerging from the first interview, provides information that is invaluable in interpreting findings and drawing conclusions. However, while this process constitutes an important validity check and adds to the investigator's confidence in interpreting findings and drawing conclusions, it might also pose a disadvantage. For example, once a rapport has developed between the investigator, the participant and family, it could be speculated that even if some participants were not in agreement with all of the investigator’s interpretations (s)he might be reluctant to say so. Worthy of consideration in a future study might be to arrange for another interviewer to make the third visit on the premise that if the participant did disagree with interpretations, (s)he might be more willing to share this information with someone less familiar. However, counterbalancing this disadvantage might be the difficulties that both the participant and second interviewer might experience, pertaining to a lack of familiarity with each other resulting in embarrassment, distress, and a hesitation on the part of the participant, to divulge and/or discuss personal and painful information. Secondly, since the discussion frequently reverts back to the original dialogues, it would be essential for the interviewer to possess a familiarity with these. This activity would require a great deal of effort, time, and result in a more expensive study. These disadvantages could cumulatively outweigh that of having the same interviewer make the third visit and affect validity equally or perhaps even more so.

Each participant's original transcript requires hours of
reading, re-reading, contemplation, reflection, and interpretation, as it evolves from its original raw form to succinct findings. While a computer program is helpful in making the technical aspects of analysis easier, in the end, the interpretations can only come from the investigator. There is no easy way around this process. Consequently, this time-consuming aspect has to be taken into account if this methodology is to be effectively employed. While analyzing the questionnaires is an easier task as responses are simply noted and aggregated, triangulating all information is a complex process and is described in more detail below.

Combining (triangulating) information provides a comprehensive understanding of the subjective and objective aspects of experience. That is, to depend only on objective data such as investigator observations and outside resources, often reveals information that the investigator deems necessary. Similarly, to rely only on participants' subjective information can sometime lead to vague, indistinct, and poorly explored topics. Hence, when sources of information are triangulated, an enhanced understanding is the result. However, using this controversial methodology is a challenging and daunting task that ought not be adopted by the faint-hearted. It is viewed with distrust by many investigators of health as being too new, too untried, and thus, too unreliable. Further, blending different forms of information is a very complex and work intensive task. This process requires hours of contemplation noting differences, similarities, and patterns in order to ensure that the end result provides an accurate interpretation of health.

One prominent criticism of ethnography is the question of whether the participant is relaying a public or private account. It is my belief that an investigator can never be sure of the total authenticity of any response, regardless of the method used. However, through employing triangulation, there is a check and balance built into the findings that would be unachievable with the use of one method alone.

The next section of this chapter will provide a brief overview of the limitations of this study.
7.5 LIMITATIONS OF STUDY

The limitations of this study are as follows:

1. One can never be sure that underlying the overall finding of positive health and function among participants in this study, that there was not a negative biological or psychosocial health condition that had not yet manifested itself.

2. The retrospective health information elicited from participants may have been subject to faulty memory which may have affected the accurate relating of past events (Hawthorne effect).

3. Most participants had all been carefully selected by Canadian Immigration Authorities before being allowed to immigrate to Canada. While all were humanitarian refugees, other factors were often taken into account such as physical health, level of education, age, family stability, former socio-economic level, employment potential, independence, and the ability to fit into Canadian society with some ease (Young, 1991). These factors cumulatively could have ensured that participants’ success rate at resolving trauma, adapting, acculturating, and eventually making a positive contribution to Canadian society was very high.

4. Participants who volunteered for the study, may have possessed some qualities and characteristics that non-volunteers did not.

5. All participants in this study had been city dwellers who may have possessed characteristics, values and beliefs that were different from country dwellers.

7.6 CONCLUSION

This research has shown that if given emotional and practical support, refugees can cope with suffering, adversity, and challenges, and still maintain health and function. Since refugee experiences vary widely among ethnic groups, more research of this nature, with resettled refugees could clarify the processes and meanings of trauma and resettlement on health. It is clear that some refugee groups could face even more daunting tasks than the Western middle-class group represented in this study. Still, health interventions based on the assumption of pathology ignore positive health and place refugees in a negative light within Canadian society. By recognizing and stressing the resilience and potential
contributions that refugees can make to a host society, any negative attitudes toward refugees might also change. Recognizing the talents, skills, resiliency, positive health and function in refugees would lead to empowerment and create new avenues for them to realize their full potential. Finally, by listening to the stories that refugees tell, knowledge pertaining to the establishment and maintenance of health from a different cultural perspective can be learned.

The responses of most Canadians to refugees are rarely detached and/or objective. That is, refugee groups are viewed either in strongly positive or negative lights. It is unfortunate, that with the tensions and anxieties pertaining to the current economic and political uncertainties in Canada, the resistance to refugees has increased (Marsella, Bounemann, Ekblad, & Orley, 1994). Further, while ethnocultural diversity in the form of multiculturalism has been a policy of this country for many decades, the economic support necessary to the survival of this ideology has seriously eroded. Thus, due to internal domestic problems, Canada has drastically decreased the number of refugees who are granted asylum. Yet, it is the fostering of this ethnic cultural diversity that will enable Bosnians and other refugee groups in Canada to develop a feeling of belonging while still maintaining some of their own culture (values, beliefs and behaviours) and to contribute positively to the country.

While Bosnian refugees do not constitute a visible minority, they are not exempt from being the victims of negative stereotypes. Given this situation, it is important for policy-makers to disseminate knowledge learned through research that pertains to the positive contributions that Bosnians can make to Canada. For example, it has been demonstrated that the participants in this study possessed the strength and mental ability not only to escape an intolerable situation, but to survive a hazardous departure, transit, and arrival in first and second countries of asylum. Thus, participants demonstrated great resourcefulness and enterprise in surviving the overwhelming challenges faced by them on their perilous journey from their country to Canada, from peace to war to peace once more. These positive strengths and attributes not only indicated a resiliency and determination to survive the trauma of
war, but ongoing strength and resiliency in facing the tasks of resettlement by participants’ willingness to work, adapt, and plan for the future.

It is important to consider that participants largely represented university educated, experienced professionals such as architects, health professional, artist, writer, etc. Thus, as with many refugees who escaped Nazi persecution in World War 2 and over time made positive contributions to the countries in which they settled, unless Canadians can understand the long-term benefits that Bosnians can contribute to the development of the country, then their abilities and skills will become underutilized resources. In order to maximize the potentials of Bosnians in Canada, policies must be put into place that will present this group as harbingers of new ideas, skills, and practices, all of which could strengthen the social fabric of the country.

These potentials can be encouraged to flourish in Canadian society by providing assistance that would go beyond short-term, piecemeal solutions. In order to be effective and offer appropriate support in this regard, positive strengths must be identified and built on and individuals must be allowed to identify the unique needs that would allow them to establish a meaningful life, to realize their potentials, and to contribute to Canada. Thus, an interdisciplinary approach that will meet the biopsychosocial needs of Bosnian refugees is necessary, one in which the concepts of health promotion, client empowerment, and holism are paramount. Balanced with this support there must be ongoing encouragement and support for refugees to assume responsibility to self-manage their lives as much and as soon as possible.
BIBLIOGRAPHY


Ministry of Supply and Services, Canada. (1988). After the door has opened: Canadian task force on mental health issues affecting immigrants and refugees. (Chapter 12).


APPENDICES
APPENDIX 1 (Letter of Introduction...English)

ARE YOU A BOSNIAN REFUGEE?

HAVE YOU BEEN IN CANADA AT LEAST 3 BUT NO LONGER THAN 7 MONTHS?

ARE YOU 19 YEARS OF AGE OR OVER?

ARE YOU INTERESTED IN PARTICIPATING IN A RESEARCH PROJECT ON

BOSNIAN REFUGEE HEALTH?

My name is Janice Kopinak. I am a graduate student in Community Health at the University of Toronto. As a nurse studying Behavioural Science I am interested in your health. If you would like to participate in this study I will talk to you at a date, time and place that is convenient for you. Three visits will be required. Completion of all three visits should require approximately 5 hours of your time. During these visits we will discuss your physical and emotional health as well as your ideas about health. I will also measure your height, weight and take your blood pressure. I want to try and find out what makes you a healthy person and how your health has affected your resettlement in Canada. This information will be useful to other health professionals and policy makers by helping them understand what Bosnian refugees bring to and can contribute to Canadian society. All contact (written or verbal) with me will be kept confidential. If you consent to participate in this study, you will not be identified by name in any written documents or to any other people. I will be the only person who will know your name and I will identify you to others by number only. All information will be kept in a locked cabinet and destroyed once the study is completed. If you are interested in participating in this study, fill out the enclosed form and mail it to me. If you have additional questions, call me collect at my home __________. Please feel free to pass this information along to any other Bosnian refugee who fits the above criteria (length of time in Canada, age) and who may be interested in participating.
Letter of Introduction (English).................................2

Please fill out the attached form below, tear it off at the dotted line, and mail it to me at:

Janice Kopinak, RN, BA, MHSc.
Graduate Department of Community Health
Faculty of Medicine
University of Toronto
Toronto, Ontario. M5S 1A8
Home Telephone #: ______________

Tear along this line:

Name: (please print)_____________________________________________________________

Daytime telephone number: _____________________________________________________

Home telephone number: _______________________________________________________

Best time for telephone contact: ________________________________________________

Home address (please include postal code)_________________________________________

Date you arrived in Canada: _____________________________________________________

Birthdate: ___________________________________________________________________

Sex: (circle one): Female Male

THANK YOU VERY MUCH FOR YOUR INTEREST. COMPLETING THIS FORM DOES NOT OBLIGATE YOU TO PARTICIPATE IN THE STUDY. IF YOU DECIDE TO PARTICIPATE AND THEN CHANGE YOUR MIND, YOU CAN WITHDRAW FROM THE STUDY AT ANY TIME.

__________________________________________  ______________________________
Signature of Investigator                      Date
APPENDIX 1a (Letter of Introduction...Bosnian)

DA LI STE IZBJEGLICA IZ BOSNE I HERCEGOVINE?

IMATE LI 19 GODINA ILI PREKO 19 GODINA?

JESTE LI U KANADI BAR 3 MJESECA ALI NE DUZE OD 7 MJESECI?

JESTE LI ZAINTERESIRANI DA UCESTVUJETE U

IZTRAZIVACKON PROJEKTU NA TEMU ZDRAVLJA IZBJEGLICA

IZ BOSNE I HERCEGOVINE?


Ako Vas interesira da ucestvujete u ovoj istrazi, molim Vas da ispunite prilozeni formular i posaljete na moju adresu prilozeno na kraju ovog pisma. Za sva dodatna pitanja, pozovite me kuci o moj trosku (collect) - telefonski broj je ____________. Molim Vas da svim Bosansko-Hercegovackim izbjeglicama koji zele da ucestvuju u ovom projektu a ispunjavaju kriterije (duzina boravka u Kanadi i godine starosti) proslijedite ovu informaciju.
Molim Vas da ispunite ovaj formular, odcijepite ga po oznacenoj liniji i posaljete ga na adresu:

Janice Kopinak, RN, BA, MHSc.
Graduate Department of Community Health
Faculty of Medicine
University of Toronto
Toronto, Ontario. M5S 1A5
Kucni telefon: ________________

Odrezite po ovoj liniji

Ime: (Molim Vas stampanim slovima) ________________________________
Telefonski broj (po danu): ________________________________
Kucni telefonski broj: ________________________________
Najbolje vrijeme za telefonski kontakt: ________________________________
Kucna adresa (molim Vas da napisete postanski broj - postal code):

______________________________
______________________________

Datum dolaska u Kanadu: ________________________________
Datum rodjenja: ________________________________
Spol (zaokružite): Zenski Muski

MNOGO VAM HVALA ZA VASU ZAINTERESIRANOST. KOMPLETIRANJE OVOG FORMLARA NE OBAVEZUJE VAS DA UCESTVUJETE U OVOM PROJEKTU. AKO ODLUCITE DA UCESTVUJETE A ZATIM PROMIJENITE ODULSKU, MOZETE SE POVUCI IZ PROJEKTA U BILO KOJE DOBA.

______________________________
Potpis Istrazivaca

______________________________
Datum
APPENDIX 2 (Letter of Consent..English)

UNIVERSITY OF TORONTO
Graduate Department of Community Health

LETTER OF CONSENT

Health and Bosnian Refugee People

Investigator: Janice Katherine Kopinak, RN, BA, MHSc.,
Telephone: ..............

Purpose and Benefits of Study

I am studying the health of refugee people. This study will explore both physical and emotional health. I am interested in the kinds of health experiences you have had before coming to Canada, what your health is like now, as well as what you think your health will be like in the future. I am also interested in your social relationships with friends and family. The purpose of this study is to understand what contributes to health. A better understanding of these factors will help other health professionals, government officials and Canadians identify what refugee people such as yourself, can contribute to this country.

Procedures

If you agree to take part in this study I will arrange 3 visits with you at dates, times and a place that is convenient for you. The total time for all three visits will take approximately 5 hours. These visits will involve my talking with you about your health.

1. The first visit will require 2 hours of your time. During most of this time (1.30 hours) we will discuss your health (past, present and future) and I will tape record our discussion.

2. The second visit will take place approximately 4-6 weeks after the first and will require 1.5 hours of your time. Two paper and pencil questionnaires will be completed during this visit. On both questionnaires I will ask you questions and write down your answers. The first questionnaire contains 37 questions that relate to your physical and emotional health as well as social and family relationships. The second questionnaire contains 31 questions that relate to information such as your level of education, income, marital status and other background information. During this visit your blood pressure, pulse, weight and height will be recorded.

3. A time and date for the third visit will be arranged by telephone and may be 4-5 weeks after the second visit. During this visit the investigator will discuss with you some of the information based on the conversations we had during the first two visits. This visit should take no more than 1 hour of your time.

Risks or Discomfort

You may find discussions about yourself and your refugee experience thought provoking and there is a chance that this may involve upsetting memories about certain people or events. Although everything you talk to me about will remain confidential there may be certain topics you may choose not to discuss. You will be free to not discuss any topic during our visits that may cause you to feel uncomfortable.
Other Information

Participation in this study is voluntary and you may choose to not answer certain questions or withdraw at any time. Your identity will only be known by the researcher and all information obtained from you will be assigned a number only. Your name will not appear on any of the tapes or on any of the written questionnaires. Only the researcher will have access to the information which will be stored in a locked cabinet. All records will be destroyed once the study is completed. The complete study will be written in partial fulfilment of the requirements for a graduate degree and placed in the library at the University of Toronto, Canada.

Signature of Investigator .................................. Date ................................

Participant’s Statement

The study described above has been explained to me and I voluntarily consent to participate in this research project. I understand that I may refuse to answer any question and I may terminate my participation in this study at any time. I have had an opportunity to ask questions and understand that future questions I may have about the research or about my rights will be answered by the investigator above.

Signature of Participant .................................. Date ................................

Copies to: Participant and Investigator
APPENDIX 2a (Letter of Consent..Bosnian)

UNIVERZITET U TORONTU
Odjel za Nauku o Fonasanju

PRISTANAK NA SURADNNU

Zdravlje i Bosanske Izbeglice

Istrazivac: Janice Katherine Kopinak, RN, BA, MHSc.
Kandidat za Doktorsku Disertaciju
Kucni telefon:.............

Cilj i Beneficije Studije

Ja se bavim studijom o zdravlju izbjeglica. Ova studija ce ispitati oba aspekta zdravlja, kako fizicki, tako i emocionalni. Interesuje me iskustvo o vasem zdravstvenom stanju prije dolaska u Kanadu, kakvo je vaso zdravlje u sadasnjem momentu kao i sta vi mislite kakvo ce vaso zdravlje biti u buducnost. Takodje me interesuje vas društveni odnos sa prijateljima i familijom. Cilj ove studije je da doznam sta doprinosi zdravlju. Bolje razumijevanje ovih faktora pomoci ce drugim zdravstvenim profesionalcima, vladinim sluubnicima i Kanadjanima da shvate sta izbjeglice kao sto ste vi mogu doprinfjeti ovoj zemlji.

Procedure

Ako pristanete da sudjelujete u ovoj studiji ja cu dogovoriti tri posjete sa vama prema datumu, vremenu i mjestu koje ce vama odgovarati. Ukupno vrijeme za sve tri posjete nece biti vece od cetiri pet i po sati. Ove posjete ce tretirati razgovore o vasem zdravlju. Ako vam se ucin da su pitanja tesko razumljiva mozete traziti prevodioca koji ce biti u mogucnosti da govori na oba jezika, Engleskom i vasem.

1. Prva posjeta ce zahtjevati dva sata vaso vremena. Vecinu ovog vremena (oko sat i cetrtdeset pet minuta) mi cemo diskutovati o vasem zdravlju (proslom, sadasnjem i buducem) i ja cu snimati na audio traku nasu diskusiju.

2. Druga posjeta ce se odrzati otprilike dvije sedmice nakon prvog razgovora i zahtjevat ce jedan i po sat vaso vremena. Dva uptina lista papira bit ce olovkom ispunjen iza vrijeme ove druge posjete. Ja cu postavljanj pitanja i upisivacu vaso odgovore. Prvi upitnik se sastoji od 37 pitanja koja se odnose na vaso fizicko i emocionalno zdravlje kao i društvene i familijarne odnose. Drugi upitnik se sastoji od 31 og pitanja koja se odnose na informacije kao naprimjer: Hivo vaso obrazovanja, materialno stanje, branci status i druge informacije o vaso porjektu. Za vrijeme ove posjete bice kontrolisani vas pritisak puls, tezina i visina i oni ce biti zapisani.

3. Vrijeme i datum trece posjete bit ce dogovoreno na telefon i moze biti mjesec i po dva nakon druge posjete. Za vrijeme ove posjete istrazivac ce diskutirati sa vama neke od informacija baziranih na razgovorima koje smo imali za vrijeme prve dvije posjete. Ova zavrsna posjeta nece uzeti vise od jednog sata i petnaest minuta vaso vremena.
**Letter of Consent (Bosnian)**

**Rizici ili Neugodnosti**

Pitanja o vama i vasem izbjeglickom iskustvu mogu biti neugodna i postoji mogucnost da to moze izazvata bolna sjecanja o nekim ljudima ili dogadjajima. Mada o svemu sto razgovorate sa mnom ostaje strogo povjerljivo moze se desiti da neke teme smatrate kao nepozeljne za diskusiju i moze to odluciti da ne diskutirate o nekim temama za vrijeme nasih posjeta. Ako nadjete da je razgovor o nekim vasim iskustvima suvise bolan bitete slobodni da prekinite intervju ili da trazite od ispitivaca da vam dozvoli dodatno vrijeme za razgovor i da se saberete (sredite) poslije bilo cega sto izaziva bolna osjecanja.

**Ostale Informacije**

Participacija (ucestvovanje) u ovoj studiji je dobrovoljno i vi mozete odabrati da ne odgovorite na neka pitanja ili da se povucete u bilo koje vrijeme. Vas identitet ce biti poznat samo istrazivacu a sve informacije dobivene od vas bit ce oznacene samo brojem. Vase ime nece pojaviti ni u najednoj traci ili na bilo kojem pisanom upitniku. Samo ce istrazivac imati pristup informacijama koje ce biti pohranjene u zaključanom ormaricu. Sve snimljeno na traku ce biti unisteno kada se studija potpuno zavrsci (kompletira). Kompletna studija ce biti izvedena prema kriterijima potrebnim za doktorsku disertaciju i bit ce pohranjena u biblioteci univerziteta Torontu, Kanada.

Potpis Ispitivaca                  Datum

---

**Izjava Ucesnika**

Gore opisana studija mi je objasnjena i ja dobrovoljno pristajem da ucestvujem u ovom istrazivackom projektu. Razumio sam da mogu odbiti da odgovorim na bilo koje pitanje i da mogu zaursiti moje ucestvonarje u ovoj studiji u bilo (koje vrijeme) kojem momentu. Imao sam priliku da postavljam pitanja i shvatam da ce istrazivac odgovoriti na sva moja buduca pitanje koja su u vezi sa istrazivackim radom ili mojim pravima.

Potpis Ucesnika                  Datum

---

**Kopije date: Ucesniku i istrazivacu**
Approval by Review Committee on the Use of Human Subjects

Principal Investigator : Dr. I. Rootman (J. Kopinak), Behavioural Science

Title : Bosnian Refugees: Trauma, Health and Time - A Holistic Approach

Review Committee : Dr. M. Disman, Political Science
                   Dr. A. Robertson, Behavioural Science
                   Professor P. Solomon, Political Science

Documents Submitted to Review Committee : A protocol, information letter, letter of consent and questionnaire.

Subjects : Bosnian refugees who have been in Canada between 3 and 7 months.

Procedures : Ethnographic interview, questionnaire, measuring height, weight and blood pressure.

Method for Obtaining Consent : Consent form, revised as attached. Participants are to be given a copy of the form to keep.

Remarks :

Date of Approval : December 5, 1994

*During the course of the research, any significant deviations from the approved protocol and/or any unanticipated developments within the research should be brought to the attention of the Office of Research Services.

*A copy of this approval form is available to Review Committee members upon request.

SP/tp

cc: Dr. H. Skinner

Susan Pilon, Executive Officer
Human Subjects Review Committee
### DEMOGRAPHIC QUESTIONNAIRE

1. **What city/town are you originally from:**

2. **When did you come to Canada:**
   - Month: ______
   - Year: ______

3. **When did you leave your country:**
   - Month: ______
   - Year: ______

4. **Have you lived anywhere else other than your city/town of origin?**
   - 1 = yes
   - 2 = no
   - If yes, specify: ____________________________

5. **Do you intend to apply for Canadian citizenship?**
   - 1 = yes
   - 2 = no
   - If yes, when: ____________________________

6. **Who did you come to Canada with?**
   - 1 = alone
   - 2 = spouse or partner
   - 3 = family members or member
     - Please circle: mother father sister(s) brother(s) child(ren)
   - 4 = relative(s)
     - Please specify their relationship to you e.g., aunt, grandmother, etc.
   - 5 = one or more friends or acquaintances
   - 6 = other, please specify: ____________________________

7. **Who sponsored your coming to Canada?**
   - 1 = Canadian Government
   - 2 = spouse/partner
   - 3 = religious institution
   - 4 = family member
     - Please circle: mother father sister(s) brother(s) child(ren)
     - Please specify relationship to you, e.g., aunt, uncle, cousin.
   - 5 = other, specify: ____________________________

8. **When were you born?**
   - Month: ______
   - Year: ______

9. **What is your marital status?**
   - 1 = single, never married
   - 2 = married or living with a partner
   - 3 = divorced
   - 4 = legally separated due to difficulties in relationship
   - 5 = geographically separated from partner/spouse due to leaving country of origin
10. Do you belong to a religious group? If yes, which of the following?
   1 = no preference
   2 = Roman Catholic
   3 = Muslim
   4 = Jewish
   5 = Christian Orthodox Catholic
   6 = Other, please specify

11. Are you currently practising this religion?
   1 = yes
   2 = no

12. What is your ethnic background?
   1 = Bosnian
   2 = Muslim
   3 = Serbian
   4 = Croatian

13. Ethnic background of spouse or partner
   8 = not married, not applicable
   2 = same as self
   3 = Canadian
   4 = different than mine, specify

14. Your current employment status (circle all that apply)
   1 = employed full time
   2 = employed part time
   3 = never employed
   4 = unemployed, looking for work
   5 = spouse/partner employed
   Other

15. Occupation in Canada. (Please describe exactly what you do. You can choose
    more than one category).
   1 = attending school
   2 = receiving government assistance
   3 = looking for work
   4 = receiving social assistance

16. Prior occupation before coming to Canada (please describe exactly what you
    did in your country before coming to Canada or another country).

17. Occupation of spouse/partner or other person providing family income or
    support to you.

18. What is your household income before deductions weekly? Include money from
    all sources including wages and salaries from all family members, social
    insurance or compensation payments, help from relatives, savings, etc.
   1 = under $249.
   2 = $249. - $299.
   3 = $300. - $349.
   4 = $350. - $399.
   5 = $400. - $449.
   6 = $450. - $499.
   7 = $500. or more

19. How many people are supported with this income?
    Please specify number
20. Are you taking any courses in Canada? If yes, which ones?
1 = no courses being taken in Canada at present
2 = enrolled in or taking ESL classes
3 = enrolled in or taking public school classes
4 = enrolled in or taking senior public school classes
5 = enrolled in or taking high school classes
6 = enrolled in or taking community college classes
7 = enrolled in or taking university classes
8 = enrolled in or taking a professional course
9 = Other

21. What is your highest level of education outside of Canada (please circle level by the original educational system and not a translation of the level into a comparable Canadian level).
1 = completed public school
2 = completed high school
3 = completed university
4 = completed a professional course
6 = Other, please specify

22. What is the highest level of education in Canada of the person providing family income or your support.
1 = not applicable
2 = none of her/his education was in Canada
3 = public school education
4 = high school graduate
5 = high school graduate
6 = college or university graduate
7 = other, please specify

23. Education in a country outside of Canada of person providing family income or support.
1 = not applicable
2 = public school education
3 = high school education
4 = university or college graduate
5 = other, please specify

24. Who do you currently live with? Please write in the relationship of any person(s), e.g., husband, partner, wife, friend, relative, and their ages.

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Age in Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
</tbody>
</table>

25. Do you have relatives or family still in your country of origin?
1 = yes
2 = no

If yes, write in the number of people who fit the following categories.

a) _____ parents (number)
Demographic Questionnaire....continued

b) ______ spouse/partner (check if still in original country)
c) ______ children (number)
d) ______ siblings (number)
e) ______ other relatives (number and relationship to you, e.g., aunt, cousin, grandparents, etc.)

26. Do you have relatives or family in the area in which you live?
1 = yes
2 = no
If yes, write in the number of people who fit the following categories.
a) ______ parents (number)
b) ______ children (number)
c) ______ siblings (number)
d) ______ other relatives (number and relationship to you)

27. Do you have additional relatives or family within a 4 hour drive of your current home? (family or relatives not specified in question 26).
1 = yes
2 = no
If yes, write in the number of people who fit the following categories.
a) ______ parents (number)
b) ______ children (number)
c) ______ siblings (number)
d) ______ other relatives (number and relationship to you)

28. What is your language of preference?
1 = English
2 = Bosnian
3 = Serbian
4 = Croatian
5 = Other, please specify

29. Please list any multicultural or ethnic organizations you belong to or are active in.

30. How did you hear about this study?
a) religious institution
b) ethnic community organization
c) Bosnian friends
d) Canadian friends
e) Educational Institution
f) Other:

31. What was your entry status into Canada?
1 = refugee
2 = temporary refugee residence status
3 = landed immigrant
4 = other, please specify
The following questions deal with your biological, social and psychological health. Each question will be asked in the present, past and future contexts when possible. If more information is needed to answer a question, we will fill out a health probe sheet.

A. BIOLOGICAL HEALTH

1. Height (without shoes). _____
2) Present weight ________
   centimetres ________ kilograms

2a) Before arriving in Canada?

   Weight ________ kilograms

2b) What would you like your weight to be?

   ________ pounds or ________ kilograms

3. Is there anything you would like to do to change your health such as.....

   Present Past Future
   a) __ nothing
   b) __ exercise more
   c) __ lose weight
   d) __ gain weight
   e) __ stop smoking
   f) __ reduce medication
   g) __ reduce drinking
   h) __ change eating patterns
   i) __ other

4. Are you able to see well enough to read ordinary newsprint without glasses or contact lenses?

   Present Future
   a) __ yes
   b) __ no

5. Are you able to see well enough to recognize a friend on the other side of the street?

   Present Future
   a) __ yes
   b) __ no

6. Are you usually able to hear what is being said in a group conversation with at least three other people?

   Present Past Future
   a) __ yes
   b) __ no
7. Are you usually able to hear what is being said in a conversation with one other person in a quiet room?

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ yes</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>b) ___ no</td>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

8. Have you seen or talked to any of the following people about your health?

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ general practitioner</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>b) ___ specialist</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>c) ___ dentist/provider</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>d) ___ optometrist/optition</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>e) ___ pharmacist/druggist</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>f) ___ physiotherapist</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>g) ___ chiropractor</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>h) ___ psychologist/social worker</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>i) ___ herbalist/naturopath</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>j) ___ other</td>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

9. Have you visited an emergency room?

<table>
<thead>
<tr>
<th>Present (Canada)</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ yes</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>b) ___ no</td>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

If yes, how many times?

___

10. Do you have any of the following health conditions?

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ skin allergies/diseases</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>b) ___ hay fever/allergies</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>c) ___ back pain</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>d) ___ arthritis/rheumatism</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>e) ___ joint/bone problems</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>f) ___ asthma/breathing problems</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>g) ___ epilepsy</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>h) ___ high blood pressure</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>i) ___ heart disease</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>j) ___ diabetes</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>k) ___ urinary/kidney problems</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>l) ___ stomach/digestive problems</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>m) ___ thyroid problems</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>n) ___ other</td>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

11. Do you take medications from a doctor or over the counter medications?

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ yes</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>b) ___ no</td>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>
12. Do you smoke cigarettes?

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) ___ no</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. Are you covered by any kind of government or private plan which pays dental or optical needs?

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) ___ no</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. Do you ever take a drink of beer, wine, liquor or other alcoholic beverage?

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) ___ no</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15. If you answered "yes" to number 14, how often do you drink alcoholic beverages?

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ everyday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) ___ 5-6 times per week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) ___ 3-4 times per week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) ___ 1-2 times per week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) ___ less than once/week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) ___ don't know</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16. How often do you use seatbelts when you ride in a car?

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ always</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) ___ most of the time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) ___ sometimes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) ___ rare or never</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

17. Do you have the following in your home?

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ smoke detector</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) ___ first aid kit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) ___ fire extinguisher</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

18. Which of the following best describes your dental health?

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ own teeth/no dentures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) ___ one or more dentures or bridges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) ___ upper &amp; lower dentures (no teeth)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
19. How often do you usually see a dental care provider?

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ regularly</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>b) ___ only when I have pain/ other trouble</td>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

20. If you have not seen a dental care provider, what are the reasons?

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ too expensive</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>b) ___ afraid/dislike dentists</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>c) ___ too busy</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>d) ___ don't know a dentist</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>f) ___ dentist's office is too far away</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>g) ___ other</td>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

21. How long has it been since you last saw a dentist, dental therapist or other dental care provider?

| a) ___ 1 - 3 months | b) ___ 4 - 6 months | c) ___ 7 - 9 months | d) ___ 10 - 12 months | e) ___ other |

22. Which of the following types of food do you feel is the most important to eat more often for the sake of your health? Foods such as...

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ fruits &amp; vegetables</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>b) ___ whole grain cereals</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>c) ___ milk &amp; milk products</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>d) ___ fish/meat/poultry</td>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

23. Which of the following do you feel are important to limit or avoid for the sake of your health? Food that is...

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ high in cholesterol</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>b) ___ high in fat</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>c) ___ high in sugar</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>d) ___ high in salt</td>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

24. Are there any special ethnic dishes that you and/or your family eat regularly?

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ yes</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>b) ___ no</td>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

If you answered "yes", what are these foods?
25. Do you take or use.....

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ oral contraceptives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) ___ condoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) ___ condom &amp; foam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) ___ diaphragm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) ___ IUD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) ___ Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

26. If you are not using a contraceptive, why not?

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ past childbearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) ___ want to be pregnant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) ___ am pregnant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) ___ unable to childbear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) ___ other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. PSYCHOSOCIAL

27. Do you think you cope well with stress?

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) ___ no</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

28. When you experience stress, what of the following helps you to relax?

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ increased exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) ___ reading</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) ___ trying to worry less</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) ___ getting out more</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) ___ seeing friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) ___ spending time with my family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) ___ other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

29. The following questions will be answered by a 'yes' or 'no'.

I can turn to family or friends for support in times of crisis.

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) ___ no</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I cannot talk to family or friends about the sadness I feel.

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) ___ no</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I feel that my family or friends accept me for who I am.

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) ___ no</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I avoid discussing my fears and concerns with others.

Present    Past    Future
a)  ____ yes
b)  ____ no

I can express feelings to others, easily.

Present    Past    Future
a)  ____ yes
b)  ____ no

30. How would you describe your ability to remember things?

Present    Past    Future
a)  ____ able to remember most things
b)  ____ a little forgetful
c)  ____ very forgetful
d)  ____ unable to remember

31. Would you describe your ability to think as:

Present    Past    Future
a)  ____ good
b)  ____ a little difficulty
c)  ____ great difficulty
d)  ____ other

32. Which of the following best describes how you spend your leisure time?

Present    Past    Future
a)  ____ almost all by myself
b)  ____ half by myself, half with others
d)  ____ almost all with others

33. Among your friends or in your family, is there someone you can confide in or talk to freely about your life?

Present    Past    Future
a)  ____ yes
b)  ____ no

34. Among your friends or in your family is there someone who can help you in a time of need?

Present    Past    Future
a)  ____ yes
b)  ____ no

35. Have you ever thought seriously about taking your own life?

Present    Past    Future
a)  ____ yes
b)  ____ no
36. Have you or would you ever try to take your own life?

<table>
<thead>
<tr>
<th>Present</th>
<th>Past</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ___ yes</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>b) ___ no</td>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

37. How many rooms are there in this home/apartment/unit? (Include kitchen, bedrooms, finished basement or attic rooms. Do not include bathrooms, halls, vestibules/rooms used for business.)
I would like to discuss your health with you. Perhaps we could start the discussion with the following question:
When you think of your health, or hear the word 'health', what feelings or thoughts come to your mind?
# APPENDIX 7

## CALENDAR OF EVENTS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MONTHS</td>
<td>JFMAMJJASOND</td>
<td>JFMAMJJASOND</td>
<td>JFMAMJJASOND</td>
<td>JFMAMJJASOND</td>
</tr>
<tr>
<td>Contact Centres</td>
<td>......&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Key People</td>
<td>....&gt;</td>
<td>......&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Select Sample</td>
<td>....&gt;</td>
<td>........&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Collection</td>
<td>....&gt;</td>
<td>........&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Analysis</td>
<td>........&gt;</td>
<td>........&gt;</td>
<td>......&gt;</td>
<td></td>
</tr>
<tr>
<td>Write-Up Findings</td>
<td>........&gt;</td>
<td>........&gt;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
LEGEND:
MAJORITY
up to 50%  over 50%

MUSLEMS
SERBS
CROATS

MUSLEMS AS THE SECOND MOST NUMEROUS PEOPLE
EXAMPLES OF INVESTIGATOR'S INTERPRETATION OF THE CENTRAL ASPECTS OF ONE INTERVIEW

**War**

Is characterized by aggression, ethnic hatreds and corruption, causing disbelief, confusion, disorientation, and fear, and changing ideologies, behaviour, and loyalties.

**Loss**

Of people, possessions and country incurs frustration, anger and grief that can result in health risks.

**Survival**

Is enhanced by ideology, life experience, flexibility, fearlessness, humour, privilege, objectivity and luck. It is a challenge that motivates all actions in war.

**Family**

 Represents love, stability, unity, and responsibility. Parents must be strong but liberal and totally committed to their children.

**Trauma**

Is human cruelty, suffering, and an abrupt change, causing a state of panic, confusion, disorientation, uncertainty and fear. Resolution requires mental and physical stability.

**Friendships**

Require emotional investment, evolve as people spend time together, and are essential to healing.

**Well-Being**

Is a choice that includes keeping medical intervention to a minimum, being aware of genetic predispositions, and maintaining a balance between mental and physical health.

**Successful Adaptation/Resettlement**

Requires safety, financial assistance, resolution of losses, family safety, confidence, good health, employment, knowledge of the culture and new friends.

**Acceptance/Belonging**

Is crucial to self-image and a feeling of comfort, and resides in relationships that fill emotional and physical needs.

**Future Success**

Requires financial assistance, resolution of the past, confidence, education, and work abilities.
PARTICIPANTS' RESPONSES PERTAINING TO THE PIVOTAL LEAD-OFF QUESTION

Females:

"Health is very important for me. If I'm not healthy I can't do anything, so it's very important."

"I discovered that vitamin C is doing me good. Vitamins are good for health."

"Good air, good food, good water and friendship. If we are closed then it's not good for the mental and it's going to the body. Some diseases coming from the mental."

"I feel like an old, grey fruit when you want to throw it away. I'm like that now."

"I think sometimes in the mind is make sickness. If mind okay, then body is too."

Males:

"I like exercise, sports, action, long walk. My fitness is consequence of exercise."

"Most important is to have normal psychological life processes. This produces instrument to defend the organism in health."

"Health is all biology and psychology."

"I think now I'm physically healthy but maybe I have problem with nerves, little bit more than before war."

"Health is all psychic, then physical. Health is together."
IMAGE EVALUATION
TEST TARGET (QA-3)

1.0
1.1
1.25

1.4
1.6

1.8
2.0
2.2
2.5

150mm

6"

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