

## Bosnian Refugees and the Stressors of Exile: A Narrative Study

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The authors used semistructured interviews to examine exile-related stressors affecting a sample of 28 adult Bosnian refugees in Chicago. The interviews covered 3 areas: life in prewar Bosnia, the journey of exile, and, most centrally, life in Chicago. Primary sources of exile-related distress included social isolation and the loss of community, separation from family members, the loss of important life projects, a lack of environmental mastery, poverty and related stressors such as inadequate housing, and the loss of valued social roles. The implications of these findings for mental health interventions with refugees are considered, and the value of narrative methods in research with refugee communities is discussed.

As we enter the new millennium, it is disheartening to note that the number of people forced into exile or internally displaced by political violence is on the rise for the first time in several years (U.S. Committee for Refugees, 2000). Recent estimates place the number of refugees and asylum seekers worldwide at approximately 14 million, an increase of 600,000 from the previous year. In addition, an estimated 21 million people are currently displaced within the boundaries of their homelands (U.S. Committee for Refugees, 2000). This figure represents a dramatic increase of 4 million internally displaced people (IDPs) over the course of a single year. Most of these 35 million refugees and IDPs have fled situations of extreme violence, and many bear the physical and psychological scars of the traumatic events they experienced prior to

being forced to flee (Arroyo & Eth, 1986; Geltman & Stover, 1997; Kinzie, Sack, Angell, Manson, & Rath, 1986; Mollica et al., 1998; Weine et al., 1998).

The adverse effects of exposure to political violence have been well documented. In contrast, much less is known about the stressors encountered by refugees once they go into exile, that is, postmigration or exile-related stressors. Although there is a growing recognition among researchers that experiences of dislocation and exile are themselves highly distressing (Miller, 1999; Silove, 1999) and may in fact account for a significant amount of the variance in the high levels of distress commonly found within refugee communities, only a handful of studies have examined the nature of exile-related stressors and their impact on refugee well-being (Gorst-Unsworth & Goldenberg, 1998; Miller et al., 2002; Pernice & Brook, 1996; Steel, Silove, Bird, McGorry, & Mohan, 1999). The present study addressed this empirical gap by examining stressors associated with the experience of exile among a sample of Bosnian refugees living in the city of Chicago, survivors of the recent war in the former Yugoslavia. Semistructured interviews were used, reflecting our belief that a narrative approach would most effectively allow participants to identify and explore those exile-related stressors most salient within their community.

Following a brief overview of research in the area of refugee mental health, a rationale is provided for the use of narrative methods in research with refugees, and the methodology of the present study is described.

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Results of the interviews are then presented, and we conclude by considering the implications of the study's findings for future research and for psychosocial interventions with refugee communities.

### Research on Refugee Mental Health

Research on the mental health of refugees has emphasized the assessment of psychiatric symptomatology, primarily through the use of symptom checklists and structured clinical interviews. Although we suggest below that our reliance on such methods has in some ways limited our understanding of the psychology of exile, we also recognize that studies using psychiatric, symptom-focused approaches have played an important role in documenting the recurrent and often enduring patterns of distress found within refugee communities. Common findings in research with adult refugees include high, though variable, rates of post-traumatic stress disorder (PTSD) and depressive disorders, as well as various symptoms of anxiety and somatic distress (Mollica et al., 1998; Pappas & Bilanakis, 1997; Weine et al., 1998). With regard to refugee children, the findings have generally mirrored those of studies with adults, though rates of distress have shown considerably greater variability (Arroyo & Eth, 1986; Kinzie et al., 1986; Miller, 1996; Servan-Schreiber, Lin, & Birmaher, 1998).

Whereas earlier studies of refugees have focused on understanding the psychological sequelae of pre-migration, war-related experiences, there has been a recent shift toward examining the ways in which prior exposure to situations of violence may interact with ongoing postmigration or exile-related stressors to produce and maintain the high levels of distress so commonly reported in the literature. As we suggested earlier, this shift reflects a growing recognition that the experience of exile is itself often highly stressful and may in fact contribute to the high prevalence of psychological symptomatology reported in the refugee mental health literature. Support for this hypothesis has been found in a number of recent studies, in which exile-related stressors such as social isolation, a lack of social support, unemployment, and discrimination have been strongly and positively associated with levels of depression and anxiety and may also function to exacerbate symptoms of war-related trauma (Beiser, Johnson, & Turner, 1993; Gorst-Unsworth & Goldenberg, 1998; Miller et al., 2002; Pernice & Brook, 1996; Smither & Rodriguez-Giegling, 1979).

Although recent studies have made important strides toward identifying exile-related stressors and

understanding their effects on refugees' well-being, we believe that the continued reliance on quantitative, symptom-focused methodologies has in some ways limited our understanding of the psychology of exile and the range of stressors it entails. In this section, we briefly consider several limitations of the dominant (i.e., quantitative-psychiatric) approach to studying refugee mental health issues and offer a rationale for the use of narrative methods as one way of addressing these limitations.

First, by operationalizing distress solely in terms of psychiatric symptomatology, we are unlikely to shed light on patterns of exile-related distress not readily captured in conventional psychiatric nosologies. Examples of such patterns include the cultural bereavement syndrome described by Eisenbruch (1988) and the profound crises of meaning, faith, and identity that may result from experiences of forced migration and exposure to extreme violence (Silove, 1999). We suggest that the identification and exploration of such phenomena call for inductive methodologies that allow participants to identify the salient features of their experience and to describe patterns of distress in ways that might lie outside the scope of conventional diagnostic categories. The value of this emic approach is underscored when one considers that the majority of the world's refugees come from non-Western societies (U.S. Committee for Refugees, 2000); consequently, an exclusive reliance on the language and constructs of Western psychiatry may obscure local (i.e., indigenous) variations in the experience and expression of psychological distress (Farias, 1994).

A second limitation of the quantitative-psychiatric approach is related to the fundamentally *temporal* or historical nature of the refugee experience. Several authors have noted that one cannot understand the experience of exile without knowing something about people's lives before they went into exile, as life prior to exile becomes a central reference point among refugees for the evaluation of their present life circumstances (Eisenbruch, 1988; Miller, 1999). Although psychiatric assessments may be conducted at multiple points in time, thereby assessing changes over time in specific patterns of distress, we believe that narrative approaches may be more effective at capturing the essentially historical and comparative aspects of the refugee experience. By definition, narrative methods emphasize the temporal or sequential description and evaluation of experience (Gergen & Gergen, 1997; Mankowski & Rappaport, 2000); consequently, the use of narrative represents an ideal approach to examining with refugees the ways in

which their experience of life prior to going into exile continues to affect their perceptions of, and reactions to, their current life circumstances.

In their critiques of positivist and postpositivist paradigms, theorists such as Guba and Lincoln (1994) have argued that quantitative methods are limited in their capacity to capture what Hinchman and Hinchman (1997) have called the “full richness and complexity” (p. xiv) of multidimensional phenomena. From this perspective, quantitative methods are seen as fundamentally reductionistic; indeed, their utility lies to a great extent in their capacity to operationally simplify complex variables and to represent large amounts of complex data in terms of central tendencies and their associated variances. The trade-off, however, lies in the risk of obscuring the various nuances and genuine complexity of the phenomena being studied.

In considering the relevance of this argument to research on refugee mental health, we might ask, for example, whether certain variables that have traditionally been conceptualized solely as stressors may actually function to *reduce* stress in certain situations. For example, to what extent might social isolation, which has been linked statistically to increased levels of depression and trauma in several studies (Gorst-Unsworth & Goldenberg, 1998; Miller et al., 2002), actually function at times as a welcome respite for traumatized individuals, for whom social interaction with other refugees elicits distressing memories of war-related violence and loss? By emphasizing the “thick description” (Geertz, 1973) and phenomenological exploration of variables of interest and the contexts in which they occur, qualitative methods such as narrative analysis may help us better understand the multidimensionality of exile-related stressors and the varied ways in which they are perceived and experienced.

A fourth and final limitation to the dominant approach lies in the fact that quantitative methods such as questionnaires rely on a priori assumptions about the range of relevant variables to be assessed, assumptions that may be problematic in understudied areas about which relatively little is known (Banyard & Miller, 1998). In our view, this is very much the case with regard to our current level of knowledge about the range of stressful phenomena confronting refugee communities. Although previous research has examined the mental health correlates of a limited number of exile-related variables, few studies have used narrative approaches that would allow refugees themselves to identify the range of stressors affecting them. In fact, with some notable exceptions (e.g., Becker,

Beyene, & Ken, 2000; Bennett & Detzner, 1997; Ekblad, Abazari, & Eriksson, 1999; Miller, 1996; Omidian, 2000), the voices of refugees are largely absent from the literature on refugee mental health. This somewhat puzzling phenomenon suggests that we have significantly underutilized a rich and vital source of information regarding the experience of exile, namely, narrative accounts by refugees concerning their own psychological well-being and the factors that affect it. By using qualitative methods such as semistructured interviews that are designed to elicit such narratives and by allowing the salient domains or categories of experience to emerge from the data they provide, we may be better positioned to understand the ways in which exile-related stressors are perceived, experienced, and negotiated within different refugee communities. Such an enhanced understanding can facilitate the development of culturally anchored quantitative measures for use in subsequent research (Dumka, Gonzales, Wood, & Formoso, 1998; Maton, 1993) and will also help to ensure that interventions designed for refugee communities are targeting the most critical variables.

Given the paucity of qualitative designs in the published refugee mental health literature, and in light of the potential contributions discussed above that qualitative methodologies can make to our understanding of the refugee experience, we opted in the present study to use a narrative approach to examining exile-related stressors experienced by Bosnian refugees living in the greater metropolitan Chicago area. The primary foci of the study were on identifying the range of salient stressors affecting participants and on understanding the ways in which participants perceived, experienced, and responded to these stressors.

### Bosnian Refugees in Chicago

Chicago is home to one of the largest communities of Bosnian refugees in the United States, estimated at approximately 21,000 at the time data were collected for this study (Smajkic, 1999). Bosnians fleeing the war in the former Yugoslavia began arriving in Chicago in 1994. Their numbers grew quickly as an ever greater number of civilians sought refuge from the “ethnic cleansing” that occurred as ultranationalist Bosnian Serbs and Croats joined forces with the armies of neighboring Serbia and Croatia to wage war against the country’s Muslim population (Donia & Fine, 1994; Malcom, 1994). In a recent study of Bosnian refugees in Chicago, Weine et al. (2000) found significantly elevated levels of PTSD and depressive symptoms in both their clinic and community

samples. Although the clinic group reported greater levels of distress, multiple symptoms of trauma and depression also were reported by members of the community group who were not receiving mental health treatment.

A variety of social service, mutual assistance, health, and mental health organizations have evolved to serve Chicago's Bosnian community. At the time of the present study, Kenneth E. Miller was the clinical director of one such organization, the Bosnian Mental Health Program, at the time the country's largest mental health program specifically designed to address the mental health needs of Bosnian refugees.

## Method

### *Participants*

Participants in the present study were clients attending either the Bosnian Mental Health Program or its sister program, the Refugee Mental Health Program. Program clients were invited to participate in the study on the basis of consecutive admission to the Refugee Mental Health Program or Bosnian Mental Health Program during the previous eight months and received a small stipend for their participation. A total of 28 program clients participated in the study, 18 women and 10 men, which corresponded closely to the gender ratio of the programs' clientele. The mean age of the participants was 49.37 years ( $SD = 10.02$ ), with a mean of 24.29 months ( $SD = 8.40$ ) in the United States at the time of the interview. Sixteen participants (57%) were married and living with their spouses, 6 (29%) were separated or divorced, and 6 (14%) were widowed. Fourteen of the participants (50%) were living with at least one child. Twenty-five participants reported their ethnicity as Bosnian Muslim, 2 as Bosnian Serb, and 1 as Bosnian Croat.

Fifteen program clients, or 35% of those invited to participate in the study, declined to take part in the research. The most common reasons given were fear of being asked about distressing memories and anxiety regarding the purpose of the study. We were unable to reach an additional 30 individuals on the list, typically because they had moved without leaving a forwarding address or their phones had been disconnected, both common occurrences within recently resettled refugee communities. A comparison of participants and nonparticipants revealed no significant differences in age, level of education, or symptomatology.

### *Instrument*

The Refugee Distress and Coping Interview (RDCI), developed for this study, asks respondents about three primary domains of their experience: life in prewar Bosnia, their journey of exile, and, most centrally, life in Chicago. To avoid defining a priori the range of exile-related stressors to be explored, we first asked participants in an open-ended way to

describe the challenges they had experienced in exile. Participants were subsequently asked to describe a typical day in their lives in Chicago, which proved to be a rich source of information regarding the challenges they had encountered and the coping strategies and resources they were able to utilize. Following these nondirective questions, we asked participants about specific categories of exile-related stressors that have previously been identified in the research and clinical literatures on refugee mental health (e.g., separation from family members, social isolation and loneliness, financial worries, health-related concerns, and problems accessing important social, educational, and employment-related resources). The RDCI was translated and back-translated following the procedure recommended by Brislin (1970).

### *Procedure*

Depending on their preference, participants were interviewed either in their homes or in an office of the Bosnian Mental Health Program. All interviews were conducted by Kenneth E. Miller and Gregory J. Worthington (the latter a practicum student in the agency), with the assistance of a bilingual, female Bosnian interpreter (Jasmina Muzurovic). Neither of the interviewers met with anyone they had previously seen in psychotherapy; however, both interviewers, as well as the interpreter, were known to many of the participants through their work in the clinic. The interviews were tape-recorded and transcribed, and the transcriptions were subsequently coded by a team of four coders, using the qualitative data management program QSR NUD\*IST (Version 4; Richards & Richards, 1997). The development of a reliable coding scheme involved applying a preliminary set of codes to a single interview, comparing the coding of the four coders, reaching consensus on discrepancies, modifying the codebook as indicated, and reapplying the revised coding scheme to a different interview. This process was repeated until an acceptable level of agreement was achieved, with the final codebook containing 45 codes. A weighted interrater agreement index, which allowed for the inclusion of partial agreements (i.e., agreement among three out of four raters), yielded an agreement index score of .90.

## Results

A pervasive theme throughout the narratives is the salience of memories of life in prewar Bosnia. Such memories seemed to function at various times both as a source of comfort and as a reference point against which the experience of life in Chicago was continually evaluated. Consequently, people's perceptions and experiences of specific exile-related stressors were inseparably embedded within a comparative, temporal framework. For example, participants contrasted their current experience of isolation with the rich social networks to which they belonged before going into exile; the lack of social support in their present lives was seen against a prewar backdrop of

close friends, family members, and neighbors to whom one could turn for assistance in times of need; the lack of meaningful employment was perceived in relation to the positions of responsibility and status people had held in Bosnia; the lack of *meaning* in people's days, a recurrent theme in the interviews, was framed within a prior context of roles and activities that had given structure and meaning to daily life; and the sense of hopelessness regarding the possibility of creating new, meaningful lives in exile (a sentiment more common among older than younger participants) was described in stark contrast to the dreams and aspirations toward which people had worked and that had been abandoned upon leaving Bosnia. Given this fundamentally comparative nature of people's narratives, for each of the stressors discussed below, we have included relevant comments that characterize life in prewar Bosnia and that permit a greater understanding of how memories and perceptions of the past have helped shape the day-to-day experience of life in the present.

### *Social Isolation and the Loss of Community*

Social isolation among refugees has its roots in the violence and dislocation in their setting of exile and in the various obstacles that impede a sense of community in their country of asylum. Previously intact social networks are profoundly affected by the loss of relatives killed in war-related violence or "disappeared" by official or paramilitary forces, and by the forced abandonment of relatives, friends, and neighbors unable or unwilling to go into exile. In addition, family members may be granted asylum in geographically distant settings, making regular contact difficult. Upon arriving in their country of temporary asylum or permanent resettlement, refugees may find themselves further isolated because of a lack of an established exile community, thus limiting their opportunities for supportive contact with others who share both their ethnocultural background and their experiences of war and uprooting. Of the various exile-related stressors that have been studied to date, social isolation and its sequelae (e.g., low social support, loneliness) have received the greatest attention, reflecting the salience of isolation as a source of distress among refugees.

In talking about their lives in prewar Bosnia, the majority of participants in the present study described a rich network of social relations that included nuclear and extended family members, good friends with whom they had frequent contact, and a network

of less intimate but highly valued relationships with acquaintances, neighbors, and coworkers. Visits with family members not living in the home (e.g., cousins, in-laws, aunts and uncles) occurred frequently, especially when relatives lived nearby.

We would visit each other very often. I visited my brother every second day. When my parents were alive, we visited often. I have two brothers, one lived in another town, the other lived in my village. (Female, age 58)

I always visited them. I had a sister in the same town and I often visited her. I had one aunt and many cousins, and my wife had her family members. My parents had nine children, so I had sisters everywhere. (Female, age 48)

The following quotation, in which a woman from a rural village in Bosnia describes a typical day, illustrates the multiple social interactions and relationships that helped shape most participants' daily lives before the war began.

In the morning when we got up, we used to have coffee together—my husband and me. After that, my husband used to go to work at his company. Actually before he left for work, he took care of the animals. He fed the animals, and after that, I prepared breakfast for the workers. And then, they used to take the animals to the fields. Then, I cleaned up the home. I cooked. Then my husband would come home, and we had dinner together. After that, we would go to meet our friends—or somebody would come to visit us. I had two sisters-in-law, and they used to help us with everyday chores and their children too, because we didn't have children. (Female, age 58)

As this woman's comments suggest, within their social networks, people found regular sources of reciprocal social support, both instrumental and affective:

I used to meet my friends almost every day for an hour, and we used to talk about everything, about what happened to each other, and we supported each other. That was a wonderful life, and I wish I could experience a little of that in my future. . . . (Female, age 50)

Sometimes I helped them [friends] with something on their home, or they helped me. I could always borrow money from my friends. We were one big family regarding that because that's how I am. That was normal to lend money or borrow it. (Male, age 43)

For many participants, the contrast with life in Chicago was stark. Although some individuals had begun to create new friendships and build new support systems, the war-related deaths of family members and friends and the social networks left behind upon going into exile had left many respondents

struggling with feelings of isolation and loneliness. Although such feelings were reported by participants of all ages, the experience of isolation was most acute among older individuals and among those who had been widowed during the war. Asked whether she felt isolated or lonely at times, a 61-year-old woman whose husband was killed in the war responded,

Always. It's always in my soul. I don't have any family members here but my sons. Maybe if there were someone else, I would feel better. I have one neighbor here from Bosnia. Sometimes I eat by myself, sometimes with the children, and sometimes with someone who comes to visit with us . . . but people usually work, and they don't have time.

Another woman, about the same age and also a widow, had a similar experience:

I feel bad a lot. I feel isolated a lot. I'm not in my home. I've completely lost my enjoyment of life. I'm not in my home. I was happy before. I was happy with my family, with my relatives, with my people, but here there is no happiness. There is no life. (Female, age 59)

For one 48-year-old man whose wife had left him and their two children while they were living in a Hungarian refugee camp, the experience of isolation was difficult not only because he felt lonely but also because it meant he had little access to much needed social support:

I really don't have anyone here. I am alone with my two children. I'm not able to work and earn anything. I have to cook for my children, to do the laundry. I don't have any friends or cousins who can take care of my children. I am not in contact with anyone else, so no one can help me.

On the other end of the spectrum were participants whose nuclear families had survived the war and gone into exile intact. Though by no means immune to the impact of separation from relatives and friends in Bosnia, individuals living with their intact nuclear families seemed buffered from the intense isolation experienced by less fortunate participants. Although the refugee mental health literature contains numerous clinical reports of intergenerational conflict within refugee families (e.g., Tobin & Friedman, 1984), such conflict was rarely mentioned by participants in the present study. Rather, families were typically described as critical sources of emotional and instrumental support. Conversely, separation from family members was consistently described as among the most painful aspects of living in exile:

Many of my family members were killed during the war, but thank God nobody from my close family was

killed. We are resettled everywhere, but we are alive. It's difficult for me. I haven't seen my brother for seven years. And my sister-in-law, the wife of my second brother who is dead, and his two children live in Spain. I haven't seen the children for seven years. (Male, age 51)

I miss my family members, and it's really very hard to be separated from the family members. I miss my brother and sister. My brother is in Germany, and my sister is in Poland. I speak with them every week. Actually, I call them or they call me. Sometimes it helps, sometimes it doesn't. Sometimes I don't cry, sometimes I do. Our mother passed away, and they didn't get to see her. (Female, age 50)

Our findings are generally consistent with other studies that have identified social isolation as a salient source of exile-related distress. However, we also found that for several participants who described persistent symptoms of war-related trauma, isolation seemed as much a choice as an imposed reality, and it appeared to function as a form of self-protection from the anxiety, intrusive imagery, and painful memories elicited during social interactions with other Bosnians:

I know I'm not able to stop that, those pictures, but I tried to avoid them. But they come. . . . If someone talks about the war, about those things, I have dreams about that, so I try to avoid company. I try to avoid places where people have been talking about the war. So that's why I want and like to be alone. (Male, age 45)

Sometimes, no, I don't enjoy talking with other Bosnians. I'm not able to listen to different kinds of stories or thoughts about politics or the dividing of Bosnia. I go back to my apartment just to avoid getting nervous. (Male, age 50)

Such comments underscore the complexity of social isolation. Though generally described as an aversive stressor, for some individuals isolation clearly served as a form of respite from other, more painful sources of distress. This finding has implications for the development of interventions aimed at reducing isolation and promoting social support within refugee communities. For some individuals, it may be necessary to achieve at least a partial resolution of posttraumatic symptomatology before participating in group activities that might otherwise trigger distressing symptoms of PTSD. An alternative strategy would involve providing group interventions that initially focus on topics unrelated to the experience of war and the current political situation in the participants' countries of origin. This approach would permit the development of new social networks earlier in the healing process while minimizing the need for posttraumatic avoidance strategies such as self-isolation.

### *The Loss of Life Projects*

The distinction between immigrants and refugees can be murky at times, as there is often considerable similarity in the settings from which both groups originate (i.e., immigrants and refugees may both come from settings characterized by the structural violence of chronic poverty and a lack of access to basic resources). In our view, however, there are a number of specific markers of the refugee experience that distinguish it from the experience of nonrefugee immigrants. Two such markers are the *valence of movement* and the *urgency of departure*. Immigrants generally move *toward* the dream of a better life and the realization of life goals unattainable in their current setting; in addition, their migration is often the result of a well-considered decision-making process, informed by the experience of others who have gone before (e.g., Nodín Valdés, 1991). Refugees, in contrast, are by definition moving *away* from situations of persecution, usually involving extreme violence, and their primary goals are often those of immediate physical safety and survival. The decision to flee is often made with great haste, for example, as enemy soldiers approach or as word arrives of a massacre in a neighboring town or village. What people bring with them under such circumstances is that which can be packed with little advance notice and carried on long journeys over difficult terrain. Left behind are deeply valued personal possessions, as well as the less tangible life goals, aspirations, and projects toward which people have worked. Such phenomena might include a home built over many years that was to be a legacy passed on from one generation to the next, a much anticipated retirement with a pension after a lifetime of employment, or the abandonment of a business that had finally taken root and shown promise of success.

The loss of these and other life projects emerged as a salient source of distress primarily among older participants in the present study. Among younger respondents, there was still a sense of optimism, a hope that life in Chicago might hold new promise and opportunities. Implicit in this optimism was a belief that there was time to start again, time to define new goals and begin working toward new life projects. Among older refugees, however, there was a sense of hopelessness, a belief that it was too late to start anew:

The most difficult thing is that we tried to build something all our lives, and then we lost everything. . . . When we should have been enjoying our lives, when our children got married, we had to leave. When my son got married, and my daughter got married, that was the time when we had everything we needed to enjoy

our lives. And that was the best time to live there, and we had to leave that. . . . (Male, age 45)

Asked whether it might not be possible to create new projects, new hopes and plans for life in Chicago, he responded, "Only for young people, there is a future here. I'm not able to do that." His wife, sitting nearby, agreed and commented, "I know I'm not able to start a new life, not like the life we had there." This sentiment was echoed in the words of a 49-year-old woman, who stated, "I feel like my life is interrupted somewhere in the middle, and I'm at the age when I'm not ready for a new beginning, so it's hard. It's too late for a new beginning actually." Another man spoke of the house he'd built himself over a period of many years and of the plans he'd had of passing the house on to his children and grandchildren.

The impact of the loss of life projects appeared to be moderated to some extent by the presence of young children and grandchildren, who seemed in some families to embody the promise of a better future. In effect, these children became their parents' or grandparents' new life projects, sources of motivation for surviving and continuing to confront the challenges of life in exile. This was especially so for a 28-year-old woman whose boyfriend was killed in the war and who was now raising two young children from a previous marriage in Bosnia:

I always used to laugh, I was always happy. You can see sometimes that there is a smile on my face, but in my soul there is misery. Just my children [have been helpful]. I always say that I live for them. I live just because of them. My children help me a lot. When I talk to them and help them finish everyday activities, I forget. I think it must be worse for the people who are really alone. My children keep me busy and I don't know what it would have been like if I didn't have them with me. My worries about the children are like a shield from everything else. (Female, age 28)

Another woman, 39 years old, spoke in similar terms of the important role her children had played in giving her a sense of purpose and hope. When asked how she managed to get through a particularly difficult first year in exile, she responded,

My children. It was about fighting for my children. Actually, I wanted to have a better future, but it seems I haven't gotten that. I didn't have enough friends to help me find my place here. But I still hope. . . . My children are my hope. They are my big hope.

The emphasis on children as a primary source of hope for a better future represented an important coping strategy for several participants who were dealing with the painful loss of life projects left

behind. Of course, raising children represents a major life project for most parents, refugees or otherwise. However, for many of the participants in this study, their children or grandchildren seemed to take on an even greater centrality than they might have otherwise, in the absence of other meaningful goals and aspirations.

### *A Lack of Environmental Mastery*

Refugees often find themselves in settings with fundamentally different adaptational demands than those they had previously mastered in their countries of origin. Adaptation to life in exile often involves learning a new language, becoming familiar with a new set of cultural values and practices, perhaps mastering a public transportation system, and learning how to access a range of available resources. Mastering these tasks can be empowering for the sense of efficacy it engenders and the new opportunities it provides (social, educational, employment related, etc.). Conversely, failing to master these tasks can lead to an increased sense of isolation, a lowered sense of efficacy, and in some instances, feelings of despair:

It is very difficult. It's very difficult when you go out and you are not able to communicate—when you go to the doctor or when you go shopping, and you are not able to communicate. Life was very hard. . . . We got just a little help—social support for just two months—and after that we were on our own. . . . My husband worked, and I worked too for a while, until I burned my hand. I was supposed to work in one hotel, but in order to reach there, I was supposed to take three buses, and I didn't know how to do that. So, I used to sit down and cry. (Female, age 46)

We recognize that many refugees do become proficient in the various tasks and abilities that allow them to succeed in their new settings. And among those who never master the local language or learn to use the public transportation system, pragmatic solutions are often developed that allow them to circumvent, at least to some extent, these seeming obstacles. Ultimately, however, the lack of environmental mastery can become a significant source of distress despite the intermittent availability of makeshift solutions. Asked whether her inability to speak English ever causes her hardships, one woman responded,

Yes, for example, my jaw is swollen and I have a few infections, and I need to go to the dentist, but I can't go there, because there is nobody there to interpret for me. (Female, age 53)

Another participant responded

The city is very big, and I don't drive. I am afraid. I'm not able to make new friendships, and I'm always dependent, I always depend on someone to drive me or to take me somewhere. It's hard because I was a completely independent person. I go shopping, but I don't go by myself. I go always with someone, or my son buys the food. If I have to go, then I never go by myself. (Female, age 43)

A critical component of environmental mastery for many refugees involves learning a new language. For refugees in the United States, this typically entails an immersion in an English as a second language (ESL) course. Unfortunately, ESL classes are rarely designed to accommodate the problems with impaired memory and diminished concentration that are common among refugees struggling with psychological trauma or depression. Several of the respondents in the present study who were experiencing significantly elevated levels of PTSD and depressive symptoms at intake described distressing experiences of failure in the ESL classroom owing to their inability to concentrate in class or to memorize course material:

We tried to study when we were in Florida, but it was very hard. It simply doesn't go into our heads. Whatever we tried to memorize, we couldn't. . . . What happened to us, it makes us unable to remember things. (Female, age 54)

When I first came here, I tried to learn English, and I couldn't memorize anything. I started forgetting things, and then I got disappointed and I gave up. (Male, age 60)

For many of the participants in this study, trauma-related cognitive impairments also manifested themselves in numerous contexts other than the ESL classroom, for example, getting lost while walking home, leaving the stove on, and “spacing out” on the bus and ending up miles from home.

The inability to communicate—to understand and be understood—can be highly disturbing, especially for survivors of extreme violence, who may feel particularly anxious in novel settings in which they experience a lack of efficacy:

I'm not able to speak English. I'm not able to express my feelings. For me, everything is harder. When I go out, I'm scared of something, though nothing is there. When I was in Bosnia and went out, I got all the news, I knew what was going on, but here it's like I'm blind and deaf. I don't know if you experienced this when you went to Sarajevo—people are talking. . . . I don't understand what they're talking about. (Female, age 43)



The experience of failure in the ESL classroom was sufficiently unpleasant for many participants as to leave them disinclined to return to ESL classes in the future. Given the importance of linguistic competence in effectively negotiating the environment and particularly in gaining access to important educational and employment-related resources, the potential consequences of this negative experience with ESL are significant. One promising approach to addressing this problem involves integrating mental health concepts and practices into the ESL curriculum and training ESL teachers in the theory and practice of secondary preventive mental health strategies. In this way, the ESL class becomes a source of social support, and impediments such as impaired memory and diminished concentration, which previously led to experiences of failure, are addressed directly and accommodated within the classroom (American Council for Nationalities Service, 1996).

### *The Loss of Social Roles and the Corresponding Loss of Meaningful Activity*

The numerous social roles people occupy help shape their identity and deeply affect their sense of well-being (Heller, 1993), in part by giving meaning and structure to their daily lives (Lavik, Hauff, Skrondal, & Solberg, 1996) and in part by promoting a sense of competence and self-esteem (Kivela, 1997). For the participants in the present study, going into exile meant leaving behind an array of previously valued social roles:

I was very active. I used to go out with my friends to hunt, and Sundays I used to play soccer. I was a professional soccer player for 10 years, and then I was the president of the soccer club for years. And as I said, I was always active. . . . I was a civil engineer for 20 years . . . and for at least 14 years, I was an officer of the court. (Male, age 52)

I worked in a factory which produced cookies, and I had gone to school for that kind of profession, making candy. I liked my job a lot. I worked three shifts. I was really excited in my factory. (Female, age 46)

Participants described a range of previously valued social roles that had been affected by the war or abandoned upon going into exile. Those individuals widowed by the war had lost the role of spouse, and as described earlier, many now struggled with feelings of isolation and a lack of social support. Men who had previously been able to provide for their families' material needs in Bosnia now faced numerous obstacles to meaningful employment (e.g., health

problems, language barriers, and lack of appropriate job skills) and the corresponding loss of their role as providers; in addition, those who had previously held positions of responsibility in their workplace had also lost the status and recognition that came with their occupational achievements. Women too had left behind meaningful jobs—physician, attorney, tailor, factory worker, and nurse, among others—and, like their husbands, experienced a marked drop in income as well as the loss of meaningful activity their work had previously provided.

The loss of meaningful structure and activity in daily life was a common theme, particularly for those respondents not involved in the care of children, or whose children attended school during much of the day.

My days are almost the same. Usually, I don't sleep during the night. I get up early in the morning, and I leave home. I go to have a cup of coffee in the Golden Nugget. Always the same place, everyday, then I go back home. I'm not able to stay in home for a long time, so I leave home again. I walk, and I go back. (Male, age 58)

Usually, I am bored. I wait . . . to pick my children up. Sometimes I go out, take a walk, or go visit someone, go for coffee, or someone comes to visit us. During the summer, I used to go down to the lobby of our building and meet the other people. (Female, age 46)

Among older respondents, the loss of social roles took a variety of forms in addition to the more obvious role changes resulting from the death of a spouse or separation from other family members. Most of the older refugees in this study had been self-sufficient in prewar Bosnia, living in their own homes and able to meet their own financial needs. Further, many enjoyed the status of respected elders in multigenerational families that lived within close proximity. Upon becoming refugees, many of these older individuals found themselves unable to work because of difficulties speaking English and because of a range of psychological and physical problems related to wartime experiences as well as the stress of life in exile. Consequently, many now lived with and depended on their grown children for financial support as well as other forms of assistance. This loss of autonomy and authority within the family was uncomfortable and at times distressing, as illustrated by the comments of a 59-year-old man now living with his adult son and daughter in law:

Actually, I feel bad because I think that we are bothering them because of the small space. . . . I feel that way really. I feel like I am a guest. When we buy a house, I will have my own room, then I will feel like a head of my family

again in that space. Right now, we have just one separate room. . . . I can't receive guests in the bedroom . . . this is a temporary solution. (Male, age 58)

The loss of social roles among refugees represents an important focus for future research and has potentially important implications for refugee mental health interventions. To the extent that role loss represents a contributing variable in the etiology and maintenance of distress within refugee communities, effective interventions will need to (a) focus on helping participants develop the skills and access the resources necessary to be able to effectively identify or create new role opportunities and (b) emphasize the creation of settings in which traditional roles may be rearticulated in the context of exile. A number of innovative, community-based projects have begun to incorporate these foci, with results that are promising, although still preliminary (Miller & Rasco, in press).

### *A Lack of Sufficient Income for Adequate Housing and Other Basic Necessities*

A lack of sufficient income for safe and adequate housing and other basic necessities was the single most common source of exile-related distress among participants in this study. Many described surviving on poverty-level incomes, and families with several children often lived in small, one-bedroom apartments that afforded little privacy. Adult children often helped out their parents financially when they could, but this often did not amount to much because many of the jobs people had found paid little better than the minimum wage. A 62-year-old woman who lives with her husband in a studio apartment said she spends \$500 of their monthly income of \$800 on rent, which their landlord had just raised by 25%. She noted that after paying the utility bills, only \$140 remained for food and other basic expenses:

At the beginning, life was better because we had more. We had \$230 to spend then, but that was decreased. . . . I'm not able to buy what I need. My children, they are not able to support me because they work for just five dollars an hour. They don't have enough for themselves, and they are not able to support us.

A 49-year-old single father who lives with his two children in a small studio apartment recognized his adolescent daughter's growing need for privacy and spoke of the frustration he felt at not being able to provide more adequately for his children:

My daughter is almost 15, and she goes to school, and I live on Social Security benefits of about \$500. My children get \$200 in food stamps and \$200 in cash, and

we all live together in one studio apartment. My daughter is almost an adult, and it's not nice to be all in one room. I know I am eligible for public housing, and I applied, but there is nothing. My daughter needs a coat, and they both need books, notebooks, pencils, and bags, and I'm not able to afford that. . . . That is distressing to me.

Similar comments were made by other participants:

I had problems with very high rent, that's why I changed my apartment, and I took a very bad apartment because it was less expensive and I was supposed to pay almost all my income for an apartment, for the rent. My apartment is so bad that the rain comes in when it's raining. And I live on the third floor, so it's too many stairs for me because I'm not able to go up stairs. I have difficulty. I would like to have a nice apartment with nice things inside. Now when I enter my apartment and see many different things from the garbage, and I see my broken walls, I really—I just feel very bad. (Female, age 53)

The poverty and inadequate housing described by the majority of participants represented a marked change from their lives in prewar Bosnia. Although a few individuals had lived in impoverished circumstances, most had come from modest means that enabled them to own or rent a comfortable home and to meet their financial obligations with enough money left over for the occasional vacation on the Adriatic or even a second home in the country. The poverty of life in Chicago was thus experienced against a backdrop of better days in the recent past. At times during the interviews, people spoke with bitterness about the hardships they were now experiencing. More often, however, they expressed sadness at how the circumstances of their lives had changed and wondered whether things might become easier in the future. Although the majority of participants were receiving some form of public assistance, such assistance had failed to lift the families in this study out of poverty. On the one hand, this observation underscores the reality that current levels of financial assistance to refugees are simply inadequate to offset the actual cost of living. On the other hand, it also speaks to the importance of developing interventions aimed at helping refugees develop the skills and access the resources needed to find employment that provides a more adequate income.

### *Health Problems Not Previously Experienced in Bosnia*

Complaints regarding health problems participants had developed since going into exile were common among individuals of all ages. Most respondents

characterized their health as significantly worse now than before the war, and most attributed the deterioration to the traumatic nature of their war experiences and to the ongoing stress of their lives in Chicago. Although the interviewers made a distinction between physical and psychological health problems, many participants did not distinguish between emotional and physical distress. Thus, when asked whether their health had changed since going into exile, people described an increase in stomachaches, headaches, cardiovascular problems, and hypertension, but they also talked about previously unfamiliar experiences of nervousness, insomnia, and a loss of appetite.

A subset of individuals continued to experience physical pain from beatings they had experienced while imprisoned in concentration camps or during the military occupation of their villages.

We really got through horrible things. I lost my mother, and we were in the concentration camp too, and many things happened to us. . . . We were there for 18 days because my husband paid for us to be released. I was beaten there, and very often have headaches because of that. (Female, age 53)

Physical health problems have traditionally been viewed as falling within the domain of medicine rather than psychology. However, mental health professionals may have an important role to play in helping refugees develop effective coping strategies that can help minimize the impact of war-related trauma and exile-related stress on their physical well-being. In addition, an awareness of health problems common among refugees can inform the development of clinical and community-based interventions that emphasize health-promoting behaviors and the management of chronic physical distress.

## Discussion

The results of this study underscore the salience of exile-related stressors in the daily lives of the study's participants. The use of an inductive methodology (i.e., semistructured interviews with narrative analysis) allowed participants to identify the critical variables affecting their psychosocial well-being and to explore the ways in which prior war experiences and ongoing stressors associated with life in exile continued to exert their influence. It is noteworthy that several of the exile-related stressors identified in this study have received scant attention in the empirical literature on the psychology of exile, which has generally relied on deductive methodologies that define a priori the set of relevant variables to be assessed. Examples of such overlooked stressors include the

loss of valued social roles and the abandonment of life projects, both of which represented significant sources of distress for many of the participants in this study. With regard to the salience of other variables such as social isolation, a lack of adequate income to meet basic needs, and language barriers that limit access to important resources, our findings are consistent with those of other recent studies (Beiser et al., 1993; Gorst-Unsworth & Goldenberg, 1998; Pernice & Brook, 1996). And like previous research, our data strongly support the recent shift among researchers away from a primary focus on the impact of war-related trauma and toward a more comprehensive model of refugee well-being that includes the impact of both war experiences and stressors rooted in the experience of exile.

The narrative approach used in the present study also facilitated a greater understanding of the ways in which war-related trauma, a hallmark of the refugee experience, may adversely influence people's capacity to effectively negotiate the many challenges of adapting to life in exile. For example, trauma-related impairments in concentration and memory clearly had a limiting effect on many individuals' ability to learn English, which in turn constrained the extent to which they were able to access the range of available resources. Similarly, recurrent war-related nightmares and chronic insomnia left several participants continually sleep deprived, thereby limiting their internal resources for coping with the range of exile-related stressors identified in the study.

Our data also suggest that exile-related stressors may adversely affect the process of recovery from war-related trauma. Hermann (1992) described the importance of creating a safe context as a prerequisite for resolving the painful and intrusive symptoms of post-traumatic stress reactions. For several of the participants in this study, however, the creation of contexts that were safe both physically and psychologically posed a considerable challenge. Chronic poverty and the periodic threat of eviction when rent money could not be found resulted in an ongoing state of anxiety for several respondents. In addition, the loss of community that was ubiquitous among participants in this study left many individuals feeling isolated and lacking in social support. Under such circumstances, the resolution of war-related trauma would seem especially challenging.

The interaction of war-related trauma and exile-related stressors suggests the importance of comprehensive interventions that integrate trauma-focused treatment strategies with community-based programs that (a) reduce isolation and facilitate the development of new social networks, (b) foster the development of

environmental mastery so that program participants may more effectively take advantage of local resources that can enhance their psychosocial and physical well-being, and (c) emphasize the identification and creation of meaningful social roles and new life projects. Such interventions may be particularly important for older refugees, who may be especially vulnerable to the effects of the various exile-related stressors discussed in this article. In the present study, older respondents were particularly affected by certain stressors, such as social isolation, the loss of life projects and the related loss of meaning and structure in everyday life, and a variety of health problems caused or exacerbated by their experiences of war and exile. The development of mental health interventions aimed specifically at older refugees, designed to address their unique vulnerabilities while building on their strengths and resources, represents an important and neglected area.

Finally, it is noteworthy that very few participants mentioned intrafamilial conflict as a source of distress. In contrast to clinical reports describing parent-child conflict as a salient issue among refugee families (e.g., Tobin & Friedman, 1984), particularly with regard to the process of acculturation and the inversion of power relationships (as parents become dependent on their children to help them negotiate the new environment), the majority of participants in this study characterized their families as highly supportive and generally low in conflict. This finding, which is consistent with the results of a recent study of parent-child relationships in Latino and Russian immigrant families (Buchanan, 2001), suggests that intrafamilial conflict within refugee families may be less pervasive than previously thought. To what extent the assumed salience of such conflict in clinical reports has been an artifact of biased samples or of factors specific to particular ethnocultural groups is not known at this point.

It is important to note several limitations to our study. Perhaps most important is the use of a clinical sample. In the present study, we were particularly interested in better understanding the range and nature of exile-related stressors affecting distressed refugees. That is, we had a specific interest in exploring factors other than war-related violence that might be contributing to the high rates of distress that have been documented among Bosnian refugees. To what extent the exile-related variables that were salient in the present study might have equal salience in a non-clinical, community sample is an important question and one that we plan to investigate as part of a larger study with Bosnians in the Bay Area of California.

The emphasis on identifying *stressors* clearly reflects a particular bias of the investigators. This study did not examine the experience of exile per se; instead, the focus was on examining factors contributing to the high rates of distress that have been documented among Bosnian refugees in previous research (Miller et al., 2002; Weine et al., 1998, 2000). More broadly, we sought to expand the current model of refugee distress, which we believe has inadequately accounted for the etiological salience of stressors affecting refugees after they go into exile. In our view, the addition of exile-related stressors to the model has significant implications for how we respond to the mental health needs of refugee communities. To the extent that factors such as social isolation and a lack of meaningful social roles represent significant sources of distress within refugee communities, the efficacy of clinic-based mental health services may be enhanced by being complemented with community-based interventions designed to address exile-related stressors, for example, by promoting the development of new social networks and helping community members identify new and meaningful social roles (Miller & Rasco, 1999).

Finally, it should be noted that the data from this study were gathered in a specific relational or interpersonal context in which Bosnian refugees, primarily of Muslim ethnicity, were asked to describe highly personal experiences to either of two White, male American interviewers and a female interpreter, also a Bosnian Muslim. We do not know to what extent and in what ways the participants may have shaped their responses on the basis of their experience of this relational context. Support for the authenticity of the data is suggested, however, by the assertion of many participants that they chose to participate, despite their concern about reexperiencing painful memories, because they were familiar with the clinical work of the research team and hoped we would use their stories to benefit the Bosnian community. Invariably, however, our data reflect a particular set of researcher-participant relationships, and we have little doubt that other researchers asking similar questions would hear some stories that were not shared with us, as well as a great many that were.

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