Psychiatria Danubina, 2008; Vol. 20, No. 4, pp 474–484 *Original paper*

MENTAL HEALTH CARE OF PSYCHOTRAUMATIZED PERSONS IN POST-WAR BOSNIA AND HERZEGOVINA – EXEPRIENCES FROM TUZLA CANTON

Esmina Avdibegovic, Mevludin Hasanovic, Zihnet Selimbasic, Izet Pajevic & Osman Sinanovic

University Clinical Centre Tuzla, Trnovac b.b, 75000 Tuzla, Bosna and Herzegovina

SUMMARY

Background: *Majority of Bosnia-Herzegovina (BH) residents were exposed to cumulative traumatic events during and after the (1992-1995) war, which demanded emergency organizing of psychosocial support as well as psychiatric-psychological treatment of psychotraumatized individuals.*

Objectives: *To describe organizing of psychosocial help during and after the BH war, institutional treatment of psychotraumatized in the frame of mental health service reform program with an overview on the model of psychosocial support and psychiatry-psychological treatment of psychotraumatized persons of Tuzla Canton region.*

Subjects and methods: *The retrospective analysis of functioning in the Department for traumatic stress disorders on the Psychiatry Clinic in Tuzla for the 1999-2003 period has been described in regard of number, gender, age and trauma related mental disorders of referred patients.*

Results: *In the observed period, 8.329 of patients in the outpatient care program were included, 617 of inpatients were treated in the Clinic, while 301 of patients in the Partial hospitalization program were included. Mean ± standard deviation of patients' age was 45±8.06 years. More psychotraumatized women (60.8%) were encompassed in the partial hospitalization program than in inpatients (23.9%) or outpatients (18.3%) care programs. In regard of trauma related mental disorders, majority outpatients had Posttraumatic stress disorder (PTSD) in co morbidity with other mental disorders (72.5%), PTSD was presented amongst the majority of inpatients (64.5%) and in partial hospitalization program there were (47.5%) patients with PTSD.*

Conclusions: *In the treatment of psychotraumatized persons, in the organizing of health care system schema in postwar Bosnia and Herzegovina, meaningful obstacles are presented still today on the both, social and political level, despite mental health service reform performed in Bosnia-Herzegovina. The stigmatization of mental health issues is an important problem in treatment of traumatized individuals especially among war veterans. The lack a single Center for psychotrauma in postwar BH shows absence of political will in BH to resolve the problem of war veterans with trauma related psychological disorders.*

Key words*: PTSD - Bosnia-Herzegovina – war – postwar - partial hospitalization*

* * * * *

INTRODUCTION

Catastrophic effect of war on the health and well being of nations is proven by many studies that show that conflict situations cause more mortality and disability than any major disease, also destroys communities and families often disrupts the development of the social and economic fabric of nations. The effects of war

include long-term physical and psychological harm to children and adults, as well as reduction in material and human capital (Murthy & Lakshminarayana 2006). The war had a particularly traumatizing effect on solders because they were often exposed to direct terror. A substantial amount of material on psychological and other health related consequences caused by traumatizing experiences during warfare exist (King et al. 1999, Simmons et al. 2004, Pizarro et al. 2006). There is also a great number of research articles on war consequences in children and adolescents, (Macksoud & Lawrence 1996, Motta et al. 1998, Hasanovic et al. 2005), women (Kastrup 2006), families, (Weine et al. 1997), refugees, (Miller et al. 2002) and in the society (Austin & Bruch 2000, Grinfeld 2003). The current understanding of the effects of traumatic experience is a result of the recognition of a delayed post-traumatic response among a significant proportion of the returning Vietnam veterans. The simultaneous recognition of the potentially devastating effects of child abuse, rape, domestic violence, disaster, kidnapping, torture, terrorism, and crime victimization led to recognition that there is a universal human reaction to overwhelming stress (Kluft et al. 2000).

Taken in account that trauma destroys the social systems of care, protection, and meaning that support human life, the recovery process requires a reconstruction of these systems. The essential features of psychological trauma are disempowerment and disconnection from others. The recovery process therefore is based upon empowerment of the survivor and restoration of relationships (Summerfield 1995). Successful rehabilitation and resocialization of psychotraumatized persons can only be achieved by intensive and well-timed treatment. Establishing mental health services that are community-based, family-focused and culturally sensitive in the post-emergency phase can create a model that helps shape future mental health policy for countries recovering from disaster (Silove et al. 2006). The new system will be characterized by safety from physical harm and re-traumatization; an understanding of clients and their symptoms in the context of their life experiences and history, cultures, and their society; open and genuine collaboration between provider and consumer at all phases of the service delivery; an emphasis on skill building and acquisition rather than symptom management; an understanding of symptoms as attempts to cope; a view of trauma as a defining and organizing experience that forms the core of an individual's identity rather than a single discrete event; and by a focus on what has happened to the person rather than what is wrong with the person (Saakvitne 2000, Harris & Fallot 2001).

Research points to that in treatment of traumatized people with both mild and severe mental disorders the program of partial hospitalization provides the optimal surroundings for therapeutical treatment and psychological rehabilitation (Samard_i_ et al. 1998, Creamer et al. 1999, Kluft et al. 2000, Kozaric-Kovacic et al. 2002).

The aim of the present paper was to describe organizing of psychosocial help during and after the BH war, institutional treatment of psychotraumatized in the frame of mental health service reform program with an overview on the model of psychosocial support and psychiatry-psychological treatment of psychotraumatized persons of Tuzla Canton region.

SUBJECTS AND METHODS

The retrospective analysis of functioning in the Department for traumatic stress disorders on the Psychiatry Clinic in Tuzla for the period 1999-2003 year has been described in regard of number, gender, age and trauma related mental disorders of referred patients.

In the observed period, 8.329 of patients in the outpatient care program were included, 617 of inpatients were treated in the Clinic, while 301 of patients in the Partial hospitalization program were included. Mean±standard deviation of patients' age was 45±8.06 years.

Diagnostic estimation was carried out in accordance with DSM-IV classification, standardized PTSD interview, and MMPI.

RESULTS

The number of psychotraumatized persons asking for help has increased after the war.

In the period from 1996 till 1998 out of the 2374 patients admitted for hospitalization in Clinic of psychiatry in Tuzla 409 (17.2%) of them had posttraumatic stress disorder.

In the period between year 1999- 2003 the number of hospitalized patients increased with 11.55%, and the number of patients with PTSD increased with 3.75%. From year 1999 when the program for reforming mental health care services was implemented and the model for institutionalized help to psychotraumatized individuals was reinforced with the program of partial hospitalization and aid outside the hospital became possible, the number of psychotraumatized people who received treatment increased. In the program Care outside the hospital from year 1999 till 2003, 8329 patients were included (Figure 1). In 72.5% of the patients included in the Care outside the hospital program, PTSD in co morbidity with other psychological disorders was diagnosed. From the total number of psychotraumatized individuals treated outside the hospital, 1873 (21.9%) were included in group supportive therapy, 73.9 % of the 1873 subjects were male.

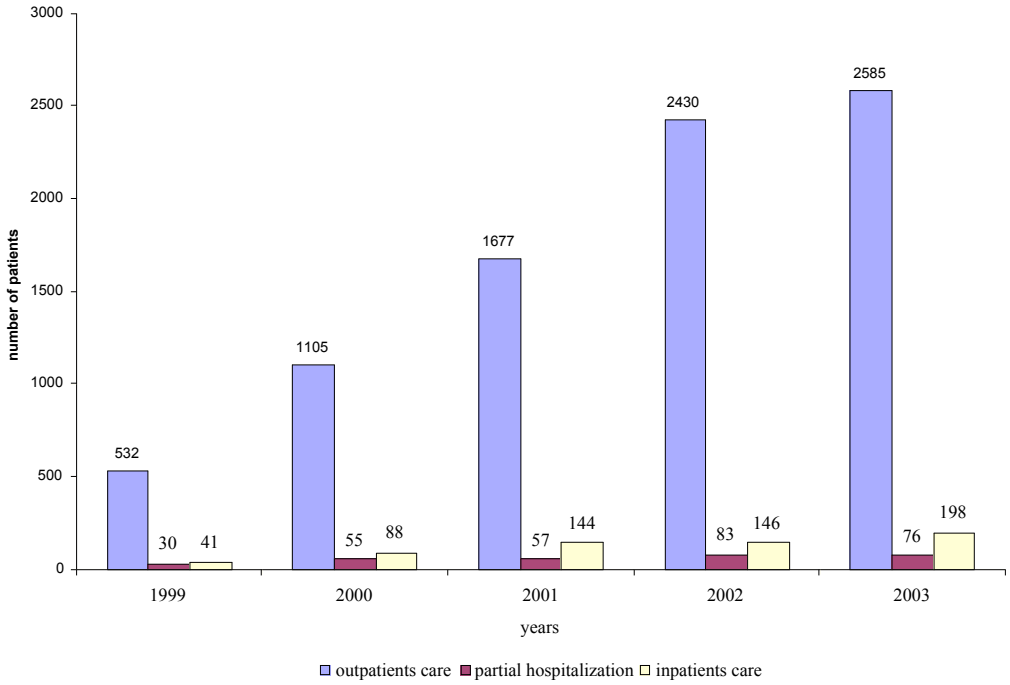

Figure 1. Distribution of patijents treated on the Department of traumatic stress disorders, Clinic of psychiatry in Tuzla for the period of 1999- 2003 year.

Supportive groups in outside the hospital treatment were considering sex homogenic. In the same period 617 individuals were hospitalized, out of them 504 (81.7%) were male. Out of the total number of hospitally treated patients 64.5% was diagnosed with PTDS, 14.6% had lasting changes of character due to catastrophic events, while 20.9% of the patients had diagnosed PTSD in co morbidity with other psychological disorders. The program of partial hospitalization included 301 patients with an average age of 45±8.1 years. Out of this 118 (39.2%) were male and 183 (60.8%) were female. The program of partial hospitalization had a higher number of psychotraumatized women than the two other cohorts, the hospitalized and out of hospital group (60.8% vs 23.9% vs 18.3%)**.** According to place of residence 239 (79.4%), and thus most of the patients, came from municipalitiy of Tuzla. The number of patients from other municipalities was limited due to difficulties associated with traveling. Concerning psychological disorders, 143 (47.5%) patients in the program of partial hospitalization had diagnosed PTSD, 132 (43.8%) had PTSD in co morbidity with depression, while 26 (8.7%) were diagnosed with trauma associated with a psychotic disorder. Number of

psychotraumatized patients included in the program of partial hospitalization gradually increased from 30 patients in year 1999 till 76 patients in 2003. The increase in the number of referred and treated patients reflects better cooperation with primary health care doctors, especially those working in family medicine who received training within day-hospital during their education. In addition, recommendations to friends and family from day-hospital patients themselves have also contributed to the increase in patient number.

DISCUSSION

Treating traumnatized people during and after the war in Bosnia and Hercegovina

The war in Bosnia and Herzegovina (1992-1995) was characterized by massive displacement, disruption and loss of life, relatives and property. Health and psychosocial well-being were affected in number of ways that are shown many studies (Hasanovic & Herenda 2008, Klaric et al. 2007, Babic et al. 2007, Hasanovic et al. 2005, Dane_ & Horvat 2005, Carballo et al. 2004, Hodgetts et al. 2003, Mollica et al. 1999). The war has almost destroyed the system of psychiatric services, and leads to lack of professional staff. Because of this, after the war, Federal Ministry of Health of Bosnia and Herzegovina has decided to carry out a complete reconstruction of psychiatric services based of new principles (Jacobson et al. 2000, Ceric et al. 1999, Regional project office of the Mental Health Project for south-eastern Europe 2004). The revision of organs responsible for mental health care did not only include a change in attitude towards people with serious mental disorders, it also made it possible for war veterans to recive help and engage in rehabilitation while still being a part of their community and the society (Edmonds 2005, Mooren et al. 2003).

When the war started in 1992 the knowledge about psychological consequences of the war and terapeutical approchement to post traumatic stress disorder (PTSD) in Bosnia and Hercegovina were quite limited. The terapeutical approach towards traumatized people in the health care system depended on psychiatrists´ own experiences and their abilities and will for additional education through foreign literature and educators (Jensen & Ceric 1994, Hasanovic et al. 2006). At the end (1994-1995) and right after the war in Bosnia and Hercegovina foreign governmental organizations and NGOs initiated various psychological programs (Dybdahl 2001, Stuvland et al. 2001, de Jong & Kleber 2003, Nelson 2003, Pupovac 2004). Humanitarian organisations helped local NGOs in organizing (Fagan 2007) various psychological programs for administration of psychological help to psyshotraumatized people. At the same time they held educational courses in different trapeutical approaches to psychotraumatized people for professionals within the mental health care sector (Powell & Durakovic-Belko 2004, Röper & Gayranidou 2003). Straight after the war the region of BiH was flooded with different concepts of trauma and there was an assumption that Bosnia was “a good marked for selling items no matter the quality”. In different regions of BiH different psychological programs and different educational programs were used, often without any attention to the given cultural, political and social setting, and often without any evaluation of the programs and their efficacy. A few of the psychosocial programs applied to BiH territories were programs provided by Doctors without borders (de Jong & Kleber 2003). Harvard trauma program for refugees (Baingana 2005)**,** and the program of International center for psychosocial trauma, University of Missouri-Columbia were used in educational courses for family practitioners (Hasanovic et al. 2006). A psychological approach to trauma had an intention, not only to minimize the risk of serious mental disorders, but also to reduce the stigmatization and increase public education on the psychological consequence of trauma (Butollo 2000). Some years after the war, after the end of crises on BiH territories, an evaluation given by the international community, the number of foreign governmental organizations sunk, and so did the number of NGOs. At the same time a network of psychosocial aid and a treatment program for traumatized people was not established, this left a gap, witch is still present in great parts of BiH (Nelson 2003). During and after the war the provided psychosocial help was not good enough planned, each organization tried to apply their own program, and

this is still symptomatic in today's treatment of psychotraumatized people. On the national level in today's BiH there is no official schedule for treatment of psychotraumatized people and for providing psychosocial help to high-risk population that still exist in great numbers (war veterans, refugees still in refugee camps, children with missing parents, families with missing family members, returnees), and it seems as if the leading politicians and authorities still rely on the international community to resolve this problem. Parallel with the situation on national level is the situation on federal level (Federation of BiH and Republika Srpska) and on cantonal level in the federation of BiH and regional level of Republika Srpska. Existing and functioning levels are: level of activity in the society providing non-selective psychological aid given by local NGOs, level of selective psychological aid provided by NGOs with professional psychosocial teams, institutional psychiatric treatment in the few mental health care centers that have a full psychiatric team, and in psychiatric clinics in Sarajevo and Tuzla that have departments for traumatic stress disorders.

The need for psychosocial aid and programs of psychosocial intervention in BiH is still present especially among populations of returnees and refugees still in refugee camps, victims who have survived the genocide in Srebrenica, mine victims, families with missing family members and other victims of war trauma and postwar social stressors.

In today's BiH post traumatic stress disorder is becoming a priority in health services but the political and structural authorities still do not recognize the presents of post traumatic stress disorder, consequences of this are minimal founding from national and cantonal budgets of Federation of BiH for psychological aid and treatment of traumatized people. Revision of mental health care institutions and educational courses for psychiatrists and other professionals within the health care system and experiences from working with psychotraumatized people during the war laid the ground for the development of a terapeutical model for psychotraumatized patients in Tuzla canton.

Terapeutical model for psychotraumatized people in Tuzla canton

Important in preparations of the treatment model for psychotraumatized people in Tuzla Canton were experiences from Croatia, educational programs Harvard trauma program (Baingana et al. 2005) and the program International center for psychosocial trauma, University of Missouri-Columbia (Hasanovic et al. 2006). In Tuzla Canton, in postwar period, as a part of psychosocial help a network of local NGOs was formed, they provided psychosocial help "Reference group Tuzla" (Fagan 2007), in helping psychotraumatized people within health services the focus was on family medicine, centers for mental health in the community and Clinic of psychiatry in Tuzla. Institutionalized psychological or psychiatrical treatment required by psychotraumatized individuals is provided by the Department of traumatic stress disorders, Clinic of psychiatry in Tuzla and on the primary health care level by 5 mental health centers within the local community. Health care institutions were included in providing help to psychotraumatized people who have a high risk of developing disorders in relation to war trauma and postwar social stressors. Risk groups are: individuals fully dependent of their surrounding (children, adolescents, disabled persons, old people and others), individuals with multiple trauma (individuals who hade been in concentration camps, refugees, survivors after the genocide in Srebrenica, raped women, individuals with missing or murdered family members, children and adolescents whose parents have been murdered or are missing and who live in governmental and non-governmental organizations for children without parents, refugees form refugee settlements), demobilized solders with multiple warfare traumas, individuals with an intensive response to trauma because of their premorbid psychiatric disorders, psychiatric patients, patients with chronic somatic diseases, patients with several diagnosis and individuals with secondary traumatization.

Assignments for the Department of traumatic stress disorders, Clinic of psychiatry are:

a) Diagnostic evaluation of psychotraumatized individuals who are hospitalized or who are in daycare hospital, this evaluation is carried out with the use of different diagnostical techniques (psychiatric, psychologic, somatic and laboratory testings) and an evaluation of their working ability;
b) Treatment of psychotraumatized individuals;
c) Development of diagnostic methods and objectification of PTSD and other related disorders;
d) Development of terapeutical programs and evaluation of these;
e) Establishment of self-help groups and societies for demobilized solders with PTSD;
f) Establishment of organizations for patients with PTSD and other psychological disorders;
g) Establishment of advice giving institutions for women and children of psychotraumatized demobilized soldiers;
h) Establishment of advice giving institutions for women in violent homes and for women who were raped during the war;
i) Establishment of algorithms for PTSD treatment;
j) Education of medical students, students of psychology-education, higher health education, social workers, educational rehabilitational faculty;
k) Populational education through media.

The professional team at the Department of traumatic stress disorders consists of: psychiatrists, doctors under specialization in psychiatry, psychologists, one social worker, working therapist, educational therapist, bibloterapist and nurses. The ward for traumatic stress disorders consists of a hospital section with five beds, a day care hospital section with partial hospitalization programs with a capacity of 28 places and a program for external, non hospitalized patients. The hospital section, Department of traumatic stress disorders, Clinic of psychiatry was founded in year 1995. Reasons for hospitalization were acute symptoms of PTSD and psychotic symptoms, and also how far away from the hospital the individual lived and inability to pay the transportation costs. Among hospitalized patients psychopharmacological therapy and supportive individual therapy were applied. Day care hospital in association with the Department of traumatic stress disorders, Clinic of psychiatry in Tuzla was founded in year 1999, with help from European Community, Doctors without borders from Belgium, World Health Organizations and HealthNet International. The program for non hospitalized external patients includes: diagnostic evaluation, individual psychoterapeutical treatment, supportive group treatment, long term psychotherapeutic groups, analytical treatment in groups, psychopharmacological treatment. Patients are referred to the ward for traumatic stress disorders by family practitioners, psychiatric center of mental health, psychiatric emergency rooms at the Clinic of psychiatry, they may be referred by recommendation of psychosocial teams of NGOs with psychosocial programs, or at they own initiative. When treatment is indicated, several factors are considered: psychological symptoms, somatic symptoms and their intensity, the reason why the person seeks treatment, motivation for treatment, level of social functionality and functionality in the family, secondary benefits, evaluation of exposure to traumatic events and determination of diagnosis. An all embracing psychiatric evaluation is applied, it includes: a history of the present illness and current symptoms, including a substance use history; medical history; review of systems and a review of prescribed and over-the-counter medications; personal history; social, occupational, and family history; history of prior treatments or interventions and their degree of success; mental status examination; physical examination; and diagnostic tests as indicated. Developmental and preexisting psychodynamic issues may make the patient especially vulnerable or reactive to a traumatic event. A psychiatric interview is used for the psychiatric evaluation, it lasts for two to three sessions, each up to 45 min. Psychiatric management of psychotraumatized individuals consists of: evaluating the safety of the patients and others, determining a treatment setting, establishing and maintaining a therapeutic alliance, and monitoring treatment response.

The goals of treatment for individuals who have experienced a traumatic event and have received a diagnosis of PTSD or trauma-related co morbid conditions include the following: reducing the patients overall level of emotional distress as well as specific target symptoms that may impair social or occupational function; prevent or reduce trauma-related co morbid conditions; improve adaptive functioning and restore or promote normal developmental progression; protect against relapse, and integrate the danger experienced as a result of the traumatic situation into a constructive schema of risk, safety, prevention, and protection (American Psychiatric Association 2004).

Terapeutical forms in treatment of psychotramatized individuals are: psychopharmacological treatment, psychotreapeutical interventions, psycho education and supportive measures. A therapeutic model is chosen on the basis of primary interview, concerning heaviness and advanceness of disorder and ego capacity of patient's personality. Terapeutical protocol contains the following: individual psychotherapy, different forms of group psychotherapy, psychoeducation, sociotherapeutical techniques and psychofarmatherapy. Psychoeducational groups: the aim is to educate the patient about his or her disorder and its treatment (psychopharmacological, social, and psychotherapeutic). Educational theme includes the topics such as meaning of survival, understanding the emotions, such as rage, anger, fear, guilt, and mourning, looking for significant and emotionally important relationships. The expert consensus guidelines on PTSD describe psychoeducation as educating patients and their families about the symptoms of PTSD and the various treatments that are available. They note that it is a useful adjunct therapy for patients with PTSD. Psychoeducational group treatment models for PTSD treatment have been described for women with multiple traumas as well as combat veterans (Foa et al. 1999, Lubin et al. 1998).

Group psychotherapy: Group psychotherapy, or group psychotherapy combined with individual psychotherapy, is the most common method of treatment of the psychotraumatized person (Gregurek 1999). Group psychotherapy includes veteran groups, groups of family members, people with concentration camp experience, women with domestic violence experiences, and other. Groups can be closed or open, with focus on the psychoeducation or trauma experiences. Different forms of group psychotherapy are used such as cognitive behavioral psychotherapy, supportive psychotherapy, and psychoanalytic psychotherapy. Group psychotherapy can be used in fulfilling various therapeutic goals and can be focused on the feelings of isolation, feelings of shame, guilt, and self-blame, which are often present in many of patients with PTSD.

Sociotherapy: This type of therapy is focused at increasing the patient’s ability to function in the environment and have meaningful relationships with people around him or her (family, work environment). Sociotherapy includes bibliotherapy, occupational therapy, therapeutic community, art therapy, and psychomotor therapy. Sociotherapeutical groups were established primarily for patients with PTDS in co morbidity with psychotic disorders, patients with PTSD in co morbidity with depression and for patients with chronic PTSD. Psychopharmacological treatment: Traumatized individuals may manifest extremely complex presentations accompanied by considerable morbidity that changes over time. Symptom reduction is important both to treat posttraumatic and co morbid conditions, and to stabilize the patient sufficiently to proceed to and manage the stage of remembrance and mourning. In this regard medication may play a valuable role. Symptom reduction, especially for intrusive symptoms and sleep difficulties, may also facilitate the engagement of the patient in therapy. So far, it appears that PTSD at least, is associated with abnormalities in the adrenergic, hypothalamic-pituitary-adrenocortical, opioid, dopaminergic, and thyroid systems, and possibly with alternations in the serotonergic, gamma-amino butyric acid-benzodiazepine and the N-methyl-D-aspartate systems (Friedman & Southwick 1995). Medications may help some of the symptoms of posttraumatic stress; they are much more successful in alleviating depression, sleep disorders, anxiety, and hyperarousal symptoms than they are helping withdrawal and numbing. According to American Psychiatric Association (2004), the purposes of medication in PTSD are as follows: reduction of frequency and/or severity of intrusive symptoms; reduction in the tendency to interpret incoming stimuli are

recurrences of the trauma; reduction in conditioned hyperarousal to stimuli reminiscent of the trauma, as well as in generalized hyperarousal; reduction in avoidance behavior; improvement in depressed mood and numbing; reduction in psychotic or dissociative symptoms; reduction of impulsive aggression against self and others. In selected patients a wide variety of medications and many combinations of medications can prove useful. In the process of deciding on type of drugs, dosage, and duration of treatment is important to define if the symptoms of PTSD exist independently or related to some other disorder. In the case of existing only the PTSD symptoms the pharmacological approach specified in the psychopharmacological algorithm for the PTSD treatment is commended (American Psychiatric Association 2004). In the cases of existing co morbidity it is indicated to include appropriate pharmacotherapy understanding dominant co morbidity symptoms. Different medications are used in the treatment of PTSD, e.g., tricyclic antidepressants, selective serotonin reuptake inhibitors, anxiolytics, mood stabilizers, hypnotics for disturbed sleeping, and antipsychotics (American Pschiatric Association 2004). Follow-up of the patient is necessary during psychopharmacotherapy.

Self-help groups focus on the development of serenity, which can be understood as a state of autonomic stability and of being at peace with one's surroundings. They promote interdependence by relearning to trust, by surrendering, by making contact, and by developing interpersonal commitments. Self help groups were established within the frames of patient organizations such as, Organization of war veterans treated for PTSD "Stecak", Society for users of psychiatric services "Feniks", Society for patients with depressions "Svjetlost". Self help groups in the Organization of war veterans treated for PTSD consist of war veterans with PTSD, who have had extremely traumatic events in associated with combat, while the self help groups in the Society for users of psychiatric services consists of patients with PTSD in co morbidity with psychotic disorders. Self help groups in the Society for patients with depressions consist of patients with severe traumatic events associated with the war, of patients living in violent homes, or who have survived great losses and suffer from depression.

Supportive psychoterapeutical approach: The goal of supportive therapies is soothing or removal of difficulties and establishment of "premorbid" equilibrium. Supportive psychotherapy means series of individual and group therapy techniques and their combinations, which main characteristic is that they are helping patient to get over some symptoms using established capacities of personality and copying mechanisms. Supportive techniques could be successfully combined with psychoactive drugs. "Covering" approach in which the emphasis is placed on addressing current life issues. Interventions explore middle-range affects such as frustration, with the goal of diffusing more extreme affects. Designed to maintain a sense of interpersonal comfort and to keep transference at a low to moderate level (Foe et al. 1999).

CONCLUSIONS

Organizational model in the approach to the psychotraumatized persons changed in Tuzla Canton with establishing the Department of psychotrauma with the program of partial hospitalization and the program of out of hospital care for psychotraumatized individuals. Even if the public reform of mental health care institutions is started, education of personnel in family medicine has begun and a clinical treatment model for work with psychotraumatized patients within family medicine is made, because of financial systems and the organization of health care institutions there still does not exist a good enough cooperation between the listed institutions in providing services for psychotraumatized individuals. Centers of mental health care organizationally belong to primary health care services so called "domovi zdravlja" (enlg. Homes of health) and the connection to hospitals is still inadequate. This is one of the obstacles to an all embracing rapprochement to psychotraumatized people. Besides organizational problems in the health care system another important obstacle is that many traumatized people do not have a health insurance.

The stigmatization associated with psychiatric hospitals is an important problem in treatment of traumatized individuals especially among war veterans. When it comes to the population of veterans it is important to mention the lack of politic will and an national resolution of the problem of psychotraumatized war veterans who are today one of the leading risk groups in Bosnia and Hercegovina. The lack of will to resolve the problem of war veterans with PTSD and other trauma associated psychological disorders may be seen in the fact that BiH does not have a single Center for psychotrauma, that psychiatric-psychological help for war veterans is mainly provided by psychiatric institutions and centers for mental health, which are primarily meant to help individuals with severe psychiatric disorders.

REFERENCES

1. *American Psychiatric Assoctiation: Practice Guideline for the Treatment of Patients With Acute Stress Disorder and Posttraumatic Stress Disorder. American Psychiatric Publishing, Inc. 2004; http://www.appi.org.*
2. *Austin JE, Bruch CE: The Environmental Consequences of War: Legal, Economic, and Scientific Perspectives. Cambridge: Cambridge University Press 2000.*
3. *Babic D, Jakovljevic M, Martinac M, Saric M, Topic R, Maslov B: Metabolic syndrome and combat posttraumatic stress disorders intensity: preliminary findings. Psychiatria Danubina 2007; 19: 68-75.*
4. *Baingana F, Bannonb I, Thomas R: The International Bank for Reconstruction and Development / The World Bank: 2005.*
5. *Butollo WH: Asocial interaction model for war traumatization: Self-processes and postwar recovery in Bosnia in subjects with PTSD and other psychological disorders. Dialogues in Clinical Neuroscience 2000; 2: 71-81.*
6. *Carballo M, Smajkic A, Zeric D, Dzidowska M, Gebre-Medhin J, van Halem J: Mental health and coping in a war situation: the case of Bosnia and Herzegovina. Journal of Biosocial Science 2004; 36: 463-477.*
7. *Ceric I, Loga S, Sinanovic O, Oruc L, Cerkez G: reconstruction of mental health services in the Federation of Bosnia and Herzegovina. Medicinski Arhiv 1999; 53: 127-130.*
8. *Creamer M, Morris P, Biddle D, Elliott P: Treatment outcome in Australian veterans with combat-related posttraumatic stress disorders: a cause for cautious optimism? Journal of Traumatic Stress 1999; 545-558.*
9. *Danes V, Horvat V: Psychological consequences of war stress in the developing population in Bosnia and Herzegovina. Psychiatria Danubina 2005; 17: 225-229.*
10. *de Jong K, Kleber R: Early psychosocial interventions for war-affected populations. In: Orner R, Schnyder U (eds) Early interventions in emergencies. Oxford University Press, 2003*
11. *Dybdahl R: Children and mothers in war: an outcome study of a psychosocial intervention program. Child development 2001; 72:1214-1230.*
12. *Edmonds LJ: Mainstreaming community based rehabilitation in primary health care in Bosnia-Herzegovina. Disability and Society 2005; 20:293-309.*
13. *Fagan A: Transnational aid for civil society development in post-socialist Europe: Democratic consolidation or a new imperialism? Journal of Communist Studies and Transition Politics 2007; 22: 115 – 134.*
14. *Foa EB, Davidson JRT, Frances A. The Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder. Journal Clinical Psychiatry 1999; 60 (Suppl):16.*
15. *Friedman MJ, Southwick SM: Towards pharmacotherapy for post-traumatic stress disorder. In: Friedman MJ, Charney DS, Deutch AY (eds). Neurobiological and Clinical Consequences of Stress: From Normal Adaptation to PTSD. Philadelphia: Lippincott-Raven Publishers, 1995.*
16. *Gregurek R: Countertransference problems in the treatment of a mixed group of war veterans and female partners of war veterans. Croatian Medical Journal 1999; 40:493-497.*
17. *Grinfeld M: National trauma: what are the consequences of war in the Middle East. Psychiatric Times; 2003 available at:*
    http://www.psychiatrictimes.com/p031001b.html.
18. *Hasanovc M & Herenda S: Post traumatic stress disorder, depression and anxiety among family medicine residents after 1992-95 war in Bosnia and Herzegovina. Psychiatria Danubina 2008; 20:277-285.*
19. *Hasanovic M, Sinanovic O, Selimbasic Z, Pajevic I, Avdibegovic E: Psychological disturbances of war traumatized children from different foster and family setting in Bosnia and Herzegovina. Croatian Medical Journal 2005; 46: 105-115.*
20. *Hasanovic M, Sinanovic O, Pajevic I, Avdibegovic E, Sutovic A: Post war mental health promotion in Bosnia and Herzegovina. Psychiatria Danubina 2006; 18: 74-78.*

21. *Hodgetts G, Broers T, Godwin M, Bowering E, Hasanovic M: Posttraumatic stress disorders among family physicians in Bosnia and Herzegovina. Family Practice 2003; 20: 489-491.*
22. *Jacobson L, Lagerquist B, Eriksson B: Swedish health care support to Bosnia –Herzegovina. Changing outpatient psychiatry and social work. Lakartidningen 2000; 97: 4153-4157.*
23. *Jensen BS, Ceric I: Community-Oriented Mental Health Care in Bosnia and Herzegovina: Strategy and Model Project. Sarajevo, WHO Office for Bosnia and Herzegovina, 1994.*
24. *Kastrup MC: Mental health consequences of war: gender specific issues. World Psychiatry 2006; 5: 33-34.*
25. *King DW, King LA, Foy DW, Keane JM, Fairbank JA. Posttraumatic stress disorder in a national sample of female and male Vietnam Veterans: risk factors, war-zone stressors, and resilience-recovery variables. J Abnormal Psychol 1999; 108:164–170.*
26. *Klaric M, Klaric B, Stevanovic A, Grkovic J, Jonovska S: Psychological consequences of war trauma and postwar social stressors in women in Bosnia and Herzegovina. Croatian Medical Journal 2007; 48: 176- 176.*
27. *Kluft RP, Bloom SL, Kinzie JD: Treating the traumatized patient and victims of violence. In Bell CC (ed) Psychiatric aspect of violence: issues in prevention and treatment. New Direction in Mental Health Services 86, 2000; 79-102.*
28. *Kozaric-Kovacic D, Kocijan-Hercigonja D, Jambrosic A: Psychiatric help to psychotraumatized persons during and after war in Croatia. Croatian Medical Journal 2002; 43: 221-228.*
29. *Lubin H, Loris M, Burt J et al.: Efficacy of Psychoeducational Group Therapy in reducing symptoms of posttraumatic stress disorder among multiply traumatized women. American Journal Psychiatry 1998; 155:1172-1177.*
30. *Macksoud MS, Lawrence AJ: The war experience and psychosocial development of children in Lebanon. Child Development 1996; 70-88.*
31. *Miller KE, Weine SM, Ramic A et al.: The Relative Contribution of War Experiences and Exile-Related Stressors to Levels of Psychological Distress Among Bosnian Refugees. Journal of Traumatic Stress 2002; 15: 377-387.*
32. *Mollica RF, McInnes K, Sarajlic N, Lavelle J, Sarajlic I, Massagli MP: Disability associated with psychiatric comorbidity and health status in Bosnian refugees living in Croatia. JAMA 1999; 282: 433-439.*
33. *Mooren TT, de Jong K, Kleber RJ, Ruvic J: The efficacy of a mental health program in Bosnia-Herzegovina: impact on coping and general health. Journal of Clinical Psychology 2003; 59: 57-69.*
34. *Motta RW, Joseph JM, Rose RD, Suozzi JM, Leiderman LJ: Secondary trauma: assessing inter-generational transmission of war experiences with a modified Stroop procedure. Journal of Clinical Psychology 1998; 53: 895-903.*
35. *Murthy RS, R Lakshminarayana: Mental health consequences of war: a brief review of research findings. World Psychiatry 2006; 5:25-30.*
36. *Nelson BS: Post war trauma and reconciliation in Bosnia and Herzegovina: observations, experiences, and implications for marriage and family therapy. The American Journal of Family Therapy 2003; 31: 305-316.*
37. *Pizarro J, Silver RC, Prause JA: Physical and mental health costs of traumatic war experiences among civil war veterans. Archive General Psychiatry 2006; 63: 190-200.*
38. *Powell S, Durakovic-Belko E: Sarajevo 2000: the psychosocial consequences of war, results of empirical research from the territory of former Yugoslavia. International Journal of Human Sciences, 2004.*
39. *Pupovac V: International therapeutic peace and justice in Bosnia. Social&Legal Sudies 2004; 13: 377-401.*
40. *Regional project office of the Mental Health Project for south-eastern Europe: Mental health policies and legislation in South-Eastern Europa. Sarajevo, 2004. Available at: http://www.seemhp.ba/.*
41. *Röper G, Gayranidou M: Capacity building in trauma therapy and trauma research in Bosnia and Herzegovina. New Direction for Youth Development 2003; 98: 99-110.*
42. *Samardzic R, Mandic-Gajic G, Alacov T & Bosic B: The role of day care hospitals in psychosocial rehabilitation of patients with psychiatric war injuries. Vojnosanitetski pregled 1998; 55: 385-390.*
43. *Silove D, Steel Z & Psychol M: Understanding community psychosocial needs after disasters: implication form mental health services. Journal of Postgraduate Medicine 2006; 52:121-125 http://www.bioline.org.br/request?jp06037.*
44. *Simmons RK, Maconochie N & Doyle P. Self-reported ill health in male UK Gulf War veterans: a retrospective cohort study. BMC Public Health 2004; 4:27.*
45. *Stuvland R, Durakovic-Belko E & Kutlaca M: 2001 BHG: Evaluation of psychosocial projects in primary and secondary schools in Bosnia and Herzegovina 1992-1998. http://www.unicef.org/ evaldatabase/index_14154.html.*
46. *Summerfield D: Addressing human response to war and atrocity-major challenges in research and proctices and the limitations of Western psychiatric models. In: Kleber et al. (eds): Beyond trauma-cultural and societal dynamics. New Yourk Plenum Press 1995; 17-31.*

47. *Weine SM, Vojvoda D, Hartman S & Hyman L: A family survives genocide. Psychiatry: Interpersonal & Biological Processes 1997; 60: 24-39.*

Acknowledgement

The authors are grateful to all individuals and institutions that support and helped in developing of better and more modern mental health care in post-war Bosnia-Herzegovina. The special thanks to Miss Jasna Avdagic, for contribution she provided in finalizing this paper.