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# MENTAL HEALTH AND COPING STRATEGIES OF BOSNIAN IMMIGRANTS IN SWITZERLAND

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**Abstract**. *Mental health is more than the absence of mental illness, it is a state of well being in which every individual realizes his/her potentials, can cope with every day stressors, can work productively and is able to contribute to the community. Immigration and its phases represent great sources of stress and stressors. Immigrants need effective coping strategies which can help them maintain their physical as well as mental health. The aim of this study is to explore the persistence of coping strategies in a non clinical population of Bosnian immigrants in Switzerland. Our results showed a statistical significance of the t-test for all the scales (General Health Questionnaire, GHQ 28, Becks Depression Inventory, BDI and Perceived Stress Scale, PSS 14) and subscales of stress, depression, anxiety, somatic complaints, insomnia and social dysfunction. At the same time, the study shows a presence of a primary coping strategy in the form of social support and its use by Bosnian immigrants while dealing with difficulties and problems.*

**Key words**: *mental health, coping strategies, immigrants, Bosnian immigrants.*

## INTRODUCTION

According to Kakar (Fernando S., 2001) the concept of «mental health» is a concept which covers different aspects and concerns such as: the absence of disabling symptoms, the integration of psychological functioning, the successful leading of personal and social life, and the feeling of ethical and spiritual wellbeing. In this paper, we define mental health as the «ability to: think logically and rationally, to adjust to transitions, stress, trauma and losses which happen to everyone, in a way which allows emotional stability and growth» (Hales D. & Hales R.E.1995).

Immigrants belong to an at risk group for mental health disorders due to many pre-emigrational, emigrational as well as post emigrational factors and phases that they go through. Acculturation phases, adjustment, the immigrants' age as well as the effects of

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factors such as small income, immigrant status, low access to psychiatric treatment etc are in close relation to the emergence of mental health problems such as depression, anxiety, suicide, alcohol and drug use by immigrants. Immigrants are at risk for mental health problems due to much pre-migration, migration as well post migration factors and phases which immigrants experience. Immigrants are an at risk population especially when they migrate with low or no prior knowledge about the country they are migrating to. Their coping strategies are not always efficient and acceptable. Coping strategies represent the immigrant's efforts, mainly psychological and behavioral, which the immigrants use to tolerate, decrease or minimize stressful events. Lazarus and Folkman (Horwitz A.V. and Scheid, T. L. 2006) coping strategies define them as «cognitive or behavioral attempts to cope with situational demands that someone perceives demanding or those that overcome someone's ability to cope. In other words, coping is actually a process by which people try to cope with the perceived difference between demands and one's own resources which they assess in a given situation. People cope with certain problems by making certain efforts in order to adjust to a problem or change their perception of it. As such, these efforts could appear in the form of effective or ineffective coping strategies.

Effective coping strategies or social support can decrease the effects of permanent stressors and have a positive effect on immigrants' mental health. On the contrary, ineffective coping strategies which appear in the form of avoidance or retreat when different stressors appear, contribute to the emergence of mental health problems (Busse and O'Mahoney 2000). Coping strategies are normally divided into primary and secondary coping strategies and problem focused and emotion focused coping strategies. Primary coping strategies are direct measures of overt problem focused behavior directed at the occurrence of disturbing events in a stressful environment (looking for social support). Unlike the primary strategies, secondary coping strategies are more cognitive than behavioral and they are most often related to changing perception and assessment of stressful situations and events. In simple words, primary coping strategies mean changing the environment so it will suite "me" and secondary, changing "me" so I will suit the environment.

Looking for social support contributes to the adjustment and helps individuals to easily cope with problems because people with social support are emotionally more stable and cope with different environmental demands, as well as with mental health problems, more easily (Horwitz and Scheid, 2006).

Social support is related to someone's social contacts and relations, social integration and the relations inside a primary group. Social support and relations (resources) and relations with others from which support emerges are not only the basis for mental health but can also serve as protection from the negative effects of different stressors. Resources or sources of coping (social support, strong feelings of control, etc.) and coping strategies reduce or diminish the negative psychological effects of stress and stressors (Horwitz and Scheid, 2006).

Horwitz and Sheid (2006) cite many studies which focused on the significance of the relation between mental health and social support (Cohen and Willis 1985, Cohen and Syme 1985, Dean and Lin 1977, Gottlieb 1981, Kessler et all 1985, Sarason and Sarason 1985, Sarason, Sarason and Pierce 1990, Turner 1983, Vaux 1988, Veil and Bauman 1992). A great many of these studies shows a great correlation between little or no support and ill mental health in general, especially with frequent depression. Cassel and Cobb

with their research have set a preliminary foundation for the hypothesis which dominates these studies: «social support is an important moderator in the effects of life stressors on mental health» and as such it represents a significant protective factor (Horwitz and Scheid, 2006). Ward states that social support is related to an improvement in the psychological wellbeing (greater social support, better psychological wellbeing and vice versa) (Ward, Bochner and Furnham, 2003). Besides, sociological studies in the domain of social support suggest the abating effect of psychological problems when there is strong and present social support, regardless of whether it comes from an ethnic community or local citizens (Khuo and Tsai, 1986).

The aim of this study is to explore the persistence of coping strategies in a non clinical population of Bosnian immigrants in Switzerland. It was assumed that specific coping strategies, which Bosnian immigrants use in coping with everyday problems and difficulties, will be found.

## PARTICIPANTS AND METHODS

### Participants

The participants (N=200) were 48 females and 53 males, aged between 18 and 60, all Bosnian immigrants in Switzerland. The mean age for the total sample was 32.9±6 months, and most of the participants were married individuals who migrated to Switzerland during three periods, before the war of 1992-1995, during the war, and after the war. Of the total number, 129 surveys were completed and delivered to the researcher. A total of 28 of them could only be partially used due to incomplete data (demographics or unanswered questions). The participants were generally healthy and were not cognitively or perceptually impaired. They were recruited from a large Bosnian community in Switzerland.

### Procedure

The process of data collection lasted five months, from January 2007 to May 2007. Participation in the study was voluntary and no compensation was given. The survey, entitled "Mental Health," consisted of the following:

*A general health questionnaire* 28 (GHQ 28) (widely used for similar purposes by, Jancz, 2000 for example, Becks' *depression inventory (BDI)* (Jancz, 2000) and *Perceived stress scale 14 (PSS 14)* and *Demographics*.

*A general health questionnaire 28 (GHQ 28)*: For the purpose of this research we used a general health questionnaire with 28 items, a shortened version of GHQ with 60 items. A general health questionnaire 28 (GHQ 28) is a multiple choice paper pen questionnaire. It is designed to detect current non psychotic psychiatric disorders in the general population. The questionnaire has four subscales: Somatic complaints, anxiety – insomnia, social dysfunction, Major depression.

The general health questionnaire can be administered to adolescents or adults of any age. It is diagnostic but it can be used to detect acute conditions (Goldberg and Hiller, 1979). Since 1972 when Goldberg first created the first version with 140 items, the general health questionnaire has been translated into 38 world languages (Croatian is one of them) and has been validated in more than 50 studies. There are four versions of it at the moment (with 60, 30, 28 and 12 items) available to psychiatrists, qualified doctors, clinical psychologists and experienced counselors (Jancz, 2000). Cronbach's (1951) alpha coefficient for internal validity ranges (for the GHQ 28 version) from .84 to .93 in different studies. Goldberg and Hiller (1979) cite that the test – retest probability coefficient on 87 psychiatric cases with a six-month follow up was .90 (Jancz, 2000) and it appears as a reliable and valid assessment technique for psychological health.

The results for general health questionnaire (GHQ 28) were obtained by adding responses on all the items and summing them up. A higher score implies more mental health problems in the form of depression, anxiety, somatic complaints or social dysfunction.

*Becks' depression inventory (BDI)*: Becks' depression inventory (BDI) is an assessment technique for measuring depression created by Beck et al. in 1961. All 21 items came from clinical observations of specific attitudes and symptoms in patients with depression, which range from neutral to very heavy symptoms (a series of four self-evaluative statements). The inventory covers a category related to open and overt behavioral manifestations of depression such as: mood, pessimism, feeling of failure, lack of satisfaction, etc. For example, I do not feel sad (0), I feel sad (1), I am sad all the time and I can't snap out of it (2) I am so sad or unhappy that I can't stand it (3). Responses were collected using a Likert scale which ranged from 0 –1-2-3. A score of 0-13 is considered minimal range, 14-19 is mild, 20-28 is moderate, and 29-63 is severe. A 25-year long revision of Becks depression scale (BDI) (Beck et al., 1988) has estimated an internal consistency of the alpha coefficient of .81. We have chosen Becks depression inventory for two reasons: (1) to follow up the assessment of the general health questionnaire GHQ 28 and (2) because it is one of the, as Wilson et al. state, most acceptable and most reliable assessment techniques for discovering depression (Jancz, 2000) also used in our country.

*Perceived stress scale (PSS 14)*: The perceived stress scale (PSS 14) is designed for use on a wide population with at least a high school diploma. The items on the scale are easily comprehended and the answers are simple to understand. The questions are very simplified thus having no content which might target any population group and the scale can be administered to a wide population. This scale assesses the degree to which someone estimates a given situation as stressful. It contains seven positive and seven negative items (for example of positive item, "in the last month, how often have you felt that you were unable to control the important things in your life? And negative, "in the last month, how often have you felt difficulties were piling up so high that you could not overcome them"). The PSS 14 scores are obtained by reversing the scores on the seven positive items, e.g., 0=4, 1=3, 2=2, etc., and then summing up across all 14 items. Items 4, 5, 6, 7, 9, 10, and 13 are positively stated items with higher scores indicating greater stress.

Cronbachs' alpha, according to earlier studies for PSS 14 had values of .84 and .86 (Cohen et.al, 1983) while the reliability coefficient in our study was .624.

*Demographics*: A few independent variables given as important predictors which have a positive influence on the mental health of immigrants, as proved by former studies and reports, were also included in our study: gender, marital status, age, year of migration, immigrants status – visa type (B visa – resident and work permit for a year – can be prolonged, or C visa – permanent work and resident permit or CH visa – Swiss citizenship, Employment before migration, Current employment, Length of residency in Switzerland). To determine the coping strategy of Bosnian immigrants in this section we asked them 2 open ended questions: Who do you talk to about your problems/difficulties, who do you seek to talk to about your problems/difficulties.

## RESULTS

The table below shows the results of the variance analysis ANOVA for the variable – who do you talk to about your problems/difficulties – found on the general health questionnaire (GHQ 28), its subscales, depression, anxiety, insomnia, somatic complaints and social dysfunction, Becks depression inventory BDI and Perceived stress (PSS 14).

**Table 1**

| Variable – who do you talk with about your problems/difficulties? Participants-answered **Family and friends** | Variability source | Sum squares | df | Variance | F – ratio | Significance |
|---|---|---|---|---|---|---|
| General health questionnaire (GHQ 28) | Between groups | 3625,568 | 3 | 1208,523 | **7,150** | **,000** |
| | Within groups | 13691,208 | 81 | 169,027 | | |
| | Total variability | 17316,776 | 84 | | | |
| Subscale somatic complaints | Between groups | 122,829 | 3 | 40,943 | 2,069 | ,110 |
| | Within groups | 1820,911 | 92 | 19,793 | | |
| | Total variability | 1943,740 | 95 | | | |
| Subscale social dysfunction | Between groups | 307,292 | 3 | 102,431 | **10,086** | **,000** |
| | Within groups | 903,826 | 89 | 10,155 | | |
| | Total variability | 1211,118 | 92 | | | |
| Perceived stress scale (PSS 14) | Between groups | 3,376 | 3 | 1,125 | ,035 | ,991 |
| | Within groups | 2913,613 | 90 | 32,373 | | |
| | Total variability | 2916,989 | 93 | | | |
| Beck's depression inventory (BDI) | Between groups | 1899,179 | 3 | 633,060 | **7,759** | **,000** |
| | Within groups | 7016,776 | 86 | 81,590 | | |
| | Total variability | 8915,956 | 89 | | | |

Significance $p < 0.05$

Table 2 shows the results for results for the variance analysis ANOVA for the variable – who do you seek to talk to about your problems/difficulties – found on the general health questionnaire (GHQ 28), its subscales, depression, anxiety, insomnia, somatic complaints and social dysfunction, Becks depression inventory BDI and Perceived stress (PSS 14).

**Table 2**

| Variable –who do you seek to talk about your problems/difficulties? Answered: **Family and friends** | Variability source | Sum squares | df | Variance | F - ratio | Significance |
|---|---|---|---|---|---|---|
| General health questionnaire (GHQ 28) | Between groups | 2987,071 | 2 | 1493,535 | **8,444** | **,000** |
| | Within groups | 14326,882 | 81 | 176,875 | | |
| | Total variability | 17313,952 | 83 | | | |
| Subscale somatic complaints | Between groups | 124,474 | 2 | 62,237 | **3,162** | **,047** |
| | Within groups | 1810,853 | 92 | 19,683 | | |
| | Total variability | 1935,326 | 94 | | | |
| Subscale social dysfunction | Between groups | 175,423 | 2 | 87,712 | **7,553** | **,001** |
| | Within groups | 1033,533 | 89 | 11,613 | | |
| | Total variability | 1208,957 | 91 | | | |
| Subscale anxiety and insomnia | Between groups | 181,622 | 3 | 60,541 | 2,657 | ,053 |
| | Within groups | 2141,644 | 94 | 22,783 | | |
| | Total variability | 2323,265 | 97 | | | |
| Perceived stress scale PSS 14 | Between groups | 48,366 | 2 | 24,183 | ,760 | ,471 |
| | Within groups | 2864,537 | 90 | 31,828 | | |
| | Total variability | 2912,903 | 92 | | | |
| Becks depression inventory BDI | Between groups | 1432,382 | 2 | 716,191 | **8,326** | **,000** |
| | Within groups | 7483,573 | 87 | 86,018 | | |
| | Total variability | 8915,956 | 89 | | | |

Significance $p < 0.05$

## DISCUSSION

According to the results obtained by an analysis of variance, our research shows the following: a significant statistical relation between two variables (Who do you talk to about your problems/difficulties and who do you seek to talk to about your problems/difficulties) found on the general health questionnaire (GHQ 28), its subscales, depression, anxiety, insomnia, somatic complaints and social dysfunction, Becks depression inventory BDI and Perceived stress (PSS 14). The most significant relation between the variable who do you talk about problems/difficulties occurs in the complete general health questionnaire GHQ 28 with p = 0,000 and its subscale social dysfunction (also p =0,000) and with Becks depression inventory BDI (p =0,000).

Our research did not show a relation between the variables "who do you talk to and who do you seek to talk with about your problems/difficulties" and the Perceived stress scale PSS 14 (p = ,991 and p = ,471 respectively ). The reasons for such an outcome could be in fact that strong social support and talking with one's family and friends are a recurring phenomenon with Bosnian people. Stressful situations have to be discussed right away, which results in diminishing of stressful factors. Emotional relief appears after such talks. Moreover, sharing problems with others results in, not only in stress relief, but problem solving as well, through social support, information exchange, gaining advice on how others solved similar problems, etc.

Even though social support as one of the coping strategies most often used by Bosnian immigrants in Switzerland, which, according to many studies has proven to serve as a mediator in the appearance and occurrence of mental health problems, it seems that by itself it is not enough. According to our results and the first hypothesis (migration stress negatively affects the mental health of immigrants) it shows that Bosnian immigrants suffer from stress, depression, anxiety, somatic complaints, insomnia and social dysfunction. This has been proven by the significance of the t-test in results on all the scales used in this study (General health questionnaire GHQ 28, Becks depression inventory BDI and Perceived stress scale PSS 14). A possible explanation for such results, which could appear contradictory at first sight, could be summarized in the following notes:

Firstly, significant results which support the thesis of strong social support as a coping strategy of Bosnian immigrants, speaks of the immigrants' two very important coping factors: integration and assimilation. Integration means shaping one's own identity by nurturing one's own traditional values (ethnic country) and adopting cultural traditions of the host country. Assimilation is a process which contains three basic elements: learning and adopting new reactions to the host society, irretrievable changes related to the adoption and acceptance of cultural, historic and intellectual forms of the new, host society and finally, the transformation into a full social member of the given new society. Strong social support from family and friends of Bosnian immigrants in Switzerland could mean the strong social networking of members of one's own ethnic group, which indicates confinement inside oen's own ethnic group and weak or no integration and assimilation.

Second, weak or no integration and assimilation, on the other hand, means weak acceptance by the host society and adjustment to it, which in turn can result in psychological maladjustment, feelings of being discriminated against, a feeling of being a second class citizen, feelings of not belonging there, rejection, feelings of being unwanted, etc. Perceived discrimination is related to increased psychological distress and pain (Furnham and Shiek, 1993 and Ying 1996). These and similar feelings form a good basis for the immigrants' even greater wish to close up into their own ethnic group because they understand each other, have the same or similar problems and thus have the need to meet even more often and discuss their problems. In the end, although their talk about their problems and social support as coping strategy is strong, these feelings of not belonging, discrimination, rejection and so on, leave traces and mental health problems appear thus showing that immigrants are an at risk group when we talk about risks for mental health.

Finally, with this study we discovered that Bosnian immigrants turn to mental health professional little or not at all when they have some problems or difficulties (only 10 % of the participants stated that they turn to mental health professionals). This data also proves a different attitude towards illness and its treatment, which is typical for Bosnian citizens who turn to mental health professional only as a last resort, when they exhaust all the other ways and means.

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# MENTALNOZDRAVSTVENI PROBLEMI I STRATEGIJE SUOČAVANJA BOSANSKOHERCEGOVAČKIH IMIGRANATA U ŠVICARSKOJ

**Selvira Draganović**

*Mentalno zdravlje je više od puke odsutnosti mentalnih poremećaja. To je stanje blagostanja u kojem svaki pojedinac realizira svoje potencijale, nosi se sa svakodnevnim stresorima, može produktivno raditi i doprinositi društvu. Imigracija sa svojim fazama predstavlja velike izvore stresa. Imigranti trebaju efikasne strategije suočavanja koje će im pomoći da očuvaju svoje fizičko i mentalno zdravlje. Cilj ovog rada je da istraži mentalnozdravstvene probleme i strategije suočavanja Bosanskohercegovačkih imigranata u Švicarskoj. Naši rezultati pokazuju statističku značajnost t-testa na svim skalama koje smo koristili (Generalni upitnik zdravlja 28, Bekova skala depresije i skala percipiranog stresa 14) i njihovim subskalama, stres, depresija, nksioznost, somatske tegobe, nesanica i socijalna disfunkcija. Istovremeno, studija pokazuje prisustvo primarne strategije suočavanja (traženje podrške od porodice i prijatelja – socijalne podrške) koju BiH imigranti koriste kad se suočavaju sa svakodnevnim teškoćama-problemima..*

Ključne reči: *mentalno zdravlje, strategije suočavanja, imigranti, bosanskohercegovački imigranti.*