Reasons for Not Receiving Treatment in People With Posttraumatic Stress Disorder Following War

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Abstract: The aim of the study was to explore why people suffering from posttraumatic stress disorder (PTSD) following war do not receive treatment. A total of 212 participants who have PTSD following war in the Balkans and have never received psychiatric treatment were interviewed (86 in Western Europe and 126 in Balkan countries). Answers were subjected to thematic content analysis. Five major and not mutually exclusive themes were identified: "need no help" (57 participants), "personal ways of coping" (72 participants), "negative attitude towards psychiatric treatment" (91 participants), "comparative insignificance" (24 participants), and "external barriers" (65 participants). While most participants, for different reasons, did not want to seek psychiatric treatment, a significant number, particularly in Western European countries, felt prevented from receiving treatment.

Key Words: Trauma, refugees, PTSD, treatment.

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Armed conflicts unfortunately frequently occur in the modern world. Only in the last decade of the 20th century, 40 wars were fought resulting in a total of more than 2 million deaths and 20 million refugees or displaced persons (Firket, 2001). Wars in the former Socialist Federal Republic of Yugoslavia during the 1990s resulted in crimes against civilians which were by far the worst savagery seen in Europe since World War II (Spasojevic et al., 2000). The traumatic experiences that people in the former Yugoslavia encountered included participating in active combat, imprisonment, the destruction of their homes, witnessing killings or atrocities, being wounded or beaten during forced evacuation from their towns, and rape (Arcel and Simunkovic-Tocilj, 1998).

There is a high prevalence of serious mental disorders including posttraumatic stress disorder (PTSD) following war (Fazel et al., 2005). Significant number of people who suffer from PTSD remain untreated (Sayer et al., 2007) despite the existence of effective treatments (National Institute of Clinical Excellence, 2005).

Studies that looked into factors associated with treatment-seeking following trauma identified various predisposing, enabling and need factors according to Anderson's behavioral model of service use (Andersen and Newman, 1973). Predisposing factors are defined as individual's tendency for mental health service use and are not related to the specifics of the illness, for example age and gender. Enabling factors are defined as those that enable a person to access mental health services and include for example employment status (related to financial means and insurance) and knowledge about services. Finally, need factors refer to subject's own view of the severity of the illness and professionals' assessment of the patient's mental health status. In summary, a review of these studies concluded that higher level of psychopathology, the type and level of the traumatic event, and sociodemographic characteristics, in particular female gender were associated with seeking treatment from mental health services after a traumatic event (Gavrilovic et al., 2005). Recent qualitative study on barriers and facilitators of PTSD treatment initiation (Sayer et al., 2009) further identified that posttrauma sociocultural environment influences help seeking for trauma-related psychiatric problems. Other studies exploring reasons for not seeking treatment following traumatic event mainly applied preconceived list of barriers. These studies identified number of common barriers that can be broadly grouped into "external barriers" related to resources (such as financial obstacles, language barrier, or lack of knowledge about services) and "internal barriers" related to beliefs and attitudes (such as mistrust toward services, not wanting to talk about trauma, etc) (Jankovic, 2006).

This important topic of why people who suffer from PTSD do not receive treatment remains understudied in terms of qualitative studies.

AIM OF THE STUDY

This study was designed to explore the reasons why people with PTSD following war and migration in the former Yugoslavia do not receive treatment. We also investigated whether these reasons are associated with other potential determinants of help seeking such as sociodemographic characteristics, current level of posttraumatic stress, and staying in the Balkans versus taking refuge in Western European countries.

METHOD

The exploratory study on treatment seeking was funded by the European Commission and conducted in 4 countries—Croatia and Serbia as the largest countries in former Yugoslavia and Germany and the United Kingdom as the 2 countries in Western Europe with the highest numbers of refugees following the war in the Balkans (Eurostat, 2004). Research teams were based at University Departments in the United Kingdom (London) and Germany (Dresden), and nongovernmental organizations providing psychosocial help to people who experienced war trauma in Croatia (Zagreb) and Serbia (Belgrade). However recruitment of participants who did not receive treatment for PTSD was designed to include different groups of people (as described below) and involved interviewing participants in different parts of each country.

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Inclusion criteria were as follows:

a. Being of Balkan origin and between 18 and 70 years of age;
b. Having been exposed to potentially traumatic events during the war in the former Yugoslavia in the 1990s;
c. Having a diagnosis of PTSD on The Clinician Administered PTSD Scale for Diagnostic and statistical manual of mental disorders. 4th ed. American Psychiatric Association, 1994. (DSM-IV) according to the original scoring rule proposed by Blake et al. (Blake et al., 1996);
d. Not having received psychological or psychiatric treatment for PTSD;
e. Capacity to provide informed consent.

The recruitment strategy was designed to identify participants from different groups who experienced war, i.e. refugees, war veterans and civilians. In all countries recruitment was conducted through personal networking and can be described as snowball sampling. In addition to personal networking, research teams devised recruitment strategies specific for each country, for example visiting collective centers in Germany and Serbia, community organizations in the United Kingdom and Germany and war veteran organizations in Serbia and Croatia.

Instruments

1. Sociodemographic data was collected using a form designed for this study.
2. The Clinician Administered PTSD Scale was used to assess current and lifetime diagnosis of PTSD. It is a structured clinical interview designed to assess adults for the symptoms of PTSD outlined in DSM-IV.
3. The Impact of Events Scale Revised (Weiss and Marmar, 1997) was used to assess the current level of PTSD symptoms.
4. An open question was used to assess the reasons for not receiving psychological or psychiatric treatment for symptoms of PTSD since the traumatic event. It has been suggested that this method captures rich information (Cox and Ferguson, 1991). The wording of the open question was "What were your reasons for not seeking or not receiving help from a psychiatrist or psychologist?" The question was asked at the end of the interview after discussing experience of war trauma and PTSD symptoms. If a participant consented, responses to the open questions were tape recorded and subsequently transcribed. If a participant did not consent to tape recording, researchers wrote down answers ad verbatim. Further probes were asked if participant had difficulties answering this question and involved reiterating PTSD symptoms that required treatment which participant reported earlier in the interview.

All study measures were translated into Bosnian, Serbian, Croatian, and Albanian after extensive discussion among the members of the team which included native speakers. Back translation was used to check the word selection.

Procedure

Interviews were conducted in Bosnian, Serbian, Croatian, and Albanian by native speakers and in Germany by a bi-lingual German researcher. Quotes presented in this paper have been translated by bi-lingual researchers working on the study. Researchers conducting interviews were psychologists, a psychiatrist, a social anthropologist, and an ethnologist. Written informed consent was obtained from all participants and ethical approval was obtained in all counties.

Data Analysis

Participants' answers to open questions were subjected to thematic content analysis and 2 raters categorized them independently. An initial list of codes was devised, discussed, and agreed within the research team. Two raters independently coded content of all the answers (J.J. and I.V.) according to this list. One of the raters is an academic psychiatrist and the other one is a clinical psychologist. After extensive discussion, these 2 raters suggested grouping codes into 5 not mutually exclusive themes and this was discussed and agreed within the Team. Content of those codes are described within each theme in the Results section.

Descriptive statistics were used to explore the sociodemographic characteristics and level of symptoms for participants reporting different reasons for not receiving treatment. Mann-Whitney and χ^2-tests were used to identify differences in sociodemographic characteristics and level of symptoms in participants reporting (versus those not reporting) each theme.

RESULTS

Description of the Sample

In 4 countries, a total of 799 participants consented to take part in the study. One-hundred-eleven participants had not experienced any potentially traumatic event during the war in former Yugoslavia, 203 participants were excluded as they had received some form of treatment (183 had psychological or psychiatric treatment, 6 had contact with other mental health services, and 14 received antidepressants from their general practitioner/family doctor [GP]), and 253 participants did not fulfil the criteria for PTSD.

In addition, 3 participants broke the interview off and data on 17 participants were excluded due to a large number of missing data. Consequently, data on 212 participants were analyzed.

Of these, 126 people were still living in the Balkan countries (68 in Croatia and 58 in Serbia) and 86 people were now in Western Europe (44 in the United Kingdom and 42 in Germany). In the whole sample, 154 were refugees, 22 war veterans, 20 were both veterans and refugees, and 16 civilians. In terms of nationality, 6 participants were Albanian, 56 Bosnians, 53 Croatian, 1 Macedonian, 70 Serbian, and 26 "Other" (mainly mixed nationality). Majority (162) of participants experienced first traumatic events in wars between years 1992 and 1995 and minority (50) in the war in year 1999. Mean age of participants was 43.4 years, 110 were females and 50 were employed or in education.

In this article, we refer to participants recruited in the United Kingdom and Germany as "refugees." All were refugees on arrival from the former Yugoslavia, although, at the time of the interview, some had been given citizenship or other forms of leave to remain.

Reasons for Not Receiving Treatment

A total of 129 participants gave answers which were classified in 1 theme only. Answers from other participants were classified into more than 1 theme (67 answers were classified in 2 themes, 15 in 3 themes, and 1 in 4 themes). This illustrates that reasons for not receiving treatment are often complex.

As described above, 2 raters independently categorized answers. A small number of codes (20 of 312) did not match. Following discussion in the research team, a consensus was achieved on the categorization of all answers.

Need No Help (57 Participants)

These participants considered their war experiences as stressful and acknowledged their symptoms. However, they did not believe that these symptoms are part of mental illness that requires treatment. Their explanatory model was that it is a normal reaction to stressful events of war. This theme was often combined together

with other reasons for not receiving help, primarily with employing personal ways of coping that helped with symptoms so that professional help was not required. Following is an example of a participant who reported both of these themes together:

"I did not have any reasons to ask for help. Difficulties go away when I talk to my family" (ID 791; 35-year-old female refugee, Serbia).

Some participants compared themselves to others and the perception that other people need help more (theme "comparative insignificance") made their posttraumatic stress symptoms seem insignificant and not serious enough to require treatment. Therefore these 2 themes were reported together.

"I did not believe that I was a 'difficult' case. There are so many people who need help more and who did not ask for it" (ID 18; 40-year-old female refugee, United Kingdom).

Personal Ways of Coping (72 Participants)

These participants found their own ways of coping with the distress caused by war trauma. The answers often included a description of how they tried to cope with symptoms. In some cases, these descriptions were general, for example "being busy," while in others it was more specific, typically mentioning work and being with friends or family.

"I have always tried to be busy; I think that working and being focused on something will help more" (ID 89; 26-year-old male refugee, United Kingdom).

"I thought that psychological problems will go away if I work hard physically, and it helped for a while" (ID 585; 35-year-old male war veteran, Croatia).

Personal ways of coping are often reported in combination with "negative attitude to treatment," for example, together with the perception that nobody can understand their problems. This theme is also often reported together with reasons belonging to the "need no help" theme (as described above).

"It will go away over time. I do not need help as I can cope on my own, and I think that nobody can understand my problems" (ID 338; 28-year-old male refugee and war veteran, Germany).

Negative Attitude Toward Treatment (91 Participants)

The most common reason for not receiving treatment was a "negative attitude toward psychiatric/psychological treatment." This was a heterogeneous group of reasons that have in common negative view of treatment.

The answers comprised of 2 subgroups, the first one describing doubts that psychological/psychiatric treatment can be helpful (43 participants). The second subgroup (65 participants) did not receive treatment because they did not want to talk about trauma. This is because they were not motivated to seek treatment, perceived help seeking as shameful, stigmatizing, and culturally inappropriate, or did not believe anyone can understand them.

"Reasons are pride and dignity. I have never spoken about that to anyone. I do not think anyone would understand me" (ID 753; 51-year-old male war veteran and refugee, Serbia).

Other important reason for not wanting to talk about trauma was that they feared it might have negative repercussions for their legal status or job situation.

"I was in the Army, if I asked for help I would have lost a job" (ID 609; 51-year-old male war veteran, Croatia).

Some reported more than 1 negative attitude that were then classified in both subgroups. For example, not believing in talking therapy and being ashamed to talk about it.

"I do not believe in psychology. I do not believe that it can be cured by words. You can only overcome it yourself. I would be ashamed to ask for help in the UK and to describe what we have done in former Yugoslavia …" (ID 37, 60 years old male refugee, United Kingdom).

The most common overlap of this theme was when negative attitude was combined with "external barriers" to accessing care, for example language barrier or concerns about confidentiality:

"The language was a problem and I was also worried about confidentiality, about disclosing information" (ID 236; 46-year-old male refugee, United Kingdom).

Comparative Insignificance (24 Participants)

These answers described that others, in particular family members or other members of the community, needed help more. For example:

"My wife needed help more; I had to be strong for my family" (ID 217; 50-year-old male refugee, United Kingdom).

"It was not necessary, at least we are all alive, other people had worse losses" (ID 513; 42-year-old female civilian, Croatia).

Some described that other duties, such as child care and work, were more important than seeking help. For example:

"I did not know about help and did not have time to think about it. I had to do house jobs and look after my family" (ID 230, 39-year-old female refugee, Germany).

As shown in the example above, this was rarely the sole reason for not receiving treatment but often combined with other themes such as "external barriers," "need no help," or "personal ways of coping."

External Barriers (65 Participants)

External barriers prevented these participants from receiving treatment. Some participants sought treatment but did not receive it (e.g., not being referred by the General Practitioner/family doctor), while others experiences hurdles even in the attempt to seek treatment (for example, lack of knowledge about services, language barriers, and financial problems).

"I wanted to see a psychologist but I have had a problem with the language, and I did not want my kids to interpret because that would upset them. If I wanted to ask for an interpreter, it would be emphasized how much it cost …" (ID 83; 40-year-old female refugee, United Kingdom).

"I asked my GP to be referred to psychological help but I was told the waiting list was too long that it's not worth it. The GP suggested medication but I declined" (ID 36, 25-year-old female refugee, United Kingdom).

"I had no money to pay for travel costs . . ." (ID 423, 56 years old male refugee, German center).

If more than 1 reason for not receiving treatment was reported in this group, it was most commonly "negative attitude towards treatment" as described under that theme.

Sociodemographic characteristics and PTSD symptoms in participants reporting different reasons for not receiving treatment.

Table 1 presents the sociodemographic characteristics (that are potential predisposing and enabling factors in treatment seeking) and current level of PTSD symptoms (according to the Impact of Events Scale Revised) for participants reporting versus those not reporting each theme of reasons for not receiving treatment.

Participants who reported "need no help" ($U = 2785.5$, $N = 212$) and "personal ways of coping" ($U = 3646.5$, $N = 212$) had significantly lower level of PTSD symptoms while participants reporting "negative attitude toward treatment" ($U = 4160.5$, $N = 212$) and "external barriers" ($U = 3808.0$, $N = 212$) had higher level of these symptoms.

With regards to gender, "negative attitude toward treatment" was significantly more often reported by males (χ^2 [1, $N = 212$] = 20.3), while "comparative insignificance" was more commonly reported by females (χ^2 [1, $N = 212$] = 10.7).

TABLE 1. Socio Demographic and Clinical Characteristic of Participants Who Reported 5 Different Themes of Reasons for Not Receiving Treatment

	1. Need No Help	2. Personal Ways of Coping	3. Negative Attitude Toward Treatment	4. Comparative Insignificance	5. External Barriers
Characteristics of participants who reported the theme					
Western Europe	15*	21*	46*	13	40**
Balkan	42	51	45	11	25
Female	58%	54%	34%**	83%**	60%
Employed	33%*	35%***	24%	25%	9%**
IES-R (mean) participants					
Who reported the theme	2	2.1	2.5	2.3	2.5
Who did not report the theme	2.5**	2.5**	2.2***	2.3	2.2*
Age (mean) participants					
Who reported the theme	42.1	43.3	42.0	41.7	43.7
Who did not report the theme	43.8	43.4	44.4	43.6	43.2

IES-R indicates the Impact of Events Scale Revised.
*$p < .05$.
**$p < .001$.
***$p < .01$.

When differences in employment (or being in education) were explored, participants reporting "need no help" (χ^2 [1, N = 212] = 4.1) and "personal ways of coping" (χ^2 [1, N = 212] = 7.5) were more likely to be employed or be in education than the participants who did not report these themes. Those reporting "external barriers" (χ^2 [1, N = 212] = 10.7) were less likely to be employed or be in education than participants who did not report this barrier.

"External barriers" (χ^2 [1, N = 212] = 17.1), and "negative attitude toward treatment" (χ^2 [1, N = 212] = 6.6) were reported more often as reasons for not receiving treatment in refugees in Western Europe, while participants from Balkan countries cited "personal ways of coping" (χ^2 [1, N = 212] = 5.9) and "need no help" (χ^2 [1, N = 212] = 6.6) more frequently as a reason for not receiving treatment.

DISCUSSION

Main Findings

Most of the people with PTSD following war in the Balkans who have never received psychiatric treatment, had not sought it because they felt they did not need it, had found alternative ways of coping, had no trust in psychiatric treatment or saw their problems as comparatively insignificant. However, there is a significant number of people particularly among refugees in Western Europe, who also have high level of symptoms and are unemployed, who felt prevented from getting treatment mostly because of barriers in the given healthcare system. Many participants reported more than 1 reason for not receiving treatment therefore indicating that the process of seeking and receiving help for PTSD following war trauma is often complex.

Strengths and Limitations

This is the first study assessing the views of different groups of people with PTSD (such as, veterans, refugees, and civilians) following war in different countries on why they did not receive treatment. It used strict inclusion criteria, standardized assessment instruments, and a qualitative methodology which is more appropriate to capture the full variation of views than a preconceived list of barriers used in the majority of previous studies (Gavrilovic et al., 2005). The study applied the same methodology across the 4 different countries in the Balkans and in Western Europe. This is a particular strength since many studies focus only on refugees in Western countries in which case it remains unclear whether the findings can be generalized to the population that stayed in the area of conflict.

The study also has several limitations. In terms of qualitative methodology, responses to an open-ended question do not offer as much detail as those obtained from in-depth interviews. Another limitation is the nonrandom nature of the selection process. The sample in this study cannot be assumed to be representative of all people with PTSD following war who never received psychiatric treatment, and there may have been a selection bias in the included countries. This makes the interpretation of quantitative findings difficult, and they should be interpreted with caution. However, the impact of the selection process on the qualitative data is less prominent and unlikely to have influenced the content of each theme. Although our method of recruitment through personal networking resulted in a nonrandom sample, it possibly reached some people with high avoidance symptoms who otherwise would not have participated in research about trauma but agreed to do so because researchers were "recommended" by a friend or a family member. The development of themes inevitably involves a degree of subjectivity. We tried to limit this by involving 2 raters and discussing any disagreements so that consensus could be reached. Information about symptoms and treatment history was obtained only from participants' self reported retrospective account, and there was no external validation of this information.

Reasons for Not Receiving Treatment

Many participants report more than 1 reason for not receiving treatment as described below in the overlap of different themes, therefore indicating that the process of treatment seeking can be complex.

A large number of participants, even though they have had PTSD think they do not need help and view their mental health difficulties as a "normal reaction" to war events rather than an illness that requires treatment. These participants were more often from Balkan countries, have lower level of PTSD symptoms, and are more likely to be employed or in education that those who do not report this theme as reasons for not receiving treatment. There are 2

not mutually exclusive possibilities—either people with lower level of PTSD are more able to function and find employment/stay in education, or working/studying can serve as a coping strategy that reduces level of PTSD.

A large number of these people have their own successful ways of coping with the distress which often involve structured activities such as work or being with friends and family. These 2 themes have a significant overlap, and some participants say they do not need help because symptoms were alleviated with their own coping strategies. It is important to recognize significance of these personal resources and explanatory systems in a natural recovery from traumatic war experiences. In addition, personal ways of coping are more commonly described by participants who were employed and stayed in the Balkans, who may have had easier access to informal support such as friends and family, than refugees in Western Europe.

Previous studies looking into barriers to treatment in people with PTSD who are not receiving treatment also identified these beliefs (not needing treatment and coping on their own) as common reasons for not seeking treatment (Kulka et al., 1990; Rodriguez et al., 2003).

Participants who state that a negative attitude toward treatment was the reason for not seeking and receiving help are significantly more often male and have higher level of PTSD symptoms (Table 1). They are also more often refugees in Western Europe. These negative attitudes are comprised of views that treatment is inefficient, culturally inappropriate, and stigmatizing, but also include the avoidance of talking about the traumatic events and mistrust. Similar discouraging beliefs toward treatment have been identified in previous studies (Koenen et al., 2003; Stecker et al., 2007).

Avoidance of trauma-related stimuli is one of the diagnostic clusters of PTSD and has been identified in other studies (Sayer et al., 2009) as a barrier to treatment in people with PTSD. Compared with other symptoms of PTSD, it is specific as in some cases it can serve as a coping strategy (particularly if intensity of avoidance and its' impact on individual's functioning are not severe) rather than a symptom of psychopathology. This represents an inherent challenge in use of services for people with PTSD as one of the symptoms of the disorder can be at the same time reason why people do not get treatment.

The question arises on whether not seeking treatment because of negative views should be considered as an "informed choice" or misconception about treatment? As current treatments for PTSD involve talking about trauma and may be stressful in a short term, it may be difficult to justify encouraging treatment for someone who views it negatively and wants to avoid it. Also, the lack of motivation and negative expectations from treatment are likely to negatively influence its effectiveness and a recent review of treatments for PTSD among refugees and asylum seekers suggested that future interventions should be developed within refugees' cultures based on local understanding of trauma and psychological distress (Crumlish and O'Rourke, 2010). However, it is important that these people with negative views have accurate information about treatments available rather than possible prejudices and misconceptions, and this is particularly relevant as many of these people have high level of PTSD symptoms. Therefore, disseminating information about possible treatment options within target groups, for example men in community refugee organizations, might be appropriate and may reduce the stigma associated with psychiatric and psychological treatment. Stigma seems to be an important factor in preventing some people from asking for professional help. There are 2 significant overlaps of this theme. The overlap of the themes of negative attitude toward treatment and personal ways of coping indicates that these participants are able to employ their own coping strategies which are more acceptable than psychological or psychiatric treatment. The overlap of themes negative attitude toward treatment and external barriers suggests that difficulties in accessing mental health services may have led to disappointment with services, which in turn was reflected in negative attitude to treatment.

While 4 other themes have all been identified in previous studies, comparative insignificance has not and seems to be specific for this group of participants. The response appears to reflect sociocultural influences in shaping individual's response to traumatic event, for example in giving priority to social commitments to family over individual needs. Also, unlike traumas that affect only individuals war in former Yugoslavia was a collective experience by the whole community. This may have led to a perception that fellow citizens who suffered bigger losses, in particular the loss of a family member, are more "entitled" to psychological help. This theme was more often reported by females. The role of looking after others and keeping a family "together" may be seen as central and more important than paying attention to individual distress and treatment needs for woman. This is in line with the observations made by Papadopoulos and Hildebrand (Papadopoulos and Hildebrand, 1997) who interviewed Bosnian families in which mothers prioritized the needs of their children and men before considering what would be important for themselves. A study on coping strategies in people from former Yugoslavia suggested that different coping strategies may be successful for man as compared with woman, at least for intrusive symptoms (Gavrilovic et al., 2003).

External barriers were reported by a large number of participants who described difficulties in accessing services such as language barriers, the GP as an obstacle, and a lack of information about services. Other studies on treatment seeking following traumatic event, identified these barriers as common both in refugees and in veterans (McFall et al., 2000; Westermeyer et al., 2002; Yeung, 1988).

In our study, these external barriers were more often perceived in Western European countries, by those who had higher level of PTSD symptoms and were unemployed (more than 80%). Although mental health services in the United Kingdom and Germany were better organized than in war-torn Balkan countries during 1990s, refugees in Western countries were probably not familiar with the health care system. That together with cultural differences and language problems may have been difficult hurdle to overcome in obtaining help. The association between high level of symptoms and barriers to treatment has been shown in other studies, for example in Maguen and Litz (2006), where soldiers most in need of services are also those who report the most barriers to care. Furthermore, association between external barriers and unemployment points toward a link between access to services and socioeconomic status as these individuals may not have been able to afford it. Even in countries like the United Kingdom where essential medical treatment was available free of charge for refugees from former Yugoslavia, availability of psychological treatment varied and financial difficulties may have prevented people from seeking this type of help in a private sector where they had to pay for treatment.

Findings from a study on life in exile in a clinical group of refugees from former Yugoslavia in Sweden indicate that a main problem is a vicious circle of high symptom levels and poor social situation (Kivling-Boden and Sundbom, 2002). These findings are from a clinical group, but the vicious circle may be even more problematic for people who have high level of distress and are unemployed but are not receiving treatment because of external obstacles.

CONCLUSIONS

The findings suggest that most of the people with PTSD who did not receive psychiatric treatment following war in the Balkans did not actively seek treatment. Their reasons for this varied. They include personal attitudes and opinions about treatment, different explanatory models of their psychological distress, and the existence of other successful ways of coping. Therefore, the intervention in this group should focus mainly on mental health promotion and providing accessible information to ensure that enough information about treatment possibilities is available to allow an "informed choice."

A more active approach is required for a minority of participants, particularly for those who have experienced more external barriers to accessing mental health services. They are more often refugees in Western countries, unemployed, and have higher level of posttraumatic stress. Therefore they potentially represent a socially marginalized group that requires active support to access appropriate treatment, particularly in Western countries. This can be done through information campaigns to GPs and increase in language support, in particular as evidence-based treatment can be delivered via interpreters (D'Ardenne et al., 2007). If mental health services do not address barriers to treatment, there is a risk of labeling distressing psychological symptoms as "a normal response" and inefficiency of services as appropriate care. Information campaigns are likely to become especially important if and when new waves of war traumatized refugees enter the country. Such campaigns, however, only make sense if services have enough capacity to provide appropriate treatment for those distressed refugees who would want to receive treatment.

As shown by the results of this study, treatment-seeking process can be complex and influenced by a variety of factors. Further research, particularly using qualitative methods, is required to explore and provide more in-depth understanding of effect of these factors on treatment seeking and their interactions.

In conclusion, the results of the study show that while many people suffering from PTSD following war view their difficulties as "normal" or do not want treatment for other reasons, a significant minority would like to receive professional help but have encountered obstacles in accessing services.

REFERENCES

Andersen RM, Newman JF (1973) Societal and individual determinants of medical care utilisation in the United States. *Milbank Mem Fund Q Health Soc*. 51:95–124.

Arcel L, Simunkovic-Tocilj G (Eds) (1998) *War Violence, Trauma and the Coping Process*. Zagreb (Croatia): Nakladnistvo Limun.

Blake DD, Weathers FW, Nagy LM, Kaloupek DG, Klauminzer G, Charney DS, Keane TM (1990) A clinician rating scale for assessing current and lifetime PTSD: The CAPS-1. *Behaviour Therapist,* 13, 187–188.

Cox T, Ferguson E (1991) Individual differences, stress and coping. In: Cooper CL, Payne R (Eds), *Personality and Stress: Individual Differences in the Stress Process* (pp 7–30). Chichester (United Kingdom): Wiley.

Crumlish N, O'Rourke K (2010) A systematic review of treatment for posttraumatic stress disorder among refugees and asylum seekers. *J Nerv Ment Dis*. 198:237–251.

D'Ardenne P, Farmer E, Ruaro L, Priebe S (2007) Not lost in translation: Protocols for interpreting trauma-focused CBT. *Behav Cogn Psychother*. 35: 293–301.

Eurostat (2004) *Population Statistic—Data 1960–2003*. Available at: http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-BP-04–001/EN/KS-BP-04–001-EN.PDF.

Fazel M, Wheeler J, Danesh J (2005) Prevalence of serious mental disorder in 7000 refugees resettled in western countries: A systematic review. *Lancet*. 365:1309–1314.

Firket H (2001) Wars of the 1990's. *Med Confl Surviv*. 17:337–347.

Gavrilovic J, Lecic-Tosevski D, Dimic S, Pejovic-Milovancevic M, Knezevic G, Priebe S (2003) Coping strategies in civilians during air attacks. *Soc Psychiatry Psychiatr Epidemiol*. 38:128–133.

Gavrilovic JJ, Schuetzwohl M, Fazel M, Priebe S (2005) Who seeks treatment after a traumatic event and who does not? A review of findings on mental health service utilization. *J Trauma Stress*. 18:595–605.

Jankovic J (2006) *Reasons for Not Seeking Treatment in Refugees With Posttraumatic Stress* [MD thesis]. London (United Kingdom): University of London.

Kivling-Boden G, Sundbom E (2002) The relationship between post-traumatic symptoms and life in exile in a clinical group of refugees from the former Yugoslavia. *Acta Psychiatr Scand*. 105:461–468.

Koenen KC, Goodwin R, Struening E, Hellman F, Guardino M (2003) Posttraumatic stress disorder and treatment seeking in a national screening sample. *J Trauma Stress*. 16:5–16.

Kulka RA, Schlenger WE, Fairbank JA, Hough RL, Jordan BK, Marmar CR, Weiss DS (1990) *Trauma and the Vietnam War Generation: Report of Findings from the National Vietnam Veterans' Readjustment Study*. New York (NY): Brunner/Mazel.

Maguen S, Litz BT (2006) Predictors of barriers to mental health treatment for Kosovo and Bosnia peacekeepers: A preliminary report. *Mil Med*. 171:454–458.

McFall M, Malte C, Fontana A, Rosenheck RA (2000) Effects of an outreach intervention on use of mental health services by veterans with posttraumatic stress disorder. *Psychiatr Serv*. 51:369–374.

National Institute of Clinical Excellence (2005) *Posttraumatic Stress Disorder (PTSD) Clinical Guidelines*. London (United Kingdom): National Institute of Clinical Excellence. Available at: http://www.nice.org.uk/page.aspx?o=57890.

Papadopoulos R, Hildebrand J (1997) Is home where the heart is? Narratives of oppositional discourses in refugee families. In: Papadopoulos RK, Byng-Hall J (Eds), *Multiple Voices: Narrative in Systemic Family Psychotherapy (Tavistock Clinic Series)* (pp 206–236). London (United Kingdom): Duckworth.

Rodriguez BF, Weisberg RB, Pagano ME, Machan JT, Culpepper L, Keller MB (2003) Mental health treatment received by primary care patients with posttraumatic stress disorder. *J Clin Psychiatry*. 64:1230–1236.

Sayer NA, Clothier B, Spoont M, Nelson DB (2007) Use of mental health treatment amongst veterans filing claims for post-traumatic stress disorder. *J Trauma Stress*. 20:15–25.

Sayer NA, Fridemann-Sanchez G, Spoont M, Murdoch M, Parker L, Chiros C, Rosenheck RA (2009) A qualitative study on determinants of PTSD treatment initiation in veterans. *Psychiatry*. 72:238–255.

Spasojevic J, Heffer RW, Snyder DK (2000) Effects of posttraumatic stress and acculturation on marital functioning in Bosnian refugee couples. *J Trauma Stress*. 13:205–217.

Stecker T, Fortney JC, Hamilton F, Ajzen I (2007) An assessment of beliefs about mental health care among veterans who served in Iraq. *Psychiatr Serv*. 58: 1358–1361.

Weiss DS, Marmar CR (1997) The impact of event scale revised. In: Wilson JP, Keane TM (Eds), *Assessing Psychological Trauma and PTSD—A Practitioners Handbook* (pp 399–411). New York (NY): Guilford Press.

Westermeyer JJ, Canive JM, Thuras P, Chesness D, Thomson J (2002) Perceived barriers to VA mental health care among Upper Midwest American Indian veterans: Description and associations. *Med Care*. 40(suppl 1):162–171.

Yeung RM (1988) *Help-Seeking Behaviour of Cambodian Refugees Experiencing Posttraumatic Stress Disorder* (UMI, order no. AAD13–33918) [master's thesis]. Long Beach (CA): California State University.