Behaviour Research and Therapy 50 (2012) 805–813

Contents lists available at SciVerse ScienceDirect

Behaviour Research and Therapy

journal homepage: www.elsevier.com/locate/brat

The effects of positive patient testimonials on PTSD treatment choice

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ARTICLE INFO

Article history:
Received 2 July 2012
Received in revised form
10 September 2012
Accepted 12 September 2012

Keywords:
Treatment choice
PTSD
Anxiety
Prolonged exposure
Sertraline
Testimonial

ABSTRACT

Despite the existence of effective treatment options for PTSD, these treatments are failing to reach those that stand to benefit from PTSD treatment. Understanding the processes underlying an individual's treatment seeking behavior holds the potential for reducing treatment-seeking barriers. The current study investigates the effects that positive treatment testimonials have on decisions regarding PTSD treatment. An undergraduate ($N = 439$) and a trauma-exposed community ($N = 203$) sample were provided with videotaped treatment rationales for prolonged exposure (PE) and sertraline treatments of PTSD. Half of each sample also viewed testimonials, detailing a fictional patient's treatment experience. All participants then chose among treatment options and rated the credibility of – and personal reactions toward – those options. Among treatment naïve undergraduates, testimonials increased the proportion choosing PE alone; and among treatment naïve members of the trauma-exposed community sample, testimonials increased the proportion choosing a combined PE plus sertraline treatment. These effects were not observed for those with prior history of either psychotherapeutic or pharmacological treatment. Major barriers exist that prevent individuals with PTSD from seeking treatment. For a critical unreached treatment sample, those who are treatment naïve, positive patient testimonials offer a mechanism in which to make effective treatments more appealing and accessible.

Posttraumatic stress disorder (PTSD) reflects the persistence of an acute reaction over time following exposure to potentially traumatic events such as rape, combat, natural and man-made disasters (e.g., Davis & Lang, 2003). PTSD is characterized by intrusive and uncontrollable memories of the traumatic event, avoidance of trauma cues and reminders, and chronic hyperarousal (American Psychiatric Association, 2000). Estimates suggest that nearly 7% of the civilian population in the United States (Kessler et al., 2005; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995) and as many as 20–30% of America's active and veteran military service members (Kulka et al., 1990; Magruder & Yeager, 2009; Ramchand et al., 2010; Stecker, Fortney, Hamilton, & Ajzen, 2007) meet diagnostic criteria for PTSD. Accordingly, PTSD represents a major mental health concern (Hoge, Auchterlonie, & Milliken, 2006; Hoge et al., 2004).

Effective, empirically-supported treatments exist for chronic PTSD (see Foa, Keane, & Friedman, 2009) including cognitive, exposure-based, and general cognitive-behavioral interventions such as prolonged exposure, cognitive processing therapy, stress inoculation training, and eye-movement desensitization and reprocessing (Bradley, Green, Russ, Dutra, & Westen, 2005). Most notably, prolonged exposure (PE; Foa, Hembree, & Rothbaum, 2007; Foa & Rothbaum, 1998) has a wealth of empirical support and is consistently more effective than wait-list and active treatment control conditions (McLean & Foa, 2011; Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). Similarly, the selective serotonin reuptake inhibitor sertraline has demonstrable superiority to placebo treatment and is a safe and well-tolerated pharmacological treatment of PTSD (Brady et al., 2000; Davidson, Rothbaum, van der Kolk, Sikes, & Farfel, 2001).

Despite known effective treatments, epidemiological data by Kessler et al. (2005) suggests that only 7.1% of individuals seek treatment in the first year after meeting PTSD criteria. Even more startling is that only 65.3% of individuals with PTSD will ever seek treatment; and for those that do, the median time before presenting for treatment is 12.1 years (Wang et al., 2005). Further, only 34.4% of individuals meeting PTSD criteria are seen by a mental health specialist, while 31.3% are seen by a general medical provider (Wang et al., 2005). This resonates with previous work suggesting that chronically anxious individuals generally present to their primary care physicians, though less than a third receive minimally adequate treatment (Hazlett-Stevens et al., 2002; Shear & Schulberg, 1995). Taken together, the majority of individuals with

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0005-7967/$ – see front matter © 2012 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.brat.2012.09.007

PTSD are not getting adequate treatment despite the existence of effective treatment options.

With the impetus for treatment seeking lying primarily upon the individual that is suffering, it is important to understand the perspectives, beliefs, and decision-making processes of individuals contemplating whether to initiate treatment. Barlow (2004) noted that consumers of mental health treatment often have clear preferences, frequently favoring psychosocial interventions to pharmacotherapy. Indeed, in a study of treatment preferences for the symptoms of PTSD, 87.4% chose prolonged exposure, while only 6.9% opted for sertraline, and 5.7% elected a no-treatment option (Zoellner, Feeny, Cochran, & Pruitt, 2003). A similar preference pattern was replicated across trauma-exposed and treatment-seeking individuals with chronic PTSD (Feeny, Zoellner, & Kahana, 2009; Roy-Byrne, Berliner, Russo, Zatzick, & Pitman, 2003). Research into the reasons that underlie an individual's PTSD treatment preferences suggests that the key issues influencing treatment choice are highly ideographic (Swift & Callahan, 2010). The reasons cited for specific treatment preferences include factors that increase the appeal of the preferred treatment (e.g., conceptualization of the problem as cognitive/behavioral versus biological), as well as factors associated with the non-preferred treatment that individuals wish to avoid (e.g., side effects; practical considerations; Cochran, Pruitt, Fukuda, Zoellner, & Feeny, 2008; Jaeger, Echiverri, Zoellner, Post, & Feeny, 2010).

However, the client's perception of the treatment mechanism may be one of the strongest predictors of treatment preference and offers insight into how to reduce treatment-seeking barriers that delay or prevent treatment seeking behavior (Angelo, Miller, Zoellner, & Feeny, 2008). Discussions of mechanism, however, typically occur after initial treatment seeking is completed and the individual has already started treatment, thus failing to address the barriers facing treatment seekers that hold a stigmatized view of therapy, who are ambivalent about seeking treatment, or who are unsure of how, where, and whether to seek treatment. These barriers argue for the use of marketing strategies that give a treatment-seeking individual information that can be utilized when making decisions about pursuing treatment.

Information, communicated by a peer who has had a positive experience with a specific treatment, is one such strategy that may alter patient preferences by relaying actual experience in the form of a positive patient testimonial (Braverman, 2008). Testimonials have been successfully used to convey health information (Braverman, 2008; Buller, Young, Fisher, & Maloy, 2007) and have a demonstrated ability to influence consumer decision-making (e.g., Shimp, Woo, & Smarandescu, 2007; Slater & Kelly, 2002). The use of patient testimonials provides an individual that is weighing treatment options with the opportunity to inform their decision, dispel potential treatment myths, and provide hope and successful treatment expectancy (Almasi, Stafford, Kravitz, & Mansfield, 2006).

Patient testimonials are commonly utilized in the advertisements of psychotropic medications (Macias, Stavchansky, & Baek, 2010; Sokol, Wackowski, & Lewis, 2010) but are not commonly used in disseminating psychosocial interventions. We are unaware of any prior research that has experimentally explored the role of patient testimonials in altering patient preferences for particular treatments for chronic PTSD. In one of the few direct investigations of testimonials for a psychosocial intervention, Morawska, Nitschke, and Burrows (2011) reported that video testimonials provided to parents of children with behavioral problems did not significantly increase the favorability of particular interventions; however, testimonials did increase parents' confidence in the effectiveness of a selected treatment option. This effect occurred regardless of whether the testimonial was generated by a peer or an expert.

The present study directly manipulated the presence or the absence of videotaped patient testimonials for two commonly utilized PTSD treatments, prolonged exposure and sertraline, in the treatment of chronic PTSD. All participants received detailed videotaped treatment rationales for both sertraline and prolonged exposure by medical providers. Presence or absence of positive patient testimonials was directly manipulated by providing participants with video of actors portraying actual comments made by real patients with a history of PTSD that had been treated with either sertraline or prolonged exposure. To maximize the generalizability of the findings, both a large undergraduate sample and a trauma-exposed community sample were examined. Specifically, we investigated the impact of patient testimonials on treatment preference, confidence in preference, and credibility and personal reactions to sertraline, prolonged exposure, a combination treatment of prolonged exposure with sertraline, and no treatment. We hypothesized that individuals who are provided with positive patient testimonials will be more likely to prefer an active treatment compared to the no-treatment option. Given low rates of preference for psychotropic treatments in past research (e.g., Zoellner et al., 2003), we hypothesized that providing testimonials will have a greater effect on the preference of sertraline alone and sertraline with prolonged exposure, compared to prolonged exposure alone. We also hypothesized that individuals who were provided testimonials, regardless of treatment type, would have higher confidence ratings, greater credibility, and more positive personal reactions ratings than individuals who were not provided with testimonials.

Method

Participants: undergraduate sample

Four hundred and thirty-nine individuals ($N = 439$) were recruited via undergraduate psychology subject pools at two large metropolitan university campuses. Inclusion criteria included being between the ages of 18 and 65 years old and fluent in English. Demographic information can be seen in Table 1. Within this sample, 51.9% ($n = 228$) reported experiencing at least one or more potentially traumatic events on the Posttraumatic Stress Diagnostic Scale (PDS; Foa, Cashman, Jaycox, & Perry, 1997). Of these, allowing for multiple events to be experienced by single individuals, 30.3% reported a life-threatening illness, 46.9% reported a serious accident, 36.8% a natural disaster, 33.8% a non-sexual assault, 23.2% a sexual

Table 1
Mean, standard deviation, percentages and range on demographic variables and psychopathology measures.

	Undergraduate sample ($N = 439$) *M* (*SD*)/%	Community sample ($N = 203$) *M* (*SD*)/%
Age (range 18–65)	19.00 (1.35)	38.92 (12.53)
Education (years)	12.80 (1.12)	13.30 (1.18)
Gender (% female)	57.8	57.9
Ethnicity		
Caucasian	57.0	35
Asian or Asian American	27.9	1.0
African American	3.7	55.5
Hispanic	3.7	5.5
Other	7.7	3.0
Prior psychotherapy	20.5	65.0
Prior pharmacotherapy	9.7	55.7
PTSD diagnosis (PDS)	14.7	45.7
PTSD severity (PDS, range 0–51)	6.69 (8.22)	21.48 (13.71)
Depression (QIDS; range 0–27)	5.33 (3.70)	10.23 (5.89)

Note. PDS = Post-Traumatic Stress Disorder Diagnostic Scale, QIDS = Quick Inventory of Depressive Symptomatology.