



Published in final edited form as:

Behav Ther. 2008 March ; 39(1): 13–21. doi:10.1016/j.beth.2007.02.002.

“I Need to Talk About It”: A Qualitative Analysis of Trauma-Exposed Women’s Reasons for Treatment Choice

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Abstract

A significant proportion of individuals suffering from posttraumatic stress disorder do not seek or receive effective treatment. Understanding the reasons why an individual chooses to seek treatment or prefers one treatment to another is a critical step to improve treatment seeking. To begin to understand these reasons, we conducted a qualitative analysis of the reasons women gave for choosing a cognitive-behavioral treatment, prolonged exposure (PE), or a pharmacological treatment, sertraline (SER). A community sample of women with trauma histories were asked to view standardized rationales, to choose among PE, SER, or no treatment, and to give 5 reasons for their choice. Women indicated that they were more likely to prefer the psychotherapy to the medication. Across reasons given, the most commonly cited reason for treatment preference highlighted why or how the treatment worked (e.g., I need to talk about it); and this reason emerged as the strongest predictor of preference for PE. Understanding this role of perceived treatment mechanism may aid clinicians and public health policy officials to identify and address help-seeking barriers regarding treatment.

Female survivors of sexual or nonsexual assault often are unlikely to seek help for assault-related psychological symptoms (Amaya-Jackson et al., 1999; Kimerling & Calhoun, 1994; Solomon & Davidson, 1997). If they do, it may be years after the precipitating event and the onset of posttraumatic stress disorder (PTSD) symptoms (Breslau, Davis, Andreski, & Peterson, 1991; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Kessler et al., 2005; Wang et al., 2005). Given the range of efficacious psychotherapy and pharmacotherapy options available for the treatment of chronic PTSD (e.g., Friedman, 2003; Rauch & Cahill, 2003), it is unfortunate that many women do not seek or receive timely care. Women’s treatment preferences may play an important role in understanding if, when, and where women are likely to seek psychological or psychiatric services following trauma exposure. In addition, this understanding may help those in contact with these women to identify and address help-seeking barriers regarding various treatment options (Barlow, 2004; Hazlett- Stevens et al., 2002).

Across clinical samples, a growing number of studies suggest a general preference for psychotherapy over pharmacotherapy (Bedi et al., 2000; Chilvers et al. 2001; Dwight-Johnson,

Sherbourne, Liao, & Wells, 2000; Goldstein and Rosselli, 2003; Hofmann et al., 1998; Priest, Vize, Roberts, Roberts, & Tylee, 1996; Roy-Byrne, Berliner, Russo, Zatzick, & Pitman, 2003; Walker, Vincent, Furer, Cox, & Kjernisted, 1999; Zoellner, Feeny, Cochran, & Pruitt, 2003). Moreover, although a number of studies have examined factors associated with treatment seeking following a traumatic event (Gavrilovic, Schutzwohl, Fazel, & Priebe, 2005), we are aware of only three published studies to date that have examined the role of treatment preference in regard to trauma exposure and related symptoms (Roy-Byrne et al., 2003; Wagner et al., 2005; Zoellner et al., 2003). Roy-Byrne and colleagues (2003) explored the preference for medication, counseling, or combined treatment in women seen in the emergency room after a physical or sexual assault. Many women indicated an interest in both medication and counseling; however, a stronger preference for counseling was reported. Further, a preference for counseling was associated with a preference for receiving treatment in general, prior treatment history, sexual assault, and perception of life threat during the assault. However, it is important to note that standardized treatment descriptions were not employed; thus, knowledge about existing treatment options was solely dependent on participants' own conceptualizations about these options. Furthermore, as Roy-Byrne et al. (2003) suggest, treatment preferences reported in the immediate aftermath of assault may shift over time as more is learned about available treatment options and depending on the extent of the survivor's need for psychological assistance.

In contrast to the approach of Roy-Byrne and colleagues, Zoellner et al. (2003) provided individuals with detailed rationales for various treatment options and explored treatment preferences. Specifically, undergraduate women with varying degrees of trauma exposure were given a hypothetical scenario involving a sexual assault and subsequent trauma-related psychological problems. After reading matched, standardized treatment rationales, women were then asked to make a forced choice among psychotherapy, pharmacotherapy, or no treatment. Consistent with Roy-Byrne et al. (2003), women showed a strong preference for psychotherapy. Women's ratings of treatment credibility and their personal reactions to each treatment were associated with their choice of treatment. Both the perceived mechanism underlying a treatment's efficacy and wariness of treatment side effects emerged as commonly cited reasons underlying treatment choice. Furthermore, these findings were similar for a subsample of women with prior trauma exposure and current PTSD. However, it is important to note that, although this study examined hypothetical treatment preferences, these findings may not generalize to trauma-exposed women with chronic trauma-related symptoms.

More recently, Wagner and colleagues (2005) explored the relationship between anxiety disorders, including PTSD, and beliefs about psychotherapy and medication in men and women recruited from a primary care setting. By telephone interview, participants stated how much they agreed, on a 5-point Likert scale, with six statements about medication and eight statements about psychotherapy. Overall, participants rated psychotherapy more favorably, but no differences in beliefs were found between individuals with a specific anxiety disorder diagnosis and those without. Wagner and colleagues suggested this might be due to the high comorbidity of diagnoses, not allowing for the examination of treatment beliefs by specific disorders. Further, medication and psychotherapy statements were not matched for anxiety symptoms, and individuals were not asked to consider statements in the context of choices they might make for the treatment of symptoms related to anxiety problems. Interestingly, consistent with previous studies (e.g., Dwight-Johnson et al., 2000), non-Caucasians rated both medication and psychotherapy less favorably than did Caucasians.

These strong findings highlighting the preference for psychotherapy raise important unanswered questions. Specifically, it is unclear what factors underlie this preference. Ultimately, one of the best ways to understand what the influential factors are is to ask individuals the reasons underlying their preferences. Qualitative analyses of these reasons will

help to provide a conceptual framework for key factors and perhaps provide a starting point from which to begin to better address barriers to help seeking. In the present study, a community sample of women exposed to potentially traumatic events viewed videotaped, therapist-delivered treatment rationales. The women were then asked to give their treatment preference and to list the top five reasons underlying this preference. Our primary goals were: (a) to examine the content and valence of women's reasons and (b) to examine the influence of demographic factors, psychopathology, and qualitative reasons on treatment choice.

Method

PARTICIPANTS

Participants were 74 women from the Seattle, WA (Department of Psychology, University of Washington) and Cleveland, OH (Department of Psychiatry, Case Western Reserve University) areas who responded to advertisements seeking women with trauma histories. Participants were part of a larger study on treatment choice (Feeny, Zoellner, Mavissakalian, & Roy-Byrne, submitted for publication). Participants ranged in age from 18 to 69 ($M=31.82$, $SD=13.10$). The majority of women were Caucasian (76.1%) followed by African American (14.1%), Asian American (4.2%), and other (5.6%). Nearly all the women were high school graduates (98.6%), with 32.4% of those reporting at least some college. Current household income was less than \$20,000 per year for 39.2%, between \$20,001 and \$50,000 for 28.4%, and over \$50,000 for 32.4%. Three participants did not complete all measures and thus were excluded from analyses, resulting in a final sample size of $N=71$. See Table 1.

Whereas all of the sample reported experiencing some type of potentially traumatic event, only 71.6% reported experiencing a *DSM-IV* Criterion-A traumatic event (American Psychiatric Association [APA], 2000), and slightly over half of the women (52.7%) met current diagnostic criteria for PTSD based on the Posttraumatic Stress Diagnostic Scale (PDS; Foa, Cashman, Jaycox, & Perry, 1997). Many of these women reported having previously sought treatment, with 76.1% reporting prior experience with psychotherapy and 67.4% reporting prior experience with psychotropic medications. Both prior psychotherapy ($M=3.81$, $SD=2.08$) and prior psychotropic medications ($M=2.94$, $SD=2.21$) were rated as somewhat effective, on a scale ranging from 0 (*not at all*) to 6 (*very much so*). Participants received \$20.00 per hour for their participation in the study.

MATERIALS

Videotaped treatment rationales—Videotapes of a therapist delivering rationales for both psychotherapy and pharmacotherapy were developed. The segments showed a therapist facing the camera and describing each treatment as if talking directly to a client. Each rationale segment featured the same middle-aged, Caucasian woman who was not involved in any other aspect of this study. Each description was approximately 5 min long and included several sections: background information, hypothesized treatment mechanisms, treatment procedures, and treatment side effects. The psychotherapy treatment option focused on prolonged exposure (PE; e.g., Foa & Rothbaum, 1998) and the pharmacotherapy option focused on sertraline (SER; e.g., Brady et al., 2000). These rationales did not differ on sentence structure, syntax, and grade level as measured by the Microsoft Word 2000 word-processing package. Earlier versions of these rationales were published in Zoellner et al. (2003) and revised rationales are available upon request.

Reasons for choice—The forced-choice question read as follows: "If you had a choice between medication, individual therapy, or no treatment to help you with trauma-related symptoms (e.g., nightmares, upsetting thoughts, fear), which would you choose?" To get a sense of both the range of factors that influenced the choice of treatment and the factor that

was most influential in that decision, participants were then asked the open-ended question, “What factors influenced your choice? Please list and RANK all the factors (1=*most important* to 5=*least important*) you considered in making the decision between medication, therapy, and no treatment.” With this ranking, participants were forced to choose only one reason as primary, not allowing for multiple ratings of equal importance. Order of the wording for medication, therapy, or no treatment was counterbalanced across participants for both questions.

MEASURES

Psychopathology measures—To assess PTSD, comorbid psychopathology, and secondary indicators of posttrauma functioning, the following self-report measures were utilized: the Posttraumatic Diagnostic Scale (PDS; Foa et al., 1997), the Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emery, 1979), the Anxiety Sensitivity Index (ASI; Reiss, Peterson, Gursky, & McNally, 1986), and the State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, & Lushene, 1970). For the current sample, internal consistency for all measures was acceptable (α ranging from .88 to .94).

Qualitative coding—All primary reasons were coded in three ways. First, reasons were coded for treatment modality (PE, SER, or no treatment). Second, reasons were coded for valence (positive, negative, or neutral) using a 1 (*positive*), 0 (*neutral*), -1 (*negative*) scale. Examples of positive reasons are: “Convenience of the treatment” and “Therapy seems most thorough and effective, and would help with other areas of life.” Examples of negative reasons are: “I don’t like medication” and “I don’t want to relive the trauma.” Only one reason was coded as neutral, and therefore, only positive and negative valence codes were used in subsequent analyses. Third, reasons were categorized into one of five content categories: (a) health concerns, reflecting statements regarding the treatment’s effects on mental or physical well-being (e.g., “I don’t want to be dependent on the medication.”); (b) practical considerations, reflecting statements regarding treatment cost and convenience (e.g., “I don’t want to take pills everyday”); (c) treatment efficacy, reflecting the perceived ability of the treatment to work (e.g., “Drugs work better”); (d) treatment mechanism, reflecting statements regarding how the treatment works (e.g., “You need to talk about the trauma”); and (e) “other,” reflecting statements that could not be categorized (e.g., “Therapy [top choice]”). Two post-baccalaureate research assistants coded all reasons. These research assistants, using a coding manual, practiced coding to reliability ($k > .80$) using a separate data set prior to independently coding all reasons. Coders were blind to treatment preference. Inter-rater reliability of independent coders for the primary reason was good across categories: mode (PE, $k = .94$; SER, $k = .91$), valence ($k = .92$), and content (health concerns, $k = .85$; treatment efficacy, $k = .87$; practical considerations, $k = 1.00$; and treatment mechanism, $k = .88$). Because two raters rated all primary ratings, the rater’s ratings used for data analysis were randomly selected.

PROCEDURE

After informed consent procedures, participants completed self-report psychopathology measures and viewed the videotaped rationales. To control for order effects, the presentation of rationales was counterbalanced. Participants then selected their treatment preference and gave five reasons for their choice, with the primary reason given first. All procedures were completed individually using a computer for presentation and responses. Finally, participants were debriefed and paid for their participation.

Results

CHOICE OF TREATMENT AND REASONS FOR CHOICE

Consistent with prior research, more women chose PE (81.7%, $n=58$) than SER (12.7%, $n=9$) or no treatment (5.6%, $n=4$), $\chi^2(2, N=71)=75.24, p<.05$. Prior experience with psychotherapy ($p=1.00$, Fisher's exact test) or psychotropic medications ($p=.40$, Fisher's exact test) did not influence treatment choice. Further, ratings of effectiveness of prior psychotherapy were not associated with choice of PE ($r=.07, ns$), and ratings of effectiveness of prior psychotropic medications were not strongly associated with choice of SER ($r=.20, ns$).

Overall, participants gave a total of 271 reasons. On average, women reported 3.66 reasons ($SD=1.45$). Of the 71 primary reasons given, approximately half the women (49.3%) cited reasons about the perceived treatment mechanism. Twenty-three percent (22.5%) of the women cited treatment efficacy, and 22.5% of the women cited health concerns. Only 2.8% cited practical considerations as the primary reason underlying their choice. No primary reasons were coded in the other category. A similar pattern emerged when all five reasons were combined: 39% perceived treatment mechanism, 34% treatment efficacy, 22% health concerns, and 5% practical considerations.

TREATMENT MODALITY, VALENCE, AND THE CONTENT OF THE PRIMARY REASON

Overall, 50.7% of the primary reasons were about PE ($n=36$), 45.1% were about SER ($n=32$), and 4.2% were about no treatment ($n=3$), $\chi^2(2, N=71)=27.41, p<.05$. In regard to the valence of the primary reasons, 53.5% of the reasons were negative ($n=38$), 45.1% were positive ($n=32$), and only 1.4% were neutral ($n=1$), $\chi^2(2, N=71)=33.24, p<.05$. To assess whether one type of treatment modality was mentioned more positively or more negatively than another, a chi-square analysis was conducted using modality (PE, SER) and valence ratings (negative, positive). Of the women who cited PE, 75% gave positively valenced reasons, whereas of the women who cited SER, only 9% gave positively valenced reasons, $\chi^2(1, N=68)=29.59, p<.05$.

To further understand women's opinions about the treatment options, we then examined each of the four content categories (treatment mechanism, treatment efficacy, health concerns, practical considerations) separately, comparing both mode and valence within content category. Of the statements that cited treatment mechanism, 89.5% about PE were positive, whereas only 14.3% of the statements about SER were positive, $\chi^2(1, N=33)=18.66, p<.05$. Similarly, of the statements that cited treatment efficacy, 72.7% of the statements about PE were positive, whereas only 20% of the statements about SER were positive, $p=0.08$, Fisher's exact test. Of the statements that cited health concerns, only 25% of the statements about PE were positive, and none of the statements about SER were positive, $p=.25$, Fisher's exact test. Cell size for practical considerations ($n=1$) was too low for analysis. Thus, across specific areas of content, consistent with the overall pattern described above, women gave reasons that tended either to be negative about SER or positive about PE.

PREDICTION OF TREATMENT CHOICE

To examine association between demographic factors, psychopathology, and qualitative reasons and treatment preference, we next conducted a series of logistic regressions. For these analyses, due to the low number of individuals who chose either SER or no treatment, these groups (SER and no treatment) were combined and coded as 0, and choice of PE was coded as 1. Thus, analyses focused on prediction of choosing or not choosing PE. First, to explore whether demographic factors were related to treatment preference, age, years of education, ethnicity (Caucasian=0, non-Caucasian=1), income (0=greater than \$20,000/year, 1=\$20,000 or less/year household income), and traumatic event (no *DSM-IV* Criterion A event=0, Criterion A event=1) were included in the logistic regression. As can be seen in Table 2, there

was a trend for this model to be reliably different from the constant-only model, $\chi^2(5, N=71) = 9.72, p=.08$, with only higher education associated with choosing PE. Overall correct prediction was 87.3%, with 100% correct prediction of PE and 30.8% correct prediction of not choosing PE.

To explore the relationship between psychopathology and choice, two logistic regressions were conducted. We first examined whether specific PTSD symptom clusters (reexperiencing, avoidance, arousal) predicted treatment choice. We then examined whether other forms of psychopathology (depression, anxiety sensitivity, state anxiety, and trait anxiety) predicted choice. Neither equation was reliably different from the constant-only model. See Table 2. When examining a PTSD diagnosis only subsample ($n=39$), the results were unchanged for both PTSD clusters and general psychopathology regressions predicting choice of PE.

Finally, to explore whether particular qualitative reasons (treatment efficacy, treatment mechanism, health concerns, practical considerations) were associated with treatment preference, a final logistic regression was conducted. For the independent variable, summary scores of each participant's reasons were calculated to account for the likelihood that some women often gave variations of the same reason. Summary scores for each category ranged from 0 (*no reasons coded in that category*) to 5 (*all 5 reasons coded in that category*). As can be seen in Table 2, this model was reliably different from the constant-only model, $\chi^2(4, N=71) = 16.38, p<.05$, with statements citing treatment mechanism predicting choice of PE and a trend toward statements citing health concerns predicting not choosing PE. Overall correct prediction was 84.5%, with 94.8% correct prediction of PE and 38.5% correct prediction of not choosing PE.

Discussion

The present study addressed the underlying question of why women prefer one treatment to another for trauma-related symptoms. When asked why, almost half of the women (49.3%) reported that the main reason influencing their treatment preference was the perceived mechanism underlying the effectiveness of the treatment. More specifically, women's reasons often reflected the desire to talk about what had happened to them and the implicit notion that this is what would make treatment effective. Both treatment effectiveness (22.5%) and health concerns (22.5%) also emerged as common reasons provided for treatment preference. Surprisingly, only 2.8% of the women cited practical concerns as the primary reason underlying their treatment preference. Consistent with Zoellner et al. (2003), this study extends previous findings to a trauma-exposed sample and more explicitly examines the nature of the reasons underlying treatment preference. Across all categories of reasons, perceived mechanism emerged as the strongest predictor of ultimate treatment choice of PE. Furthermore, consistent with a general preference for psychotherapy over pharmacotherapy (Barlow, 2004), despite the equating of treatment rationales, the reasons women gave were usually positive regarding prolonged exposure and negative regarding sertraline. Among demographic and psychopathology factors, only higher years of education was associated with an increased likelihood to choose PE. Our results, which highlight the importance of beliefs about mechanisms underlying a treatment, echo Wagner et al. (2005), who suggested that, rather than making assumptions about treatment beliefs and expectations, clinical assessment of treatment-related beliefs may be critical for increasing treatment adoption and adherence.

Interestingly, although the videotaped rationales provided hypothesized treatment mechanisms, participants often suggested their own hypotheses about what mechanism was important for recovery. Specifically, within the treatment mechanism category, the majority of women who chose PE emphasized the importance of talking about or dealing with the trauma memory as necessary for improvement (76.7% of those who gave this reason; e.g., "I think

you need to talk about it with somebody;” “Confronting trauma is important for healing”). The majority of these reasons were positive. This perception of the need to talk about or deal with the event may reflect commonly held beliefs about how recovery from psychological problems occurs and from personal experiences of talking out problems (Hayes, Kohlenberg, & Melancon, 1989; Hayes & Wilson, 1993). Alternatively, this emphasis on mechanism may be specific to the perceived external cause of trauma-related symptoms and may not generalize to other psychological or psychiatric conditions. As one woman put it, “The problem is psychologically based, so the therapy must be also.”

In contrast, when women gave reasons about the pharmacotherapy that highlighted treatment mechanism, the majority of the reasons were negative. In particular, these reasons revealed an underlying concern that psychiatric medications mask symptoms (e.g., “I think that medication is a way to cover thoughts and mask things that are happening to you”), that psychiatric medications offer temporary relief (e.g., “Medication is only a temporary solution”), and that pharmacotherapy does not teach needed skills (e.g., “Wouldn’t give you a chance to learn to cope with symptoms”). These statements seem to echo the same underlying belief suggested above, namely that psychotherapy is needed to get to the “root” of the trauma-related symptoms. Accordingly, these reasons reveal an important potential misconception regarding pharmacotherapy for trauma-related symptoms. Namely, despite explicitly being told of the established efficacy of sertraline in the pharmacotherapy treatment rationale, women indicated that they believed medications do not adequately promote trauma-related recovery. Thus, beliefs that psychotherapy is the only way to ameliorate suffering may lead female trauma survivors to conclude that their treatment options are limited, and this may preclude these women from pharmacological treatment options, despite the established efficacy of these options.

Another reason that emerged as a potential predictor of treatment preference was health concerns; citing such concerns was predictive of choosing sertraline or no treatment. This was surprising given that the majority of participants who expressed health concerns reported fear of medication side effects or possible addiction to medication. However, concerns about the negative effects of psychotherapy also were coded in this category (e.g., “The prolonged exposure therapy sounds like it would be too uncomfortable”). Accordingly, it may be that women who cited health concerns were uncomfortable seeking treatment in any form. Indeed, an examination of the reasons given by the women who chose no treatment showed that their reasons tended to focus on the negative aspects of receiving treatment in general. For example, one woman’s reasons included: “I don’t like to take medications,” “I don’t like doctors,” and “I especially don’t like talking to strangers.” However, it should be noted that there were only a small number of women who chose no treatment and cited any health concerns (5.6%, $n=4$) and thus the importance of this should not be overly interpreted.

Among the demographic and psychopathology factors, higher education was associated with choosing prolonged exposure. Similar findings that higher education level predicts choosing psychotherapy have been previously reported (Hazlett-Stevens et al., 2002). Our results from a less-educated, community sample highlight the generalizability of education as an independent predictor of treatment preference and are consistent with the observed relationship between higher education and the receipt of nonmedical treatment reported by the National Comorbidity Survey Replication (Kessler et al., 2005). The lack of association between minority status and preference should not be overly interpreted due to the basic, categorical nature of this classification and the small minority sample in this study. Notably, none of the psychopathology factors were associated with predicting treatment choice. In previous studies, greater levels of psychopathology and comorbidity were associated with a greater willingness to consider pharmacotherapy (Bedi et al., 2000; Hazlett-Stevens et al., 2002). Both Bedi et al. (2000) and Hazlett-Stevens et al. (2002) recruited participants from medical facilities whereas

we recruited participants from the community via advertisement. Thus, individuals recruited from medical facilities may already exhibit a greater willingness to receive medications and potentially may even have expectations of receiving psychotropic medications for their trauma-related symptoms. Although our sampling may capture a broader sample of PTSD sufferers (e.g., Amaya-Jackson et al., 1999), a non-treatment-seeking sample may have lower levels of psychopathology, thereby restricting the range with which to detect a potential relationship.

One of the main limitations of the present study is its focus on a theoretical, rather than a real, treatment choice. Moreover, this study used a forced-choice scenario and did not provide treatment based on the participant's choice. When seeking treatment, patients may be confronted with varying treatment options ranging from only one option to multiple options. As suggested by both DeSteno and Salovey (1996) and Harris (2003), in a forced-choice situation, choosing one option inappropriately indicates decreased interest in another option when more complex relationships may exist. Despite this important point, when other psychotherapies for PTSD are included, exposure-based therapies are still ranked among the most preferred (Tarrier, Liversidge, & Gregg, 2006). Similarly, eventual treatment choice could be influenced by the expectation of and practical matters related to actually receiving treatment and thus may be different from hypothetical treatment choices. Other factors, besides prior treatment and its perceived success, such as the current treatment and the time elapsed since previous treatment may also impact actual choice. When factors such as access to care, ability to pay, and level of distress are included in the choice decision, women might decide differently. Further, this sample was not currently treatment seeking, though the majority had sought mental health treatment, and only half met *DSM-IV* criteria for current PTSD. Thus, we do not know whether perceived viability of treatment would look different in a sample of women ready to commit to treatment. Likewise, as we focused exclusively on women in this study, it is unclear if these results would generalize to men who have experienced traumatic events.

Our findings have clear clinical applications. With fewer than 30% of sexual assault survivors ever seeking services for the psychological sequelae of trauma (George, Winfield, & Blazer, 1992; Golding, Siegel, Sorenson, Burman, & Stein, 1989) and with the lifetime prevalence of PTSD ranging as high as 50% to 80% for this group (Breslau et al., 1991; Kessler et al., 2005; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993), a need exists to identify women suffering from PTSD and to assist them to seek out a beneficial treatment. Whereas most providers are well versed in their own treatment rationales, our data suggest that providers need to become well versed in describing the hypothesized treatment mechanisms underlying alternative treatments. These discussions also would do well to engage women's preferences and concerns in an effort to increase treatment adoption and adherence (Addis & Jacobson, 2000). Given that practical considerations such as transportation problems, unstable housing situations, cost of treatment, and time consideration often are cited when dropping out of PTSD treatment (Zayfert & Becker, 2000) but were not commonly cited as reasons regarding preference, it may be important for clinicians to draw attention to and discuss potential practical barriers up front with clients prior to treatment choice. Doing this early on may help to prevent premature treatment discontinuation. Importantly, providers should also address up front misconceptions about alternative treatments that may preclude women from seeking help. In particular, providers should be able to offer biological theories for the etiology of PTSD and the efficacy of psychopharmacology and be able to set realistic expectations of side effects in an effort to address the established preference for psychotherapy over medication and to encourage the adoption of accessible, efficacious treatment.

Acknowledgements

We would like to thank Sheridan Stull and Jennifer Goodpaster at CWRU and Larry Pruitt and Seiya Fukuda at UW for their help with data collection. This study was supported in part by a grant to Drs. Zoellner and Feeny from the Anxiety Disorders Association of America (ADAA). In addition, we would like to thank Drs. Matig Mavissakalian and Peter Roy-Byrne for their support on this ADAA grant.

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Table 1
Sample demographic and psychopathology characteristics

Variable	Range	Mean	SD
Age	18–69	31.82	13.10
Event Type (%)			
Adult or Childhood Sexual Assault	58.1%		
PTSD Severity (PDS)	0–43	22.10	11.48
Reexperiencing Cluster	0–15	5.67	3.92
Avoidance Cluster	0–19	8.67	5.27
Hyperarousal Cluster	0–15	7.75	3.77
Depression (BDI)	0–42	13.51	9.86
Anxiety (STAI)			
State Anxiety	23–75	47.49	12.53
Trait Anxiety	28–78	50.83	13.12
Anxiety Sensitivity (ASI)	21–74	43.00	12.23

Note. PDS=Posttraumatic Diagnostic Scale; BDI=Beck Depression Inventory; STAI=State Trait Anxiety Inventory; ASI=Anxiety Sensitivity Inventory.

Table 2
Logistic Regression Analyses for Prediction Treatment Choice (PE)

Variables	B	SE	Wald	p	Odds ratio
Demographics					
Ethnicity (0=Caucasian, 1=non-Caucasian)	-.67	.84	.63	.43	.51
Income (1=less than \$20,000/year)	.17	.77	.05	.83	1.19
Age	-.03	.02	1.32	.25	.97
Education (years)	.47	.19	5.91*	.02	1.60
Criterion A Event	-.45	.87	.27	.60	1.58
PTSD Clusters					
Re-experiencing (PDS)	.01	.12	.01	.90	1.01
Avoidance (PDS)	-.03	.09	.11	.75	.97
Hyperarousal (PDS)	.04	.13	.09	.76	1.04
Psychopathology					
Depression (BDI)	-.01	.05	.08	.77	.90
State Anxiety (STAI)	.01	.04	.07	.80	1.01
Trait Anxiety (STAI)	-.03	.04	.39	.53	.97
Anxiety Sensitivity (ASI)	.03	.03	.87	.35	1.03
Reasons					
Treatment Mechanism	.97	.45	4.58*	.03	2.63
Health Concerns	-.72	.37	3.85	.05	.49
Treatment Efficacy	-.28	.34	.65	.42	.76
Practical Considerations	-.24	.61	.16	.69	.79

* Note. $p < .05$. PDS=Posttraumatic Diagnostic Scale; BDI=Beck Depression Inventory; STAI=State Trait Anxiety Inventory; ASI=Anxiety Sensitivity Inventory.