Going direct to the consumer: Examining treatment preferences for veterans with insomnia, PTSD, and depression

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ARTICLE INFO

Abstract

Inclusion of consumer preferences to disseminate evidence-based psychosocial treatment (EBPT) is crucial to effectively bridge the science-to-practice quality chasm. We examined this treatment gap for insomnia, post-traumatic stress disorder (PTSD), depression, and comorbid symptoms in a sample of 622 young adult veterans through preference in symptom focus, treatment modality, and related gender differences among those screening positive for each problem. Data were collected from veteran drinkers recruited through targeted Facebook advertisements as part of a brief online alcohol intervention. Analyses demonstrated that veterans reported greater willingness to seek insomnia-focused treatment over PTSD- or depression-focused care. Notably, even when participants screened negative for insomnia, they preferred sleep-focused care to PTSD- or depression-focused care. Although one in five veterans with a positive screen would not consider care, veterans screening for both insomnia and PTSD who would consider care had a preference for in-person counseling, and those screening for both insomnia and depression had similar preferences for in-person and mobile app-based/computer self-help treatment. Marginal gender differences were found. Incorporating direct-to-consumer methods into research can help educate stakeholders about methods to expand EBPT access. Though traditional in-person counseling was often preferred, openness to app-based/computer interventions offers alternative methods to provide veterans with EBPTs.

1. Introduction

A decade ago, the Institute of Medicine (2006) mandated the gap between research and practice be addressed through both scientific findings and patient preferences. Yet the longstanding chasm between research findings and practice of evidence-based psychosocial treatments (EBPTs) continues to exist (Barlow, 2004; Butler et al., 2006; Glasner-Edwards and Rawson, 2010; Lancaster et al., 2016; Weisz et al., 2006). “Direct-to-consumer” is an approach to address this gap and engages patients and caregivers to increase consumer awareness and demand for quality EBPTs when available (Becker, 2015). In that model, understanding individuals’ treatment preferences is crucial and can complement EBPT roll-outs by increasing the probability that individuals access available care. This is particularly important within the Veterans Affairs Healthcare System (VA), where EBPTs are nationally implemented to address the mental health care needs of over nine million United States (U.S.) veterans every year (Cook et al., 2015; Eftekhari et al., 2013; Karlin et al., 2012, 2015, 2013; Karlin and Cross, 2014; Watts et al., 2014).

Despite national EBPT roll-outs within the VA, only about half of U.S. veterans in need seek care (Bagalman, 2013; Schell and Marshall, 2008; Department of Veterans Affairs, 2013), in part due to well-documented barriers including multiple comorbidities, perceived stigma, availability of services, and gender differences in pursuit of treatment (Department of Veterans Affairs, 2006; DeViva et al., 2016; Kehle et al., 2011; Kulesza et al., 2015; Pietrzak et al., 2009; Seal et al., 2010). Women are more likely to use outpatient mental health services and report higher levels of distress, yet once men recognize their symptoms, men and women are equally likely to use services (World Health Organization, 2002; Wang et al., 2007). However, there remains a gap in knowledge about gender differences in treatment preference, especially with respect to modality of services. Taken together, these barriers are particularly important to address in a system such as the VA where EBPTs should be widely available given the government initiatives to offer such care to all veterans who need it.

With respect to comorbidities and stigma, insomnia is a primary complaint of the military population (Alexander et al., 2016; Hoge et al.,...
care (Department of Veterans Affairs (World Health Organization, 2002; Wang et al., 2007), women are traditionally more likely than men to seek mental health help for mental health symptoms (McDermott et al., 2017; Nash et al., 2009; Westphal and Convoy, 2015). Symptoms perceived as physical (e.g., problems with sleep) may be more digestible, and, as such, they may be more willing to pursue care for sleep problems over PTSD and depression care, which may be perceived to be more stigmatized.

In addition to knowing veterans’ symptom-focus preferences, knowing their preferences for treatment modality may also increase the likelihood of veterans accessing care. Indeed, the VA offers multiple telehealth care options for veterans with insomnia, PTSD, and/or depression (e.g., Gehman et al., 2016; Luxton et al., 2016; Porcar et al., 2009), as well as mobile application (“app”) and Internet-based approaches (e.g., Kuhn et al., 2014, 2016). Although some qualitative work has explored treatment preferences with veterans seeking VA care (e.g., preference for behavioral or pharmacological therapy; Epstein et al., 2012), preferences for treatment modality (e.g., in-person care versus self-delivered via mobile app or Internet) among veterans with insomnia, PTSD, and/or depression have been largely unexplored.

The present study was designed with three aims to better understand veterans’ treatment preferences for insomnia, PTSD, and depression care. First, we examined veterans’ preferences for symptom focus related to the three mental health concerns. Based on the rationale that veterans may view sleep problems as less stigmatizing than PTSD and/or depression symptoms, we hypothesized they would report higher willingness to seek care to address sleep concerns over the others. Second, we examined treatment modality preferences (i.e., in-person counseling, mobile application/online treatment, neither, or both) among those screening positive for each of the three targeted concerns, hypothesizing veterans would report a high degree of preference for mobile/internet-based care given perceived stigma among this population and other barriers to seeking in-person care. Lastly, we explored gender differences in preference for symptom focus and treatment modality. Although women are traditionally more likely than men to seek mental health services (World Health Organization, 2002; Wang et al., 2007), women veterans face significant barriers to seeking VA care, such as limited resources available to women veterans within VA clinics, concerns about safety and comfort, and few outreach efforts encouraging pursuit of VA care (Department of Veterans Affairs, 2015). Findings from this study can help researchers and clinicians better develop interventions and treatments aligning with veteran preferences, as well as provide researchers and clinicians with important information about how to couch recruitment and outreach efforts to veterans in need.

2. Method

2.1. Participants and procedures

All materials and procedures were approved by the local Institutional Review Board. Data were collected as part of a larger alcohol intervention study with young adult veterans recruited via Facebook to target a non-clinical sample outside the VA (Pedersen et al., 2017b). Eligibility criteria were: age between 18 and 34; separation from active duty service in the Air Force, Army, Marine Corps, or Navy; and, a score on the 10-item Alcohol Use Disorder Identification Test (Saunders et al., 1993) of at least 3 (women) or 4 (men). Although participants were recruited for an alcohol intervention study, very low alcohol use criteria were used to enroll participants in an effort to enroll veteran drinkers of various levels. In addition, the advertisements were devised to attract non-treatment seeking individuals, with advertisements not mentioning treatment/intervention, but rather a brief survey followed by feedback (i.e., the “Veteran Behaviors Feedback Study”). Eligible participants completed a baseline survey and were randomized to receive the intervention or an attention control condition (N = 784). One month later, 79% (N = 622) of these participants completed a follow-up survey where the measures for the present study were added; thus, data are cross-sectional and from the 622 participants at follow-up. More details about the larger study are described further in previous work (Pedersen et al., 2016, 2017a).

2.2. Measures

2.2.1. Demographics and military characteristics

Participants responded to questions regarding age, gender, race, ethnicity, former branch of service, rank at discharge, and pay grade at discharge.

2.2.2. Treatment receipt

Participants were asked if in the past month they had attended an appointment at a VA facility for a mental health concern (e.g., stress, depression, nightmares), an alcohol or substance use concern, or any other reason (e.g., physical exam, compensation/pension). Participants indicated if in the past month they had attended an appointment at a non-VA clinic, hospital, doctor’s office, or at a Vet Center for a mental health concern.

2.2.3. Behavioral health symptoms

Participants completed the Insomnia Severity Index (ISI), to assess the severity of nighttime and daytime insomnia in the past two weeks (Bastien et al., 2001). Possible scores ranged from 0 to 28, with summary scores of 10 indicating an optimal cutoff for insomnia (Morin et al., 2011). The 8-item Patient Health Questionnaire (PHQ-8; no suicidality item) assessed depression symptoms over the past two weeks (Kroenke et al., 2009). Scores ranged from 0 to 24 with cutoff scores of 10 indicating optimal screening for a depression diagnosis (Kroenke et al., 2009). Participants also completed the 20-item PTSD Checklist (PCL-5;Weathers et al., 2013). Scores ranged from 0 to 80 with cutoff scores of 33 indicating optimal screening for a PTSD diagnosis (Wortmann et al., 2016).

2.2.4. Willingness to seek care (preferences for symptom focus)

Participants completed a modified version of the Intentions to Seek Counseling Inventory (Cash et al., 1975; Cepeda-Benito and Short, 1998) and rated how likely (1: very unlikely-4: very likely) they were to consider “counseling” (i.e., talking with a therapist individually or in a group) if they were experiencing (1) difficulty falling or staying asleep (not including nightmares), (2) feeling down, depressed, or hopeless, (3) having little interest or pleasure in doing things they used to enjoy, (4) nightmares or recurring thoughts about a stressful experience, (5) avoiding people or places they used to go that remind them of a stressful experience, (6) being constantly on guard, watchful, or easily startled, and (7) feeling numb or detached from others, activities, or surroundings. Item 1 reflected insomnia, items 2 and 3 were averaged to reflect depression (r = 0.82), and items 4 through 7 were averaged to reflect PTSD (α = 0.95).

2.2.5. Treatment modality preference

Using a measure developed for this study, participants responded to four items regarding preferences for treatment modality (see Table 1).
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