

Exposure Therapy for PTSD Delivered to Veterans via Telehealth: Predictors of Treatment Completion and Outcome and Comparison to Treatment Delivered in Person

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Recent research has focused on the effectiveness of evidence-based psychotherapy delivered via telehealth services. Unfortunately to date, the majority of studies employ very small samples and limited predictor and moderator variables. To address these concerns and further replicate and extend the literature on telehealth, the present study investigated the effectiveness of 12-session exposure therapy delivered either via telehealth ($n=62$) or in person ($n=27$) in veterans with posttraumatic stress disorder (PTSD). Findings demonstrated that although older veterans and Vietnam veterans were more likely to complete the telehealth treatment, telehealth findings were not influenced by patient age, sex, race, combat theater, or disability status. Exposure therapy delivered via telehealth was effective in reducing the symptoms of PTSD, anxiety, depression, stress, and general impairment with large effect sizes. Interestingly, exposure therapy via telehealth was less effective than exposure therapy delivered in person; however, lack of random assignment to condition limits

conclusions of differential effectiveness. Overall, these findings support the utility of telehealth services to provide effective, evidence-based psychotherapies.

OVER THE PAST DECADE, growing interest has focused on using advances in technology to improve the accessibility of mental health services. One such venue is incorporation of telehealth into treatment options. Telehealth involves using telecommunication technology to provide assessment and treatment to patients (for review, see [Frueh et al., 2000](#); [Monnier, Knapp, & Frueh, 2003](#); [Richardson, Frueh, Grubaugh, Egede, & Elhai, 2009](#)). Research demonstrates that telehealth services may have numerous advantages over standard in-person care, such as decreasing patients' costs (e.g., transportation costs, travel time, and missed work), providers' costs, and increased system coverage area to providers ([Dunn, Hongyung, Almagro, Recla, & Davis, 2000](#); [Trott & Blignault, 1998](#)). Investigations of these procedures in numerous settings and populations exist, and include research on patients in rural areas ([Brown, 1998](#); [Grady & Melcer, 2005](#)), older adults in community dwellings ([Poon, Hui, Dai, Kwok, & Woo, 2005](#)), ethnoracial minorities ([Shore, Savin, Orton, Beals, & Manson, 2007](#)), patients adjudicated by the courts ([Zaylor, Whitten, & Kingsley, 2000](#)), and veteran populations ([Dunn et al., 2000](#); [Frueh et al., 2007](#)).

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In a recent review of the research on telehealth, Richardson et al. (2009) concluded that several significant areas of investigation are still needed. In particular, emphasis was placed on the need for evidence supporting the use of telehealth services to provide evidence-based psychotherapy for specific mental health disorders, and the need for comparable effectiveness research of telehealth practices across various underserved groups. Preliminary findings for the use of evidence-based psychotherapy have been found for providing cognitive behavioral therapy (CBT) to patients with anxiety disorders, including panic disorder and agoraphobia (Bouchard et al., 2004), obsessive compulsive disorder (Himle et al., 2006), social anxiety disorder (Pelletier, 2003), and posttraumatic stress disorder (PTSD; Germain, Marchand, Bouchard, Drouin, & Guay, 2009; Tuerk, Yoder, Ruggiero, Gros, & Acierno, 2010). Together, these studies support the notion that CBT could be delivered successfully via telehealth to patients with anxiety disorders.

Research on treatment of PTSD via telehealth has recently become a focus of attention, due in large part to emphasis placed on the treatment modality by the Department of Veteran Affairs (House Veterans' Affairs Subcommittee on Health, United States House of Representatives, 2005). Although early research on telehealth practices were less promising (e.g., a 14-session group CBT in veterans with PTSD, Frueh et al., 2007), recent research shows that individual CBT for PTSD can be delivered successfully via telehealth. Germain et al. (2009) assigned 48 treatment-seeking participants with PTSD from two community anxiety disorders clinics to either in-person individual CBT ($n=32$) or individual CBT delivered via telehealth ($n=11$). The CBT procedures incorporated four manualized modules targeting psychoeducation, anxiety management training, imaginal and in-vivo exposures to avoided memories and situations, and relapse prevention strategies. The length of treatment averaged 21 and 19 sessions for the in-person and telehealth groups, respectively. Significant pre- to posttreatment effects were demonstrated for both groups on self-report measures of PTSD, depression, and anxiety symptomatology, and on a measure of current functioning. Although the study likely was underpowered for group comparisons, no differences were observed between the two treatment conditions. In addition, analyses of patients' self-reported comfort with telehealth procedures did not differentially impact treatment outcome. A similar pattern of findings was demonstrated in a veteran population with PTSD. In this study, an average of

10 sessions of prolonged exposure therapy (Tuerk et al., 2010) was associated with significant treatment effects for symptoms of PTSD and depression in both in-person ($n=35$) and telehealth ($n=12$) treatment conditions.

Although existing studies on telehealth CBT for PTSD (Germain et al., 2009; Tuerk et al., 2010) and related disorders (Bouchard et al., 2004; Himle et al., 2006) provide early evidence for the efficacy of these practices, the small samples of telehealth patients (n ranging from 1 to 13) involved in these studies have not allowed investigation of individual differences associated with treatment completion and effectiveness (e.g., age and race). In addition, studies with larger samples are needed to further investigate the reliability of these preliminary findings. The present study addresses these limitations by investigating the effectiveness of telehealth exposure therapy, a specific type of evidence-based CBT, for patients with PTSD in a large sample of veterans. As a secondary goal, the study investigates the influence of demographic variables (e.g., age, race, combat theater, disability status) and baseline symptomatology (e.g., depression, anxiety, impairment) on treatment completion and outcome. Based on previous research (Germain et al., 2009; Tuerk et al., 2010), it was hypothesized that exposure therapy delivered via telehealth would be effective in reducing the symptoms of PTSD and related constructs. In addition, we predicted that comparable effectiveness of exposure therapy would be evidenced across the two treatment settings (telehealth vs. in person) and various demographic groups.

Method

PARTICIPANTS

Patients were selected from a large southeastern Veterans Administration Medical Center (VAMC; direct service population estimated at 550,000 at 2000 U.S. Census) and its associated community-based outpatient clinics (CBOCs; service populations ranged from 140,000 to 290,000 at 2000 U.S. Census) as part of standard clinic practice. All patients had been referred for exposure therapy for PTSD within the PTSD clinic at the VAMC. As the study was conducted within standard clinical practice, patients received treatment at their local facility (telehealth at CBOCs; in person at VAMC) and were not randomly assigned within the two primary treatment conditions (telehealth and in person). The telehealth sample was comprised of 62 veterans who initiated individual exposure therapy for PTSD via telehealth services at any one of the three CBOCs. The average telehealth patient was 45.1

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