

*Treating trauma during COVID-19:
Factors for adapting treatment to telehealth*

Joshua Nadeau, PhD, and Loren Post, PhD

Thursday, May 21, 2020



1

Disclosures

The presenters have each declared that s/he does not, nor does his/her family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation. The presenters have each declared that s/he does not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships.

2

Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Identify at least three advantages to telehealth delivery of PTSD treatment.
2. Describe two ways to manage the needs of patients with various comorbid psychiatric disorders while implementing prolonged exposure (PE) via telehealth.
3. Explain one inter- and one intra-state stressor that drives changes in treatment of PTSD due to implementation and relaxation of stay-at-home/quarantine orders in response to COVID-19.

3

What we'll cover in this webinar

- 1. Evidence-based PTSD treatment via telehealth**
Feasibility and effectiveness
Dropout, compliance, patient preferences
Prolonged exposure in person vs. telehealth
- 2. PTSD and co-occurring disorders**
Increased severity of PTSD transdiagnostic symptoms in response to COVID-19 concerns
Normalizing concerns and reactions while setting expectations for symptom improvement in response to PE
Managing co-occurring disorders and life stressors throughout PE treatment
- 3. Virtual PE for PTSD context and clinical considerations**
Conducting virtual imaginal exposures
In vivo exposures during social distancing with special attention to safety behaviors
Pros and cons of both current telehealth and future return to the clinic

4

Evidence-based PTSD treatment via telehealth

- Feasibility and effectiveness
- Dropout, compliance, patient preferences
- Prolonged exposure in person vs. telehealth

 Please use the Q&A feature to send your questions to the moderator.

5

Treatment of PTSD: Comparing telehealth with in-person

- Non-inferiority (“as good as”) of telehealth delivered PE relative to in-person PE for the treatment of PTSD in terms of reducing PTSD scores at posttreatment and follow-up (Acierno et al., 2017; Morland et al., 2020)
- The in-person dynamic is not necessary for meaningful clinical gains following PE treatment



6

Telehealth therapy factors

- Telehealth has been shown to be equivalent to in-person CBT treatment on *fidelity in delivering treatment* (Frueh et al., 2007)
- Telehealth has been shown to be superior to in-person treatment on *lower dropout rates* (Morland et al., 2020)

7

Telehealth therapy factors

- **Working alliance** in telehealth has been shown to be inferior to in-person treatment delivery
 - Despite weaker alliance, telehealth produced as much improvement in symptoms as in-person treatment (Norwood et al., 2018)
- Patient Preference
 - Approximately 50% of veterans prefer to receive PTSD treatments via telehealth (Morland et al., 2020)

8

Overcoming treatment barriers via telehealth

- Stigma and trauma-related concerns
- Logistic-based:
 - Travel time to and from appointments
 - Parking issues
 - Lost work time to difficulties in scheduling and location
 - Living in smaller communities with less access to specialized PTSD interventions

Morland et al., 2017

9

Administering PE via telehealth

- Administering PE for PTSD via telehealth is not much different from in-person treatment
- Very few modifications to the treatment protocol are necessary
- Enhancements to telehealth PTSD therapy often include the use of mobile apps (i.e., PTSD Coach, PE Coach)

10

Modifications: therapy setting

- Inform patients prior the first appointment to treat telehealth sessions as they would in-person care
 - Wearing appropriate clothing
 - Having a private and quiet location to meet
 - Minimizing disruptions (e.g., people/pets in the room)
- Brainstorming ideas:
 - Use of headphones
 - Sit in car
 - Let others know that you need privacy within a designated time period

11

Modifications: Session materials

- Establish an electronic exchange protocol for written materials (e.g., homework forms and assessment self-report measures)
- Patients should have all handouts in advance (e.g., PE rationale handout) for provider and patient to review together during session
- Can ask that completed materials be sent prior to start of session by attaching documents or screenshots of documents to a secure email

12

Modifications: Imaginal exposure

- Patients need to record session in the location where they sit
 - Can use phone's voice memo (if not using phone for telehealth session) or digital recorder
- Ask patients to position webcam so their full body is in view, if possible, to allow provider to watch for engagement level/safety behaviors
- In anticipation of technological difficulties
 - Consider not asking patients for SUDS every 5 minutes, rather, ask for Pre, Post, and Peak SUDS
 - Allow patient to continue through imaginal exposure without interruption ("I can't hear you") if there are momentary glitches in the connection

13

PTSD and co-occurring disorders

- Increased severity of PTSD transdiagnostic symptoms in response to COVID-19 concerns
- Normalizing concerns and reactions while setting expectations for symptom improvement in response to PE
- Managing co-occurring disorders and life stressors throughout PE treatment



Please use the Q&A feature to send your questions to the moderator.

14

Psychiatric comorbidity of PTSD

- PTSD has the highest psychiatric comorbidity rates of any disorder but depression
- The most common comorbid diagnoses include:
 - Major depression
 - Anxiety disorders
 - Substance use disorders
 - Borderline personality disorder
 - Psychotic disorders

15

Prolonged exposure therapy (PE)

- **Imaginal exposure** – revisiting the trauma memory and processing the experience
- **In vivo exposure** – exposure to trauma reminders in life
- **Education** – psychoeducation about common reactions to trauma
- **Breathing retraining** – learn to breathe in a calming way

16

PE is effective for PTSD patients with...

<p>Comorbid disorders</p> <ul style="list-style-type: none"> • Major depression • Substance use disorders • Borderline personality disorder (mild to moderate) • Mild traumatic brain injury (mTBI) 	<p>Associated symptoms</p> <ul style="list-style-type: none"> • Guilt • Anger/Aggression • Dissociation • Suicide ideation/gestures • Poor health
--	---

17

PE does not lead to worsening in PTSD patients with comorbid conditions

Across multiple indices of complexity (*co-occurring disorder, a target trauma of childhood sexual abuse or a history of childhood abuse*) **differences were not seen in the tolerability of imaginal exposure** as compared to those without these complexities (van Minnen et al., 2012)

Comorbid conditions and additional symptomatic features **decreased along with the PTSD symptoms** (*depression, general anxiety, problems in social and work functioning, dissociation, physical health problems, trauma-related negative cognitions and emotions*) **or at least did not increase during PE** (*substance abuse, delusions, hallucinations, suicidality*; van Minnen et al., 2015)

18

Normalizing COVID-19 concerns

- For most people, the current COVID-19 situation will be a significant stressor that they cope with in real time
- Even for those highly distressed acutely, most will eventually naturally recover in time
- Do **not over-pathologize** a “normal” response to this very abnormal situation

Rauch, Simon, & Rothbaum, 2020

19

Self-managing concerns

- Assess what usually helps/healthy coping (exercise, social support)
- Suggestions to:
 - Increase a sense of community and/or individual social support efforts
 - Gain access to structured self-care and enhanced mindfulness, exercise, sleep or relaxation strategies
- COVID Coach – app created to support self-care and overall mental health during the COVID-19 pandemic



Rauch, Simon, & Rothbaum, 2020

20

PE during COVID-19

- Some people may report worsened PTSD symptoms
 - Particularly anxiety and depressive disorder transdiagnostic symptoms (e.g., sleep disturbance, negative emotional state, problems with concentration)
- Worsened symptoms likely do not warrant an additional diagnosis and/or change in treatment plan
- Note that there have been findings that telehealth performed more poorly than in-person PE with respect to depression symptom scores (Acierno et al., 2017; Olthuis et al., 2016)

21

Maintaining focus on PTSD

- If initial assessment determined PTSD to be primary, maintain the focus on PTSD with periodic reassessment of other problem areas/projecting confidence for natural recovery of COVID-19 related stress
- Patients with chronic PTSD often face multiple life stressors; crises during treatment are common
- Self-destructive impulse control problems (e.g., alcohol binges, substance abuse, risky behaviors) need to be addressed

22

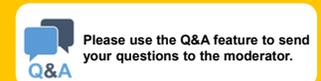
Maintaining focus on PTSD

- Remind patient that adhering to treatment, and thereby decreasing PTSD and associated symptoms, is the best help you can give
- Clearly state support for the patient's desire to recover from PTSD; applaud health coping and homework effort
- The overall aim is to provide emotional support through the crisis, yet keep PTSD as the major focus

23

Virtual PE for PTSD context and clinical considerations

- Conducting virtual imaginal exposures
- In vivo exposures during social distancing with special attention to safety behaviors
- Pros and cons of both current telehealth and future return to the clinic



24

Virtual exposures – what’s changed?

- Any exposure – imaginal or *in vivo* – requires 2 ingredients:
 - “Activation of the fear structure”
 - “Incorporation of incompatible information”

(Foa & Kozak, 1986)

- The change is not in the ingredients, but in the *implementation*

25

Remote/virtual imaginal exposures

Assumptions

- The question of within-session habituation...

Expectations

- Between-session habituation and treatment response

Concerns

- Gathering sufficient information (pre-, peri-, post-exposure)
- Attrition

(Gros et al., 2013; Hernandez-Tejada et al., 2014; Nacasch et al., 2015; van Minnen & Foa, 2006)

26

So...how to approach?

Assessment:

- Distress/arousal – Intensity and ‘Velocity’

Communication:

- Expectations and experience (therapist and client!)

Processing:

- Disconfirmatory information
- Revisiting psychoeducation and rationale for PE/IE

27

Social distancing and in vivo exposures

Areas of concern (things to watch)

- Remember, imaginal can inform *in vivo*!
- The importance of collaborative treatment planning/goals

Social distancing and safety behaviors

- The counterintuitive nature of structural avoidance:
 “Why go to the store when you can buy online?”

28

Treatment via telehealth

<p>Advantages</p> <ul style="list-style-type: none"> • Environmental authenticity • Bypassing common obstacles • (Potentially) higher dosage • Increased “societal arousal” 	<p>Challenges</p> <ul style="list-style-type: none"> • Role shift (facilitator vs. witness) • Safety behaviors by proxy • Technology • Reimbursement
--	---

29

“The new normal” and transitional considerations

<p>Shift to fully telehealth</p> <ul style="list-style-type: none"> • Individual/Social concerns <ul style="list-style-type: none"> • Getting sick/Dying • Endangering others • Mandates/Policies <ul style="list-style-type: none"> • Stay-/Safer-at-home (Quarantine) 	<p>Going back to ‘normal’</p> <ul style="list-style-type: none"> • Individual/Social concerns <ul style="list-style-type: none"> • Financial necessity • Impact of isolation on MH • Policies <ul style="list-style-type: none"> • Expiration of telehealth exceptions
---	--

30

Time for questions and answers...



Q&A

31

Where to get additional information...

 <p>https://www.coronavirus.gov</p>	 <p>https://www.nih.gov/health-information/coronavirus</p>
 <p>https://www.ptsd.va.gov/covid/</p>	 <p>https://adaa.org/finding-help/coronavirus-anxiety-helpful-resources</p>

32

About the presenters....



Joshua Nadeau, PhD
Clinical Director, Tampa
Dr. Nadeau is a licensed psychologist who directs the clinical programs at Rogers Behavioral Health's Tampa location. Dr. Nadeau focuses on the use of cognitive behavioral therapy for the treatment of OCD and related disorders, as well as in the adaptation of evidence-based techniques to address the unique needs of youth and adults with autism spectrum disorder (ASD) and other neurodevelopmental disorders.



Loren Post, PhD
Clinical Director, Atlanta
Dr. Post is a licensed clinical psychologist and serves as clinical director of Rogers Behavioral Health in Atlanta. Dr. Post specializes in evidence-based cognitive-behavioral treatments for posttraumatic stress disorder (PTSD) and anxiety and mood disorders.

Call or visit:
800-767-4411
rogersbh.org

