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Cognitive Processing Therapy With an Older Woman Veteran During COVID-19: A Case Study

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Abstract

With advances in technology, telehealth has become an acceptable way of conducting psychotherapy. During the COVID-19 pandemic, telehealth and ways to modify treatments for delivery via telehealth have become increasingly important. Researchers and clinicians have issued recommendations on providing telehealth-based care in response to the COVID-19 global pandemic. However, recommendations are limited for audio only telephone-based care, which may be the only option for specific clients. This is a case study of an older adult who completed Cognitive Processing Therapy (CPT) for military sexual trauma. Halfway through her treatment, COVID-19 resulted in transitioning from in-person services to a virtual format. Client X did not have video capabilities aside from her cell phone, and it was determined she would complete treatment via telephone-based sessions. Client X's outcome data is presented, and the reductions in her PTSD and depressive symptoms provide preliminary support suggesting that telephone-based care may be an acceptable method of receiving CPT. Recommendations for telephone-based CPT are provided.

Keywords: COVID-19; telehealth; trauma; cognitive processing therapy

Theoretical and Empirical Rationale for Treatment

Cognitive Processing Therapy (CPT; Resick et al., 2016) is one of the first-line evidence-based psychotherapies for posttraumatic stress disorder (PTSD). Originally, CPT was an in-person 12-session group therapy for survivors of sexual trauma (Resick & Schnicke, 1992) and was shown to reduce symptoms related to PTSD and depression symptoms. Over time, CPT has demonstrated efficacy with various trauma types (e.g., Chard, 2005; Monson et al., 2006) and as an individualized treatment (Resick et al., 2017). Multiple studies have examined the use of CPT for survivors of military sexual trauma (MST) and found CPT to be efficacious in reducing PTSD symptoms in both men and women survivors of MST (e.g., Surís et al., 2013). Furthermore, there is a growing body of evidence to suggest that CPT can be applied flexibly in 8 to 18 sessions based upon the needs of the client (Galovski et al, 2012).

As technological advances progress, more research has focused on the implementation of evidence-based psychotherapies, such as CPT, through telemedicine avenues (e.g., Morland et al, 2011). Typically, telehealth is conducted through video sessions and contains the same content as in-person sessions, but with specialized considerations related to out-of-session assignments and therapy workbooks. In a group comparison of in-person CPT versus video conferencing (VTC) CPT, no treatment outcome differences were noticed between the groups. Both treatment modalities demonstrated significant reduction in PTSD symptoms (Morland et al., 2011), which suggested that VTC CPT was a feasible alternative to in-person sessions. These results were replicated by Maieritsch and colleagues (2016) examining the differences between individual VTC CPT and in-person CPT, demonstrating no differences between groups, but significant reductions in PTSD symptoms.

Recently, clinicians and researchers have focused on identifying ways to provide clinical care and continue research studies given the restrictions on in-person therapy due to the COVID-19 pandemic. Moring and colleagues (2020) developed a set of suggestions for implementing CPT for telehealth during the pandemic. These suggestions primarily focused on video sessions, including recommendations to ensure HIPAA-compliant video conferencing platforms and clear documentation of the location of the client at the outset of each video session. Further, Moring and colleagues discuss the various methods of sharing files, given the high reliance on worksheets in CPT. These suggestions include utilizing fillable forms and sharing the worksheets on screen as well as sending the client hard copies of the materials and asking the client to take pictures of the completed worksheets to send to the clinician via secure messaging. The majority of the suggestions assume the client has ready access to technology and the necessary skills to use technology effectively.

Moring and colleagues (2020) also discuss how to address COVID-19 related beliefs within the CPT framework. The authors outline how to address pandemic-related index traumas as well as working through overaccommodated stuck points about COVID-19 later in treatment after addressing assimilated trauma-related beliefs. The review provided by Moring and colleagues is extensive, but it is not exhaustive. There is little information about working around technological difficulties and with populations with lower technology literacy and accessibility. Older adults may be a particularly vulnerable population to this barrier for telehealth (Schreurs, Quan-Haase, & Martin, 2017). The authors offer few suggestions for telephone-based care; however, they state it is an alternative to video-based telehealth. Given that previous research has demonstrated that telephone-based sessions are an acceptable treatment modality (e.g., Cuijpers et al., 2019), it is important to understand how to best implement treatments such as CPT with

clients who chose not to or cannot engage in video-based care. This case study focuses on an older adult who did not have access to video-based telehealth; therefore, telephone-based sessions were completed.

Randomized Clinical Trial Assignment

Client X was self-referred, prior to COVID-19, to participate in an outpatient randomized clinical trial focused on treating posttrauma nightmares and PTSD. This trial examines the efficacy of a treatment for nightmares (e.g., Exposure, Relaxation, and Rescripting Therapy [ERRT; Davis, 2008]) and posttraumatic stress symptoms (e.g., Cognitive Processing Therapy [CPT; Resick et al., 2016]). The trial was approved by the University of Tulsa Institutional Review Board. Eligibility for the trial was initially determined by a brief phone screen interview followed by an initial assessment conducted by supervised doctoral-level graduate students. Inclusion criteria consisted of having at least one nightmare per week over the last 4 weeks and meeting criteria for a diagnosis of PTSD as listed in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (American Psychiatric Association, 2013). Exclusion criteria consisted of being 17 years of age or younger, having acute or apparent psychosis, having a diagnosis of bipolar disorder, inability to read or write in English that would interfere with treatment, active suicidality, and/or recent parasuicidal behaviors. There were no additional exclusion criteria. Following an initial assessment, individuals were randomized to one of three conditions: (1) CPT only (12 weeks), (2) CPT followed by ERRT (17 weeks), and (3) ERRT followed by CPT (17 weeks). All conditions utilized CPT without the trauma account (CPT). Client X was randomized into condition one of the trial, meaning she would receive CPT only.

Due to the trial's investigation of post-trauma nightmares, all clients, including those in the CPT only condition, are asked to complete weekly sleep logs.

Case Introduction

Client X is a 70-year-old White/non-Hispanic, single, cisgender woman, Air Force veteran. During the initial assessment, Client X endorsed experiencing nine traumatic events on the Life Events Checklist for DSM-5 (LEC-5; Weathers et al., 2013b; four traumatic experiences were endorsed as she experienced them, and five she endorsed being a witness). Additionally, she endorsed having four nightmares over the past week, in which the average severity was two (1–5 scale; 1 = *minimal intensity*; 5 = *maximum intensity*). Her index trauma was identified as a military sexual trauma perpetrated by a fellow service member during the course of a noncombat mission. Client X reported leaving the military with an honorable discharge approximately 35 years ago. Client X denied receiving trauma focused, or another type of mental health treatment in the past.

Assessment

Prior to COVID-19, Client X engaged in in-person initial assessments. During the initial assessment, her Posttraumatic Checklist for DSM-5 (PCL-5; Weathers, Litz, et al., 2013) score (71) qualified for a preliminary diagnosis of PTSD per the guidelines suggested by Bovin and colleagues (2016). In order to confirm a diagnosis of PTSD, Client X was administered the Clinician Administered PTSD Scale for DSM-5 (CAPS-5; Weathers et al., 2013a). Client X's initial CAPS-5 score was a 36 (maximum score = 80). Client X met diagnostic criteria for PTSD and was eligible to receive treatment through the randomized clinical trial.

Case Conceptualization

As with other cognitive behavioral treatments, CPT conceptualizes trauma-related symptoms through the cognitive triad (i.e., the relationship between thoughts, emotions, and behaviors; Resick et al., 2016). Traumatic events, in which an individual experiences imminent danger, elicit a biological response known as the fight, flight, or freeze response. Survivors of traumatic events often attribute their biological responses to conscious decisions that influence their beliefs about themselves, others, and the world (Duros & Crowley, 2014). Additionally, these new beliefs, either assimilated (molded beliefs to fit preexisting schemas) or overaccommodated (maladaptively modified schemas to incorporate new beliefs), lead to changes in their emotional and behavioral responses to nonthreatening stimuli. As a result, the individual becomes stuck in processing the traumatic event.

CPT (Resick et al., 2016) focuses on modifying the assimilated and overaccommodated beliefs (i.e., stuck points) to more well-balanced and realistic thoughts (i.e., accommodated beliefs, or adaptively modified schemas to incorporate new beliefs). Similar to other trauma-focused treatments, avoidance remains the double-edged sword. Immediately after a traumatic event, survivors often avoid internal (e.g., thoughts, emotions, sensations) and external (e.g., people, places, situations) reminders to maintain safety. Avoidance in this form is an evolved adaptive response. However, in the long term, avoidance is the perpetuating factor for maintaining trauma-related symptoms. CPT educates clients on avoidance and helps them detect when avoidance is causing additional barriers to their treatment (e.g., skipping sessions, incompleteness of practice assignments).

Treatment and Assessing Progress

Client X completed five in-person therapy sessions; however, during an upsurge in COVID-19 cases in the spring of 2020, services transitioned to telehealth platforms. Her co-therapists were doctoral-level graduate students receiving supervision by a licensed clinical psychologist. Client X provided written consent to all sessions being both audio and video recorded for training and supervision purposes. Client X's history with the Department of Veteran Affairs is unknown; however, she stated she was not service connected at the time, meaning she was not receiving compensation for the MST. At the outset of treatment, Client X stated she initiated reporting the index trauma (i.e., MST) to the Department of Veteran Affairs. Both the therapists (first and second author) and supervisor (senior author) provided documentation of her initial assessment data to support her in this process. At the outset of therapy, Client X was provided with a client binder for maintaining her treatment materials. Each week she was provided with session handouts and practice assignments. Client X was provided with handouts that corresponded to each session, as well as the necessary amount of worksheets to complete the practice assignments between sessions. Prior to each therapy session, Client X was administered assessments (e.g., PCL-5, Center for Epidemiological Studies Depression scale; CESD; Eaton et al., 2004) via a Qualtrics link that allowed her to submit responses before arriving for her sessions. During session one, Client X was provided with psychoeducation on PTSD and the theory of why some people get stuck in recovery, cognitive theory, and the role of emotions in trauma recovery. Additionally, the index trauma was reviewed, the co-therapist described the course of therapy, and the impact statement (i.e., narrative on beliefs of why the traumatic event occurred and how beliefs have changed since the traumatic event) was assigned as the practice assignment. Client X's description of her index trauma took approximately 20

minutes, as she went into detail about the history of military culture, and became tearful as she was relaying her experience. Specifically, she discussed the sexism and sexual harassment experienced by women in the military, including being told by leadership that the “women service members were there for the entertainment of the men.” Otherwise, Client X's affect was generally euthymic. She endorsed motivation for treatment and participated actively throughout.

During session two, Client X read her impact statement aloud. Additionally, a focus of session two is identifying potential stuck points and assisting the client in identifying and recognizing the connections among events, thoughts, and emotions. Client X was introduced to Antecedent, Beliefs and Consequences (ABC) worksheets, and assigned seven ABC worksheets as her practice assignment to complete over the next week. During session three, the therapists and Client X worked to identify thoughts and emotions in response to the index trauma. Additionally, changing thoughts was discussed as a way to change the intensity or type of emotions that are experienced and associated with the index trauma. During session four, the ABC and Challenging Questions worksheets were used to engage in Socratic questioning about stuck points. During session five, the challenging questions worksheets were reviewed, and the Patterns of Problematic Thinking worksheets were introduced. Session five was completed during the second week of March 2020 as pandemic concerns were on the rise in the midwest. Stay-at-home orders were implemented for the city in which treatment was being conducted. Session five was Client X's last in-person session due to COVID-19. Throughout sessions one through five, behavioral observations, such as Client X becoming tearful, were informative of her emotional engagement and processing. For the remaining sessions, observations of emotional engagement were limited. Figure 1 outlines Client X's summary data and sessions 1–5 are

indicated as in-person sessions. Sessions 6–12 were conducted via telephone only and considered telehealth psychotherapy sessions.

When in-person sessions were no longer an option, transitioning to telehealth was presented to the client. Client X appeared understanding and supportive of the transition to telehealth. Client X reported she did not have video capabilities on a device other than her cell phone. When asked if she would like to use video on her phone, Client X declined as she believed the video would be too small and she felt uncomfortable with using the technology. She stated it would be easier for her to continue her treatment over the phone. Together, co-therapists and Client X decided to proceed with treatment via audio-only phone calls. At this point in treatment, Client X was sent the necessary treatment materials and practice assignment worksheets via mail. Unsure if treatment would resume in-person, Client X made copies of the necessary worksheets at home. Client X was able to prioritize her treatment despite current events as evidenced by her consistent adherence to attending sessions and completing all practice assignments. Client X verbally discussed her sleep logs and practice assignments, and was instructed to keep the originals until they could be safely obtained. Client X continued to receive the assessments via Qualtrics which she completed prior to the start of each telephone-based session. Furthermore, Client X was provided with a reminder call and email the day before her scheduled session regarding the Qualtrics link as well as the session date and time.

During session six, the problematic patterns of thinking worksheet was reviewed, and the challenging beliefs worksheet (CBW) was introduced. While reviewing the worksheets, it was important for the co-therapists to be patient, allowing for longer pauses, as the nonverbal cues were absent. Client X typically spoke at a slower rate, and would often pause to think before responding. This session was longer (e.g., 90 minutes) than the typical session time (i.e., 60

minutes). Filling out the first CBW was expected to take longer than subsequent challenging beliefs worksheets as the Client was being oriented to the worksheet. As this orientation to the CBW was conducted over the phone, the therapists directed Client X to look at columns individually, and when Client X began to discuss her thoughts the therapists asked clarifying questions regarding which column she was working on. Additionally, for the first CBW, Client X picked an assimilated stuck point (“I let it happen”). At this session, a clinically significant decline in Client X’s PCL-5 scores was observed (session 5 PCL = 67 and session 6 PCL = 44).

During session seven, a CBW was reviewed, and the safety module was introduced. Since there was no way to physically view Client X’s completed CBW, the co-therapists would reference a blank CBW and ask Client X to verbalize what she wrote in each column. When necessary, co-therapists would engage in Socratic questioning or supportive reflection to enhance the content Client X completed for homework. At this point, Client X was awaiting a COVID-19 test result. She reported experiencing a low-grade fever for approximately 2 weeks and started taking a steroid to reduce her fever. Unfortunately, her physical symptoms persisted, which initiated her seeking COVID-19 testing.

During session eight, another CBW was reviewed, and the trust module was introduced. By this session, Client X had begun to fill out her CBWs more completely and did not require as much assistance from the therapists in accurately completing all columns, as evidenced by Client X asking for less assistance in how to complete certain sections. However, she appeared to struggle somewhat in the development of the alternative thought. Usually, by reviewing the CBW together, the co-therapists and Client X were able to revise her original alternative thought with one that was slightly more inclusive while maintaining relativity to the original stuck point. Additionally, Client X disclosed she had received a negative COVID test result.

During session nine, a CBW and the trust star homework assignments were reviewed, and the power/control module was introduced. Client reported she completed the trust star with a deceased individual in mind. This was new to the co-therapists; however, due to time constraints we decided to spend the rest of the session on the CBW rather than completing another trust star. Client reported she completed a CBW each day, and she was instructed to pick one to review. Client X chose to review a CBW she had completed, but it did not align with the power/control theme. Co-therapists decided to let her use her completed CBW that did not align with the theme for session nine as the benefit of her completing the CBW may outweigh the consequences of not prioritizing the stuck points based on the CPT topic.

During session ten, Client X completed a CBW, and the esteem module was introduced. This week, Client X noted experiencing two nightmares, which was an increase from her previous five sessions. She attributed her nightmares to completing her therapy practice assignments close to bedtime. Due to the client's mastery of completing CBWs, co-therapists encouraged her to complete additional CBW for non-trauma-related stressors as needed. During session 11, Client X reviewed a challenging beliefs worksheet, and the intimacy module was introduced. Additionally, Client X was introduced to the practice assignment of rewriting her impact statement (without reviewing the initial impact statement beforehand). Furthermore, during this session a spike in her PCL-5 and CESD scores were observed. Client X and both therapists attributed this spike in scores to a new stuck point that she addressed in a CBW. Notably, this stuckpoint was complex and a realistic belief was embedded within the stuck point. Client X was encouraged to address a related stuck point as one of her CBWs over the next week.

During session 12, Client X read aloud her new impact statement, which differed dramatically from her original impact statement in regards to the self-blame and intense guilt she expressed in the impact statement completed at the beginning of treatment. Client X expressed gratitude for the outcomes she has experienced from participating in therapy, and was able to attribute her success to her hard work. Regarding the transition to telephone-based sessions, no qualitative feedback was solicited regarding client reactions. Client X did not display signs of frustration, grief, or decreased satisfaction with the remaining sessions being telephone based. Client X provided consent for 1- and 2-month follow-up calls and 3- and 6-month posttreatment follow-up assessments. For a summary of Client X's self-reported PTSD and depression symptom severity, see Figure 1. Additionally, her nightmare frequency (Figure 2) and severity (Figure 3) were recorded each week, as sometimes residual posttrauma nightmares persist following trauma-focused treatment. For Client X, an increase in nightmare frequency was observed as treatment was ending. Her nightmares subsided by her 3-month follow-up assessment (reported below). If she reports experiencing nightmares at her 6-month follow-up assessment, she will be offered ERRT to target her nightmares.

Complicating Factors

Similar to most other in-person clinics, during COVID-19, the trial had to transition to telehealth services in order to continue providing services. The field has been forthcoming and supportive during this transition as webinars were made available, guidelines were developed, testing companies produced electronic versions of assessment materials, and leadership from American Psychological Association (APA) and the state board was engaged and available. Our trial required all assessors and therapists to complete the APA's Telepsychology Best Practice

101 Series (APA, 2019) prior to conducting telehealth services. Additionally, we revised our informed consent to reflect the changes of transitioning from in-person to telehealth services. All necessary documentation was reviewed and approved by the Institutional Review Board. During the 4-week transition, no clients were physically seen. Instead, check-in calls were made to active clients, which consisted of 15-minute telephone-based calls from a masked phone number. Client interest in participating in telehealth services was gauged before the first telehealth call was made.

In this case study, Client X's stressors increased as the COVID-19 virus continued to spread, as she is considered part of the vulnerable population. She received a COVID-19 test while we were transitioning to telehealth services, which could have severely derailed the treatment plan. Fortunately, her results were negative, and therapy continued. However, for others, this could have been a complicating factor: as real-world stressors increased, the priority to complete trauma-focused treatment might be reduced.

Homework adherence is already a potential complicating factor throughout treatment, especially trauma-focused treatment (e.g., Scott & Stradling, 1997). Fortunately, CPT remained one of her top priorities as she continued to find time to complete her weekly practice assignments. There were a number of potential reasons for Client X's commitment to trauma-focused treatment despite the ongoing pandemic. At the time of the intake and the first sessions, Client X disclosed that her nightmares sometimes resulted in screaming and waking her family members. Client X reported she felt shame and guilt about the responsibility her family members had to take on as a result of these nightmares and she hoped to no longer suffer from these posttrauma nightmares. Additionally, Client X noted that her symptoms had been ongoing for such a long period of time that she wanted to take back some control over her life through

treatment. It is likely that when she began treatment and started to learn techniques to examine the trauma and her subsequent thoughts in less negative way, she felt hopeful for additional changes in her maladaptive cognitions by continuing treatment, which aided in her commitment to the treatment during the transition from in-person to telephone based CPT. Furthermore, rapport was easily established during the in-person sessions through giving Client X the time and space to disclose her index event and experience her emotions as they came up in session. By developing this trust with her co-therapists in person, it is possible that Client X felt more confident in her ability to continue to see benefit when engaging in care over the telephone.

Even when completing CPT in-person, there are several considerations regarding treatment adherence that might interfere with the protocol. For example, due to avoidance being a key factor in PTSD, research has found that it can sometimes be difficult for clients to engage with homework (Reger et al., 2013). Resick and colleagues (2016) provide multiple recommendations for addressing homework avoidance and how to handle it in traditional CPT; however, it may be more difficult for providers to determine if a client has completed their homework over the phone without visual confirmation of completed worksheets. Therapists may want to start sessions by asking about the number of completed worksheets and any potential barriers to completing the worksheets, then when selecting an example to review in session make sure to ask detailed Socratic questions to determine the level of completion. Additionally, with treatment being administered over the phone, there is the potential for avoidance taking the form of not answering the therapist's call. This avoidance could be similar to clients not attending in-person sessions. In an effort to address this over the phone, it could be beneficial for therapists to provide weekly check-in calls to assess for potential avoidance in between sessions to increase the opportunity for the client to discuss any desire to avoid sessions.

Follow-up

At this time, the 1- and 2-month follow-up calls (with co therapists) and 3-month follow-up assessment (assessor was blind to condition) have been completed. Data collected at future follow-up assessment sessions will be available upon request.

During the 1-month posttreatment follow-up call, Client X reported experiencing an increase in nightmare frequency and severity immediately following the conclusion of treatment. Additionally, she reported increased stressors as multiple family members were seeking medical attention or in-hospice care, and due to COVID-19, she was unable to visit them. Related to these stressors, Client X also noticed an increase in her depression symptoms. Client X was encouraged to complete CBWs on her current stressors in order to examine her thought processes.

During the 2-month follow-up call, Client X denied experiencing any nightmares over the past month. Reportedly, she had been coping well with current events (e.g., COVID-19, family member in hospice) and had noticed an improvement in sleep quality. Moreover, Client X had not noticed any depression or PTSD symptoms interfering with her daily life since treatment ended. Client X expressed gratitude for the treatment she received and reported she heard back from the Department of Veterans Affairs after reporting her MST. Client X's report was acknowledged, and she is now receiving service-connected benefits regarding the MST.

Client X completed her 3-month follow-up assessment with a doctoral-level graduate student who was blind to her condition and working under the supervision of the licensed clinical psychologist (J.L.D). At her 3-month follow-up assessment, Client X reported zero nightmares in the past week and month. Her PCL-5 score was a 23 and her CESD score was a 17. Additionally, at the 3-month follow-up Client X was administered the CAPS-5 to determine her PTSD

diagnosis status. Based on the CAPS-5, Client X no longer met diagnostic criteria for PTSD with a total severity score of 2 out of a possible 80. At this follow-up, Client X reported two subthreshold symptoms in the arousal symptom cluster (exaggerated startle response and problems with concentration). It is notable that during the time between the end of treatment and the 3-month follow-up, Client X experienced the death of a family member. Despite this significant loss, Client X was able to largely maintain her treatment gains. Client X's 6-month posttreatment assessment is scheduled to be completed, and if her nightmares return, she will be offered ERRT.

Treatment Implications

Overall, the current study provides evidence for the effectiveness of CPT as services transitioned from an in-person setting to a telephone-based setting. Furthermore, the case of Client X demonstrates the success of an evidence- and telephone-based treatment in an older female veteran during a global pandemic. Limitations of the current study are the generalizability to other cognitive behavioral treatments or trauma-focused treatments (such as Prolonged Exposure [PE; Foa et al., 2007]), and client demographics. Clinicians interested in implementing telephone-based care for other trauma-focused treatments should consult existing literature (e.g., Fina et al., 2020) and/or seek consultation from other providers to determine the best way to approach telephone-based trauma-focused intervention.

In this case example, two co-therapists delivered CPT. We recognize that this is not the standard arrangement for CPT. However, our clinical trial requires each therapist to complete an in-depth training process in which they first observe a student supervisor delivering CPT, then

conduct co-therapy, and then lead with a student supervisor observing. Both therapists attend weekly supervision with the principal investigator who is a licensed clinical psychologist.

Additionally, it is important to note that sessions 1–5 were conducted in person prior to transitioning to telephone-based CPT. During this time, we were able to build rapport and help to orient Client X to using CPT worksheets, which may have helped with her transition to telephone-based care. However, Client X's first introduction to the CBW was via the telephone, and these are difficult worksheets to introduce and think through even during in-person treatment. Client X's success with learning to complete the CBWs and using them to challenge her own stuck points over the phone demonstrates how CPT can still be efficacious through many modalities. Furthermore, these results are preliminary. As our field continues to become more comfortable with telehealth services and implementation of telehealth services becomes more widespread, there may be less of a difference in client outcomes between in-person and telehealth settings.

Recommendations for Engaging in Telephone-Based Care

The case of Client X supports the acceptability and effectiveness of telephone-based CPT with older adults. As Moring and colleagues (2020) have outlined suggestions for implementing CPT via video telehealth, we hope to provide recommendations for other providers considering conducting CPT over the phone. Our first recommendation is to utilize a protected phone number. Services such as *67, Google voice, and Doximity Dialer are highly suggested to ensure confidentiality of phone numbers. With our clinical trials, we were able to link our lab phone number to our virtual platform account, allowing for multiple therapists to log into the account and take part in a telehealth with the client.

Second, remind your client to treat the phone session as they would an in-person session, such that they are in a quiet room with limited distractions. It is also important to confirm their location at the outset of each session should emergency protocols need to be enacted during the session. Additionally, confirming their physical address ensures they are in the same state that the providing psychologist is licensed in. Sometimes, clients will sign in from temporary out-of-state locations as they are on vacation, or traveling for school or work, which would be an issue for providing services due to state licensure rules and may result in the session not continuing. During telehealth psychotherapy, both co-therapists relocated to out-of-state residences. Regulations vary by state and it is important that clinicians understand these. We learned, in order to provide telehealth services from another state, from where the client and supervising psychologist were located, approval from the new residential state board is needed.

Third, allow space and time for the client to respond to your questions. Over the phone, clinicians are unable to see facial reactions from clients and see when/what clients might respond to. For this reason, it is important to allow pauses in conversation and give the client the opportunity to fill the space. Along with this, in the event both client and clinician begin speaking at the same time, allow the client to complete their thought first. With Client X, the co-therapists would take long pauses after asking questions to allow the client to formulate her thoughts and begin to verbalize them. Especially since the content of sessions is focused on developing more balanced thoughts regarding traumatic experiences, allowing Client X ample time to create these thoughts and verbalize them was of the utmost importance.

Fourth, for clients with limited technological skills, make sure the client has all necessary paperwork prior to engaging in treatment and they have their assignments with them at the beginning of each session. During the transition to telehealth, Client X was sent all remaining

materials for CPT to add to her binder. Prior to resuming treatment, we confirmed with Client X that she had received all the paperwork. When discussing new worksheets and/or assigning homework assignments, it is important to tell the client the associated page numbers to ensure the correct information is getting across. Before explaining new worksheets we would give the name of the worksheet and page number to Client X and wait for confirmation she had reached that page before reviewing it together. Additionally, when assigning homework, we would give Client X the name of the handout and the page number to make sure she was completing the correct homework assignments for each session. As part of our clinical trial procedures, we provided reminder calls the day before each session, and during these reminder calls we would provide an additional reminder of the homework for the upcoming session.

Finally, when reviewing homework from CPT, if the provider does not have ready access to completed worksheets, the provider should ask the client to select one completed assignment to discuss in session as they would in-person. However, the provider should follow along with a blank copy of the worksheet and ask Socratic questions as needed. In our sessions with Client X, we were not able to physically see her completed worksheets, but we would begin each session by asking her to pick one completed worksheet to discuss. The therapists would follow along with their own worksheets and stop Client X as needed to engage in clarification and/or Socratic questioning.

Therapists could instruct clients to scan in or take photos of their completed worksheets and electronically send them to the therapists prior to their scheduled session. Best practice would be utilizing a HIPAA compatible electronic platform. If that is not possible, the therapist should explain the limitations in protecting the materials through a non-HIPAA compatible platform prior to sending. Moreover, therapists could provide clients with a return envelope with

required postage in order to turn in completed materials. Mailing material might be more secure than sending electronically, although it does add a time variable and therapists might not receive materials back before the next session.

Client X is a high-functioning individual who has some technology literacy and maintained a high level of motivation for treatment despite transitioning to telephone-based sessions. She was adherent to all treatment tasks, despite the lack of visual or in-person instruction for some of the worksheets (e.g., CBW). We recognize that some clients struggle with completing treatment assignments due to comprehension or motivation difficulties. If this was the case with Client X, we would have utilized the modified versions of the worksheets—specifically, the versions of the worksheets that were adapted for those with TBI or cognitive impairments. Although telephone-based psychotherapy falls under the umbrella term of telehealth, relatively limited research focuses on the acceptability and implementation of telephone-based psychotherapy. This case study serves as a first step in determining the utility of telephone-based CPT for individuals requesting telehealth over in-person treatment. Client X was an older woman with limited technological capabilities but a strong determination to complete her trauma-focused treatment during the pandemic. The significant decreases in her PTSD and depressive symptoms in the face of a pandemic and switch in treatment modalities provides limited, preliminary evidence that telephone-based CPT may be efficacious and acceptable.

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Figure 1.

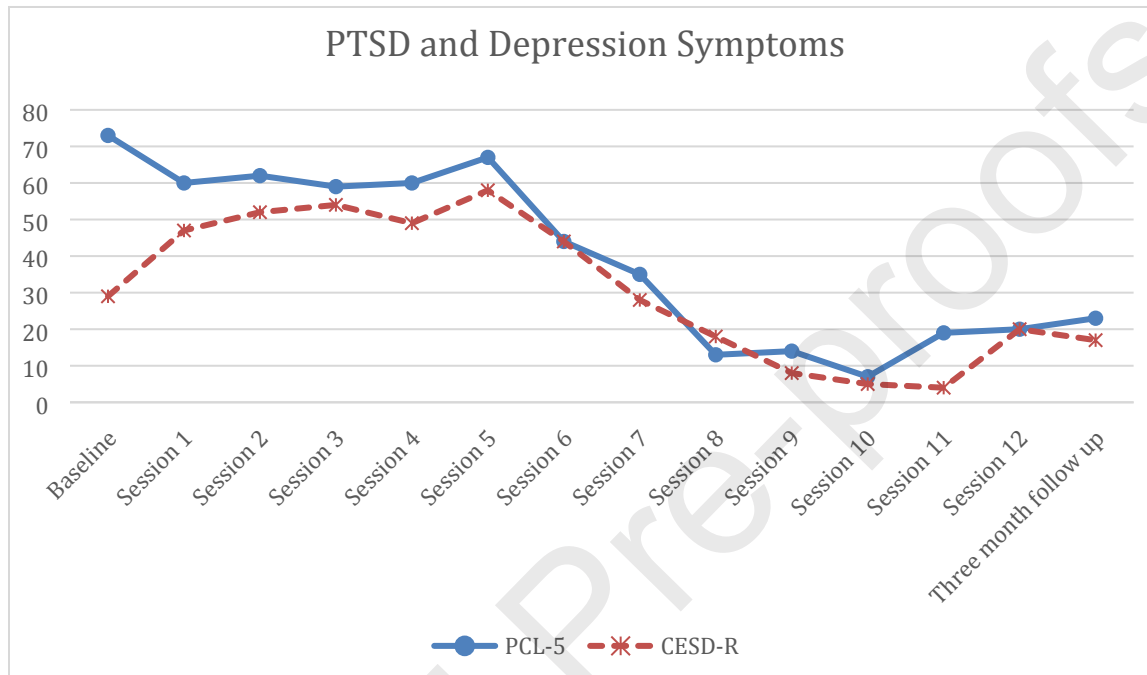


Figure 2.

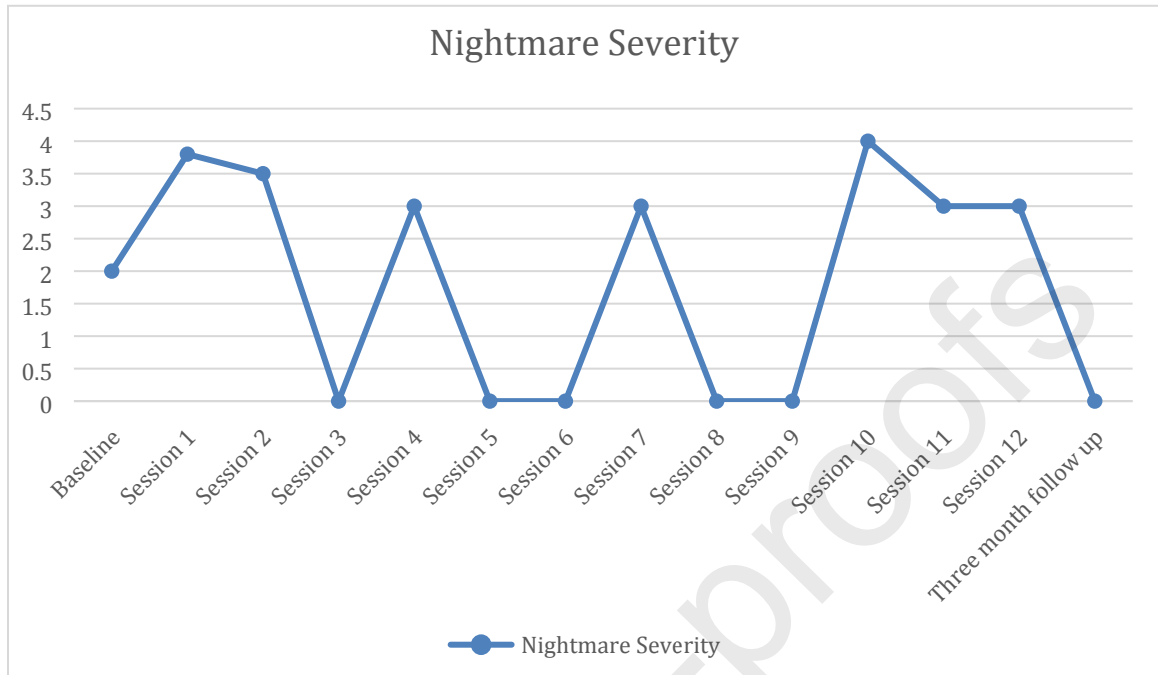
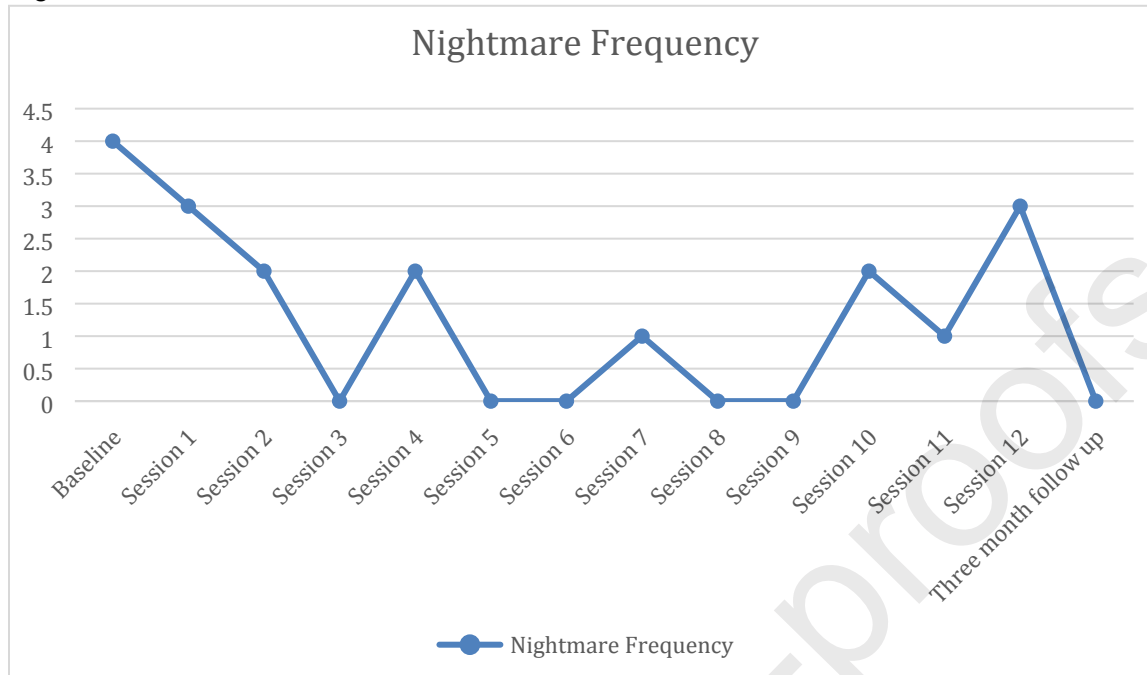


Figure 3.



Highlights

- This is a case study of an older adult who started Cognitive Processing Therapy (CPT) for military sexual trauma.
- The client had limited technological abilities, which led to telephone-based care being chosen as an alternative to in-person sessions during COVID-19.
- The treatment outcomes and initial follow-up data provide preliminary support for the acceptability of telephone-based CPT.