

# Cognitive Processing Therapy for Posttraumatic Stress Disorder via Telehealth: Practical Considerations During the COVID-19 Pandemic

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The global outbreak of COVID-19 has required mental health providers to rapidly rethink and adapt how they provide care. Cognitive processing therapy (CPT) is a trauma-focused, evidence-based treatment for posttraumatic stress disorder that is effective when delivered in-person or via telehealth. Given current limitations on the provision of in-person mental health treatment during the COVID-19 pandemic, this article presents guidelines and treatment considerations when implementing CPT via telehealth. Based on lessons learned from prior studies and clinical delivery of CPT via telehealth, recommendations are made with regard to overall strategies for adapting CPT to a telehealth format, including how to conduct routine assessments and ensure treatment fidelity.

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The novel coronavirus (COVID-19) has rapidly impacted the world, evoking, among many reactions, those of increased stress, uncertainty, sadness, anxiety, and grief. Perhaps most susceptible to the deleterious consequences of these impacts are individuals with preexisting mental health conditions, particularly those with trauma-related conditions such as posttraumatic stress disorder (PTSD). To meet the needs of these individuals, many mental health providers have had to adopt new modalities of service provision to ensure continuity of care. In this unprecedented landscape of mental health care delivery, telebehavioral

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health, or “telehealth,” has become a vital and necessary tool that enables mental health professionals to provide care while minimizing in-person contact, thereby ensuring adherence to current physical distancing protocols currently in place. Fortunately, this mode of care is not new and, instead, has been well studied and shown to be an efficacious treatment modality for the treatment of PTSD across a variety of trauma-exposed populations, with good client and provider satisfaction (Gros et al., 2018; Morland et al., 2014, 2015; Richardson et al., 2009).

Predating the current pandemic, many barriers to mental health care prevent or delay individuals’ ability to seek PTSD treatment. Distance, costs associated with travel, limited local availability of mental health treatment providers, and time away from family or work have been documented as significant barriers that may prevent individuals from receiving psychotherapy (Brown, 2017; Kazdin & Blasé, 2011). Perceived stigma is another well-documented barrier to seeking and receiving in-person, evidence-based psychotherapy for PTSD (Greene-Shortridge et al., 2007) that has also been associated with premature dropout from treatment (Hoge et al., 2014). Other deterrents include avoidance, lack of flexible hours and after-hours access, work responsibilities, lack of childcare, limited mobility, and transportation limitations. Telehealth has proven to be a promising solution to many of these obstacles. However, until recently, this was a modality utilized by only a subset of practitioners. In the wake of COVID-19, telehealth has quickly become an essential and safe mode of care delivery for mental health services.

Telehealth is an effective method of delivering psychotherapy and was initially implemented to extend therapy beyond the boundaries of the clinic and reach populations that may reside in rural areas (Fortney et al., 2020; Hassija & Gray, 2011). Telehealth is broadly defined as behavioral health services that are delivered via communication technologies, such as telephone and clinical video teleconferencing (Brown, 2017). Clinical video teleconferencing is the most widely used and studied form of telehealth for the delivery of PTSD treatments. For the remainder of this article, we will use the term telehealth to refer to providers and clients meeting synchronously via a videoconferencing application while located in separate locations. Telehealth can be conducted through the traditional “hub-and-spoke model” of office-based telehealth in which a provider located in one healthcare facility meets with a client, located in a second facility, through video. Alternatively, home-based telehealth can be implemented, whereby providers and clients complete the therapy session from home, independent of a healthcare facility (McGeary et al., 2012), or via a combination in which one individual is at home while the other is at a clinical setting.

In response to the COVID-19 pandemic, guidelines set forth by the American Psychological Association (APA) regarding the practice of telehealth and managed care reimbursement policies have rapidly evolved to accommodate the provision of mental health services. For example, clients are now allowed to receive treatment live via videoconferencing in their homes

without having to travel to a qualifying “originating site” for Medicare telehealth encounters regardless of their geographic location (APA, 2020). In addition, many providers are pivoting to providing care virtually in order to adhere to mandated physical distancing protocols. Almost overnight, providers and healthcare systems have shifted specifically toward home-based telehealth delivery as even office-based telehealth options have become less plausible as stay-at-home requests and shelter-in-place orders are put into place nationwide. Beyond meeting the clear need of continued mental health care during the COVID-19 crisis, home-based telehealth may also provide several additional benefits to the consumer, including, in some cases, the increased convenience of accessing services from home, which may help overcome even more non-COVID-19 related barriers to care than office-based telehealth. The widespread adoption of home-based care is, perhaps, the most substantial adaptation of mental health services during this crisis, during which staying at home is an imperative part of the public health response to the COVID-19 pandemic.

### Research on Cognitive Processing Therapy and Telehealth

Cognitive processing therapy (CPT; Resick, Monson, & Chard, 2017) is a trauma-focused, evidence-based, cognitive behavioral therapy for PTSD that has been demonstrated to be efficacious across a range of populations and settings (e.g., Chard, 2005; Galovski et al., 2012; Monson et al., 2006; Resick et al., 2008; Resick, Wachen, et al., 2017; Rosner et al., 2019). Briefly, treatment begins with psychoeducation about trauma exposure and PTSD, followed by the identification of problematic beliefs, or “stuck points,” related to the traumatic experience and how the experience has impacted how the patient thinks about themselves, others, and the world (i.e., the “impact statement”). Through Socratic dialogue and a series of progressive worksheets, stuck points related to the traumatic experience are challenged, such as erroneous blame about the cause of the traumatic event. Moving forward, cognitive strategies are used to continue to process larger trauma-related themes concerning safety, trust, power and control, esteem, and intimacy. The last session consists of a review of the progress the patient has made during therapy; a final impact statement that is used to compare pre- and posttreatment thinking; a discussion of goals for the future; and the conclusion of therapy.

Fortunately, research demonstrates that the efficacy of CPT is not compromised when it is delivered via telehealth. The findings from several uncontrolled trials, randomized clinical trials (RCTs), and noninferiority trials conducted in various trauma populations have shown that CPT significantly reduces PTSD symptoms when delivered through telehealth and is noninferior to in-person therapy (Hassija & Gray, 2011; Maieritsch et al., 2016; Morland et al., 2014, 2015). Hassija and Gray (2011) conducted an uncontrolled trial that examined the effectiveness and feasibility of CPT and prolonged exposure therapy (PE), using the hub-and-spoke-model, for 15 female domestic

violence and sexual assault survivors. Their results indicated that participants had large reductions in self-reported PTSD,  $d = 1.17$ , and depressive symptoms,  $d = 1.24$ , following CPT and PE delivered through telehealth. More recent RCTs have shown that PTSD symptoms can be significantly reduced following telehealth, and there are no significant differences when telehealth is compared to in-person care. Maieritsch et al. (2015) conducted an RCT to compare CPT provided through office-based telehealth and in-person care in veterans who served in Iraq and Afghanistan. The results indicated there were no significant differences between conditions for a reduction in symptoms or participant drop-out. These two studies provide support that CPT significantly reduces PTSD symptoms when delivered through telehealth.

Morland and colleagues (2014) conducted a noninferiority trial to determine if group CPT delivered through office-based telehealth was equivalent to an in-person CPT group. They found that group CPT delivered via office-based telehealth was noninferior to in-person CPT at posttreatment, 3-month, and 6-month follow-ups. Office-based telehealth and in-person care had large effect sizes for all veterans from baseline to 3- and 6-month follow-ups in clinician-assessed PTSD. Morland and colleagues (2015) also found similar results for veteran and civilian women exposed to various trauma types who were engaging in individual CPT through office-based telehealth or in-person treatment. The authors established that office-based telehealth was noninferior to office-based care. Overall, these findings highlight that CPT can be conducted through office-based telehealth or home-based telehealth without compromising its effectiveness.

Peterson et al. (2019) conducted a patient-preferences trial and used an equipoise design in which veterans with PTSD could opt out of one of three conditions: CPT delivered in office; in-home, in-person CPT; or through home-based telehealth. If participants chose to opt-out, they were randomized to one of the other two formats. Individuals could also choose not to opt-out of any condition if they were willing to receive CPT via any of the three conditions. The fewest participants declined telehealth (19%), followed by in-office (28%) and in-home treatment (53%). In-home CPT had the lowest drop-out rates (21%), followed by telehealth (33%) and in-office treatment (44%). However, there were no significant differences in the reduction of PTSD symptoms across conditions at 1-, 3-, and 6-month follow-ups. The authors suggest that telehealth is a favored approach for patients establishing a CPT delivery preference, and, regarding PTSD symptom reduction, the results for telehealth were comparable to those for in-home and in-office treatment modalities.

The existing research shows that telehealth can be used effectively to deliver CPT to a diverse range of trauma survivors. Given the current limitations and expected demands placed on mental health professionals in response to COVID-19, it has become increasingly important and necessary to implement CPT via telehealth for civilians, veterans, and active duty service members suffering from PTSD. In the following sec-

tions, we provide important guidelines and considerations for implementing CPT via telehealth with regard to the following domains: considerations for technology, file sharing, client expectations and starting therapy, assessment and pretreatment, considerations during treatment, and other considerations in CPT telehealth.

### Considerations for Technology

In response to this exceptional time in our recent history and given the need to maintain ongoing mental health services as well as meet new demands, the U.S. Department of Health and Human Services (HHS) has waived penalties for using non-HIPAA-compliant videoconferencing software, allowing for popular solutions, such as Skype and FaceTime, to be used to conduct telehealth sessions via video (APA, 2020; HHS, 2020). However, when possible, practitioners should attempt to use platforms that provide secure, encrypted videoconferencing technology. Certain platforms have adopted a “waiting room” function to increase privacy and security whereby only the clinician can control entrance. Some platforms also offer a convenient method to exchange important documents, such as completed measures and practice assignments, with end-to-end encryption. Clients can use a desktop or laptop computer, tablet, or smartphone to conduct CPT sessions. When funds are available (e.g., through research grants, large healthcare systems), providers may be able to temporarily loan a client a data plan-equipped tablet for clients to use during therapy if they do not own the necessary equipment.

Providers can consider several factors when selecting telemedicine software or web-based platforms to implement CPT via telehealth. Some features are universally important for all psychotherapy encounters, whereas other features may be sought based on provider preference or organization-specific demands. We recommend using HIPAA-compliant platforms that are functional across multiple devices (i.e., desktop and laptop application, Android, and iOS platforms). For example, Doxy.me (<https://doxy.me>) and Webex (<https://www.webex.com>) have no-cost, HIPAA-compliant versions as well as professional and clinic paid-tier versions that include waiting rooms, secure files, and screen sharing, among other security options. Other platforms, such as TheraNest (<https://theranest.com>), Simple Practice (<https://www.simplepractice.com>), and TheraPlatform (<https://www.theraplatform.com>) have HIPAA-compliant, paid versions, that offer several features to support CPT. Alternatively, Zoom for Healthcare (<https://zoom.us/healthcare>) is more tailored to group or agency practice, with multiple-line capabilities.

If care is being provided to a client in their home or any non-clinic setting, it is critical to obtain and document the client's location at each visit in case of a medical or mental health emergency. Additionally, a “patient support person” may be identified as a contact in the event of an emergency. If the client is willing to name someone, this person should be able to be contacted via telephone and should be able to arrive at the client's

house in a short period of time to perform a wellness check, if necessary. Proper releases of information should be completed for the patient support person prior to the start of CPT. Service providers should also have information for other critical community resources, such as hospitals, the police department, and shelters, accessible in case they become clinically necessary. Providers and clients should establish an agreed-upon back-up plan for service delivery in the event of technology failures, such as rescheduling or completing the session via phone to ensure minimal interruptions to treatment. Providers should also obtain and document proper consent for any electronic communication and file sharing between provider and client. Providers should inform clients about any risks to confidentiality that may occur when conducting therapy or sending documents electronically, and they should be candid regarding any potential limitations to security. Additionally, if providers plan to offer services across jurisdictional lines, it is necessary to be aware of laws regarding the licensure and registration of the therapist.

### File Sharing

When implementing CPT, there are a number of documents and resources that must be used and shared between the client and provider, including assessment measures and a CPT client workbook. First, providers should consider telehealth platforms that allow for the secure transmission of materials and ensure sufficient flexibility to meet the client's capabilities (e.g., personal preferences, technological limitations) to receive the materials. Under ideal circumstances, providers and clients should share resources through a compliant and secure electronic file-sharing platform. Conventional email platforms do not have appropriate levels of security, although email file sharing may be acceptable with appropriate client consent. To allow for the ease of electronic sharing, assessment measures and client materials can be shared as an editable PDF. The CPT therapist manual and client materials are available through download after purchase through Guilford Press (Resick, Monson, et al., 2017). At this time, the downloadable CPT forms are not editable PDF files, although providers can transform the CPT forms into editable PDF forms, which can then be filled out, using a program called Adobe® Acrobat® Pro. Alternatively, if clients already have or can be sent a hard copy of the client materials, they can take photos of handwritten practice assignments and share them electronically via secure messaging, a file-sharing option in the telehealth platform, or by utilizing a screen-share function with their provider. Clients can also hold the document up to the camera to allow the provider to take a screenshot. Depending on the platform, the provider may choose to share their screen when introducing a new skill, and the client can share their screen to review their practice assignments. Additionally, CPT Coach, a free Veterans Affairs (VA) mobile app, is available for Apple and Android devices and hosts PTSD assessments and CPT treatment materials. Less than ideal, but acceptable, solutions include the therapist or client physically mailing materials to one another or the therapist reading assessment measures to the

client and/or the client reading completed practice assignments aloud to the therapist.

Providers should be prepared for technological challenges. For example, when a client is reviewing CPT worksheets using the same electronic device as the video encounter, the video connection may be disabled for that period. In these instances, the provider is encouraged to take detailed notes on hard-copy worksheets to follow along with the client's written work. Alternatively, if the client can see the provider, the provider can share their screen with the client while the provider completes fillable PDFs along with the client to confirm that the provider understands the client's responses on the worksheets. The provider can also do this to teach the client how to fill out forms as the client follows along on their electronic or hard copies. In sum, whenever possible, it is best to send and receive documents electronically, but flexibility in obtaining this information will be pivotal moving forward with CPT through telehealth because of technical difficulties and clients' variable levels of technological literacy.

### Client Expectations and Starting Therapy

Given the unexpectedness of COVID-19, many providers are rapidly transitioning to telehealth. Therefore, many clients and providers will be new to telehealth, and it can be helpful to establish guidelines and boundaries early in therapy. It is recommended that prior to the first telehealth session, providers give clients a document with expectations for telehealth, sent through secure messaging or via postal mail, or verbally review these guidelines at the first telehealth session. These tasks are usually completed prior to PTSD assessment sessions and CPT initiation, although some clients may be transitioning mid-CPT treatment.

Clients should be advised to treat telehealth appointments as they would in-person appointments. For example, clients should be instructed to receive therapy in a private, quiet location without distraction. To minimize potential risks to confidentiality and/or disruptions, clients may need to inform family members or roommates about the need for privacy. If this is not possible due to small or shared living spaces, clients may consider sitting in a parked car to conduct the session; however, providers need to inform clients that they should not drive the car while the session is in progress. For some clients, especially those in low-income communities or shared living spaces, computers or smartphones may be a communal resource, and clients may have difficulties with privacy at the device level. Clients may need to be reminded to make sure to fully log out of programs and to protect their login credentials so that others do not access their online information. Documents or worksheets may need to be password-protected as well.

Clients should be instructed to minimize any distractions during therapy, such as "web surfing," cooking, cleaning, eating, or smoking, and providers should point out these behaviors to limit avoidance and increase therapeutic engagement. Clients should arrive on time to telehealth appointments and

inform their providers through telephone or other agreed-upon forms of communication if they are going to be late to a session. Providers may encourage clients to remove pets from the therapy space if they become a distraction; providers can ask clients if they have pets in the room at the beginning of each session as they may not be able to see them in the field of view. Clients will need to have a back-up communication technology, usually a telephone, readily available and in silent mode in case the telehealth equipment fails and the session needs to be conducted via telephone. It is also important for clients to wear appropriate attire, similar to what they would wear to a clinic, and to remain seated or have the telehealth device on a stable surface to reduce motion sickness for the provider.

### Assessment and Pretreatment

Regardless of the treatment delivery method, it is recommended to complete a PTSD assessment and discuss treatment options before initiating CPT. The Primary Care PTSD Screen (PC-PTSD) for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* ([*DSM-5*]; PC-PTSD-5; Prins et al., 2016) is the recommended screening measure. If clients respond “yes” to at least three of the five items on the PC-PTSD-5, a more thorough assessment for PTSD is warranted. The therapist can administer the PC-PTSD on the telephone or via telehealth by reading the questions to the client. For a more thorough PTSD assessment, it is recommended that clients complete the Life Events Checklist for the *DSM-5* (LEC-5; Weathers, Blake, et al., 2013), which is used to assess lifetime exposure to potentially traumatic events. Based on their responses to items on the LEC-5, clients may then identify the event they consider to be the “most distressing,” based on the frequency and severity of their PTSD symptoms, and report details regarding the experience, such as when it happened, how many times it happened, and how they experienced it, as well as whether someone’s life was in danger, someone was seriously injured or killed, it involved sexual violence, and/or the event happened to a close family member or friend. These assessments will help the provider determine whether this index event meets Criterion A of the *DSM-5* PTSD diagnostic criteria (APA, 2013) and might be the appropriate index trauma for CPT. The PTSD Checklist for the *DSM-5* (PCL-5; Weathers, Litz, et al., 2013) should then be completed. Each PCL-5 item should be completed and anchored to the identified index event from the LEC-5. Scores on the PCL-5 higher than 33 are indicative of a probable PTSD diagnosis and warrant a discussion about proceeding with CPT (Bovin et al., 2015).

### Considerations During Treatment

Tracking client progress is important in helping to guide conceptualization and treatment planning; thus, it is important that clients understand expectations for completing measures before each session. It is recommended that prior to each session, clients complete, at a minimum, a measure of PTSD symptoms (PCL-5) and, ideally, also a measure of depression, such as the

Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001). Providers conducting CPT sessions twice weekly can alternate between obtaining PTSD and depression measures each session so that each measure is administered once per week. It may be necessary to remind clients to complete the measures prior to each session and share their responses by the previously agreed upon method. If a client does not complete the measures, providers can briefly meet with them via telehealth to instruct them to complete measures, sign off, and then reconnect once the measures are completed. Alternatively, providers may choose to administer the measures orally before conducting the session. Most importantly, providers should be flexible and gather as much assessment information as is feasible considering the circumstances. Internet bandwidth and file-sharing capabilities may change session to session.

Between-session practice is an important component of CPT, and, therefore, providers should emphasize to clients the importance of bringing their practice assignments to every session or sending them prior to each session, depending on the agreed-upon method. Referencing the handouts or worksheets is frequently necessary. For example, providers may suggest, “Let’s look at your workbook. Do you see the handout titled, 5.1: Recovery or Nonrecovery From PTSD Symptoms Following Traumatic Events?” Or, “Let’s take a look at the practice assignment for this week. On Handout 5.3, your first assignment is explained. Please write at least one page . . .” Again, providers may also find it helpful to display an electronic version of the relevant handout on their computer and share their screen so clients know to which handouts the provider is referring.

Throughout CPT, there are some more interactive exercises that can be explained and taught effectively through telehealth. For example, perhaps the client is working on the stuck point, “If I go to a crowded place, I’ll be hurt.” During Session 8 of CPT, likelihood estimates are discussed, and the process of calculating the estimates is often helpful. Some telehealth platforms have a whiteboard feature, allowing the provider can draw on the whiteboard for the client to follow. If this is not available, the provider and client could each use a blank piece of paper. The client should be following the provider by writing down the exact numbers on a piece of paper. The therapist should hold the work up to the screen so their client can ensure that they are aware of how the calculations were conducted and then match their own work. Of course, in the case of COVID-19, the actual safety of the situation should be assessed (e.g., appropriate physical distance, the use of a mask and hand sanitizer). It is important to differentiate careful COVID-19 practices with PTSD avoidance.

Session 9 of CPT focuses on trust issues, and, remaining Socratic in nature, providers should inquire about the meaning of “trust” and ask for examples of different kinds of trust. The provider and client can then both complete the trust-star diagram per the CPT protocol, either through the whiteboard feature or on a piece of paper. Afterward, the diagram can be held up to the screen to increase clients’ understanding of the material.

While delivering telehealth, providers should implement the same CPT protocol elements as they would in the office, and the same considerations about when to conclude CPT should be given during telehealth delivery. Originally, CPT was developed as a 12-session protocol, but some clients may need fewer sessions and some may need additional sessions to recover from PTSD. In a study of variable-length CPT, Galovski et al. (2012) found that 58% of civilians in their sample were “early responders,” recovering from symptoms of PTSD and depression in less than 12 sessions. Another 34% of participants were “late responders,” characterized as achieving PTSD recovery in 13 to 18 sessions. Current guidance from the CPT manual (Resick, Monson, et al., 2017) suggests providers and clients should consider discussing the completion of CPT when PCL-5 scores are reduced below 20 and client goals are achieved (pp. 242–243). The discussion between the client and provider to determine CPT completion should be collaborative. During the last session, the client should receive or be shown a graph demonstrating their improvement in PTSD and depression symptoms (Resick, Monson, et al., 2017; p. 59). The graph can be sent electronically or held up to the screen for the client to see. Alternatively, it may be more easy or convenient to use screen-sharing, if available. If the client has been using the CPT Coach app, they can complete the PCL-5 and see the graph there. Completion certificates should also be shared with the client. Both the graph and completion certificate should be sent via the clients’ preferred method of delivery.

Traditional guidance when delivering CPT is to recognize the importance of staying on track with the CPT sessions and remaining trauma-focused (see “Therapist Readiness” in the CPT manual; Resick, Monson, et al., 2017; pp. 68–78). At the outset, therapists should assure clients that if a crisis occurs, they will discuss the possibility of adding an off-protocol crisis session. If or when a crisis does occur, providers and clients should collaboratively discuss whether to continue the CPT session as planned or to have a crisis session. Clients should be encouraged to use their CPT skills out of session to examine their thoughts related to the crisis. If a crisis session is offered, providers should utilize the CPT framework and assign appropriate practice assignment worksheets to examine some of the big thoughts or stuck points the client is having regarding the crisis. These stuck points can be added to the log for continued practice after the crisis session. At the end of the crisis session, the provider and client should discuss getting back on track with the CPT protocol, and the provider should reassign the appropriate practice assignments for the next session.

We have observed clients engaged in CPT responding to COVID-19 in several different ways. Some clients have been minimally affected and are proceeding with treatment as usual. Others are finding that the physical distancing associated with COVID-19 has reinforced avoidance and, in some ways, lessened some of their immediate PTSD symptoms. It is possible that clients have been affected economically and may have new stressors that require case management, a problem-solving approach to therapy, or a break from mental health treat-

ment. Additionally, some clients have been struggling with the COVID-19 pandemic and all it entails, and these reactions have been able to be incorporated into CPT while keeping the treatment trauma-focused.

There are individuals for whom the index trauma is a COVID-19–related event. Early research findings from countries first affected by the COVID-19 pandemic have shown PTSD symptoms to occur among individuals most affected by COVID-19–related traumatic events (Chew et al., 2020; Wang et al., 2020). For example, exposure to patient or colleague deaths, involuntary quarantine, working in settings with a high risk of viral exposure and without protective gear, or having to make difficult decisions about the allocation of medical interventions all are the types of events that can lead to PTSD. For these types of events, assimilation stuck points may involve hindsight bias concerning ways the index event could have been prevented or may involve inappropriate self- or other-blame (e.g., “I should not have attended the concert in February 2020;” “If I had intu-bated the patient, my colleague, sooner, he wouldn’t have died;” “My mother should have been better at self-quarantine”). Using Socratic dialogue, these beliefs would be addressed early in CPT as assimilation in the same way other index traumas are addressed. This includes consideration of the context at the time, the likely options the individual had, and the information they had at the time.

For other cases in which COVID-19 is not the focus of PTSD treatment, erroneous beliefs about COVID-19 can be labeled as thoughts and added to the client’s Stuck Point Log for later examination. Early in CPT, the focus is on stuck points regarding the index traumatic event itself (i.e., resolving assimilated beliefs, including erroneous beliefs about the causes of the event). Therefore, beliefs about COVID-19 should not take precedence over these early treatment targets. Most likely, stuck points related to COVID-19 will be overaccommodated beliefs (i.e., inaccurate, overgeneralized beliefs; beliefs about the present and the future), and, therefore, they can be addressed later in treatment after assimilated beliefs are targeted. However, if the COVID-19 beliefs are interfering with early treatment delivery, there are ways to incorporate them earlier, even while keeping the primary focus on the index trauma. For example, if a client is indicating that “There’s no point working on my PTSD because I am going to die from COVID-19,” the provider may choose to use this stuck point as the example when introducing a new worksheet. Additionally, when clients are first assigned the A-B-C and Patterns of Problematic Thinking worksheets, they are encouraged to notice their day-to-day thinking and complete worksheets on everyday thoughts as well as stuck points about their traumatic experience. Therefore, clients can focus on COVID-19 stuck points, even early in treatment, when needed. However, it is important that treatment does not come to focus exclusively on COVID-19 and that the primary focus remains on beliefs about the traumatic event. If COVID-19 beliefs or issues are more significant than can be addressed in these ways during the early phases of treatment, providers may offer the client one of their crisis sessions to problem-solve is-

sues or process emotions, returning to the CPT protocol at the next session. It may also be helpful for providers to consider whether resolving PTSD symptoms may help clients manage COVID-19 stress as motivation to continue to work on their trauma-related symptoms. It is important to note that clients may vacillate between being affected and unaffected, and flexibility and collaborative decision-making is essential.

As assimilated beliefs are resolved, the next phase of treatment moves to a focus on overaccommodated beliefs, and beliefs about COVID-19 can fit into a number of the later modules. For example, beliefs about COVID-19 may fit in the safety module (e.g., “If I go outside, I will get sick and die”) or the power/control module (e.g., “I’m completely powerless”). These beliefs can be targeted using the same CPT skills used to address other overaccommodated beliefs (e.g., considering probabilities, weighing the evidence, noticing exceptions, recognizing problematic thinking patterns such as jumping to conclusions). For example, providers and clients can calculate probabilities based on the evidence similar to the recommendations in the CPT safety module (Resick, Monson, et al., 2017; pp. 185–187). Whenever possible, providers are encouraged to look for thematic connections between COVID-19 beliefs and other trauma-related stuck points. For example, do the client’s stuck points regarding COVID-19 fit with a broader pattern of jumping to conclusions and assuming the worst or of underestimating their control? Likewise, clients may have thoughts like, “It’s wrong that innocent people are dying,” reflecting the just-world belief that “Good things happen to good people, and bad things happen to bad people;” in other words, that things are supposed to be fair. This type of thinking about COVID-19 may be consistent with previously identified just-world beliefs related to the traumatic event and can be pointed out and examined.

Finally, although many beliefs about COVID-19 may be stuck points, it is likely that other thoughts and emotions that arise may, in fact, be accurate and appropriate to the situation and would thus be handled differently in treatment. For example, some clients may experience the natural emotions of grief and loss related to COVID-19, which need to be processed, consistent with how CPT encourages clients to experience natural emotions related to stressful events. Overall, it is possible to incorporate COVID-19 beliefs and emotions into CPT while adhering to fidelity and remaining trauma-focused.

### Other Considerations in CPT Telehealth

When implementing CPT, telehealth with video is recommended, yet there may be times where streaming video is unreliable or unstable. In these times, completing a session via telephone is acceptable. If a video connection is poor or lost completely, providers and clients should be prepared to complete the session via telephone. Research on client acceptability, comfort, and preferences regarding telephone-based therapy is limited, but telephone care appears to be as acceptable as other modalities (Cuijpers et al., 2019). Although many providers

and organizations have rapidly moved to telehealth with video capabilities, there are still many clients who are unable to engage in telehealth for a variety of reasons, including unstable or no internet access and lack of access to acceptable technology. If there is no capability of conducting telehealth sessions via video, we recommend collaborative decision-making with the client to determine if implementing CPT without video capabilities is appropriate. Through collaborative decision-making and using clinical judgment for situations in which video is not feasible, CPT may be conducted via telephone.

Telehealth can create other challenges due to factors that may be apparent during an in-person visit that may be easy to miss in telehealth sessions. For example, it can be more difficult for a provider to identify or respond to clients who are intoxicated or high due to the loss of immediate cues (Gros et al., 2013). Providers should be attentive to cues indicating a client may be under the influence of alcohol or drugs and be able to address it as a clinical issue (e.g., slurred speech). In cases where this is a higher level of concern, such as with clients undergoing treatment of PTSD with alcohol dependence, clients can be provided with a device to estimate breath alcohol content remotely. Generally, providers should discuss treatment expectations regarding substance use before starting CPT via telehealth, including the importance of abstaining from use before sessions. This should also include a treatment contract or safety plan and plans to respond to acute crises.

An early discussion regarding planning for anticipatory anxiety and how to manage these emotions virtually may enhance motivation for clients to remain engaged in therapy. This discussion can be integrated into the first session of CPT. Though rare, clients may become extremely upset during a session. It is necessary to use clinical judgment and keep them online until their distress is attenuated. If clients prematurely leave a session, it is necessary to attempt to contact the client via telephone. If a patient support person has been designated, this individual should be notified if the client is unable to be contacted. If clients indicate increased risk during a session, a full risk assessment should be conducted, as would be the case with in-person care, with appropriate risk intervention. If an immediate intervention is required, providers should continue to remain on the video call or telephone with the client until additional support arrives. It is important to note that CPT has been shown to decrease suicidal ideation in active duty military service members (Bryan et al., 2016). Therefore, it is appropriate to conduct CPT via telehealth with clients who have preexisting suicidal ideation if there is no imminent danger to self or others.

### Discussion

Previous studies have demonstrated that CPT is effective when delivered via telehealth. Given the recent COVID-19 pandemic, providers and clients have had to adjust how therapy is delivered. Our hope is that this article provides practical

recommendations and guidance regarding the delivery of CPT via telehealth. It is necessary to obtain required consents, use the most secure methods to deliver the intervention and exchange documents, and adhere to jurisdiction-specific licensure requirements. It is also necessary to strategize how to send and receive relevant measures and practice assignments to maintain fidelity while working within clients' capabilities. Telehealth offers a way to increase access to care in general as well as in unexpected circumstances, such as the COVID-19 pandemic. Client-centered care encourages providers to consider clients' preferences when making decisions, and some individuals may prefer telehealth because it overcomes numerous barriers to care.

The challenges for mental health providers during the COVID-19 pandemic are currently unfolding. From a broad perspective, responses to a pandemic include increased anxiety, sleep disturbance, increased alcohol and drug use, and exacerbated mental health conditions, such as PTSD (Centers for Disease Control and Prevention [CDC], 2020). Clinicians are challenged to target trauma-related cognitions, overgeneralizations, and exaggerated beliefs related to financial insecurity and isolation; encourage self-care; and combat misinformation related to COVID-19. Additionally, there is currently no research on trauma-related responses secondary to a diagnosis of COVID-19, an ongoing concern given the lethality of the virus compared to common influenza (CDC, 2020). Patients who have recovered from COVID-19, have loved ones with a COVID-19 diagnosis, or are first responders may experience acute stress disorder or PTSD, for which CPT would be helpful. Healthcare workers who have witnessed frequent deaths and concurrent helplessness, as well as the danger to themselves when given inadequate protection, may also develop PTSD. Future research should examine specific COVID-19-related acute and chronic psychological responses, and any necessary adaptations to CPT given expected trauma exposure, grief, depression, and isolation.

At this time, the CPT manual (Resick, Monson, & Chard, 2017) is available in English and Polish. Patient handouts are available in French, Spanish, and Japanese. Spanish translations of the CPT manual are available on the CPT for PTSD website ([www.cptforptsd.com](http://www.cptforptsd.com)). The CPT Coach smartphone application is available in English. There is a great need for additional resources to be developed for non-English speakers, both now and in the future. Future research is also needed to extend CPT and other therapies to telephone delivery and asynchronous texting. Should the pandemic continue, future research should also explore whether CPT skills could be used prophylactically to reduce the risk of PTSD among groups with a higher risk of developing symptoms.

Although it may not be medically necessary to continue delivering CPT via telehealth after the pandemic, providers may consider continuing to provide telehealth as a standard option for clinical care given its acceptability, feasibility, and effectiveness. The use of telehealth has the potential to not only deliver effective care but also to increase the reach of CPT to individu-

als who need it most and reduce the emotional, economic, and societal impact of PTSD.

## References

- American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- American Psychological Association (2020, April 9). *Telepsychiatry and COVID-19: Update on Telehealth Restrictions in Response to COVID-19*. [https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/apa-resources-on-telepsychiatry-and-covid-19?utm\\_source=Internal-Link&utm\\_medium=COVID-HUB&utm\\_campaign=Covid-19](https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/apa-resources-on-telepsychiatry-and-covid-19?utm_source=Internal-Link&utm_medium=COVID-HUB&utm_campaign=Covid-19)
- Bovin, M. J., Marx, B. P., Weathers, F. W., Gallagher, M. W., Rodriguez, P., Schnurr, P. P., & Keane, T. M. (2016). Psychometric properties of the PTSD Checklist for the *Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition* (PCL-5) in veterans. *Psychological Assessment, 28*, 1379–1391. <https://doi.org/10.1037/pas0000254>
- Brown, F. W. (2017). Telepsychiatry and health technologies: A guide for mental health professionals. *The American Journal of Psychiatry, 174*, 1126–1126. <https://doi.org/10.1176/appi.ajp.2017.17040418>
- Bryan, C. J., Clemans, T. A., Hernandez, A. M., Mintz, J., Peterson, A. L., Yarvis, J. S., Resick, P. A., & the STRONG STAR Consortium. (2016). Evaluating potential iatrogenic suicide risk in trauma-focused group cognitive behavioral therapy for the treatment of PTSD in active duty military personnel. *Depression and Anxiety, 33*, 549–557. <https://doi.org/10.1002/da.22456>
- Center for Disease Control and Prevention (2020, April 8). *Coronavirus (COVID-19)*. <https://www.cdc.gov/coronavirus/2019-ncov/index.html>
- Chard, K.M. (2005). An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood sexual abuse. *Journal of Consulting and Clinical Psychology, 73*, 965–971. <https://doi.org/10.1037/0022-006X.73.5.966>
- Chew, N. W., Lee, G. K., Tan, B. Y., Jing, M., Goh, Y., Ngiam, N. J., Yeo, L. L., Ahmad, A., Khan, F. A., Shanmugam, G. N., & Sharma, A. K. (2020). A multinational, multicentre study on the psychological outcomes and associated physical symptoms amongst healthcare workers during COVID-19 outbreak. *Brain, Behavior, and Immunity*. Advance online publication. <https://doi.org/10.1016/j.bbi.2020.04.049>
- Cuijpers, P., Noma, H., Karyotaki, E., Cipriani, A., & Furukawa, T. A. (2019). Effectiveness and acceptability of cognitive behavior therapy delivery formats in adults with depression: A network meta-analysis. *JAMA Psychiatry, 76*, 700–707. <https://doi.org/10.1001/jamapsychiatry.2019.0268>
- Fortney J. C., Heagerty, P. J., Bauer, A. M., Cerimele, J. M., Kaysen, D., Pfeiffer, P. N., Zielinski, M. J., Pyne, J. M., Bowen, D., Russo, J., & Ferro, L. (2020). Study to Promote Innovation in Rural Integrated Telepsychiatry (SPIRIT): Rationale and design of a randomized comparative effectiveness trial of managing complex psychiatric disorders in rural primary care clinics. *Contemporary Clinical Trials, 90*, 105873. <https://doi.org/10.1016/j.cct.2019.105873>
- Galovski, T. E., Blain, L., Mott, J., Elwood, L., & Houle, T. (2012). Manualized therapy for PTSD: Flexing the structure of cognitive processing therapy. *Journal of Consulting and Clinical Psychology, 80*, 968–981. <https://doi.org/10.1037/a0030600>
- Greene-Shorridge, T. M., Britt, T. W., & Castro, C. A. (2007). The stigma of mental health problems in the military. *Military Medicine, 172*, 157–161. <https://doi.org/10.7205/MILMED.172.2.157>
- Gros, D. F., Lancaster, C. L., López, C. M., & Acierno, R. (2018). Treatment satisfaction of home-based telehealth versus in-person delivery of prolonged exposure for combat-related PTSD in veterans. *Journal of Telemedicine and Telecare, 24*, 51–55. <https://doi.org/10.1177/1357633X16671096>

- Hassija, C. M., & Gray, M. J. (2011). The effectiveness and feasibility of videoconferencing technology to provide evidence-based treatment to rural domestic violence and sexual assault populations. *Telemedicine and e-Health, 17*, 309–315. <https://doi.org/10.1089/tmj.2010.0147>
- U.S. Department of Health and Human Services (2020). *Notification of enforcement discretion for telehealth remote communications during the COVID-19 nationwide public health emergency*. <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>
- Hoge, C. W., Grossman, S. H., Auchterlonie, J. L., Riviere, L. A., Milliken, C. S., & Wilk, J. E. (2014). PTSD treatment for soldiers after combat deployment: Low utilization of mental health care and reasons for dropout. *Psychiatric Services, 65*, 997–1004. <https://doi.org/10.1176/appi.ps.201300307>
- Kazdin, A. E., & Blasé, S. L. (2011). Rebooting psychotherapy research and practice to reduce the burden of mental illness. *Perspectives on Psychological Science, 6*, 21–37. <https://doi.org/10.1177/1745691610393527>
- Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of Internal Medicine, 16*, 606–613. <https://doi.org/10.1046/j.1525-1497.2001.016009606.x>
- Maierssch, K. P., Smith, T. L., Hessinger, J. D., Ahearn, E. P., Eickhoff, J. C., & Zhao, Q. (2016). Randomized controlled equivalence trial comparing videoconference and in person delivery of cognitive processing therapy for PTSD. *Journal of Telemedicine and Telecare, 22*, 238–243. <https://doi.org/10.1177/1357633X15596109>
- McGeary, D. D., McGeary, C. A., & Gatchel, R. J. (2012). A comprehensive review of telehealth for pain management: Where we are and the way ahead. *Pain Practice, 12*, 570–577. <https://doi.org/10.1111/j.1533-2500.2012.00534.x>
- Monson, C. M., Schnurr, P. P., Resick, P. A., Friedman, M. J., Young-Xu, Y., & Stevens, S. P. (2006). Cognitive processing therapy for veterans with military-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 74*, 898–907. <https://doi.org/10.1037/0022-006X.74.5.898>
- Morland, L. A., Mackintosh, M. A., Greene, C. J., Rosen, C., Chard, K., Resick, P., & Frueh, B. C. (2014). Cognitive processing therapy for posttraumatic stress disorder delivered to rural veterans via telemental health: A randomized noninferiority clinical trial. *Journal of Clinical Psychiatry, 75*, 470–476. <https://doi.org/10.4088/JCP.13m08842>
- Morland, L. A., Mackintosh, M., Rosen, C. S., Willis, E., Resick, P., Chard, K., & Frueh, B. C. (2015). Telemedicine vs. in-person delivery of cognitive processing therapy for women with posttraumatic stress disorder: A randomized non-inferiority trial. *Depression and Anxiety, 32*, 811–820. <https://doi.org/10.1002/da.22397>
- Peterson, A. L., Mintz, J., Moring, J. C., Nability, P. S., Bira, L. M., McCaughan-Young, S., Hale, W. J., McGeary, C. A., Litz, B. T., McGeary, D. D., Velligan, D. I., Macdonald, A., Mata-Galan, E., Holliday, S. L., Dillon, K. H., Roache, J. D., & Resick, P. A., for the STRONG STAR Consortium. (2019, October). In-office, in-home, and telebehavioral health cognitive processing therapy for combat-related PTSD: Preliminary results of a randomized clinical trial. Paper presented at the San Antonio Combat PTSD Conference, San Antonio, TX.
- Prins, A., Bovin, M. J., Kimerling, R., Kaloupek, D. G., Marx, B. P., Pless Kaiser, A., & Schnurr, P. P. (2015). *Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)*. [Measurement instrument]. <https://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp>
- Resick, P. A., Galovski, T. E., Uhlmansiek, M. O., Scher, C. D., Clum, G. A., & Young-Xu, Y. (2008). A randomized clinical trial to dismantle components of cognitive processing therapy for posttraumatic stress disorder in female victims of interpersonal violence. *Journal of Consulting and Clinical Psychology, 76*, 243–258. <https://doi.org/10.1037/0022-006X.76.2.243>
- Resick, P. A., Monson, C. M., & Chard, K. M. (2017). *Cognitive processing therapy for PTSD: A comprehensive manual*. New York, NY: Guilford Press.
- Resick, P. A., Wachen, J. S., Dondanville, K. A., Pruiksma, K. E., Yarvis, J. S., Peterson, A. L., & Mintz, J., for the STRONG STAR Consortium. (2017). Effect of group vs. individual cognitive processing therapy in active-duty military seeking treatment for posttraumatic stress disorder: A randomized clinical trial. *JAMA Psychiatry, 74*, 28–36. <https://doi.org/10.1001/jamapsychiatry.2016.2729>
- Rosner, R., Rimane, E., Frick, U., Gutermann, J., Hagl, M., Renneberg, B., Schreiber, F., Vogel, A., & Steil, R. (2019). Effect of developmentally adapted cognitive processing therapy for youth with symptoms of posttraumatic stress disorder after childhood sexual and physical abuse: A randomized clinical trial. *JAMA Psychiatry, 75*, 484–491. <https://doi.org/10.1001/jamapsychiatry.2018.4349>
- Richardson, L. K., Frueh, B. C., Grubaugh, A. L., Eggede, L., & Elhai, J. D. (2009). Current directions in videoconferencing tele-mental health research. *Clinical Psychology Science and Practice, 16*, 323–338. <https://doi.org/10.1111/j.1468-2850.2009.01170.x>
- Wang, C., Pan, R., Wan, X., Tan, Y., Xu, L., McIntyre, R. S., Choo, F. N., Tran, B., Ho, R., Sharma, V. K., & Ho, C. (2020). A longitudinal study on the mental health of general population during the COVID-19 epidemic in China. *Brain, Behavior, and Immunity*. Advance online publication. <https://doi.org/10.1016/j.bbi.2020.04.028>
- Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013). *The Life Events Checklist for DSM-5 (LEC-5)*. Instrument available from the National Center for PTSD at [www.ptsd.va.gov](http://www.ptsd.va.gov)
- Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). The PTSD Checklist for DSM-5 (PCL-5). Scale available from the National Center for PTSD at [www.ptsd.va.gov](http://www.ptsd.va.gov)