

Accelerated Prolonged Exposure Therapy for Posttraumatic Stress Disorder in a Veterans Health Administration System

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Background: Prolonged exposure (PE) therapy for posttraumatic stress disorder (PTSD) is an evidence-based psychotherapy (EBP) supported by multiple clinical practice guidelines. This article describes an innovative program delivering EBP PE therapy for veterans with PTSD.

Observations: The Intensive Virtual EBP Team (iVET) for PTSD was developed and implemented at the Veterans Affairs Pacific Islands Health Care System. iVET for PTSD is a 3-week telehealth program with 3 main components: (1) massed PE therapy for PTSD (4 sessions per week); (2) whole health and wellness classes (4 group sessions per week); and (3) individual health coaching to address personal wellness goals (1 session per week). In the initial 2.5 years of operation, the program had an 81% retention rate. Patients who participated in iVET for

PTSD experienced significantly reduced PTSD, depression, anxiety, and substance use; improved quality of life; and reported high satisfaction with mental health care services. iVET for PTSD mental health care practitioners had increased compassion satisfaction and perceived support, and reduced burnout, secondary traumatic stress, and moral distress over the initial 6 months of providing massed PE in iVET.

Conclusions: Virtual massed PE therapy for a diverse veteran population with PTSD is feasible, acceptable, and effective, with high retention rates and patients reporting high satisfaction with mental health services. In addition, delivering PE for PTSD in a massed format is feasible and acceptable among staff and appears to contribute to improved job satisfaction and professional quality of life.

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Evidence-based psychotherapy (EBP) for posttraumatic stress disorder (PTSD), such as prolonged exposure (PE), is supported by multiple clinical practice guidelines and is expected to be available to veterans served by the Veterans Health Administration (VHA).¹⁻⁵ However, traditional models of EBP delivery with 1 or 2 sessions weekly have high dropout rates.^{6,7} Few veterans who could benefit from such EBPs receive them, and those who do have low completion rates.^{8,9} Over a 15-year period, VHA records review of > 265,500 veterans with PTSD showed only 9.1% completed EBP treatment that included but was not limited to PE.¹⁰

One empirically supported solution that has yet to be widely implemented is delivering EBPs for PTSD in a massed or accelerated format of ≥ 3 sessions weekly.¹¹ While these massed models of EBP delivery for PTSD are promising, their implementation is limited in federal health care settings, such as the VHA.¹² PE therapy is a first-line treatment for PTSD that has been evaluated in numerous clinical trials since the early 1990s and in a wide range of trauma populations.^{13,14} Massed PE is effective and PE has been found to be effective both in-person and via telehealth.^{11,15,16}

Another approach to accelerated PE is the inclusion of a massed PE course within a

broader treatment context that includes augmentation of the massed PE with additional services, this is referred to as an intensive outpatient model (IOP).¹⁷ PE-IOP has also been shown to be feasible, acceptable, and effective with increased completion rates in comparison to the traditional (1 or 2 sessions weekly) model of PE.^{12,16,18,19} Ragsdale et al describe a 2-week IOP with multiple treatment tracks, including a PTSD track. The PTSD treatment track includes massed PE and additional standard services including case management, wellness services, family services, and a single session effective behaviors group. Additional augmentation services are available when clinically indicated (eg, repetitive transcranial magnetic stimulation, transcranial direct current stimulation treatment, psychoeducation, motivational interviewing, and/or relapse prevention).¹⁷

Rauch et al studied the first 80 patients completing an IOP program that consisted of PE (5 sessions weekly) and complementary interventions (eg, mindfulness and yoga) and reported a 96% retention rate, significant reductions of self-reported PTSD symptoms, significant reduction in self-reported co-occurring depression symptoms, and significant increase in self-reported satisfaction with social functioning.¹⁸ In another study, Sherril et al explored

patient reactions to participation in massed PE (5 sessions weekly) and found that patients reported significantly more positive than negative reactions. Sherrill et al noted that according to patients, the benefits of massed PE included a structured format that limits avoidance and distraction. The resulting fast pace of progress enhanced motivation; however, drawbacks included short-term discomfort and time demands.¹⁹ Yamokoski et al explored the feasibility of massed PE in a larger study of PTSD treatment in an intensive outpatient track (IOT) in a VHA PTSD clinic with minimal staffing. The 48 patients who completed IOT PTSD treatment in 2 or 4 weeks (including 35 patients who received massed PE) had high retention rates (85%), reported high satisfaction, and had significantly reduced PTSD and depression symptoms.¹²

The massed IOT PE model implemented by Yamokoski et al included the primary EBP intervention of massed PE with adjunctive groups. The addition of these groups increased both retention and patient-reported satisfaction. The PE-IOP model implemented by Rauch et al and Sherrill et al also included wellness and educational groups, as well as access to complementary interventions such as mindfulness and yoga.^{18,19} The addition of wellness education along with a primary EBP aligned with the VHA focus on whole health well-being and wellness. The whole health approach includes understanding the factors that motivate a patient toward health and well-being, provision of health education, and providing access to complementary interventions such as mindfulness.²⁰ Dryden et al describe the whole health transformation within VHA as a proactive approach to addressing employee and patient wellness and health. Their research found that the whole health model promoted well-being in patients and staff and was sustained even during the COVID-19 pandemic.²¹ Dryden et al also noted that use of virtual technologies facilitated and promoted continued whole health implementation. The literature illustrates that: (1) massed PE can be provided with complementary education and wellness offerings, and that such offerings may increase both retention and satisfaction by enriching the massed PE treatment (eg, delivering PE-IOP); (2) whole health including wellness education and complementary interventions (eg, mindfulness, mo-

TABLE 1. iVET for Posttraumatic Stress Disorder Demographics (N = 132)

Characteristic	Result
Age, y	
Mean	46.2
Range	23-79
Gender, No. (%)	
Male	92 (69.7)
Female	40 (30.3)
Nonbinary	0
Race, No. (%)	
White	37 (28.0)
Black/African American	20 (15.2)
Asian/Pacific Islander	38 (28.8)
Native American/Alaska Native	4 (3.0)
Other/multiple	18 (13.6)
Prefer not to answer	9 (6.8)
Ethnicity, No. (%)	
Hispanic	17 (12.9)
Non-Hispanic	103 (78.0)
Prefer not to answer	12 (9.1)

tivational enhancement) promotes well-being in both patients and mental health professionals; and (3) whole health education and complementary interventions can be delivered virtually.

Health Care Need

Prior to the implementation of a massed EBP for PTSD program at US Department of Veterans Affairs (VA) Pacific Islands Health Care System (VAPIHCS), our setting included a traditional outpatient program for treatment of PTSD and a 12-bed residential program for treatment of PTSD for male-identified (self-identified and identified as male in the electronic medical record) veterans via a cohort model with an 8- or 9-week length of stay. Both programs were located on Oahu. Thus, veterans who received care at VAPIHCS had access to PE in both outpatient and residential settings and via in-person and telehealth modalities. However, their access to PE was limited to the traditional models of PE delivery (eg, 1 or 2 session per week) and very few veterans outside of the island of Oahu had accessed PE treatment for PTSD. Moreover, when looking at PE reach within VAPIHCS, in the fiscal year prior to the implementation of the massed EBP program, only 32 of the > 5000 eligible veterans with a PTSD diagnosis had received PE. VAPIHCS serves veterans in a catchment area across the Pacific Basin which includes 3 time zones: Hawaii Standard Time (HST), Chamorro

TABLE 2. iVET for Posttraumatic Stress Disorder Program Outcomes (n = 132)

Test	Initial session (mean)	Final session (mean)	P value
PCL-5 ^a	44.63	26.27	< .005
PHQ-9			
All 9 items ^a	14.14	9.36	< .005
Item 9 only ^{a,b}	0.42	0.21	< .005
GAD-7 ^a	12.90	7.88	< .005
Brief Addiction Monitoring			
Use ^a	1.78	0.92	< .005
Risk ^a	11.62	8.97	< .005
Protective	12.15	12.50	.35
Q-LES-Q-SF ^a	37.65	46.08	< .005

Abbreviations: GAD-7, Generalized Anxiety Disorder 7-item scale; PCL-5, PTSD Checklist for DSM-5; PTSD, posttraumatic stress disorder; PHQ-9, Patient Health Questionnaire 9-item scale; Q-LES-Q-SF, Quality of Life Enjoyment and Satisfaction Questionnaire - Short Form.

^aStatistically significant.

^bEvaluates suicidal ideation or self-injury.

Standard Time (ChST), and Samoa Standard Time (SST). ChST is 20 hours ahead of HST, making service delivery that is inclusive for patients in Guam and Saipan especially challenging when providing care from Hawaii or other US states or territories. Given all of this, implementation of a new program offering accelerated PE virtually to any veterans with PTSD within the VAPIHCS would increase access to and reduce barriers to receiving PE.

PROGRAM DESCRIPTION

The Intensive Virtual EBP Team (iVET) for PTSD consists of an accelerated course of PE therapy and whole health education provided via VA Video Connect (VVC). iVET is a 3-week program and includes 3 parts: (1) massed individual PE therapy for PTSD; (2) group whole health and wellness classes; and (3) individual health coaching to address personal wellness goals. Programming is offered over 10-hour days to increase access across multiple time zones, especially to allow for participation in Guam and Saipan.

When a patient is referred to the iVET, their first contact is a video (or telephone) appointment with a registered nurse (RN) for a screening session. The screening session is designed to educate the patient about the program, including interventions, time commitment, and resources required for participation. In addition, following the educational discussion, the RN completes screening for safety with the patient including suicidal ideation and risk, as well as intimate partner violence risk. If urgent safety

concerns are present, a licensed social worker or psychologist will join the screening to complete further assessment of risk and to address any safety concerns. Following screening, patients are scheduled for a VVC intake with a licensed therapist (social worker or psychologist) to complete the Clinician-Administered PTSD Scale (CAPS-5) for the *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition), a clinical interview for PTSD assessment. Patients are also sent a secure link to complete a measurement-based care (MBC) battery of self-report measures including measures assessing demographics, PTSD symptoms, anxiety symptoms, depression symptoms, substance use, quality of life (QOL), and satisfaction with mental health care. The results of the CAPS-5 and self-report measures are discussed with the patient during the intake session when planning next steps and engaging in shared decision-making. This initial VVC intake not only allows for diagnostic goodness of fit but also provides the opportunity to troubleshoot any technical difficulties the patients might have with the virtual platforms.

There are minimal exclusion criteria for participation in iVET, which include active unmanaged psychosis or manic symptoms, recent suicidal crises (attempt within 8 weeks), active nonsuicidal self-injurious behaviors (within 8 weeks), and moderate-to-severe cognitive impairment. Following intake, patients are scheduled to begin their course of care with iVET. Upon completion of intake, patients are sent program materials for their individual and group

classes, asked to obtain or request a recording device, and told they will receive email links for all VVC appointments. Patients are admitted to the iVET in a rolling admission fashion, thereby increasing access when compared to closed group and/or cohort models of care.

Patients receiving care in iVET attend 2 or 3 telehealth appointments daily with practice exercises daily between telehealth sessions. The primary EBP intervention in the iVET for PTSD program is a massed or accelerated course of PE, which includes 4 primary components: psychoeducation, in-vivo exposure, imaginal exposure, and breathing retraining. Specifically, PE is delivered in 4 90-minute individual sessions weekly allowing completion of the full PE protocol, to fidelity, in 3 weeks. In addition to receiving this primary intervention, patients also participate in four 50-minute group sessions per week of a whole health and wellness education class and have access to one 30- to 60-minute session weekly of individual health coaching should they wish to set wellness goals and receive coaching in support of attaining wellness goals. During iVET, patients are invited to complete MBC batteries of self-report measures including measures assessing PTSD symptoms, anxiety symptoms, depression symptoms, substance use, QOL, and satisfaction with mental health care at sessions 1, 5, 9, and the final session of PE. Following discharge from the iVET, patients are offered 1-month, 3-month, and 6-month individual postdischarge check-up sessions with a therapist where they are invited to complete MBC measures and review relapse prevention and maintenance of treatment gains. Likewise, they are offered 1-month, 3-month, and 6-month postdischarge check-up sessions with an RN focused on maintaining wellness gains.

The iVET for PTSD staff includes 3 therapists (psychologists or social workers) and an RN. Additionally, the iVET for PTSD is supported by a program manager and a program support assistant. The primary cost of the program is salary for staff. Additional iVET for PTSD resources included computer equipment for staff and minimal supplies. Due to the virtual environment of care, iVET staff telework and do not require physical space within VAPIHCS.

OUTCOMES

All veterans receiving care in iVET for PTSD are invited to complete a MBC at multiple

timepoints including pretreatment, during PE treatment, and posttreatment. The MBC measures included self-reported demographics, a 2-item measure of satisfaction with mental health services, the Brief Addiction Monitor-Intensive Outpatient Program questionnaire,²² the Generalized Anxiety Disorder-7 scale,²³ the Patient Health Questionnaire (PHQ-9),²⁴ the QOL Enjoyment and Satisfaction Questionnaire-Short Form,²⁵ and the PTSD Checklist for DSM-5 (PCL-5), both weekly and monthly versions.^{26,27}

The retention rate has averaged 81% since the iVET for PTSD opened in 2022. To date, 132 veterans have completed the iVET for PTSD program, including a full course of massed PE (Table 1). Veterans experienced reduced PTSD ($P < .005$), depression ($P < .005$), anxiety ($P < .005$), and substance use risk ($P < .005$). Veterans experienced improved QOL ($P < .005$) and reported high satisfaction with mental health care in iVET for PTSD (Table 2). Veterans also experienced reduced thoughts of death or suicidal ideation (SI) based on PHQ-9 item 9 responses. When looking categorically at presence or absence of SI on PHQ-9 item 9, a significant relationship was found between the absence of suicidal ideation and completion of a course of massed PE: $\chi^2 (1, N = 132) = 13.75, P < .001$. In addition, veterans who completed the program showed a significant decrease in severity of SI as measured continuously (range, 0-3) on PHQ-9 item 9 ($P < .005$).

Another important aspect to consider when implementing massed models of EBP is the impact on employee well-being and job satisfaction. The impact of EBP on staff was assessed following the initial EBP project. To explore this further, all staff members in the iVET for PTSD were invited to engage in a small program evaluation. iVET staff were guided through a visualization meditation intended to recall a typical workday 1 month prior to starting their new position with iVET. After the visualization meditation, staff completed the Professional Quality of Life (ProQOL) scale, a 30-item, self-reported questionnaire for health care workers that evaluates compassion satisfaction, perceived support, burnout, secondary traumatic stress, and moral distress.²⁸ One week later, staff were asked to complete the ProQOL again to capture their state after the first 6 months into their tenure as iVET staff. iVET employees

experienced significantly increased perceived support ($P < .05$), reduced burnout ($P < .05$), reduced secondary traumatic stress ($P < .05$), and reduced moral distress ($P < .05$). Team members also remarked on the rewarding nature of the work and care model.

Future Directions

Future research should aim to sustain these outcomes as the iVET program continues to serve more veterans. Another important line of inquiry is longer-term follow-up, as exploring if outcomes are maintained over time is an important question that has not been answered in this article. In addition, we hope to see the accelerated model of care applied to treatment of other presenting concerns in mental health treatment (eg, anxiety, depression, insomnia). Expansion of accelerated mental health treatment into other federal and non-federal health care settings is another worthy direction. Finally, while short term (6 months) assessment of staff satisfaction in iVET was promising, ongoing assessment staff satisfaction over a longer timeframe (1-5 years) is also important.

CONCLUSIONS

PE for PTSD has been demonstrated to be effective and improve functioning and is supported by multiple clinical practice guidelines.¹⁻⁵ However, as federal practitioners, we must consider the reality that many of the individuals who could benefit are not engaging in PE and there is a high dropout rate for those that do. It is vital that we envision a future state where access to PE for PTSD is equitable and inclusive, retention rates are dramatically improved, and clinicians providing PE do not experience high rates of burnout.

We must continue exploring how we can better care for our patients and colleagues. We posit that the development of programs, or tracks within existing programs, that provide massed or accelerated PE for PTSD with virtual delivery options is an imperative step toward improved care. Federal health care settings treating trauma-exposed patients with PTSD, such as those within the US Department of Defense, Indian Health Services, Federal Bureau of Prisons, and VA, are well positioned to implement programs like iVET. We believe this model of care has great merit and foresee a future where all patients seeking PTSD treatment have the option to complete an accelerated or

massed course of PE should they so desire. The experiences outlined in this article illustrate the feasibility, acceptability, and sustainability of such programs without requiring substantial staffing and financial resources.

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Ethics and consent

The development of iVET was an Evidence Based Practice (EBP) Council approved project at Veterans Affairs Pacific Islands Health Care System and, as such, it is not considered research and is exempt from institutional review board review. The project was approved by the council on May 17, 2022, and Chief of Staff on May 20, 2022. The project final report was submitted to the EBP Council on February 9, 2023, and the project remains in the sustainment phase.

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