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Re-engaging Dropouts of Prolonged Exposure for PTSD Delivered via Home-Based Telemedicine or In Person: Satisfaction with Veteran-to-Veteran Support --Manuscript Draft--

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RUNNING HEAD: Veteran-to-Veteran Support during PE

Re-engaging Dropouts of Prolonged Exposure for PTSD Delivered via Home-Based Telemedicine or In Person: Satisfaction with Veteran-to-Veteran Support

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Abstract

This paper describes feasibility of and patient and peer satisfaction with a Veteran-to-Veteran peer support program purposefully integrated into Prolonged Exposure (PE) for Post-Traumatic Stress Disorder (PTSD) to address barriers contributing to dropout from both in person and telemedicine delivered PE. Specifically, patients who had dropped out of PE were offered the opportunity to return to treatment, this time with a peer who themselves had completed PE, who would join them during a limited number of PE in vivo exposure homework trials. About half of the Veterans who dropped out indicated willingness to return to treatment, noting the peer as central to this decision, and about a third actually returned to treatment. Participants reported high satisfaction with the program, as did peers. Peers reported that their own symptoms were not exacerbated by engaging in exposure homework with the patients. While in the military, service members are trained to leverage the power of the group toward mission specific tasks; and this training appears relevant to PTSD treatment in the present context.

Introduction

Prolonged Exposure (PE) is an effective treatment for Post-Traumatic Stress Disorder (PTSD) in Veterans, defined both in terms of symptom amelioration and subsequent reduced use of mental health services.¹⁻⁴ Indeed, among therapies for PTSD, PE has the most consistent support for its efficacy.⁵ Unfortunately, rate of dropout from PE and other evidence based PTSD treatments is about 28% in Randomized Control Trials (RCTs) and even higher in actual clinical practice.⁶ As such, identifying and resolving barriers to effective treatment completion is paramount. Telemedicine-delivered PE, specifically home-based telemedicine delivered PE in particular, was posited as a strategy to reduce dropout by addressing several factors related to psychotherapy attrition, such as travel time, cost, and stigma associated with visiting mental health clinics.⁷ Moreover, home-based telemedicine offers an affordable way to provide mental health services to rural and remote populations, or to those with physical conditions that make office based care difficult to obtain.^{8,9}

Despite apparent advantages of telemedicine in delivering evidence based PTSD treatment such as PE, recent research demonstrates comparable rates of dropout across in person and telemedicine modalities.¹⁰ In their examination of dropouts from two very large treatment outcome studies, Hernandez-Tejada et al.¹⁰ noted that, whereas Veterans receiving in person treatment expectedly cited problems with logistics (e.g., parking, travel time) as reasons for leaving treatment, those receiving care via home-based telemedicine reported higher levels of discomfort during PE in vivo exposure homework, although they did complete more therapy sessions prior to dropout (see also Morland, Greene, Ruzek, and Godleski).¹¹ Similar findings were observed by Tuerk, Ruggiero, Yoder, Gros, and Acierno,¹² who noted increased hyper-vigilance symptoms in patients receiving exposure therapy via telemedicine vs. in person. Overall, these findings suggest a need for clinical and administrative modifications to the standard exposure therapy protocol when delivered via home-based telemedicine.

Along these lines, prior research indicates social support may lower attrition from psychotherapy,¹³⁻¹⁵ and formalized peer social support programs, often referred to as “peer navigation” services, enhance treatment engagement by creating a means by which peers who have completed treatment assist those currently in treatment.^{16,17} Hernandez-Tejada et al.¹⁰ hypothesized that peer social support, brought to bear *directly during in vivo exposure homework*, might be particularly useful when treating PTSD via home-based telemedicine, potentially addressing, in part, the problem of dropout from PE. Note that employing peers in this way (i.e., directly in core treatment components) extends beyond typical peer support programs, which center on encouraging Veterans to enter and remain in treatment through peer-patient interactions that occur outside the specific context of actual treatment procedures (see Money et al.¹⁸ for a discussion of such Department of Defense and Veterans Administration programs).

To date, peer support has not been used directly during in vivo exposure homework, an aspect of PE often described as problematic by patients suffering from PTSD, particularly when PE is delivered remotely via telemedicine.¹⁰ Concerns related to using peers directly during treatment components include issues of confidentiality and liability, and fears that the peers themselves may experience intensified symptoms. Whereas confidentiality and liability issues are no different than those present in group therapy or other peer support programs, questions about peer impact and patient and peer satisfaction remain unanswered.

The present project examined patient and peer satisfaction when peers were used to provide social support directly during PE exposure therapy homework sessions. The authors focused on patient and peer satisfaction, an often neglected area of treatment outcome research, because treatment effectiveness is not the only indicator of quality of health services, and higher patient satisfaction tends to produce increased treatment compliance.^{19,20} The present study leveraged two randomized controlled trials (RCTs) comparing exposure therapy for PTSD delivered via in person vs. home-based telemedicine to assess feasibility and

patient/peer satisfaction of direct peer support when integrated with PE treatment in those who had dropped out of PE. The authors hypothesized that PE + Peer support would be feasible insofar as veterans would agree to return to treatment and complete additional PE sessions, and that this integrated treatment would be viewed as particularly welcome by those receiving treatment via telemedicine, and that patients and peers would report high satisfaction with the program.

Methods

Participants

Eighty-two Veterans (75 male and 7 female) who had dropped out of the aforementioned PTSD treatment outcome studies that compared PE delivered in person vs. home-based telemedicine were screened for this satisfaction study. Veterans ranged in age from 27 to 72 years and were from across war service eras (Vietnam, Post-Vietnam, Persian Gulf and OEF/OIF). As this paper describes patient and peer satisfaction with the program, outcome measures are presented only for descriptive purposes as follows: PTSD Checklist (PCL; described below) scores at treatment re-initiation (week 0 of the PE + peer support program that followed PE dropouts return to treatment) were $\bar{x} = 65.5$, (SD = 10.6) for those receiving treatment via Home-based telemedicine and $\bar{x} = 65.3$, (SD = 9.2) for those receiving treatment via traditional In Person methods. PCL scores showed a typical pattern of early intensification, followed by gradual reduction at week 12 for participants receiving PE+ Peer support via both Home-based telemedicine ($\bar{x} = 47.1$; SD = 5.6) and In Person ($\bar{x} = 50.2$, SD = 6.6).

Measures

Quantitative Measures

a. Number of post-dropout treatment sessions: count of additional PE treatment sessions completed by participants after treatment re-initiation with individualized Veteran-to-Veteran peer support.

b. Number of peer/participant interactions regarding in vivo assignments: minimum of 4 (1 per week for 4 weeks). The research team encouraged patients and peers to try to meet at least once a week but they could meet as many times they could in a period of 4 weeks which was the set period of time peer and participants were allowed to interact.

c. Patient Satisfaction with Treatment/Peer: Select item scores from the Barriers to Participation Scale (BTPS)-Modified.¹⁰ The original BTPS²¹ consists of 68 items (45 items rated on a 5-point-likert scale, 23 items in a yes/no format), asking participants to rate how often they experienced a variety of barriers that may have interfered with treatment. For this study, a subset of 7 satisfaction questions were adapted to focus on peer support as part of treatment, and were asked after the final meeting between patient and peer. As with the original BTPS, statements were rated on customized 5-point-likert scales. For the first four questions:

#3: "Scheduling of in vivo exposure with the peer was a problem."

#18: "I felt I had to give too much personal information to the peer."

#26: "The peer did not seem confident that treatment would work for me."

#27: "The peer did not seem confident in my ability to carry out homework."

The Likert scale response ranged from "0 never a problem, to 4 very often a problem."

For the fifth question:

7: I did not like the peer support specialist

The Likert scale response ranged from "0 I liked the peer a lot, to 4 I did not like the peer at all."

For the sixth question:

#22: "The atmosphere of the clinic..." (or for in home sessions: "The atmosphere created by using the iPad) ...made it uncomfortable for appointments."

The Likert scale response ranged from "0 no, the atmosphere was fine, to 4 it was very uncomfortable."

For the final question:

32: *“I do not feel the peer support specialist supported me or my efforts.”*

The Likert scale response ranged from *“0 peer was very supportive to 4 peer was never supportive.”*

d. *PTSD Checklist-Military (PCL-M)*.²² The PCL is a 17-item self-report measure of PTSD symptoms based on DSM-IV criteria. The PCL uses a 5-point Likert scale response format ranging from not at all (1) to extremely (5). Total scores on the PCL range from 17 to 85. A change of 10 points from the baseline score is considered clinically meaningful. The instrument is highly correlated with the Clinician Administered PTSD Scale ($r = .93$), has good diagnostic efficiency ($> .70$), and robust psychometrics with a variety of trauma.

²³ This measure was used to describe the sample, above.

Qualitative Measures

The authors created debriefing questions that were analyzed via content analysis.²⁵ The responses to the questions were tape-recorded and then transcribed verbatim by the research coordinator. Two of the three authors then independently reviewed the responses, identifying topics/themes related to the issue of satisfaction and treatment retention. The authors then compared their work to identify common topics or differences in their review. After eliminating redundancies and integrating their work, then common categories/topics were finally identified.

e. *Debriefing questions, open ended (peers and patients)*: Peers were debriefed by therapists after every meeting with patients using the following questions:

“What was your general impression of the in vivo homework meeting with the patient?”

“Was there anything about the in vivo meeting that you would like to tell us about?”

“Was there any area you think we need to improve or do differently?”

Similarly, patients were debriefed after every meeting using the following questions:

“What was your general impression of the in vivo homework meeting with the peer?”

“Do you think having a peer involved in your treatment in this way is useful?”

“Was there any area you think we need to improve or do differently?”

These questions rather than being done by the research coordinator were done by the therapist as the therapist was monitoring that the interactions were occurring as planned and to address any issues that would rise during the debriefing questions. Those questions are mostly related to the process of the in vivo activities when adding a third party but they may convey satisfaction wording as well.

Procedure

All participants who withdrew from treatment prior to achieving the minimum ‘dose’ of 8 sessions from the parent PTSD treatment studies, yet still met DSM-IV criteria for PTSD, were given the opportunity to re-initiate treatment, this time with the help of a peer support specialist who offered social support and encouragement during 3-4 in vivo exposure trials for a maximum of 3 weeks (i.e., for a maximum of 12 accompanied visits). Veterans who indicated that they would like to try treatment again, this time with the assistance of peer, continued PE treatment with their therapist from the point of their last session. If significant time had elapsed since their last session (greater than 3 months), treatment began from PE session 1. A research coordinator assisted with data collection including number of treatment sessions completed after returning from dropout, patient satisfaction with treatment and peer satisfaction. Information on satisfaction was collected by telephone by the research coordinator. Moreover, therapists debriefed peers weekly to query their opinions on how treatment was progressing and to give any information they thought relevant to therapists to make any adjustments needed for the next therapy session with their patients. Satisfaction questions were collected after patient and peer decided the supplemental in vivo homework peer support was no longer needed, or the maximum number of weeks of peer support had been met. In addition, study clinicians were

asked to query patients who had successfully completed treatment and no longer met criteria for PTSD as to their interest in serving as an in vivo exposure therapy homework support peer. Peer recruitment was continuous with the primary purpose of developing a geographically diverse set of peers so that logistical issues were minimized. Peer training was very focused and highlighted that peers were not acting in the role of therapists, but instead were to serve as ‘workout buddies’, meeting patients at the site of in vivo exposure homework assignments, and offering support and encouragement during the homework. With the patient’s permission, therapists telephoned peers weekly to ask how the in vivo exposure homework was progressing. Peer training also included a review of situations that warrant calling for help (e.g. suicidality), and both patients and peers were briefed on these safety procedures.²⁶

As mentioned, peers were trained to offer support during in vivo exposure homework using the analogy of a PTSD treatment “workout buddy”. They were taught that their task was merely to encourage patients to engage in the in vivo session and to endure the situation as much as they could tolerate. They were instructed to use phrases such as, “you are doing great, I am here with you, let’s face this like we were on a mission (a peer recommended this as it matched the usual language of communication among Veterans). Peers were also allowed to share their own recovery stories during in vivo homework if they observed similarities between the patient’s avoided situations and their own. Peers were matched to patients based on geographic proximity. For safety purposes, peers were instructed not to drive with patients in their own or the patient’s car, or to accompany patients in any situations or places they felt might be dangerous; nor were they permitted to go to each other’s residences or shooting ranges. In general, most meetings for in vivo homework took place in locations such as grocery stores, department stores, coffee shops, parking lots, parks and public gathering areas of the city.²⁶

Results

Fifty-two percent (n = 43) of Veterans who had dropped out of PE but still met criteria for PTSD indicated their interest to return to PE treatment, this time with the assistance of a peer during in vivo exposure homework, and 34% (n = 29) actually did so, and thus comprise the sample for this study (see Figure 1). Twenty-four Veterans who had successfully completed PE treatment and no longer met PTSD criteria indicated that they were interested in acting as peers, and 14 presented for, and completed a peer training program. Table 1 presents demographic information for the 29 Veterans who chose to return to treatment. The average age was $\bar{x} = 47.9$ years (SD=12.9) with no differences between telemedicine and in person service modalities. A majority of Veterans in both treatment delivery modalities were male, Black, and most served during the Persian Gulf and OIF/OEF conflicts. A majority of patients who had received PE in person resided within 30 miles of the VA hospital (87.5%) while 54.5% of those receiving PE via telemedicine resided in rural areas outside this radius.

Quantitative Outcomes Regarding Satisfaction and Feasibility

Prior to dropping out, patients receiving PE via home-based telemedicine completed an average of $\bar{x} = 3.0$ (SD=2.2) sessions with their therapist, and those in person, completed an average of $\bar{x} = 2.6$ (SD=2.6) sessions. With respect to the in vivo exposure homework assignments per se completed before dropping out (i.e., before the peer program), those in the telemedicine group completed $\bar{x} = 2.8$ (SD= 2.31) and those in the in person group completed $\bar{x} = 2.6$ (SD= 3.1). Following re-initiation of treatment with a peer, those in the telemedicine group completed an additional $\bar{x} = 6.0$ (SD= 8.0) in vivo homework assignments (with a maximum of 28), and those in the in person group completed an additional $\bar{x} = 6.4$ (SD= 9.0) in vivo assignments (with a maximum of 30).

Considering satisfaction questions from the BTPS: a majority of patients reported most of their answers in terms of scale extremes (either “0” reflecting no problems or “4” indicating problems). Virtually no participants in either telemedicine ($\bar{x} = 0.3$, $SD = 0.5$) or in person ($\bar{x} = 0$, $SD = 0$) conditions gave negative ratings to the query “*Scheduling in vivo exposure with the peer support specialist was a problem.*” Consistent with this, the average rating to the query “*I do not like the peer support specialist*” for telemedicine participants was “0”, compared to an average rating of “1.0” ($SD = 1.0$) for in person participants. All telemedicine participants endorsed “0” to the query “*I felt as if I had to disclose too much personal information to the peer specialist,*” and most in person participants rated this item similarly ($\bar{x} = 0.6$, $SD = 1.3$). Telemedicine participants also endorsed “0” in response to the query “*The atmosphere of the clinic (or for in home sessions the atmosphere created by using the iPad) made it uncomfortable for appointments,*” while the average rating for in person participants to this query was $\bar{x} = 0.2$ ($SD = 0.5$). All participants in both telemedicine and in person conditions endorsed “0” (no issues, yielding a mean of 0) in response to the final 3 queries: “*The peer support specialist did not seem confident that treatment would work for me; The peer support did not seem confident in my ability to carry out homework; I do not feel the peer support specialist supported me or my efforts.*”

Qualitative Outcomes Regarding Peer and Patient Impressions

A total of 29 patients were debriefed by therapists about their individual number of peer in-vivo exercises. A total of 15 peers were debriefed by therapists regarding patient of in-vivo exercises (approximately 4 meetings per patient).

Peers were debriefed after in vivo exposure homework assignments. A major theme of the debrief centered on their confidence in the participant’s capabilities to successfully complete treatment, including future in vivo homework assignments independently. Below are some of

the examples of the comments they offered illustrating both their excitement regarding the program, and their confidence in participant's capabilities for successful treatment:

DG (peer) regarding in vivos with LB (patient):

-“We went in Walmart and got groceries – she did well; went to Burger King and she stayed a while talking; “she did good, she got anxious, but did good!”

-Peer reported “...feeling proud of myself and patient for completing our in-vivos together.”

DB (peer) regarding in vivos with JL (patient):

-“He did fantastic: Spent 3 hours in bowling alley – went well – very crowded and we even worked on dealing with sudden noises, people walking behind, sitting with back turned to crowd, standing and observing others, greeting strangers and meditation.”

-“He’s really been enthusiastic about these meetings and it’s been very rewarding to hear him say that it’s helping him”.

-“All went well. J and I spent 1 hour and 20 minutes at Lowes in Goose Creek followed by 40 minutes at Dairy Queen. He was motivated, timely, communicated well and expressed a willingness to commit to continued therapy. We both look forward to meeting again today and Friday also.”

MJ (peer) regarding CS (patient):

-“Met with C. on Sunday for coffee.....There were zero people at first but gradually got busy. At over an hour I asked if he was ready and we headed out....We did leave after the influx of people had come and gone and it was only us. He also had his back to the crowd of people. All in all a very good run. Goal is to sit at a sporting event. Gave him some pointers on how I was able to get to that point. Seems motivated to push forward.”

Therapists also asked *patients* about their experience with their peer. The main theme identified was patient overall appreciation of, and satisfaction with the peer in helping to achieve in vivo goals. They indicated that peer assistance positively affected treatment engagement.

Here are some of the therapist and patient quotes:

LB (patient) regarding in vivos with DG (peer):

"I only shopped late at night to avoid crowds, but I was able to meet peer in Walmart on Friday afternoon!"

-reported being proud of herself for the activities with the peer.

IG (patient) regarding in vivos with MJ (peer):

-He reported overall positive experience, stating that Veteran peer was "...*helpful and supportive by going at patient's pace, one step at a time,*" and "*I did not feel pressured*".

JL (patient) regarding DB (peer):

"I wouldn't have done it by myself...but it is much easier now".

"The first few weeks I was really avoidant – wouldn't do it without him – now I'll do whatever I want without him".

-About a local recreation exhibit of a Vietnam US Army Camp, which he attended as a 'graduation' from treatment: "*I LOVED it... I can't thank you enough...you would be amazed how much of it I actually remember and the whole time scale of 1 to 10 maybe about a 4*" (regarding anxiety).

JL regarding overall experience with treatment:

"D. is great! There should be a question JUST about how great he is" (said when answering peer specialist questions)

**When asked about program the patient reported:

"I personally feel that everyone should have a peer specialist... just having someone who has been through the program gives you more confidence. I mean I came (to treatment) before and flat gave up, but this time was very different. At first, I didn't have any hope of getting better, I'd been like this since 2008, didn't go anywhere, not even around my own family - totally isolated, but now I am doing things I never thought I'd do again -I went to the beach yesterday, ON THE 4TH OF JULY, something I would have NEVER done before!"

CS (patient) regarding MJ (peer):

-Trip to coffee shop: *"Everything went fine - I liked him! I thought having him was a lot of help, I am VERY comfortable with him especially knowing he's a Veteran and not a civilian."*

--> G. (therapist) on CS (patient): *"This is a patient that I saw for 8 weeks and couldn't get him to do in-vivos!"*

CS (patient): Patient went to Walmart alone for in-vivo after help from peer stating *"When I met with peer it was like a trigger; something in my head said you can do it-if he can, you can too! When speaking with him I got a whole lot more confidence. He told me how he did it and I knew I could do it."*

CS (patient): *"Since I started this program I've gone out more times than I have in the last 10 years."*

"The experience with M. gave me the courage to make these changes - that one experience is all I needed - I realized if he could do it, I can do it. I made up my mind right then. This program is more beneficial than y'all think."

"I'm now spending more quality time with my wife." (He's been taking her out to eat...and for the first time in 15 years was able to take his daughter out to lunch).

Summary of Common Themes: The main theme identified was high satisfaction with the in vivo peer-participant interaction, and engaging in treatment with peer. Peer verbalizations expressed consistent confidence in both the program and the Veterans they were serving. They exhibited professionalism and were clearly enthusiastic about the work patients were doing. Similarly, patients were extremely complimentary regarding their peers. Of note, many patients stated that they would not have either tried treatment again, or engaged in in vivo exposure homework without the support of the peer. Finally, patient verbalizations reflected increased confidence in their own abilities to engage in exposure trials, which the team found refreshing, as the authors were cautiously aware of the potential for developing dependence on the peer.

Discussion

High dropout rates from psychotherapy in general, and evidence-based PTSD treatment in particular are a matter of great concern. While some preliminary work illustrates reasons for dropout, very little research on actual programs to address and even reverse dropout exists. Therapies like PE, though effective, present great challenges,²⁷ and patients often report being uncomfortable with, or avoid altogether, treatment components that are most demanding. In the case of PE delivered via home-based telemedicine, this appears to be the in vivo exposure tasks.¹⁰ Social support may enhance engagement and reduce posttraumatic cognitions,²⁸ and social support applied directly toward overcoming avoidance, such as that characteristic of PE-based in vivo exposure, may be particularly helpful. Indeed, low social support is associated with increased risk and severity of PTSD²⁹ and lower treatment engagement.³⁰ Thus, enhancing social support precisely during in vivo exposure trials may be particularly useful in terms of treatment re-engagement, and represents a departure from, or perhaps, intensification of the manner in which peer support programs are traditionally used. That is, while evidence exists in support of using peers to enhance *engagement* in substance use and PTSD treatments, these programs generally use peers in a tertiary manner to enhance treatment initiation and attendance, such as through adjunct support groups or talks where peers and patients discuss difficulties associated with treatment³¹ (see also <https://www.ptsd.va.gov/apps/AboutFace/>). This contrasts with the present project, which uses peers *directly* in core components of the PE treatment itself. As a group, Veterans may be in particularly well suited for peer-based support during difficult treatment components such as in vivo exposure, insofar as their military training has imparted useful skillsets regarding collaboration, protection and support of the other, and teamwork. Specifically, military culture emphasizes camaraderie,³² which can be used in the service of each Veterans' mental health. Indeed, military service men and women have been trained to rely on fellow Veterans, and this interpersonal bond and reliance does not easily disappear after their post-deployment life begins. Thus, leveraging camaraderie through a peer

program, wherein peer support is directly applied to those aspects of treatment reported as most difficult, resonates well with military personnel.^{10,25,33}

Thus far, following the introduction of the peer support program participants receiving PE via home-based telemedicine have completed an average of 4 additional sessions post dropout, and those in in person treatment have completed an average 2.5 additional sessions post dropout. While this may not represent a complete resolution of the dropout problem, it did represent a doubling of the 'dose' of PE they received. Nonetheless, the VA has targeted eight treatment sessions completed within 14 weeks as the best practices goal for PTSD care, and additional enhancements to our peer-based program may be warranted.

Every participant reported very positive experiences with this peer assisted intervention, and the results indicate not only a return to evidence-based PTSD treatment, itself, a major accomplishment, but extremely high satisfaction with the program on the part of the patient and peer for both telemedicine and in person treatment delivery modalities. Note that the present program speaks not to treatment outcome per se, but to treatment engagement in that patients who otherwise would not receive evidence-based PTSD care did so based on the offer of help from a fellow Veteran. As mentioned, this feasibility study is part of a larger outcome study and treatment is ongoing. Future reports will complement these feasibility findings regarding engagement and satisfaction with data on actual PTSD outcomes.

Strengths and Limitations.

Limitations of this study include its small sample size and limited number of feasibility measures. A program to reverse PTSD treatment dropout has not actually been examined before, and while our overall sample was small, converting more than 30% of those dropouts back into treatment is notable in and of itself. As this was a feasibility study of individuals who had already decided to leave treatment, dependent measures were purposefully focused on

feasibility and satisfaction. Future work should include additional measures of feasibility, such as determining the amount of increased therapist effort related to integrating peers into this evidence-based PTSD treatment, and examination of parameters associated with treatment re-initiation and completion in a larger sample, perhaps across several VA medical centers. Another possible limitation was that therapists questions regarding debriefing after in vivos may have overlapped with information from peers regarding their satisfaction with in vivo homework activity, but these questions were asked in the context of therapy to assist therapists with patients, more than to gauge peer satisfaction per se. Nonetheless, it is always preferable for a neutral party, such as the research coordinator, to query peer satisfaction, as was done for patients. Finally, increased representation of women and Hispanics would have been preferable. In fact, currently this team is conducting a large clinical trial addressing the limitations found in this feasibility study.

Implications for Behavioral Health

Future studies of sufficient sample size should also include actual treatment outcome data to determine whether patients who dropout, but subsequently return to treatment with the help of a peer improve to a degree comparable to patients who complete treatment without dropping out. Future research should also examine expansion of the peer support concept to other PTSD-affected populations for which dropout is also problematic, such as sexual assault victims. Additionally, this strategy of dropout reversal may also be useful with other evidence-based treatments for PTSD such as Cognitive Processing Therapy,³⁴ and for other clinical populations for whom in vivo exposure therapy is central (e.g., obsessive compulsive disorder).

Conflict of Interest Statement

The authors declare that they have no conflict of interest.

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Table 1
Demographics Characteristics of the 29 Participants returning to treatment.

	Telehealth (n=12)	In person (n=17)	Total (n=29)
Age (years)	\bar{x} = 48.3 (SD=13.7)	\bar{x} = 47.7 (SD=12.0)	\bar{x} = 47.9 (SD=12.5)
Education (years)	\bar{x} = 13.6 (SD=1.2)	\bar{x} = 13.1 (SD=4.1)	\bar{x} = 13.3 (SD=3.15)
Gender			
Female	16.7%	41.2%	31.0%
Male	83.3%	58.8%	69.0%
Race			
Black	66.7%	70.6%	69.0%
White	33.3%	29.4%	31.0%
Marital Status			
Married	75.0%	47.0%	58.6%
Not married	25.0%	53.0%	41.3%
Employment			
Employed	58.3%	58.8%	58.6%
Unemployed/Retired	33.3%	29.4%	31.1%
Other	8.3%	11.8%	10.3%
War Era			
Persian Gulf/OEF/OIF	72.8%	75.0%	74.0%
Vietnam	28.2%	22.5%	25.0%
Other		2.5%	1.0%
Distance to VA Clinic			
Less than 30 miles	50.0%	88.2%	72.4%
More than 30 miles	50.0%	11.8%	27.6%

Figure 1
Consort diagram

