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Case Report: Concurrent Treatment of PTSD and Alcohol Use Disorder via Telehealth in a Female Iraq Veteran

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Abstract

Background and Objectives—A growing literature provides evidence for the use of integrated treatments (e.g., *Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure*; COPE); however, no known studies have applied COPE via telehealth.

Method—COPE was delivered via telehealth to treat a black female veteran with combat trauma and alcohol use disorder.

Results—The patient demonstrated significant reductions in alcohol consumption and PTSD and depressive symptoms.

Conclusions and Scientific Significance—Although preliminary, findings demonstrate that integrated treatment via telehealth is feasible and effective, and may be useful for female veterans reluctant to seek services at male-dominated VAMCs.

Keywords

prolonged exposure; PTSD; telehealth; telemedicine; telepsychiatry; alcohol use disorder; alcohol dependence; veteran

Evidence for the efficacy of Prolonged Exposure (PE) therapy as a gold standard treatment for posttraumatic stress disorder (PTSD) is shown in diverse populations.¹ However, there is a notable absence of research examining the use of PE among individuals with co-occurring substance use disorders (SUD). Clinical research demonstrates the frequent co-occurrence of PTSD and substance use disorders.² Despite long-standing concerns, studies using

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integrated, exposure-based approaches to treat co-occurring PTSD and SUD show that trauma-focused treatments are safe, significantly reduce PTSD severity and substance use, and reduce risk of relapse.³ In particular, “COPE” (*C*oncurrent treatment of *P*osttraumatic Stress Disorder and substance use disorders using *P*rolonged *E*xposure) is an evidence-based treatment that uses PE to treat PTSD while integrating cognitive-behavioral treatment for SUD.^{3,4}

While Veterans Affairs Medical Centers (VAMC) have made important strides to increase the availability of evidence-based psychological treatments for veterans, significant barriers to receiving care remain. However, technological advances can help bridge the gap for veterans who would otherwise go untreated. Research on the treatment of PTSD via telehealth is growing and findings are encouraging.⁵ Exploring ways to reduce barriers and improve access for women and ethnic minorities is an especially valuable element of telehealth.⁶ The current study adds to existing literature by examining the application of COPE via telehealth to treat a female minority U.S. military veteran with PTSD and alcohol use disorder (AUD).

Case Presentation

The patient is a 41-year-old, married, unemployed, black female veteran who served one U.S. Army deployment in Iraq. While on active duty, the patient’s encampment was heavily mortared. During the attack, she closely monitored and ensured the safety of approximately 20 soldiers seeking shelter, but felt helpless to assist the severely wounded soldiers that she could see outside her bunker. In addition to combat trauma, the patient reported two incidents of military sexual trauma that occurred while on active duty two years prior.

Assessment Measures

The Clinician-Administered PTSD Scale (CAPS) for DSM-IV was used to diagnose PTSD and assess symptom frequency and severity.⁷ The Posttraumatic Stress Disorder Checklist-Military (PCL-M) is a 17-item self-report measure of PTSD symptoms based on DSM-IV criteria.⁸ The Beck Depression Inventory (BDI-II) is a 21-item self-report inventory used to assess depression,⁹ and the Timeline Followback (TLFB) was used to assess alcohol use.¹⁰

Presenting Concerns

The patient met DSM-IV criteria for current PTSD, alcohol use disorder, and major depressive disorder. After an in-person medical assessment by her psychiatrist she was referred to the substance abuse treatment center (SATC). Medical issues that could contribute to psychological concerns and medication management were addressed during regular in-person visits with her primary care provider and psychiatrist. During her SATC intake interview, the patient reported heavy daily drinking to avoid intrusive trauma memories, as well as to “self-medicate” feelings of irritability, anxiety, depression, and insomnia. At baseline, she was drinking 4-8 standard alcoholic beverages daily, after which she would typically fall asleep for approximately 3 hours. The pattern of heavy drinking began approximately 7 years ago.

The patient reported that following her return from Iraq, she experienced excessive feelings of anger, guilt, and self-blame associated with her combat trauma. She also reported irritability, fatigue, and depressive symptoms, including anhedonia, poor concentration, low energy and feelings of worthlessness. She was mostly house-bound, and avoided crowded settings and social gatherings where she might experience hyperarousal. Her goals for treatment included managing feelings of anger and guilt, reducing intrusive memories, becoming abstinent from alcohol, and increased engagement in activities. Although the patient was first diagnosed with AUD, she reported her depression and PTSD developed concurrently.

Telehealth Treatment Rationale

Despite the patient's desire to receive treatment for AUD, she indicated that it would be difficult for her to continue to travel to treatment after the initial medical assessment (the nearest VAMC was 90 miles away). Given her history of military sexual trauma, the patient stated that she did not feel comfortable entering the VAMC because the majority of patients are male. The patient was informed that she would be eligible to receive home-based telehealth treatment for her AUD and PTSD from a licensed clinical psychologist.

COPE Treatment via Telehealth

To initiate treatment, the patient was asked to sign the consent for services and a telehealth-to-home liability waiver. Treatment required the download of VAMC-approved videoconferencing software to her home computer. Routine clinical standard of care using telehealth required that at each session the patient confirm her physical location in case emergency response was required. For each session the patient also provided an emergency phone number of a family member, was assessed for suicidality and homicidality, informed how to manage imminently dangerous or self-harming thoughts, and provided with the Suicide Prevention Hotline telephone number.

COPE consists of 12 individual, 90-minute sessions integrating PE for PTSD and relapse prevention for SUD.⁴ At the beginning of each session the patient self-reported BDI-II, PCL-M, and TLFB scores so the psychologist could assess PTSD and depressive symptoms as well as toxicology. Of note, situations that increase exposure to substances or have high probability of inducing craving were not included in the in-vivo exposure hierarchy. Patients are instructed not to use any substances before, during, or immediately after engaging in exposures. Alcohol use in this context would represent a "safety behavior" that would undermine therapeutic effects.

Results

The patient engaged in 88% (8 out of 9) of the in-session imaginal exposures effectively and according to the COPE protocol. Additionally, she reported engaging in imaginal exposures outside of sessions on a daily basis, and listening to her imaginal exposures at least once per day approximately 40% of the time. Overall, the patient completed 100% of protocol

sessions and homework assignments. Her progress in treatment is demonstrated in Figures 1 and 2.

Figure 1 depicts the patient's reduction in PTSD and depressive symptoms from baseline to six-month follow-up. At baseline she scored a 114 on the CAPS and a 75 on the PCL-M, both demonstrating clinically significant levels of PTSD symptoms. At the six-month follow-up, she demonstrated significant reductions to subclinical levels on both measures of PTSD symptoms, including a 63% reduction in symptoms endorsed on the PCL-M and an 82% reduction on the CAPS. The patient's score of 48 at baseline on the BDI-II indicated "severe" symptoms and at six-month follow-up her score was 6. Figure 2 depicts the patient's consumption of alcohol per day from baseline to six-month follow-up using the TFLB demonstrating a significant decrease from an average of six drinks per day to less than one drink per day.

Discussion

Integrated treatment approaches (e.g., COPE) demonstrate safety and efficacy in reducing PTSD and SUD symptoms.¹ The implementation of telehealth technologies offers unique opportunities for enhancing dissemination efforts for these promising treatments. Telehealth may also be used strategically to aid veterans living in rural areas as well as individuals with anxiety and avoidance symptoms characteristic of PTSD that might otherwise serve as a barrier to traditional face-to-face therapy. While there may be concern that delivery of COPE (or PE) via telehealth would serve to reinforce avoidance behaviors associated with PTSD, the benefits may outweigh the consequences for veterans who would not otherwise access psychological services. Moreover, there is evidence to suggest that PE is equally effective for treating PTSD among veterans regardless of whether it is delivered via telehealth or face-to-face.⁵ Finally, telehealth may help to overcome unique barriers experienced by female veterans seeking care in a traditionally male-dominated healthcare system. Adoption of telehealth technologies may be particularly useful as the VAMC continues its efforts to expand services sensitive to the experiences of female veterans including an expanded awareness and focus on providing MST related services.

This study represents the first known demonstration that telehealth can be successfully used not only to deliver PE for PTSD, but that it may also be a useful tool for delivering integrated treatments for co-occurring PTSD and SUD. The current patient was able to successfully complete the 12-session therapy, and she evidenced clinically-significant reductions in symptoms of PTSD and depression, as well as alcohol use. These gains were maintained 3- and 6-months post-treatment. Despite the veteran's avoidance of treatment within the VAMC, the patient was able to successfully engage with the in-vivo exposure exercises and reported less distress and diminished need to use alcohol upon treatment completion. Moreover, the patient successfully completed trauma-focused imaginal exposures throughout treatment, and although the clinician was not in the room, she felt safe to continue engaging with the trauma memory via telehealth.

It is worth noting that AUD symptoms were moderate for this veteran. It will be important for future studies to examine whether COPE or other integrated treatments can be safely and

effectively delivered via telehealth among veterans with more severe SUD symptoms. Telehealth intervention guidelines for SUD have been published and were followed in this case report.¹¹ Overall, this case report adds to research demonstrating the safety and efficacy of COPE, and provides preliminary support for the use of telehealth to disseminate integrated treatments in a way that may overcome barriers to accessing care.

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Figure 1.
Change in PTSD and Depression Scores

Figure 2.
Average Number of Standard Drinks Per Day