

**Efficacy of Psychotherapy Conducted Over the Telephone**

**Summary**

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The recent developments of the global pandemic Coronavirus (COVID-19) have led to rapid transition to conducting meetings, conferences, and medical/psychological appointments all through virtual means, including telephone, video, and web-based. While there’s a large amount of evidence of the efficacy of conducting psychological therapy over the Internet or Video, there is also evidence that psychotherapy over the telephone can be equally as effective as Internet, Video, or face-to-face. More of the research has examined provision of CBT via phone than other types of psychotherapies but nothing in this research suggests that other therapy modalities cannot be effectively delivered via phone. This disparity in the amount of research reflects differences in research emphasis and practices and not a difference in the possibility for effective care. Here we summarize the efficacy of psychotherapy over the telephone for individuals with depression, anxiety, comorbid psychological and medical conditions, substance use/misuse disorders, psychosis, suicide, and special populations (children/adolescents, older adults and people with disabilities). However, overall, research supports the efficacy of telephone delivered psychotherapy (Varker et al., 2019).

In general, research finds that treatment delivered over the phone can be as efficacious as treatment delivered in person. Patients in general report high satisfaction and find the use of teletherapy to be accessible (Turgoose et al., 2018). There was also no difference in treatment dropout rates in patients who received teletherapy versus those who received face-to-face therapy (Hernandez-Tejada et al., 2014). In fact, Hernandez-Tejada and colleagues (2014) found that patients completed more teletherapy sessions prior to dropout. In a time when many people are feeling particularly overwhelmed and anxious, continuity of care is essential and the data support that psychotherapy can be effectively delivered via telephone and other virtual means.

**Evidence of reduction in symptoms in patients with anxiety and depression**

There is evidence showing that providing psychological services over the telephone is equally as effective as face-to-face visits for patients with depression and anxiety. A review of 13 studies have shown reduction in symptoms of anxiety and depression when therapy was conducted via telephone (Coughtrey & Pistrang, 2018). Patients have also benefited from receiving various interventions over the telephone, such as combined tele-pharmacotherapy and tele-cognitive-behavioral therapy (tele-CBT, Ludman et al., 2007), tele-CBT alone (Mohr et al., 2005; Stiles-Shields et al., 2014, 2015) receiving short-term tele-CBT in primary care setting (Watzke et al., 2017), and tele-bibliotherapy for older adults with anxiety (Brenes et al., 2010), and tele-CBT along with exposure and response prevention for patients with obsessive-compulsive disorder (Taylor et al., 2003). Strong therapeutic alliance has also been shown in tele-CBT for patients with depression (Stiles-Shields et al., 2014) and tele-CBT has also shown cascading effects in the reduction of depressive symptoms post-treatment (Stiles-Shields et al., 2015). Various interventions over the telephone have shown evidence in reducing suicidality in patients, including solution focused brief therapy and common factors therapy (Rhee et al., 2005). According to a review by Baker and colleagues (2018), they found telephone psychotherapy for prevention of relapse and improving health behaviors in patients with psychosis to be equally as effective as face-to-face psychotherapy.

**Evidence of reduction in symptoms in comorbid medical populations**

There is evidence that telephone therapy greatly benefits patients who have comorbid medical and psychological conditions, ranging from providing tele-interpersonal psychotherapy for rural individuals who have HIV and are experiencing depressive symptoms (Heckman et al., 2017, 2018) to providing tele-mindfulness-based cognitive therapy for reduction of major depressive disorder symptoms in individuals with epilepsy (Thompson et al., 2015). Veterans with comorbid psychological distress and combat-related mild traumatic brain injury have also benefited significantly from receiving telephone-problem solving therapy (Tele-PST) (Bell et al., 2017). After receiving tele-PST, Veterans reported improved quality of sleep and reduction of symptoms of depression and PTSD. Older adults have also benefited from receiving telephone therapy for the management of chronic pain (Helstrom et al., 2018). Rehabilitative patients may also benefit from receiving psychological services over the telephone. For example, patients who received a specific form of CBT for traumatic injury over the telephone reported a reduction in fear and anxiety towards the pain itself (Davidson et al., 2019). In a review of the literature of telecounselling for individuals with spinal cord injury, the authors found that patients who received counseling over the telephone showed slight improvement in sleep and management of pain as well as an increased sense of hope, self-efficacy, and improved mood versus patients who received only psychoeducational materials or usual care in a clinic setting (Dorstyn et al., 2013).

**Smoking cessation / management of drug misuse**

There is increasing evidence of higher smoking cessation rates for individuals who received telephone quitline services versus those that received self-help materials (Boyle et al., 2008; Gates, 2014). Higher smoking cessation rates were evident in pregnant smokers who participated in a teletherapy program adapted from the common “quitline” program versus those who received self-help materials (Cummins et al., 2016). Acceptance and commitment therapy (ACT) have also been shown to work over the telephone for individuals seeking to reduce cigarette smoking compared to standard CBT quitline therapy (Bricker et al., 2014). For individuals who use illicit substances, such as opioids and cocaine, abstinence rates were higher in those who received telephone therapy services through an “Interactive Voice Response” system versus usual care (Moore et al., 2013).

**Maternal Fetal Medicine / Child & Adolescent Population**

A review of the literature by Dennis & Kingston (2008) have found that pregnant women who received telephone support showed a reduction in postpartum depression symptoms and cigarette smoking as well as an adherence to breastfeeding practices. While studies on telephone therapy for children and adolescents are sparse, the authors of this review (Slone et al., 2012) have found several studies where children and adolescents benefited from telephone therapy services more so than online chat. Slone and colleagues (2012) also reported a reduction in smoking in adolescents who received psychotherapy services over the telephone. Another study found that the use of hypnosis over the telephone has shown reduction in children’s school refusal (Aviv, 2006).

**Evidence of reduction in symptoms in older adults and individuals with disabilities**

Not only was there evidence of efficacy for tele-bibliotherapy for the treatment of anxiety in older adults (Brenes et al., 2010), it is also shown to relieve depression in caregivers of loved ones with dementia (Schinköthe & Wilz, 2014). Veteran older adults with spinal cord injury have also benefited from receiving telephone services for reducing their psychological symptoms due to spinal cord injury and have found it to be beneficial than traditional face-to-face therapy (Mozer et al., 2008). Individuals who had an acquired physical disability have reported improved outcomes in the ability to cope with their disability, which therefore reduced their symptoms of depression (Dorstyn et al., 2011). Tele-CBT has also been found to be more effective than tele-supportive emotional support therapy in reducing physical fatigue in individuals with multiple sclerosis (Mohr et al., 2007).

**Efficacy of Psychotherapy Conducted Over the Telephone**

**References (with Abstracts)**

**Individuals with Disabilities**

Dorstyn, D. S., Mathias, J. L., & Denson, L. A. (2011). Psychosocial outcomes of telephone-based counseling for adults with an acquired physical disability: A meta-analysis. *Rehabilitation Psychology, 56*(1), 1–14. <https://doi.org/10.1037/a0022249>

**Abstract**

Background: The delivery of mental health services by telephone, referred to as telecounseling, has the potential to improve the health outcomes of adults with an acquired physical disability in a cost-effective way. However, the efficacy of this form of treatment requires further evaluation before it is used on a larger scale. Aim: This meta-analysis provides a critical and quantitative evaluation of the impact of telephone-administered psychological interventions on the psychosocial functioning of adults with an acquired physical disability caused by spinal cord injury, limb amputation, severe burn injury, stroke, or multiple sclerosis. Method: A comprehensive search of eight electronic databases identified eight studies (N = 658 participants) that compared treatment efficacy to that of matched control groups. Differences in the psychosocial outcomes of treatment and control participants were examined using Cohen's d effect sizes. Fail-safe Ns and 95% confidence intervals were used to evaluate the significance of these results. Results: Significant improvements in coping skills and strategies (overall d = 0.57), community integration (overall d = 0.45), and depression (overall d = 0.44) were observed immediately after telecounseling, with modest improvements in quality of life maintained at 12 months post-intervention (overall d = 0.37). Conclusions: The results suggest that telecounseling is an effective treatment modality for adults adjusting to a physical disability; however, further trials are needed to establish the long term psychosocial benefits. (PsycINFO Database Record (c) 2016 APA, all rights reserved)

Mohr, D. C., Hart, S., & Vella, L. (2007). Reduction in disability in a randomized controlled trial of telephone-administered cognitive-behavioral therapy. *Health Psychology, 26*(5), 554-563. <https://doi.org/10.1037/0278-6133.26.5.554>

**Abstract**

Objective: The authors examined the efficacy of telephone-administered cognitive-behavioral therapy (T-CBT) and telephone-administered supportive emotion-focused therapy (T-SEFT) in reducing disability among disabled patients with multiple sclerosis and depression. Telephone administration of therapy allowed care to be delivered to a more disabled population. This is a secondary analysis of a randomized controlled trial; the primary outcome results for depression are reported in D. C. Mohr, S. L. Hart, L. Julian, C. Catledge, L. Honos-Webb, L. Vella, et al. (2005). Design: A randomized controlled trial, comparing 16 weeks of T-CBT with T-SEFT. Main Outcome Measures: Disability was measured using Guy's Neurological Disability Scale; fatigue was measured using the Fatigue Impact Scale; depression was measured using the Hamilton Depression Rating Scale and the Beck Depression Inventory-II. Results: Patients in both treatments showed significant improvements in disability and fatigue. These improvements were related to reductions in depression. T-CBT produced significantly greater decreases in disability and fatigue, compared with T-SEFT, even after controlling for depression. The greater benefit of T-CBT on disability was mediated by physical fatigue. Conclusion: These findings support the hypothesis that significant reductions in disability can be achieved by reducing depression in patients with multiple sclerosis. There was also evidence that further reductions could be achieved through CBT-specific interventions that include a focus on symptoms such as fatigue management.

**Older Adults**

Brenes, G. A., McCall, W. V., Williamson, J. D., & Stanley, M. A. (2010). Feasibility and acceptability of bibliotherapy and telephone sessions for the treatment of late-life anxiety disorders. *Clinical Gerontologist, 33*(1), 62-68. <https://doi.org/10.1080/07317110903344968>

**Abstract**

This article describes the development of Biblio and Telephone Therapy, or BTT, a cognitive-behavioral treatment program for late-life anxiety disorders. Although studies have examined bibliotherapy for the treatment of late-life depression, none have studied it as a format for treating late-life anxiety. The application of this treatment to four older adults with generalized anxiety disorder (GAD) and/or panic disorder (PD) is described, and benefits, advantages, and limitations are discussed.

Mozer, E., Franklin, B., & Rose, J. (2008). Psychotherapeutic intervention by telephone. *Clinical Interventions in Aging, 3*(2), 391-396. <https://doi.org/10.2147/cia.s950>

**Abstract**

Psychotherapy conducted over the telephone has received increasing amounts of empirical attention given practical advantages that side-step treatment barriers encountered in traditional office-based care. The utility and efficacy of telephone therapy appears generalizable across diverse clinical populations seeking care in community-based hospital settings. Treatment barriers common to older adults suggest that telephone therapy may be an efficient and effective mental health resource for this population. This paper describes empirical studies of telehealth interventions and case examples with psychotherapy conducted via telephone on the Spinal Cord Injury Unit of the Palo Alto Veterans' Administration. Telephone therapy as appears to be a viable intervention with the aging population.

Schinköthe, D., & Wilz, G. (2014). The assessment of treatment integrity in a cognitive behavioral telephone intervention study with dementia caregivers. *Clinical Gerontologist, 37*(3), 211-234. <https://doi.org/10.1080/07317115.2014.886653>

**Abstract**

Assessment of treatment integrity, such as therapists’ adherence and competence, is essential for the development and evaluation of evidence-based therapeutic interventions, but in most intervention studies proof of treatment integrity has not been considered on a regular basis. One reason is that there is a lack of appropriate assessment instruments. For dementia caregiver trials treatment adherence and competence scales do not exist. To evaluate treatment integrity in a cognitive behavioral therapy (CBT) telephone intervention with dementia caregivers, we developed a new adherence scale and adapted the Cognitive Therapy Scale (CTS) for CBT with dementia caregivers. We also analyzed whether CBT can be delivered with treatment integrity for interventions with dementia caregivers and by telephone. Eighty-six entire sessions with 45 caregivers in a randomized-controlled intervention study were judged by four independent raters. Inter-rater reliability was high for overall score on the adherence scale (intraclass correlation [ICC] = .85) and the CTS (ICC = .82). Overall adherence was moderate and competence was high. Both scales proved to be reliable; thus they can be used for assessing treatment integrity in other research fields with dementia caregivers, including measuring the impact of treatment on outcome criteria. The results also reveal that CBT can be delivered with adherence to the manual and competently to dementia caregivers and by telephone, opening up new options for future research and practice.

**Depression, Anxiety, PTSD**

Coughtrey, A. E., & Pistrang, N. (2018). The effectiveness of telephone-delivered psychological therapies for depression and anxiety: A systematic review. *Journal of Telemedicine and Telecare, 24*(2), 65–74. <https://doi.org/10.1177/1357633X16686547>

**Abstract**

Objectives: The telephone is increasingly used to deliver psychological therapies for common mental health problems. This review addressed the following question: are evidence-based psychological therapies for adults with depression and/or anxiety effective in reducing psychological symptoms when delivered over the telephone? Method: A systematic search for articles published over a 25-year period (January 1991–May 2016) was performed using the databases PsycINFO, PubMed and Web of Science. Citation searches, manual searches of bibliographies of relevant papers, and hand searches of key journals were also conducted. The quality of the studies included for review was assessed using the Effective Public Health Practice Project Quality Assessment Tool. Results: Fourteen studies met inclusion criteria for the review. Ten reported findings from telephone treatment for depression and four for anxiety. Nine studies used randomised controlled designs, two used quasi-experimental designs and three used uncontrolled designs. Thirteen studies reported reductions in symptoms of depression or anxiety. Cohen’s d ranged from 0.25–1.98 (median = 0.61) for controlled studies and from 1.13–1.90 (median = 1.26) for uncontrolled studies. Only four studies reported clinically significant change. Conclusions: The findings indicate that telephone-delivered interventions show promise in reducing symptoms of depression and anxiety. Further research is required to establish the types of interventions that are most effective and the characteristics of clients who find them beneficial. (PsycINFO Database Record (c) 2018 APA, all rights reserved)

Hernandez-Tejada, M. A., Zoller, J. S., Ruggiero, K. J., Kazley, A. S., & Acierno, R. (2014). Early treatment withdrawal from evidence-based psychotherapy for PTSD: Telemedicine and in-person parameters. *The International Journal of Psychiatry in Medicine, 48*(1), 33-55. <https://doi.org/10.2190%2FPM.48.1.d>

**Abstract**

Objective: To determine differences in reported barriers to treatment completion associated with telemedicine vs. in-person delivery of evidence-based treatment for PTSD in combat veterans.

Method: The present study was derived from two ongoing randomized controlled trials (RCTs) comparing in-person vs. telemedicine delivery of exposure therapy for PTSD. A onetime telephone assessment of participants who dropped out from the treatment phase of these two studies was conducted, with measures focusing on reported reasons for dropout, and perceived comfort and efficacy of the treatment modality. Dichotomous data were analyzed via chi-square and logistic regression; continuous data via ANOVA.

Results: Forty-seven of 69 total dropouts participated. There was no difference in rate of dropout between modalities. A greater proportion of participants receiving in-person exposure therapy reported difficulties with logistical aspects of care (e.g., parking), whereas a greater proportion of participants receiving telemedicine therapy reported difficulty tolerating certain stressful aspects of treatment; however, those receiving telemedicine delivered treatment completed more sessions before dropping out. Participants in both conditions reported that they liked and were confident in their therapist Conclusions: Dropout reasons varied according to type of treatment delivery. Recommendations for future research are given in terms of modification of treatment protocol according to delivery modality.

Conclusions: Dropout reasons varied according to type of treatment delivery. Recommendations for future research are given in terms of modification of treatment protocol according to delivery modality.

Lamb, Pachana, Dissanayaka. (2019) Update of recent literature on remotely delivered psychotherapy interventions for anxiety and depression. *Telemedicine and e-Health,* 671-677. <https://doi.org/10.1089/tmj.2018.0079>

**TELEPHONE INTERVENTIONS FOR ANXIETY** The efficacy of remotely delivered psychotherapy interventions in treating anxiety has been shown to vary between telephone-administered therapy, videoconferencing, and online therapy to differing degrees. Bee et al. conducted a meta-analysis that analyzed 10 telephone-administered therapies and 3 telephone-administered therapies combined with other modalities in treating anxiety and depression compared with control conditions, from which it was found that there are fewer studies investigating the efficacy of telephone administered CBT interventions for treating anxiety than depression. However, they also found telephone-administered psychotherapy to be more efficacious in treating anxiety than depression (see Table 1 for summary of systematic reviews). This large effect size (pooled effect size: 1.15, 95% confidence interval=0.81–1.49) in anxiety reduction suggests that telephone-delivered therapy is effectual in reducing anxiety outcomes. Furthermore, RCT studies have shown that compared with usual care, telephone-delivered CBT is associated with reduced anxiety severity as measured by the Generalized Anxiety Disorder Severity Scale and increased mental health quality of life. In comparing the long-term effects of telephone-delivered CBT for late-life anxiety, Brenes et al. found that CBT is superior to nondirective supportive therapy in decreasing anxiety symptoms 15 months after treatment. This suggests that there are long-term reductions in anxiety when CBT is administered through telephone.

**TELEPHONE INTERVENTIONS FOR DEPRESSION** There is more literature on the efficacy of telephone interventions in treating depression. In depressed patients, 6-weekly sessions of telephone-administered CBT led to a significant decrease in depression scores (as measured by the Beck Depression Inventory and Hamilton Rating Scale for Depression) compared with care as usual. Patients who received telephone support that helped them access and use online CBT therapy compared with patients who received usual care reported greater accessibility to advice and greater satisfaction with received support.

Telephone-delivered CBT has also been found to be efficacious in a combined treatment with antidepressants, and also in a combined treatment with online therapy. Telephone delivered CBT for depressed patients taking antidepressants led to significantly decreased depression as measured by the Hopkins Symptom Checklist Depression Scale. Patients taking antidepressants for depression who received management in structured telephone CBT therapy reported lower depression scores (measured by the Hopkins Symptom Checklist Depression Scale and Patient Health Questionnaire) and more satisfied treatment reports compared with usual care and a regular telephone care management program. Furthermore, treatment participation rates were very high in those who received the structured telephone CBT therapy at 93%, just below the 97% for regular telephone care management. More recently, Gilbody et al. found telephone-delivered CBT combined with computerized therapy to be more effective in treating depression symptoms than computerized therapy alone. There was no significant difference in improvement in severity of depression (as measured by the Hamilton Depression Rating Scale and self-reported depression with the Patient Health Questionnaire) between depressed patients who had received telephone CBT or face-to-face CBT.44 However, patients who received telephone CBT showed improved adherence, but lowered maintenance of gains at 6 months compared with the face-to-face group.

**Conclusions and Recommendations for Future Research Evidence** suggests that remotely delivered psychotherapy is efficacious for treating anxiety and depression in diverse population groups. More specifically, there appears to be more evidence for the use of telephone-administered psychotherapy in treating both anxiety and depression than psychotherapy delivered through videoconferencing and online modality. Similarly, more evidence exists demonstrating the efficacy of telephone- and online-administered therapy than video-delivered therapy when treating patients with anxiety or depression and other comorbid disorders. Furthermore, although there are more RCTs that support remotely delivered CBT in treating depression and anxiety, the systematic reviews suggest that the treatment effect is greater for treating anxiety than depression in both telephone-administered and online-administered modalities. With regard to the practical benefits of remotely delivered psychotherapy and mental health services in general, it appears to be cost effective and leads to high satisfaction because of the accessibility, reduced travelling time, and ease of application. Remotely delivered psychotherapy may be an inexpensive and convenient therapy alternative that can be particularly useful in patients without access to any forms of psychotherapy, such as those living in rural and remote areas and those with impaired mobility. Future research should explore the efficacy of video-delivered psychotherapy interventions in treating anxiety and depression. In conclusion, good efficacy was found for treating anxiety and depression through remotely delivered modalities. Major benefits of remote administering of psychotherapy are its cost-effectiveness, accessibility, reduced travel time, ease of application, and the large range of populations that can be treated with either telephone, video, or online modalities of psychotherapy. Remotely delivered depression and anxiety treatment is particularly promising for treating older persons and those living in rural communities who may otherwise be unable to access therapy.

Ludman, E. J., Simon, G. E., Tutty, S., & Von Korff, M. (2007). A randomized trial of telephone psychotherapy and pharmacotherapy for depression: Continuation and durability of effects. *Journal of Consulting and Clinical Psychology, 75*(2), 257-266. <https://doi.org/10.1037/0022-006X.75.2.257>

**Abstract**

Randomized trial evidence and expert guidelines are mixed regarding the value of combined pharmacotherapy and psychotherapy as initial treatment for depression. This study describes long-term results of a randomized trial (N = 393) evaluating telephone-based cognitive-behavioral therapy (CBT) plus care management for primary care patients beginning antidepressant treatment versus usual care. In a repeated measures linear model with adjustment for baseline scores, the phone therapy group showed significantly lower mean Hopkins Symptom Checklist (HSCL) Depression Scale scores (L. Derogatis, K. Rickels, E. Uhlenhuth, & L. Covi, 1974) from 6 months to 18 months versus usual care, F(1, 336) = 11.28, p = .001. Average HSCL depression scores over the period from 6 months to 18 months were 0.68 (SD = 0.55) in the telephone therapy group and 0.85 (SD = 0.65) in the usual-care comparison group. Addition of a brief, structured CBT program can significantly improve clinical outcomes for the large number of patients beginning antidepressant treatment in primary care. (PsycINFO Database Record (c) 2016 APA, all rights reserved).

Mohr, D. C., Hart, S. L., Julian, L., Catledge, C., Honos-Webb, L., Vella, L., Tasch, E. T. (2005). Telephone-administered psychotherapy for depression. *Archives of General Psychiatry, 62,* 1007-1014. <https://jamanetwork.com/journals/jamapsychiatry/article-abstract/1108409>

**Abstract**

Background Several studies have shown that telephone-administered cognitive-behavioral therapy (T-CBT) is superior to forms of no treatment controls. No study has examined if the skills-training component to T-CBT provides any benefit beyond that provided by nonspecific factors.

Objective To test the efficacy of a 16-week T-CBT against a strong control for attention and nonspecific therapy effects.

Design Randomized controlled trial including 12-month follow-up.

Setting Telephone administration of psychotherapy with patients in their homes.

Participants Participants had depression and functional impairments due to multiple sclerosis.

Interventions A 16-week T-CBT program was compared with 16 weeks of telephone-administered supportive emotion-focused therapy.

Main Outcome Measures Hamilton Depression Rating Scale score, Structured Clinical Interview for DSM-IV diagnosis of major depressive disorder, Beck Depression Inventory score, and Positive Affect scale score of the Positive and Negative Affect Scale.

Results Of the 127 participants randomized, 7 (5.5%) dropped out of treatment. There were significant improvement during treatment on all outcome measures (P<.01 for all) and an increase in Positive Affect Scale score. Improvements over 16 weeks of treatment were significantly greater for T-CBT, compared with telephone-administered supportive emotion-focused therapy, for major depressive disorder frequency (P = .02), Hamilton Depression Rating Scale score (P = .02), and Positive Affect Scale score (P = .008), but not for the Beck Depression Inventory score (P = .29). Treatment gains were maintained during 12-month follow-up; however, differences across treatments were no longer evident (P > .16 for all).

Conclusions Patients showed significant improvements in depression and positive affect during the 16 weeks of telephone-administered treatment. The specific cognitive-behavioral components of T-CBT produced improvements above and beyond the nonspecific effects of telephone-administered supportive emotion-focused therapy on evaluator-rated measures of depression and self-reported positive affect. Attrition was low.

Stiles-Shields, C., Corden, M. E., Kwasny, S., Schueller, M., & Mohr, D. C. (2015). Predictors of outcome for telephone and face-to-face administered cognitive behavioral therapy for depression. *Psychological Medicine, 45*(15), 3205-3215*.* <https://doi.org/10.1017/S0033291715001208>

**Abstract**

Background Cognitive behavioral therapy (CBT) can be delivered efficaciously through various modalities, including telephone (T-CBT) and face-to-face (FtF-CBT). The purpose of this study was to explore predictors of outcome in T-CBT and FtF-CBT for depression.

Method A total of 325 depressed participants were randomized to receive eighteen 45-min sessions of T-CBT or FtF-CBT. Depression severity was measured using the Hamilton Depression Rating Scale (HAMD) and the Patient Health Questionnaire-9 (PHQ-9). Classification and regression tree (CART) analyses were conducted with baseline participant demographics and psychological characteristics predicting depression outcomes, HAMD and PHQ-9, at end of treatment (week 18).

Results The demographic and psychological characteristics accurately identified 85.3% and 85.0% of treatment responders and 85.7% and 85.0% of treatment non-responders on the HAMD and PHQ-9, respectively. The Coping self-efficacy (CSE) scale predicted outcome on both the HAMD and PHQ-9; those with moderate to high CSE were likely to respond with no other variable influencing that prediction. Among those with low CSE, depression severity influenced response. Social support, physical functioning, and employment emerged as predictors only for the HAMD, and sex predicted response on the PHQ-9. Treatment delivery method (i.e. telephone or face-to-face) did not impact the prediction of outcome.

Conclusions Findings suggest that the predictors of improved depression are similar across treatment modalities. Most importantly, a moderate to high level of CSE significantly increases the chance of responding in both T-CBT and FtF-CBT. Among patients with low CSE, those with lower depressive symptom severity are more likely to do well in treatment.

Stiles-Shields, C., Kwasny, M. J., Cai, X., & Mohr, D. C. (2014). Therapeutic alliance in face-to-face and telephone-administered cognitive behavioral therapy. *Journal of Consulting and Clinical Psychology, 82*(2), 349-354. <https://psycnet.apa.org/fulltext/2014-02032-001.html>

**Abstract**

Objective: Telephone-administered therapies have emerged as an alternative method of delivery for the treatment of depression, yet concerns persist that the use of the telephone may have a deleterious effect on therapeutic alliance. The purpose of this study was to compare therapeutic alliance in clients receiving cognitive behavioral therapy (CBT) for depression by telephone (T-CBT) or face-to-face (FtF-CBT). Method: We randomized 325 participants to receive 18 sessions of T-CBT or FtF-CBT. The Working Alliance Inventory (WAI) was administered at Weeks 4 and 14. Depression was measured during treatment and over 1 year posttreatment follow-up using the Hamilton Rating Scale for Depression and Patient Health Questionnaire–9. Results: There were no significant differences in client or therapist WAI between T-CBT or FtF-CBT (Cohen’s f2 ranged from 0 to .013, all ps > .05). All WAI scores predicted depression end of treatment outcomes (Cohen’s f2 ranged from .009 to .06, all ps < .02). The relationship between the WAI and depression outcomes did not vary by treatment group (Cohen’s f2 ranged from 0 to .004, ps > .07). The WAI did not significantly predict depression during posttreatment follow-up (all ps > .12). Conclusions: Results from this analysis do not support the hypothesis that the use of the telephone to provide CBT reduces therapeutic alliance relative to FtF-CBT.

Taylor, S., Thordarson, D. S., Spring, T., Yeh, A. H., Corcoran, K. M., Eugster, K., & Tisshaw, C. (2003). Telephone-administered cognitive behavior therapy for obsessive-compulsive disorder. *Cognitive Behaviour Therapy, 32*(1), 13-25. <https://doi.org/10.1080/16506070310003639>

**Abstract**

Exposure with response prevention and cognitive behavior therapy are widely recognized as effective treatments for obsessive-compulsive disorder. Unfortunately, many people with obsessive-compulsive disorder - particularly those living in rural areas - do not have access to therapists providing these treatments. Accordingly, we investigated the efficacy of telephone-administered cognitive behavior therapy for obsessive-compulsive disorder. Two open trials are reported, for a total of 33 people with obsessive-compulsive disorder (without major depression). The first trial consisted of 12 weeks on a waiting list followed by 12 weeks of treatment (delayed treatment). The second trial consisted of 12 weeks of immediate treatment. Obsessive-compulsive symptoms did not change during the waiting period. Symptoms declined from pre- to post-treatment, with gains maintained at 12-week follow-up. For the pooled sample our pre-to-post-treatment effect size was as large or larger than those obtained in other studies of reduced contact treatment, and similar to those of face-to-face exposure with response prevention. Our proportion of treatment dropouts tended to be lower than those of other reduced contact interventions. The results suggest that telephone-administered cognitive behavior therapy is effective and well-tolerated, at least for people with obsessive-compulsive disorder without major depression. It remains to be seen whether this treatment is safe and effective when comorbid major depression is present.

Turgoose, D., Aswick, R., & Murphy, D. (2018). Systematic review of lessons learned from delivering tele-therapy to veterans with post-traumatic stress disorder. *Journal of Telemedicine and Telecare 24*(9), 575-585. <https://doi.org/10.1177/1357633X17730443>

**Abstract**

Introduction: Despite increases in the number of ex-service personnel seeking treatment for post-traumatic stress disorder (PTSD), there remain a number of barriers to help-seeking which prevents many veterans from accessing psychological therapies. Tele-therapy provides one potential method of increasing the number of veterans accessing support. This review aimed to systematically review the literature in order to summarise what lessons have been learned so far from providing trauma-focused tele-therapies to veterans with PTSD. Methods: A systematic literature review was conducted from which 41 papers were reviewed. Studies were included if they involved the use of trauma-focused therapies carried out using tele-therapy technologies. Only studies using tele-therapy interventions via video or telephone with populations of ex-military personnel with PTSD were included. Results: In the majority of cases tele-therapy was found to be as effective in reducing PTSD symptoms as in-person interventions. Similarly, there were few differences in most process outcomes such as dropout rates, with tele-therapy helping to increase uptake in some cases. Veterans using tele-therapy reported high levels of acceptability and satisfaction. Some challenges were reported in terms of therapeutic alliance, with some studies suggesting that veterans felt less comfortable in using teletherapy. Several studies suggested it was harder for clinicians to read non-verbal communication in tele-therapy, but this did not affect their ability to build rapport. Technological issues were encountered, but these were not found to impede therapy processes or outcomes. Discussion: Tele-therapy provides a viable alternative to in-person therapies and has the potential to increase access to therapy for veterans. Tele-therapy should continue to be evaluated and scrutinised in order to establish the most effective methods of delivery. (PsycINFO Database Record (c) 2019 APA, all rights reserved)

Varker, T., Brand, R. M., Ward, J., Terhaag, S., & Phelps, A. (2019). Efficacy of synchronous telepsychology interventions for people with anxiety, depression, posttraumatic stress disorder, and adjustment disorder: a rapid evidence assessment. *Psychological Services 16*(4), 621-635. <http://dx.doi.org/10.1037/ser0000239>

**Abstract**

Telepsychology holds promise as a treatment delivery method that may increase access to services as well as reduce barriers to treatment accessibility. The aim of this rapid evidence assessment was to assess the evidence for synchronous telepsychology interventions for 4 common mental health conditions (depression, anxiety, posttraumatic stress disorder, and adjustment disorder). Randomized controlled trials published between 2005 and 2016 that investigated synchronous telepsychology (i.e., telephone delivered, video teleconference delivered, or Internet delivered text based) were identified through literature searches. From an initial yield of 2,266 studies, 24 were included in the review. Ten studies investigated the effectiveness of telephone-delivered interventions, 11 investigated the effectiveness of video teleconference (VTC) interventions, 2 investigated Internet-delivered text-based interventions, and 2 were reviews of multiple telepsychology modalities. There was sufficient evidence to support VTC and telephone-delivered interventions for mental health conditions. The evidence for synchronous Internet-delivered text-based interventions was ranked as “unknown.” Telephone-delivered and VTC-delivered psychological interventions provide a mode of treatment delivery that can potentially overcome barriers and increase access to psychological interventions.

**Telephone-Delivered Interventions** Overall, 11 studies investigated the effectiveness of telephone delivered psychological interventions. Two meta-analyses looked at a range of telepsychology modalities, including telephone delivered therapy (Bee et al., 2008; Osenbach et al., 2013), while a third meta-analysis looked specifically at telephone-delivered psychotherapy for depression (Mohr et al., 2008). Eight individual RCTs assessed telephone-delivered therapy for a range of disorders (i.e., generalized anxiety disorder, depression, and obsessive– compulsive disorder), with TAU comparisons (Dwight-Johnson et al., 2011; Gellis et al., 2014; Ludman et al., 2007; Mohr et al., 2011), in-person therapy comparisons (Lovell et al., 2006; Mohr et al., 2012), and telepsychology comparisons (Brenes et al., 2015; Mohr et al., 2005). Overall, the strength of the evidence for telephone-delivered therapy was rated as high, given that there were three meta analyses, one of which had a low risk of bias (Bee et al., 2008) and two of which had a moderate risk of bias (Mohr et al., 2008; Osenbach et al., 2013), which had results supporting the use of telephone-delivered therapy. In addition to this, there were several other high-quality individual RCTs (Brenes et al., 2015; Dwight, Johnson et al., 2011; Gellis et al., 2014; Lovell et al., 2006; Ludman et al., 2007; Mohr et al., 2011, 2012). The direction of the evidence was judged to be positive, since all studies except for one reported that telephone-delivered therapy was as effective as standard in-person treatment or was better than TAU on a range of outcomes. One study did not find a significant difference in improvement between telephone-delivered cognitive–behavioral therapy (T-CBT) and TAU groups (Mohr et al., 2011), but given the strong positive weight of the rest of the evidence, this finding was judged not to be significant enough to lower the direction rating to “Unclear.” The consistency of the findings was judged to be moderate to high, as the majority of studies reported similar trends in the findings, with telephone-delivered therapy being as effective as TAU or standard in-person treatments. Specifically, T-CBT was found to be as effective as in-person treatments in noninferiority trials (i.e., trials comparing a novel treatment to an existing standard treatment) but was found to be superior to TAU. Given that the majority of studies were consistent in their findings, it was determined that these results are highly likely to be replicable. The generalizability of these studies was rated as moderate to high, as the studies included a range of disorders and samples. The applicability of these findings was judged to be high, as the treatments and delivery formats are highly relevant and applicable to a Western health system. Thus, given the high strength, positive direction, moderate to high consistency, moderate to high generalizability, and high applicability, the use of telephone-delivered telepsychology for clients with mental health conditions was ranked as “Supported.”

**Conclusions** Based on the findings of this REA, both telephone- and VTC delivered interventions for mental health conditions are “Supported” by the current available evidence.

Watzke, B., Haller, E., Steinmann, M., Heddaeus, D., Härter, M., König, H.-H., Wegscheider, K., & Rosemann, T. (2017). Effectiveness and cost-effectiveness of telephone-based cognitive-behavioural therapy in primary care: study protocol of TIDe – telephone intervention for depression. *BMC Psychiatry, 17*(263). <https://doi.org/10.1186/s12888-017-1429-5>

**Abstract**

Background Despite the availability of evidence-based treatments for depression, a large proportion of patients remains untreated or adequate treatment is initiated with delay. This situation is particularly critical in primary care, where not only most individuals first seek help for their mental health problems, but also depressive disorders – particularly mild to moderate levels of severity – are highly prevalent given the high comorbidity of chronic somatic conditions and depression. Improving the access for evidence-based treatment, especially in primary care, is hence a priority challenge in the mental health care agenda. Telephone usage is widespread and has the potential of overcoming many barriers that individuals suffering from mental health problems are facing: Its implementation for treatment delivery presents an option for optimisation of treatment pathways and outcomes.

Methods/design This paper details the study protocol for a randomised controlled trial (RCT) evaluating the effectiveness of a telephone-administered short-term cognitive-behavioural therapy (T-CBT) for depression as compared to treatment as usual (TAU) in the Swiss primary care setting. The study aims at randomising a total of 216 mildly to moderately depressed patients, which are either identified by their General Practitioners (GPs) or who self-refer to the study programme in consultation with their GP. The trial will examine whether telephone-delivered, manualised treatment leads to clinically significant reduction in depression at follow-up. It will further investigate the cost-effectiveness and acceptability of the intervention in the primary care setting.

Discussion Conducting a low-intensity treatment on the telephone allows for greater flexibility for both patient and therapist, can grant more anonymity and can thus lead to less hesitation in the patient about whether to attempt treatment or not. In order to benefit from this approach, large-scale studies need to prove superior effectiveness and cost-effectiveness of telephone-delivered therapy over routine care for patients with mild to moderate depression.

**Natural Disasters**

Lennart, R., Bassilios, B., & Pirkis, J. (2012). National telemental health responses to a major bushfire disaster. *Journal of Telemedicine and Telecare, 18*(226), 226-230. <https://doi.org/10.1258%2Fjtt.2012.110902>

**Abstract**

In response to the Victorian bushfire disaster in 2009, various telemental health services were provided by three national agencies: Kids Helpline (BoysTown), MensLine Australia (Crisis Support Services) and Lifeline Australia. All provider agencies used their existing national service structures and staff resources, which were expanded to respond to bushfire-related service demand. We examined service provider reports and conducted key informant interviews. Despite a lack of quantitative data on consumer outcomes and perspectives, it appears that all three telemental health services experienced significant increases in overall service uptake levels in the wake of the bushfires. Uptake of specialized telephone-, web-, email- and crisis counselling services was substantial, although that of callback services was very limited. Potential clients encountered specific barriers in relation to service access and the callback model. The bushfire experience highlighted the impact of transitory living circumstances and the increased complexity of post-disaster calls on service provision. Telemental health services need to be integrated into mainstream services and disaster response structures.

**Suicide**

Rhee, W. K., Merbaum, M., Strube, M. J., & Self, S. M. (2005). Efficacy of brief telephone psychotherapy with callers to a suicide hotline. *Suicide and Life-Threatening Behavior, 35*(3), 317-328. <https://guilfordjournals.com/doi/pdf/10.1521/suli.2005.35.3.317>

**Abstract**

The efficacy of two types of therapy conducted exclusively over the telephone was studied. Clients (N = 55) were recruited from a pool of callers to a suicide hotline and were randomly assigned to a waiting list control (WC) or Solution Focused Brief Therapy (SFBT) or Common Factors Therapy (CFT). It was hypothesized that improvements would be significantly higher in the two therapy conditions compared to the waitlist control and SFBT would be significantly more efficacious than CFT. Results confirmed that improvement was significantly higher in the two treatment conditions compared to the waitlist control, but no difference in improvement was found between SFBT and CFT. The implications of these findings for suicide hotlines are discussed.

**Comorbid Medical Populations**

Anderson, T., McClintock, A. S., McCarrick, S. S., Heckman, T. G., Heckman, B. D., Markowitz, J. C., & Sutton, M. (2018). Working alliance, interpersonal problems, and depressive symptoms in tele‐interpersonal psychotherapy for HIV‐infected rural persons: Evidence for indirect effects. *Journal of Clinical Psychology, 74*(3), 286–303. <https://doi.org/10.1002/jclp.22502>

**Abstract**

Objective. Interpersonal psychotherapy (IPT) has demonstrated efficacy for the treatment of depression, yet little is known about its therapeutic mechanisms. As a specific treatment, IPT has been shown to directly reduce depressive symptoms, although it is unclear whether these reductions occur via interpersonal changes. Within IPT, the potential role of the working alliance, a common factor, as a predictor of depression and interpersonal changes is also unclear.

Method. Participants were 147 depressed persons living with HIV in rural communities of 28 U.S. states enrolled in a randomized clinical trial. Seventy‐five patients received up to 9 sessions of telephone‐administered IPT (tele‐IPT) plus standard care and 72 patients received standard care only. Two models were tested; one included treatment condition (tele‐IPT vs. control) and another included the working alliance as independent variables.

Results. The first model found an indirect effect whereby tele‐IPT reduced depression via decreased social avoidance. There was a direct effect between tele‐IPT and reduced depression. In the second model, the working alliance influenced depressive symptom relief via reductions in social avoidance. Both goal and task working alliance subscales were indirectly associated with reductions in depressive symptoms, also through reductions in social avoidance. There were no direct effects involving the working alliance. Tele‐IPT's influence on depressive symptom reduction was primarily through a direct effect, whereas the influence of working alliance depression was almost entirely via an indirect effect through interpersonal problems.

Conclusion. Study findings have implications for IPT when intervening with depressed rural people living with HIV/AIDS over the telephone.

Bell, K. R., Fann, J. R., Brockway, J. A., Cole, W. R., Bush, N. E., Dikmen, S., Hart, T., Lang, A. J., Grant, G., Gahm, G., Reger, M. A., De Lore, J. S., Machamer, J., Ernstrom, K., Raman, R., Jain, S., Stein, M. B., & Temkin, N. (2017). Telephone problem solving for service members with mild traumatic brain injury: a randomized, clinical trial. *Journal of Neurotrauma, 34*, 313-321. <https://doi.org/10.1089/neu.2016.4444>

**Abstract**

Mild traumatic brain injury (mTBI) is a common injury for service members in recent military conflicts. There is insufficient evidence of how best to treat the consequences of mTBI. In a randomized, clinical trial, we evaluated the efficacy of telephone-delivered problem-solving treatment (PST) on psychological and physical symptoms in 356 post-deployment active duty service members from Joint Base Lewis McChord, Washington, and Fort Bragg, North Carolina. Members with medically confirmed mTBI sustained during deployment to Iraq and Afghanistan within the previous 24 months received PST or education-only (EO) interventions. The PST group received up to 12 biweekly telephone calls from a counselor for subject-selected problems. Both groups received 12 educational brochures describing common mTBI and post-deployment problems, with follow-up for all at 6 months (end of PST), and at 12 months. At 6 months, the PST group significantly improved on a measure of psychological distress (Brief Symptom Inventory; BSI-18) compared to the EO group (p = 0.005), but not on post-concussion symptoms (Rivermead Post-Concussion Symptoms Questionnaire [RPQ]; p = 0.19), the two primary endpoints. However, these effects did not persist at 12-month follow-up (BSI, p = 0.54; RPQ, p = 0.45). The PST group also had significant short-term improvement on secondary endpoints, including sleep (p = 0.01), depression (p = 0.03), post-traumatic stress disorder (p = 0.04), and physical functioning (p = 0.03). Participants preferred PST over EO (p < 0.001). Telephone-delivered PST appears to be a well-accepted treatment that offers promise for reducing psychological distress after combat-related mTBI and could be a useful adjunct treatment post-mTBI. Further studies are required to determine how to sustain its effects.

Cummins, S. E., Tedeschi, G. J., Anderson, C. M., & Zhu, S.-H. (2016). Telephone intervention for pregnant smokers: A randomized controlled trial. *American Journal of Preventive Medicine, 51*(3), 318-326. <https://doi.org/10.1016/j.amepre.2016.02.022>

**Abstract**

Introduction Pregnant smokers are advised to quit; however, many struggle to do so. Behavioral counseling can increase quitting success, but the efficacy of telephone counseling for pregnant smokers has not been established. This study tests the efficacy of pregnancy-specific counseling, embedded in the ongoing operations of a state quitline.

Design In this two-group RCT, participants were randomly assigned to the intervention (telephone counseling plus self-help materials, n=584) or the control group (self-help materials only, n=589).

Setting/participants Participants were pregnant smokers (N=1,173) in the first 27 weeks of gestation who called a state quitline between September 2000 and May 2003 for help with quitting.

Intervention The primary component of the intervention was telephone counseling using a semi-structured protocol developed specifically for pregnant smokers. It drew its basic structure and clinical content from a previously tested counseling protocol for adult quitline callers, while including pregnancy-specific content and additional counseling sessions (nine rather than the standard five).

Main outcome measures Subjects were evaluated on prolonged abstinence at the third trimester (about 29 weeks’ gestation) and at 2 and 6 months postpartum. Data were analyzed in 2015.

Results Abstinence was higher for the intervention than the control group at the end of pregnancy (30-day abstinence, 29.6% vs 20.1%; p<0.001); 2 months postpartum (90-day abstinence, 22.1% vs 14.8%; p<0.001); and 6 months postpartum (180-day abstinence, 14.4% vs 8.2%; p<0.001). Cotinine-corrected (≤13 ng/mL) 7-day abstinence rates at the end of pregnancy supported the intervention effect (35.8% vs 22.5%, p<0.001).

Conclusions A pregnancy-specific counseling protocol, embedded in a state quitline, was effective in helping pregnant smokers quit and stay quit postpartum. Wide adoption of this intervention could help reduce the rate of maternal smoking and prevent its devastating health consequences.

Davidson, C. A., Coronado, R. A., Vanston, S. W., Blade, E. G., Henry, A. L., Obremskey, W. T., Wegener, S. T., & Archer, K. R. (2019). Feasibility and acceptability of telephone-delivered cognitive-behavioral-based physical therapy for patients with traumatic lower extremity injury. *Journal of Applied Biobehavioral Research, 24*, Article No. e12163. <https://doi.org/10.1111/jabr.12163>

**Abstract**

Purpose To determine feasibility and acceptability of a telephone‐based Cognitive‐Behavioral‐Based Physical Therapy program for patients following traumatic lower extremity injury (CBPT‐Trauma).

Methods Patients were screened for high psychosocial risk factors and then completed the 6‐week CBPT‐Trauma program. Physical function, pain, and psychosocial outcomes were assessed at baseline and 6‐months follow‐up. Descriptive statistics assessed change in outcomes.

Results Recruitment rate was 59%. Twenty‐seven patients (73%) had a high psychosocial risk profile. Twelve patients completed the program and the follow‐up assessment at 6 months and found the program to be very or extremely helpful to their overall recovery. All demonstrated a clinically meaningful increase in physical function. Six patients demonstrated a clinically relevant decrease in pain intensity, pain catastrophizing, and fear of movement. Seven patients reported a clinically meaningful increase in pain self‐efficacy.

Discussion Findings suggest that recruitment is feasible for CBPT‐Trauma program. However, engagement in the CBPT‐Trauma study was low. For those that completed the program, patients were satisfied with the CBPT‐Trauma program and experienced meaningful improvement in psychosocial factors and patient‐reported outcomes. This open pilot study highlights the importance of targeted treatment for patients at high‐risk for poor outcomes and the potential for increased access to services through telephone‐delivery.

Dorstyn, D., Mathias, J., & Denson, L. (2013). Applications of telecounselling in spinal cord injury rehabilitation: a systematic review with effect sizes. *Clinical Rehabilitation, 27*(12), 1072-1083. <https://doi.org/10.1177%2F0269215513488001>

**Abstract**

Objective To investigate the short- and medium-term efficacy of counselling services provided remotely by telephone, video or internet, in managing mental health outcomes following spinal cord injury.

Data sources A search of electronic databases, critical reviews and published meta-analyses was conducted.

Review methods Seven independent studies (N = 272 participants) met the inclusion criteria. The majority of these studies utilized telephone-based counselling, with limited research examining psychological interventions delivered by videoconferencing (Nstudy = 1) or online (Nstudy = 1).

Results There is some evidence that telecounselling can significantly improve an individual’s management of common comorbidities following spinal cord injury, including pain and sleep difficulties (d = 0.45). Medium-term treatment effects were difficult to evaluate, with very few studies providing these data, although participants have reported gains in quality of life 12 months after treatment (d = 0.88). The main clinical advantages are time efficiency and consumer satisfaction.

Conclusion The results highlight the need for further evidence, particularly randomized controlled trials, to establish the benefits and clinical viability of telecounselling.

Heckman, T. G., Heckman, B. D., Anderson, T., Lovejoy, T. I., Markowitz, J. C., Shen, Y., & Sutton, M. (2017). Tele-interpersonal psychotherapy acutely reduces depressive symptoms in depressed HIV-infected rural persons: A randomized clinical trial. *Behavioral Medicine, 43*(4), 285-295. <https://doi.org/10.1080/08964289.2016.1160025>

**Abstract**

Human immunodeficiency virus (HIV)-positive rural individuals carry a 1.3-times greater risk of a depressive diagnosis than their urban counterparts. This randomized clinical trial tested whether telephone-administered interpersonal psychotherapy (tele-IPT) acutely relieved depressive symptoms in 132 HIV-infected rural persons from 28 states diagnosed with Diagnostic and Statistical Manual of Mental Disorders-IV major depressive disorder (MDD), partially remitted MDD, or dysthymic disorder. Patients were randomized to either 9 sessions of one-on-one tele-IPT (n = 70) or standard care (SC; n = 62). A series of intent-to-treat (ITT), therapy completer, and sensitivity analyses assessed changes in depressive symptoms, interpersonal problems, and social support from pre- to postintervention. Across all analyses, tele-IPT patients reported significantly lower depressive symptoms and interpersonal problems than SC controls; 22% of tele-IPT patients were categorized as a priori “responders” who reported 50% or higher reductions in depressive symptoms compared to only 4% of SC controls in ITT analyses. Brief tele-IPT acutely decreased depressive symptoms and interpersonal problems in depressed rural people living with HIV.

Heckman, T. G., Markowitz, J. C., Heckman, B. D., Woldu, H., Anderson, T., Lovejoy, T. I., Shen, Y., Sutton, M., & Yarber, W. (2018). A randomized clinical trial showing persisting reductions in depressive symptoms in HIV-infected rural adults following brief telephone-administered interpersonal psychotherapy. *Annals of Behavioral Medicine, 52*(4), 299-308. <https://doi.org/10.1093/abm/kax015>

**Abstract**

Background. Rural areas account for 5% to 7% of all HIV infections in the USA, and rural people living with HIV (PLHIV) are 1.3 times more likely to receive a depression diagnosis than their urban counterparts. A previous analysis from our randomized clinical trial found that nine weekly sessions of telephone-administered interpersonal psychotherapy (tele-IPT) reduced depressive symptoms and interpersonal problems in rural PLHIV from preintervention through postintervention significantly more than standard care but did not increase perceived social support compared to standard care.

Purpose. To assess tele-IPT’s enduring effects at 4- and 8-month follow-up in this cohort.

Methods. Tele-IPT’s long-term depression treatment efficacy was assessed through Beck Depression Inventory self-administrations at 4 and 8 months. Using intention-to-treat and completer-only approaches, mixed models repeated measures, and Cohen’s d assessed maintenance of acute treatment gains.

Results. Intention-to-treat analyses found fewer depressive symptoms in tele-IPT patients than standard care controls at 4 (d = .41; p < .06) and 8-month follow-up (d =.47; p < .05). Completer-only analyses found similar patterns, with larger effect sizes. Tele-IPT patients used crisis hotlines less frequently than standard care controls at postintervention and 4-month follow-up (ps < .05).

Conclusions. Tele-IPT provides longer term depression relief in depressed rural PLHIV. This is also the first controlled trial to find that IPT administered over the telephone provides long-term depressive symptom relief to any clinical population.

Helstrom, A., Haratz, J., Chen, S., Benson, A., Streim, J., & Oslin, D., (2018). Telephone-based management of chronic pain in older adults in an integrated care program. *International Journal of Geriatric Psychiatry, 33*(5), 779-785. <https://doi.org/10.1002/gps.4860>

**Abstract**

Objective Few studies have explored behavioral strategies for managing chronic pain in older adults. Pain Care Management (PCM) is a telephone‐based behavioral intervention for chronic pain. The present study examined chronic pain characteristics among older adults and tested the delivery of PCM as an adjunct to depression and anxiety care management.

Methods Participants were drawn from a state‐sponsored program offering care management services to community members aged 65 and older who were prescribed a psychotropic medication by a primary care provider. Chronic pain information was collected for all participants in the state program (N = 250) and treatment outcome data were collected for a subset with significant chronic pain. Eighty participants with high chronic pain interference were offered PCM and compared to 80 participants with chronic pain who received monitoring only on depression, anxiety, and pain interference outcomes.

Results Chronic pain was identified in 14% of older adults newly prescribed a psychotropic medication. Compared to monitoring only, PCM participants had higher odds of seeing a reduction of 2 or more points in pain interference at 6 months. Pain care management participants' anxiety scores significantly decreased over the study period.

Conclusions Older adults treated with psychotropic medications often also experience chronic pain that interferes with daily activities. A telephone‐based care management intervention is acceptable and feasible with an older community‐based population and can lead to improvements in anxiety symptoms and interference from chronic pain. Further research will help to refine interventions that may help improve symptoms and increase functioning with this population.

Thompson, N. J., Patel, A. H., Selwa, L. M., Stoll, S. C., Begley, C. E., Johnson, E. K., & Fraser, R. T. (2015). Expanding the efficacy of Project UPLIFT: Distance delivery of mindfulness-based depression prevention to people with epilepsy. *Journal of Consulting and Clinical Psychology, 83*(2), 304–313. <https://doi.org/10.1037/a0038404>

**Abstract**

Objective: Depression affects about 16% of the U.S. population over a lifetime. People with chronic diseases have especially high rates of comorbid depression; 32% to 48% of people with epilepsy experience depression. This study evaluated the efficacy of a mindfulness-based cognitive therapy intervention for preventing major depressive disorder (MDD) episodes in people with epilepsy. Method: Participants (n = 128) were adults from Georgia, Michigan, Texas, and Washington with epilepsy and mild/moderate depressive symptoms. The 8-session weekly Project UPLIFT intervention, based on mindfulness-based cognitive therapy, was group-delivered via Web or telephone. Using a randomized, controlled crossover design, participants were assigned to Project UPLIFT or a treatment-as-usual (TAU) waitlist and assessed at baseline, and after intervening in the intervention group (∼10 weeks) and in the TAU group (∼20 weeks). Assessments included valid self-report measures of depression and MDD, knowledge/skills, and satisfaction with life. Results: The incidence of MDD episodes (new or relapse) from baseline to interim assessment was significantly lower in the intervention condition (0.0%) than in TAU (10.7%). Depressive symptoms decreased significantly more in the intervention condition than in TAU; Web and telephone did not differ. Change in knowledge/skills mediated the effect, which persisted over the 10 weeks of follow-up. Knowledge/skills and life satisfaction increased significantly more in the intervention condition than in TAU. Conclusions: Distance delivery of group mindfulness-based cognitive therapy can prevent episodes of MDD, reduce symptoms of depression, and increase life satisfaction in people with epilepsy. This intervention is easily modified for persons with other chronic diseases and other disparity populations. (PsycINFO Database Record (c) 2018 APA, all rights reserved)

**Smoking Cessation / Substance Use / Misuse Disorders**

Bricker, J. B., Bush, T., Zbikowski, S. M., Mercer, L. D., & Heffner, J. L. (2014). Randomized trial of telephone-delivered acceptance and commitment therapy versus cognitive behavioral therapy for smoking cessation: A pilot study. *Nicotine & Tobacco Research, 16*(11), 1446-1454. <https://doi.org/10.1093/ntr/ntu102>

**Abstract**

Objective We conducted a pilot randomized trial of telephone-delivered acceptance and commitment therapy (ACT) versus cognitive behavioral therapy (CBT) for smoking cessation.

Method Participants were 121 uninsured South Carolina State Quitline callers who were adult smokers (at least 10 cigarettes/day) and who wanted to quit within the next 30 days. Participants were randomized to 5 sessions of either ACT or CBT telephone counseling and were offered 2 weeks of nicotine replacement therapy (NRT).

Results ACT participants completed more calls than CBT participants (M = 3.25 in ACT vs. 2.23 in CBT; p = .001). Regarding satisfaction, 100% of ACT participants reported their treatment was useful for quitting smoking (vs. 87% for CBT; p = .03), and 97% of ACT participants would recommend their treatment to a friend (vs. 83% for CBT; p = .06). On the primary outcome of intent-to-treat 30-day point prevalence abstinence at 6 months postrandomization, the quit rates were 31% in ACT versus 22% in CBT (odds ratio [OR] = 1.5, 95% confidence interval [CI] = 0.7–3.4). Among participants depressed at baseline (n = 47), the quit rates were 33% in ACT versus 13% in CBT (OR = 1.2, 95% CI = 1.0–1.6). Consistent with ACT’s theory, among participants scoring low on acceptance of cravings at baseline (n = 57), the quit rates were 37% in ACT versus 10% in CBT (OR = 5.3, 95% CI = 1.3–22.0).

Conclusions ACT is feasible to deliver by phone, is highly acceptable to quitline callers, and shows highly promising quit rates compared with standard CBT quitline counseling. As results were limited by the pilot design (e.g., small sample), a full-scale efficacy trial is now needed.

Boyle, R. G., Enstad, C., Asche, S. e., Thoele, M. J., Sherwood, N. E., Severson, H. H., Ebbert, J., & Solberg, L. I. (2008). A randomized controlled trial of telephone counseling with smokeless tobacco users: The ChewFree Minnesota study. *Nicotine & Tobacco Research, 10*(9), 1433-1440. <https://doi.org/10.1080/14622200802279872>

**Abstract**

Although a considerable body of evidence supports telephone quit lines for smoking cessation, much less is known about the effectiveness of proactive Telephone Counseling with smokeless tobacco (ST) users. We conducted a randomized controlled trial comparing Telephone Counseling with the distribution of a self-help manual for ST cessation. We recruited 406 adult ST users throughout the state of Minnesota and randomized them to receive either: (a) a self-help manual (Manual only) or (b) a self-help manual plus proactive telephone-based cessation counseling (Telephone Counseling). The telephone-based treatment included up to four calls in support of quitting, and personalized various cognitive and behavioral strategies that are generally considered effective in tobacco cessation (such as setting a quit date, examining patterns of use, developing stress reduction skills, avoiding known triggers to use). Participants were surveyed by phone at 3 and 6 months to assess both point prevalence and continued abstinence. Prolonged abstinence from all tobacco was 6.8% and 30.9% (p<.001) at 3 months and 9.8% and 30.9% (p<.001) at 6 months in Manual only and Telephone Counseling, respectively. We found older age, lower dependency, and increased readiness predicted quitting success. Proactive telephone-based counseling is an effective strategy for improving cessation rates among ST users. Future research should determine the components contributing to the intervention success.

Gates, P. (2014). The effectiveness of helplines for the treatment of alcohol and illicit substance use. *Journal of Telemedicine and Telecare, 0*(0). <https://doi.org/10.1177%2F1357633X14555643>

**Abstract**

While tobacco helplines (quitlines) are thought to be effective, helplines which treat other substance use do not have an established evidence base. A review was conducted of the literature on illicit drug or alcohol (IDA) helplines. The literature search was conducted in five databases. Studies prior to 2014 were included if published in English, and involved the use of a telephone counselling helpline for the treatment of illicit drug or alcohol use. Review papers, opinion pieces, letters or editorials, case studies, published abstracts and posters were excluded. Initial searching identified 2178 articles and after removing duplicates and those meeting the exclusion criteria, there were 36 publications for review. A total of 29 articles provided descriptive information about 19 different IDA helplines which operated in the US (42%), Europe (21%), Australia (21%), Asia (11%) and Canada (5%). These services reported monthly call rates from 3.7 to over 23,000 calls per month. A total of nine articles provided evaluative information on eight different IDA helplines: four articles included a comparison of treatment outcomes against a control group and five articles included information on treatment satisfaction or service utilisation. Together they provide some evidence that these services are effective. Although there was little consistency in the measures used between articles which assessed helpline satisfaction, all but one reported high satisfaction. Although the evidence is mainly supportive of IDA helplines, further work is required to compare treatment outcomes in randomized groups.

Moore, B. A., Fazzino, T., Barry, D. T., Fiellin, D. A., Cutter, C. J., Schottenfeld, R. S., & Ball, S. A. (2013). The recovery line: a pilot trial of automated, telephone-based treatment for continued drug use in methadone maintenance. <https://doi.org/10.1016/j.jsat.2012.12.011>

**Abstract**

The current pilot study evaluated feasibility, acceptability, and initial efficacy of a therapeutic Interactive Voice Response (IVR) system (“the Recovery Line”) for patients receiving methadone maintenance who continue to use illicit drugs. Patients were randomized (N = 36) to 4 weeks of treatment-as-usual (TAU) or Recovery Line plus TAU. Ratings of the Recovery Line were high and remained stable throughout the study. However, despite instructions and reminders, patients used substantially less than the recommended daily use (< 10 days of 28). Patients were more likely to report abstinence from opioids and cocaine on days they used the Recovery Line (p = .01) than those they did not. Conditions did not differ significantly on patient satisfaction, urine screen outcomes, or coping efficacy. As with other computer-based treatments, findings suggest the Recovery Line is acceptable and feasible. However, additional methods to increase patient utilization of automated systems and larger clinical trials are needed.

**Psychosis**

Baker, A. L., Turner, A., Beck, A., Berry, K., Haddock, G., Kelly, P. J., & Bucci, S. (2018). Telephone-delivered psychosocial interventions targeting key health priorities in adults with psychotic disorder: systematic review. *Psychological Medicine, 48*, 2637-2657. <https://doi.org/10.1017/S0033291718001125>

**Abstract**

Background The mental and physical health of individuals with a psychotic illness are typically poor. Access to psychosocial interventions is important but currently limited. Telephone-delivered interventions may assist. In the current systematic review, we aim to summarise and critically analyse evidence for telephone-delivered psychosocial interventions targeting key health priorities in adults with a psychotic disorder, including (i) relapse, (ii) adherence to psychiatric medication and/or (iii) modifiable cardiovascular disease risk behaviours.

Methods Ten peer-reviewed and four grey literature databases were searched for English-language studies examining psychosocial telephone-delivered interventions targeting relapse, medication adherence and/or health behaviours in adults with a psychotic disorder. Study heterogeneity precluded meta-analyses.

Results Twenty trials [13 randomised controlled trials (RCTs)] were included, involving 2473 participants (relapse prevention = 867; medication adherence = 1273; and health behaviour = 333). Five of eight RCTs targeting relapse prevention and one of three targeting medication adherence reported at least 50% of outcomes in favour of the telephone-delivered intervention. The two health-behaviour RCTs found comparable levels of improvement across treatment conditions.

Conclusions Although most interventions combined telephone and face-to-face delivery, there was evidence to support the benefit of entirely telephone-delivered interventions. Telephone interventions represent a potentially feasible and effective option for improving key health priorities among people with psychotic disorders. Further methodologically rigorous evaluations are warranted.

**Maternal/Fetal Medicine / Child & Adolescent Population**

Aviv, A. (2006). Tele-hypnosis in the treatment of adolescent school refusal. American *Journal of Clinical Hypnosis, 49*(1), 31-40. <https://doi.org/10.1080/00029157.2006.10401550>

**Abstract**

Few studies have presented the use of hypnosis in the treatment of school refusal. These studies haven't approached the problem of self-hypnosis during the stressful morning hours. This paper introduces a therapeutic approach, which utilizes known hypnotic techniques, but rehearses them via the telephone, while the patient is at his/her house or on the way to school and the therapist is at the office. Twelve school-refusal adolescents were treated with different hypnotherapy techniques. Equipped with cellular phones and with the therapist's availability, these adolescents could benefit from hypnosis as an alternative coping strategy when the anxiety occurred. Results showed that 8 of the participants maintained full-time attendance, 3 showed partial improvement and 1 failed to improve his attendance. This study illustrates the benefits of self-hypnosis in the treatment of school refusal, while also enabling the patient to maintain the connection with the therapist so that the anxiety may be confronted when it arises.

Dennis, C.-L., & Kingston, D. (2008). A systematic review of telephone support for women during pregnancy and the early postpartum period. *Journal of Obstetrics, Gynecologic, & Neonatal Nursing, 37*(3)*,* 301-314. <https://doi.org/10.1111/j.1552-6909.2008.00235.x>

**Abstract**

Objective To assess the effects of telephone-based support on smoking, preterm birth, low birthweight, breastfeeding, and postpartum depression.

Data Sources Cochrane Pregnancy and Childbirth Group trials register (March 2006), Cochrane Central Register of Controlled Trials (March 2006), Medline (1966-2006), EMBASE (1980-2006), and CINAHL (1982-2006). Secondary references were scanned and experts in the field were contacted.

Study Selection All published, unpublished, and ongoing randomized controlled trials of telephone support interventions in which the primary aim was smoking, preterm birth, low birthweight, breastfeeding, or postpartum depression were reviewed.

Data extraction Data were independently extracted by both authors and double entered into the Cochrane Collaboration’s Review Manager (2003) software.

Data Synthesis Trials evaluating different primary outcomes were analyzed separately. For dichotomous data, results were presented as summary relative risk with 95% confidence intervals. For continuous data, weighted mean difference was used.

Conclusions Proactive telephone support may (a) assist in preventing smoking relapse, (b) play a role in preventing low birthweight, (c) increase breastfeeding duration and exclusivity, and (d) decrease postpartum depressive symptomatology. No telephone interventions were effective in improving preterm birth or smoking cessation rates. Additional research is encouraged.

Slone, N. C., Reese, R. J., & McClellan, M. J. (2012). Telepsychology outcome research with children and adolescents: A review of the literature. *Psychological Services, 9*(3), 272-292. <https://doi.org/10.1037/a0027607>

**Abstract**

Using technology as a service medium has been touted as a potentially feasible and effective alternative and/or adjunct to in-person services. The telepsychology literature has given less attention to children and adolescents in comparison to adults. This review provides a summary and critique of the empirical research focused on psychological services provided to children and adolescents using three technology media (i.e., videoconferencing, Internet, and telephone). The evidentiary support for providing services with each of these media for a range of concerns is encouraging. The quantity and quality of research, however, both need to be enhanced to better understand how technology mediates the provision of youth services, as well as to elevate telepsychology within professional psychology. Future research and its subsequent impact on policy and practice are considered.