Provider Perceptions of In-Person Telehealth HRT for BFRBs

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Disclosures and COI

Dr. Wiese has no financial interests to disclose.
Telehealth is here to stay

• Covid-19 pandemic necessitated a transition to telehealth (Shklarski et al., 2021)
  • Telehealth was not new, but the size of delivery was

• Telehealth is here to stay because of the many benefits it offers (Townsend et al., 2022; Tuerk et al., 2018)
  • Lower provider cost/burden; transportation; rural access to care; specialty care providers; etc.

• Treatment research suggests tele-HRT can be effective (Batastani et al., 2021)
  • But it does not specify when and for whom is this the case?
The Curious Case of Arthur

- Arthur, 70 yo white male, living with his wife of 49 years (Wiese et al., 2023)
- Presented Fall 2020 with MDD (partial remission) and excoriation disorder
- Followed by Psychiatry with extensive medication regimen
- Initiated a course of Cognitive Behavioral Therapy (CBT) with Habit Reversal Training (HRT)
  - Completed three telehealth visits before discontinuing
Arthur’s Redemption

- Presented again, Summer 2021, in-person
- Completed Reevaluation, 12 CBT with HRT sessions and four maintenance visits
What may Explain the Differential Responses to Treatment?

• Technology literacy (Jabarpour et al., 2021; Kruse et al., 2020; Traina et al., 2020)
  • Increased frustration
  • Ad-hoc tech support

• Limited field of view (Keuthen & Sprich, 2012)
  • On-going assessment in the context of BFRBs

• Family involvement
  • Difficult to engage multiple family members over video (Burgoyne & Cohn, 2020)

• Symptom severity
Provider Perceptions

• Providers ($n = 172$) treating BFRBs with HRT; rating feasibility of in-person and telehealth for:
  • Different ages
  • Different levels of symptom severity
  • Implementation of different pieces of HRT
  • Identifying and addressing patient factors that may impact with HRT
  • Identifying and addressing environmental factors that may impact HRT
Tele HRT may be suboptimal at younger ages

- Perceived feasibility for telehealth relative to in-person was:
  - Lower for patients under 13 years old
  - Higher for patients 13+ years old

![Graph showing self-reported feasibility ratings for delivering HRT via telehealth relative to in-person for different age-groups (1 – “much less feasible”; 5 – “much more feasible”). Error-bars reflect standard error of the mean. ***p < .001](image_url)
Tele HRT may be suboptimal for more severe presentations

- Perceived feasibility for telehealth relative to in-person was:
  - Lower for more severe presentations

![Graph showing self-reported feasibility ratings for delivering HRT via telehealth relative to in-person across different levels of BFRB symptom severity (1 = “much less feasible”; 5 = “much more feasible”). Error-bars reflect standard error of the mean. ***p < .001](image)

Fig. 2 Self-reported feasibility ratings for delivering HRT via telehealth relative to in-person across different levels of BFRB symptom severity (1 = “much less feasible”; 5 = “much more feasible”). Error-bars reflect standard error of the mean. ***p < .001
Provider Ability to Identify and Address Various Factors

• Greater ability to identify and address various characteristics and/or behaviors in-person:
  • Evidence of picking/pulling
  • Eliciting about using CRs and SC
  • Use of instruments
  • Non-verbal communication
  • Difficulty delivering psychoeducation
  • Limited patient insight into sx severity
<table>
<thead>
<tr>
<th></th>
<th>In-person</th>
<th>Telehealth</th>
<th>( t )-statistic</th>
<th>( p )-value</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical evidence of picking/pulling behaviors</td>
<td>4.52</td>
<td>3.38</td>
<td>13.69</td>
<td>&lt;.001**</td>
<td>1.08</td>
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<tr>
<td>(e.g., scabs, bald spots, damage to nail bed, etc.)</td>
<td>.61</td>
<td>.99</td>
<td></td>
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<tr>
<td>Elicit feedback from patients about the use of</td>
<td>4.64</td>
<td>4.38</td>
<td>5.28</td>
<td>&lt;.001**</td>
<td>.41</td>
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<tr>
<td>competing responses and stimulus control</td>
<td>.53</td>
<td>.69</td>
<td></td>
<td></td>
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<tr>
<td>techniques</td>
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<tr>
<td>Use of instruments to engage in BFRBs (e.g.,</td>
<td>4.38</td>
<td>4.03</td>
<td>4.54</td>
<td>&lt;.001**</td>
<td>.36</td>
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<tr>
<td>tweezers)</td>
<td>.77</td>
<td>.88</td>
<td></td>
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<tr>
<td>Affective/ environmental factors that facilitate</td>
<td>4.34</td>
<td>4.25</td>
<td>1.35</td>
<td>0.09</td>
<td>.11</td>
</tr>
<tr>
<td>picking/pulling behaviors</td>
<td>.77</td>
<td>.76</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Non-verbal communication</td>
<td>4.62</td>
<td>3.38</td>
<td>14.98</td>
<td>&lt;.001**</td>
<td>1.18</td>
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<tr>
<td>Difficulty delivering/patient understanding</td>
<td>4.37</td>
<td>3.86</td>
<td>6.00</td>
<td>&lt;.001**</td>
<td>.47</td>
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<td>psychoeducational materials</td>
<td>.89</td>
<td>1.01</td>
<td></td>
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<tr>
<td>Limited patient insight into symptom severity</td>
<td>4.31</td>
<td>3.72</td>
<td>7.88</td>
<td>&lt;.001**</td>
<td>.62</td>
</tr>
<tr>
<td></td>
<td>.78</td>
<td>1.05</td>
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</table>

*Note.* Self-reported ratings for ability to identify and address patient characteristics were reported using a 1 ("strongly disagree") to 5 ("strongly agree") scale. Cohn’s \( d \) was used to calculate effect size. **\( p < .001 \).
Provider Ability to Identify and Address Various Factors

- Greater perceived feasibility of implementing telehealth relative to in-person HRT for:
  - High versus low awareness of BFRBs
  - High versus low treatment motivation
  - High versus low cognitive ability
  - High versus low family support
  - Low versus high anxiety sensitivity
<table>
<thead>
<tr>
<th></th>
<th>Low M</th>
<th>Low SD</th>
<th>High M</th>
<th>High SD</th>
<th>t-statistic</th>
<th>p-value</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness of Repetitive</td>
<td>2.40</td>
<td>.79</td>
<td>3.29</td>
<td>.77</td>
<td>-11.37</td>
<td>&lt;.001***</td>
<td>-.87</td>
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<tr>
<td>Behavior</td>
<td></td>
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<td>Treatment Motivation</td>
<td>2.14</td>
<td>.86</td>
<td>3.42</td>
<td>.82</td>
<td>-13.97</td>
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<td>Anxiety Sensitivity</td>
<td>3.09</td>
<td>.63</td>
<td>2.80</td>
<td>.87</td>
<td>3.78</td>
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<td>.29</td>
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<td>Cognitive Ability</td>
<td>1.84</td>
<td>.66</td>
<td>3.31</td>
<td>.74</td>
<td>-20.40</td>
<td>&lt;.001***</td>
<td>-1.56</td>
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<td>Family Support</td>
<td>2.43</td>
<td>1.00</td>
<td>3.31</td>
<td>.74</td>
<td>-9.38</td>
<td>&lt;.001***</td>
<td>-.72</td>
</tr>
</tbody>
</table>

*Note. Self-reported ratings for individual differences were reported using a 1 ("much less feasible") to 5 ("much more feasible") scale. Cohn’s d was used to calculate effect size. *** p < .001*
Provider Ability to Implement HRT

• Greater perceived ability to implement all aspects of HRT in-person relative to telehealth:
  • Awareness training
  • Competing response training
  • Social Support
  • Stimulus Control

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Awareness Training</td>
<td>4.75</td>
<td>4.36</td>
<td>6.47</td>
<td>&lt;.001***</td>
<td>.50</td>
</tr>
<tr>
<td>Competing Response</td>
<td>4.79</td>
<td>4.43</td>
<td>6.68</td>
<td>&lt;.001***</td>
<td>.52</td>
</tr>
<tr>
<td>Training</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Support</td>
<td>4.48</td>
<td>4.22</td>
<td>3.77</td>
<td>&lt;.001***</td>
<td>.29</td>
</tr>
<tr>
<td>Stimulus Control</td>
<td>4.63</td>
<td>4.36</td>
<td>4.02</td>
<td>&lt;.001***</td>
<td>.31</td>
</tr>
</tbody>
</table>

*Note.* Self-reported ratings for feasibility of implementing HRT techniques were reported using a 1 (“very unfeasible”) to 5 (“very feasible”) scale. Cohn’s *d* was used to calculate effect size. ****p* < .001
Future Directions

• These findings do not appear unique to BFRBs
  • OCD (Wiese et al., 2022)
  • Tic/Tourette (Stiede, in preparation)

• Parallel treatment studies
  • Who is and is not responding

• Telehealth training in PhD/PsyD programs

• Patient perceptions
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References


