



## Article

# The COVID Shift: Comparing Hybrid Telehealth to In-Person Group Therapy for Incarcerated Women Survivors of Sexual Violence Victimization

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**Abstract:** Incarcerated women report extremely high rates of lifetime sexual violence victimization. Survivors Healing from Abuse: Recovery through Exposure (SHARE) is an exposure-based group therapy specifically designed for incarcerated women survivors of sexual violence. SHARE has been continuously delivered in a women's prison for more than 12 years. However, like many prisons during the COVID-19 pandemic, the prison ceased all in-person programming between March 2020 and July 2021. In response, the SHARE treatment team pivoted to a hybrid telehealth delivery model (i.e., group participants gathering in a facility group room and therapists joining via video, displayed on a computer screen within the group room). Given the lack of evidence for hybrid telehealth in carceral settings, and specifically for group therapy for sexual trauma, the current study compared ratings on internalizing symptoms (Brief Symptom Inventory-18 or BSI-18), posttraumatic stress symptoms (Posttraumatic Checklist-5 or PCL-5), and group cohesion ratings (Inclusion of Self in Other scale, or IOS) for participants who received SHARE in person ( $n = 21$ ) or through hybrid telehealth ( $n = 19$ ). The results demonstrated that participants of in-person and hybrid telehealth SHARE groups reported similar significant reductions in BSI-18 (15.21 in person vs. 16.00 in hybrid telehealth) and PCL-5 (30.78 in person vs. 26.40 in hybrid telehealth) scores pre- to post-treatment and comparable IOS ratings (5.06 in person vs. 5.31 in hybrid telehealth). The findings suggest hybrid telehealth is an effective and feasible treatment modality for meeting the need for trauma-focused therapy in prisons. Future studies examining the effectiveness and implementation of trauma-focused hybrid telehealth groups in prisons are warranted.

**Keywords:** incarcerated women; sexual violence; trauma-focused treatment; COVID-19; telehealth



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## 1. Introduction

Incarcerated women experience extremely high rates of lifetime sexual violence victimization. Estimates indicate between 50 and 66% of women who are incarcerated have experienced childhood sexual abuse and between 25 and 68% have experienced sexual

abuse in adulthood (Karlsson and Zielinski 2020). Experiences of sexual violence are associated with adverse psychiatric symptoms, including symptoms of posttraumatic stress disorder (PTSD), depression, and anxiety (Dworkin 2020; Dworkin et al. 2023). Untreated trauma and associated psychiatric symptoms are linked to behaviors that are criminalized, including substance use, sex work, and antisocial behavior (Anklesaria and Gentile 2012; Herrenkohl and Jung 2016; McLachlan 2024; Ullman et al. 2013). Consequently, repeated trauma exposure has been conceptualized as a risk factor for subsequent legal involvement as many women are routed to the justice system following experiences of sexual violence (Baumle 2018; Saar et al. 2015). The observation that traumatic experiences may result in externalizing behaviors that are criminalized, which in turn result in involvement with the legal system, has been described as the “sexual abuse-to-prison pipeline” or “trauma-to-prison-pipeline” (Baumle 2018; Browne et al. 1999; Salisbury and Van Voorhis 2009).

A growing body of research has focused on the treatment of trauma-related sequelae among incarcerated women (Bradley and Follingstad 2003; Bridges et al. 2020; Cole et al. 2007; Karlsson et al. 2014; King 2017; Kubiak et al. 2012; Lehrer 2021; Paquin et al. 2013; Roe-Sepowitz et al. 2014; Wolff et al. 2012; Zielinski et al. 2016). Evidence suggests that treating trauma in carceral settings is feasible and effective for reducing symptoms immediately post-treatment and after a follow-up period (Karlsson et al. 2015, 2020, 2022; King 2017), reducing substance use relapse after release, and lowering criminal recidivism (Kubiak 2004). Providing mental health therapies in prisons and other carceral settings is complicated by high need and relatively low resources (Dumont et al. 2012; Wildeman and Wang 2017). Group psychotherapy may be ideal for prison settings given their efficacy and relative brevity (Feucht and Holt 2016; Morgan et al. 2006; Yoon et al. 2017). In particular, second-wave therapies (i.e., cognitive treatments where unhelpful thoughts and beliefs believed to be linked to psychopathology were challenged using logic and Socratic questioning) and third-wave therapies (i.e., treatments focused on contextual changes and flexibility, and a heavier emphasis on mindfulness and acceptance; Benfer et al. 2021) are beneficial. A recent meta-analysis of third-wave therapies for PTSD revealed these therapies were effective for both individual and group formats, were more effective when they included exposure than when they did not, and that effectiveness was not moderated by treatment duration (Benfer et al. 2021). Similarly, a meta-analysis of cognitive processing therapy for PTSD revealed effectiveness was not linked to individual vs. group format or treatment duration, and that therapy outperformed inactive control groups (Asmundson et al. 2019). Furthermore, these treatments tend to focus on the here-and-now and modifiable factors that tend to be rapidly responsive to intervention. Cognitive-behavioral group therapies are especially well supported for use in prisons (Amoke et al. 2020; Khodayarifard et al. 2010; Wilson et al. 2005).

### 1.1. Shift to Telehealth During COVID-19

The COVID-19 pandemic significantly impacted mental health care programming within carceral settings (Burton et al. 2021). Many prisons ceased all in-person therapy services and rehabilitative programming to manage and contain the spread of COVID-19 (Zielinski et al. 2022). Despite limited data on the use of telehealth for prison-based mental health treatment, studies of telehealth as a delivery modal for community-based mental health treatment have been promising (Fernandez et al. 2021). Given the exigent mental health needs of incarcerated populations and promising community-based findings, some prisons implemented alternative models of mental health treatment delivery, such as telehealth and telepsychiatry, in the months following the initial COVID-19 lockdowns (Burton et al. 2021; Donelan et al. 2021; Khairat et al. 2021; Zielinski et al. 2022). At San Quentin State Prison in California, for instance, telehealth services were implemented

to increase access to needed mental health care. Prison staff added external cameras, microphones, and speakers to existing desktop computers located in semi-private spaces (e.g., nurse exam rooms, conference rooms) to create telepsychiatry stations for patients to meet virtually with mental health care providers (Burton et al. 2021). Patients and staff reported these services were highly satisfactory and of similar quality to in-person services.

In Massachusetts, the Franklin County jail used grant funds to purchase telehealth equipment and adapt a medication-assisted treatment program for opioid use disorders. The jail used a “hub-and-spoke” model of telehealth, whereby behavioral health staff would log in from their homes and meet virtually with clients who were in the jail (Donelan et al. 2021). In North Carolina, telemedicine equipment and software were purchased and carceral staff were trained to assist incarcerated people in attending specialty medical visits via telehealth. Data on satisfaction with telehealth services were high, 94% of patients and 86% of providers reported a positive experience with telemedicine, and most people were comfortable using telehealth for treatment (Khairat et al. 2021). However, the visits were not specific to mental health concerns.

While studies generally agree that the use of telehealth was critical to ensuring continuity of care during the COVID-19 pandemic, empirical support for the effectiveness of these programs remains understudied. Further, although satisfaction rates tend to be high (Burton et al. 2021; Khairat et al. 2021), there is a notable lack of information about whether these shifts were effective at reducing targeted symptoms in people who were incarcerated. While the general shift to telehealth for the delivery of mental health care during the COVID-19 presented challenges to all providers (e.g., AlRasheed et al. 2022), shifting to telehealth in a prison setting may present additional challenges over those present in outpatient community settings. For instance, privacy and confidentiality may be more easily compromised in prisons, both because of being constantly monitored by prison staff and because prisons are communal living quarters with limited access to private spaces. Technology is also more restricted in prisons. There tends to be a lack of available electronic equipment and access to the internet is controlled or prohibited. Finally, there is a greater likelihood of sessions being interrupted because of security protocols and normal operations (e.g., regular population counts).

There is a dearth of information surrounding the use of telehealth in carceral settings to treat trauma-related sequelae and relatively little information regarding how telehealth functions as a delivery modality for group-based therapies in these settings. The limited research thus far, however, is promising. For instance, Batastini and Morgan (2016) explored how cognitive-behavioral group therapy delivered in person ( $n = 12$ ), via telehealth ( $n = 24$ ), or no treatment ( $n = 13$ ) was associated with reductions in psychiatric symptoms and criminal thinking in a sample of incarcerated individuals. The authors found no significant group by time interactions, indicating comparable reductions in symptoms across all group formats. In a meta-analysis, Batastini et al. (2016) found comparable effects of telehealth vs. in-person therapy services in incarcerated populations. A comparative effectiveness review suggested telehealth services were more effective than wait-list control conditions for treating depression and PTSD symptoms in community samples (Sloan et al. 2011). Telehealth was also comparable to in-person treatment for depression. However, telehealth interventions were less effective than in-person interventions for treating PTSD.

### 1.2. The Current Study

The current study investigated the outcomes of an exposure-based group treatment for sexual violence victimization delivered via telehealth during the COVID-19 pandemic compared to in-person delivery the year prior. Both groups were provided to female victims of pre-incarceration sexual violence residing in a minimum-security prison. We wanted to

know if treatment outcomes, such as pre- to post-treatment reductions in internalizing and posttraumatic stress symptoms and sense of group cohesion, were comparable between groups delivered via a hybrid telehealth format during the COVID-19 pandemic and groups delivered in person. Given the exploratory nature of the study, no specific hypotheses were made.

## 2. Method

### 2.1. Participants

Participants were women incarcerated for nonviolent offenses at a minimum-security prison in the southern region of the United States. The study included women who participated in a treatment titled *Survivors Healing from Abuse: Recovery through Exposure* (SHARE; described in detail below) in person between August 2019 and March 2020 (i.e., pre-COVID-19) and via hybrid telehealth between October 2020 and June 2021 (i.e., peri-COVID-19). There was a total of 40 participants across 8 groups. Four SHARE groups delivered through hybrid telehealth were compared to four SHARE groups delivered in person during the eight months prior to the COVID-19 pandemic. In the four in-person groups, 21 women participated; 18 provided post-treatment data and were included in analyses (1 dropped out and 2 did not complete post-treatment measures). In the four hybrid telehealth groups, 19 women participated; 17 provided post-treatment data and were included in analyses (1 was quarantined for COVID-19, and 1 was released early).

The women’s ages ranged from 20 to 57 years, with an average age of 35.40 ( $SD = 9.21$ ). In terms of race/ethnicity, 2 participants were Latina (5%), 32 were White (80%), 1 was Black (3%), 3 were Native American (8%), and 4 were multi-racial (10%). These demographics mirror the broader demographics of the prison where the women were incarcerated. In terms of marital status, 15 were single (38%), 9 were married (23%), 8 were divorced (20%), and 8 reported another marital status (20%), such as widower, separated, or dating. Most women (93%) had children; the average number of children participants reported was 3.28 ( $SD = 1.88$ ). All women were incarcerated between 1 and 12 months, with an average incarceration time of 5.5 months. About a quarter (26%) answered “yes” to the question “Have you ever gotten treatment for sexual abuse trauma?” and 81% reported they had disclosed their abuse history to someone before. There were no significant differences in sociodemographic characteristics for participants across the two group formats (all  $p$  values  $> 0.05$ ; Table 1).

**Table 1.** Participant demographic characteristics by group modality.

	In-Person SHARE Groups		Hybrid Telehealth SHARE Groups		Test Statistic
	<i>n</i>	<i>M (SD) or N (%)</i>	<i>n</i>	<i>M (SD) or N (%)</i>	
Age	21	34.29 (9.12)	19	36.63 (9.41)	$t(38) = -0.80, p = 0.429$
Race	21		19		$\chi^2(3) = 4.04, p = 0.258$
		White		17 (89.5%)	
		Black/African American		0 (0.0%)	
		Native American		0 (0.0%)	
		Another race		2 (10.5%)	
Latina ethnicity	21	2 (9.5%)	18	0 (0.0%)	$\chi^2(1) = 1.81, p = 0.179$
Marital status	21		19		$\chi^2(4) = 3.48, p = 0.482$
		Married		3 (15.8%)	
		Divorced		3 (15.8%)	
		Single		7 (36.8%)	
		Another status		6 (31.6%)	
Has children	21	20 (95.2%)	19	17 (89.5%)	$\chi^2(1) = 0.48, p = 0.489$
Number of children	21	3.19 (1.72%)	19	3.37 (2.09%)	$t(38) = -0.30, p = 0.769$

## 2.2. Treatment

Karlsson et al. (2014) developed SHARE, a brief, structured group treatment specifically developed for incarcerated women who have experienced sexual violence. SHARE incorporates treatment components from gold standard evidenced-based treatments for PTSD, such as prolonged exposure therapy (PE; Foa et al. 2007; Powers et al. 2010) and cognitive processing therapy (CPT; Asmundson et al. 2019; Resick and Schnicke 1993). The primary component of SHARE is imaginal exposure, conducted in a group setting with two group leaders. Imaginal exposure involves asking someone to recall a traumatic memory in a safe way. The person describes their memory out loud, with the guidance of a therapist. The therapist often prompts the person to describe in detail the event(s), including using all five senses, as well as emotions and thoughts that the person experienced at the time the traumatic event happened. After the memory is imagined and shared, the therapist will often guide the person into reflecting on the experience of sharing, emphasizing insights or changes in emotions and reactions they noticed. Other treatment components include supportive feedback (both from group leaders and group members), cognitive restructuring, and emotion processing following the sharing of a trauma narrative. SHARE was initially developed to be delivered in person with all group members and therapists physically present in a confidential setting within the prison. Group members and therapists are seated in chairs arranged in a circle.

SHARE incorporates therapeutic aspects of the group format that are not present in individual trauma-focused therapy, including the facilitation of social connections among group members and opportunities for group members to practice trusting one another. The group modality also creates a safe space in which symptoms and experiences are normalized (Sloan et al. 2013; Yalom and Leszcz 2020). Initial SHARE sessions focus on setting group norms, creating and reviewing the group structure, and providing psychoeducation with goals of building rapport, enhancing motivation, and increasing treatment efficacy. Once group norms and rapport have been established, imaginal exposure begins and is followed by supportive feedback from group members and therapists. These sessions emphasize approaching rather than avoiding trauma-related memories, reducing memory and fear associations, using non-judgmental listening, and normalizing trauma experiences and reactions. As the group progresses, imaginal exposure continues and group leaders begin to incorporate discussion of common trauma-focused themes (e.g., safety, trust, intimacy). In the final sessions, the focus shifts to relapse prevention and consolidation of treatment gains (e.g., coping skills and trauma-focused themes).

### Shift to Hybrid Telehealth Delivery

Treatment adaptations were implemented to optimize delivery of SHARE during the COVID-19 pandemic while abiding by safety protocols and maintaining the health and safety of SHARE participants and therapists. The most significant adaptation was that the co-therapists were no longer physically present during groups; instead, group participants attended sessions together in a single room within the prison while therapists attended remotely. Although other models of telehealth service delivery are common (e.g., having every participant on their own computer, joining group remotely), the prison lacked the space or technology to allow for every individual to participate in SHARE virtually. For logistic reasons, therefore, all participants were in a single room together, while therapists joined virtually from their homes. Participants were seated in chairs placed 3 feet apart in a semi-circle format and a television with a computer was wheeled into the room for each session. The prison staff connected to a Zoom link and the therapists, each located in their own homes, joined virtually. Prison staff then left the room and the therapists co-led SHARE through this hybrid telehealth format.



All group participants wore masks per prison COVID-19 protocol. When it was a participant's turn to complete an exposure, that person moved to a chair located next to the computer to increase proximity to the microphone and facilitate therapists' ability to hear the narrative. When there were technological glitches (e.g., pop-up window reminders to update Zoom software), these were quickly managed by prison staff or therapists. The session content, order, and structure of hybrid telehealth SHARE groups remained identical relative to in-person groups.

### 2.3. Procedures

All SHARE participants were asked to complete self-report measures to index changes from pre- to post-treatment. A double consent procedure was used at pre- and post-treatment, meaning participants provided consent prior to completing measures and again once they had completed measures. All study procedures were approved by the Institutional Review Board at the [blinded for review] and the [state] Division of Community Corrections.

#### 2.3.1. In-Person SHARE Groups

In-person SHARE groups were delivered by the SHARE treatment team within a group room located in the facility. All treatment materials were provided to group members at the start of Session 1. For in-person groups, participants completed self-report measures the week prior to the start of the group and post-treatment measures during the last group session. Pre- and post-treatment measures were distributed by the SHARE treatment team, completed in a confidential setting, and promptly collected and sealed in a manila envelope by the SHARE treatment team upon completion.

#### 2.3.2. Hybrid Telehealth SHARE Groups

For hybrid telehealth SHARE groups, group members attended the group together in the same group room, wore masks, and sat several feet away from one another. Group leaders attended through Zoom and were displayed on a computer monitor that was wheeled into the group room by prison staff who left the room prior to the group starting. All treatment materials were dropped off to the prison by the SHARE treatment team and provided to group participants by prison staff prior to Session 1 of SHARE. Participants were instructed to complete pre-treatment measures at the start of the first group session and post-treatment measures at the conclusion of the last group session, while therapists waited silently on Zoom. Prison staff then collected the completed measures and sealed them in a manila envelope. For hybrid telehealth SHARE groups, measures were dropped off and picked up at the prison by the SHARE treatment team and delivered to/collected from the participants by prison staff.

### 2.4. Measures

#### 2.4.1. Psychiatric Symptoms

The Brief Symptom Inventory-18 (BSI-18; [Derogatis 2000](#)) was used to assess psychological distress and symptoms of psychopathology. The BSI-18 provides an overall global distress score (i.e., Global Severity Index; GSI), as well as subscale scores for depression, anxiety, and somatization. Items assess symptoms experienced in the past week, with responses ranging from 0 (*not at all*) to 4 (*extremely*). Higher scores indicate higher levels of psychological distress. The BSI-18 has been shown to demonstrate strong internal consistency (global distress  $\alpha = 0.89$ ; [Derogatis 2000](#)) and construct validity ([Derogatis 2000](#)). In the current study, Cronbach alpha was 0.91 at pre-treatment and 0.89 at post-treatment.

#### 2.4.2. PTSD Checklist for DSM-5 (PCL-5)

Traumatic stress symptoms were assessed using the PTSD Checklist Version 5 (PCL-5; [Weathers et al. 2013](#)). The PCL-5 is a 20-item self-report measure assessing symptoms associated with PTSD. Participants were asked to rate how bothered they have been in the past month by symptoms of traumatic stress on a scale of 0 (*not at all bothered*) to 4 (*extremely bothered*). For example, “*In the past month, how much were you bothered by...repeated, disturbing, and unwanted memories of the stressful experience?*” Total symptom severity scores, ranging from 0 to 80, were calculated by summing item responses. The PCL-5 has been shown to demonstrate strong internal consistency ( $\alpha = 0.94\text{--}0.96$ ), test–retest reliability ( $r = 0.74\text{--}0.82$ ), and convergent and discriminant validity ([Blevins et al. 2015](#); [Bovin et al. 2016](#)). In the current study, Cronbach alpha was 0.91 at pre-treatment and 0.92 at post-treatment.

#### 2.4.3. Group Cohesion

To assess for group cohesion, at the final session, participants completed a modified version of the Inclusion of Other in the Self Scale (IOS; [Aron et al. 1992](#)). The IOS is a single item that assesses the degree of closeness respondents feel they have with the group. Seven pairs of circles are presented to respondents; one circle is labeled “self” and the other circle is labeled “group”. The circles range in degree of overlap, from 1 (not overlapping at all) to 7 (highest degree of overlap). Higher overlap indicates a greater sense of cohesion that the person felt with the group. While this measure was originally designed to assess closeness of interpersonal dyads ([Aron et al. 1992](#)), it has been useful for assessing how close individuals feel to a group or a community (e.g., [Vyrastekova 2021](#)), including in incarcerated populations ([Mashek et al. 2007](#)).

#### 2.5. Analytic Approach

We began by examining missing data patterns and running frequency and descriptive statistics for all variables to ensure all values were entered accurately and none were out of bounds. We also examined distributions to check for assumptions of normality. No variables required transformation. To examine our hypotheses, we conducted two mixed-factor analyses of variance (ANOVAs). The independent variables in both ANOVAs were group (in person vs. hybrid telehealth) and time (pre- and post-treatment). We also examined group by time interactions. For the first ANOVA, the dependent variable was the BSI total score. For the second ANOVA, the dependent variable was the PCL-5 total score. Finally, we conducted an independent samples *t*-test to compare group cohesion rates in in-person vs. hybrid telehealth groups.

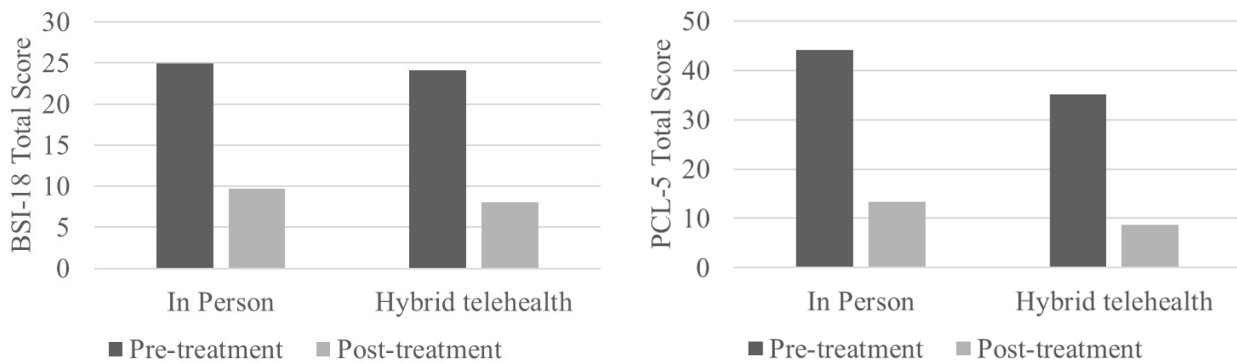
### 3. Results

Results are provided in [Table 2](#) and [Figure 1](#). Across all participants, we found that BSI-18 scores significantly decreased from pre- to post-treatment, with an average decline of 15.61 points, Wilks’ Lambda = 0.43,  $F(1, 32) = 42.19$ ,  $p < 0.001$ . The effect of time on BSI-18 scores was strong, as indicated by a large effect size (partial eta squared = 0.57), meaning the decrease in scores from pre- to post-treatment was meaningful and substantive. There was no interaction between the type of group participants were in and time, meaning BSI-18 scores decreased similarly from pre- to post-treatment in in-person groups (decline of 15.21 points) as they did in hybrid telehealth groups (decline of 16.00 points), Wilks’ Lambda = 0.99,  $F(1, 32) = 0.03$ ,  $p = 0.87$ .

**Table 2.** Pre- and post-treatment psychological distress, traumatic stress symptoms, and IOS.

	In-Person SHARE Groups		Hybrid Telehealth SHARE Groups		All Groups	
	<i>n</i>	<i>M (SD)</i>	<i>n</i>	<i>M (SD)</i>	<i>n</i>	<i>M (SD)</i>
BSI Total Scores						
Pre-treatment	17	24.94 (14.98)	17	24.06 (13.07)	34	24.50 (13.85)
Post-treatment	17	9.73 (8.85)	17	8.06 (9.45)	34	8.89 (9.06)
PCL-5 Total Scores						
Pre-treatment	18	44.17 (14.06)	18	35.18 (16.50)	35	39.80 (15.74)
Post-treatment	17	13.39 (10.42)	17	8.78 (9.76)	35	11.15 (10.23)
IOS Scores	16	5.06 (1.77)	16	5.31 (2.18)	32	5.19 (1.96)

Scores. Average scores were similar across in-person and hybrid telehealth group formats across the different measures at each time point.



**Figure 1.** Pre- and post-treatment psychological distress and traumatic stress symptoms. Similar declines in symptoms were found for both in-person and hybrid telehealth group formats.

When examining PCL-5 scores, we found a similar pattern of results. PCL-5 scores significantly decreased from pre- to post-treatment across all participants, with an average decline of 28.65 points, Wilks’ Lambda = 0.20,  $F(1, 33) = 130.15, p < 0.001$ . The effect of time on PCL-5 scores was strong, as indicated by a large effect size (partial eta squared = 0.80). PCL-5 scores decreased meaningfully from pre- to post-treatment regardless of the type of group participants were in, Wilks’ Lambda = 0.98,  $F(1, 33) = 0.76, p = 0.39$ . Specifically, participants in the in-person groups (decline of 30.78 points) showed a similar-level decrease in PCL-5 scores across treatment as participants in hybrid telehealth groups (decline of 26.40 points).

We also compared pre-treatment BSI-18 and PCL-5 scores for participants in in-person versus hybrid telehealth groups. There were no differences in pre-treatment BSI-18 scores for participants in the in-person groups compared to those in the hybrid telehealth groups,  $t(32) = 1.22, p = 0.232$ . Similarly, there were no differences in pre-treatment PCL-5 scores for participants in the in-person groups compared to those in the hybrid telehealth group,  $t(34) = 1.76, p = 0.088$ . Self-group cohesion (IOS) scores were similar for participants in the in-person and hybrid telehealth groups,  $t(30) = -0.36, p = 0.724$ .

#### 4. Discussion

Because of COVID-19 safety protocols and lockdowns, people who were incarcerated lost access to needed mental health treatment. Fortunately, as soon as it was safe and feasible to do so, many carceral facilities made a rapid shift to telehealth as a way to maintain therapeutic programs. The adoption of telehealth for group therapy, especially hybrid forms like the one used in this study, remains under-investigated in the mental health field in general, and in carceral settings in particular. We thus explored whether symptom reductions differed when we shifted our exposure-based group treatment for



sexual violence victimization from entirely in person to a hybrid telehealth form. We found that participants in the hybrid telehealth groups evidenced similar significant declines in psychiatric symptoms when compared to participants in the in-person groups occurring before the COVID-19 pandemic. The SHARE treatment team was able to work collaboratively and effectively with prison staff to leverage telehealth to reach a vulnerable and underserved population during an unprecedented time of reduced service access.

Prior studies of telehealth in carceral settings found high satisfaction with specialty medical visits (Khairat et al. 2021) and rapid innovation to move behavioral health care to virtual platforms (Burton et al. 2021; Donelan et al. 2021). Our study contributes to this literature, supporting the benefits of cognitive-behavioral interventions for incarcerated women with sexual violence victimization histories. Unlike Sloan et al.'s (2011) meta-analysis of telehealth treatments for traumatic stress-related symptoms, we found comparable declines across a range of psychiatric symptoms, including depression, anxiety, somatic symptoms, and posttraumatic stress symptoms. Perhaps telehealth options are inferior to in-person treatments when delivered individually, but because group therapies include additional curative factors beyond those seen in individual therapy, they may be more robust to hybrid telehealth delivery. Specifically, Yalom and Leszcz (2020) note that group therapy, as opposed to individual therapy, can provide a sense of universality (e.g., the knowledge that group members are not alone in their experiences), altruism (e.g., the opportunity for group members to both receive *and* provide help), and interpersonal learning (e.g., enhancing interpersonal trust, reducing shame, and tolerating distress by sharing secrets with other group members). All of these group-specific curative factors remain, whether groups are delivered in hybrid telehealth format or in person. On the other hand, fully remote groups may lack some of the same emotional connection and intimacy group members experience when they are physically present with each other, whether therapists are also in the room or joining virtually. Indeed, a qualitative study of patients with bipolar disorder found that fully remote groups were less preferred than hybrid or in-person groups because they were seen as more emotionally distant and less engaging (Sousa et al. 2024). Our results confirm that group cohesion was similar among participants in both types of groups. Group cohesion is an important variable, given it is associated with treatment outcomes across a range of therapies (Burlingame et al. 2018). Because the IOS measure specifically asked about how close the participant felt to others in the group, it is not surprising that scores were similar. It may be that a measure of closeness between participants and therapists would have found differences for in-person versus hybrid telehealth group participants.

#### 4.1. Lessons Learned

Although the use of the hybrid telehealth treatment format addressed a clear and pressing need, the novelty of using telehealth in a carceral setting presented some logistical considerations and contributed to lessons learned for the future. For example, group sessions were occasionally interrupted when technological issues with the computer or video-sharing platform arose. This prompted considerations for future hybrid telehealth groups including (1) prefacing the possibility of such delays and/or interruptions to group members, (2) the development of a prison staff call list so group therapists could quickly request on-site technological assistance, and (3) the allotment of additional time and increased flexibility by therapists to account for any session time lost to technological problems.

Another logistical consideration for hybrid telehealth SHARE groups is that therapists were no longer able to have one-on-one conversations with group participants. SHARE is designed to be delivered by two co-therapists to allow one therapist to lead exposures while the other monitors group members' responses to listening to exposures. If a group member

becomes distressed or agitated while listening to another member's trauma narrative, they may briefly step away from the group. At this point, they are joined by the non-leading co-therapist to practice emotion regulation exercises, such as grounding, and return to the group once regulated. As a future consideration, the treatment team may consider offering brief individual check-ins with group members prior to or following group sessions to assess for emotional activation and reorient members to emotion regulation strategies that can be utilized during exposures. Although group leaders noted that observing group members' emotions during the hybrid telehealth SHARE groups was more difficult due to facial coverings, no marked instances of acute distress were observed by therapists and no members chose to step away or leave the group room during any exposures. Furthermore, the issue of facial coverings obscuring emotional expression is specific to COVID-19 precautions and not the hybrid telehealth treatment modality in general.

The pivot to innovative models to maintain therapeutic programming that was required by the pandemic presented us with a unique opportunity to explore alternative forms of treatment. Despite the lessons learned here, group participants informally reported a similar feeling of cohesion, connection to each other and the group leaders, and quantitative measures evidenced similar cohesion and significant declines in psychiatric symptoms across the eight weeks of treatment. While in-person treatments may present fewer technological or logistical considerations, hybrid telehealth appears to be both feasible and effective as evidenced by comparable declines in mental health symptoms relative to in-person groups—findings consistent with research by [Morgan et al. \(2008\)](#) and [Batastini and Morgan \(2016\)](#).

#### *4.2. Practice and Policy Implications*

Overall, telehealth is a feasible treatment modality in times of limited access or in the presence of environmental or contextual barriers to treatment. Both in-person and telehealth formats of treatment offer different forms of flexibility. In-person formats allow therapists more physical mobility to attend to group dynamics and meet with group members individually. The use of telehealth allows therapists to be flexible in physical location and allows carceral facilities more flexibility in treatment offerings. Hybrid telehealth in particular provides group members the opportunity to gather in a private setting, thus supporting interpersonal dynamics comparable to in-person groups. Allowing therapists flexibility in treatment modality may increase opportunities for clinicians who want to serve incarcerated populations, but who do not want to work in prisons fulltime. Telehealth may also ameliorate the challenges associated with gaining physical entry into prisons—a typically lengthy screening process that varies from facility to facility. The use of telehealth may be particularly warranted when there are limited mental health professionals in a particular area, if there are limits on individuals visiting the prison, or if prisons or other carceral facilities must be locked down (e.g., a pandemic).

These findings are of particular importance given that justice-involved people are more likely to endorse mental health problems compared to community samples (i.e., serious psychological distress, bipolar disorder, PTSD, and schizophrenia), but are unlikely to receive mental health services while incarcerated ([Maruschak et al. 2021](#)). Although the COVID-19 pandemic caused an abrupt pause in prison-based programming, even in times of global prosperity, mental health treatments (specially trauma-focused therapies) are seldom available to people who are incarcerated. The paucity of treatment availability is maintained by legislature supporting mass incarceration within the U.S. justice system ([Sawyer and Wagner 2024](#)), the disproportionate incarceration of people with mental illness ([Maruschak et al. 2021](#)), and a lack of mental health providers working in prisons ([Buche et al. 2018](#)).

Since the COVID-19 pandemic, the literature on the benefits of therapy delivered remotely, whether fully remote or in hybrid form, has expanded (Burton et al. 2021; Donelan et al. 2021; Khairat et al. 2021; Oesterle et al. 2024; Sousa et al. 2024; Zielinski et al. 2022). As a whole, research suggests these are effective and beneficial forms of extending the reach of psychological services, especially for underserved populations such as people in carceral settings. Policies that promote the use of telehealth services should be implemented and funding and reimbursement for providing such services provided at rates that are comparable to in-person treatment. Importantly, such policies should include carceral settings such as prisons as reimbursable settings for telehealth. As of November 2024, some states did not require private insurance companies to reimburse for telehealth services, nor did states that did allow for private insurance reimbursement require that reimbursements for telehealth be comparable to in-person services (Center for Connected Health Policy (CCHP) 2024). While it may involve some up-front costs, telehealth mobile “kiosks” can be rather affordable ways to increase access to treatment in under-resourced settings such as prisons. For instance, carts can be purchased for as little as \$100, which can hold a tablet computer and be wheeled into different rooms, allowing for flexibility of where telehealth services are provided and greater privacy to users.

#### 4.3. Limitations and Future Directions

This study’s findings should be considered with the following limitations. We had a relatively small sample size. Each SHARE group takes eight weeks to run and typically enrolls no more than eight women. The period of time when hybrid telehealth groups were running was limited; once COVID-19 lockdowns were eased, we returned to delivering in-person groups with mandatory COVID-19 testing and the use of personal protective equipment. We wanted to compare the hybrid telehealth groups with the same number of groups pre-COVID; thus, our sample sizes were limited. Future studies may consider larger samples and exploring group therapy in hybrid formats for longer durations of time and after the COVID-19 pandemic. Furthermore, we used a hybrid approach to telehealth, where therapists were on video, but group participants were all together. It is not clear that we would have received comparable results had all group participants joined virtually. Indeed, we would surmise that peer support contributes to the efficacy of SHARE, so perhaps fully remote telehealth groups would not have performed as well. Future studies comparing different versions of telehealth groups are warranted. Recently, Oesterle et al. (2024) found hybrid group therapy outperformed fully virtual group therapy in treating people with substance use disorders involved in an intensive outpatient treatment program. Sousa et al. (2024) found patients with bipolar disorder who engaged in virtual group therapy found it to be less intimate and engaging compared to being in physical proximity with other group members. Together, these studies suggest that hybrid models of telehealth may indeed hold promise.

We also did not use random assignment. In-person groups all occurred pre-COVID, while hybrid telehealth groups were during the height of the pandemic. Future studies may want to explore randomization to conditions to see if our findings replicate. Ideally, future studies would ensure groups were running concurrently so any significant contextual or confounding factors, such as the anxiety and stress that comes with being incarcerated during a global pandemic, are reduced. Finally, we employed only brief self-report measures of psychiatric symptoms, and only at two time points (pre- and post-treatment). It would be interesting to have a wider array of psychiatric measures and to examine changes both within the group (e.g., at mid-treatment) and at a follow-up period to see whether declines in symptoms are sustained (e.g., Karlsson et al. 2022). Qualitative evaluations

of factors that hinder or support group members' perceptions of telehealth treatment acceptability, therapeutic alliance, and group cohesion were not formally assessed but are of high interest. Similarly, explorations of how acceptable and feasible telehealth or hybrid telehealth group therapies are to carceral staff and leadership are essential to supporting future implementation.

#### 4.4. Conclusions

The current study supports the use of exposure-based group therapy delivered in a hybrid telehealth modality to increase access to care for people who are underserved, such as those who are incarcerated. We add to the growing scholarly literature by demonstrating that group interventions and trauma treatments can feasibly be delivered through telehealth platforms (e.g., [Batastini and Morgan 2016](#); [Fernandez et al. 2021](#); [Sloan et al. 2011](#)). Taken together, the findings of the current study suggest providing access to effective trauma-focused treatment to populations with high clinical need in carceral settings is both necessary and feasible whether via in-person or hybrid telehealth methods. Expanding carceral infrastructure to support the use of traditional and hybrid telehealth treatment delivery methods is particularly important given the alternative to such methods may be no treatment, rather than in-person treatment. By allowing for remote treatment options, it is likely that more prisons will be able to offer mental health care and therapists can provide services to more than one facility. Funding and reimbursement expansions to support hybrid telehealth, including within prisons, is also warranted if we are to make a positive impact on the well-being of underserved populations.

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