

Exploring the acceptability of delivering Cognitive Processing Therapy (CPT) to UK veterans with PTSD over Skype: a qualitative study

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ABSTRACT

Background: Research shows that veterans with mental health difficulties are reluctant to engage with treatment due to a number of practical and psychological barriers. Tele-therapy has been proposed as an alternative method of delivering therapy to ensure hard-to-reach groups receive the care they need.

Objective: This study aimed to explore the acceptability of using tele-therapy for treating PTSD in a sample of UK veterans.

Methods: Sixteen participants who had engaged with tele-therapy for PTSD were contacted following the cessation of their treatment, including those who had not completed the full course of therapy. Semi-structured qualitative interviews were conducted and the transcripts were analysed using thematic analysis.

Results: Five key themes emerged: Effect of your own environment, Importance of good therapeutic alliance, Technicalities and practicalities, Personal accountability and Measuring change. Effect of your own environment was described with sub-themes of control over your own environment, lack of support between sessions and snap back to reality. The Importance of good therapeutic alliance encompassed putting a face to the name, impersonal feeling and no different from being in the room. Technicalities and practicalities depicted good preparation is key, the flexibility of Skype, technical aspects and session length and timing. Personal accountability detailed finding the time and space, managing attendance and engagement and moving forward. Measuring change illustrated negative past experiences with therapy, improving self-recognition and managing symptoms.

Discussion: Tele-therapy appeared to be acceptable within this sample of veterans with many reporting overall positive experiences and improvements to their health. Future research is needed to foster a more supportive environment during and after therapy.

Explorando la aceptabilidad de realizar Terapia de Procesamiento Cognitivo (CPT) a veteranos del Reino Unido a través de Skype: un estudio cualitativo

Antecedentes: La investigación muestra que los veteranos con dificultades de salud mental son reticentes a comprometerse con un tratamiento debido a un número de barreras psicológicas y prácticas. La tele-terapia ha sido propuesta como un método alternativo de realizar terapia, para asegurar que grupos difíciles de alcanzar reciban el cuidado que necesitan.

Objetivo: Este estudio apuntó a explorar la aceptabilidad de usar tele-terapia para tratar TEPT en una muestra de veteranos del Reino Unido.

Métodos: Se contactó a 16 participantes que participaron en tele-terapia para TEPT, tras el cese de su tratamiento, incluyendo aquéllos que no completaron totalmente la terapia. Se realizaron entrevistas cualitativas semiestructuradas y las transcripciones se analizaron utilizando análisis temático.

Resultados: Surgieron cinco temas clave: Efecto de su propio ambiente, Importancia de una buena alianza terapéutica, Aspectos prácticos y tecnicismos, Responsabilidad personal, y Cambio medible. El efecto de su propio ambiente fue descrito con sub-temas de control sobre su propio ambiente, falta de apoyo entre sesiones y vuelta a la realidad. La importancia de una buena alianza terapéutica abarcó poner una cara al nombre, sentimientos impersonales, y no es diferente de estar en una habitación. Los Aspectos prácticos y tecnicismos indicaron que una buena preparación es clave, la flexibilidad de Skype, aspectos técnicos, duración y momento de la sesión. La responsabilidad personal destacó encontrar el tiempo y espacio, manejo de asistencia y compromiso y seguir adelante. Cambio medible ilustró experiencias pasadas negativas con terapias, mejorar el autoconocimiento y manejo de síntomas.

Discusión: La tele-terapia parece ser aceptable en esta muestra de veteranos con varios reportes de experiencias positivas y mejoras en su salud. Se necesita investigaciones futuras para fomentar un ambiente más alentador durante y después de la terapia.

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关键词

可接受性; Skype; PTSD; 远程医疗; 创伤后应激障碍; 老兵

HIGHLIGHTS

- This article aimed to examine the acceptability of using tele-therapy for UK veterans with PTSD.
- Overall positive experiences were reported with veterans commending the similarities of tele-therapy to face-to-face therapy, the flexibility, having control over their own environment and improvements in PTSD symptoms.
- Difficulties faced included tele-therapy feeling impersonal, less support between sessions, technical difficulties and having to manage their own therapy time.
- Given the new GDPR regulations, the use of Skype may need to be reconsidered in favour of more secure tele-therapy platforms.

探索通过Skype为患PTSD的英国退伍军人提供认知加工治疗 (CPT) 的可接受性：一个质性研究

背景：研究表明，由于一些实际和心理上的障碍，有心理健康困扰的退伍军人不愿意接受治疗。远程治疗可以作为替代方法，以确保远距离群体接受到他们所需的护理。

目的：本研究旨在探讨在英国退伍军人样本中使用远程疗法治疗PTSD的可接受性。

方法：16名接受PTSD远程治疗的被试，在其结束治疗后取得联系，其中包括那些未完成全程治疗的患者。对其进行半结构化定性访谈，并使用专题分析对转录本进行分析。

结果：出现了五个关键主题：自身环境的影响，良好治疗联盟的重要性，技术和实践，个人责任和测量变化。‘自身环境的影响’包括：对环境的控制，会话之间缺乏支持和跳跃回现实。‘良好治疗联盟的重要性’包括：面对名称（*putting a face to the name*），客观感觉，和在房间里一样（*no different from being in the room*）。‘技术性和实用性’包括：良好的准备是关键，Skype的灵活性，技术方面，会话长度和时机。‘个人责任’具体包括：找到时间和场所，管理出勤和参与，向前进展。‘测量变化’包括：过去的负面治疗经验，改善自我认知和控制症状。

讨论：在退伍军人样本中远程治疗是可以接受的，其中许多人报告了整体积极的经历以及他们的健康状况得到了改善。未来的研究需要在治疗期间和治疗后培养更有利的环境。

1. Introduction

The mental health of veterans has become an area of increasing concern over recent years. Following the wars in Iraq and Afghanistan, there has been a six-fold increase in the number of veterans presenting with new mental health conditions (Seal et al., 2009) and a four-fold increase in the number of UK veterans seeking help for posttraumatic stress disorder (PTSD) over the past 20 years (Murphy, Weijers, Palmer, & Busuttill, 2015).

Despite the increased need, there are numerous barriers that prevent veterans from engaging with treatment. Specialized treatment for military PTSD generally comprises of lengthy residential programmes with long waiting lists (Rosenheck & Fontana, 2001). Where outpatient services are offered, veterans also experience internal barriers such as stigma surrounding mental health (Sayer et al., 2009) and practical barriers, such as getting time off of work, travelling and costs, preventing access (Hoge et al., 2004). Veterans who do engage often drop-out or experience poorer treatment outcomes compared to civilians (Creamer & Forbes, 2004; Garcia, Kelley, Rentz, & Lee, 2011).

Combating these barriers and offering a more accessible alternative to face-to-face therapy, promising findings have been demonstrated with tele-therapy in both children (Myers, Valentine, & Melzer, 2007) and adults (Tutty, Ludman, & Simon, 2005). One study examining US veterans found no differences between outcomes and acceptability for tele-therapy versus face-to-face therapy (Morland, Hynes, Mackintosh, Resick, & Chard, 2011). Due to limited generalizability, research into the acceptability of tele-therapy for UK veterans is needed to ensure resources are allocated to services that veterans will engage with.

This is the first study to explore the acceptability of tele-therapy in a sample of UK veterans with PTSD. If tele-therapy is found to be acceptable to UK veterans this could impact service development, decrease

healthcare costs and improve the accessibility of treatments. Veterans who had been offered tele-therapy by Combat Stress over Skype were interviewed to learn about their experiences.

2. Methods

2.1. Setting

This study was conducted at Combat Stress, a national charity and the largest provider of veteran mental healthcare in the UK. Combat Stress is recognized as a treatment pathway by the National Health Service (NHS) and specializes in treating veterans with PTSD.

2.2. Participants

Inclusion criteria for this study were that participants needed to be a UK veteran (defined as having completed one full day of service) with a diagnosis of PTSD who had completed a tele-therapy trial with Combat Stress. Participants who were actively suicidal or under the influence of substances were excluded. Consecutive sampling was used until data saturation was reached, meeting minimum guidelines of 12 (Guest, Bunce, & Johnson, 2006). Sixteen participants who engaged with the tele-therapy were contacted. This included 15 individuals who had completed the course of therapy and one participant who ended therapy early.

2.3. Intervention

The aim of the tele-therapy trial was to assess the efficacy, feasibility and acceptability of delivering CPT to veterans over Skype. Whilst this paper explores acceptability gathered via qualitative interviews, quantitative data collected using a cross-sectional design on the efficacy and feasibility of tele-therapy with 27 participants will be published in the future. Mental health outcomes pre- and

post-therapy were collected to explore efficacy and the drop-out rates, number of sessions not attended and total sessions per participant were recorded for feasibility. All data were gathered simultaneously between November 2016 and November 2017.

Participants were offered 12 video-based sessions of Cognitive Processing Therapy (CPT) for PTSD delivered over Skype, which has proven efficacy in veterans and has been used in US tele-therapy studies (Fortney et al., 2015; Monson et al., 2006). The CPT sessions were manualized to ensure treatment fidelity. Skype was used due to its universal accessibility and Skype for Business in particular due to its higher levels of encryption which offer greater privacy and data protection than standard Skype software. Skype for business encrypts data transferred from one computer to another. It also requires server authentication to ensure only the users can access data (Charlebois-Laprade et al., 2017). For increased confidentiality, sessions were conducted from private clinic rooms within Combat Stress.

2.4. Data collection

Participant demographics were collected prior to therapy via written questionnaires. One week following treatment cessation, a research assistant phoned each participant, explained the purpose of the interviews, assured them of anonymity and asked for informed consent to record via Dictaphone. A semi-structured interview schedule was followed aligning with the research question but allowing flexibility for the participant to talk about their experience. The following four questions were asked:

- (1) Have you had any previous experience with mental health professionals? If so, how was meeting over Skype different from face-to-face therapy?
- (2) What were some of the positives of using Skype for therapy?
- (3) What were some of the negatives of using Skype for therapy?
- (4) How did you find the relationship you had with the therapist? How was it different to face-to-face therapy?

Exploratory prompts were used throughout, including 'How did the use of Skype affect that?', 'do you think that would have happened anyway?' and 'how did you find that was different from a face-to-face session?' Upon completion, veterans were debriefed and the research assistant then transcribed the interviews verbatim into Microsoft Word.

2.5. Data analysis

An inductive approach to thematic analysis was used to analyse the transcripts (Braun & Clarke, 2013), allowing researchers to obtain an objective view of veterans' experiences. First, the researchers familiarized themselves with the text, developed initial codes for the data, searched for emerging patterns and grouped and defined themes. The lead author derived the themes and triangulation was achieved through discussion with co-authors.

2.6. Ethics

Full ethical approval for both the clinical trial and acceptability study was given by the Combat Stress Ethics Committee. Participants were informed of the risks associated with video-conferencing and full informed consent was gained before commencing therapy.

3. Results

3.1. Sample demographics

The sample comprised of primarily male veterans (94%) of white ethnicity (94%) with a mean age of 41 years (ranging from 27 to 58 years). The majority of participants were either married or in a relationship (94%) and were employed (56%). In terms of military history, 75% had served in the British Army with a mean duration of 14.7 years in service. The average time between leaving the service and commencing therapy was 6.4 years and the average number of sessions completed was 11.6. Sample demographics are shown in Table 1.

3.2. Overview of themes

Thematic analysis of the interview transcripts revealed five key themes relating to the acceptability of Skype: Effect of your own environment, Importance of good therapeutic alliance, Technicalities and practicalities, Personal accountability and Measuring change. Each theme and sub-theme has been explored individually. A summary of the themes is presented in Table 2.

4. Key theme 1: Effect of your own environment

The first theme encompasses the positive and negative aspects of doing therapy in the participant's own environment.

Table 1. Sample demographics.

Participant	Age	Gender	Ethnicity	Employment status	Relationship status	Service	Years in service	Years passed since leaving	Number of sessions completed
1	58	Male	White	Not working – ill health	In a relationship	Army	42	1	12
2	31	Male	White	Full time	Single	Army	6	3	12
3	49	Male	White	Not working – ill health	In a relationship	Army	14	25	12
4	42	Male	White	Not working – ill health	In a relationship	Navy	n/a	2	6
5	52	Male	White	Not working – ill health	In a relationship	Army	31	2	12
6	34	Male	White	Not working – ill health	In a relationship	RAF	14	2	12
7	47	Male	White	Part time	Married	Army	5	1	12
8	27	Male	White	Full time	Married	Army	7	2	12
9	45	Male	White	Full time	Married	RAF	7	20	12
10	48	Male	White	Full time	Married	Army	12	19	12
11	43	Female	White	Part time	Married	Army	12	6	12
12	44	Male	White	Not working – seeking	Married	Army	26	2	12
13	36	Male	Black	Not working – ill health	Married	Army	6	7	12
14	32	Male	White	Full time	Married	Marines	7	6	12
15	48	Male	White	Full time	Married	Army	24	2	12
16	27	Male	White	Full time	Married	Army	7	2	12

Table 2. Summary of key themes and sub-themes.

Key theme	Sub-theme
Effect of your own environment	Control over your own environment Lack of support between sessions Snapback to reality
Importance of good therapeutic alliance	Putting a face to the name Impersonal feeling No different from being in the room
Technicalities and practicalities	Good preparation is key Flexibility of Skype Technical aspects Session length and timing
Personal accountability	Finding the time and space Managing attendance and engagement Moving forward
Measuring change	Negative past experiences with therapy Improving self-recognition Managing symptoms

4.1. Control over your own environment

Participants mentioned that being able to do therapy in their own environment helped them to relax and engage better than if they had had to go somewhere unfamiliar:

if I needed to nip off and go for a pee or grab myself a cup of coffee, I could just go ‘oh give me a sec’ and I could do that, rather than feeling like I was literally in the room and there for that hour, kind of thing. But that in a sense made the therapy much more relaxing. (Participant 5)

That made me feel a lot more comfortable, you know, I could relax a bit more and I listened more ... it’s just that sensation of being in your own place and being able to talk to people on Skype. So it’s not invading your space, if you can see what I mean. (Participant 10)

Doing therapy sessions over video-conferencing appears to alleviate the anxiety associated with having to leave the house, go to new places and meet new people:

The positive is that with PTSD, the build-up of going out and being out, it’s just you didn’t have to worry

about none of that because you could just wait in your apartment, then just talk about what you need to talk about and then they come into your house via Skype. (Participant 7)

you didn’t have all this apprehension about going somewhere and people seeing me afterwards. (Participant 11)

4.2. Lack of support between sessions

One of the downsides of using Skype was that participants missed out on the support in-between sessions which they had in residential programmes, such as additional therapies and social interaction. However, tele-therapy provides a similar experience to weekly therapy in outpatient settings:

But there’s nothing quite like a support worker or even sitting in the garden at the back end there and just chilling out or doing the occupational therapy and having some sort of mindfulness activity. (Participant 1)

On the residential, you would get all-day, you know, I mean, you would get your different therapies all-day. Whereas on Skype you’re just getting that one blast and then that’s it for another couple of days or another week. (Participant 3)

This lack of support could also sometimes lead to the participants reportedly feeling lonely or isolated between sessions:

But it’s the post-care afterwards isn’t it, I suppose, because as you come out from talking for an hour about what the incidents are, you know, who is there to take care of you? (Participant 4)

But Skype means that I’m kept in my room and it does not really help that much if I want to go out. (Participant 13)

4.3. Snapback to reality

One of the difficulties experienced with working in your own environment was that once the session was

finished, participants would suddenly be jolted back into their everyday lives and have no time for acclimatization:

then you're kind of instantly back into the room as it were and whatever your mind and emotions are in the course of that hour, suddenly that therapeutic bubble is burst and you're back to being with all the normal stuff around you ... it's a very jarring, very sudden transition. (Participant 5)

That's why it was hard to switch from talking all about it and then sort of, the hour's up and then you've got to try and get on with normal life. (Participant 8)

Occasionally, this quick snap back to reality would occur in the middle of the session:

if my doorbell rings and it's the postman, you know, and I'm straight away back in the real world. (Participant 1)

we would be in the middle of something deep and meaningful and the connection would fail and then you have to immediately break out of that sort of therapeutic mode of thought. (Participant 5)

5. Key theme 2: Importance of good therapeutic alliance

5.1. Putting a face to the name

One factor that helped with good therapeutic alliance in tele-therapy over Skype was that participants could see the therapist's face:

Sometimes I'd spoken to counsellors over the phone and things like that, but actually being able to see someone that made a big difference. (Participant 2)

Having the same therapist throughout the process emerged as particularly valuable from the participants' perspectives for a sense of familiarity and helping to build trust and rapport:

I found the relationship very good and I found it very easy to talk to him because it was the same person. (Participant 11)

I don't want to move on and tell somebody else my story again and go through it all again. (Participant 16)

Some participants found it particularly helpful having met the therapist in-person before starting the therapy sessions:

What I would say if he hadn't been there and met him face-to-face it would have been a little bit more difficult to engage. (Participant 1)

I first met David when I had an hour or two session with Dr Thompson, it was. And that when David explained what, where and how. But ever since we just got on with it. (Participant 9)

5.2. Impersonal feeling

Despite being able to see the therapists face, several participants reported that they felt that doing therapy over Skype felt impersonal because they weren't in the same room:

I do a lot of Skype calling for work, so it felt more like a work meeting more than a personal, you know, a personal meeting really. (Participant 4)

I think some people may find it a little bit impersonal just having someone on the end of a computer, but I think people are more and more used to it these days. (Participant 11)

A factor in the therapy feeling impersonal was the fact that participants found it difficult to read body language without seeing the whole individual:

it's hard to pick up on another person's non-verbal communication, which is key to therapy in my view. (Participant 4)

it's much harder to read non-verbal cues ... I realised I would overcompensate that by vocalising much more and kind of emphasizing what I was saying. (Participant 5)

5.3. No different from being in the room

In contrast to the impersonal experience, most participants felt that doing therapy over Skype was no different from in-person therapy:

It didn't really feel any different to him sitting right in front of me, in person. It was just like it was, yeah, like I said, he was with me. (Participant 2)

Whereas sitting in front of somebody and talking on Skype is not that different from meeting somebody, you get the same treatment as you would sitting in front of somebody. (Participant 7)

It's just, I don't think there's much difference between seeing a CPN or doing it on Skype. I didn't feel that I would have gained anymore by seeing someone. (Participant 8)

6. Key theme 3: Technicalities and practicalities

6.1. Good preparation is key

A practical subtheme that emerged from the interviews was participants reporting that they would have liked to have known more before starting the therapy to better prepare:

I'll say a lot can be done in terms of the preparation of the client for therapy themselves, kind of through an explanatory leaflet or note because I do think the more aware you are of the issues that are likely to come up, the better chance you have of recognising when that happens. (Participant 5)

If I'd have known at the beginning, if they'd have said that 'right, this is the same stuff that's covered in the 6-weeker', I think I'd have been a lot more at ease with stuff as well (Participant 14)

Many participants said the workbooks and additional information given to them between sessions were beneficial:

whenever we had a session, I could relate back to a previous session or that current session in the workbook, so it wasn't as hard, erm, as I thought it was going to be. (Participant 2)

a lot of it was down to the sort of little assignments that David was giving me so I could get my head into the space I needed to before we had the session. (Participant 6)

6.2. Flexibility of Skype

The flexibility of doing therapy over Skype appealed to the majority of participants, with key factors including it having minimal impact on the individual's day-to-day life and adapting to their schedules:

it has a minimal impact on your ability to go about your day-to-day life. (Participant 5)

because my job is a lot of the time weather based, so if its bright sunshine I need to get out and do something in the field, I was having to ring him up first thing in the morning and say 'I'm really sorry, can we rearrange it for another day?' and it was sort of perfect for me really, in the fact that it was the flexibility of it. (Participant 6)

you can always go find a quiet room on your lunch break, you know, in work and do it that way. (Participant 16)

Additionally, being able to do it anywhere and at any time was beneficial to participants who travelled or lived in remote areas:

The convenience of being once a week, anywhere. I even did one session from the cab of my truck. (Participant 9)

we had this move out to Kenya and David was fantastic and said that we could just put some of the sessions on hold and finish it off when you get to Kenya. (Participant 11)

With the residential, you've got to go to the mainland and travel ... It's ideal for those from Northern Ireland or if you're up in the islands of Scotland. (Participant 12)

In particular, the cost-saving benefit of doing therapy over Skype and not having to travel or take time off of work emerged as a key theme:

That was the main one for me because if I came in for the 6-week programme that you guys do, erm, I would have had to take more time off and I'd have lost money. (Participant 2)

I didn't have to worry about the hour's travelling or the cost of transport. So, for me, it was a lot better. (Participant 7)

6.3. Technical aspects

Throughout their therapy sessions, some participants reported experiencing problems with the technology, such as a bad connection, interference or poor image quality:

in my view, Skype isn't particularly stable for a long call. And so there were a couple of sessions where we finished over the phone because Skype just wouldn't connect. (Participant 5)

I think that there needs to be a better way than the Skype because I think, at some points, the line kept dropping and you can't hear him properly. (Participant 13)

But, in general, participants reported that they found Skype easy to use:

Well, being ex-forces, I've done a lot of Skype to try and keep in touch with family and friends while I've been away on deployment, so I didn't find it as difficult as I thought I would. (Participant 6)

I had to YouTube it just to see how it all sort of worked because I'm not the best at technology and to be fair, it was pretty easy, once I got the account set up and I'd done a trial with my wife, it was very easy. (Participant 14)

6.4. Session length and timing

One of the main areas for improvement were the times that the sessions were run, during the workday. Participants would have preferred more flexible timings:

the time of day the therapy takes places I'd encourage you to think about, because actually for some people, during the working day is not ideal. (Participant 5)

I think, the only problem, maybe it was a bit negative, was the hours, because of the working hours I've got to do, you know, anything after 5 o'clock. (Participant 10)

In addition, the majority of participants said they felt that they would have benefited from more than 12 sessions:

probably could have been longer than just 12 sessions ... could use a couple more sessions to build up speaking to somebody every week. (Participant 7)

I felt like I was obviously getting a lot and I learnt a lot from recognising things but I felt like maybe it could have gone on longer ... 12 weeks seems like a long time, but it's not, in reality, the sessions fly by. (Participant 14)

7. Key theme 4: Personal accountability

7.1. Finding the time and space

This subtheme encompasses the difficulty experienced by participants in having to find a private place or manage their time themselves to complete a therapy session over Skype:

if you're living in a two bedroom flat with your partner and kids, finding a quiet hour where you can focus on a conversation between you and your therapist isn't necessarily going to be straightforward. (Participant 5)

our house is open plan, so I can only really do it if nobody else is here because you can really hear it everywhere in the house. (Participant 11)

7.2. Managing attendance and engagement

Taking part in the tele-therapy meant that individuals had to manage their own time and be responsible for their own engagement, which some found difficult:

so it's very easy for me to avoid it and to email David and say 'I'm sorry I'm not going to make tonight's session' ... I mean, if you're not going into a room to do it nobody can hold you to account, so procrastination is very easy. (Participant 4)

if you're having a bad session, you can just switch him off and walk out the room easily. (Participant 7)

7.3. Moving forward

This theme surrounded veterans concerns about moving forward on their own following therapy and what the next steps are:

If I start to experience more profound symptoms again, what do I do? Do I contact Combat Stress again? (Participant 15)

I'm a little bit nervous, you know, a little bit worried about kinda where I go from here and where this leaves me now. (Participant 16)

8. Key theme 5: Measuring change

8.1. Negative past experiences with therapy

A prevalent theme surrounded participants having had negative experiences with therapies, which led to them not making progress or hitting a plateau. Tele-therapy appeared to break the plateau:

So I got more out of the Skype than I did sitting in a room with a senior person who didn't understand the military. (Participant 1)

because if I was in like Audley Court or something and I was in there for 6-weeks, I might have forgotten most of it because, you know, you're listening to

other people's problems. But with Skype, you're only listening to your own problems. (Participant 10)

8.2. Improving self-recognition

As a result of the Skype therapy, participants reported being able to better recognize and understand their traumatic experiences and their problems, for example triggers:

I was able to spot it yesterday whereas normally I would have just carried on ... and then either had an argument with my wife at the end of the day or been in a foul mood ... I feel as if David's helped me notice what the triggers are. (Participant 6)

8.3. Managing symptoms

A common theme was that many veterans saw improvements in how they managed their symptoms of PTSD, depression and anxiety following the intervention:

I don't have flashbacks anymore but I do have the sort of anxiety around it which I can spot earlier now instead of letting it take over completely. (Participant 6)

one of the things was lack of sleep and I'm actually getting more sleep now and feeling better. (Participant 12)

I was experiencing quite a lot of flashbacks before I started these sessions with David and they seem to have, well they've certainly, a lot of it has gone. (Participant 15)

Nevertheless, participants stressed that although their symptoms had reduced, the therapy was not a cure:

I mean, sometimes it's good, sometimes it's bad. But I would say that it has helped me but not all. (Participant 13)

I definitely did get things from it, it hasn't cured me or anything like that, as in what my main problems are but they're things that I spoke to him about and they're long-term things. (Participant 14)

9. Discussion

This study examined the acceptability of using tele-therapy to deliver PTSD therapy to a sample of UK veterans. Five key themes emerged from the data in relation to both positive and negative experiences. These themes were: Effect of your own environment, Importance of good therapeutic alliance, Technicalities and practicalities, Personal accountability and Measuring change.

Sub-themes of control over your own environment, lack of support between sessions and snapback to reality described the key theme Effect of your own environment. In line with previous findings, participants

reported feeling safer and more comfortable in their own homes which reduced their anxiety compared to in-person therapy (Wood, 2009). Tele-therapy is particularly beneficial for individuals with anxiety disorders or external triggers such as unfamiliar places and crowded spaces and who would otherwise not access treatment (Bouchard et al., 2004). Conversely, not having to travel for therapy could feed into avoidant behaviour and exacerbate symptoms, therefore, follow-up support and assessments are essential when conducting tele-therapy. Additionally, participants reported that doing therapy at home meant they lost out on multidisciplinary input and support in-between therapy sessions. Not being immersed in a therapeutic residential environment meant that when the therapy session finished, participants immediately had to return to their day-to-day lives which some struggled with. One patient mentioned that even with outpatient appointments, they had time to reflect and adjust owing to travel time. To counteract this jarring effect, it could be beneficial for the therapist to set relaxation or reflective tasks for the participants to complete post-session.

Putting a face to the name, impersonal feeling and no different from being in the room detailed the key theme of Importance of good therapeutic alliance. Some veterans felt that not being in the same room was impersonal. However, seeing a face as opposed to speaking over the phone appeared to remove this barrier in most cases and, in particular, meeting the therapist in-person beforehand helped combat this. Overall, veterans felt that because they could see the therapist, tele-therapy was no different from regular face-to-face therapy. These findings support previous studies on civilian adults, evidencing the universal applications of tele-therapy (Choi, Wilson, Sirrianni, Marinucci, & Hegel, 2013).

Sub-themes including good preparation is key, the flexibility of Skype, technical aspects and session length and timing formed Technicalities and practicalities. Veterans said having information outlining the course of therapy and workbooks to prepare helped with engagement. Consistent with the purpose of tele-therapy, veterans who would otherwise have been unable to commit to residential treatments or weekly outpatient appointments for PTSD due to life commitments complimented the flexibility of tele-therapy (Iversen et al., 2011). Nevertheless, veterans reported several issues with connection during their sessions but this did not appear to affect their positive overview of tele-therapy. Moreover, many participants felt that they could have benefitted from more sessions. As the usual treatments offered by Combat Stress comprise of 15 sessions, perhaps this could be implemented in tele-therapy to ensure consistency (Murphy & Busuttill, 2015).

Finding the time and space, managing attendance and engagement and moving forward comprised the theme

of Personal accountability. Some veterans reported difficulty organizing sessions and managing their time as tele-therapy requires a greater level of independence than face-to-face therapy. Therefore, tele-therapy may not be acceptable to veterans with more complex presentations of PTSD due to poor day-to-day functioning and cognitive deficits (Grubbs et al., 2015).

Finally, negative past experiences with therapy, improving self-recognition and managing symptoms described the theme of Measuring change. Many individuals had tried regular therapies and seen little improvement or struggled to engage. Consistent with a systematic review showing that tele-therapy was as effective as face-to-face therapy (Turgoose, Ashwick, & Murphy, 2017), veterans within this study reported they had made progress and were better able to recognize triggers and manage PTSD symptoms (Fortney et al., 2015).

Within this sample of UK veterans, tele-therapy appeared to be an acceptable alternative to traditional face-to-face therapy with many providing positive feedback. The implications of exploring tele-therapy in a wider population of UK veterans could have the potential to eventually improve treatment accessibility and reduce dropout rates. Using video-conferencing platforms such as Skype could also help to reduce healthcare costs associated with travel, professional time and lengthy residential treatments. Nonetheless, greater preparation, session timing and support in-between sessions were highlighted as areas that could be improved.

9.1. Limitations

As the data were gathered by the same organization that administered the therapy, this may have biased participants' responses. Participants may have been more likely to report positive experiences due to concerns over judgement or impact on future help-seeking. Nevertheless, a research assistant not involved in the therapy interviewed the participants and assured them their interviews were confidential and separate from the clinical services. There was also an imbalance in the number of participants who completed the therapy ($n = 15$) and who did not ($n = 1$) which may have led to more positive feedback. However, the researchers contacted participants who had not completed the therapy to ensure their views were represented, therefore, this may reflect the low number of dropouts.

The data presented has limited generalizability to overall UK veterans as the sample was limited to 16 veterans who sought help from one mental health charity and excludes other veteran care pathways. In addition, veterans were primarily white males, limiting generalizability to females and individuals from other cultures. However, participants varied in terms

of age, employment status and military experience and Combat Stress is a nationally recognized treatment pathway.

Given the new General Data Protection Regulations (GDPR) introduced in May 2018, the use of Skype for business may need to be reconsidered in the therapeutic context. As Skype stores data on a third party server, organizations will need to take extra precautions to follow Microsoft guidance in order to comply with GDPR (Microsoft Office 365, 2018). Although Skype for business benefits from compliance with the Health Insurance Portability and Accountability Act (HIPAA; Bramstedt, 2016), tele-therapy platforms designed specifically for medical purposes may offer greater flexibility and protection. Agnisarman et al. (2017) identified four commonly used telemedicine platforms, including Doxy.me, Vidyo, Vsee and Polycom, which can be used as alternatives. These platforms may also help to alleviate technical issues.

9.2. Future research

Future research is needed to explore the acceptability of tele-therapy to a larger sample, female veterans and different cultures. Indeed, previous studies on the general population have shown varied attitudes towards tele-therapy across cultures (Yellowlees, Marks, Hilty, & Shore, 2008). Further trials are required to determine the ideal length of tele-therapy, improve support between sessions and overcome technical difficulties.

9.3. Conclusion

This study explored the acceptability of using Skype to deliver therapy to a sample of UK veterans with PTSD. Positive and negative aspects were both reported but overall, these veterans appeared to support the use of tele-therapy. Key themes emerged from interviews regarding the Effect of your own environment, the Importance of good therapeutic alliance, Technicalities and practicalities, Personal accountability and Measuring change. Veterans felt more comfortable in their own homes, were able to establish a good rapport with the therapist and reported symptom improvements. However, further research is needed to overcome technological difficulties, improve community support and determine the optimal length of tele-therapy.

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