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**Remote Access Therapy For Veterans With Psychological Problems:**

**Current State of The Art**

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ABSTRACT

Introduction: The past decade has seen both an increase in use and research into ways in which psychological therapy might be delivered remotely. Remote access therapy uses technology to deliver talking therapies. It is important to understand how remote technologies are being used as part of the therapeutic process and consider what effect this has on the success of therapeutic interventions. This review discusses what is currently known about the use of remote access therapy with a veteran population. Moreover, the review summarises potential benefits and barriers to conducting therapy remotely.

Materials and Methods: This review was conducted to explore the use of remote access therapies with veterans. All available literature identified for this review focused on veteran cohorts from the United States and United Kingdom. To meet search criteria studies had to include veteran participants engaging with any form of talking therapy delivered remotely. A total of 15 studies met the inclusion criteria, two from the UK and 13 from the US. Searches were carried out during June and July 2019.

Results: A number of potential benefits to remote therapy delivery were observed in the research reviewed, including improved accessibility to therapy for people living in remote locations (providing infrastructure existed to facilitate the remote access technologies), increased flexibility of timing and being able to undergo therapy alongside other life commitments. The studies also suggested that those involved in remote therapy found the technology accessible and easy to operate. Digital technologies could generally be relied upon and although there were some technical difficulties reported these were generally not seen as a barrier to the use of remote technologies as a whole. Some limitations to using remote therapies were observed, such as the acceptability of remote therapy, particularly in the UK, and the willingness of practitioners to engage with digital technologies to facilitate remote therapy. There was also caution raised that the apparent cost effectiveness of delivering therapy remotely needs to be further investigated, particularly in relation to costs involved in enabling remote access technologies in locations where poor infrastructure exists.

Conclusions: Overall, studies reported largely positive outcomes for veterans undergoing remote access therapy and in general participants did not find the therapeutic process compromised by remote delivery. Studies showed that remote access therapy is being conducted successfully in both the US and UK. There is however a need for more research into the use of remote access therapies to treat a wider range of psychological difficulties in veterans.

INTRODUCTION

The purpose of this review is to provide an overview of the literature on remote access therapies and interventions as used with veterans. Furthermore, it summarises study findings and outlines those studies which have identified both the potential benefits and the barriers to using these modes of therapy delivery. This review also serves as an introduction to this subject area in relation to the veteran population in the United States and United Kingdom.

METHODS

Searches were carried out during June and July 2019 on the Veterans and Families Research Hub (www.vfrhub.com), Google Scholar and academic databases CINAHL, MEDLINE, Psychology and Behavioural Sciences Collection, PsychARTICLES and the Military & Government Collection, accessed through the EBSCOhost online research platform available at Anglia Ruskin University. The VFR Hub is a repository of international research and related resources on military veterans and their families. The VFR Hub aims to provide access to evidence-based information to assist in the development of better understanding of veteran matters across communities. The VFR Hub is curated by the Forces in Mind Trust Research Centre at Anglia Ruskin University, UK.

Search terms included remote access therapy, digital therapy, teletherapy, veteran and ex-Service person. Studies were deemed relevant to this review if they included a veteran population receiving any type of therapeutic intervention via any mode of therapy delivered remotely. Searches returned a total of 15 papers matching the inclusion criteria, two discussing studies from the UK and 13 discussing studies from the US. Studies were published between 2010 and 2019. Study cohorts included veteran participants with post traumatic stress disorder (PTSD), PTSD symptoms, combat trauma, alcohol use disorder and mild traumatic brain injury. Interventions included those delivered via teletherapy for trauma-focused therapies; telehealth for evidence-based psychotherapy and, in separate studies, for cognitive rehabilitation and delivery of a RVTRI CAT (Rural Veterans Telerehabilitation Initiative Creative Arts Therapy) Project; clinical video teleconferencing (CVT) for PTSD anger management therapy and, in a separate study, for cognitive-behavioural group therapy as part of cognitive processing therapy (CPT); telemental health (TMH) treatment; a telephone-based collaborative care model; cognitive behavioural therapy via video and CPT sessions conducted over SkyPe.

THE UNITED KINGDOM AND UNITED STATES EXPERIENCE

Remote access therapy uses remote access technology to deliver talking therapies, often referred to as teletherapy.1 In the United Kingdom (UK) ‘talking therapies’ include all the psychological therapies that involve a person talking to a therapist about their problems2, for example, counselling, cognitive behavioural therapy (CBT) and psychotherapy. In the literature included in this commentary, other terms for teletherapy include telemedicine3, telehealth4 and telemental health.5 These types of remote access therapy are part of the wider ‘Digital Health Technologies’ (also known as e-health), which encompass all health-related services and information delivered through the Internet and online communication technologies.6 Digital health technologies include the use of mobile technology, social media and sensor technology to assist in the prevention, diagnosis, treatment, monitoring and management of health and lifestyle. Remote-access therapy can be delivered in a number of ways, for example via an internet video-conferencing facility such as Skype1 and over the telephone.7

Many of the studies included in this commentary support the general feasibility and safety of using remote access therapy in place of an in-person therapy delivery. One particular study into attitudes towards telemental health8 found that younger age and higher education do not predict an individual’s level of experience of using technology or favourable/less favourable attitudes towards telemental health, suggesting there is potential for remote access therapy to encompass a range of users, and not necessarily those with prior experience of using remote access technologies.

Most studies focus on veteran populations receiving remote access therapy within the United States (US), with the majority of the therapy being delivered via video teleconferencing, and in most cases to treat post-traumatic stress disorder (PTSD). Firstly, it is pertinent to bear in mind the differences which exist between the United States and other countries, the United Kingdom for example, and the conflicts in which veterans from different countries might have served. A significant difference in this respect may be the prior involvement of US veterans in the Vietnam War. A further difference relates to the statutory support for veterans in each nation. For example, the United States Department of Veterans Affairs (VA) provides near-comprehensive healthcare services to veterans at VA medical centres and outpatient clinics. However, this comprehensive service is available to veterans based on eligibility criteria9; whereas, in the UK, veterans receive most of their healthcare through the National Health Service (NHS) along with the general population. The UK Armed Forces Covenant stipulates that in certain circumstances, where the health need is related to military service, veterans are eligible to receive priority treatment under the NHS. However, this priority access is subject to clinical need.10 In particular, it is useful to note the way in which veterans with mental health problems receive statutory support and treatment in the UK; this support and treatment comes either from veteran-specific mental health services (e.g. the Transition, Intervention and Liaison Service (TILS) and the Complex Treatment Service (CTS)) or through general NHS mental health services (e.g. Improving Access to Psychological Therapies (IAPT)).

This review found no available data on the total numbers of veterans receiving therapy remotely, in either the US or UK. The most comprehensive insight into the number of people receiving remote therapy is provided in a systematic review by Turgoose et al12, which documented participant numbers in 41 studies into the use of remote access therapy with veterans with post traumatic stress disorder. Most studies were conducted in the US, with the addition of one Canadian study. Across the 41 studies, all of which were published between 2004 and 2017, 4143 participants received some form of remote access therapy12.

CURRENT RESEARCH

Possibly the most significant research to date on remote access therapy in the UK, with regards to the veteran population, is the study by Turgoose et al1, carried out in conjunction with Combat Stress (a charity) and funded by the Forces in Mind Trust (a UK based veteran research funding body). This research is discussed further by Ashwick, et al11, and a further systematic review from Turgoose et al12 provides a recent and informative overview of the international literature on remote access therapy. This systematic review suggests that remote access therapy can provide a viable alternative to in-person therapy and has the potential to increase access to therapy for veterans.

A potential limitation to the deeper understanding of remote therapy is that the majority of the literature focuses on PTSD to the relative neglect of other mental health conditions. This would indicate a need for further research to consider other mental health conditions and their response to remote access therapy. This need is supported by research which suggests that PTSD is low among UK personnel and that other mental health problems such as alcohol misuse, depression and anxiety disorder are more common in ex-Service personnel.13,14 This suggests further research is needed to ascertain whether or not remote access therapy would be of benefit in treating conditions more common among UK serving personnel and veterans. Furthermore, the majority of the literature available is based on research from the United States and this would in turn suggest a need for more research that focuses on remote access therapies used with UK personnel and veterans to treat a variety of mental health and post-traumatic related conditions.

Few studies provide controlled data on effect. However, Morland et al15 compared use of video teleconferencing (VT) to the in-person delivery of a group form of cognitive therapy and found that their results support the general feasibility and safety of using VT. Both the group receiving VT and the group receiving an in-person delivery showed reductions in PTSD symptoms and there were no significant between-group differences.

Findings from other studies similarly supported the feasibility of VT.8,16,17 Ziemba et al3 found telemedicine to be equivalent to face-to-face therapy, with no differences between the two. Findings from the Turgoose et al study1 suggest, similarly to Morland et al15, that for one-to-one therapy, teletherapy is a feasible, acceptable and effective way to deliver evidence-based trauma-focused care to veterans with mild to moderate PTSD. The study identifies advantages of using remote access therapy, including that participants have control over where therapy sessions are held and do not have to travel, saving time in a busy schedule, or travel to somewhere unfamiliar.

BENEFITS

Studies have confirmed that remote access therapy can increase the accessibility of therapy.12 Remote therapy offers increased flexibility to overcome barriers that could prevent a person attending traditional in-person therapy, such as work, childcare or the stigma of facing someone in person. One study18 in particular draws attention to the challenge posed by veterans residing in rural locations in the United States and their access to treatment provided through Veterans Affairs. The study suggests that delivering therapy via video teleconferencing does not compromise a therapist’s ability to deliver therapy, effectively structure sessions or manage patient care, and therefore may be a viable option for the delivery of therapy to veterans residing in remote locations.

The study by Jaconis et al4 found that a participant engaging with remote access therapy demonstrated “significant reductions in alcohol consumption and PTSD and depressive symptoms.” The authors posit that their findings may support the delivery of integrated treatments for co-occurring PTSD and substance use disorders.

Two studies that support remote access therapy for other types of care are from Hoerster et al7 and Spooner et al.19 The first suggests a collaborative care model, Translating Initiatives for Depression into Effective Solutions (TIDES), which can be delivered by telephone to veterans with PTSD symptoms and the second that telehealth can be used to deliver creative arts therapies to veterans. Another study20 focuses on home-based telemedicine (HBT) as a way of removing a barrier to care from female veterans who have experienced military sexual trauma (MST). The study suggests that female veterans who have experienced MST may find attending a VA Medical Centre to be a reminder of their trauma, as many other patients will share features with the perpetrator, for example gender.

Research also suggests that a further benefit of remote access therapy is cost-reduction, in comparison to in-person delivery, in being able to provide access to care for veterans living in geographically remote locations.21

LIMITATIONS

The acceptability of remote therapy to practitioners is less clear, at least in the UK. A substantial increase in people accessing mental health services remotely in the UK has been reported in the lay press22; this newspaper article reported figures showing an almost nine-fold increase in webcam and instant messenger appointments through the IAPT between 2012-13 and 2015-16. Despite the increase in take-up of these remote access opportunities, the same newspaper article also reported that many health professionals themselves do not support the use of remote access therapy. The article reported a range of responses to remote access therapy; for example, that remote therapies reinforce that those suffering with mental illness want to distance themselves from other people, thus presenting a barrier to effective treatment; that the process of receiving remote therapy is cold and dehumanising; and that remote access therapy reinforces the misinformed idea that quick and easy interventions are available to solve complex mental health difficulties.

In terms of the effect of remote access therapy on the relationship between participant and therapist, one study1 reported that some participants thought it important they see their therapist’s face, for example, through the use of video teleconferencing rather than telephone. With regards to video teleconferencing, some participants in the same study described challenges in reading body language, whilst others felt using Skype was no different to being in the same room as the therapist. This is supported by a systematic review of earlier studies12 which found that most studies reported no affect in the quality of rapport between participant and therapist when using remote access therapy, but some participants reported feeling less comfortable in using teletherapy, for example, due to finding it difficult to read body language. This was also the case in findings from the 2019 Ashwick et al study.11 Furthermore, the same study identified that remote access therapy could feel impersonal due to the two people not being in the same room together and identified that participants in remote access therapy could also feel lonely or isolated between sessions, in comparison to therapy delivered in residential settings. Conversely, some participants did find that the reduction in formality allowed them to feel more comfortable with teletherapy whilst others felt that this perceived informality made it easier to cancel appointments and therefore not be as committed to the cycle of treatment.

Participants in the same study reported that they found Skype easy to use. However, a minority of people experienced difficulties with internet connections being lost during a session. A systematic review of studies12 found that some research described challenges in using technology, such as reduced image resolution on video calls, not being able to connect, or audio delays. However, within the systematic review, there was no reported evidence that these difficulties impacted negatively on the therapeutic processes or outcomes.

A lack of investment in cellular or online infrastructure in some geographical areas may be a barrier to the availability of reliable remote access technology and to newer telehealth technologies. Morland et al21 recognised that there is a lack of cost evaluation of services delivered by telemedicine in the US. Furthermore, this cost analysis should take into account factors such as investment in equipment, software, maintenance and repair of the supporting infrastructure. 21 There is widespread Internet coverage throughout the UK, but in the US there may be certain States that have gaps in the necessary infrastructure to provide full Internet coverage, which in turn may disadvantage veterans living in some remote locations. More research is needed to investigate whether living in some geographical locations puts veterans at a disadvantage in being able to receive remote access therapy in both the US and UK.

Turgoose et al1 acknowledged that, when engaging with remote access therapy, some participants found there was less time to reflect on their therapy session before having to go back to their daily routine. This point is expanded upon in Ashwick et al11, through the acknowledgement that the “quick snap back to reality”, of, for example, undergoing remote access therapy within the home, could occur during the therapy session, if, for example, the doorbell rang.

The Turgoose et al1 study raised several further points for consideration when delivering remote access therapy and ensuring good practice. Firstly, teletherapy might be most suited to those with less severe mental health difficulties, because those engaging with teletherapy would need to have a high level of functioning to manage their time, environment and the quick transition in and out of the therapeutic setting. Some people taking part in remote access therapy found it difficult to be responsible for their own engagement in the therapy.11 Furthermore, some people felt it was difficult to fit the sessions around their schedules; this was accommodated by some appointments being offered outside office hours.11 It was also found that participants in remote access therapy also needed to be prepared prior to their session, in terms of knowledge and understanding of background reading materials.11

Morland et al15 noted that, where group therapy is delivered via VT, it is useful to have a person onsite to help manage logistics, distribute relevant materials and collect any paperwork. This suggests that forethought and extra planning may be needed to facilitate certain forms of remote access therapy, particularly within the group setting.

CONCLUSION

Remote access to therapy for psychological conditions has passed from the theoretical to the practical and is now validated in the veteran population, particularly in PTSD. The technology is proven and robust although some practitioners may have more concerns than those receiving therapy as to its safety in delivery. Its role needs to be extended to other psychological and psychiatric disorders associated with military service. Furthermore, research into the timing of provision of service, the technological infrastructure needed to facilitate and support delivery, a more global body of evidence and the level of training needed by the practitioner require resolution.

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