The Cognitive Behaviour Therapist (2023), vol. 16, e26, page 1 of 11
doi:10.1017/S1754470X2300020X

BABCP
www.babcp.com

SERVICE MODELS, FORMS OF DELIVERY AND CULTURAL ADAPTATIONS OF CBT

'I almost felt like I can be a little bit more honest': experiences of a telehealth group for bipolar disorder

Tania Perich[1,2], Kelly Kakakios[1] and Isabel Fraser[1,2]

[1]School of Psychology, Western Sydney University, Sydney, Australia and [2]Translational Health Research Institute, Western Sydney University, Sydney, Australia
Corresponding author: Tania Perich; Email: t.perich@westernsydney.edu.au

(Received 9 February 2023; revised 10 July 2023; accepted 22 August 2023)

Abstract

Despite the increasing use of telehealth platforms to deliver cognitive behavioural group therapy programs, few studies have been conducted that explore the experience of using telehealth platforms for those living with bipolar disorder. The present study aimed to explore the impact of the telehealth platform on the delivery of a recovery-orientated well-being plan group program for participants living with bipolar disorder. A total of 19 participants completed the qualitative interviews (3 male, 16 female). Using content analysis, data were deductively coded in line with pre-existing codes and matrix categories with unexpected data that discussed the telehealth experience being coded using an inductive content analysis framework. Two themes were identified: (1) Social inclusion, which included the subthemes of (a) connection to others via telehealth and (b) feeling safe using telehealth; and (2) Barriers and engagement, which included the subthemes of (a) removing barriers by using telehealth and (b) symptom impacts to engagement using the telehealth platform. Participants reported increased connection with others using telehealth and feeling greater safety overall when using the telehealth platform; however, some noted that dominant personalities could contribute to feeling unsafe within the group at times. Overall, the platform reduced barriers and was easy to use with this being a convenient way to attend, even if in some instances the platform highlighted differences between the members.

Key learning aims

(1) Telehealth platforms provide a unique opportunity for connection for those living with bipolar disorder.
(2) Telehealth platforms may increase feelings of personal safety but may also increase feelings of difference between group members.
(3) Symptoms may impact on engagement with anxiety and mood symptoms playing a role; however, telehealth may also decrease barriers to engagement.

Keywords: Bipolar disorder; Cognitive behaviour therapy; Group therapy; Telehealth; Qualitative

Introduction

Bipolar disorder (BD) is lifelong mental health condition diagnosed on the basis of mania or hypomania symptoms along with periods of depression (American Psychiatric Association, 2022). Although pharmacotherapy is the primary treatment option for people living with this condition, psychological interventions have also been found to be useful in assisting in the management of

bipolar disorder as an adjunctive treatment, with many effective programs being conducted in a group therapy setting (Miklowitz *et al.*, 2021).

Telehealth programs and telehealth-delivered therapy became a standard way to deliver mental health services during the COVID-19 pandemic (Shakeri *et al.*, 2022) and these platforms continue to be used post-pandemic by many pracitioners. Telehealth/video conferencing group therapy and individual therapy programs have been shown to be as effective as face-to-face therapy in several studies (Gentry *et al.*, 2019; Poletti *et al.*, 2020; Scott *et al.*, 2022) showing support for the use of these platforms for mental health service delivery beyond COVID-19. As such, growing interest in researching telehealth-delivered interventions has been seen as a result of the pandemic in a wide range of mental health areas such as caregiver psychoeducation in schizophrenia (Mueser *et al.*, 2022), anxiety in multiple sclerosis (Kever *et al.*, 2022), clergy-delivered group therapy CBT treatments for depression (Weaver *et al.*, 2022) and OCD treatment for rural veterans (Fletcher *et al.*, 2022).

Despite both face-to-face and telehealth interventions being efficacious, there are many perceived differences that have been noted between these forms of delivery in some studies by participants. When assessing neurology telemedicine visits, those who attended telemedicine cited that convenience was a positive aspect of attendance, whilst those who attended in-person visits reported they perceived increased quality of care during in-person sessions (Olszewski *et al.*, 2022). For psychotherapy delivered by mental health nurses with a range of mental health conditions, participants reported that they found telehealth less personal than face-to-face therapy, but also more convenient, with the reduced need to travel being a positive aspect to telehealth (Moeller *et al.*, 2022). Young people attending an early psychosis program also noted improved convenience, but that technological issues were problematic in some instances. Others reported that they were better able to express themselves using telehealth and that it improved their sense of autonomy in treatment (Randall *et al.*, 2022).

Qualitative studies in other health areas have also noted similar themes such as improved access to care, security and privacy, personalisation of care and patient empowerment as being areas that were impacted both positively and negatively using telehealth (Donovan *et al.*, 2021). For example, in sleep medicine patients reported improvements in areas such as improved accessibility, and that they could avoid anxiety-provoking situations, such as attending the clinic, using the telehealth platform. However, increases in areas of concern, such as lower levels of privacy using telehealth were reported by some participants, and that additional needs requiring physical demonstrations, such as mask fittings, could not be met using the telehealth platform (Donovan *et al.*, 2021).

For mental health conditions, qualitative research has supported these findings and themes. In a study exploring a telehealth-delivered group program for women with perinatal depression, participants reported that the program normalised depression and decreased a sense of isolation. Whilst some reported technology as being more convenient, others reported frustrations with logging in, technology issues and delaying starting the group due to technological issues (Parameswaran *et al.*, 2022). For veterans with trauma participating in a web-based skills training program supported by individual coaching via telehealth, participants reported good therapeutic alliance over this medium, with this being built up over the course of the intervention (Fletcher *et al.*, 2021). For other populations, such as those receiving OCD treatment, telehealth offered additional benefits such as being able to access exposure settings outside of the office, although some in this program reported that they were not as comfortable talking about some issues over video (Fletcher *et al.*, 2022).

Despite the widespread use of telehealth platforms in a range of mental health settings, few research studies have been conducted to explore telehealth or video conferencing in the delivery of psychological group therapy treatment programs for participants with BD specifically. One study has assessed telehealth delivery of a psychological intervention for young adults and adolescents

https://doi.org/10.1017/S1754470X2300020X Published online by Cambridge University Press

with BD and noted high retention rates (77%) and high scores on measures of client satisfaction (Sankar *et al*., 2021), although qualitative outcomes were not reported.

The present study aimed to explore user experiences of the use of a telehealth-delivered well-being plan group therapy program for people living with bipolar disorder. Using qualitative interviews, the primary aim of the study was to assess the experience of the group program, assessing the impact of the use of the telehealth platform (Zoom) and how it impacted on engagement and participation in the program.

Method

Participants

Participants were part of a larger study that aimed to assess the feasibility and acceptability of telehealth-delivered recovery-orientated well-being plan group program for bipolar disorder (ACTRN12623000043639).

Participants were recruited via social media (Facebook, Instagram) with advertisements targeted to people living in Australia. To take part, participants were required to be over 18 years of age, with a confirmed diagnosis of bipolar disorder and under the care of a GP or psychiatrist.

A total of 19 participants completed the qualitative interviews (3 male, 16 female) after completing the treatment. Fourteen participants were diagnosed with BD I disorder and five with BD II. Nine participants were married, with 10 divorced/separated or never married.

For country of birth, 17 (89.5%) participants reported that they were born in Australia, one (5%) in Ireland and one (5%) in Czechoslovakia.

Eleven (58%) participants reported having a bachelor's degree or higher, with six (32%) reporting a vocational qualification and one (5%) reporting 'other'. Ten participants reported having a job, and nine reported not having current employment. Most participants (16; 84%) were currently taking prescribed medication for bipolar disorder.

Procedure

For the feasibility and acceptability study (ACTRN12623000043639), participants were recruited online and provided a link to a Qualtrics study information page. This page contained the participant information sheet, online consent form and eligibility questions which included being under the care of a GP or psychiatrist, over 18 years of age, and previously diagnosed with bipolar disorder.

When participants consented to be contacted and to take part in the study, they then were contacted via email to undertake a telephone interview confirming their diagnosis of bipolar disorder using the SCID V (Research Version) (First *et al*., 2015), with current symptom severity assessed using the MADRS (Montgomery and Asberg, 1979) and YMRS (Young *et al*., 1978). After completion of the interview and confirmation of the diagnosis, participants were enrolled into the study and asked to complete online questionnaires assessing a range of areas such as mood, stigma and recovery. After this, participants were then randomly assigned to either the treatment condition or the wait-list control condition, with those in the wait-list control condition being invited to take part in the intervention and the conclusion of the wait-list (8 weeks). Participants in both conditions completed the same questionnaires after the 8-week period.

The treatment consisted of an 8-week well-being planning group telehealth delivered via the Zoom platform after business hours on Monday evenings, with each session lasting for approximate 1.5 hours. The program was designed for participants to develop their own well-being plan to enhance recovery, improve symptoms and prevent relapse. The program contained elements of cognitive behaviour therapy, psychoeducation about bipolar disorder, stigma and coping. Participants completing the treatment were required to complete a mood chart and

https://doi.org/10.1017/S1754470X2300020X Published online by Cambridge University Press

Table 1. Description of the content of the well-being plan programme

Session	Content description
1.	Introduction to the programme, well-being planning and mood charting
2.	Symptoms and illness course including depression, hypomania and common co-occurring conditions
3.	Common early warning signs and triggers
4.	Sleep and routines in bipolar disorder, medications and medication adherence
5.	Stigma/internalised stigma, impact of bipolar disorder on identity and acceptance of bipolar disorder
6.	Skill building through using coping strategies. Identifying social supports and well-being planning
7.	Individual whole plan review and discussion of mood charting over the programme
8.	Implementing the plan and barriers to success, planning for setbacks

journal throughout the 8-week period as part of the intervention, and to complete the well-being plan each week along with some questions about the content that week via Qualtrics. Those who completed the treatment were then invited to complete a telephone qualitative interview. The well-being plan program was conducted by a registered psychologists (T.P., I.F.) and Clinical Psychology Master's students throughout the trial. The research assistant/student assisted with the delivery via Zoom, noted attendance and any technical issues with Zoom. See Table 1 for program description.

Telephone qualitative interview

The qualitative interview was administered by a researcher who was not involved in the study or treatment delivery (K.K.). Questions asked of participants included: What about the program had the most impact on you?; What aspects of the program did you find most useful?; What aspects of the program did you find least useful?; What, if anything, would you change or improve about the program? Participants were also asked about Zoom and the telehealth platform specifically and asked: How did you find the experience of using Zoom for the program?

Data analyses

Qualitative telephone interview data were analysed in line with previous studies that have explored the experience of telehealth interventions employing a content analysis approach (Donovan *et al.*, 2021). This approach was chosen as it allowed for the targeted analysis of key areas of interest that were relevant to assess the experiences of a telehealth delivered program and the use of this platform, rather than group therapy or content experiences more broadly.

The interviews were transcribed verbatim, de-identified, quality checked and analysed (T.P. and K.K.) (Elo and Kyngäs, 2008) with Microsoft Excel. Using the content analysis method, data were deductively coded in line with pre-existing codes and matrix categories that had been pre-identified based on prior research by author K.K. and reviewed by T.P. For this research question which related to the use of telehealth, the matrix included: (1) Structure of program and delivery (breakout rooms, online, therapist, telehealth platform); (2) Process (group environment, community/togetherness, impact on understanding of self). K.K. coded the data into the matrix codes which was then reviewed by T.P. Unexpected data that discussed the telehealth experience was coded using an inductive content analysis framework by K.K. This included open coding, grouping, categorisation and abstraction leading to the final main category (Elo and Kyngäs, 2008). Themes were then derived from both the inductive and deductive coding matrixes, guided by the principles and steps of thematic analysis (Braun and Clarke, 2006). Consensus discussion between K.K., I.F. and T.P. was then undertaken to confirm the final themes for inclusion in the analysis.

https://doi.org/10.1017/S1754470X2300020X Published online by Cambridge University Press

Results

Two themes were identified in the analysis: (1) Social inclusion, which included the subthemes of connection to others and feeling safe; and (2) Barriers and engagement, which included the subthemes of removing barriers and symptom impacts to engagement (see Table 2).

1. Social inclusion

a. Connection to others via telehealth

Several participants reported that the telehealth platform allowed for connection with others. Many also reported that the benefits of engaging with a wider community of people living with bipolar disorder was helpful and valued. Some ($n = 3$) living in a rural location noted that this was particularly beneficial as it allowed them to connect with others living with bipolar disorder.

This suggests that the telehealth platform allowed for an experience of connection that otherwise would not have occurred without the use of this medium.

Participants ($n = 3$) also reported that specific features of the platform allowed for greater connection with others. For example, the use of breakout groups within Zoom allowed for individual time other members who they connected with (see Table 2).

Whilst others ($n = 2$) reported that this was both good and bad, with increased connection being valued with people who they had a rapport with, but for those who they didn't connect with, this was less desired. For example, one participant noted: '*I would just be dreading counting down who I was going to be assigned with*', suggesting that the breakout room platform feature increasing connection between members was not always seen as helpful.

Some participants ($n = 2$) noted that the telehealth platform increased a sense of difference to others, with them noting points of difference between themselves and others. The personal nature of the platform, where participants were Zooming in from their homes, also brought up mixed feelings, where participants noted that their location was different to others and highlighted their own sense of being different.

Here the telehealth platform highlighted the experience of being in a personal space whilst attending the sessions. This allowed for greater connection with others in some instances, but resulted in some members comparing themselves with others or noticing differences between themselves and other members.

b. Safety by using telehealth

Some participants ($n = 4$) reported experiences regarding feeling safe in the group, with the size of the group and the other group members enhancing feelings of safety along with other features unique to the medium, such as not needing to travel home afterwards.

Others reported feelings of safety in the group overall due to participating from home, with communication with others being enhanced by the telehealth medium, increasing their sense of control.

However, some also noted feeling unsafe ($n = 3$) with some members of the group more directly during the group program, with telehealth highlighting feelings of being different from some members at times. Here some participants noted that dominant members may contribute to members feeling unsafe in the group process. In some instances, this was due to not allowing equal time for participation for other members of the group. This experience was reported by participants as being enhanced by the telehealth platform which allowed these participants to be highlighted when speaking, cutting off other members and their contributions, and discouraging them from speaking in some instances during the group program.

https://doi.org/10.1017/S1754470X2300020X Published online by Cambridge University Press

Table 2. Quotes from participants by theme

Theme	Subtheme	Example quotes
1. Social inclusion	a. Connection to others via telehealth	'*I live in a place where there's, it's a rural town, which I don't have any actual connections with other people with mental illness. So having a connection with people was massive for me.*'
		'*Everybody got an opportunity to talk and discuss things . . . so it was good to like good to I guess meet people more . . . one on one and more personally.*'
		'*I think a lot of a lot of us in the group have been displaced, or moved about or, you know, or gone through some horrendous things or, or life experiences that haven't, hadn't been great . . . everybody that was in the group was in a house. I was the only one working from my office . . . other people that have the disorder are doing quite well, and not living on the streets.*'
		'*And we obviously all live all over Australia, we're not all in the same place . . . So doing the Zoom, which was my first ever, I've never used actually Zoom before. And so, I found it so easy. And but it was just so nice, being able to sort of see you know, each other, and not just, you know, talking or whatever, but to actually see each other and discuss, like in real time. That's what I loved, I loved that.*'
	b. Safety using telehealth	'*Probably, it made the stakes feel a bit lower for me. So it was a lot less stressful in terms of being able to do it in my own space. And also knowing that if I got triggered, it wasn't like, I then had to travel home or anything. I like this small group.*'
		'*I kind of feel like it's safer because I'm still home alone on my couch and I can pull the plug whenever I like. And I almost felt like I can be a little bit more honest and say more what I think than if I'm face to face.*'
		'*I recall one session where a participant was in quite an aggressive mind frame and, combined with her strong personality/on-screen presence, I felt quite unsafe.*'
		'*I don't think Zoom works as well with large numbers of people, especially on something like this where it's very intimate what you're discussing . . . doing the breakout groups was a good idea for the large numbers, because yeah, I think what tends to happen is you got one or two people who will tend to dominate, and you'll have another subset of people who will be very reticent to speak freely, and by bringing them into breakout groups it sort of encourages those who are less likely to speak up, or those who are less likely to be fully frank, to do so.*'
2. Barriers and engagement	a. Removing barriers by using telehealth	'*There were a few weeks where I was like, "ugh I don't want to do this" but once I logged in and said hello and got chatting I was glad I did . . . that happened on more than one occasion.*'
		'*I think that was very helpful because you didn't have to travel . . . convenient place, like you know I was doing it work or at home, it was already very convenient.*'
		'*. . . part of everyday life now you know like Zoom is is fine.*'
	b. Symptom impacts to engagement using the telehealth platform	'*Part of my illness is high anxiety. So it took me, I sort of, I kind of get that frozen in the headlights thing. And I don't particularly like looking at myself but after about the third, by the third week, I was okay with that. So in a way, in a way it's sort of stretched me. Like I was out of my comfort zone but then I stretch to,*

(*Continued*)

https://doi.org/10.1017/S1754470X2300020X Published online by Cambridge University Press

Table 2. (*Continued*)

Theme	Subtheme	Example quotes
		so then after that I feel quite comfortable ... I think we while, our video our face was encouraged, I think there were a couple of people who turned off the pictures or the video and just listened to you know, so I think there was sort of the option of that but with the preference, you know, for being able to see each other but I think generally you know, have living in a regional area, you know, Zoom is terrific.'
		'I was just experiencing quite high levels of discomfort, and I just needed to get out. So at all times, the illness is going to colour your ability to engage, and it's going to shape the way you engage.'
		'Cause there was a lot of social anxiety about that too like I would just be dreading counting down who I was going to be assigned with.'

2. Barriers and engagement

a. Removing barriers by using telehealth

Participants ($n = 9$) reported that the telehealth platform removed barriers to engagement and participation. This included removing physical barriers to group attendance, such as travel to and from the location, and having to obtain childcare if attendance at a group was conducted face to face.

Using telehealth meant that for some ($n = 6$), they were able to attend the sessions more easily by allowing them to address other barriers to attendance such as low mood or motivation. Here the ease of use of the platform allowed participants to 'log on' even though they may have had low motivation that day and allowed them to address this barrier more easily, increasing the potential for participation in the group on a weekly basis. Ease of use was further referred to by many other participants in the interviews, with many referring to their confidence in using these platforms at work and at home and feeling comfortable engaging in the use of these platforms.

However, although the ease of use and convenience was reported as being positive by most, some noted they '*Like(d) having a day out in person doing it*', which was now missed by using the telehealth platform. The face-to-face component allowed for travel, which was valued by some members of the group and was now removed when using the telehealth platform.

b. Symptom impacts to engagement using the telehealth platform

Impacts to engagement within the group included mood and other symptoms which were reported by some ($n = 4$) as impacting on engagement in the group process. Some noted that telehealth increased the impact of mood or anxiety on participation in the breakout groups when assigned with other members they did not have a connection with. However, others reported that the use of telehealth decreased the impact of anxiety on engagement with others.

Levels of comfort were improved throughout the program for some, whilst others further noted that the experienced pushed them in a positive way and assisted in the management of anxiety so they could engage with the program more deeply. The breakout room feature telehealth and using this feature was reported by some to assist further in allowing greater levels of engagement despite experiencing anxiety initially, but also anxiety-provoking for other members in some instances. Thus, how symptoms impacted was largely individual, depending on how the person experienced telehealth and also how they engaged with the other group members.

https://doi.org/10.1017/S1754470X2300020X Published online by Cambridge University Press

Discussion

The present study explored user experiences of the use of a telehealth-delivered well-being plan group therapy program for people living with bipolar disorder. Two themes were identified in the analysis: (1) Social inclusion, which included the subthemes of connection to others and feeling safe; and (2) Barriers and engagement, which included the subthemes of removing barriers and symptom impacts to engagement.

The primary aim of the study was to assess user-reported experience of the use of the telehealth platform. In the first theme it was found that participants reported increased sense of connection to others, and that they felt that they were able to participate and connect with those around the country. This was seen as beneficial by participants, and it allowed for some to take part who would otherwise have been unable to attend, particularly those in rural areas. This supports other findings from previous research that have also indicated improved access to services due to engagement with telehealth platforms (Donovan *et al.*, 2021). This could also be particularly beneficial for those living with bipolar disorder who may have limited opportunity for engagement with others diagnosed with this condition, particularly in rural settings.

Some participants reported some unique experiences when using this medium and engaging in telehealth from home. One participant who was homeless throughout the study noted that this was a source of difference between themselves and other members, who were participating in the group from their homes. Equity issues have been considered as problematic for some members of the community in previous research, where they may not have access to devices or technology (Jonnagaddala *et al.*, 2021) and in addition, participants may experience unique challenges when using telehealth in various environments. Although this may improve access, it may also highlight individual inequities. This needs to be considered when conducting programs via telehealth and in future research programs.

Novel findings of this study include participant reports of feelings of safety within the group process and how this was impacted by the telehealth delivery. Some reported that dominant personalities were problematic within telehealth group setting, where it was easier for these members to talk more frequently than others. This may be associated with bipolar-specific symptoms, such as increased speech during hypomania, although mood state was not assessed during the group session in this study. Changing the telehealth settings may assist in addressing this, where a gallery view may be preferred to ensure that there is equal engagement among members when having larger group conversations.

However, participants further reported enhanced feelings of safety using telehealth specifically, by being able to log off and leave the group when they wanted, not having to travel from the group to home after participating in the group and also being able to withdraw from the platform if this was wanted or needed for any reason throughout the group. This is consistent with other research in young adults, where participants noted a preference for this form of delivery, where it increased feelings of autonomy (Randall *et al.*, 2022). These unique additional features of the telehealth platform may make this a viable and preferred form of group delivery for some members who perceive increased safety online through this platform.

The telehealth platform in this study was also found to decrease barriers to engagement, with the convenience of the platform also being found be important for participants. This is consistent with other studies where participants reported this convenience as a key area where barriers to attendance can be removed (Donovan *et al.*, 2021). Most participants in this study reported that they found using the platform easy and did not report any significant technological issues. This is contrary to previous research which has noted that technological issues were problematic for some participants (Parameswaran *et al.*, 2022), yet consistent with other research which supports ease of use of these platforms (Donovan *et al.*, 2021).

This study also noted other impacts to engagement where some participants found engaging in the platform less anxiety-provoking than expected. This is consistent with research in non-psychiatric

https://doi.org/10.1017/S1754470X2300020X Published online by Cambridge University Press

samples (Donovan *et al.*, 2021), where participants also reported that attendance via telehealth was less anxiety provoking than attending face-to-face sessions. However, other mixed reports were noted here, where some participants noted increased anxiety when using the breakout room feature and being placed with other members, whilst others reported decreased anxiety through this same feature. More research is needed to determine what aspects of the telehealth platform may increase anxiety and explore if increased symptoms due to the use of these platforms may be mitigated in some way, particularly for those living with bipolar disorder.

Future recommendations for delivery for the program via telehealth could include running smaller groups with fewer members than what would usually be required in face-to-face settings, where groups of 8–12 are the norm. Participants in this study reported greater safety when the group size was smaller (less than 6). Feedback regarding the use of breakout rooms was mixed, and as such, the use of these would not be recommended in future research.

There were several limitations noted in this study. Firstly, this was a research study where recruitment was conducted online, and participants were asked to take part in a telehealth-delivered program. This favoured participants who preferred this form of delivery and felt comfortable using this form of technology. More research is needed to assess the experiences of those who are not as comfortable with these platforms to explore how this impacts their capacity to engage in group programs via this medium.

A further limitation was the low rate of male participants who took part in this study. Although recruitment was targeted to male and female participants equally via social media channels, fewer male participants took part in the study. More research is needed to explore if telehealth-delivered programs are a viable and acceptable form of delivery for male participants and to further assess barriers to engagement for this group of participants.

In conclusion, participants reported increased connection with others, but also noted points where they felt different to others participating in a group therapy program delivered via telehealth. They further reported feeling enhanced personal safety online when using the telehealth in some instances; however the telehealth platform highlighted differences between members at times, contributing to feeling unsafe in the group for some during the group process. Overall, participants reported that the platform reduced barriers and was easy to use, with this being a convenient way to attend a bipolar-specific program.

Key practice points

(1) Telehealth is a viable and acceptable way to deliver group programs for people living with bipolar disorder.
(2) Smaller group sizes should be considered to improve engagement and feelings of safety.
(3) Strategies should be considered to assist in allowing participants to engage in a manner which enhances safety, which may include turning off the camera and utilising the chat feature.

Further reading

Bauer, M. S., Krawczyk, L., Tuozzo, K., Frigand, C., Holmes, S., Miller, C. J., ... & Godleski, L. (2018). Implementing and sustaining team-based telecare for bipolar disorder: lessons learned from a model-guided, mixed methods analysis. *Telemedicine and e-Health*, *24*, 45–53.

Sankar, A., Panchal, P., Goldman, D. A., Colic, L., Villa, L. M., Kim, J. A., ... & Blumberg, H. P. (2021). Telehealth social rhythm therapy to reduce mood symptoms and suicide risk among adolescents and young adults with bipolar disorder. *American Journal of Psychotherapy*, *74*, 172–177.

Data availability statement. The data relating to this study are available on reasonable request from the corresponding author.

Acknowledgements. The authors would like to acknowledge David Gilfillan, Margo Orum and Meg Smith.

https://doi.org/10.1017/S1754470X2300020X Published online by Cambridge University Press

Author contributions. **Tania Perich:** Conceptualization (lead), Data curation (lead), Formal analysis (supporting), Investigation (lead), Methodology (lead), Project administration (equal), Resources (equal), Supervision (equal), Writing – original draft (equal), Writing – review & editing (equal); **Kelly Kakakios:** Data curation (equal), Formal analysis (equal), Methodology (equal); **Isabel Fraser:** Investigation (equal), Methodology (equal), Project administration (equal), Writing – original draft (equal), Writing – review & editing (equal).

Financial support. This research received no financial support from any funding agency.

Competing interests. The authors have no competing interests to declare.

Ethical standard. The authors have ensured that this research adhered to the ethical principles as set out by the Declaration of Helsinki. Informed written consent was obtained from all participants and the study was approved by the Western Sydney University Human Research Ethics Committee (H14254).

References

American Psychiatric Association (2022). *Diagnostic and Statistical Manual of Mental Disorders* (5th edn, text rev). https://doi.org/10.1176/appi.books.9780890425787

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101.

Donovan, L. M., Mog, A. C., Blanchard, K. N., Magid, K. H., Syed, A. S., Kelley, L. R., Palen, B. N., Parsons, E. C., McCall, C. C., Thompson, W., Charlton, M., Spece, L. J., Kirsh, S., Au, D. H., & Sayre, G. G. (2021). Patient experiences with telehealth in sleep medicine: a qualitative evaluation. *Journal of Clinical Sleep Medicine*, *17*, 1645–1651. https://doi.org/10.5664/jcsm.9266

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, *62*, 107–115. https://doi.org/10.1111/j.1365-2648.2007.04569.x

First, M. B, Williams, J. B. W., Karg, R. S., & Spitzer, R. L. (2015). Structured Clinical Interview for DSM-5 – Research Version (SCID-5 for DSM-5, Research Version; SCID-5-RV). American Psychiatric Association.

Fletcher, T. L., Amspoker, A. B., Wassef, M., Hogan, J. B., Helm, A., Jackson, C., Jacobs, A., Shammet, R., Speicher, S., Lindsay, J. A., & Cloitre, M. (2021) Increasing access to care for trauma-exposed rural veterans: a mixed methods outcome evaluation of a web-based skills training program with telehealth-delivered coaching. *Journal of Rural Health*, *38*, 740–747. https://doi.org/10.1111/jrh.12628

Fletcher, T. L., Boykin, D. M., Helm, A., Dawson, D. B., Ecker, A. H., Freshour, J., Teng, E., Lindsay, J., & Hundt, N. E. (2022). A pilot open trial of video telehealth-delivered exposure and response prevention for obsessive-compulsive disorder in rural Veterans. *Military Psychology*, *34*, 83–90. https://doi.org/10.1080/08995605.2021.1970983

Gentry, M. T., Lapid, M. I., Clark, M. M., & Rummans, T. A. (2019). Evidence for telehealth group-based treatment: a systematic review. *Journal of Telemedicine and Telecare*, *25*, 327–342. https://doi.org/10.1177/1357633X18775855

Jonnagaddala, J., Godinho, M. A., & Liaw, S.-T. (2021). From telehealth to virtual primary care in Australia? A rapid scoping review. *International Journal of Medical Informatics*, *151*, 104470. https://doi.org/10.1016/j.ijmedinf.2021.104470

Kever, A., Aguerre, I. M., Vargas, W., Straus Farber, R., Levine, L., Riley, C. S., Vasquez, M., & Leavitt, V. M. (2022). Feasibility trial of a telehealth support group intervention to reduce anxiety in multiple sclerosis. *Clinical Rehabilitation*, *36*, 1305–1313. https://doi.org/10.1177/02692155221107077

Miklowitz, D. J., Efthimiou, O., Furukawa, T. A., Scott, J., McLaren, R., Geddes, J. R., & Cipriani, A. (2021). Adjunctive psychotherapy for bipolar disorder: a systematic review and component network meta-analysis. *JAMA Psychiatry*, *78*, 141–150. https://doi.org/10.1001/jamapsychiatry.2020.2993

Moeller, A. M., Hansen, J. P., & Andersen, P. T. (2022). Patients' experiences of home-based psychotherapy via videoconference: a qualitative study. *Archives of Psychiatric Nursing*, *39*, 91–96. https://doi.org/10.1016/j.apnu.2022.03.004

Montgomery, S. A., & Asberg, M. (1979). A new depression scale designed to be sensitive to change. *British Journal of Psychiatry*, *134*, 382–389. https://doi.org/10.1192/bjp.134.4.382

Mueser, K. T., Achtyes, E. D., Gogate, J., Mancevski, B., Kim, E., & Starr, H. L. (2022). Telehealth-based psychoeducation for caregivers: the family intervention in recent-onset schizophrenia treatment study. *JMIR Mental Health*, *9*, e32492. https://doi.org/10.2196/32492

Olszewski, C., Thomson, S., Pring, K., Cox, S., Merrill, R., Fishman, E., Ambrosini, A., Soltany, K. A., Bognet, G., Strauss, L., Graham, R., Guzik, A., & Strowd, R. E. (2022). A comparison of telemedicine and in-person neurology visits: what are the factors that patients consider when selecting future visit type? *Journal of Neurology*, *269*, 5022–5037. https://doi.org/10.1007/s00415-022-11149-0

Parameswaran, U. D., Pentecost, R., Williams, M., Smid, M., & Latendresse, G. (2022). Experiences with use of technology and telehealth among women with perinatal depression. *BMC Pregnancy Childbirth*, *22*, 571. https://doi.org/10.1186/s12884-022-04889-4

Poletti, B., Tagini, S., Brugnera, A., Parolin, L., Pievani, L., Ferrucci, R., Compare, A., & Silani, V. (2020). Telepsychotherapy: a leaflet for psychotherapists in the age of COVID-19. A review of the evidence. *Counselling Psychology Quarterly*, *34*, 352–367. https://doi.org/10.1080/09515070.2020.1769557

Randall, L.-A., Raisin, C., Waters, F., Williams, C., Shymko, G., & Davis, D. (2022). Implementing telepsychiatry in an early psychosis service during COVID-19: experiences of young people and clinicians and changes in service utilization. *Early Intervention in Psychiatry*. 10.1111/eip.13342. Advance online publication. https://doi.org/10.1111/eip.13342

Sankar, A., Panchal, P., Goldman, D. A., Colic, L., Villa, L. M., Kim, J. A., Lebowitz, E. R., Carrubba, E., Lecza, B., Silverman, W. K., Swartz, H. A., & Blumberg, H. P. (2021). Telehealth social rhythm therapy to reduce mood symptoms and suicide risk among adolescents and young adults with bipolar disorder. *American Journal of Psychotherapy*, *74*, 172–177. https://doi.org/10.1176/appi.psychotherapy.20210011

Scott, A. M., Clark, J., Greenwood, H., Krzyzaniak, N., Cardona, M., Peiris, R., Sims, R., & Glasziou, P. (2022). Telehealth v. face-to-face provision of care to patients with depression: a systematic review and meta-analysis. *Psychological Medicine*, *52*, 2852–2860. https://doi.org/10.1017/s0033291722002331

Shakeri, A., Chu, C., Stamenova, V., Fang, J., Barker, L. C., Vigod, S. N., Bhatia, R. S., & Tadrous, M. (2022). Comparison of healthcare utilization between telemedicine and standard care: a propensity-score matched cohort study among individuals with chronic psychotic disorders in Ontario, Canada. *Schizophrenia Bulletin Open, 3*, sgac046. https://doi.org/10.1093/schizbullopen/sgac046

Weaver, A., Landry, C., Zhang, A., McQuown, L., Hahn, J., Harrington, M., Tucker, K. M., Holzworth, J., Buys, T., Smith, F. N., Grogan-Kaylor, A., Pfeiffer, P. N., Kilbourne, A. M., & Himle, J. A. (2022). Study protocol: a randomized controlled trial of Raising Our Spirits Together, an entertaining, group-based technology-assisted cognitive behavioral therapy for depression, tailored for rural adults and delivery by clergy. *Contemporary Clinical Trials Communications*, *29*, 100952. https://doi.org/10.1016/j.conctc.2022.100952

Young, R. C., Biggs, J. T., Ziegler, V. E., & Meyer, D. A. (1978). A rating scale for mania: reliability, validity and sensitivity. *British Journal of Psychiatry*, *133*, 429–435. https://doi.org/10.1192/bjp.133.5.429

Cite this article: Perich T, Kakakios K, and Fraser I. 'I almost felt like I can be a little bit more honest': experiences of a telehealth group for bipolar disorder. *The Cognitive Behaviour Therapist*. https://doi.org/10.1017/S1754470X2300020X