

## **APPENDIX**

### **(“Clinician Perceptions of Virtual Reality to Assess and Treat Returning Veterans,” by Teresa L. Kramer, Ph.D., et al.)**

Group comments were digitally recorded, transcribed, and downloaded into Ethnograph software, a qualitative data management program. Printed transcripts were reviewed for accuracy and all identifying information was confirmed. Several transcripts were distributed to the research team to identify top-level coding (or general themes) that were discussed in the focus groups. Two primary themes were identified. The team developed category definitions for these codes to allow for consistent coding across raters. Once the codebook had been created, the first and fourth authors independently coded each utterance from the same transcript and reviewed their work to identify areas of disagreement. Each disagreement was discussed, and the codebook revised accordingly. Discussion notes were recorded to create an audit trail for validation purposes. Following this process, the raters independently coded two of the focus groups and achieved 80% concordance on the primary coding of each.

Next, the research team reviewed several of the transcripts to develop a secondary level coding scheme, which segmented each of the primary codes into more descriptive categories. This resulted in five secondary codes. Definitions for these categories were created to aid in the coding process. The first and fourth author reviewed transcripts of each focus group and applied the secondary coding scheme. Disagreements were discussed, noted and resolved.

Segments of text from each of the focus groups were printed from Ethnograph, resulting in 10 sets of transcripts (two primary codes, each assigned to one of five secondary codes). Each utterance with a specific code was tallied, resulting in a quantitative summary of the main themes discussed by the focus groups. These results are shown in the table that follows. Most importantly, the VR's characteristics, such as effectiveness, technology, utility and safety, were most likely to be mentioned as barriers

and facilitators to more widespread implementation. However, clinicians also frequently mentioned other factors, such as clinician, veteran and organizational characteristics that would be critical to adoption of VR across VA settings.