serious mental health issues, Craig determined that Geneva was an ideal candidate for this type of therapy. Craig felt that Geneva was an ideal candidate for this type of therapy. She called and scheduled a telephone appointment who offered online counseling. Geneva decided it might be a good idea for her to try. She called and scheduled a telephone appointment with Craig, a licensed clinical social worker in the state capitol. Craig asked her numerous questions, and screened Geneva at length to ensure she was not suicidal. Geneva has been working with Craig in weekly online sessions, and has also been doing workbooks online for cognitive behavioral therapy (CBT) for depression. Geneva has begun feeling more in control of her depression over the last few weeks, and has recommended Craig to several friends.

Craig felt that Geneva was an ideal candidate for this type of therapy. After carefully evaluating her for suicidality, psychosis, and other serious mental health issues, Craig determined that Geneva was suffering through an adjustment disorder, in part triggered by the death of her mother. Craig has been pleased with Geneva’s progress and believes her case will soon be closed successfully.

Bob:
Bob is a 36-year-old man on disability for a long history of alcoholism. Bob has been hospitalized seven times since the age of 18 for suicide attempts and severe depression. He has been noncompliant with several psychiatrists regarding medication over the years, and he tends to only go into counseling during times of acute crisis. Bob was having issues with transportation, as his license is suspended because of two DUls. Bob had heard of Craig, a counselor who provided online therapy, and Bob thought that he wanted to try this type of therapy, so that he wouldn’t have to hassle with taking the bus to appointments. In addition, Bob had been feeling suicidal a great deal lately, and had made a plan to overdose on his mother’s pain medication. He wanted to talk to someone about feeling suicidal.

Geneva:
Geneva is a 42-year-old woman who lives in a rural area of Montana. Geneva has been struggling with what she believes is depression for several months. She was crying frequently, had trouble sleeping, and lost her appetite. Her mother died recently, and this event, combined with her divorce 2 years ago, made life harder to manage recently. Geneva wanted to talk to a counselor, but the area in which she lives has only one counselor within 100 miles of her home. Her pastor had counseled her, but felt he is not able to help her further. At his suggestion, Geneva went on the internet and found a social worker who offered online counseling. Geneva decided it might be a good idea for her to try. She called and scheduled a telephone appointment with Craig, a licensed clinical social worker in the state capitol. Craig asked her numerous questions, and screened Geneva at length to ensure she was not suicidal. Geneva has been working with Craig in weekly online sessions, and has also been doing workbooks online for cognitive behavioral therapy (CBT) for depression. Geneva has begun to feel more in control of her depression over the last few weeks, and has recommended Craig to several friends.

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Chapter 7: The Use of the Internet in Therapy: Guidelines and Best Practices

By: Leah Walker, MFS, LMFT

Learning objectives

- Define the key areas of controversy over online therapy.
- List the major types of online therapy modalities.
- Explain the findings of at least two studies regarding the efficacy of online therapy.
- Identify the findings of two studies comparing outcomes of online to face-to-face therapy.
- List at least two benefits perceived by patients in online therapy settings.
- Describe two complaints that patients have had about online therapy.
- Discuss two benefits to online therapy as perceived by therapists.
- Explain the biggest frustration that therapists have regarding online therapy.
- Define the ways in which distance creates unique ethical dilemmas.
- List at least three ways therapists can protect clients and themselves in online situations.
- Be able to define at least three common themes in all the professional codes of ethics.
- Explain two suggestions for practice that can overcome some of the inherent issues in online therapy.

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Craig evaluated Bob, and did not agree to provide online therapy to him. Craig felt that Bob’s current suicidal ideations, which included having a plan to kill himself, combined with his history of noncompliance, numerous hospitalizations, and long mental health and substance abuse history, would be better served in face-to-face therapy in a local clinic specializing in treating dually diagnosed persons and those with long-term psychiatric issues. He arranged to have Bob taken to the local emergency center for an evaluation, based on his concerns about Bob’s suicidal thoughts and plans. Bob was admitted to the local crisis stabilization unit for 3 days, and followed up with the local clinic.

These two cases represent two ends of the possible spectrum of people who seek to participate in online therapy. Obviously, they are the types of cases in which it is fairly clear if they can be treated through online services. Many of these cases, however, fall in between these two types of situations, and the appropriateness of participation in online therapy is less clear.

Overall, the majority of therapists are not providing online services. Prabakar (2012) noted that only about 2% of counseling professionals surveyed were providing the service. However 60% of counselors wanted more information about doing this type of work. So while there is a great interest in online therapy, most providers are unsure of how online therapy works, the effectiveness of the approach, especially as compared to face-to-face therapy, the benefits and drawbacks, the ethical situations involved with this form of therapy, and some of the best practices in the approach.

CONTROVERSY OVER ONLINE THERAPY

It can be argued that Freud offered the first recorded incidence of distance therapy, through his exchanges of letters with patients. As noted by Prabakar (2012), beginning in the mid-1990s, a handful of therapists began experimenting with the idea of online therapy. Today, the definition that seems to fit most appropriately is, online therapy is a form of service delivery by “a licensed mental health care professional providing mental health services via email, video conferencing, virtual reality technology, chat technology, or any combination of these” (Manhal-Baugus, 2001).

Barak, Hen, Boniel-Nissim, and Shapira (2008), published a meta-analysis of online therapy in which they explained the history and practice of online therapy. The authors noted that online therapy has been described as cybertherapy, telehealth, ehealth, and internet
therapy. Some therapy programs are self-help, web-based sites in which users can log in and complete exercises and workbooks. Other times, a provider and patient may exchange emails. Online therapy can be provided asynchronously, which means it occurs in a delayed fashion, such as a patient sending an email, and a therapist answering the email at a later time. Online therapy can also be provided in real-time, or synchronously, such as in the case of using a webcam, or instant messaging type of software program for the patient and therapist to interact. The authors note that historically, the implementation of this type of therapy was met with great resistance. The resistance can be divided into four broad categories:

1. Concern over the inability of the therapist to see body language, facial expressions and the like, as nonverbal communication was considered to be of extreme importance in therapy.
2. Concerns over privacy—including computer hacking of emails, webcam transmissions, and websites—that could expose an individual’s secrets, as well as concerns over the safety of patients in crisis.
3. Concerns that technology was outpacing both the law and the ethics of this type of therapy. Without a firm ethical understanding of online therapy, licensing and professional boards were concerned as to how to guide therapists into unknown territory, and there were no laws to govern such issues as crossing state lines for service delivery.
4. Concerns over the lack of qualifications and training for therapists providing online therapy.

Other researchers voiced additional concerns, noting that the distance involved would make it easier for a client to terminate therapy. Furthermore, there were beliefs in the therapeutic community that the physical distance would also prevent the formation of transference from the client’s unconscious to the therapist, as well as countertransference from the therapist to the client (Ragusea & VandeCreek, 2003). Some studies also presented concerns about the technology itself, such as having the power going out in the middle of a critical point in a session, or dealing with poor video or audio quality (Hamburger, et al., 2014). Kingsley and Henning (2015) noted that the unreliability of internet connections could force sessions to be canceled if the power or the internet was out, which could frustrate and upset the client.

It is important to note that some types of clients may also not benefit from email interactions. People with low literacy and those who have limited access to the internet, such as low-income persons who have to use public access services may not have adequate privacy (Finfgeld-Connett, 2006).

In response to these types of criticisms, other researchers presented counter-arguments. Hamburger et al. (2014), noted that while there is certainly concern for the confidentiality and security of information, traditional face-to-face therapy has its own problems in this area, and breaches of confidentiality and improper releases of information occur in these settings as well. Furthermore, in relation to therapeutic relationships, it is suggested that an online therapeutic setting may actually lead to more openness and a faster therapeutic alliance as not having to be face-to-face with a therapist can actually reduce anxiety about disclosure (Amichai-Hamburger & Barak, 2009). Hamburger et al. note that the assessment and planning of how to handle a patient in crisis is not that different than it is in traditional settings. The authors argue that with the use of proper assessment, and taking steps to insure that therapists have client’s location information and information regarding resources where the client is located, the problem of suicide is not as hard to deal with as some researchers would claim.

In issues of transference, Hamburger et al. (2014) make a persuasive argument that resistance occurs in online therapy and not just in face-to-face therapy. Furthermore, in citing the work of Scharff (2013), they note that transference, countertransference, and other aspects of the therapeutic relationship still occur in online settings. “Those welcoming etherapy believe that resistance in psychotherapy via the internet may take both similar and/or different forms from that of face to face psychotherapy. Examples of resistance may be forgetting to go online/call, speaking softly, not using a headset, moving away from the microphone, accepting other calls, and chatting as if on a social call, in addition to silence, hesitation, coughing, lateness, nonpayment, displacement, and so on’” (p. 289).

**HOW DOES ONLINE THERAPY WORK?**

Barak, Klein, & Proudfoot (2009) attempted to explain the different types of online therapy. They stated that “web-intervention” is the best term to use, as it incorporates a variety of service types. They described a web-based intervention as, “a primarily self-guided intervention program that is executed by means of a prescriptive online program operated through a website and used by consumers seeking health- and mental-health related assistance. The intervention program itself attempts to create positive change and or improve/ enhance knowledge, awareness, and understanding via the provision of sound health-related material and use of interactive web-based components” (p. 5). They further noted that web-based interventions can be subdivided into three categories: 1) self-help, 2) self-guided, and 3) therapist-supported.

Self-guided interventions utilize sophisticated software and some are highly interactive, providing multimedia applications and immediate feedback. The individualization provided varies depending on the complexity of the software used. Therapist-supported sites usually offer some form of interactive features. Overall, the main focus is on direct human interaction, whether it occurs from instant messaging, email, Skype, or webcams. The quickness of responses from the therapist can vary from immediate to days, depending on the format of the site. Other forms of interaction can include group chat rooms or group bulletin boards where users can post messages and receive replies from others as peer support. The amount of time spent interacting with the therapist varied from a few minutes to a few hours per week. The authors noted an example of a highly interactive site, PTSD Online, which is a CBT program treating those persons with posttraumatic stress disorder (PTSD) in a format with a high level of therapist support and multimedia features that are highly interactive. The authors cite some recent research that indicates that overall, the therapist-supported online therapy may be more effective than the self-guided programs (Barak, Boniel-Nissim, & Shapira, 2008; Spek, et al., 2006).

The approaches vary amongst the various models. For example, in one program for social phobia, which is self-guided, a user logs in and is directed to a “contact” module in which the therapist has left information about him/herself and invites the participant to contact him/her. The therapist responds within 3 days of receiving the email. Therapists were also required to send each client an email each week with motivating messages. Other parts of the program included an interactive guide with 57 different websites of five pages each. The progress through the programs is self-guided. The participants are free to repeat sessions as they wish. There is also a group area in which clients can share experiences with others in the program. It is designed to last 10 weeks.

Participants are educated about social phobia and asked to complete such exercises as ranking how high their anxiety is during various activities. For example, if they were to be engaged in public speaking, how high would their anxiety be on a scale of 1 to 10? Throughout the program, assessment and exercises like these are used and feedback is given to the participants. The participants also keep a behavioral diary. They are encouraged to plan in vivo exposure exercises and follow
through with them. Then participants report about the experience. The participants are then taught to decrease negative self-talk. Each section builds upon the next (Berger, Hohl, & Caspar, 2009).

Does online therapy work?

Early studies on the efficacy and satisfaction with online therapy produced mixed results. The authors noted that some studies found that online and face-to-face therapy were found to be very comparable in patient satisfaction and outcomes. There were some studies that found certain aspects of online therapy, such as the therapeutic alliance, to be inferior to face-to-face therapy. Some patients expressed concerns over privacy, but liked the convenience of not having to attend appointments. However, Barak et al. (2014) noted that the studies varied tremendously in how online therapy was evaluated. They observed that many of the studies focused only on one diagnosis, such as depression or anxiety, and many studies only examined one specific type of service delivery.

There have been many studies examining the efficacy of online treatment for a variety of psychiatric diagnoses. One approach, self-guided CBT, has been studied extensively. Internet CBT has been found to be effective in persons with PTSD. Ivarsson et al. (2014) studied a group of Swedish adults who met the diagnostic criteria for PTSD. The participants were assessed and provided the Internet-based treatment for PTSD. The participants did show significant improvement over the control group, both immediately after treatment, and at the 6-month follow-up evaluation.

Is face-to-face therapy more effective?

The comparison of face-to-face and online therapy is still in the early stages of research. One of the most comprehensive studies to date, Othluis, Watt, & Stewart, 2011, argued that there were simply not enough studies to effectively and fairly compare the two forms of treatment. However, the studies currently available have not found any real differences in the outcomes for patients (Andersson, Cuijpers, Carlbring, Riper, & Hedman, 2014). Another study of online CBT had similar findings. In this study, patients were treated for either PTSD or depression. The patients followed a manualized treatment program and aside from an initial telephone screening, they completed their assessments and workbooks online, and exchanged emails with their therapists. The outcomes over a period of several months were found to be comparable to another group of participants who received the same therapy in a clinic face-to-face with a therapist. Overall, about 80% of patients felt satisfied with the treatment and their therapists, and would recommend the online therapy to a friend. However, 30% of patients did state that they would have liked to have had face-to-face contact with the therapist. Andrews et al. (2010) noted that in comparing online therapy with face-to-face therapy using the CBT model for persons with anxiety and depression, there were no significant differences in outcome or patient satisfaction with the two types of treatment (Ruwaard, et al., 2012).

In treating panic disorders, Kiropoulos et al. (2008) found that online therapy was just as effective as face-to-face therapy. O’Reilly et al. (2007) also compared video therapy to face-to-face therapy for a group of clients with a variety of psychiatric disorders. The study showed that the two groups were equivalent in both patient satisfaction and clinical outcomes.

Barak et al. (2007) in their meta-analysis of online therapy, noted that overall, in the numerous studies they reviewed, the effectiveness of online therapy was equal to face-to-face therapy for a variety of behavioral health diagnoses. In therapeutic approaches, the authors did find support that CBT was the most effective form of online therapy. Furthermore, no differences were found in the efficacy of web-based interventions versus those approaches that used interactive approaches between patient and therapist.

However, some recent studies have indicated that periodic phone contact with a therapist did not increase the adherence to the online treatment in any significant way (Berger et al., 2012). Other studies have shown than when used with a specific form of coaching, it increased adherence to online treatment and resulted in better outcomes (Mohr et al., 2013). Mohr and his fellow researchers found that in working with persons who had a diagnosis of major depressive disorder, their model, called TeleCoach, did show significantly lower rates of dropout than those not receiving TeleCoach. TeleCoach involved having a therapist make a weekly phone call to the program participant to develop a supportive relationship, reviewing goals for participation in the online program, positively reinforcing using the site, and encouraging the participants to stay with their goals. Therapists were also allowed to discuss the technical aspects of using the online program, but were not allowed to do any type of therapy over the phone to ensure that the actual therapy was only occurring online. However, as in the previously cited study by Berger et al. (2012), the improvement in symptoms did not differ between participants who had TeleCoach and those who did not. So it appears that while there is no difference in effectiveness of the treatment in this approach when the therapist provides telephone support, the program participants are more likely to finish their treatment with the telephone support.
In addition to measurable outcomes of effectiveness using online therapy, it is also important to consider the patient’s perceptions of this form of therapy. Participants often note that convenience of therapy was a reason they liked online therapy. They stated that the ease of access made them more able to actually start working on their issues. One participant noted that in using MoodGym (an online self-help program for depression), “working with MoodGym, the best thing about it all was that I was doing something about it. You know, coming to these sessions every week, getting to talk, starting the next chapter. You know, the things I worked with did not suffice, but I felt good working with it. I felt sort of like I was getting out from getting back to normal.” The researchers noted the ability to start treatment quickly, rather than waiting for an office appointment, also kept participants motivated once they decided to start treatment (Lillevol et al., 2013).

One recent study of college students noted that among the reasons they liked online therapy was the convenience and accessibility. Some admitted that if they had had to go to an office, they would have missed the sessions due to not wanting to get out of bed and feeling too stressed to leave home. This particular study examined an email-based therapy approach, rather than a website where the participants logged in and thus, the participants developed an ongoing therapeutic relationship with a provider who exchanged emails with them. In addition to convenience, another added benefit for the college students was being able to receive ongoing support during spring break and Christmas break when they left campus and would not have been able to have attended therapy in a traditional setting (Mishna, Boggs & Sawyer, 2013).

Other participants in the Mishna, Boggs and Sawyer study also noted that they felt more comfortable disclosing certain issues online that they might have otherwise have avoided discussing in a face-to-face setting. Some participants also felt that writing out their emotions and issues made it more real, noting that they would re-read their emails and this made the situation more real to them, noting that in traditional therapy, they would speak and then forget about their issues after the session. One participant was quoted as saying, “cyber was very profound because it’s one thing to talk about it, but it’s almost like it doesn’t exist, it’s hypothetical. But when you’re reading something and it’s either on the screen or on the paper, which almost makes it more legitimate. You can’t run away from it, it’s like in your face kind of thing versus when you’re talking to someone and you can tune out, you can check out” (p. 174).

The authors noted that as is common in younger people, college students may be particularly responsive to online therapy due to their constant use and familiarity with the internet and social media. Overall, participants stated they felt a strong emotional connection to their therapists, despite not having a face-to-face relationship. Of course, as these participants were college students who are more comfortable with the internet and are used to communicating with peers via social media and numerous chat applications, this may predispose them to feel a bond through a media connection. Therefore, it is somewhat difficult to assume that older people would feel the same way about online therapy, particularly if they do not use computers routinely. It may not be possible to generalize these findings to older adults who may not be used to such forms of communication on a routine basis (Mishna, Boggs, & Sawyer, 2013). Indeed, older people’s frustration with computers was noted in one recent study (Beattie, Shaw, Karr, & Kessler, 2009).

The lack of face-to-face contact may not be a problem for some participants because of another factor. Bengtsson, Nordin, and Carlbring (2013) also noted that a reason clients may be happy with the therapeutic alliance in online therapy is due to a lack of comparison. A therapist is quoted as saying, “I experience that you get a stronger alliance in face-to-face, but at the same time I know (laughs) that there are studies that show that it is not always that big a difference when you assess it, so it is simply relative, that . . . we who go for both parts, we might experience a greater difference than patients who only experience the one” (p. 475). Another important consideration of patient satisfaction with the online therapeutic bond is the patient themselves. The type of patients who want to participate in online therapy may be happier with the alliance that forms because the patient selects the online therapy (Bengtsson, Nordic, and Carlbring, 2015).

Another plus is easier accessibility to services for clients with physical illnesses or disabilities that keep them from being able to leave home easily to attend traditional office-based services Hertlein, Blumer, & Mihaloliakos (2013). The APA also cited this as one of the major reasons that clients often prefer online therapy, as they do not have to worry about traveling to an office, missing work, and can just log on to a computer (APA, 2016). Another group of people that prefer to seek online services may be those who have trouble leaving the home and getting to appointments due to their responsibilities with childcare and/or eldercare (Pollock, 2006).

There is a definite advantage for those who live in rural areas to participate in online therapy, as they have access to services that would not be available otherwise. As noted by the APA (2016), psychologists are relatively rare in remote areas, and patients may have to drive hours to reach the nearest provider, which simply is not feasible for everyone. In addition, even those who live in more populated areas may not have easy access to a specialist for their particular clinical needs, and through online therapy, they have access to specialized services without having to travel (Rummell & Joyce, 2010). Pollock (2006) also notes that gay and lesbian couples who live in rural or remote areas may also have difficulty finding a therapist open to treating gay couples.

Furthermore, Shaw and Shaw (2006) noted that some who are reluctant to seek mental health services in person are more willing to engage in what they perceive as the safety of online therapy. Mishna, Boggs, & Sawyer (2013) noted that many of their participants cited that having some distance between themselves and the clinician made it more comfortable to discuss certain issues via email that they otherwise might have not spoken about face-to-face. This is also echoed in the study by Bengtsson, Nordic, and Carlbring (2013) in which a therapist noted in working with patients with social anxiety, “I think that many times, for some patients, it can be an advantage that you have not . . . met live because it feels a little more threatening and revealing to sit face-to-face and tell someone things that are shameful, anxious” (p. 475). Likewise, participants in another study noted that being somewhat anonymous helped increase their disclosure (Beattie, Shaw, Karr, & Kessler, 2009).

When looking at the perceived benefits of online therapy, it is also important to note how the expectations of online therapy met the experiences of those participants. One recent study explored what a patient initially expected of online CBT and how those expectations matched the outcomes of the actual process. A sample of expectations was:

- “I don’t think you would get the same feeling as if you were one-to-one in a room. You get more, you get to know the other person, so in a way you would. To me it would be like talking to a machine” (P21 Pre, female, 50–59, completer, 10 sessions).
- “It’s perhaps more difficult for them to offer the right advice because they’re not seeing you. I see that is perhaps the one disadvantage” (P19 Pre, male, 60–69, completer, 10 sessions).
- “I don’t know….I’ll be nervous….it’ll be strange….I suppose it’ll be just like talking to someone you don’t know….Well, people could not tell, say how they really feel. If you’re with someone one-to-one, say yeah, like now and I said something and you thought...
well, you could tell really if it was bothering me or if, if I just said that because I didn’t want to talk about things And maybe you encourage me to talk about it more, whereas maybe on-line I could just say, ‘Oh, I don’t want to think about that’. And the person on the other end wouldn’t really, really know” (P20 Pre, female, 20–29, withdrew from therapy, 2 sessions).

- “There might be some issues of trust, with people feeling, you know, that they’re not really talking to a psychologist if they can’t see them” (P12 Pre, male, 30–39, completer, 10 sessions, no post-therapy interview).

- “I’m actually excited that there might be something that might do something for me, that I can actually commit to, because I can commit to it, if there’s nobody, if I don’t have to face someone then it’s easier to commit to, and it’s easier to be honest as well because you’re not, you know, if you say something to someone’s face and it’s something really personal that you care about, you know, whether you know you’re doing it or not, the way they react will probably frame and what you say afterwards. You might modify what you’re saying without knowing it” (P4 Pre, female, 40–49, withdrew from therapy, 1 session) (p. 50).

After coming in for services, a posttreatment evaluation was completed. The participants noted that some of their fears were unfounded and they developed a relationship with their therapists, and others noted that not seeing the therapist made the process easier. However, some quit due to feeling that the process did not feel comfortable for them and they did not feel a bond with the therapist.

- “After a couple of sessions when it felt dry and then starting to feel that it was fluid, but I don’t think that’s to do with the medium, I think that’s actually just to do with communicating with someone there...We had built a relationship. It took a while but yeah, I was pleased with the way things were going at the end. Yes, it was a bit difficult at first because you know, it’s...you’re just communicating with a computer and you don’t know the person at the other end, who you’re communicating with... I was emailing, and I had a picture of somebody else in my mind and I was convinced I was talking to somebody else, so you know, you’ve got that potential, sort of trying to get over that sort of not knowing, but I guess, given the constraints and the fact that the persons not there, it was, it worked I would say, yeah” (P14 Post, male, 30–39, completer, 10 sessions).

- “I was surprised, I felt as though it was flowing quite well, which I didn’t think it would. And I warmed to him [psychologist], you know, straight away, you can do that over the internet...I think you could build up a good relationship over the internet, I was quite surprised” (P1 Post, female, 40–49, withdrawn from therapy, 2 sessions).

- “I don’t honestly think I could have sat down with someone and talked to them face-to-face, I don’t think I’d have had the confidence to do that. I’d talk to them but I think I’d have expressed what I express on a computer; having the therapy on there. So I don’t think it would have worked as well because I wouldn’t have been as honest with them” (P2 Post, male, 30–39, completer, 9 sessions).

- “I enjoyed the anonymity. You know, I think it was, to start off with, but come the end, it didn’t worry me. It didn’t worry me, because I, I didn’t feel it was anonymity come the end. I thought I knew [psychologist’s name], I thought I knew the lady that I was talking to, you know, as if I was talking to her one-to-one, face-to-face, that’s what it felt like. I didn’t feel like I was typing things on a computer, you know, it didn’t feel like that at all, and I’ve never done that before on a computer; talked to anybody on, on a computer like that and yeah, it was, it was okay” (P16 Post, female, 40–49, completer, 10 sessions).

- “I’m not sure there was a relationship. And that, because of that, part of the reason for that was the lacking the face-to-face, it’s like having a telephone conversation isn’t it? You don’t have the same closeness as you would meeting somebody round a table, it’s inevitable. And that, that’s got to impact on the benefit of the therapy...I didn’t build a relationship with him” (P19 Post, male, 60–69, completer, 10 sessions).

- “I didn’t feel comfortable with it. I think that what I need, or what I needed was to talk to someone one-on-one rather than talk through a machine...I could see the idea of it, and I think it’s a good idea but I personally didn’t feel comfortable with it...the idea I think is good. But it wasn’t for me” (P24 Post, male, 50–59, withdrew from therapy, 6 sessions).

- “I don’t know if it would have been the same if I’d been face-to-face with the same person. And that’s nothing against her [psychologist] it’s just sometimes you can’t always relate to everybody and I don’t know if it was that, or if it was the computer, I honestly don’t know” (P20 Post, female, 20–29, withdrew from therapy, 2 sessions).

- “Are they concentrating on what you’re saying? Are they focusing really on what you’re saying or are they doing something else...are they on the telephone, having a cigarette, maybe not taking me seriously” (P5 Post, female, 20–29, withdrew) (p. 51).

In these cases, certainly some participants did not feel that online therapy was right for them. They were displeased with the process and usually chose to quit. So at times, there can be negative outcomes associated with online therapy.

**NEGATIVE OUTCOMES**

The use of online therapy is not recommended for all types of patients, and there have been a few studies that have examined negative outcomes for those who have participated in online therapy. Notably, Rozental, et al. (2015) did find that about 9% of participants reported negative experiences with online therapy. Some of the negative feelings about the experiences stemmed from frustration with technology. Failure to be able to easily log in and navigate the sites made patients feel incapable of handling a simple task, which reinforced the negative feelings they had about themselves. Others reported that their negative feelings resulted from not having therapeutic support adequate for their needs. Some stated that the program did not incorporate enough therapeutic support, and others stated that they felt the therapist who provided the support did not do an adequate job.

The resulting frustrations resulted in greater feelings of sadness and distress than before beginning the treatment. However, the authors noted that it is impossible to tell if some of these negative feelings would also have occurred for these patients in a face-to-face treatment setting, based upon their particular needs and issues. Some patients got worse and some had other life events that complicated their treatment, but this is no different for online therapy than for any other treatment setting. The participants noted that some of their worsening feelings while participating in therapy were caused by various life events, and they did not ascribe their worsening symptoms or more negative feelings to the therapy. Some patients in the study also reported frustration with the rigid approach in the manualized treatment and felt pressured to complete the assignments too quickly. For some people, the pressure may be too much, and as the authors noted, this failure to complete the program in a timely fashion made them feel even more negative about themselves. One participant noted that he knew he could never finish in the allotted number of weeks, and this made him feel worse about his already problematic procrastination. The authors suggested that therapeutic support is a valuable tool to help patients feel supported, motivating them and encouraging them to finish if they
were procrastinating, and provided competent technical support to ensure clients could navigate the sites without feeling so frustrated.

Beattie, Shaw, Karr, and Kessler (2009) also noted that for some depressed persons, some of the inherent issues in online therapy actually reinforce their depression, due to their tendency to go quickly into negative self-talk. When these patients could not visually see a therapist, they felt the therapist was lacking in commitment to their case. They complained about not being able to read the body language of the therapist to ensure the therapist was really engaged in their treatment. During the lag time after their emails were sent and were being read by the therapist, these patients stated that they wondered what the therapist was actually doing. They wondered if the therapist was doing something else, or taking a break. Other patients reported that having to wait for a therapist to respond was wasted time and during the lag, they would lose focus or motivation to work on their issues.

**The therapist’s perspective**

Most of the research regarding online therapy has been from the patient’s point of view. However, the therapist’s perspective is a vital aspect of the process. One recent study, Bengtsson, Nordin, and Carlbring (2013), focused specifically on the use of CBT and how therapists felt the experience of online therapy compared to doing CBT face-to-face. The therapists in this study provided therapy through email and the use of a manualized CBT approach. The patients they treated had diagnoses including PTSD, eating disorders, and depression. All therapists had extensive experience in CBT, both face-to-face and online, and were thus well qualified to compare the two types of service delivery.

Several themes emerged from the qualitative study. Overall, therapists found that in some ways, online therapy was less frustrating, because they did not have to deal with clients cancelling sessions, as they did in face-to-face therapy. In addition, some of the therapists cited that face-to-face therapy often resulted in being more emotionally drained, and that online therapy freed them somewhat from this potentially negative outcome. One therapist noted, “I think that is has been both, well, fun and occasionally also very, like, demanding. You feel very much less burdened by (ICBT) than in regular outpatient care. It does not get as, like . . . heavy in the moment, as it can get when you are sitting with someone who become like that really sad or really angry or dissatisfied or—you become protected by the screen in some way” (p. 473).

Other therapists felt that online therapy protected them from burnout as illustrated in this statement, “I think it is good that you, you are protected and you will last a little longer and you do not get tired and you will not, like, you will not be negatively impacted. Uh, you do not get run down. I think you will last longer as an internet therapist” (p. 474).

The reasons given for the preference for online therapy also go beyond the positive effects that occur from the therapy itself. Other benefits of the online format include not having clients getting frustrated by having to coordinate hectic schedules, especially for those therapists who provide couple or family therapy involving multiple parties.

Therapists also reported liking the ability to have more control over their schedules. They noted that the online therapy approach enabled them to choose when they wanted to work. For example, it was easy to rearrange their schedules as needed and check client’s progress at different times then they had originally planned. Some of the therapists who had family responsibilities noted that it was an advantage over face-to-face therapy if a child became ill, so instead of having to cancel a full day of booked clients, they could just log on later in the day. The online format also enabled the therapists to easily have a colleague take over cases in the event of an emergency. In addition, the website did some of the work for the therapists, which included automated reminders for clients to complete assignments or email their therapists. Furthermore, the therapists felt they were also able to reach more people and provide more help than they could seeing all the patients face-to-face.

Furthermore, counselors in other studies had noted that online therapy is easier to do with some patients. For some patients, email and written communication works better than face-to-face communication, such as in the case of clients who tend to not be very verbal (Fantus & Mishna, 2013).

In terms of the negative feelings about online therapy, most of the therapists in the study by Bengtsson, Nordin, and Carlbring (2013) felt that the therapeutic alliance was not as strong for online therapy as face-to-face therapy. Their main concern was not being able to read body language, such as gestures and facial expressions. One therapist described this feeling, “in some way maybe it is easier to create a working alliance”, that is, when you are sitting in the room, because you have access to the body in some way. And then you have gestures and like . . . yes, but, facial expressions and gaze” (p. 474).

Similar concerns were cited by other therapists in other studies as well. “Yeah, I felt more uncomfortable trying to gain control. Like it was harder for me to say, ‘Stop, let's go back to this. I know that I feel more comfortable saying it face-to-face, because at least I would be able to show that I was more interested. But online, you know, that could come across that I was upset, or that I was being rude, or that I was, you know, just being different” (Haberstroh, et al., 2008, p. 465).

Despite their feelings that the alliance was not as strong, Bengtsson, Nordin, and Carlbring (2013) noted that the therapists still felt that online therapy was just as beneficial for their patients. Some expressed surprise that the alliances formed were much stronger than they had originally expected before providing online therapy.

Another positive finding in online therapy was the perception by the therapists that in online work, the focus really remained on the therapy itself. One therapist stated, “There is more focus on me, that is also . . . uh, could actually be a disadvantage in live therapy, that there is less focus on the therapy. Progress is also attributed more to me as therapist than to the therapy itself and what the patient does” (p. 473).

Mishna, Boggs, and Sawyer (2013) noted in their study that social workers reported some frustration with the format of online therapy, stating that they felt they missed experiencing certain emotional events simultaneously with a client, which could cause a disconnect in their therapeutic alliance with the patient. One provider noted that she received an email detailing a very positive experience that a client had, and while she was happy for the client, she really wished she could have experienced the client’s feelings of satisfaction and happiness in the moment with the client, rather than reading about it later. It is interesting to note that the social workers in the study were master-level interns, and most were quite young, so their experiences might differ from those of more experienced therapists. Even though they lacked the experience of having done much face-to-face therapy and are more comfortable with computerized communication, they cited many of the same feelings about not having the face-to-face experience as older, more experienced therapists in other studies (Bengtsson, Nordin, and Carlbring, 2013). They did feel they were missing the chance to view body language and gestures, and worried they were missing something in the therapeutic alliance. On the positive side, the social workers liked to be able to reread emails from the patient and this helped them think more about which interventions were best, as well as reread their own responses to the patient. They felt this was a good learning tool for them as emerging clinicians. Another interesting finding was that while the social workers were concerned they did not feel as emotionally connected to the client, due to not seeing the client face-to-face, the client did not feel the same way.
Therapists in other studies have expressed similar frustrations. In Haberstroh, et al., 2008, a therapist lamented that she could not see her patient in person saying, “I thought this was different, obviously, not to even know what she looks like. Just to have no idea. I mean, I do know that she is female and that’s about it. That’s all I know. I try to imagine someone I’m talking to. That was really hard, because I don’t want to do that, because I don’t want to stereotype what they look like. I challenge myself not to assume anything. I think I have a tendency to assume my client is more like me than different from me, if that makes sense. I do find myself wondering about her appearance, etc. When she’s telling her story” (p. 464-465).

Technology could also prove to be a frustration for therapists. In this same study, a therapist explained her experiences with a patient who had little computer knowledge and experience stating, “It hasn’t gone anywhere. I still feel like we’re on the first session. We had one full hour, before that it was sporadic. I still feel like we are on the first session. I feel like I really don’t know a lot about her. She called my cell number to tell me she couldn’t get on, and admitted to trying this project to help get better acquainted with the computer. It has been very frustrating to be there. Now she’s gone. Will she come back? Do I need to wait? I was trying last night to help her. I explained that AOL [America Online Service Provider] was not a good way to communicate, that explorer [Microsoft Internet Explorer] was better. She did get on for about 15 or so minutes. Got bumped and called again. We got nowhere” (p. 464).

Overall, the therapists who were interviewed in these studies did feel a certain disconnect from their patients in the online setting, and did experience some frustration with technology. However, the therapists did feel a decrease in the burnout and stress they often felt in face-to-face therapy, and overall they felt their schedules were more manageable and they could reach more clients this way.

Online couples and family therapy

Most of the information explored thus far pertains to individual counseling. Online couples and family counseling is an emerging field. Pollock (2006) was an early advocate for family and couples therapy being done online. She noted that one advantage of online therapy was the ability to bring together geographically separated family members into a therapy session that might be otherwise impossible. She noted that this can be done through videoconferencing, or through synchronous chat rooms, where all the members participate at once. She also believed that emails can be used effectively, especially with communication being written down and read by everyone, creating less chance for family members to argue over who said what, as often occurs in live sessions. Furthermore, she found that practices such as email communication through a therapist can be a good alternative to live sessions for those who are too hostile to communicate face-to-face but who need to communicate with one another. She cites the example of two parents having custody issues as a situation in which the use of email can be effective.

ETHICAL CONCERNS WITH ONLINE THERAPY

Janet:
Janet has been a licensed clinical social worker for 18 years. She began providing services online 5 years ago. Janet carefully screens her clients and takes only those cases she feels qualified to treat. Janet has clear, written procedures explaining online therapy, its benefits, the potentially negative aspects of online therapy, and confidentiality. Janet worked with a web-hosting company that ensured her that her site was HIPAA compliant. Janet counsels her patients via email, instant messaging, and sometimes uses phone support. However, in all of her technical consultations, no one had ever advised Janet to have a series of passwords set up with clients to ensure the client was indeed the person on instant messaging or email. Today, Janet received an email from John, a client she has been treating online for 3 months for an anxiety disorder. John discovered that last week, his wife, who was aware of the treatment he had been receiving, logged into his account and not only read the emails from Janet, but also exchanged instant messages with Janet, posing as him, to obtain more information about what, if anything, John was saying to Janet about their marriage. John is furious, and is threatening to complain to the state social worker about the breach of confidentiality. He is also threatening to sue Janet.

Michael:
Michael is a marriage and family therapist who has been treating Marissa, a 19-year-old college student, through online therapy and phone therapy for 2 months. Marissa is from a very religious family and has been struggling with issues of sexual identity and whether or not she is a lesbian. Marissa pays Michael via a Paypal account. Michael has been careful to maintain privacy and has worked closely with a company to ensure his website is secure. He also makes clients use a series of password and images to ensure no one is posing as his client. Michael has policies and procedures regarding safety, confidentiality, boundaries, and other important ethical and legal considerations that he has clients electronically sign. However, Michael never thought to verify that clients are really who they say they are. Today, he received an email from Marissa, who told him that she felt guilty about lying to him. Marissa admitted that she was only 16 years old and lied to Michael when she said she sought online therapy to avoid revealing her sexual issues to her family, which she was afraid Michael would do since she was a minor. Marissa is completely unaware of how much trouble Michael can now be in for providing services to a minor without the informed consent of a parent. Michael is panicking and called his attorney to ask how to proceed. Michael is furious with himself for not thinking to verify the client’s identity and believed he had covered all his bases related to ethics and regulations.

Jackie:
Jackie is a professional counselor who has been providing online services for 2 years. She has been a counselor for 3 years. Jackie is 29 years old and like many people her age, she is savvy in social media, having accounts on Twitter, Instagram, and Facebook. Jackie is careful to keep her personal and professional accounts separate and labeled clearly. She has received consultation from IT specialists and feels that her site is confidential and HIPAA compliant. She has taken numerous workshops in the provision of online therapy. She also has clearly written policies and procedures to protect herself and her patients. Jackie has been treating Blake, a 28-year-old female. Despite what Blake has told her about her history with alcohol being very minimal, Jackie became suspicious that Blake was more of a partier than she was letting on. Jackie decided to look at Blake’s Facebook page, which Blake had not set up with privacy controls. Just as she suspected, Blake was in numerous pictures holding cocktails and looking intoxicated. Of course, Jackie is now faced with dilemma of having information about a client that she cannot confront her with, and she feels guilty about snooping, acknowledged it was a boundary violation, and promised herself to never do it again. Unfortunately, Jackie did not know that while scrolling through the Facebook page, she had accidentally pushed the “like” button on one of Blake’s pictures. Blake noticed this and left Jackie an angry message, asking why she had been spying on her. Blake told Jackie that she felt violated. She also asked Jackie if she was “being funny or sarcastic by liking the picture of me drinking?”. Jackie is frantic and is calling her attorney for advice, but also is deeply worried that she will never be
able to rebuild her trust and rapport with Blake and feels really awful about what she did.

These vignettes illustrate the complexities of online therapy and potential pitfalls, even for therapists who are being careful and have sought technical and regulatory consultation. As the field develops, there will be unforeseen problems. Technology is rapidly growing and often outpaces ethical and regulatory oversight. In 1999, no governing board had to think about therapists lurking on a patient’s Facebook page as a boundary issue because there was no Facebook. Guidelines on how to ensure your client is really your client online could never have been predicted as a real ethical and legal dilemma in 1985. In 1985, therapy could not have been envisioned by most providers as something that occurs via computer. In 1985, few people owned home computers, and the ones that existed were nothing like we have today. There were no webcams, email accounts, or even an internet.

Certainly, the last vignette with Jackie could occur with a provider who provides face-to-face therapy only and snoops on social media trying to glean information regarding clients. Thus, even for therapists who do not provide online services, the power of the medium cannot be ignored as a potential source of regulatory and ethical issues, and many therapists will at least use email with a client.

Distance can create a real concern for safety and ethical practice in online therapy. One of the more complex issues surrounds the differences in state laws. Hertlein, Blumer, and Mihaloliakos (2013) cited the work of Derrig-Palumbo and Eversole (2011), who brought up an interesting dilemma. For example, duty-to-warn laws may differ substantially from the state where the therapist practices and the state in which the patient lives. Does the therapist follow the laws of his/her home state or that of the client? Hertlein, Blumer, and Mihaloliakos noted that the management of crisis, concerns for privacy, laws and regulations, training and education, and the quality of the therapeutic alliance remain the biggest ethical concerns for marriage and family therapists.

Crisis management was the greatest concern, with the therapist being concerned about not knowing the location of a client who was suicidal to obtain emergency services. Therapists were also concerned about the security of the internet in general, how emails and chat transcripts might be hacked, and noted that they were unsure as to how long to keep these items. These therapists also were worried that the person on the phone or the computer may not be the person the therapist believed they were dealing with. For example, what if someone’s significant other somehow got into the correspondence between the patient and therapist and wrote emails to the therapist in hopes of gaining confidential information regarding the patient’s issues. Several therapists developed special passwords and other security procedures to ensure this type of situation did not occur. Rummell and Joyce (2010) also expressed concerns that a counselor has no way to verify if the patient is actually a consenting adult. There is a possibility, for example, that an adolescent could be the patient and the counselor would be violating several laws by treating a minor without parental consent.

Another potential risk that emerges in this form of therapy is, due to issues with email servers and programs and software, if a client inadvertently does not receive the therapist’s communication and then does not respond, the therapist may assume the client has dropped out of services and discharge them inappropriately. In addition, clients may have unrealistic expectations of response times and become upset when a therapist does not answer within a few quickly (Reamer, 2013).

Boundaries are another issue that vary from online therapy to face-to-face therapy. Fantus and Mishna (2013) noted that due to the nontraditional atmosphere of online therapy, face-to-face boundaries of office hours no longer exist. As emails can be answered at any time, some patients may get upset if the provider does not respond right away, not realizing that even though an email can be sent late at night, it does not mean the therapist is working at that time. Boundaries and response times should be covered in the initial discussion between client and therapist. In addition, providers need to be aware that their own information is more accessible than ever before, and patients may become privy to details about the provider’s personal life through social media. Not only should providers ensure their accounts are private, but they also need to accept that patients will discover information about them that they may not be comfortable with patient’s knowing. The authors note that, “It is argued that practitioners cannot block certain aspects of their lives from patients, and they must learn to adapt to the new world that cyberspace has created” (Gabbard, Kassaw, and Perez-Garcia, 2011).

The National Board of Certified Counselors (NBCC) has spent many years examining the role of internet therapy in the practice of counseling. The NBCC prefers the term “distance professional services” rather than online therapy, as they recognize that other modes of communication, such as phone calls, play in role in these types of therapeutic relationships.

The organization has a detailed list of ethical considerations and some of the highlights summarized are:

1. Maintaining strict control over computer security and the appropriate backup to ensure that records are not lost in the event that a computer system fails.
2. Educating patients fully and clearly regarding the licensing and credentials of the counselor.
3. Explicit, written information explaining the process of distance professional services and the appropriateness of the interventions for the patient’s presenting issues.
4. Proper screening of clients for the appropriateness for distance professional services.
5. Taking extra caution to ensure that electronic information regarding a client is not accidentally sent to someone else.
6. Counselors must adhere to regulations in their home state, as well as the state in which the client lives and note this compliance in the record as appropriate.
7. Counselors must provide clients with detailed instructions on how to obtain emergency treatment in their community if it is needed.
8. Counselors shall create codes or passwords to ensure the client is really the one involved in distance professional services and have a written procedure as to how this will occur.
9. Counselors will provide information to clients on where to obtain internet service for free.
10. Copies of emails and other materials shall be kept and maintained for at least 5 years, unless otherwise indicated by state laws that the records should be kept longer.
11. Counselors shall ensure their personal social media accounts are carefully distinguished from their professional accounts and counselors should avoid interacting with patients in a personal manner on social media.
12. Counselors will respect the privacy of their patients on social media and will not view personal information on websites such as Facebook or Twitter.

The American Counseling Association (ACA) addresses similar issues in their code of ethics. In addition, they specify in section H.4.f. Communication Differences in Electronic Media, “Counselors consider the differences between face-to-face and electronic communication (nonverbal and verbal cues) and how these may affect the counseling process. Counselors educate clients on how to prevent and address potential misunderstandings arising from the lack of visual cues and voice intonations when communicating electronically” (American Counseling Association, 2014).

The ACA also requires that counselors who maintain websites provide accessibility for those with disabilities and language translation when possible.
The American Association of Marriage and Family Therapists (AAMFT) code of ethics covers several broad areas, but is not as detailed as those of the ACA or NBCC. The general areas covered under the Standard VI: Technology Assisted Professional Services include:

“Therapy, supervision, and other professional services engaged in by marriage and family therapists take place over an increasing number of technological platforms. There are great benefits and responsibilities inherent in both the traditional therapeutic and supervision contexts, as well as in the utilization of technologically assisted professional services. This standard addresses basic ethical requirements of offering therapy, supervision, and related professional services using electronic means.

### 6.1 Technology assisted services

Prior to commencing therapy or supervision services through electronic means (including but not limited to phone and internet), marriage and family therapists ensure they are compliant with all relevant laws for the delivery of such services. Additionally, marriage and family therapists must: (a) determine that technology assisted services or supervision are appropriate for clients or supervisees, considering professional, intellectual, emotional, and physical needs; (b) inform clients or supervisees of the potential risks and benefits associated with technology assisted services; (c) ensure the security of their communication medium; and (d) only commence electronic therapy or supervision after appropriate education, training, or supervised experience using the relevant technology.

### 6.2 Consent to treat or supervise

Clients and supervisees, whether contracting for services as individuals, dyads, families, or groups, must be made aware of the risks and responsibilities associated with technology assisted services. Therapists are to advise clients and supervisees in writing of these risks, and of both the therapist’s and clients’/supervisees’ responsibilities for minimizing such risks.

### 6.3 Confidentiality and professional responsibilities

It is the therapist’s or supervisor’s responsibility to choose technological platforms that adhere to standards of best practices related to confidentiality and quality of services, and that meet applicable laws. Clients and supervisees are to be made aware in writing of the limitations and protections offered by the therapist’s or supervisor’s technology.

### 6.4 Technology and documentation

Therapists and supervisors are to ensure all documentation containing identifying or otherwise sensitive information that is electronically stored and/or transferred is done using technology that adheres to standards of best practices related to confidentiality and quality of services, and that meet applicable laws. Clients and supervisees are to be made aware in writing of the limitations and protections offered by the therapist’s or supervisor’s technology.

### 6.5 Location of services and practice

Therapists and supervisors follow all applicable laws regarding location of practice and services and do not use technology assisted means for practicing outside of their allowed jurisdictions.

### 6.6 Training and use of current technology

Marriage and family therapists ensure they are well trained and competent in the use of all chosen technology assisted professional services. Careful choices of audio, video, and other options are made to optimize quality and security of services, and to adhere to standards of best practices for technology assisted services. Furthermore, such choices of technology are to be suitably advanced and current so as to best serve the professional needs of clients and supervisees’ responsibilities for minimizing such risks.

Sections of the Code of Ethics that address confidentiality also cover distance services:

- Social workers should protect the confidentiality of clients’ written and electronic records and other sensitive information. Social workers should take reasonable steps to ensure that clients’ records are stored in a secure location and that clients’ records are not available to others who are not authorized to have access.
- Social workers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible (NASW, 2008).

The American Psychological Association (APA) offers advice for those seeking online therapy and their tips for consumers offer important details for providers to consider as well. In general, they note that consumers should be aware of the following items:

1. Online therapy is not right for everyone in all situations.
2. Is the therapist or counselor actually licensed? Consumers are advised to investigate who the provider of the services actually is, and verify he/she is a qualified, licensed provider.
3. Check with your state licensing board to verify the provider is licensed where you live. Licensing is not across all 50 states.
4. For reasons of privacy and security, please make sure the website is HIPAA-compliant, there is a process in place to ensure you can verify the identity of the therapist, and there is a way to ensure the therapist can also verify your identity.
5. Check to make sure your insurance company will cover online therapy and, if not, you will need to pay for services yourself.

Ethics and laws by state

States vary in regulation and oversight of online therapy. The most comprehensive review to date (Haberstroh, Barney, Foster and Duffey, 2014) noted that no state boards prohibited online therapy for counselors or psychologists, but only half specifically allowed for the practice in regulations and laws. However, 32% of states offered no guidance on the practice of online therapy. Many states referred to the national organization’s code of ethics for guidance.

This lack of specific guidance at the state level is an issue that needs to be addressed as the practice of online therapy continues to grow. Some states, such as Oklahoma, have developed specific laws, noting that social work services provided to anyone living in Oklahoma, regardless of where the social worker is located or how the service is delivered, are to be regulated by the state of Oklahoma.

SUGGESTIONS FOR PRACTICE

Sucala et al. (2013) suggested that having more than one mode of communication such as email, video chat, phone, etc. enabled a stronger therapeutic alliance to form. Fewer forms of communication available seemed to impact the therapeutic alliance negatively. In addition, more means of communication led to an easier ability to assess patients for suicidality.

In overcoming some of the deficits of not being face-to-face, Barak, Klein, and Proudfoot (2009) suggested, “therapists should take special action, especially employing words and expressions that might not be used in face-to-face contact, to communicate empathy, care, concern, and warmth toward their clients. Similarly, clients have to be aware that their feelings are not as obvious and vivid as they would be in a face-to-face relationship. Therefore, clients have to communicate their emotions in more explicit ways, sometimes even describing what could easily have been visible (e.g., crying, sweating, laughing) (p.10).

Clinicians who have provided online therapy successfully have important insight into what types of techniques work in these settings. One therapist noted:

“It would be important that they [online counselors] could do a lot of reflecting and summarizing and that they can pull together the session that way, because I think it could get real fragmented if you don’t. And, so I think it’s really important to use that technique. I also think that, because it seems like you are a little limited in terms of what you can cover, it should be a little more action oriented, and even if it is insight oriented, taking action to increase insight. It’s funny because so many of the techniques you learn in school kind of need to be done in a face-to-face session. I think you can adapt a lot of them. It becomes almost a different technique, I think, here on Web counseling. I think it’s really neat because I think it adds a different component to it. You can’t really express empathy or understanding nonverbally, and so I think it really helps me make sure I’m reflecting or summarizing rather than going straight to a question. So I kind of like that, and it kind of strengthens those skills. It seems like there’s some real specific techniques that can be effective for Web counseling, and it’s like we don’t know what those are yet. We’re defining those. I think some of those would be more homework stuff because it feels a little bit like you can’t cover as much ground in the same amount of time. So if you could have the client do something that they typed out, whether it’s a journal entry. . . something to process that week, or whatever. And then if the counselor reads it right at the beginning of the session, then I think that might be helpful. I guess that I was thinking about some theories that already have a lot of that in place. Like cognitive [theory] seems to have a lot of worksheets and charts and different stuff like that. So it seems like that would be real conducive to Web counseling, but I think that you could also adapt whatever theory it is that you go by and just whether it’s an assignment to explore this particular issue this week and write a little entry about it” (p.466, Haberstroh, et al., 2008).

There are a few ideas regarding a set of best practices that are being developed, but it is not yet fully formulated. Some suggestions from NASW are: 1) requiring pre-session information gathering from clients, 2) license practitioners in all states to allow for service delivery across state lines, 3) require that clients give therapists proof of their physical location and a list of emergency contacts, 4) provide clients with several means of electronic support, 5) make policies regarding payment, privacy, treatment outcomes, and such in plain language on the social worker’s website (NASW, 2007).

FUTURE DIRECTIONS

There is a definite need to have education and training in the field of online therapy. One recent survey showed that around 80% of marriage and family therapists reported that online or cyber issues had not been presented in their graduate training (Goldberg et al. 2008). Only 1.2% of all presentations at marriage and family therapy conferences were on cyber-related issues (Blumer et al. 2014a).

Family therapists who responded to a survey regarding their interest in learning more about online therapy identified five key areas where they felt they were least knowledgeable and most in need of education. The areas were:
1. Ethical issues and legal advice.
2. Privacy and confidentiality.
3. General training in how to provide online clinical services.
4. Information on safety and security.
5. Evidence-based practices information for online services (Blumer, Hertlein, and VandenBosch, 2015).

The field of online therapy is likely to continue to grow as the internet and other forms of electronic communication become part of our daily lives. The younger generation of people who have grown up with Facebook, email, and texting as a way of life are particularly likely to have an interest in online therapy. It is not likely to ever replace face-to-face therapy as the leading format of service delivery, but it is a viable and growing option that cannot be ignored. The need is vast for more research concerning efficacy, particularly in comparing models of therapy for different needs. Regardless, any therapist or counselor seeking to provide these services should seek appropriate training under supervision of a knowledgeable practitioner. Furthermore, it is critical to seek ethical and legal guidance from governing bodies and professional associations.

Client safety and confidentiality remain two major issues that need to be addressed by any provider of online therapy. If a therapist is planning to develop a website, this should only be undertaken with IT professionals who are experienced in cyber security and HIPAA compliance for websites. A therapist should stay abreast of the
constantly changing regulatory and ethical issues with online therapy. Certainly, the advantages are there: Flexible schedules, low overhead, and the ability to reach more clients in a larger geographical area. However, not all practitioners will ever feel comfortable with this approach and the lack of face-to-face interaction with a patient, just as not all potential clients are satisfied with not seeing a therapist and instead working through electronic means. Nonetheless, the potential of online therapy cannot be ignored and providers should be aware of the growing trend in this area.

References
7. Responsibilities with childcare and elder care are part of:
   a. Patient outcomes.
   b. A reason to seek online therapy.
   c. Therapist burnout.
   d. Anxiety.

8. Frustration with technology:
   a. Was not a problem for most clients.
   b. Was a pervasive issue in online therapy.
   c. Resulted in negative feelings about the online process.
   d. Only happened with older adults.

9. In Rozental’s study, negative feelings about therapy occurred in:
   a. About 9% of clients.
   b. Young adults only.
   c. Only male clients.
   d. Only those persons with PTSD.

10. Not being able to see a therapist in person, for some patients, resulted in:
    a. A question of the therapist’s commitment.
    b. Wondering what the therapist was doing while the patient was waiting for a response.
    c. Increased negative feelings about the process.
    d. All of the above.

11. Increased schedule flexibility and _____________ were factors in therapists’ satisfaction with online therapy.
    a. Less emotional drain.
    b. Increased fee schedules.
    d. Improved patient outcomes.

12. Fantus and Mishna noted that for this type of patient, online therapy could be especially helpful.
    a. Nonverbal.
    b. Bipolar.
    c. Anxiety disorders.
    d. Females.

13. A frequently cited area of dissatisfaction for therapists in online therapy is:
    a. The lack of therapeutic alliance.
    b. Increased work load.
    c. Increased burnout.
    d. Increased paperwork.

14. Crisis management and internet security are:
    a. Two of the biggest concerns for patients in online therapy.
    b. Two of the biggest concerns for therapists in online therapy.
    c. Not a factor in online therapy.
    d. Two of the biggest variables in treatment adherence.

15. Proper screening of clients and internet security are:
    a. Two areas of ethical concern noted by the NBCC.
    b. Not a major factor in online therapy.
    c. Just as important in face-to-face as online therapy.
    d. Important for treatment outcomes.

16. AAMFT recommends that _______________ are given to clients in writing.
    a. Limitations and protections offered by technology.
    b. Fee schedules.
    c. Duty to warn information.
    d. Therapist’s licenses.

17. __________ passed legislation that services provided electronically to anyone who lives in this state are subject to regulation by this state.
    a. Texas.
    b. New York.
    c. Florida.
    d. Oklahoma.

18. Describing verbally what is visible (crying, laughing) is recommended to clients in online therapy:
    a. Only in crisis.
    b. Never.
    c. To assist the therapist in understanding what he/she cannot see.
    d. If the client wants to.

19. Licensing across all states is recommended by:
    a. Congress.
    b. NAMI.
    c. NASW.
    d. NBCC.

20. 1.2% of training at marriage and family therapy conferences was on:
    a. Cyber-related issues.
    b. Domestic violence.
    c. Ethics.
    d. Confidentiality.