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Ethical Issues in the Provision of Online Mental Health Services (E-Therapy)

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Abstract

A number of ethical and legal implications of on-line therapy [e-Therapy] are examined. e-Therapy is defined and its strengths and weaknesses listed. Specific ethical issues addressed include boundaries of competence, basis in science, avoidance of harm, confidentiality, avoidance of false or deceptive statements, media presentations, testimonials, solicitation of clients, fees and informed consent. Legal issues are discussed including the issue of interstate eTherapy. As a necessary measure to protect the public, the profession and the practitioner, it is recommended that federal legislation be enacted, informed by the American Psychological Association based upon APA's review of other disciplines' (e.g., medicine) e-Practice standards.

Ethical and Legal Implications in the Provision of Online Mental Health Services [e-Therapy]

The rapid emergence of information technology over the past decade has led it to become an integral component of day-to-day living (Barak, 1999; Newman, 2004; Tate & Zabinski, 2004). The relatively user friendly and low cost computer has contributed to more than 600 million people worldwide using the Internet, nearly one-third of them living in the United States and Canada (Nua Internet Surveys, 2002). The advancement of information technology has profoundly influenced how people live their lives (Barnett & Sheetz, 2003). Computer mediated communication using tools such as e-mail, open virtual discussion groups, forums, chat rooms, telephony, and video conferencing has become a routine part of everyday operations for business, education, convenience and pleasure (Hopps, Pepin, & Boisvert, 2003). The use of rapidly developing communication technologies has created a successful evolution of multimedia-aided commerce including telemedicine, distance education, news gathering, advertising and various forms of recreation (Garton, Haythornwaite, & Wellman, 1997; Jones, 1995; Morris & Ogan, 1996).

Mental health care providers such as those who practice psychology, psychiatry, counseling, and social work had modestly joined this trend toward the end of the 1980s (Barak, 1999; Zgodzinski, 1996). The Internet as a medium for the delivery of mental health treatment and information today is becoming increasingly wide spread (Alleman, 2002; Benderly, 2005; Newman, 2004; Rotondi, Haas, Anderson, Newhill, Spring, Ganguli, Gardner & Rosenstock, 2005; Tate & Zabinski, 2004). As these technologies developed rapidly and consistently, mental health care providers began hanging out their cyber-shingles. The pace of legal and regulatory bodies in establishing guidelines for online mental health services has lagged behind

(Barak, 1999; Frankel, 2000; Maheu, 2001; Rosik & Brown, 2001). This paper will address several consequent ethical and legal issues.

There are many types of psychological services provided on the Internet. Information resources are available that include accumulated information and knowledge banks covering a variety of psychological phenomena, issues, symptoms, disorders and concepts (American Psychological Association, 2006). Numerous Internet sites offer self-help topics and support groups while other websites include exercises, reports and information regarding psychological research, psychological tests and questionnaires (e.g., Barak, 1999; Seligman, Steen, Park, & Peterson, 2005). This article focuses on defining two computer mediated psychological services that are becoming increasingly visible online, and exploration of several legal and ethical implications in the provision of those services.

E-THERAPY

The term e-Therapy remains somewhat ambiguously defined and justifiably debated with regard to the appropriate use of the word "therapy." There are those who suggest using terms like "web counseling", "online counseling", "computer-mediated psychotherapy", "education information", "advice", and so on, as more fitting descriptors of the mental health services being provided online (Alleman, 2002; Grohol, 1999; Maheu & Gordon, 2000; Metanoia, 2001). The caution behind the debate is understandable, given that circumscribed therapeutic claims and careful use of terminology may prevent harmful errors in practice and ward off liability or professional criticism (Alleman, 2002). However, this may create a false sense of security because simply advising caution neglects the roles of our legal system, our ethical standards and the role empiricism plays in the provision of mental health care. In any event, the Internet is creating a new environment to be navigated, as did the advent of the motor vehicle, phone, and

airplane. In those instances the old rules did not always address the new technologies, but they served as a solid foundation on which to build regulatory and legal bodies' development of safe practices. We support the term e-Therapy to define a therapeutic intervention modality bound by the challenges of legal, ethical, and empirical demands. Later in this paper we explore some of those challenges and offer potential solutions. For now, e-Therapy is defined as a computer mediated, text-based relationship between an independently licensed mental health provider and a client who are in separate or remote locations, targeting behavioral or mental health improvement (Alleman, 2002; Childress, 2000).

E-MAIL THERAPY

One of the most prevalent, but controversial, forms of e-Therapy is asynchronous communication, or e-Mail therapy (Barak, 1999; Shapiro & Schulman, 1996). Asynchronous communication can take many forms including list-servs, one-time question-and-answer services, as well as public and private forums. However, we will focus only on e-Mail therapy as characterized by an ongoing exchange of messages between a licensed therapist and client that do not take place simultaneously (Tate & Zabinsky, 2004).

There are advantages to e-mail communications, one of which is that clients may communicate at their own convenience whether they are at home, work or on vacation. E-mail is almost always available to the client to request support, or pose a question or concern at any time. Using e-mail as a means of communication also allows the parties involved to carefully consider and edit their thoughts, which may be an advantage over real-time text or in-person communication (Childress, 2000; Tate & Zabinsky, 2004).

However, there are some disadvantages to e-mail communications specific to a

therapeutic relationship. While value can be found in being able to take one's time and generate a carefully posed thought, there is therapeutic benefit in spontaneous free responding to verbal stimuli. Moreover, though the client has the convenience of time in posing questions, lag time between responses could be significantly distressing. E-mail communication also involves the loss of non-verbal social cues that provide valuable contextual information in conversation and which influence the interpretation of communication. Thus, incidents of miscommunication may be more likely with interactive e-mail conversations. As a result, a therapist must accurately communicate these pros and cons on his or her website in ways that inform potential clients prior to undertaking therapy.

The words people use and the way they put them together in print can maximize the effectiveness of the intent behind the message (Alleman, 2002). The least sophisticated computer user is likely to understand that font size helps enhance expression. For example, words that are **ALL CAPS BOLDED** can express excitement or another intense emotion. Apology can be emphasized with font size - I am sorry. Colors and font style can have impact on meaning – as in an expression of *Love*. In addition to font size, style, color, and intonation, most e-mail packages, forums, and chat programs offer still and animated icons as a means of augmenting expression: (Insert icons here)

I am really happy! ✉ I am so angry.

Nevertheless, room for miscommunication still exists. Hasty e-mail replies or postings and poor writing skills are just a few of the problems for which an e-Therapist must account so as to optimally address client problems in an ethical, professional, and successful manner.

INTER-RELAY-CHAT THERAPY

Computer mediated communication is viewed as a dynamic social institution, a social

gathering place and a place to form virtual social networks (Sproull & Feraj, 1997; Wellman, 1997). While e-mail remains a popular (as defined by frequency of use) tool within the Internet therapeutic communities, technological advances are rapidly improving the methods of text-based communications. Computer mediated technology has now added synchronous (real time) text-based conversations. This technological upgrade is adequately addressing some of the disadvantages of asynchronous communications (e.g., immediate responses and opportunities to minimize or quickly correct misunderstandings are made possible). As with asynchronous communications, there are several ways that synchronous communications are available through the Internet. These include inter-relay-chat (IRC), telephony, and videoconferencing. However, we will focus only on IRC therapy as characterized by simultaneous, ongoing text-based computer mediated conversation between a licensed therapist and client (Hopps, et al 2003).

There are advantages and disadvantages to IRC within a therapeutic context. On one hand, text-based communication is particularly attractive for people who feel isolated, excluded or lonely (Hopps, et al, 2003). Studies have indicated that the most common reason lonely people are attracted to online conversation is that electronic settings provide opportunities for social relationships and support which they feel are unavailable to them elsewhere (Morahan-Martin & Schumacher, 1999; Sproull & Kiesler, 1991). However appealing this may be, it is important to assess whether supplementing basic and hierarchical needs via a virtual surrogate and/or quasi-illusory community is an acceptable alternative to learning social skills or assertiveness training. Some suggest the element of anonymity, the lack of regulating feedback (e.g., eye contact, tone of voice, and other non-verbal expressions) and diminished impact of status and prestige cues may allow people with disabilities to feel more confident within the relative safety of a computer screen (Barak, 1999; Benderly, 2005; Hopps et al, 2003; Skarderud,

2003; Winzelberg, Luce, & Abscal, 2004). However, not only does the lack of non-verbal cues increase the probability of miscommunication (as with e-mail), one may ask whether this is an adequate replacement for building repertoires of adaptive behaviors and healthy self-esteem. This is a professional/ethical issue with no obvious answer, an issue which may best be determined on an individual basis. Another disadvantage of IRC is the absence of human contact. In face-to-face therapies, a client in duress may benefit from the offer of a tissue, a touch on the hand, or even an empathic tear. However with IRC these nuances are not easily obtained.

IRC & E-MAIL THERAPY – DOES IT WORK?

The body of knowledge regarding the efficacy of therapeutic interventions utilizing e-mail and IRC communications is still in its infancy. However, there is noteworthy progress being made. A comparison study of Internet IRC therapy with face-to-face delivery of treatment for body image and eating disordered complaints found that post-intervention, and at two months follow-up, both groups had shown significant improvement on all observed outcome variables. The authors specifically recognized that the Internet mode of delivery has potential to overcome geographical distance (Gollings & Paxton, 2006).) It has been found that goal-oriented cognitive-behavioral group therapy via IRC reduced feelings of loneliness among chronically lonely people with physical disabilities (Hopps et al, 2003). However, in both studies a face-to-face initial assessment was conducted to tailor treatment interventions to clients' desired goals. As yet there are no significant studies demonstrating efficacy of IRC therapy utilizing solely computer-mediated psychological interventions.

Asynchronous communication has been studied in more detail, probably because of its stronger historical presence, compared to IRC. In a six-group, random-assignment, placebo-

controlled Internet study, it was found that in the absence of face-to-face interaction, written exercises with behavioral components increased happiness and decreased depressive symptoms. The results were stable over time. In addition to receiving direction from online text-based communication, participants received reminder e-mails that repeated the instructions for their assigned exercises. The authors' rationale for using the Internet was its convenience. They report 300 new registrants every day to their web site www.authentichappiness.org (Seligman, Steen, Park & Peterson, 2005). Other cognitive and behavioral interventions using similar exercises (e.g., written protocols with behavioral components) for the treatment of problems such as obesity, post-traumatic stress disorder and grief have been demonstrated to be effective via the delivery of asynchronous communications (Lange, Van de Ven & Shrieken, 2003; Tate, Jackvony & Wing, 2003; Tate, Wing & Winett, 2001; White, Martin, Newton, Walden, York-Crowe, Gordon, Ryan & Williamson, 2003).

LEGAL AND ETHICAL CONCERNS

The Internet is an ever expanding frontier exhibiting a powerful human gravitational pull. Online commerce and text-based communication is evidently here to stay, and true to its name, is a super highway of information spanning the web, worldwide. Supply and demand are the economic fuel behind this commerce and are factors that also tend to drive e-Therapy. A recent Google search for e-Therapy yielded 32,300 hits, evidence of the ubiquitous interest in the provision of online mental health services. From the demand perspective, there are utilities available as part of most web hosting plans that allow webmasters to assess the popularity of certain words in Google searches – essentially tools which aid businesses to identify the services individuals are looking for, and the frequency with which they are searching. The impetus behind such a tool is to enhance the webmaster's capability of maximizing specific URL

exposure to the typical searcher. An analysis for June, 2006 indicates that the word *depression* was searched in Google 354,899 times, while the phrase *depression treatment* was searched in Google 244,021 times. Certainly many such searches were by individuals other than those seeking therapy (e.g., students who were writing papers), but it is unreasonable to assume that substantial numbers are not seeking therapy. For comparison, *chocolate* was searched 172,750 times, while the word *coupon* was searched 285,574 times.

Given the widespread nature of the unique and growing relationship between practitioner and client via the Internet, it is reasonable to anticipate the possibility of misuse and abuse (e.g., privacy issues, boundaries of competence, avoidance of harm such as failure to adequately respond to crises, etc.). Governing and regulatory bodies of mental health professions are charged with establishing standards and principles of practice as a means of facilitating prevention and resolution of the inevitable problems that will arise within this, or any, new treatment environment.

ETHICS

There are several major mental health organizations that have put forth ethical guidelines for e-Therapy. The American Counseling Association [ACA] (1999); American Mental Health Counselors Association [AMHCA] (2000); International Society for Mental Health Online, [ISMHO] (2000); and the National Board for Certified Counselors [NBCC] (2001) all have issued ethical guidelines for online treatment. Earlier the Ethics Committee of the American Psychological Association issued a statement regarding services by telephone, teleconferencing, and Internet (Ethics Committee, 1997). The statement contained no new e-Therapy-specific standards but pointed out that although there were no ethics rules prohibiting such services, psychologists are to follow the applicable ethical standards. What follows are recommendations

regarding the APA's ethical standards that could require interpretation and/or additional steps when applied to e-Therapy.

The first recommendation, one that will be referred to throughout the remainder of the ethics section, is that the online therapeutic provider should develop a comprehensive informed consent procedure, including the development of a consent "Forms Packet." They include but are not limited to, informed consent, cultural values and privacy policy.

STANDARD 2.01E BOUNDARIES OF COMPETENCE

> In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.

Written verbal competence on the part of the clinician is particularly relevant in the delivery of behavioral e-health services (Maheu, 2001). Skill in face-to-face verbal communication does not necessarily translate into skill in written communication, especially interactive text-based communication that involves a series of interpersonal interpretations within each exchange (Childress, 2000). It may be of benefit if the online clinician is required to demonstrate through either formal methods (CEUs; course work) or informal methods (published written work; solicitation of collegial review, etc.) his or her abilities to communicate emotion and contextual intent solely through the written word.

Cultural competency is a relevant issue as well. The therapist's familiarity with colloquial expressions, idioms, and local variations of word usage is important, given the many potential locations of their identified clients. Knowledge of the individual's age, race, and religious beliefs often allows for the sort of cultural awareness that the online clinician should be

able to demonstrate. This could be addressed in the assessment component as well as included in the "Forms Packet" on a form titled Cultural Values.

Competence in the areas of assessment, diagnosis and treatment is also of significant concern (Rosik & Brown, 2001; Shapiro & Schulman, 1996). Given that face-to-face assessment works against the convenience nature of online therapy, the online therapist should be sensitive to nuances that are absent when it comes to online assessment. For example, there are distinctions of affect, hygiene, and other aspects of appearance that provide valuable information in assessing severity of pathology during a face-to-face mental status examination. However, these elements are lost with online assessment. One could opt to not provide online services without an initial face-to-face meeting, or to include video conferencing at the onset of services. At a minimum and with heightened awareness of chat-only limitations, a therapist should assure that an extensive initial IRC assessment is conducted. As with all assessment the goal is to determine the client's mental health treatment needs and whether, as with face-to-face treatment, the e-Therapy modality is appropriate. If not, the therapist must consider offering available alternatives and make referrals as needed.

STANDARD 2.04 BASIS FOR SCIENTIFIC AND PROFESSIONAL JUDGMENT

Psychologists' work is based upon established scientific and professional knowledge of the discipline.

The provision of online therapeutic interventions has a promising future, especially for technologies of a cognitive and behavioral nature (Gollings & Paxton, 2006; Hopps et al, 2003; Lange, Van de Ven & Shreiken, 2003; Seligman et al, 2005; Tate, Jackvony & Wing, 2003; Tate, Wing & Winett, 2001; White et al, 2004). The online clinician should be sensitive to, and demonstrate knowledge of several e-issues. First, the e-Therapist must possess knowledge of

proven effective online treatment strategies, their scopes and limitations. This should be clearly spelled out and included in the "forms Packet," likely under a heading of Professional Responsibility.

Second, a clinician not only should be knowledgeable in the study and practice of psychology, he or she should also possess proficiency in the uses of computer technology. He or she should have an understanding of the computer and its relationship to the Internet. An online therapist should be proficient in the area of e-mail programs (e.g., send, receive, attachments, cc, bcc, dating of messages, flagging prioritization, HTML links, etc.) and chat room environments (e.g., the role of avatars, emoticons, backgrounds, displays, group dynamics, potential for misunderstandings, etc.). A clinician should also have basic understanding of web development and hosting plans, in part to better utilize resources that enhance confidentiality. Such proficiency by an online therapist could well be demonstrated by a review of his or her experience, training, etc. Should state licensing boards develop such standards, they could devise and administer an exam to insure that any licensed psychologist who wishes to engage in e-Therapy possesses these proficiencies.

STANDARD 3.04 AVOIDING HARM

Psychologists take reasonable steps to avoid harming their clients.

To "do no harm" is the first and most oft-quoted principle when it comes to the provision of health care (Shapiro & Schulman, 1996). As with all health care interventions, the evaluation of the potential harms must be balanced against the potential benefits. The simple presence of risk does not necessarily preclude the use of an intervention if it is sufficiently justified by the potential benefits (Childress, 2000). However, expectations are that the therapist maintains a full understanding of the nature of the risks and informs clients of those risks. The Forms Packet's

"Informed Consent" document should include statements that are consistent with the research regarding the risks, benefits, and scope of research with regard to efficacy of such interventions. It would be prudent for this and other such sections of the website to be reviewed by at least one (and preferably two or three) psychologists who are experienced in clinical practice and known to have special interest in ethical issues, as a means to optimize accuracy of information dissemination. A qualifying statement could be included on the web site's home page to read, "The risks/benefits of techniques used here have been reviewed by a panel of experts in the field. For more information contact _____."

STANDARD 4.01 MAINTAINING CONFIDENTIALITY

> Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship.

Today's technology provides the web site developer the abilities to incorporate Secure Sockets Layers (SSL) and encryption technologies for IRC and e-mail programs into his or her web site. Such programs are designed to maximize confidentiality. Encryption provides security for information while in transit or in storage by converting plain text to cipher text, and is recommended for e-mail therapies. Decryption refers to the reversal of this process. The SSL is suggested for the use of payment transactions, forums or virtual reality therapeutic environments, or any instance where conversation is carried on or stored. The SSL was first developed by Netscape Communications Corporation to provide security and privacy over the Internet. "The protocol supports server and client authentication and is application independent, allowing protocols like HTTP, FTP and Telnet to be layered on top of it transparently. The SSL protocol

is able to negotiate encryption keys as well as authenticate the server before data are exchanged by the higher-level application. It maintains the security and integrity of the transmission channel by using encryption, authentication and message authentication codes" (Report of the Technical Working Group on Telemedicine Standardization, 2003).

Together, SSL and encryption services work to insure security for the therapist and the client in the electronic transfer of patient health information. HIPPA (Health Insurance Portability and Accountability Act of 1996, 1998) regulations are also helpful in guiding the online practitioner with respect to maximizing electronic security. The online therapist should be knowledgeable of the applicable regulations and demonstrate that knowledge to the potential client. This can be noted in the Forms Packet – Privacy Practices. For example, HIPPA requires a password-protected computer as well as a timed "log out" on any computer used in mental health treatment facilities. This serves as a measure to prevent any unauthorized person from accessing client information. Automatic virus filtering, spam filtering and spyware removal are also required (HIPPA Compliance Requirements, 1996). It is essential for the online therapist to educate his or her client as to measures that could be taken to increase security at the client's end of the computer. Examples include installing firewalls, using encrypted e-mail software, being aware of who in the household may have access to the computer and trying to limit or restrict access. However, ultimately, the potential for a breech of confidentiality remains, just as it remains for material kept in a manila folder in one's locked office. The therapist must remain up-to-date with current technological standards with regard to encryption and the like. The website homepage should have a link to a page which explains the nature of the site's SSL and encryption technology, HIPPA regulation, and the limits to confidentiality as are typically addressed in face-to-face therapy.

STANDARD 4.02 (A,B,C) DISCUSSING THE LIMITS OF CONFIDENTIALITY

(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities.

It is important to note that limits of confidentiality vary state to state. The online therapist should be aware of each state for which he/she provides services and their laws governing this principle. The example below is reflective of West Virginia guidelines and suggests a manner byywhich the information may be communicated to the potential client:

> Limits of Confidentiality: Information obtained during the provision of psychological services remains confidential in accordance with the American Psychological Association (APA) ethics and state law. However, APA ethics and West Virginia state law permit exception to confidentiality in the following circumstances: When a patient is believed to be a danger to himself or herself; when a patient is believed to be a danger to someone else; or when a minor is believed to be experiencing abuse or neglect, a report must be made to the local Department of Family and Children's Services.

Taking into consideration the absence of federal or international standards for child abuse or neglect reporting, the most sensible approach for the online therapist is to be knowledgeable regarding the reporting laws and child protective services procedures in the states and/or countries where the practitioner and client reside (Riemersma & Leslie, 1999; Rosik et al, 2001). This information is readily available on most states' websites, or by calling any state's Department of Health & Human Resources and asking for reporting requirements.

(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

Informed consent is to be collected, signed, and verified prior to initiation of services. Some online providers do not offer services to individuals under the age of eighteen due to the added complexities of providing mental health services to under-aged children. Nevertheless, validation of identity is an essential component of informed consent. Given the anonymity of the web, validating identities can be difficult. One suggestion to aid in verification of client identity is to require a photo ID and/or a signature declaration regarding personal demographics. Other suggestions include a more subjective approach such as looking for trends of dishonesty. This can be accomplished by cross-checking Internet Protocol (IP) addresses with the stated address given at assessment. If these two do not match then one could suspect dishonesty on behalf of the client and therefore trigger a plan of action (i.e. require additional proof of identity).

It is also important to make arrangements in the client's local area so that one may address emergency and crisis situations that arise (Barnett & Sheetz, 2003; Childress, 2000). For example, in addition to being aware of requirements where the client resides, knowing contact emergency numbers is also an important measure to insure that if future problems arise they can be adequately addressed. This information, collected at assessment, should include numbers for a personal emergency contact, as well as the direct numbers to the local emergency fire and police departments, and location of the local hospital emergency room. Perhaps ironically, one might reconsider the convenience of online therapies, given that when provided in an ethical, legal, and prudent manner, much of the convenience may be lost.

(c) Psychologists who offer services, products, or information via electronic transmission

inform clients/patients of the risks to privacy and limits of confidentiality.

In addition to the above statements it is also important to inform the client of the measures being taken to ensure that the standard technologies are in place to protect their privacy. The same cautions as in face-to-face therapy should be provided (See Standard 4.01). Moreover, the online therapist should also provide advance notice as to when technologies will be down for repair and offer backup strategies for unexpected crashes or electrical outages. For example, the website should offer instruction (whom to call, phone numbers, etc.) in the event of a power outage in the client's local area, should the client have an emergency during a time the website is unavailable.

STANDARD 5.01 AVOIDANCE OF FALSE OR DECEPTIVE STATEMENTS

(a) Public statements include but are not limited to paid or unpaid advertising, product endorsements, grant applications, licensing applications, other credentialing applications, brochures, printed matter, directory listings, personal resumes or curricula vitae, or comments for use in media such as print or electronic transmission, statements in legal proceedings, lectures and public oral presentations, and published materials. Psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated.

(b) Psychologists do not make false, deceptive, or fraudulent statements concerning (1) their training, experience, or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical

basis for, or results or degree of success of, their services; (7) their fees; or (8) their publications or research findings.

(c) Psychologists claim degrees as credentials for their health services only if those degrees (1) were earned from a regionally accredited educational institution or (2) were the basis for psychology licensure by the state in which they practice.

To insure that the above standards are met, it would be wise for the website to be reviewed for accuracy and clarity by one or more psychologists familiar with the therapist, prior to placing the site on-line. This may be best done by means of hard copy of the content rather than by on-line review of a website that is under construction. As was the case with the first author, information about her website fell into the hands of those not targeted, at a time when the site was under construction. Hard copy development would most probably have prevented this. An alternative measure in website development, taking into consideration that editing of content, feature, and function requires publishing to the web, would include clear wording that the website is "under construction" as a prudent cautionary measure to prevent any misrepresentation of the information.

STANDARD 5.04 MEDIA PRESENTATIONS

When psychologists provide public advice or comment via print, Internet, or other electronic transmission, they take precautions to ensure that statements (1) are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice; (2) are otherwise consistent with this Ethics Code; and (3) do not indicate that a professional relationship has been established with the recipient.

Internet therapeutic forums are common supportive services offered online. The premise behind these forums is to provide a peer-to-peer supportive environment for those seeking individuals with common experiences. It is not uncommon for the administrator or moderator of these forums to be a therapist, although the activities in the forum should be noted as helpful information only, and in our opinion should not be termed "therapy." Moderators may offer question and answer sections, such as "ask the therapist," or offer support for participation in the forum and so on. Forum users should be required to complete an acknowledgement that they understand and accept these premises.

Given the likelihood that without structure certain misuse or abuse could occur in this particular arena, it is important for standards to be set and effectively communicated. In line with the ethical standards, some ground rules are suggested. First, forum topics should be issue specific, rather than general. Second, the forum administrator or moderator must make it clear that a forum is not a substitute for therapy. Third, the moderator should state the terms under which one may participate in the forum. Ordinarily these terms would include: That the established topic (e.g., smoking cessation; child conduct, etc.) be adhered to, that verbal style be respectful, and that uninvited solicitation of other services by participants or by outside vendors is prohibited. Similarly, the terms must state that those who fail to follow the rules will be barred from the forum by the administrator. It is here that standard 2.04 regarding implications of technical proficiency is also valuable. The administrator should be capable of blocking IP addresses and user names by navigating the forum administration panel (e.g., Ban Control, Permissions, Rank, Word Censors, Styles, Pruning, etc.).

STANDARD 5.05 TESTIMONIALS

Psychologists do not solicit testimonials from current therapy clients/patients or other

persons who because of their particular circumstances are vulnerable to undue influence.

Very likely it is unwise to use testimonials on a website, except under very specific conditions. Identities must be protected, testimonials must be spontaneous, and permission must be obtained in writing and kept on file by the web site owner.

STANDARD 5.06 IN-PERSON SOLICITATION

> Psychologists do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence. However, this prohibition does not preclude (1) attempting to implement appropriate collateral contacts for the purpose of benefiting an already engaged therapy client/patient or (2) providing disaster or community outreach services.

Whether e-communication is best thought of as "in-person" is a matter of some discussion. However, assuming that in some sense it is in-person, the web site owner and client would tend to be protected, assuming that no overture is ever initiated by the therapist. A rule of thumb is – no first contact by the therapist. For example, forum members who are not therapy clients (most members would not be clients) should never be solicited by the owner/therapist to become clients, although they should receive direction (confidentially) regarding therapeutic alternatives, should the therapist/moderator become aware that the client is dangerous or otherwise may benefit from therapy. Should a forum member inquire, the owner/therapist should follow standard precautions to insure that the client's best interests are served. The online therapist may query as to the individual's primary concern and offer suggestions with viable treatment options (e.g. face-to-face psychotherapy, online IRC, psychiatric consult, etc.).

STANDARD 6.04 (A,B,C) FEES AND FINANCIAL ARRANGEMENTS

(a) As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements; (b) Psychologists' fee practices are consistent with law; (c) Psychologists do not misrepresent their fees.

Refer to Standard 4.01 above with regard to technologies securing online payments.

STANDARD 10.01(A,B,C) INFORMED CONSENT

(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers.

(b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation.

Online clients must sign an informed consent form, as with any therapy. This process can be achieved in two ways. More traditionally the individual may sign and fax the information to the provider. Another option is incorporating electronic signatures into the consent package. The Digital Signature Act (1999) was formed to "require the adoption and utilization of digital signatures by Federal agencies and to encourage the use of digital signatures in private sector electronic transactions." Text signatures are now considered to be an electronic representation of

the individual's signature and therefore as legally binding as pen and paper signatures. Appropriate record keeping is required to maintain evidence of signed informed consent. Standards 2.04, 3.04, 4.01, 4.02 and 6.04 all should be reflected in the informed consent.

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

At this point, given the sensitive nature and loosely defined standards for the provision of online therapy services, we recommend that supervisees not provide online therapeutic services.

THE LEGAL ISSUE OF JURISDICTION

While the vision of a global Internet community has a great deal to offer in the health care service arena, a number of legal sensitivities must be faced. In particular, jurisdictional questions have become increasingly complex with the explosion in Internet usage and technology (Frankel, 2000; Rosik, et al, 2001). Views vary on this topic. Some suggest that cyberspace does not belong to a single state or country, but to a whole range of geographical topographies with diverse legal concepts, making regulation extremely difficult (Frankel, 2000, Markoff, 1995). A consumer traveling the information superhighway has also been likened to the consumer driving the interstate highway (Stofle, 1996). No one argues that the physician who prescribes a ten-day course of antibiotics to prevent infection in an auto accident victim should be licensed to practice medicine in states to which the patient may travel upon leaving the emergency room. However, it is logical to maintain that the Internet is not a free city in the sky, where no standards apply.

Traditionally, the licensure of health professionals is a function performed at the state level. Laws governing individual health care providers are enacted through state legislative action, with authority to implement the practice acts delegated to the respective state licensing boards (Rosik et al, 2001; Telemedicine Licensure Report, 2003). In 1996 the Federation of State Medical Boards took the lead in addressing the issue of jurisdiction by adapting state licensure requirements to accommodate practice across state lines (Rosik et al, 2001). They published, "A Model Act to Regulate the Practice of Medicine Across State Lines." Section II (Definitions) of the Model Act states:

> It is important to view the practice of medicine as occurring in the location of the patient in order that the full resources of the state would be available for the protection of that patient. The same standard of care, already in existence in the patient's home state, would be required of all individuals practicing medicine within that jurisdiction…(p. 2).

There are even more conservative approaches. California law now states that only therapists licensed in California can provide online therapy to residents of California (Frankel, 2000; Rosik, et al, 2001; Stofle, 1996), although it is unclear how California authorities might undertake legal sanctions against, for example, e-therapists located in New York, West Virginia, Illinois or any other state.

Current law in the state of West Virginia has no prohibition against the provision of online mental health services across state lines, as exists in California. However, given (1) the broad territorial landscape of the Internet and the diversity of law across states; (2) the premise of licensure regulations (e.g., protect the public) and (3) knowledge that several courts have ruled that a professional relationship does exist when an individual pays a fee to a professional for advice or there is evidence of repeated communications between a therapist and client, it is

prudent until further measures are taken that the online therapist makes an informed decision and proceeds cautiously, if it all, when crossing state lines (Hunt v. Disciplinary Board, 1980; Rosik, 2001).

One option is to acquire licensure in every state in which an e-Therapy client resides. However, that restriction is likely problematic for several reasons including that it may well deny services to individuals who have found one's website and responded to it favorably. This mimics the way that a potential client may respond favorably to a *Yellow Pages* ad or to an appearance in public by a therapist. What brought about the favorable response may have been some vague quality that nevertheless prompted an inquiry. A refusal, even with a referral, may delay services, or cause the client to become discouraged about the prospects of treatment entirely.

Another problem with requiring "every-state" licensure is that it is not practical, at least at present. Such a requirement would serve as a *de facto* requirement that e-Therapy be limited to one, (or perhaps two or three) states for the majority of therapists. Additionally, a law such as California's probably harms clients when it denies access to therapists who possess expertise in treatment of specific disorders. For example, a potential client whose problem is trichotillomania may find expert treatment on-line and out-of-state, while no affordable face-to-face expert exists within a hundred miles of the client's home or even online elsewhere in California. In such a case, it is conceivable that the California law is overly restrictive and inconsistent with the principle of protecting the public.

Given the above, some suggested alternatives to the restrictive California law come to mind. One of these is to require that a client be connected to a qualified therapist in his or her home state, if the e-therapist is out-of-state. That could be accomplished if the e-therapist

requires that the client verify that at least one face-to-face visit to a local therapist is accomplished prior to the start of e-Therapy, and that the local therapist approve his or her own status as a "back up" professional, rather than as a primary therapist. An extension of this plan is to require a visit to the local therapist following, for example, every fifth e-Session. An ancillary legal issue is whether the local therapist may also be an e-Therapist. An online network of providers (governed and regulated by standards accepted by the mental health communities) may facilitate that process.

Another alternative to the restrictive nature of the California law is for the therapist to determine that he or she meets the requirements of the practice law in the client's state, without actually seeking licensure in that state. For example, if the therapist's state and the client's state requirements for licensure are that the therapist have (1) a doctoral degree in clinical psychology from an APA accredited program, (2) a one-year internship, (3) a score of 140 on the national licensing exam, and (4) an oral exam, then the online therapist might consider it "safe" to conduct e-Therapy with that client. As with many issues involving online services, licensing regulations vary state to state and therefore an assumed "reciprocity" should match accordingly if it is to be thought of as a "due diligence" effort. Nevertheless, such a standard not only invites a risky test in the courts, but is quite vague and, thus, is not highly suitable.

Thus, it seems that national minimum standards for e-Therapy across state lines ought to be established. This likely entails federal legislation that should be informed by APA and those who are familiar with the Internet services of other professions such as medicine.

CONCLUSION

Although there are thoughtful and principled positions from various sides of the issues of e-Therapy, it remains clear that the Internet and e-Therapy have established a sense of

permanence in our lives. The legal and ethical issues of online therapy are not going away, and they contain the potential for tragedy if not adequately addressed. We think it is important to echo the sentiment, "If the ethical therapist is not online, who is?" (Stofle, 1996).

Frankel (2000) writes effectively as to the need for such caution. While visiting in the East African country of Malawi, a friend cautioned him while walking one morning to watch out for the poisonous snake nicknamed, "The Third Man Death." The snake earned its namesake because the first passerby would awaken it, the second would irritate it, and the third person would be bitten and killed by it. Despite the emergence and pace of dot.com mental health practices, there are several barriers yet to be addressed in order to protect the public, the profession, and the practitioner from harm. Similarly, it may not be the first or second e-Client who suffers. Rather, harm may come about because potential hazards are either unknown to the "passerby" or have not been addressed by the client's "guide."

The most pressing barriers include the lack of case law, lack of federal regulations, and absent professional guidelines for online mental health practitioners. It is our intent to contribute to the debate by providing both a contemporary review of the literature and discussion of several perspectives on e-Therapy, its ethical and legal concerns. In order to adequately and expeditiously address the potential traps articulated here, practitioners working within professions that lack legal, regulatory or ethical guidelines are encouraged to reinforce this discussion. Additional helpful measures may include contacting federal legislators, state licensing boards, malpractice carriers and professional associations with requests for written, clearly defined standards of acceptable practice (Maheu, 2001). Beyond all of this, the national nature of e-Services demands that professional organizations devise standards that inform both their members and the U.S. Congress, and that the organizations encourage the Congress to

establish equitable e-Practice laws.

References

Alleman, J. R. (2002). Online counseling: The Internet and mental health treatment. *Psychotherapy: Theory/Research/Practice/Training, 39*(2), 199-209.

American Counseling Association. (2005). *ACA Code of Ethics Technology Standards.* Retrieved June 17, 2006, from http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx

American Mental Health Counselors Association. (2000). *Code of Ethics.* Retrieved June 17, 2006, from http://www.amhca.org/code/

American Psychological Association Help Center (1997). *Mind/body health interactive.*. Retrieved June 25, 2006, from http://www.apahelpcenter.org/

Barak, Z., (1999). Psychological applications on the Internet: A discipline on the threshold of a new millennium. *Applied and Preventive Psychology, 8*, 231-245.

Barnett, J. E., & Scheetz, K. (2003). Technological advances and telehealth: Ethics, law, and the practice of psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 40*(1/2), 86-93.

Benderly, B. L. (2005). The promise of e-therapy. *Scientific American Mind, 16*(4), 72-77.

Childress, C. A. (2000). Ethical issues in providing online psychotherapeutic interventions. *Journal of Medical Internet Research, 2*(1), e5. <URL:http://www.jmir.org/2000/1/:e5.

Ethics Committee of the American Psychological Association. (1997). *APA statement on services by telephone, teleconferencing, and Internet.* Retrieved June 17, 2006, from http://apa.org/ethics/stmnt01.html

Frankel, S. A., (2000). Watch out for the "Third Man Death". Retrieved on June 22, 2006 from http://www.psychboard.ca.gov/pubs/12_2000.pdf

Garton, L., Haythornwaite, C., & Wellman, B. (1997). Studying online social networks. *Journal of Computer-Mediated Communication, 3*(1).

Gollings, E. K., & Paxton, S. J., (2006). Comparison of Internet and face-to-face delivery of a group body image and disordered eating intervention for women: A pilot study. *Eating Disorders 14*, 1-15.

Grohol, J. M. (1999). *Best practices in e-therapy: Definition and scope of e-therapy.* Retrieved June 17, 2006, from http://www.ismho.org/issues/9902.htm

Health insurance portability and accountability act of 1996, Publ. L. No. 104-191, 110 Stat. 1998.

HIPPA compliance requirements (1996). *164.306 Security standards: General rules*. Retrieved July 13, 2006, from http://www.safetysend.com/HIPPA.htm

Hopps, S. L., Pepin, M., & Boisvert, J. M. (2003). The effectiveness of cognitive-behavioral group therapy forloneliness via inter-relay-chat among people with physical disabilities. *Psychotherapy: Theory, Research, Practice, Training, 40*, 136-147.

Hunt v. Disciplinary board, 381 S. 2d 52 (Ala. 1980).

International Society for Mental Health Online. (2000). *Suggested Principals for the Online Provision of Mental Health Services.* Retrieved June 18, 2005, from http://www.ismho.org/suggestions.html

Jones, S. G., Ed. (1996). *Cybersociety: Computer-mediated communication and community.* Newbury Park, CA: Sage.

Lange, A., van de Ven, J. P., & Shrieken, B. (2003). Interapy: Treatment of post-traumatic stress via the Internet. *Cognitive Behaviour Therapy, 32*(3), 110-124.

Maheu, M. M. (2001). Practicing psychotherapy on the Internet: Risk management challenges and oppurtunities. *Register Report, 27,* 23-28.

Maheu, M. M., & Gordon, B. L. (2000). Counseling and therapy on the Internet. *Professional Psychology: Research and Practice, 31,* 484-489.

Markoff, J. (1995). *Online service blocks access to topics called pornographic.* New York Times, December 29.

Metanoia. *ABC's of "Internet therapy."* Retrieved June 17, 2006, from http://www.metanoia.org/

Morahan-Martin, J. L. & Schumacher, P. (1999, August). *Loneliness and social use of the Internet.* Paper presented at the annual convention of the American Psychological Association, Boston, MA.

Morris, M., & Ogan, C. (1996). The Internet as mass medium. *Journal of Communication, 46,* 39-50.

National Board for Certified Counselors. *The practice of Internet counseling.* Retrieved June 17, 2006, from http://www.nbcc.org/webethics2

Newman, M. G. (2004). Technology in psychotherapy: An introduction. *Journal of Clinical Psychology, 60*(2), 141-145.

Nua Internet Surveys. (2002). *How many online?* Retrieved April 23, 2002, from http://www.nua.ie/surveys/how_many_online/index.html

Rimersma M., & Leslie, R. S., (1999). Therapy counseling over the Internet: Innovation or unnecessary risk. *The California Therapist.* 33-36.

Report of the Technical Working Group on Telemedicine Standardization. (2003) *Recommended guidelines and standards for practice of telemedicine in India.* Retrieved June 20, 2006 from http://www.mit.gov.in/telemedicine/Report%20of%20TWG%20on%20Telemed%20Standardisation.pdf

Rosik, C. H., & Brown, R., (2001). Professional use of the Internet: Legal and ethical issues in a member care environment. *Journal of Psychology and Theology. 2*, 106-120.

Rotondi, A. J., Haas, G. L., Anderson, C. M., Newhill, C. E., Spring, M. B., Ganguli, R. & Gardner, W. B. & Rosenstock, J. B. (2005). A clinical trial to test the feasibility of a telehealth psychoeducational intervention for persons with schizophrenia and their families: Intervention and 3-month findings. *Rehabilitation Psychology, 50*(4), 325-336.

Seligman, M., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology progress: Empirical validation of interventions. *American Psychologist, 60*(5), 410-421.

Shapiro, D. E., & Schulman, C. E. (1996). Ethical and legal issues in e-mail therapy. *Ethics and Behavior, 6,* 107-124.

Skarderud, F. (2003). Shame in cyberspace. Relationships without faces: The E-media and eating disorders. *European Eating Disorders Review, 11,* 155-169.

Sproull, L., & Faraj, S. (1997*).* Atheism, sex, and databases: The Net as a social technology. In S. Kiesler (Ed.), *The culture of the internet (pp. 35-52).* Mahwah, NJ: Erlbaum.

Sproull, L., & Kiesler, S. (1991). *Connections: New ways f working in the networked organization.* Cambridge, MA: MIT Press.

Stofle, G. S. (1996). Thoughts about online psychotherapy: Ethical and practical considerations. Retrieved June 21, 2006 from http://www.members.aol.com/stofle/index.htm

Tate, D. F., & Zabinski, M. F. (2004). Computer and interne applications for psychological treatment: Update for clinicians. *JCLP/In Session, 60*(2), 209-220.

Tate, D. F., Jackvony, E. J., & Wing, R. R. (2003). Effects of Internet behavioral counseling on weight loss in adults at risk for type 2 diabetes: A randomized trial. *Journal of the American Medical Association, 289,* 1172-1177.

Tate, D. F., Wing, R. R., & Winett, R. A. (2001). Using Internet technology to deliver a behavioral weight loss program. *Journal of the American Medical Association, 285,* 1172-1177.

The Digital Signature Act (1999). *Library of Congress, HR 1572 IH*. Retrieved July 13, 2006 from, http://www.techlawjournal.com/cong106/digsig/hr1572ih.htm

Telemedicine licensure report (2003). Center for Telemedicine Law: Washington, D.C.

Wellman, B. (1997). An electronic group is virtually a social network. In S. Kiesler (Ed.), *The culture of the Internet* (pp. 179-208). Mahwah, NJ: Erlbaum.

White, M. A., Martin, P. D., Newton, R. L., Walden, H. M., York-Crowe, E. E., Gordon, S. T., Ryan, D. H., & Williamson, D. A., (2004). Mediators of weight loss in a family-based intervention presented over the Internet. *Obesity Research 12*(7), 1050-1059.

Winzelberg, A. J., Luce, K. H., & Abascal, L. B. (2004). Risk factors for body image dissatisfaction. In J.K. Thompson (Ed.), *Handbook of eating disorders and Obesity* (pp. 279-296). New Jersey: John Wiley.

Zgodzinski, D. (1996). Cybertherapy. *Internet World, 96*, 50-53.