east metro
youth services

ONLINE COUNSELLING:

A REVIEW OF THE LITERATURE

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INTRODUCTION

East Metro Youth Services (EMYS) has commenced offering online counselling services to a limited number of the agency's clients. Online counselling services are provided by EMYS therapists by way of asynchronous e-mail, primarily to EMYS' day treatment clients; however, it is anticipated that the service will eventually be available to clients in other EMYS programs. The purpose of this literature review is to inform EMYS' online counselling service by identifying the potential merits and risks of online counselling, summarizing the existing research with respect to online counselling, and outlining suggestions for conducting online counselling in a manner that maximizes its benefits and minimizes its risks.

The primary focus of this literature review will be online counselling by asynchronous e-mail, given that it is the most frequently used mode of online counselling (Chester & Glass, 2006) and it is the mode currently being used by EMYS; however, other modes of online communication, such as private chat, text messaging and videoconferencing, will be discussed. In addition, this literature review will provide information regarding the provision of online counselling to clients of all ages but will also highlight information applicable to youth, where available.

TERMINOLOGY, DEFINITIONS AND FORMS OF ONLINE COUNSELLING

Various terms are used for online counselling, including e-therapy (Manhal-Baugus, 2001), cybertherapy (Suler, 2000), online or Internet therapy (Rochlen, Zack, & Speyer, 2004), e-mail therapy (Shapiro & Schulman, 1996), e-counselling (Tate, Jackvony & Wing, 2003), Internet counselling (Pollock, 2006), web counselling (Urbis Keys Young, 2002), cybercounselling (Maples and Han, 2008), and therap-e-mail (Murphy & Mitchell, 1998).

A number of definitions of online counselling have been proposed, including the following. Bloom (1998) defines online counselling as "the practice of professional counselling that occurs when client and counsellor are in separate or remote locations and utilize electronic means to communicate with each other" (p.53). Alleman (2002) refers to online counselling as "ongoing, interactive, text-based, electronic communication between a client and a mental health professional aimed at behavioural or mental health improvement" (p. 200). Mallen and Vogel (2005) define online counselling as:

> Any delivery of mental and behavioural health services, including but not limited to therapy, consultation, and psychoeducation, by a licensed practitioner to a client in a non-[face-to-face] setting through distance communication technologies such as the telephone, asynchronous e-mail, synchronous chat, and videoconferencing (p. 764).

These definitions suggest that online counselling can take many forms. Internet-based mental health interventions can include mental health information websites, online mental health screening and assessment tools, online support groups, individual therapy, group therapy and self-help programs (Ybarra and Eaton, 2005), as well as online forums, bulletin boards and chat rooms (Fenichel et al., 2002). Individual therapy carried out over the Internet can include asynchronous methods, such as e-mail, or synchronous methods, such as web-based messaging (instant messaging), chat, videoconferencing or voice-over IP (Internet phone) (Kanani & Regehr, 2003). Virtual

reality therapy (Luo, 2007) and online video game therapy (Wilkinson, Ang, & Goh, 2008) are two additional emerging online modalities. Online counselling may be provided as the primary treatment modality or as an adjunct to more traditional forms of mental health treatment (Wells, Mitchell, Finkelhor, & Becker-Blease 2007).

HISTORY, PREVALENCE AND SCOPE OF ONLINE COUNSELLING

History

Mental health services first emerged on the Internet as early as 1982 through online self-help support groups (Kanani & Regehr, 2003). The earliest know organized service to provide mental health advice to individuals online was "Ask Uncle Ezra", a free service offered to students of Cornell University that has been in operation since 1986 (Ainsworth, 2002). As early as 1993, Ivan Goldberg, M.D., began answering questions online about the medical treatment of depression (Skinner & Zack, 2004). In 1995, John Grohol, Psy.D., developed a free mental health advice website (Young, 2005). Fee-based mental health services offered to the public began to appear on the Internet in the mid-1990s and consisted primarily of mental health advice services that offered to answer one question for a small fee (Ainsworth, 2002). The first known fee-based Internet mental health service was established by Sommers in 1995 (Skinner & Zack, 2004). Rather than just answering a single question, Sommers sought to establish longer term online therapeutic relationships. Also in 1995, Needham became the first practitioner to offer e-therapy via real time chat (Ainsworth, 2002). By the late 1990s, counsellors began experimenting with online counselling as extensions of their existing private practices (Young, 2005). E-clinics then emerged and offered member therapists resources such as secure websites, active marketing and other practice management tools (Skinner & Zack, 2004). The founding of the International Society for Mental Health Online (ISMHO), an organization that promotes the understanding, use and development of online communication, information and technology for the international mental health community, in 1997 was a key milestone in the development of e-therapy (Walker, 2007).

Finfgeld (1999) attributes the emergence of online counselling to a number of factors, including the movement of psychiatric care from inpatient to outpatient settings, the availability of personal computers and user friendly computer and Internet technology and the resourcefulness of health care providers in the application of technology to meet mental health care needs. The expansion of online mental health services has also been attributed to the need to provide greater access to mental health services for underserved populations, the expectation of third party payers and health care organizations for increased efficiency in the delivery of mental health services and public demand for Internet-based psychological services (Glueckauf, Pickett, Ketterson, Loomis & Rozensky, 2003).

Prevalence

It is difficult, if not impossible, to estimate the current prevalence of online counselling. Attempts to determine the number of professionals providing online counselling services have been made in the past. Sampson, Kolodinsky, and Greeno (1997) conducted an online search in an effort to determine the number of individuals providing online counselling in 1996. They found at least 275 individuals offering online counselling services over the Internet and estimated the annual growth rate of

such services to be 55%. Ainsworth (2002) estimated that, in 2001, there were over 300 private practice websites where e-therapists offered services and e-clinics which represented, collectively, more than 500 more e-therapists. In 2006, one online therapy company (www.mytherapynet.com) had more than 1000 registered therapists in its database (Lavallee, 2006). Today, a Google search of the term "online counselling" yields approximately 468,000 results while a search of the term "e-therapy" yields approximately 130,000 results. These searches result in listings for individual therapists (see, for example, www.e-mailtherapy.com or www.asktheinternettherapist.com), as well as e-clinics that offer the online services of a number of therapists (see, for example, www.liveperson.com or www.helphorizons.com). The International Society for Mental Health Online (ISMHO) currently has over 400 members throughout the world (ISMHO, 2008). It is expected that the provision of online counselling services will continue to grow. In a Delphi poll conducted by Norcross, Hedges, & Prochaska (2002), 62 psychotherapy experts predicted psychotherapy trends in the next decade. Technological interventions, including e-mail and videophone, were viewed as one of the future scenarios with the highest likelihood. The panel also concluded that virtual reality therapy will flourish, ranking the use of virtual reality as the therapeutic intervention third most likely to increase the greatest by 2010.

Scope of Online Counselling

A number of studies have attempted to determine the scope of online counselling, including who is offering online counselling, who is seeking help over the Internet, and for what issues online help is being sought.

Wells, Mitchell, Finkelhor and Becker-Blease (2007) surveyed 2,098 social workers, psychologists, and other professionals regarding the use of the Internet as part of professional mental health practice. Only a little over 2% of the sample reported using the Internet to provide online therapy. Across professional groups, use of the Internet for online therapy ranged from 1% among mental health counsellors to about 5% among marriage and family therapists. Less than 2% of social workers reported providing online therapy or counselling. Some respondents reported using electronic communication as an adjunct to traditional mental health practice.

Powell (1998, as cited in Chester and Glass, 2006) surveyed 13 practitioners about their online practice. The study found that most online counsellors were typically male and American, with a median age in the 40s. It was noted that there were three females for every two males receiving services. Relationship issues were the most frequent problem for which clients sought online help, with depression the second most common. While six sessions per client was the most frequently occurring amount, the average number of sessions per client was three.

Maheu and Gordon (2000) conducted an online practitioner survey aimed at gaining an understanding of individuals who were offering therapy and counselling via the Internet and what services they were providing. 60 participants completed the survey. More than 90% indicated that they were currently licensed, certified, or registered to provide therapy or counselling to the public and more than half were psychologists. Most (63%) described their online services as "education" or "advice", whereas only 18% described them as "therapy" or "counselling". Problems for which help was provided on the Internet were grouped into three major areas. 41% included clinical areas (mood, anxiety, sexual, or adjustment disorders), 22% included

relationship problems (family, relationship, grief, or bereavement), and 37% were listed as "other" problems. In terms of the technology used to deliver online counselling, services were evenly distributed between e-mail, websites, and real-time interactive communication, including chat rooms and videoconferencing. 50% of the respondents indicated that individuals normally received services for less than one month, and 20% provided individual services for 1 to 3 months.

Chester and Glass (2006) conducted a survey of individuals (n=67) who provided counselling services on the Internet. Results of the study present a picture of online counsellors as primarily Western-based, relatively experienced, cognitive behavioural therapy or eclectic practitioners. While as much as 100% of some online counsellors' professional work was conducted online, on average 19.6% of all professional work was performed online. Nearly half the respondents combined online and face-to-face counselling with at least some clients. Email was the most popular technology, used in 71% of all online counselling, with chat the next common. Counsellor estimates of the proportion of female and male clients suggested online clients were predominantly female. Estimates of client age revealed a concentration in the 25-44 age group. Clients most commonly presented with "relationship" issues. The second most common presenting problem was "family issues", followed by "mood disorders" and "anxiety". In general, online counselling was short-term, with a mean of five sessions per client.

A study by Heinlen, Welfel, Richmond and O'Donnell (2003) examined a sample of e-therapy websites. 44 websites that claimed to have at least one psychologist licensed in the United States and that offered e-therapy as a substitute for face-to-face or voice-to-voice contact were evaluated. The majority of websites (84%) provided services via asynchronous e-mail. The other primary means of service delivery was synchronous communication via chat, with almost half of the websites offering individual chat sessions and two sites offering group chat.

DuBois (2004), a clinical social worker, explored the demographics and clinical characteristics of her own online counselling clients. Of the 217 clients surveyed, 15% were male and 85% were female. Only 16% were in the 13 to 19 age group, 28% were 20 to 30 years old, 23% were 31 to 40, 25% were 41 to 50 and 6% were 51 to 60. Despite the social worker being located in Canada, most people seeking online counselling through her website lived in the United States. The issues that people cited as their primary reason for seeking online counselling included relationship issues with partner (55%); depression (13%); low self-esteem (6%) and anxiety (5%).

Kids Help Phone is a national counselling, information and referral service for children and youth in Canada (Kids Help Phone, 2005). They provide 24-hour toll-free confidential and anonymous phone and on-line service. A retrospective study of the counselling services that they provided in 2004 indicated that their online counselling services received 14,038 posts during that year (Kids Help Phone, 2005). A random selection of 4000 posts from the period May to December 2004 were read and categorized for content. Females were found to be the predominant users of Kids Help Phone's online counselling services. In addition, the online counselling service appears to attract youth who are too shy or too scared to use other resources, including the Kids Help Phone anonymous phone line. The issues for which kids sought help through the service were relationships (38%), emotional and mental health (22%), physical and sexual health (20%), abuse and violence (9%), school (5%), identity and self-concept (5%), school (5%), and becoming independent (2%).

Kids Help Line, the Australian equivalent of Kids Help Phone, provides phone counselling as well as email counselling and synchronous web counselling (Kids Help

Line, 2007). An overview of the services that they provided in 2006 (Kids Help Line, 2007) revealed that web and email counselling accounted for 20% of their counselling sessions. Females made up the majority of counselling sessions in 2006. Boys and young men made one-in-four contacts via the telephone service compared with one-in-ten via the online service. Online clients tended to be older, with 15 to 25 year-olds involved in 72% of online counselling sessions (compared with 62% of telephone sessions). The overview also showed that online counselling is used in a different way to telephone counselling. Mental health issues, self-image, eating and weight issues were presented online at almost triple the rate presented on the telephone. In addition, suicidal thoughts, deliberate self-injury and emotional and/or behavioural management presentations online were double the rate presented on the telephone.

The results of the studies conducted in this area are constrained by their small sample sizes and/or low response rates, thus limiting the ability to generalize their results and make definitive conclusions about the scope of online counselling being offered. However, they do help to provide a basic picture of some of the online counselling services being provided, including who is offering these offering these services, to whom they are being provided and for what issues.

INTERNET USE IN CANADA

As noted above, the availability of personal computers and their ease of use is one of the reasons behind the growth of online counselling. An understanding of the use of personal computers and the Internet by Canadians is important in developing online counselling services that meet the needs of the target clientele.

The *Canadian Internet Use Survey* (Statistics Canada, 2008) examined the use of the Internet by Canadians during 2007. The results indicate that 73% of Canadians aged 16 and older went online for personal reasons during the 12 months prior to the survey. Among people who used the Internet at home, 68% went online every day during a typical month and 50% for five hours or more during a typical week. Gaps in the rate of Internet among certain groups of Canadians, specifically on the basis of income, education and age, were found. Email and general browsing were found to be the most popular online activities from home. The web was also found to be popular for searching for medical or health related information.

Young Canadians in a Wired World, a study carried out by The Media Awareness Network (2005), looks at the online behaviours, attitudes and opinions of more than 5,200 children and youth from grades 4 to 11 in schools across Canada. The results indicate that 94% of young people say they go online from home, compared to 79% in 2001. 37% reported having their own Internet-connected computer. 86% of students report that they have email accounts, compared with 71% in 2001. Twenty-eight per cent of Grade 4 students use instant messaging on an average school day, a number that jumps to 43 per cent in Grade 5; by Grade 11 that number is 86 per cent. Chat rooms rank last out of preferred ways to socialize online. Points of access to the Internet include more than computers. Twenty-three per cent of students report having their own cell phone, 44 per cent of which have Internet capability. Fifty-six per cent of students' cell phones have text messaging. Twenty-two per cent of students have their own Webcam.

An Ipsos Reid study (2008) – *Inter@active Teens: The Impact of the Internet on Canada's Next Generation* – presents the results of interviews with more than 1200 Canadian youth aged 12-17. The results indicate that youth spend, on average, 13 hours

per week on the Internet. The study reports that online socializing is by far the overwhelming reason why teens surf the net. Many teens reported that the Internet is important to the social life (61%) and among those who visit online social networks, half (52%) say it is important to their day-to-day life. Also of importance to teens on a daily basis is participating in live, online chats and the majority of teens who participate in this online social activity do so on a weekly or daily basis. Teens are also heavy users of instant messaging. Three-quarters of teens (74%) have used instant messaging to communicate with friends or family members.

The use of the Internet by youth goes beyond online socializing. Adolescents use the Internet for seeking information about health (Gray, Klein, Noyce, Sesselberg, & Cantrill, 2005) and also appear to be willing to seek help for emotional problems on the Internet (Gould, Munfakh, Lubell, Kleinman, & Parker, 2002; Nicholas, Oliver, Lee, & O'Brien, 2004).

ADVANTAGES AND DISADVANTAGES OF ONLINE COUNSELLING

Online counselling has both potential advantages and disadvantages, each of which is summarized below. While the primary focus of this discussion will be asynchronous communication, the advantages and disadvantages of other modes of online counselling will also be considered.

Advantages

Access

One of the primary advantages of online counselling is its potential for increasing access to mental health services. It can bring mental health services to persons in underserved or geographically isolated areas (Sussman, 2004), as well as to those who cannot leave their home due to illness, physical limitations, transportation difficulties or family obligations (Maples & Han, 2008). It may also be beneficial for those who are socially phobic (Fenichel et al., 2002), who are ambivalent and tentative about the in-person counselling process (Barnett, 2005), or who are afraid to seek face-to-face therapy due to anxiety or stigmatization (Lange, van de Ven & Schrieken, 2003). In addition, use of computer-mediated communication may allow family therapists to engage absent family members in family therapy (King, Engi & Poulos, 1998). Lastly, private therapists may offer online counselling services at less than the customary cost of a face-to-face therapy session, making online counselling services more financially accessible (Griffiths, 2001).

Convenience

Online counselling is also convenient. Services can be provided at any time of day (Manhal-Baugus, 2001) and clients can send messages whenever they feel most in need of, or interested in, therapy (Bailey, Yager, & Jensen, 2002). Online counselling can be accessed from anywhere in the world having Internet access (Maples & Han, 2008). It also allows individuals to access therapists from the comfort of their home (Manhal-Baugus, 2001). From the therapist's perspective, it allows them more flexibility in their work schedules. There are no difficulties in having to schedule a particular appointment time because the therapist and client do not have to be sitting at their computers at the same time (Suler, 2000). The flexibility of electronic communication can also increase a

therapist's accessibility, especially for clients with erratic or demanding personal schedules (Peterson & Beck, 2003).

Time Delay

While the time delay inherent in asynchronous communications can be viewed as a disadvantage of e-mail counselling, it allows both counsellor and client the time to compose a thought or question that precisely reflects the concern or issue (Tate & Zabinski, 2004). There is no pressure to think quickly; the client can reply when he/she is ready to reply (Suler, 2000).

A Permanent Record

The value of online counselling can also be seen in its ability to provide a permanent and tangible record of counselling sessions (Pollock, 2006). This record can provide many benefits. It gives clients the ability to re-read e-mails to look for approaches that they have used to overcome previous problems and to review positive and encouraging comments that their therapist has made about them (Murphy & Mitchell, 1998). It can be used to remind both clients and therapists of things they had previously expressed (Barak, 1999), to allow both the client and the therapist time to fully reflect on issues discussed in previous correspondence (Manhal-Baugus, 2001) and to explore the client's progress at various stages in the course of treatment (Oravec, 2000). The recordkeeping provided by online counselling can also hold clients and therapists to higher standards of accountability (Finfgeld, 1999). Murphy and Mitchell (1998) also emphasize the potential of a permanent record as a tool for both supervision and consultation.

Writing

The act of writing itself can be therapeutic (Walker, 2007). It can be viewed as a mechanism that facilitates self-disclosure, ventilation, and externalization of problems and conflicts and that promotes self-awareness (Barak, 1999). Some online clinicians suggest that some individuals are more honest, uninhibited and more expressive in writing that in face-to-face sessions (Fenichel et al., 2002). Writing can also reduce the emotional burden on patients by enabling them to say whatever they want to say (Yager, 2001). Yager (2001) further explains: "Computers benignly and approvingly accept whatever patients care to reveal without interrupting them, including all confessions, admonitions, quirky ideas, and other communications" (p. 135).

Anonymity

The anonymity provided by online counselling may also be beneficial. Some suggest that, in online counselling, being an "invisible" client can reduce or eliminate the stigma associated with seeking mental health services (Suler, 2000). It may also be easier for patients to disclose information about themselves via the computer since certain social markers such as age, gender and ethnicity are removed (Tate & Zabinski, 2004). Honesty and candour may also increase as clients may feel less defensive and vulnerable when they cannot see the therapist (Maples & Han, 2008) and when they do not have to contend with the therapist's immediate emotional feedback signals (Bailey, Yager, & Jenson, 2002). The anonymity of online counselling may also ease the discomfort and potentially embarrassing and stigmatizing disclosure of behaviors and thoughts (Manhal-Baugus, 2001). It may be especially important for individuals with

issues of shame or fear and also for those who are afraid of being judged (Fenichel et. al, 2002).

Client Autonomy and Empowerment

With the ability for patients to say whatever they want to say and to initiate contact, online counselling also has the potential to enhance patient autonomy in the therapeutic relationship, thus decreasing the power differential between client and therapist (Yager, 2001). Finfgeld (1999) emphasizes that e-mail therapy, in particular, empowers clients by allowing them to transmit their unique ideas without interruption by the therapist's premature interpretations and perspectives. She notes that this may be particularly beneficial for clients who have been frustrated by the lack of sensitivity of therapists to their unique concerns.

A Novel Technique

Mehta and Chalhoub (2006) point out that gaining the trust of adolescents and establishing a therapeutic alliance sometimes requires novel techniques and creativity on the part of the therapist. They suggest that e-mail may function as an innovative hook to engage an adolescent patient.

Advantages of Particular Modes of Online Counselling

E-mail as an Adjunct to Face-to-Face Counselling

E-mail used as a therapeutic adjunct increases the frequency and amount of time of contact with clinicians and therapeutic processes and lets the patient know that the clinician is present, listening and thinking about him/her between face-to-face sessions (Yager, 2001). E-mail contact can allow clients to raise issues they may have forgotten during a session or were reluctant to raise in person (Maheu, 2003). It can also be used for self-monitoring, which can increase patient accountability between sessions and free up therapy time for discussion of other issues (Tate & Zabinski, 2004). E-mail provides another opportunity to build the working alliance with patients who are reluctant to self-disclose (Murdoch & Connor-Greene, 2000). Yager (2003) also points out that e-mail is helpful with patients who easily become inattentive to therapeutic expectations between office visits.

Murdoch and Connor-Greene (2000) highlight some of the advantages of using e-mail as a therapeutic adjunct to cognitive behavioural therapy:

- integrates the patients' attention to therapeutic goals, strategies, and progress into their everyday routines
- provides opportunities for practice and strengthening of skills for patients who have persistent negative cognitions
- e-mail prompts may overcome negative thoughts regarding the usefulness of homework or the patient's perceived competency

Some view online therapy as a way of enhancing traditional treatments and, in this regard, suggest that it be used as extended support in particular steps of the clinical process (e.g. follow up) or as an augmentation of face-to-face communication during the central and final parts of psychotherapy (Castelnuovo, Gaggioli, Mantovani, & Riva, 2003). McDaniel (2003) suggests that that there are many potential functions of e-mail as an adjunct to therapy including facilitating collaboration with other professionals, bridging family cut-offs and allowing patients to communicate with family members,

collecting data for therapy, helping a patient find his/her voice, providing validation and support, anchoring a face-to-face session, revealing new material for therapy, and facilitating integration and insight.

Instant Messaging/Chat

Suler (2000) points out the benefits of synchronous communication, such as chat and instant messaging:

- The ability to schedule sessions defined by a specific, limited period of time
- A feeling of presence created by being with a person in real time
- Interactions may be more spontaneous, which may result in more uncensored disclosures by the patient
- Making the effort to be with the client for a specific appointment may show commitment and dedication
- Pauses in the conversation, coming late to a session, and no-shows are not lost as psychologically significant cues

Fenichel et al. (2002) point out that chat and instant messaging enable more direct and immediate communication. They also provide for continuous and immediate feedback in both directions (Sussman, 2004). Given that chat can be conducted with a number of individuals, it has been suggested that it may be of value for family therapy (Jencius & Sager, 2001). Tate and Zabinski (2004) suggest that it may also be an appropriate forum for discussion and practice of particular skills, such as cognitive restructuring or role playing.

Videoconferencing

The use of videoconferencing can serve to increase the access of mental health services to isolated and marginalized people, including rural populations, disadvantaged populations, and individuals with disabilities (Rees & Stone, 2005). In addition, it provides multiple sensory cues, such as visual appearance, body language and vocal expression, that can provide valuable information for understanding the client (Suler, 2000) and for use as diagnostic criteria (Maheu, 2003). Suler (2000) outlines other advantages of videoconferencing:

- The feeling of the therapist's presence may be powerful when multiple sensory cues are available, which can enhance the impact of the therapist's interventions, the sense of intimacy, and commitment to therapy
- It may be less ambiguous than typed text, which can lead to less misunderstandings
- It may be of benefit to those that express themselves better through speaking than writing
- Speaking is faster than typing and may therefore convey information more quickly

Text Messaging/Short Message System(SMS)

Text messaging has some of the advantages of e-mail communication, namely visual anonymity and asynchronicity (Robinson et al., 2006). Bauer, Percevic, Okon, Meermann and Kordy (2003) outline some additional advantages of text messaging:

- The use of mobile phones is possible everywhere, i.e. it is independent of time and place

- SMS is an interactive medium
- The medium forces patients to express themselves briefly and concisely thereby focusing on essential points

Disadvantages

Loss of the Human Factor

It can be said that computers simply do not offer the human interaction that is present and, as some would argue, that is essential in the counsellor's office (Maples & Han, 2008). For some people, the lack of physical presence may reduce the sense of intimacy, trust, and commitment in the therapeutic relationship (Suler, 2000). Some question the ability of the counsellor to show care and positive regard (or the perception of the counsellor in that regard) given the absence of direct contact between therapist and patients and "a relationship based on an exchange of typed letters" (Barak, 1999, p. 236). The inability to interact face-to-face may thus impair the development of a therapeutic alliance between the counsellor and the client.

Lack of Non-Verbal Cues

A disadvantage of online counselling cited by many authors is the absence of visual and vocal cues, such as facial expressions, body language and voice tone (Manhal-Baugus, 2001). Peterson and Beck (2003) explain: "Sighs, frustrated emotions, terseness, irritation – all may be lost in the process of the e-mail transaction" (p. 168). The lack of visual and vocal cues can result in difficulty, or even inability, for therapists and clients to establish a strong therapeutic relationship (Cook & Doyle, 2002). In addition, therapists traditionally rely on non-verbal cues in order to interpret what clients may be feeling or thinking (Maples & Han, 2008). Accordingly, as Recupero and Rainey (2005) point out, crying and other "red flags" may go by unnoticed in online counselling. This can result in a greater potential for miscommunication (Manhal-Baugus, 2001). Lack of access to non-verbal behaviour may also make it difficult to correctly assess and diagnose disorders (Gingerich, 2007). Some clinicians believe that some highly experiential approaches may depend so heavily on the use of real-time non-verbal cues that they simply cannot be adopted for delivery in any mode other than face-to-face (Alleman, 2002).

The Impact of the Written Word

Some suggest that text-based communication has the potential to be stark and cold (Stofle, 1997). Typed text may feel more formal and lack a supportive, empathic tone (Suler, 2000). Accordingly, words may come across as sounding harsher than intended (Childress, 2000). There can also be a difference in the interpretation of text messages as compared to verbal exchanges (Ybarra & Eaton, 2005), which can lead to a greater potential for misunderstanding (NASW, n.d.). In addition, hypersensitive patients who are prone to distortion of facts and events might misinterpret aspects of e-mail communications (Yager, 2003). Lastly, the nature of text-based communication makes it easy to conceal emotions and information, which can make appropriate treatment and intervention difficult to accomplish (NASW, n.d.).

Access

Whereas access was noted above as an advantage of online counselling, it can also be viewed as a limitation in that online counselling is only available to clients who have

access to a computer and the Internet (Gingerich, 2007). Barnett (2005) points out that those who therapists have the greatest desire to serve – those in traditionally underserved populations – may in fact have the least access to the needed technologies.

Lack of Skills

Online counselling requires that clients and counsellors have the skills necessary to utilize the Internet and the chosen method of text-based communication (e.g. e-mail or chat) efficiently (Maples & Han, 2008). In addition, both therapist and client must be fairly good readers and writers (Abbott, Klein & Ciechomski, 2008). Some also suggest that online counselling should be limited to clients who can write expressively (NASW, n.d.).

Time Delay/Technological Failure

Time delay is a natural result of asynchronous communication but can also result from technological failure. While time delay was seen above as an advantage of e-mail, it can also alter the nature of the counselling process (Rochlen, Zack, & Speyer, 2004). Time delay can lead to frustration on the part of the client (Maples & Han, 2008). It can also lead to uncertainty, which in turn may result in many questions and self-doubt (Suler, 1997). Delays due to technological failure may delay or interfere with services (NASW, n.d.). If a client is cut off with no means of reconnection, it can create feelings of isolation and alienation (Walker, 2007).

Disadvantages of Particular Modes of Online Counselling

E-mail as an Adjunct to Face-to-Face Counselling

In addition to the potential consequences of using e-mail generally, using e-mail as an adjunct to therapy has its own potential negative aspects. Patients may resist the use of e-mail or neglect e-mail assignments (Yager, 2003). Some clinicians may not want the added task of processing client's thoughts and feelings between sessions and particularly want to avoid creating such expectations with difficult-to-manage clients (Maheu, 2000).

Instant Messaging/Chat

Secure web-based instant messaging systems can be expensive to implement (Manhal-Baugus, 2001). Chat rooms are generally more difficult to secure (Ragusea & VandeCreek, 2003) and the technology can be very slow and is prone to crashes (Manhal-Baugus, 2001). In addition, both private chat and instant messaging require clients to arrange a time to talk (Maples and Han, 2008). This can be inconvenient and difficult, particularly if the client and therapist are in different time zones (Suler, 2000). In addition, with synchronous modes of communication, such as private chat and instant messaging, there is less time between exchanges to think and compose a reply (Suler, 2000). As well, the typing speed of the participants can affect the flow of the conversation and the amount of participation (Tate & Zabinski, 2004).

Videoconferencing

Suler (2000) outlines some of the disadvantages associated with the use of videoconferencing:

- Requires extra equipment, more technical knowledge and fast Internet connections to work efficiently
- Some clients may be less expressive when face-to-face with the therapist or may be more uncomfortable with too many visual/auditory cues
- Saving a record of audio-visual files consumes a great deal of storage space

Technical concerns, such as poor audio and video quality and lag in audio and video transmission, may also negatively affect counselling conducted through videoconferencing (Lewis, Coursol, & Wahl, 2003).

Text Messaging/Short Message System(SMS)

One of the difficulties with text messaging is that it is not possible to write very much in a text message (Robinson et al., 2006) and it can be time-consuming, particularly if the phone does not have a QWERTY keyboard. In addition, confidentiality concerns can arise if someone has access to the client's or therapist's phone or if the client or therapist's phone is lost or stolen. It is also difficult to keep a record of text messages given the limited storage space on cell phones and the inability to print out text messages. Lastly, given that text messages are typically received from family and friends, clients may view text messages from a therapist as an invasion of their private life (Robinson et al., 2006)

ETHICAL AND LEGAL ISSUES

The following are potential ethical and legal issues associated with providing online counselling services.

Confidentiality

With respect to the provision of online counselling services, threats to confidentiality exist at two levels: during transmission and at the client and therapist ends (Kanani & Regehr, 2003). With respect to the former concern, e-mails may be misdirected by typos in the "to" field or intercepted by computer hackers (Recupero & Rainey, 2005). With respect to the latter concern, other persons may have access to the client's e-mail, such as employers or family members; similarly, client e-mail may be available to staff in the therapist's office (Childress, 2000). Confidentiality issues also arise with respect to the storage of transcripts of online counselling sessions by either the therapist or the client (Mallen, Vogel & Rochlen, 2005).

Jurisdiction/Culture

As Mora, Nevid and Chaplin point out, "the reach of the Internet extends beyond state and even international boundaries " (p. 3053). When the client resides in a different jurisdiction than the therapist, it is currently unclear which laws apply – those of the jurisdiction in which the therapist is providing the counselling services or those of the jurisdiction in which the client resides (Kanani & Regehr, 2003). The issue of jurisdiction applies not only to the legality of the activity, but also to the rights of clients to redress grievances (Childress, 2000). Some states in the United States have regulatory

policies that suggest that cyberspace is not a geographical location and insist that therapists will be construed to be practicing professionally in the jurisdiction where services are received (Fenichel et al., 2002). It is unlikely to make a difference if the contract between the client and the counsellor deems the counselling to take place in the counsellor's jurisdiction because it is the state/province that determines whether a license is required for the practice of various occupations (Zack, 2008).

Practising outside of one's jurisdiction can also result in competence issues if the therapist lacks adequate experience within a given culture or a language barrier exists (Fenichel et al, 2002). In addition, without the benefits of non-verbal cues, counsellors may miss important clues and make incorrect assumptions regarding the client's cultural identity (Frame, 1997). The potential lack of appreciation of cultural issues that affect clients may limit counsellor credibility or lead to inappropriate counselling interventions (Sampson, Kolodinsky & Greeno, 1997).

Boundary Issues

Clients may interpret the availability of e-mail to mean that the counsellor's door is always open (Peterson & Beck, 2003). Zur (2008) explains that "there is an expectation that anyone with an e-mail address is instantly available and responsive, 24/7, therapists included" (p.2). In addition, e-mail appears to encourage familiarity and spontaneity, which can lead to misunderstandings about the nature of the relationship between the counsellor and the client (Bailey, Yager, & Jenson, 2002). Some clients may continue to send the therapist e-mails after the termination of the relationship or may even use the Internet to harass or stalk current or former therapists (Childress, 2000).

Competence

Codes of ethics require that, in order to provide a particular client service free of professional misconduct, counsellors must be competent in their chosen practice modality and have sufficient education to declare their expertise (Kanani & Regehr, 2003). Therapists may not possess the relatively high level of technological understanding of computers that is required for online counselling (Ragusea & VandenCreek, 2003). More importantly, most practitioners have not had specific training in psychotherapeutic contact in text-based environments (Maheu, 2001). As Childress (2000) explains, "[i]t takes considerable skill to communicate emotion and contextual intent solely through the written word" (p. 9).

Duty to Warn and Protect

Therapists of various disciplines have an ethical duty to warn or protect if clients present a danger to themselves or others (Mallen, Vogel & Rochlen, 2005). Delivering online counselling can provide difficulties with respect to assessing and intervening in an emergency (Mallen, Vogel & Rochlen, 2005). First, Internet communication does not always allow counsellors to evaluate the violence potential of a client (Kanani & Regehr, 2003). When therapy is conducted face-to-face, the therapist in on hand to assess and manage a psychological crisis (Carlbring & Andersson, 2006). With online counselling, the potential to fail to perceive and appropriately respond to troubling communications exists (Yager, 2003). Second, identity verification can be a problem when working

online (Ragusea & VandenCreek, 2003). As Griffiths (2001) points out, anyone can log on and lie about their situation, age or identity.

Duty to obtain Informed Consent

As noted above, providing counselling services over the Internet can provide challenges with respect to client identification (Fisher & Fried, 2003). In situations where there is no pre-existing relationship between therapist and client, the therapist may be unable to determine with certainty whether the client possesses the appropriate mental capacity to consent. Similarly, given the prevalence of youth using the Internet, there is a possibility of individuals under the age of 16 using online counselling services without parental consent (Shaw & Shaw, 2006).

The duty to obtain informed consent also requires that the client understands the potential risks and possible benefits of a proposed intervention. This can be a difficult task when the mental health benefits of different forms of online counselling are still being explored and debated in the literature (Fisher & Fried, 2003) and when research on the effectiveness of online counselling is limited in scope and breadth (Oravec, 2000).

Credentials

The use of the Internet makes it easy for professionals without sufficient credentials to offer counselling services (Barak, 1999). As Ragusea and VandeCreek (2003) point out, fraud is much easier to commit in the anonymous online world. It may also be difficult for consumers to make an accurate and informed decision about which online counselling services are good and which are not as good (Griffiths, 2001).

ONLINE COUNSELLING RESEARCH

Research conducted in the area of online counselling falls into four categories: 1) client attitudes; 2) counsellor perceptions/experiences; 3) the therapeutic alliance; and 4) the effectiveness of online counselling.

1. **Client Attitudes toward Online Counselling**

In a randomized controlled trial of psychotherapy for eating disorders delivered via e-mail (Robinson & Serfaty, 2008), the 17 participants (mean age: 24.5 years) who had received e-mail therapy were asked qualitative questions at the completion of the therapy. Overall, about 60% of the comments were positive. In particular, the anonymity was regarded favourably and the therapy was regarding as helping the participants gain control. On the negative side, some regarded the gap between their e-mails and the responses from the therapists as a disadvantage.

In an open study of e-mail therapy delivered to 23 participants with eating disorders (Robinson & Serfaty, 2001), participants were asked to comment on their treatment at the end of therapy. Most respondents felt they had been helped, either to reduce their bulimia or to accept the idea of referral for treatment in a clinic. There was a balance of opinion about the positive and negative aspects of e-mail therapy. On the positive side, participants liked the anonymity of e-mail therapy and liked that it gave them more time to think about their responses. On the negative side, participants found e-mail therapy easier to ignore, missed the personal touch of face-to-face contact and found it easier to misunderstand what was being communicated.

In a study by Tsan and Day (2007), 176 college student participants were assessed in respect of their personalities and attitudes toward seeking professional

psychological help through different modes: traditional face-to-face counselling, video-conferencing, e-mail, instant text message, and microphone. Overall, all participants preferred traditional face-to-face over online counselling modes. Women were found to hold more favourable attitudes toward online counselling than men. With respect to specific modes of seeking help, men preferred in order from most to least, face-to-face, instant message, video, e-mail, then microphone, and women preferred in order from most to least, face-to-face, e-mail, instant message, video, then microphone. Extroverts were found to have positive attitudes toward participating in online counselling, particularly online counselling with the use of an Internet microphone. Introverts favoured instant messaging next to face-to-face counselling. There was no significant relationship found between neuroticism and seeking help using online counselling.

King et al. (2006) used a consensual qualitative research methodology to explore the motivations and experiences of youth who utilized the Internet for counselling. Semi-structured online focus groups were conducted with 39 participants from the Kids Help Line, a national Australian counselling service that provides free online and telephone counselling for youth. The main benefits of online counselling cited by the participants were the privacy and emotionally safe environment. It also emerged that some participants felt better protected in the text environment from negative counsellor emotions such as boredom or criticism. Another frequently mentioned aspect that was reported by adolescents was that the online environment provided a sense of privacy, unlike the telephone where they may be in fear of someone else listening to their conversations. Youth reported that time constraints were the biggest problem with the online counselling service. Insufficient time allowed per counselling session, long wait times while in the queue, and insufficient hours of availability for the service were consistently reported throughout the focus groups. In some instances, participants reported the impression of being rushed and not being valued. A number of adolescents mentioned difficulties expressing their emotions through text communications; however this was not as prominent a theme as had been expected by the researchers.

Robinson et al. (2006) conducted a pilot study to explore the feasibility, acceptability and efficacy of a text messaging intervention in the aftercare of patients with bulimia nervosa who had received outpatient therapy. A total of 21 patients participated in the 6-month text messaging intervention as a step-down treatment after outpatient therapy. Participants were asked to rate their motivation to take part in the intervention and to complete a questionnaire exploring their views of the program. In the study, the participants' low response rates and answers to the views questionnaire suggested to the researchers that the intervention was only moderately well accepted by participants. However, at least a subgroup of participants felt supported and encouraged by the feedback messages. A significant proportion of participants were dissatisfied with the lack of personal contact, and there were suggestions to supplement the intervention with phone calls. Some participants found the program ''too formal'' and ''computerized'' and the content of the texts ''impersonal'' or ''patronizing.'' There were also occasional technical problems.

Young (2005) used a survey research design to study client attitudes towards online counselling. A total of 48 e-clients seen by the principal investigator who suffered from Internet addiction were evaluated. The mean ages of the participants were 44 (males) and 48 (females). The online counselling was in the form of cognitive behavioural therapy in a chat format. Anonymity from friends, family and coworkers was the most often cited reason for seeking online counselling, with 96% of participants

indicating that online treatment provided a viable way to get help without having to risk being seen in a psychologist's office or risk having a loved one know he or she was in counselling. The convenience of online counselling was cited by 71% of participants as a reason for seeking online counselling, while the clinical skills and credentials of the counsellor were important to 52% of participants. Access (38%) and cost (27%) were other reasons cited by participants. Participants were also asked to report their concerns regarding online counselling. The main concerns reported were: lack of privacy with using technology, lack of security associated with using technology and concerns about being caught by a spouse or employer while participating in online sessions. 27% of participants reported that they had no concerns about e-counselling.

In a qualitative study conducted by Haberstroh, Duffey, Evans, Gee and Trepal (2007), the experiences of 5 participants who engaged in online chat-based synchronous counselling sessions were explored. Participants were counsellor education graduate students ranging in age from 24 to 53 and the online counselling was provided by advanced counselling internship students. Reactions to establishing an online counselling relationship varied among the participants with some participants finding the online environment unsatisfying while others had positive experiences. Problems with technology and the technical abilities of the participants were the most immediate and apparent barriers to establishing an online relationship.

In an exploratory study of client perceptions of online counselling (Liebert, Archer, Munson, & York, 2006), 81 participants were recruited though self-selection from postings about the study on 80 Yahoo public e-groups related to mental health. The postings asked for people to take the survey if they had past or present experience as clients in online mental health counselling. The average age of participants was 29.4 years, with the majority of the sample being female. Online clients were already regular Internet users. The two most frequently cited reasons for using online counselling were convenience and privacy/anonymity. The findings also revealed that clients receiving online counselling, although satisfied with treatment, did not report as high a level of satisfaction as is reported in studies where clients received face-to-face treatment. Nevertheless, clients qualitatively reported experiencing greater ease self-disclosing with their Internet mental health counsellors compared to self-disclosing with face-to-face counsellors, especially during the beginning stages of counselling. Similarly, clients' qualitative reports of gains in psychological safety through anonymity outweighed their reported sense of loss from not having nonverbal cues or the personal warmth received from face-to-face contact.

In Cook and Doyle's study (2002) of the working alliance in online counselling provided by e-mail or chat (discussed below), the 14 participants were given the opportunity to provide comments about their experience of receiving counselling online. The theme discussed in the most depth was disinhibition. Participants described the sense of freedom they felt to express themselves online without embarrassment or fear of judgment from therapists. Many discussed the stress they typically feel in a face-to-face therapy situation and indicated that, with online counselling, there were able to be completely honest and open with a therapist. Other themes that emerged were the viability of online therapy, the affordability of online therapy, the advantages for those who have mobility challenges or who live in isolated areas, the strength of the client/counsellor relationship, the benefits of written communication (the ability to re-read messages and the ease felt when expressing thoughts and feelings through writing), and the convenience and flexibility of online therapy.

Rochlen, Beretvas, and Zack (2004) conducted an instrument-development project that addressed preliminary validation of measured attitudes toward online and face-to-face counselling services. Factor analyses of the Online Counselling Attitude Scale (OCAS) and the corresponding Face-to-Face Counselling Attitude Scale (FCAS) yielded similar two-factor structures, which assess perceived levels of value and discomfort with the two respective counselling modalities. Overall, respondents expressed more favorable evaluations of face-to-face than online counselling (although none of the clients had ever engaged in online counselling).

Lewis, Coursol and Wahl (2003) carried out an exploratory study of the client and counsellor experience with respect to online counselling. The participants were two female graduate students enrolled in a graduate counselling program. The counsellor was a female in the second year of a counselling masters program. Three sessions of cybercounselling were provided via videoconferencing. The counsellor and clients were interviewed at the end of each session. The interviews with the clients revealed a number of themes, including the following: more comfortable than face-to-face counselling, unexpected depth of emotion, empowerment and equal relationship but lack of emotional connection.

Summary

The studies in the area of client attitudes towards online counselling have methodological problems that limit the generalizability of their results. With the exception of the study by Tsan and Day (2007), the studies all had small sample sizes. In addition, other than the study by Liebert, Archer, Munson and York (2006), the studies all used convenience sampling and, in the case of the studies by Tsan and Day (2007), Haberstroh, Duffey, Evans, Gee and Trepal (2007), and Rochlen, Bertvas and Zack (2004), the sample did not contain individuals who were actually involved in online counselling. Thus, one cannot conclude that the results would reflect the attitudes, not only of those are actually involved in online counselling, but of populations beyond the samples studied. Lastly, King et al. (2006) used focus group methodology which, while advantageous in certain circumstances, has its disadvantages, including the fact that the results may be biased by either the facilitator or by dominant members (Centers for Disease Control and Prevention, 2008).

Despite these limitations, the studies can still provide useful insight as long as care is taken not to overgeneralize from them. In particular, the studies help to identify some of the reasons why individuals might prefer online counselling over face-to-face counselling:

- Privacy
- Anonymity from family, friends and coworkers
- Emotionally safe environment
- Empowerment; equal relationship with therapist
- Protection from negative counsellor emotions, such as boredom or criticism
- Convenience/Access
- Greater ease with self-disclosing; less awkward and intimidating than face-to-face counselling
- Disinhibition/freedom to express themselves without embarrassment or fear of judgment from therapist
- Ability to be completely honest and open

The studies also highlight potential disadvantages of online counselling, as seen from the perspective of both individuals using online counselling and those who have not used it:

- Feeling of being rushed
- Gap between e-mail from client and response from therapist
- Feeling of not being valued
- Difficulty expressing emotions through text communication
- Lack of emotional connection
- Lack of privacy
- Lack of security
- Concerns about being caught by spouse or employer
- Problems with the technology and technical abilities of the participants
- Sense of loss from not having nonverbal cues or the personal warmth received from face-to-face contact

Lastly, the results of the studies illustrate that online counselling may not be for everyone. For some, face-to-face counselling may simply be the preferred method of receiving help.

2. Counsellor Experiences/Perceptions

In a study by Mora, Nevid and Chaplin (2008), the attitudes of members of a state psychological association regarding the use of Internet-based therapies were examined. Psychologists in the sample did not express strong levels of endorsement of online therapies, nor did they express strong interest in using online interventions or receiving training to use these therapeutic modalities. The respondents did express concerns about the limitations of online interventions with respect to the lack of accessibility to nonverbal behaviour of patients, difficulties establishing working alliances, and the lack of legal guidelines. On the other hand, the respondents on the average recognized that online therapy offers some advantages, such as meeting needs of patients in rural areas and patients with disabilities, who may have difficulty participating in face-to face therapy.

One of the primary findings was that therapists provided stronger endorsement of Internet-based therapies as adjunctive treatments than as alternative treatments. In addition, cognitive behavioural practitioners expressed higher levels of endorsement of Internet-based interventions. While the use of e-mail emerged as the most highly endorsed adjunctive Internet modality, videoconferencing received the highest endorsement rating for alternatives to face-to-face treatment.

In an exploratory study conducted by Wangberg, Gammon, and Spitznogle (2007), the use of and attitudes of Norwegian psychologists' towards e-media such as e-mail and mobile text messaging in interaction with clients (e-therapy) was explored. A total of 1040 (23%) members of the Norwegian Psychological Association responded to a questionnaire. The results indicated that the overall attitude toward e-media in therapeutic communication was neutral, with only 3% of the psychologists believing that e-communication between therapist and client was unacceptable. 31% believed that it could work as the only form of communication, while 64% believed that it would only work as a supplement to face-to-face consultation. Regarding text messaging (SMS) communication, 40% of the psychologists said that they would use it themselves, 48% said that they would not use it themselves, but accept others using it and 11% found such communication was unacceptable. Attitudes towards e-therapy were

associated with theoretical stance. Dynamically oriented therapists were less likely to endorse e-therapy and more likely to hold negative attitudes toward e-therapy. Cognitive theoretical stance was related to holding a more positive attitude; however, this relation did not reach statistical significance. Lastly, a positive attitude towards e-therapy was related to greater use.

Bambling, King, Reid and Wegner (2008) examined the experience of counsellors providing synchronous single session counselling to young people through Kids Help Line, a national Australian counselling service that provides free online and telephone counselling for youth. Data was obtained from two semi-structured focus groups attended by 26 participants. Counsellors reported the main benefit of the online environment to be emotional safety, due to reduced client emotional proximity to the counsellor. The online environment was reported to reduce young people's anxiety about receiving counselling, making it easier to discuss problems and be assertive with counsellors. However, the reduced emotional proximity, and in particular the absence of non-verbal cues, made it difficult for the online counsellor to accurately assess the severity of young people's problems and emotional issues. Counsellors also reported specific communication problems. For example, the use of traditional active listening skills was sometimes perceived as patronizing by young people, whereas the use of communication principles and conventions developed in chatroom environments resulted in some risk of misunderstanding. Information gathering was reported as being time consuming, with therapeutic exchanges characterized by pauses while either the counsellor or the client composed a message. Efficient communication exchange was often difficult to achieve due to prolonged and sometimes inexplicable pauses in client text responses. The result was that the counselling work achieved over the space of an hour was considerably less than might be achieved in an hour of telephone or face-to-face counselling. Maintaining an empathic connection was also affected by the speed and quality of text exchange: delayed responses from a young client made it difficult for the counsellor to feel engaged in the counselling process.

In an exploratory study, Finn (2006) surveyed 384 Pennsylvania social workers working in human services agencies with respect to their email use, attitudes and difficulties. The majority of the social workers believed that it is ethical to use e-mail with clients for non-therapeutic reasons, such as to schedule appointments or provide factual information. However, most respondents (87.7%) did not agree that e-mail is a good means for providing therapeutic services.

Wells, Mitchell, Finkelhor and Becker-Blease (2007) surveyed 2,098 social workers, psychologists, and other professionals regarding the use of the Internet as part of professional mental health practice. When asked to select from a list of concerns regarding the provision of mental health services over the Internet, participants noted three primary areas of concern: confidentiality, liability, and misinformation being provided by clients.

Hanley (2006) used online forums to host an asynchronous focus group with the intention of bringing together the views of counsellors regarding the development of online counselling services for youth in the United Kingdom. The results of the survey revealed that regulation of online counselling was a major concern to counsellors. Specifically, the focus group discussed the minimum requirements that organizations in the UK should be responsible for, namely ensuring that practitioners have appropriate levels of training or experience (including counsellor training, experience or training in working with youth and relevant experience or training in developing therapeutic relationships online), ensuring that individuals offering online counselling services for

youth are aware of the appropriate legalities of running such a service (such as child protection and data protection issues) and ensuring that practitioners are working within an appropriate and recognized set of ethical guidelines and are a member of a professional counselling body.

Lewis, Coursol & Wahl (2003) carried out an exploratory study of the client and counsellor experience with respect to online counselling. The participants were two female graduate students enrolled in a graduate counselling program. The counsellor was a female in the second year of a counselling masters program. Three sessions of cybercounselling were provided via videoconferencing. The counsellor and clients were interviewed at the end of each session. The interviews with the counsellor revealed a number of themes, including the following: two-dimensional experience (i.e. process felt "flat"), lack of emotional connection and need to modify counselling skills.

A study by Finn (2002) reports on the results of a survey of 378 Masters of Social Work students about their attitudes towards the efficacy and ethics of e-therapy. The students surveyed had little experience with e-therapy. Only 17.5% of the students had ever seen an e-therapy website and only about 2% of the students knew colleagues that practiced e-therapy or knew clients who had participated in e-therapy. While there was no consensus in student attitudes, the majority of students believed that e-therapy alone is not effective or is less effective than in-person services. Students were particularly doubtful that e-therapy can provide proper assessment, can create a therapeutic relationship, or can maintain the confidentiality of client records. However, more than one third of the sample saw e-therapy as a good adjunct to in-person services.

<u>Summary</u>

The studies in the area of counsellor perceptions/experiences have a number of methodological flaws. The studies by Bambling, King, Reid and Wegner (2008), Hanley (2006) and Lewis, Coursol and Wahl (2003) had small sample sizes and the surveys conducted by Mora, Nevid and Chaplin (2008), Wangberg, Gammon and Spitznogle (2007) and Wells, Mitchell, Finkelhor and Becker-Blease (2007) had low response rates. In addition, all of the studies used convenience or purposive sampling. Lastly, the studies by Bambling et al. and Hanley used focus group methodology which, while advantageous in certain circumstances, has its disadvantages, including the fact that the results may be biased by either the facilitator or by dominant members (Centers for Disease Control and Prevention, 2008).

Accordingly, it is difficult to generalize the results of these studies beyond the populations studied. However, the results do give some helpful indications of some of the benefits and areas of concern perceived by counsellors and counselling students with respect to online counselling.

Benefits:
- Emotional safety
- Makes clients less anxious about receiving counselling, making it easier to discuss problems and be assertive with counsellors
- Might be a good adjunct to face-to-face services
- May meet the needs of patients in rural areas and patients with disabilities who may have difficulty participating in face-to-face therapy

Concerns:

- Reduced emotional proximity and absence of non-verbal cues make it difficult for online counsellors to accurately assess the severity of young people's problems and emotional issues
- Difficulties establishing a working alliance
- Communication problems
- Confidentiality
- Liability
- Misinformation being provided by clients
- Need for appropriate training or experience
- Need for awareness of legalities of offering online counselling
- Need to work within a recognized set of ethical guidelines

As Wangberg, Gammon and Spitznogle (2007) point out, studies of counsellor attitudes towards online counselling illustrate that, like any form of therapy, it is unlikely that there will ever be a consensus about the merits and disadvantages of online counselling. However, understanding the concerns of those who are, or who may be, involved in providing online counselling is helpful in setting up online counselling services that are responsive to those concerns.

3. Therapeutic Alliance

In a study by Knaevelsrud and Maercker (2007), 96 patients with posttraumatic stress reactions were allocated at random to ten sessions of Internet-based cognitive behavioural therapy conducted over a 5-week period or a waiting list control group. The intervention used was Interapy (described below). High ratings of the therapeutic alliance (as measured by the Working Alliance Inventory) and low drop-out rates indicated that a positive and stable therapeutic relationship could be established online. Significant improvement in the online working alliance in the course of treatment was observed. In addition, a substantial correlation between the quality of the online relationship at the end of treatment and treatment outcome emerged.

A study by King, Bambling, Reid and Thomas (2006) used a naturalistic design and standardized measures to compare outcomes, session impact and therapeutic alliance for samples of 100 young people receiving a single session of telephone counselling and 86 young people receiving a single session of online counselling, provided by Kids Help Line, a national Australian counselling service that provides free online and telephone counselling for youth. The online counselling involved real-time text exchange, supported by emoticons. While self-reported alliance scores were substantially higher for the telephone counselling group, compared with the online counselling group, alliance was not a major mediating variable in counselling outcome. Client reported session impact was a much stronger mediating factor.

In Leibert's (2006) exploratory study of client perceptions of Internet counselling and the therapeutic alliance (described above under "Client Attitudes toward Online Counselling"), participants rated themselves as having established a working alliance with their mental health counsellors. However, levels of working alliance (as measured by the Working Alliance Inventory – Short Form) were not as strong as levels reported in past studies involving face-to-face mental health counselling.

Cook and Doyle (2002) conducted a study of 14 clients receiving online therapy through either e-mail or chat. The therapeutic alliance was measured using the Working Alliance Inventory (WAI). The results indicated that participants felt a collaborative, bonding relationship with therapists. Results of the WAI for the online group were

compared to a face-to-face comparison group that was the small sample on which the WAI was initially validated. Both the total score for the WAI and its three constructs were as strong for online as for face-to-face clients. The total score was significantly higher for the online group as compared to the face-to-face group.

In their study, Hufford, Glueckauf and Webb (2005) sought to examine differences between the perceptions of adolescents with epilepsy and their parents in regard to comfort, distraction, and therapeutic alliance across three different modalities: (a) home-based video-system counselling, (b) home-based speakerphone counselling, and (c) videotaped, office-based counselling. Three mothers and three adolescents participated in the study. The specific at-risk or problematic behaviors selected for intervention were (a) depressed affect, (b) poor school performance-attendance, (c) social isolation, (d) verbal-physical aggression, (e) noncompliance with medical routine, (f) promiscuous sexual behavior, (g) use of nonprescription drugs-alcohol, or (h) a combination of any of these behaviors. Mothers and adolescents reported moderately high levels of comfort and therapeutic alliance and low levels of distraction across all modalities. Adolescents were more comfortable and less distracted than their mothers across all three conditions.

In a study comparing the therapeutic alliance in face-to-face versus videoconferenced psychotherapy (Rees and Stone, 2005), 30 clinical psychologists were randomly assigned to watch an identical therapy session, either face-to-face or videoconferencing format, and to then evaluate the therapeutic alliance. The psychologists in the videoconferencing condition rated the therapeutic alliance significantly lower than psychologists in the face-to-face condition.

In the study by Bouchard et al. (2004) comparing the effectiveness of cognitive-behavior therapy for panic disorder with agoraphobia when the therapy is delivered either face-to-face or by videoconference (described below), the participants in the videoconferencing group reported the development of an excellent therapeutic alliance as early as the first therapy session.

Mallen, Day and Green (2003) examined relational and discourse variables in online versus face-to-face conversations. Sixty-four undergraduate students who did not previously know each other were placed in 32 pairs and randomly assigned to a conversation with a partner in either a face-to-face setting or an Internet chat program for a 30-minute period. Emotional understanding, self-disclosure, closeness, and depth of processing were measured. The findings indicate that the face-to-face group felt more satisfied with the experience and experienced a higher degree of closeness and self-disclosure with their partner. There were no significant differences between groups in regard to the level of emotional understanding of their partner, although the face-to-face group reported higher levels of positive and negative affect.

Summary

The studies outlined above show mixed results with respect to the therapeutic alliance in online counselling. In addition, methodological flaws limit the ability to generalize their results. Other than the study by Knaevelsrud and Maercker (2007), small sample sizes, artificial conditions and convenience sampling limit the generalizability of these studies. The study by Knaevelsrud and Maercker (2007) had very strict exclusion criteria and a sample that was mainly female, better educated and younger than the general population, thus limiting its external validity. Lastly, the

studies use measures of working alliance that were not designed for Internet therapy and they may therefore be less valid for capturing an online therapeutic alliance (Knaevelsrud & Maercker, 2007).

4. **Effectiveness of Internet-based Therapy**

Barak, Hen, Boniel-Nissim and Shapira (2008) conducted a comprehensive review and meta-analysis of all of the empirical articles published up to March 2006 (n=64) that examined the effectiveness of online therapy and performed a meta-analysis of all the studies reported in them (n=92). The studies involved clients who were treated for a variety of problems through various Internet-based psychological interventions, whose effectiveness was assessed by different types of measures. The authors also examined interacting effects of various possible relevant moderators of the effects of online therapy, including type of therapy, type of outcome measure, time of measurement of outcome (post-therapy or follow-up), type of problem treated, therapeutic approach, and communication modality, among others. With respect to type of therapy, it is important to note that, for the purposes of the meta-analysis, the authors differentiate between online intervention methods that include human communication (termed "e-therapy") and self-help, website-based therapy (termed "web-based therapy"). Studies with respect to both e-therapy (n=27) and web-based therapy (n=65) were included in the meta-analysis. The results of the meta-analysis include the following:

1. The overall mean weighted effect size was found to be 0.53 (medium effect), which the authors state is quite similar to the average effect size of traditional, face-to-face therapy. This average effect size was found across different intervention methods and approaches, types of measure of effectiveness, problem areas, Internet channels and modalities, age of patients, and other variables.
2. The mean effect size of the 27 studies that examined the effectiveness of e-therapy was 0.46.
3. In the 14 studies that compared Internet and face-to-face interventions, there was no difference in effectiveness.
4. A number of factors were found to moderate the effects of Internet therapy, including the following:
   a) *Type of Problem* – Internet-based interventions were found to be better suited to treat problems that are more psychological in nature and less suited to treat problems that are primarily physiological or somatic.
   b) *Therapeutic approach* – Cognitive behavioural therapy was more effective than other therapeutic approaches applied online, while behavioural techniques (interventions primarily based on modification and shaping of target behaviours based on learning principles) were less effective.
   c) *Type of Therapy* - On average, self-help web-based interventions provide as effective therapy as online communication-based e-therapy.
   d) *Synchronicity of Communication* – Of the 27 studies that investigated the effectiveness of e-therapy, the mean effect size of the 12 studies that studied the use of the synchronous communication modality (chat, audio or webcam) was 0.49, whereas the mean effect size of the 15 studies that investigated asynchronous therapeutic communication tools was 0.44. The difference was not found to be statistically significant.

e) *Type of Modality* – The results indicate that chat and e-mail may be more effective than forum and webcam in the delivery of e-therapy.

f) *Age of Patients* - Clients' age made a difference in terms of difference in terms of their ability to gain from therapy. Specifically, among four age-group categories employed, the findings showed that the effect size of Internet-based therapy provided to mid-age adults (19-39) was higher than either to older or younger clients. However, the authors suggest that this finding might be a temporal result of a vanishing factor: that of pervasiveness, acceptance, and usage skills associated with the Internet. They also point to studies of Internet-based therapy for older adults and children published after the end of the data collection for their analysis that showed strong therapeutic effects.

5. Very little outcome research has been published on Internet components that may be used to complement face-to-face therapy (e.g. use of e-mail in between face-to-face sessions). However, the authors state that findings published on such therapeutic use have been promising.

The meta-analysis has a number of methodological limitations to which meta-analyses are generally subject, including sampling bias (only quantitative studies that reported magnitude of effect size were included) and publication bias (studies with significant effects are more likely to be published) (King & Jun, 2005). In addition, the authors did not use quality of research as a criterion and thus treated methodologically strong studies in the same manner as methodologically weak studies (Rubin & Babbie, 2005). This might have introduced error variance into the results (Barak, Hen, Boniel-Nissim and Shapira, 2008). Lastly, significant for the purpose of this literature review is the fact that, of the 27 studies that evaluated the effectiveness of e-therapy, 18 of them used a group intervention (a forum or chat room). Accordingly, the number of studies that examined individual e-therapy was only 9. With a small sample of individual e-therapy studies, it is difficult to draw any definitive conclusions from the included studies.

Despite these limitations, the meta-analysis does illustrate the potential of Internet-based psychotherapeutic interventions, particularly web-based self-help interventions.

<u>Self-Help Interventions</u>

As indicated by the meta-analysis carried out by Barak, Hen, Boniel-Nissim and Shapira (2008), much of the research in computer-mediated therapy has been carried out with respect to Internet self-help interventions, including computerized cognitive behavioural therapy. Although outside the scope of this review given the limited therapist involvement in these interventions, this research is helpful in illustrating the potential uses, limitations and effects of Internet interventions.

A number of systematic reviews and meta-analyses have been carried out in the area of Internet self-help interventions. A moderate overall mean effect size has been found with respect to treatment of symptoms of depression and anxiety with Internet-based cognitive behavioural therapy programs (Spek et. al., 2007). Computerized cognitive behavioural therapy has also been found to be as effective as therapist-led cognitive behavioural therapy for the treatment of phobia/panic and more effective than treatment as usual in the treatment of depression and anxiety; however, computerized cognitive behavioural therapy was found to not be as effective as therapist-led CBT in the treatment of obsessive-compulsive disorder (Kaltenthaler et al.,

2006). In addition, Internet self-help interventions have been found to show promise as a means of 1) improving symptoms of depression, 2) reducing anxiety and anxiety-related cognitions in patients with panic disorder and posttraumatic stress disorder, 3) reducing some risk factors for eating disorders. 4) leading to improvements in some aspects of sleep in those with insomnia, and 5) leading to reduced headache frequency in those suffering from headaches (Griffiths and Christensen, 2006). Computerized self-help intervetions aimed at targeting pain and headaches have also been found to be effective (Cuijpers, van Straten & Andersson, 2008).

Therapist involvement in the self-help studies ranges from no involvement to e-mail instruction or reminders from therapists to e-mail feedback from therapists. The self-help interventions where there is more substantial therapist involvement have also been shown to be effective. "Interapy" and interventions for panic disorders are two examples.

Interapy is a protocol-driven Internet treatment for post-traumatic stress and grief (Lange, van de Ven and Schrieken, 2003). Interapy includes psycho-education, screening, effect measures and protocol-driven treatment via the Internet for clients. Unlike the self-help interventions described above, therapists are involved in Interapy, providing both instructions and feedback. The treatment takes place over a period of 5 weeks in which participants have 10 writing sessions, two 45-minute sessions a week. They write 4 times in the self-confrontation phase, then 4 times in the phase of cognitive reappraisal and, finally, twice in the last phase of sharing and taking leave. The first instruction/feedback is after the trauma-description. In the middle of each phase and at the end of each phase, the therapists provide the participants with feedback about their writings and instructions on how to proceed.

A number of studies into the effectiveness of Interapy have been carried out (e.g. Lange et al. 2003; Lange et al., 2000; Lange, van de Ven, Schreiken, and Emmelkamp, 2001; Wagner, Knaevelsrud and Maercker, 2006; and Knaevelsrud and Maercker, 2007). The studies indicate that Interapy may be a viable treatment alternative for post-traumatic stress disorder with large effect sizes and sustained treatment effects. Participants in the studies showed improvements on trauma-related symptoms, pathological grief symptoms and in psychological functioning.

Studies of the effectiveness of Internet-based cognitive behavioural panic treatment with email contact involving the therapist providing individualized support and feedback to the participant according to their request and needs have also been carried out. This intervention has been found to be effective in reducing panic disorder symptomatology, panic and agoraphobia-related cognition and negative affect (Klein, Richards & Austin, 2006; Richards, Klein, & Austin, 2006.)

<u>Single Session Counselling</u>

A study by King, Bambling, Reid and Thomas (2006) used a naturalistic design and standardized measures to compare outcomes, session impact and therapeutic alliance for samples of 100 young people receiving a single session of telephone counselling and 86 young people receiving a single session of online counselling, provided by Kids Help Line, a national Australian counselling service that provides free online and telephone counselling for youth. The online counselling evaluated used real-time text exchange, supported by emoticons. It was provided by trained counsellors with typical session duration of 50-80 minutes. Counselling had a positive effect in both the telephone and online conditions and, overall, young people were significantly and substantially less distressed at the end of the counselling session than they were at the

beginning. The results indicated that the telephone counselling group showed a larger counselling effect (evidenced by a greater reduction in distress) than did the online group. The magnitude of the difference was sufficient to indicate that telephone counselling was clearly superior to online counselling. While self-reported alliance scores were substantially higher for the telephone counselling group, compared with the online counselling group, alliance was not a major mediating variable in counselling outcome. Client reported session impact was a much stronger mediator.

In a study by Cohen and Kerr (1998, as cited in Mallen, Vogel, Rochlen & Day, 2005) 24 undergraduate students were assigned to a semi-structured single session of face-to-face counselling or one semi-structured session of online counselling delivered through synchronous chat. Results indicated significant decreases in anxiety level in both groups, with no difference in the level of change in the two modes and similar evaluations of intervention sessions and counsellors.

<u>Eating Disorders</u>

Robinson and Serfaty (2008) conducted a pilot randomized controlled trial of e-mail therapy for bulimia nervosa and binge eating disorder. 110 people in a university population responded to e-mailed eating disorder questionnaires. 97 fulfiling criteria for eating disorders were randomized to therapist administered e-mail bulimia therapy (eBT), unsupported self directed writing (SDW) or waiting list control groups (WLC). Diagnosis, Beck depression inventory and Bulimia investigatory test scores were recorded. The results demonstrated that therapy (either eBT or SDW) significantly reduced the number of participants fulfilling DSM-IV eating disorder criteria, compared to WLC. Comparing each therapy with controls and each other suggested that eBT was significantly better than control, SDW was better than control at a borderline non-significant level and the two therapies were not different from each other.

In an earlier open study by Robinson and Serfaty (2001), 23 women with Bulimia Nervosa or Binge Eating Disorder were treated via e-mail therapy. The therapeutic approaches used were cognitive behavioural therapy and eclectic techniques. Frequency of contact was negotiated between e-therapist and subject. The advice was for the subject to keep a diary of food consumed, eating disorder and other symptoms and problems for 3 days and then return it, with e-mails initially at a rate of twice a week. A 3-month follow up showed significant improvement in symptoms and severity of problem, as well as in depression. Significant, modest correlations were noted between words written and improvement in scores noted.

<u>Weight Loss</u>

In their study, Tate, Jackvony and Wing (2003) compared the effects of an Internet weight loss program alone versus the addition of behavioral counselling via e-mail on weight loss in adults at risk for Type 2 diabetes. Participants were randomized to a basic Internet (n=46) or to an Internet plus behavioral e-counselling program (n=46). Both groups received one face-to-face counselling session and the same core Internet programs and were instructed to submit weekly weights. Participants in e-counselling submitted calorie and exercise information and received weekly e-mail behavioral counselling and feedback from a counsellor. Counsellor e-mails provided feedback on the self-monitoring record, reinforcement, recommendations for change, answers to questions, and general support. The results of the study showed that adding e-mail counselling to a basic Internet weight loss intervention program significantly improved weight loss in adults at risk of diabetes. Specifically, the behavioral e-counselling group

lost more mean weight at 12 months than the basic Internet group and had greater decreases in percentage of initial body weight body mass index, and waist circumference.

Tate, Wing and Winett (2001) conducted a randomized, controlled study to determine to determine whether a structured Internet behavioral weight loss program produces greater initial weight loss and changes in waist circumference than a weight loss education Web site. Participants were randomly assigned to a 6-month weight loss program of either Internet education (n=32) or Internet behavior therapy (n=33). All participants were given one face-to-face group weight loss session and access to a Web site with organized links to Internet weight loss resources. Participants in the behavior therapy group received additional behavioral procedures, including a sequence of 24 weekly behavioral lessons via e-mail, weekly online submission of self-monitoring diaries with individualized therapist feedback via e-mail, and an online bulletin board. Participants in the online behavioural therapy group had better weight loss compared with those in the Internet education group.

Chat-Based Online Cognitive Behavioural Therapy

Rassau and Arco (2003) examined the effects of chat-based online cognitive behavioural therapy on a university student's study-related behaviour and anxiety. The researcher and the participant interacted during six 45-minute weekly on-line sessions, which aimed at advising the participant on the following: (a) how anxiety occurs, and its connection to antecedents, thought, and consequences; (b) basics of cognitive behavioural therapy; (c) how to set study goals and strategies, and self-evaluate behaviour; and (d) basic strategies for reducing study-related distractions and anxiety. The results showed that chat-based online cognitive behavioural therapy increased a range of positive study behaviours, accompanied by a decrease in anxiety to moderate and stable levels.

Videoconferencing

Bouchard et al. (2004) studied the effectiveness of telepsychotherapy for panic disorder with agoraphobia. The aim of this study was to compare the effectiveness of cognitive-behavior therapy (CBT) for panic disorder with agoraphobia (PDA) when the therapy is delivered either face-to-face or by videoconference. A sample of 21 participants (median age of 30) was treated either face-to-face or by videoconference. Results showed that CBT delivered by videoconference was as effective as CBT delivered face-to-face. There was a statistically significant reduction in all measures, and the number of panic-free participants among those receiving CBT by videoconference was 81% at post-treatment and 91% at the 6-month follow-up. None of the comparisons with face-to-face psychotherapy suggested that CBT delivered by videoconference was less effective.

Another study (Nelson, Barnard & Cain, 2003) evaluated an 8-week, cognitive-behavioural therapy intervention for childhood depression either face-to-face or over videoconferencing. 28 children (between the ages of 8 and 14) were randomized to either the face-to-face or videoconferencing treatment. The cognitive behavioural therapy treatment across the two conditions was effective in decreasing depression. 23 (82%) of the 28 children no longer met the depression criteria at the end of the study.

Day and Schneider (2002) randomly assigned 80 participants, who volunteered to participate through numerous media and referral sources, to three modes of psychotherapy: face-to-face, videoconference, and two-way audio. They also used a

wait-list group as a control condition. The participants ranged in age from 19 to 75 years and presented a variety of issues, including body image or weight, family relationships, other relationships, self-esteems and work or school. The outcome measures included the Brief Symptom Inventory, Global Assessment of Functioning, Target Complaints method, and modified versions of the Client and the Therapist Satisfaction Scales. Results suggested that differences in process and outcome among the three treatments were small and clinically promising in comparison with the untreated control group.

Facebook/MySpace

The literature review did not reveal any research conducted with respect to using Facebook or MySpace as a modality for conducting online counselling. The use of blogging within an online social networking community as a form of self-therapy is beginning to be explored (Tan, 2008). In addition, the use of social networking sites as tools for mental health professionals has been suggested. Clemens, Shipp and Pisarik (2008) suggest two approaches when working with adolescent MySpace users. First, MySpace reflection can be used as a homework assignment. Adolescents can be asked to reflect on the MySpace profile that they have created. The second method is to invite the adolescent to share his or her MySpace profile during a counselling session. Questions about the profile could be used to engage adolescents in a discussion of the exploration process of identity development.

E-mail therapy as a Therapeutic Adjunct

As Barak, Hen, Boniel-Nissim and Shapira (2008) point out in their meta-analysis, little outcome research has been published on Internet interventions that may be used to complement face-to-face therapy, such as the use of e-mails in between face-to-face sessions. However, a number of case studies that describe the use of e-mail as a therapeutic adjunct have been carried out.

Georgiades (2008) carried out a 4-year therapeutic intervention, combining in-person and e-mail communication with a 13-year-old teenager who witnessed and later was the victim of severe domestic violence. The intervention was based on an empowerment philosophy and solution-focused strategies, and its usefulness was evaluated by three standardized measures at five time points between the years 1999 and 2003. The intervention may have helped to produce better perpetrator-youth relations, remission of the client's depression and post-traumatic stress symptoms and improvement in his academic performance. The author notes that the case study "…illustrates the vitality of e-mail therapy with youth clients who are technologically literate and lack physical proximity to their therapist" (p. 148).

Roy and Gillett (2008) discuss the use of e-mail therapy with a teenager who had a 4-year history of low mood and unpredictable self-harming behaviour. The therapy involved weekly e-mails over a 3-month period. The authors report that e-mail enabled engagement to occur and a strong therapeutic alliance to develop. From the authors' perspective, the therapeutic relationship established through the use of e-mail allowed the client to explore and understand past experiences and start resolving present problems. It also allowed diagnosis to become clearer. The client felt that e-mailing gave her time to sort out how she was feeling and what she was thinking so that she could respond to the therapist's thoughts and questions. She also said that it gave her a sense of distance and control so she didn't feel overwhelmed and could modulate her emotions more effectively. The main disadvantage of the e-mail therapy cited by the authors was that the therapist felt that she needed to bring up potentially difficult

subjects gradually, over several sessions. She attributed this to not being able to gauge how the client was immediately feeling as she did not have nonverbal or immediate written feedback.

Bailey, Yager & Jenson (2002) utilized e-mail as an adjunctive treatment tool in the outpatient management of an adolescent with anorexia nervosa. As part of her treatment program, the 17-year old patient e-mailed her psychiatrist several times a week regarding the amount and variety of her meals and other issues pertinent to cognitive, behavioural and emotional aspects of therapy. Outcomes of the e-mail therapy observed by the authors were weight gain and reasonably good biological and psychosocial recovery. The psychiatrist elicited feedback from the patient with respect to the e-mail process. The patient felt that the use of e-mail kept her in check with things and acted as an incentive to do well. She also found that reading the psychiatrist's responses was encouraging. She also described the e-mails as a good way to release what was on her mind at the moment that she might otherwise forget to mention in a session. The patient noted three cons of the e-mail exchanges: 1) she viewed it as one more thing that she had to do; 2) she disliked reporting bad news because of her own doing; and 3) forgetting to check in regularly made her feel bad.

Yager (2001) explored the use of e-mail with patients suffering from anorexia nervosa. E-mail was used with 10 patients in various ways including 1) as a supplement to weekly psychotherapy sessions, 2) as a treatment monitoring system for "checking in" and 3) as a way of maintaining contact with a patient who was followed briefly, as a bridge between other care providers. Yager found that all patients showed good clinical improvement. Patients provided their assessments of contributions made by the use of e-mail and generally found it to be helpful.

Murdoch and Connor-Greene (2000) supplemented cognitive behavioural therapy sessions with e-mail homework assignments with a 24 year old patient being treated for depression and a 19 year old patient being treated for an eating disorder. E-mail was specifically used for reporting, monitoring and feedback of patient homework assignments. In both cases, the use of e-mail as a therapeutic adjunct appeared to have a positive impact on treatment efficacy. The authors found that e-mail was an effective adjunct to therapy in two ways: 1) it can strengthen the therapeutic alliance by increasing communication between therapist and patient and 2) consistent with CBT, an increased opportunity for practice with feedback appeared to enhance the effectiveness of interventions.

<u>Summary</u>

Other than studies with respect to Internet self-help interventions, there is limited research with respect to the effectiveness of online counselling. From the limited number of studies that evaluate online counselling between therapist and client, the following results have been obtained:

➢ Internet self-help interventions that involve e-mail support and feedback from the therapist may be effective in treating post-traumatic stress and grief, as well as panic disorder.
➢ Single session counselling using real-time text exchange may be effective in reducing distress among youth and anxiety in students.
➢ Chat-based online cognitive behavioural therapy may be effective at improving university students' study-related behaviour and anxiety.

- E-mail therapy may be effective in treating young women with eating disorders.
- The Internet and e-mail appear to be viable methods for delivery of structured behavioral weight loss programs.
- Cognitive behavioural therapy via videoconferencing may be a potential treatment modality for childhood depression and panic disorder with agoraphobia.
- The use of e-mail as an adjunct to face-to-face counselling may have effective clinical outcomes in the case of eating disorders, depression and post-traumatic stress disorder.

However, the studies in this area have a number of methodological flaws that limit the external validity, or generalizability, of their results. First, many of the studies have small sample sizes. Second, most of the studies used convenience sampling or had self-referred samples. With self-referral, it is possible that those who feel uncomfortable with computers or who do not have access to the Internet would not respond to recruitment methods (Klein, Richards & Austin, 2006). Third, some of the studies had strict inclusion criteria. As Andersson et al. (2008) explain, efforts to include "real patients" with diagnosis may be a contributing factor to the strong effects found. Fourth, with the studies that evaluate Internet self-help interventions that include e-mail support and feedback from a therapist, while there are some indications that therapist factors may make a difference in treatment (Andersson, et al., 2008), it is difficult to conclude to what extent the effectiveness of the intervention can be attributed to the therapist involvement. Fifth, the study on chat-based cognitive behavioural therapy (Rassau & Arco, 2003), as well as the studies that explored the use of e-mail as an adjunct to therapy, were case studies and they therefore cannot provide generalizing conclusions given their small and idiosyncratic samples (Hodkinson & Hodkinson, 2001). Lastly, only a limited number of the reviewed studies used interventions targeted at youth and none of the studies evaluated asynchronous e-mail counselling with youth, thus limiting the extrapolation of the results of the studies to the online counselling services currently being provided by East Metro Youth Services.

In addition, only a limited number of the studies were carried out by way of randomized controlled trials. Without a randomized controlled trial, it can be difficult to control for threats to internal validity and it is thus difficult to demonstrate causality (Rubin & Babbie, 2005).

It is clear that further research into the effectiveness of online counselling is needed. Future research should focus on, among other things, the therapeutic effectiveness of online counselling (Finfgeld, 1999), the kinds of issues that are appropriate for online counselling (Lewis, Coursol & Wahl, 2003), what types of clients might be good candidates for online counselling (Rochlen, Beretvas, & Zack, 2004), and how socio-economic status , ethnicity, culture, geographic location , age and gender affect a patient's access to, and acceptance of, online counselling. In the meantime, the studies do illustrate the potential uses of online counselling as both an alternate and adjunct to face-to-face counselling (Griffiths, 2005).

SUGGESTIONS FOR PRACTICE

Suggestions for practice have been put forward to address many of the disadvantages and ethical/legal concerns identified in respect of online counselling and

to recognize any relevant research findings. These suggestions have been summarized in respect of the named disadvantage or ethical/legal concern.

Confidentiality

> ➤ Counsellors should inform clients of the standard limits to confidentiality (e.g. child abuse reporting mandates) and the threats to confidentiality that are unique to electronic transmission of information (Fisher & Fried, 2003).

> ➤ Counsellors should take steps to mitigate the risk of potential security breaches; for example, secure websites and e-mail encryption should be used (Manhal-Baugus, 2001).

> ➤ Counsellors should advise clients of the procedures being used to protect confidentiality (Fisher & Fried, 2003).

> ➤ Clients should be informed of their own confidentiality burden (Kanani & Regehr, 2003). They should be advised to participate in online therapy in a private room in which family members or others are not likely to intrude (Ragusea & VandeCreek, 2003). Clients should also be informed of the risk of keeping records of online sessions (Mallen, Vogel & Rochlen, 2005).

> ➤ Counsellors should inform clients of the methods in which and the time period for which records of online sessions are being retained (Kanani & Regehr, 2003).

> ➤ Clients should be made aware of the extent to which various parties (such as supervisors) will be given access to the records of online sessions (Oravec, 2000).

Jurisdiction/Culture

> ➤ Online counsellors should be familiar with the licensure restrictions and exemptions in their jurisdiction and the jurisdictions in which they clients are located (Zack, 2008)

> ➤ Therapists should only deliver mental health services in jurisdictions in which they are licensed (Mallen, Vogel & Rochlen, 2005).

> ➤ Counsellors need to develop sensitivities to the differences in meaning and nuances across cultures . They must be careful in making conclusions about things such as names and idiomatic expressions (Fenichel et al., 2002).

> ➤ Counsellors should prepare for a client in a particular location by becoming familiar with local cultural norms and recent local events (Sampson Jr., Kolodinsky, & Greeno, 1997).

- ➢ The intake form could contain information regarding the ethnic and cultural background of the client (Frame, 1997); however, this may be perceived as bias on the part of the therapist (Midkiff & Wyatt, 2008).

- ➢ If the therapist encounters an unanticipated reaction on the part of the client, the therapist should proceed slowly, clarifying client perceptions of their thoughts, feelings, and behaviours (Sampson Jr., Kolodinsky, & Greeno, 1997).

Boundary Issues

- ➢ Counsellors must take steps to avoid encouraging undue familiarity or excessive dependence (Bailey, Yager, & Jenson, 2002).

- ➢ Counsellors can attempt to maintain boundaries with respect to expectations for immediate responses by establishing a time frame for responses (Kanani & Regehr, 2003).

- ➢ Counsellors must work with clients to establish rules with regard to appropriate use of e-mail communication (Tate & Zabinski, 2004).

- ➢ The tone of e-mails should always be professional (i.e. avoid anger, annoyance and other unprofessional tones) (Silk & Yager, 2003).

- ➢ Counsellors should use the same professional tone and language that is used in the office; inappropriate jokes, unprofessional social or self-disclosing remarks should be avoided (Gutheil & Simon, 2005).

- ➢ E-mail should not be used with clients suffering from severe boundary problems (Bailey, Yager, & Jenson, 2002).

Competence/Lack of Skills

- ➢ Counsellors should seek out training necessary to acquire competence in online counselling (Zack, 2008).

- ➢ Online counselling training should cover technology, theory, applications and ethics (Fenichel et. al., 2002), as well as licensing laws (Maheu, 2003). It should also include skills in text-based communication (Murphy, MacFadden & Mitchell, 2008) and protecting client information online (Wells, Mitchell, Finkelhor, Becker-Blease, 2007).

- ➢ Counsellors should lobby for the development of e-therapy courses and certificates (Kanani & Regehr, 2003).

- With respect to technological competence, counsellors should only use software that is congruent with their capabilities or if new software is used to expand competencies (Sampson Jr., Kolodinsky, & Greeno, 1997).
- Counsellors must develop an ability to interpret the style and content of e-mails written by the client; this is especially important with youth given that youth have developed their own language on the Internet that is "characterized by abbreviations, spelling phonetically, and the absence of many of the rules of grammar" (Kids Help Phone, 2005, p. 21).

- Counsellors must assess the client's suitability for online therapy, looking at such factors as knowledge of computer systems and Internet technology, motivation and capability of experimenting with new communication environments and techniques; and physical or cognitive problems that may limit ability client's typing ability and/or ability to read and write (Suler, 2001).

Duty to Warn and Protect

- Counsellors should acquire identity information from the client (Ragusea & VandeCreek, 2003).

- Counsellors should only conduct online therapy in conjunction with face-to-face therapy or with a prerequisite meeting in person, so that identity can be verified via conventional means (Ragusea & VandeCreek, 2003).

- Counsellors should have back up resources to avail themselves of in the event of an emergency. Maheu (2003) recommends that backup resources include the emergency department of a local hospital, a trusted colleague, the client's primary care provider, his or her specialty provider or a family member.

- Counsellors should be part of a network of e-therapists so as to be able to obtain assistance or effect referrals to someone in a client's local jurisdiction as required (Kanani & Regehr, 2003).

- Counsellors should provide clients with clear written guidelines regarding planned emergency practices (Koocher & Morray, 2000).

- Online counselling websites should have a notice for suicidal individuals with information about hotlines, crisis centres and emergency departments of hospitals (Manhal-Baugus, 2001).

- Counsellors should not take on clients for online counselling who are suffering from psychiatric disorders needing immediate attention, who are significantly depressed (Carlbring & Andersson, 2006), who pose a danger to themselves or others, such as serious substance abusers and clients presenting psychotic or actively suicidal concerns (Mallen, Vogel & Rochlen, 2005), or who are highly reactive and potentially dangerous, such as those with borderline personality disorder, paranoia or dissociative disorders (Maheu, 2001).

➢ Crisis situations requiring quick response should not be addressed online and clients who are experiencing such situations should be encouraged to seek face-to-face counselling (Murphy, MacFadden & Mitchell, 2008).

➢ Online counselling websites should disclose topics that are not appropriate for online counselling, such as sexual abuse and violent relationships (Maheu, 2001).

Informed Consent

➢ Counsellors should confirm the age and legal status of the client through an initial interview (Fisher & Fried, 2003) or through another screening or intake procedure (Shaw & Shaw, 2006).

➢ Counsellors should fully describe the online services to be provided as well as any factors that might discourage clients from wanting to participate in online counselling (Shapiro & Shulman, 1996).

➢ Counsellors need to make clients aware of additional risks due to the online medium (e.g. confidentiality, possibility of technical difficulties, possibility of misunderstandings due to limitations inherent in text-based communication and difficulties intervening in the case of an emergency) (Zack, 2008).

➢ In obtaining informed consent, counsellors must disclose the fact that there is little empirical evidence on the benefits of online counselling (Kanani & Regehr, 2003).

➢ Counsellors should stay aware of emerging developments in research as to the efficacy of online counselling, including research as to which clients can benefit from online counselling and which modes of online care are most beneficial (Oravec, 2000). Informed consent should be an ongoing process that is re-evaluated periodically as new information about online counselling becomes available (Recupero & Rainey, 2005)

➢ A click-wrap agreement should not be used in place of an informed consent discussion as clients must be able to demonstrate understanding of the material (Recupero & Rainey, 2005).

Scope of Practice

➢ Counsellors should contact their licensing body to ensure that they are able to practice e-therapy (Kanani & Regehr, 2003).

➢ Counsellors should contact their insurer to ensure that their policy covers online counselling (Murphy, MacFadden & Mitchell, 2008).

Credentials

- Online therapists should provide links to websites of all relevant certification and licensing boards (Jencius & Sager, 2001).

Access

- Therapists/agencies should seek grants and other forms of funding to develop and support programs to bring technologies to those in greatest need and actively engage in outreach (Jencius & Sager, 2001).

Time Delay/Technological Failure

- Back-up procedures to be implemented in case of technological failure (such as telephone contact by the counsellor) should be provided to the client in advance of commencing online therapy (Jencius & Sager, 2001).

Loss of the Human Factor/Lack of Non-Verbal Cues/Impact of the Written Word

- Two techniques suggested by Murphy and Mitchell (1998) are emotional bracketing and descriptive immediacy. Emotional bracketing involves bracketing the emotional context behind the typed words to allow the client to hear the intended vocal tone in the words. Descriptive immediacy involves providing the client with images that will give him/her a context for understanding the counsellor's words.

- The use of metaphor, story-telling and poetry can also be used to convey quality and intensity of emotion, as well as to broaden levels of meaning (Murphy & Mitchell, 1998).

- Use spacing and pacing techniques to exercise a higher degree of control over the online counselling process (Murphy, MacFadden & Mitchell, 2008).

- The use of "smileys", emoticons and other commonly used symbols can convey not only facial expressions but also a variety of emotional nuances (Fenichel et al., 2002). The client and counsellor can develop a set of standardized emoticons and acronyms. It can be tailored into the software used for online practice or the client can be provided with a sheet of the emoticons and acronyms (Menon and Miller-Cribbs, 2002).

- To prevent misunderstandings, the counsellor should check with the client often to make sure the client understands what the counsellor is saying and that the counsellor understands what the client is saying (Stofle, 1997).

- Counsellors should actively check in with clients with follow-up questions to comments that may cause concern (Zabinski, Celio, Jacobs, Manwaring & Wilfley, 2003)

- Monitor clients for potential barriers to continuing with online counselling (Abbott, Klein, & Ciechomski, 2008).

➢ Clients should be empowered along with counsellors to suspend online treatment if they feel uncomfortable (Oravec, 2000).

➢ Counsellors should not use e-mail with patients with borderline personality disorder as the risk of hypersensitive distortions of e-mail communications may be substantial (Yager, 2003).

➢ Online counselling should perhaps not be used for experiential, insight-oriented or psychodynamic psychotherapy (Bouchard et. al., 2000).

➢ Online therapy should only be used as an adjunct to face-to-face counselling (Maheu, 2003). With respect to using e-mail as a therapeutic adjunct, Peterson and Beck (2003) suggest that the adjunctive model of e-mail application presumes the following:
  • An already established therapeutic alliance;
  • Therapist preparedness for the implications of e-mail dialogue;
  • A clearly negotiated e-mail contract to include boundaries and mutual expectations;
  • A "promises kept" understanding in which the patient can rely on the therapist to respond, even if not instantaneously; and
  • A "bailout" safeguard, wherein the therapist calls for a face-to-face sessions when e-mail use is regarded as countertherapeutic.

➢ The use of videoconferencing allows for multiple sensory cues, such as visual appearance, body language and vocal expression (Suler, 2000).

CODES OF ETHICS AND GUIDELINES

A number of codes of ethics and guidelines have been developed to deal with the ethical challenges associated with the provision of online counselling. These codes and guidelines reflect many of the suggestions for practice outlined above. The International Society for Mental Health Online, the Association for Counselling and Therapy Online and the National Board for Certified Counsellors have each published guidelines with respect to the practice of Internet counselling. Other mental health professional associations have added the concept of online counselling to their existing codes of ethics. For example, the codes of ethics (or similar documents) of the American Counselling Association, the American Mental Health Counsellors Association and the Canadian Counselling Association each have provisions dealing with technology-assisted services. The provisions of these aforementioned codes and guidelines focus on, among other things, informed consent, emergencies, standard operating procedures, the Internet counselling relationship, licensure and certification, confidentiality, client and counsellor identification and legal considerations.

The Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association specifically state that the provisions apply to activities across a variety of contexts, such as in person, postal, telephone, Internet, and other electronic transmissions. In addition, references to electronic communication can be found in the Informed Consent and Confidentiality principles. Similarly, the Code of Ethics of the

National Association of Social Workers refers to providing service via electronic media in both its Informed Consent and Privacy & Confidentiality sections.

Set forth in the Appendix hereto are the relevant codes and guidelines or excerpts therefrom.

The codes of ethics of the following associations do not refer to, or contain specific provisions with respect to, online counselling: Canadian Association of Social Workers, College of Psychologists of Ontario, Ontario Association of Consultants, Counsellors, Psychotherapists and Psychometrists, and Ontario Association of Social Workers and Social Service Workers.

CONCLUSION

As seen, online counselling has both advantages and disadvantages and a number of legal and ethical considerations surrounding its offering and provision. In addition, research in the area of Internet therapy focuses primarily on self-help interventions with little therapist involvement and there is limited conclusive empirical evidence with respect to the efficacy of online counselling between therapist and client. As the research with respect to client and counsellor attitudes highlights, online counselling may simply not be for everyone.

Until more conclusive research is conducted, the safest course may therefore be for East Metro Youth Services to solely use online counselling with existing clients as an adjunct to face-to-face counselling. In so doing, East Metro Youth Services must ensure that online counselling services will only be provided to clients that are suitable for, and willing to engage in, online counselling. In addition, all appropriate safeguards must be in place and the suggestions for practice outlined herein, as well as the codes and guidelines set forth in the Appendix hereto, will be of assistance in ensuring that East Metro Youth Services' online counselling services are carried out in a way that maximizes the benefits and mitigates the risks.

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APPENDIX

CODES AND GUIDELINES

A.12. Technology Applications

A.12.a. Benefits and Limitations
Counselors inform clients of the benefits and limitations of using information technology applications in the counseling process and in business/ billing procedures. Such technologies include but are not limited to computer hardware and software, telephones, the World Wide Web, the Internet, online assessment instruments and other communication devices.

A.12.b. Technology-Assisted Services
When providing technology-assisted distance counseling services, counselors determine that clients are intellectually, emotionally, and physically capable of using the application and that the application is appropriate for the needs of clients.

A.12.c. Inappropriate Services
When technology-assisted distance counseling services are deemed inappropriate by the counselor or client, counselors consider delivering services face to face.

A.12.d. Access
Counselors provide reasonable access to computer applications when providing technology-assisted distance counseling services.

A.12.e. Laws and Statutes
Counselors ensure that the use of technology does not violate the laws of any local, state, national, or international entity and observe all relevant statutes.

A.12.f. Assistance
Counselors seek business, legal, and technical assistance when using technology applications, particularly when the use of such applications crosses state or national boundaries.

A.12.g. Technology and Informed Consent
As part of the process of establishing informed consent, counselors do the following:
1. Address issues related to the difficulty of maintaining the confidentiality of electronically transmitted communications.
2. Inform clients of all colleagues, supervisors, and employees, such as Informational Technology (IT) administrators, who might have authorized or unauthorized access to electronic transmissions.
3. Urge clients to be aware of all authorized or unauthorized users including family members and fellow employees who have access to any technology clients may use in the counseling process.

4. Inform clients of pertinent legal rights and limitations governing the practice of a profession over state lines or international boundaries.
5. Use encrypted Web sites and e-mail communications to help ensure confidentiality when possible.
6. When the use of encryption is not possible, counselors notify clients of this fact and limit electronic transmissions to general communications that are not client specific.
7. Inform clients if and for how long archival storage of transaction records are maintained.
8. Discuss the possibility of technology failure and alternate methods of service delivery.
9. Inform clients of emergency procedures, such as calling 911 or a local crisis hotline, when the counselor is not available.
10. Discuss time zone differences, local customs, and cultural or language differences that might impact service delivery.
11. Inform clients when technology-assisted distance counseling services are not covered by insurance. *(See A.2.)*

A.12.h. Sites on the World Wide Web
Counselors maintaining sites on the World Wide Web (the Internet) do the following:
1. Regularly check that electronic links are working and professionally appropriate.
2. Establish ways clients can contact the counselor in case of technology failure.
3. Provide electronic links to relevant state licensure and professional certification boards to protect consumer rights and facilitate addressing ethical concerns.
4. Establish a method for verifying client identity.
5. Obtain the written consent of the legal guardian or other authorized legal representative prior to rendering services in the event the client is a minor child, an adult who is legally incompetent, or an adult incapable of giving informed consent.
6. Strive to provide a site that is accessible to persons with disabilities.
7. Strive to provide translation capabilities for clients who have a different primary language while also addressing the imperfect nature of such translations.
8. Assist clients in determining the validity and reliability of information found on the World Wide Web and other technology applications.

Principle 14   Internet On-Line Counseling

Mental health counselors engaged in delivery of services that involves the telephone, teleconferencing and the Internet in which these areas are generally recognized, standards for preparatory training do not yet exist. Mental health counselors take responsible steps to ensure the competence of their work and protect patients, clients, students, research participants and others from harm.

A) Confidentiality
Mental health counselors ensure that clients are provided sufficient information to adequately address and explain the limitations of computer technology in the counseling process in general and the difficulties of ensuring complete client confidentiality of information transmitted through electronic communications over the Internet through on-line counseling. Professional counselors inform clients of the limitations of confidentiality and identify foreseeable situations in which confidentiality must be breached in light of the law in both the state in which the client is located and the state in which the professional counselor is licensed. Mental health counselors shall become aware of the means for reporting and protecting suicidal clients in their locale. Mental health counselors shall become aware of the means for reporting homicidal clients in the client's jurisdiction.

B) Mental Health Counselor Identification
Mental health counselors provide a readily visible notice advising clients of the identities of all professional counselor(s) who will have access to the information transmitted by the client. Mental health counselors provide background information on all professional communications, including education, licensing and certification, and practice information.

C) Client Identification
Professional counselors identify clients, verify identities of clients, and obtain alternative methods of contacting clients in emergency situations.

D) Client Waiver
Mental health counselors require clients to execute client waiver agreements stating that the client acknowledges the limitations inherent in ensuring client confidentiality of information transmitted through on-line counseling and acknowledge the limitations that are inherent in a counseling process that is not provided face-to-face. Limited training in the area of on-line counseling must be explained and the client's informed consent must be secured.

E) Electronic Transfer of Client Information
Mental health counselors electronically transfer client confidential information to authorized third-party recipients only when both the professional counselor and the authorized recipient have "secure" transfer and acceptance communication capabilities ;the recipient is able to effectively protect the confidentiality of the client's confidential information to be transferred; and the informed written consent of the client, acknowledging the limits of confidentiality, has been obtained.

F) Establishing the On-Line Counseling Relationship

1. **Appropriateness of On-line Counseling**
   Mental health counselors develop an appropriate in-take procedure for potential clients to determine whether on-line counseling is appropriate for the needs of the client. Mental health counselors warn potential clients that on-line counseling services may not be appropriate in certain situations and, to the extent possible, inform the client of specific limitations, potential risks, and/or potential benefits relevant to the client's anticipated use of on-line counseling services. Mental health counselors ensure that clients are intellectually, emotionally, and physically capable of using on-line counseling services, and of understanding the potential risks and/or limitations of such services.
2. **Counseling Plans**
   Mental health counselors develop individual on-line counseling plans that are consistent with both the client's individual circumstances and the limitations of on-line counseling. Mental health counselors who determine that on-line counseling is inappropriate for the client should avoid entering into or immediately terminate the on-line counseling relationship and encourage the client to continue the counseling relationship through a traditional alternative method of counseling.
3. **Boundaries of Competence**
   Mental health counselors provide on-line counseling services only in practice areas within their expertise. Mental health counselors do not provide services to clients in states where doing so would violate local licensure laws or regulations.

G) Legal Considerations
Mental health counselors confirm that the provision of on-line services are not prohibited by or otherwise violate any applicable state or local statutes, rules, regulations or ordinances, codes of professional membership organizations and certifying boards, and/or codes of state licensing boards

American Psychological Association

Ethical Principles of Psychologists and Code of Conduct

2002

INTRODUCTION AND APPLICABILITY

The American Psychological Association's (APA's) Ethical Principles of Psychologists and Code of Conduct (hereinafter referred to as the Ethics Code) consists of an Introduction, a Preamble, five General Principles (A – E), and specific Ethical Standards. The Introduction discusses the intent, organization, procedural considerations, and scope of application of the Ethics Code. The Preamble and General Principles are aspirational goals to guide psychologists toward the highest ideals of psychology. Although the Preamble and General Principles are not themselves enforceable rules, they should be considered by psychologists in arriving at an ethical course of action. The Ethical Standards set forth enforceable rules for conduct as psychologists. Most of the Ethical Standards are written broadly, in order to apply to psychologists in varied roles, although the application of an Ethical Standard may vary depending on the context. The Ethical Standards are not exhaustive. The fact that a given conduct is not specifically addressed by an Ethical Standard does not mean that it is necessarily either ethical or unethical.

This Ethics Code applies only to psychologists' activities that are part of their scientific, educational, or professional roles as psychologists. Areas covered include but are not limited to the clinical, counseling, and school practice of psychology; research; teaching; supervision of trainees; public service; policy development; social intervention; development of assessment instruments; conducting assessments; educational counseling; organizational consulting; forensic activities; program design and evaluation; and administration. **This Ethics Code applies to these activities across a variety of contexts, such as in person, postal, telephone, internet, and other electronic transmissions.** These activities shall be distinguished from the purely private conduct of psychologists, which is not within the purview of the Ethics Code.

2.01(c) Boundaries of Competence ("Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or *technologies* new to them undertake relevant education, training, supervised experience, consultation, or study.").

3.10(a) Informed Consent ("When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person *or via electronic transmission or other forms of communication*, they obtain the informed consent . . . .").

4.02(c) Discussing the Limits of Confidentiality ("Psychologists who offer services, products, or information via *electronic transmission* inform clients/patients of the risks to privacy and limits of confidentiality.").

5.01(a) Avoidance of False or Misleading Statements ("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.").

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. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

Association for Counselling and Therapy Online

Code of Ethics

ACTO have produced this document to help promote safe professional practice for those psychological therapists who work online. All ACTO members are required to adhere to and follow the Code of Ethics of the organisation with whom they hold membership or accreditation in addition to the ethical framework laid out below.

ACTO expects all its members to adhere to the following:

a. Be aware of and familiarise themselves with the differences between online and face to face psychological therapy and the impact that online work can have on the relationship between therapist and client and the therapeutic process

b. Be aware of and work within their limitations and competence; seeking regular supervision preferably from an experienced online supervisor; and be willing to undertake continuing professional development.

c. Recognise and respect diversity and difference especially when working across international/cultural boundaries and be alert to the possibility of misinterpretation of the written and/or spoken word.

d. Have the ability to assess clients appropriately and ensure their suitability for online work.

e. Ensure that clients have read, understood and agreed on their personal contract/agreement for working online together before the therapeutic work begins.

f. Take appropriate hardware and software measures to protect the integrity and privacy of their computer systems and to remove client material from their computers at the end of the contracted work.

g. Ensure that all clients have access to clear written statements, in an explicit format, of all email transactions and monies paid to their therapist.
h. Ensure that all clients have a clear understanding of what to do in the event of server or computer outage and breakdown.

i. Respect and be aware of their clients' right to take decisions and to act for themselves.

j. Supply accurate and up-to-date information about the service they are offering the client; including fees for all the forms of online therapy they offer.

k. Avoid taking advantage of clients or exploiting them in any way; (For example, sexually, financially, psychologically, or emotionally).

l. Work only when both client and therapist are deemed fit to do so (physically / psychologically / technologically) to ensure the quality of the therapy they provide.

m. Protect their own position, if possible, by obtaining appropriate insurance to cover the work they undertake.

n. Keep at least brief records of their counselling work with clients, unless there are exceptional reasons for not doing so.

o. Keep up to date with any legal requirements that affect their online work.

p. Avoid offering services to a child or young person where they believe 'informed consent' cannot apply, without first obtaining permission from a person with parental responsibility, unless they are working for a registered voluntary or statutory organisation that offers anonymity and does require 'parental consent' as a pre-requisite for using the service.

q. Never indicate or imply that they are working for ACTO. Membership of ACTO is not a contract of employment.

r. Never indicate or imply that membership of ACTO offers proof of the therapist's qualifications or training.

s. Treat their online colleagues with professional courtesy and respect both directly and indirectly (i.e. in how they represent themselves to others).

B16. Computer Use

When computer applications are used as a component of counselling services, counsellors ensure that: (a) client and counsellor identities are verified; (b) the client is capable of using the computer application; (c) the computer application is appropriate to the needs of the client; (d) the client understands the purpose and operation of client-assisted and/or self-help computer applications; and (e) a follow-up of client use of a computer application is provided to assist subsequent needs. In all cases, computer applications do not diminish the counsellor's responsibility to act in accordance with the CCA Code of Ethics, and in particular, to ensure adherence to the principles of confidentiality, informed consent, and safeguarding against harmful effects.

B17. Delivery of Services by Telephone, Teleconferencing, and Internet

Counsellors follow all additional ethical guidelines for services delivered by telephone, teleconferencing, and the Internet, including appropriate precautions regarding confidentiality, security, informed consent, records and counselling plans, as well as determining the right to provide such services in regulatory jurisdictions.

D5. Use of Technology

Counsellors recognize that their ethical responsibilities are not altered, or in any way diminished, by the use of technology for the administration of evaluation and assessment instruments. Counsellors retain their responsibility for the maintenance of the ethical principles of privacy, confidentiality, and responsibility for decisions regardless of the technology used.

Clinical Social Work Association

Position Paper on Internet Text-based Therapy

2001

The general coverage of online counseling, both in professional and general print and other media, has exploded within the past couple of years and the debate about such issues as liability, efficacy and jurisdiction is raging. Clinicians across all disciplines are bombarded with information and solicitation by online counseling companies and recent reports indicate that there are several hundred therapists across the country providing such e-therapy services. The belief of the Clinical Social Work Federation is that psychotherapy services cannot be delivered online because of the inherent nature of the service and, therefore, the Federation is opposed to the practice of Internet-based treatment. By the term Internet-based treatment, the Federation is referring specifically to, and this paper asserts a position about, psychotherapy services that are limited to text-based exchanges between therapist and client.

This position paper does not address telephone counseling or email when used as an adjunct to in-person sessions, or two-way video conferencing either as a primary means or adjunct to in-person sessions, or any other technological medium that is used as primary or adjunctive to a basically in-person treatment process. While this paper does not express a position with respect to those forms of communication when used as an adjunct to the therapeutic process, the Federation recommends that the principles detailed later in this paper be used as a means of evaluating whether those adjunctive techniques meet well-accepted professional standards. According to some sources, 90% of the e-therapy field is totally text-based; this position paper addresses that arena and, for the purposes of this paper, the terms "online counseling" and "e-therapy" are used to indicate text-based services.

This paper is intended as a working document and may be amended in the future as new forms of telehealth develop. It is recommended that the principles detailed below serve as standards with which to examine and evaluate various forms of telehealth as they emerge. The position of the Federation, as detailed in this paper, is related to professional and ethical standards and is not intended as legal advice.

It is a fact that whenever and wherever a licensed clinical social worker delivers a professional service, that clinician is working under their state license; that is, they are governed by the laws, ethics and professional standards of their profession whether they are seeing clients in a hospital, school, private practice office, employee assistance setting, prison, clinic or in cyberspace. However, it seems that the obliteration of the usual limits of time and distance in the Internet world have led somehow to a similar blurring in the minds of some clinicians, and they believe that "new rules" apply to the Internet world. Licensing boards have clarified, and the Federation wishes to emphasize, that the limits imposed by the usual standards of professional practice are unchanged by the "freedom" of the Internet world.

In 1997, The Joint Working Group on Telemedicine1 identified for its specific attention the need for clinical standards of practice in the area of telehealth. While telehealth is the broader area under which online counseling is subsumed (in other words, on-line counseling is a form of telehealth), the principles for practice are a very good fit in terms of providing a framework for our analysis. These principles are explained in a recent journal article entitled "Ten Interdisciplinary Principles for Professional Practice in Telehealth"2.

There are several reasons that interdisciplinary collaboration in this area is essential; certainly, first and foremost, is the protection of clients. In this way, our concern with establishing a position on the delivery of online therapy services and the primary mission of state licensing boards - protecting the consumer - is in absolute alignment. With this primary goal in mind, the following principles are offered as both an explanation for the Federation's position and a framework for the analysis of online services:

1. The basic standards of professional conduct governing each health care profession are not altered by the use of telehealth technologies to deliver health care, conduct research, or provide education. Developed by each profession, these standards focus in part on the practitioner's responsibility to provide ethical and high-quality care.

Discussion: As noted above, even though the Internet profoundly influences the aspects of time and distance in that it may obliterate those boundaries, this technology does not change, in any sense, the duties and responsibilities of the clinician. If we consider the most fundamental and basic ethic in our role as providers of treatment - to not harm and to help heal3 - and we review the Code of Ethics developed by the Federation4, we can immediately identify the serious gaps between the quality of in-person services vs. services that are delivered online.

2. Confidentiality of client visits, client health records, and the integrity of information in the health care information system is essential.

Discussion: The need to protect client confidentiality is a standard of professional conduct for clinical social workers and, of course, mental health records are particularly sensitive. The role of confidentiality is central in the delivery of mental health services; without that assurance, the clinician risks both the loss of the working alliance with the client and the addition of tremendous legal exposure. Confidentiality is the foundation upon which the structure of treatment is built.

One may assert with conviction that confidentiality is impossible to ensure when information is transmitted over the Internet, at least at this point in time and perhaps ever; consider that computer hackers have found their way into the Department of Defense, that family members may share a log-in password and/or the view of the computer screen, and that, generally, "the possibility that information transmitted via E-mail or the Internet may be intercepted by a third party is a constant threat."5

3. All clients directly involved in a telehealth encounter must be informed about the process, the attendant risks and benefits, and their own rights and responsibilities, and must provide adequate informed consent.

Discussion: It is unknown as to how the clinician could accomplish the above when the primary information as to even the basic identity (age, gender, location, ethnicity) of the client comes from words on a computer screen - the tremendous amount of information that is provided by sight and sound is not available. Given that the identity and location of the client is impossible to confirm, providing adequate informed consent is a moot point.

Clinicians may practice only in the state or states in which they are licensed; while client honesty about location, identity and presenting facts may be desired by the clinician, the medium of the Internet provides no way in which to confirm this information. In fact, it is possible that clients who choose to access services on-line may not be the same clients who walk into our waiting rooms. With regard to risk, online clients may be self-selected in ways that serve to significantly increase clinician exposure to liability.

4. Services provided via telehealth must adhere to the basic assurance of quality and professional health care in accordance with each health care discipline's clinical standards.

Discussion: This principle arises from the obligation to assure quality in clinical care and relates to the comparison regarding quality between in-person services and those delivered via telehealth; in this sense, this principle is more applicable to the broader area of telehealth than the narrower focus of online counseling. For our purposes, this comparison is relevant only for those clients who do not have access to in-person services; in fact, according to the 1998 Bureau of Census figures, 20% of the U.S. population lives in rural areas.

While clearly in-person services would be far preferable for this population, travel to a metropolitan area may simply not be possible and an alternative method of delivering service may be better than no service at all. If telephone communication is available, this medium would be preferable to online communication, as there is much more information available from the human voice than from a computer screen. There may be rare instances in which telephone access is not available and computer access is available; providing online services on these rare occasions, then, would be based appropriately on the client's need and not on the clinician's.

5. Each health care discipline must examine how its patterns of care delivery are affected by telehealth and is responsible for developing its own processes for assuring competence in the delivery of health care via telehealth technologies.

Discussion: Again, this principle relates to the larger area of telehealth; however, the primary message is applicable to the issue of online counseling. Clinical social work needs to take the lead in establishing its position on this topic so that government and other oversight entities do not become involved in regulating the behavior of clinicians in this arena.

The current development of telehealth technology, including online therapy, is being driven primarily by commercial forces; instead of responding to the need of potential clients, the industry around online services is being driven by the technology itself (witness the recent proliferation of "Online Therapy Certification Workshops".) The authors of this article state that "If the technology drives consumer applications and systems development, rather than the technology being responsive to the real health needs of its users, the result could be extremely costly and elaborate systems that do not deliver better - or even effective - health care." This understatement, when applied to online therapy, would suggest that the question "can we do it?" has, unfortunately, replaced the far better question "should we do it?"

6. Documentation requirements for telehealth services must be developed that assure documentation of each client encounter with recommendations and treatments, communication with other health care providers as appropriate, and adequate protections for client confidentiality.

Discussion: Documentation of each client contact is an accepted professional standard of care. However, as described earlier in this paper, electronic communications are subject to inappropriate access by third parties and it is impossible to assure confidentiality. In addition, contacts that are recorded via email contain far more information than is normally in a paper record; that fact increases the stakes in terms of the lack of privacy and confidentiality when using electronic mediums.

Even if there were some method of ensuring client confidentiality, the issue of documentation poses another subtle, yet potentially very significant, risk for both the client and the clinician. Does documentation of each client encounter, the usual standard of care, mean that the clinician maintains the record in its original form (emails) or does a paper summary meet the professional standard? Certainly the existence of a "real time" record of the client-therapist interactions provides a very useful document for attorneys to subpoena during the discovery phase of a lawsuit. Then, the "raw record", as it were, is in the hands of non-clinicians to read and interpret as they wish, placing the clinician in a uniquely vulnerable position.

7. Clinical guidelines in the area of telehealth should be based on empirical evidence, when available, and professional consensus among involved health care disciplines.

Discussion: In contrast with practice guidelines, clinical guidelines provide specific recommendations about treatments to be offered to clients; clinical guidelines are client-focused and are condition or diagnosis-dependent, e.g., major depression, adjustment disorder. As described above, there is no assurance that the presenting information delivered online is accurate; there is also no empirical evidence that providing therapy services online is effective. Methods and recommendations for treatment of various conditions, as per commonly accepted professional standards, is unchanged by the medium used to deliver services.

8. The integrity and therapeutic value of the relationship between client and health care practitioner should be maintained and not diminished by the use of telehealth technology.

Discussion: Again, this refers to the larger area of telehealth and one can imagine that there are situations in which video conferencing may serve to not only deliver services but save lives - for example, when the physician at the hospital is able to view the patient being treated by paramedics and determine the course of treatment based on visual contact as well as readings from machines. There are many other effective and "safe" applications of telehealth as a tool in the medical world; those applications find only rare analogies in the world of mental health.

Managed care has already served to diminish the commonly accepted vehicle for change in mental health - the therapeutic relationship - and online therapy, as a tool, serves to nearly eradicate it. Barbara Gutek's (1995)6 analysis of service interactions in late 20th century America makes the distinction between relationships and encounters; it is essential that clinical social workers, in their rush to embrace the Internet and its promise of ubiquitous communication, not contribute to the further erosion of quality mental health services.

9. Health care professionals do not need additional licensing to provide services via telehealth technologies. At the same time, telehealth technologies cannot be used as a vehicle for providing services that otherwise are not legally or professionally authorized.

Discussion: The scope of practice, as defined at the state, professional and individual level, is not changed by the introduction of telehealth tools as technologies for service delivery. This principle underlines again that clinicians will be held to the in-person standard of care in terms of the major aspects of service delivery. State licensing boards are very concerned about this issue and many are in the process of developing recommendations. Given the high potential for harm to the consumer such as breach of confidentiality, misdiagnosis because of limited or incorrect information and jurisdiction issues (practicing, perhaps unwittingly, in a state in which one is not licensed), it would not be a surprise to see some licensing boards, in the near future, caution against or prohibit online counseling except for specific, unusual situations.

10. The safety of clients and practitioners must be ensured. Safe hardware and software, combined with demonstrated user competence, are essential components of safe telehealth practice.

Discussion: The assurance described in this principle is possible only in theory as it relates to online therapy, as detailed above. User competence is more of an issue with certain complex telehealth technology than with online counseling; however, online counseling is only available to those individuals who have adequate written expressive capability.

Conclusion:

Psychotherapy has at its heart a profoundly human connection; a connection that is, in itself, the major vehicle for change. Healing and restoration occur when the therapist and the client together find the bridge leading back, and forward at the same time, to the true self. It will always be the case that the best in our field, the most expert and gifted clinical social workers, blend art and science into a seamless whole in their daily

work. So much human suffering has been caused by disconnection - disconnection between individuals, between thought and feeling, between body and mind - and e-therapy offers yet another form. Clients seek our services in order to improve the quality of their lives, the quality of their relationships. Alienation from others and the self will not be healed through a virtual connection in cyberspace, a "connection" that is fraught with risks and hazards for both clients and clinicians.

By: Renee B. Lonner, MSW, BCD, for the Clinical Social Work Federation; Review Committee: Susan Trimm, MSW, BCD; David G. Phillips, DSW, BCD; Betsy Amey, LCSW-C; and Betty Jean Synar, MSW.

Endnotes:

1 This Group was convened in 1995 by the Secretary of the Department of Health and Human Services; it is now coordinated by the federal Office for the Advancement of Telehealth, created in 1998. The JWGT is an ad hoc group of representatives from federal agencies, departments and programs who are involved in significant telehealth activities and provides recommendations regarding federal telehealth policy.

The Clinical Social Work Federation wishes to express its appreciation to authors Reed, McLaughlin and Milholland, and to publisher, the American Psychological Association, for a most articulate, comprehensive and relevant paper.

2 Reed, G.M., McLaughlin, C. J. and Milholland, K., (2000). Ten Interdisciplinary Principles for Professional Practice in Telehealth: Implications for Psychology, Professional Psychology: Research and Practice, 31, 170-178.

3 Kass, L. R., Professing Ethically (1983). Journal of the American Medical Association and the Clinical Social Work Federation Code of Ethics.

4 Clinical Social Work Federation, Code of Ethics.

5 Ibid

6 Gutek, B. (1995). The dynamics of service: Reflections on the changing nature of customer/provider interactions, San Francisco: Josey-Bass.

International Society for Mental Health Online

Suggested Principles for the Online Provision of Mental Health Services

Version 3.11
January 9, 2000

Online mental health services often accompany traditional mental health services provided in person, but sometimes they are the only means of treatment. These suggestions are meant to address only those practice issues relating directly to the online provision of mental health services. Questions of therapeutic technique are beyond the scope of this work.

The terms "services", "client", and "counselor" are used for the sake of inclusiveness and simplicity. No disrespect for the traditions or the unique aspects of any therapeutic discipline is intended.

1. Informed consent

   The client should be informed before he or she consents to receive online mental health services. In particular, the client should be informed about the process, the counselor, the potential risks and benefits of those services, safeguards against those risks, and alternatives to those services.

   a. Process

      1. Possible misunderstandings

         The client should be aware that misunderstandings are possible with text-based modalities such as email (since nonverbal cues are relatively lacking) and even with videoconferencing (since bandwidth is always limited).

      2. Turnaround time

         One issue specific to the provision of mental health services using asynchronous (not in "real time") communication is that of turnaround time. The client should be informed of how soon after sending an email, for example, he or she may expect a response.

      3. Privacy of the counselor

         Privacy is more of an issue online than in person. The counselor has a right to his or her privacy and may wish to restrict the use of any copies or recordings the client makes of their communications. See also the below on the confidentiality of the client.

b. Counselor

When the client and the counselor do not meet in person, the client may be less able to assess the counselor and to decide whether or not to enter into a treatment relationship with him or her.

1. Name

   The client should be informed of the name of the counselor. The use of pseudonyms is common online, but the client should know the name of his or her counselor.

2. Qualifications

   The client should be informed of the qualifications of the counselor. Examples of basic qualifications are degree, license, and certification. The counselor may also wish to provide supplemental information such as areas of special training or experience.

3. How to confirm the above

   So that the client can confirm the counselor's qualifications, the counselor should provide the telephone numbers or web page URLs of the relevant institutions.

c. Potential benefits

The client should be informed of the potential benefits of receiving mental health services online. This includes both the circumstances in which the counselor considers online mental health services appropriate and the possible advantages of providing those services online. For example, the potential benefits of email may include: (1) being able to send and receive messages at any time of day or night; (2) never having to leave messages with intermediaries; (3) avoiding not only intermediaries, but also voice mail and "telephone tag"; (4) being able to take as long as one wants to compose, and having the opportunity to reflect upon, one's messages; (5) automatically having a record of communications to refer to later; and (6) feeling less inhibited than in person.

d. Potential risks

The client should be informed of the potential risks of receiving mental health services online. For example, the potential risks of email may include (1) messages not being received and (2) confidentiality being breached. Emails could fail to be received if they are sent to the wrong address (which might also breach of confidentiality) or if they just are not noticed by the counselor. Confidentiality could be breached in transit by hackers or Internet service providers or at either end by others with access

to the email account or the computer. Extra safeguards should be considered when the computer is shared by family members, students, library patrons, etc.

e. Safeguards

The client should be informed of safeguards that are taken by the counselor and could be taken by himself or herself against the potential risks. For example, (1) a "return receipt" can be requested whenever an email is sent and (2) a password can be required for access to the computer or, more secure, but also more difficult to set up, encryption can be used.

f. Alternatives

The client should be informed of the alternatives to receiving mental health services online. For example, other options might include (1) receiving mental health services in person, (2) talking to a friend or family member, (3) exercising or meditating, or (4) not doing anything at all.

g. Proxies

Some clients are not in a position to consent themselves to receive mental health services. In those cases, consent should be obtained from a parent, legal guardian, or other authorized party -- and the identity of that party should be verified.

2. Standard operating procedure

In general, the counselor should follow the same procedures when providing mental health services online as he or she would when providing them in person. In particular:

a. Boundaries of competence

The counselor should remain within his or her boundaries of competence and not attempt to address a problem online if he or she would not attempt to address the same problem in person.

b. Requirements to practice

The counselor should meet any necessary requirements (for example, be licensed) to provide mental health services where he or she is located. In fact, requirements where the client is located may also need to be met to make it legal to provide mental health services to that client. See also the above on qualifications.

c. Structure of the online services

The counselor and the client should agree on the frequency and mode of communication, the method for determining the fee, the estimated cost to the client, the method of payment, etc.

d. Evaluation

The counselor should adequately evaluate the client before providing any mental health services online. The client should understand that that evaluation could potentially be helped or hindered by communicating online.

e. Confidentiality of the client

The confidentiality of the client should be protected. Information about the client should be released only with his or her permission. The client should be informed of any exceptions to this general rule.

f. Records

The counselor should maintain records of the online mental health services. If those records include copies or recordings of communications with the client, the client should be informed.

g. Established guidelines

The counselor should of course follow the laws and other established guidelines (such as those of **professional organizations**) that apply to him or her.

3. Emergencies

a. Procedures

The procedures to follow in an emergency should be discussed. These procedures should address the possibility that the counselor **might not immediately** receive an online communication and might involve a **local backup**.

b. Local backup

Another issue specific to online mental health services is that the counselor can be a great distance from the client. This may limit the counselor's ability to respond to an emergency. The counselor should therefore in these cases obtain the name and telephone number of a qualified local (mental) health care provider (who preferably already knows the client, such as his or her primary care physician).

National Association of Social Workers

Code of Ethics

1999

1.03(e) Social workers who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services.

1.07(m) 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.

National Board for Certified Counselors

The Practice of Internet Counseling

2007

This document contains a statement of principles for guiding the evolving practice of Internet counseling. In order to provide a context for these principles, the following definition of Internet counseling, which is one element of technology-assisted distance counseling, is provided. The Internet counseling standards follow the definitions presented below.

A Taxonomy for Defining Face-To-Face and Technology-Assisted Distance Counseling

The delivery of technology-assisted distance counseling continues to grow and evolve. Technology assistance in the form of computer-assisted assessment, computer-assisted information systems, and telephone counseling has been available and widely used for some time. The rapid development and use of the Internet to deliver information and foster communication has resulted in the creation of new forms of counseling. Developments have occurred so rapidly that it is difficult to communicate a common understanding of these new forms of counseling practice.

The purpose of this document is to create standard definitions of technology-assisted distance counseling that can be easily updated in response to evolutions in technology and practice. A definition of traditional face-to-face counseling is also presented to show similarities and differences with respect to various applications of technology in counseling. A taxonomy of forms of counseling is also presented to further clarify how technology relates to counseling practice.

Nature of Counseling

Counseling is the application of mental health, psychological, or human development principles, through cognitive, affective, behavioral or systemic intervention strategies, that address wellness, personal growth, or career development, as well as pathology.

Depending on the needs of the client and the availability of services, counseling may range from a few brief interactions in a short period of time, to numerous interactions over an extended period of time. Brief interventions, such as classroom discussions, workshop presentations, or assistance in using assessment, information, or instructional resources, may be sufficient to meet individual needs. Or, these brief interventions may lead to longer-term counseling interventions for individuals with more substantial needs. Counseling may be delivered by a single counselor, two counselors working collaboratively, or a single counselor with brief assistance from another counselor who has specialized expertise that is needed by the client.

Forms of Counseling

Counseling can be delivered in a variety of forms that share the definition presented above. Forms of counseling differ with respect to participants, delivery location, communication medium, and interaction process. Counseling *participants* can be

individuals, couples, or groups. The *location* for counseling delivery can be **face-to-face or at a distance** with the assistance of technology. The *communication medium* for counseling can be what is **read** from text, what is **heard** from audio, or what is **seen** and heard in person or from video. The *interaction process* for counseling can be **synchronous** or **asynchronous**. Synchronous interaction occurs with little or no gap in time between the responses of the counselor and the client. Asynchronous interaction occurs with a gap in time between the responses of the counselor and the client.

The selection of a specific form of counseling is based on the needs and preferences of the client within the range of services available. Distance counseling supplements face-to-face counseling by providing increased access to counseling on the basis of **necessity** or **convenience**. Barriers, such as being a long distance from counseling services, geographic separation of a couple, or limited physical mobility as a result of having a disability, can make it **necessary** to provide counseling at a distance. Options, such as scheduling counseling sessions outside of traditional service delivery hours or delivering counseling services at a place of residence or employment, can make it more **convenient** to provide counseling at a distance.

A Taxonomy of Forms of Counseling Practice. Table 1 presents a taxonomy of currently available forms of counseling practice. This schema is intended to show the relationships among counseling forms.

Table 1
A Taxonomy of Face-To-Face and Technology-Assisted Distance Counseling

Counseling

- Face-To-Face Counseling
  - Individual Counseling
  - Couple Counseling
  - Group Counseling

- Technology-Assisted Distance Counseling

  - Telecounseling

    - Telephone-Based Individual Counseling

    - Telephone-Based Couple Counseling

    - Telephone-Based Group Counseling

  - Internet Counseling

    - E-Mail-Based Individual Counseling

    - Chat-Based Individual Counseling

    - Chat-Based Couple Counseling

▪ Chat-Based Group Counseling

▪ Video-Based Individual Counseling

▪ Video-Based Couple Counseling

▪ Video-Based Group Counseling

Definitions

Counseling is the application of mental health, psychological, or human development principles, through cognitive, affective, behavioral or systemic intervention strategies, that address wellness, personal growth, or career development, as well as pathology.

Face-to-face counseling for individuals, couples, and groups involves synchronous interaction between and among counselors and clients using what is seen and heard in person to communicate.

Technology-assisted distance counseling for individuals, couples, and groups involves the use of the telephone or the computer to enable counselors and clients to communicate at a distance when circumstances make this approach necessary or convenient.
Telecounseling involves synchronous distance interaction among counselors and clients using one-to-one or conferencing features of the telephone to communicate.

Telephone-based individual counseling involves synchronous distance interaction between a counselor and a client using what is heard via audio to communicate.

Telephone-based couple counseling involves synchronous distance interaction among a counselor or counselors and a couple using what is heard via audio to communicate.

Telephone-based group counseling involves synchronous distance interaction among counselors and clients using what is heard via audio to communicate.

Internet counseling involves asynchronous and synchronous distance interaction among counselors and clients using e-mail, chat, and videoconferencing features of the Internet to communicate.

E-mail-based individual Internet counseling involves asynchronous distance interaction between counselor and client using what is read via text to communicate.

Chat-based individual Internet counseling involves synchronous distance interaction between counselor and client using what is read via text to communicate.

Chat-based couple Internet counseling involves synchronous distance interaction

among a counselor or counselors and a couple using what is read via text to communicate.

Chat-based group Internet counseling involves synchronous distance interaction among counselors and clients using what is read via text to communicate.

Video-based individual Internet counseling involves synchronous distance interaction between counselor and client using what is seen and heard via video to communicate.

Video-based couple Internet counseling involves synchronous distance interaction among a counselor or counselors and a couple using what is seen and heard via video to communicate.

Video-based group Internet counseling involves synchronous distance interaction among counselors and clients using what is seen and heard via video to communicate.

Standards for the Ethical Practice of Internet Counseling

These standards govern the practice of Internet counseling and are intended for use by counselors, clients, the public, counselor educators, and organizations that examine and deliver Internet counseling. These standards are intended to address practices that are unique to Internet counseling and Internet counselors and do not duplicate principles found in traditional codes of ethics.

These Internet counseling standards of practice are based upon the principles of ethical practice embodied in the NBCC Code of Ethics. Therefore, these standards should be used in conjunction with the most recent version of the NBCC ethical code. Related content in the NBCC Code are indicated in parentheses after each standard.

Recognizing that significant new technology emerges continuously, these standards should be reviewed frequently. It is also recognized that Internet counseling ethics cases should be reviewed in light of delivery systems existing at the moment rather than at the time the standards were adopted.

In addition to following the NBCC® Code of Ethics pertaining to the practice of professional counseling, Internet counselors shall observe the following standards of practice:

Internet Counseling Relationship

1. In situations where it is difficult to verify the identity of the Internet client, steps are taken to address impostor concerns, such as by using code words or numbers.

2. Internet counselors determine if a client is a minor and therefore in need of parental/guardian consent. When parent/guardian consent is required to

provide Internet counseling to minors, the identity of the consenting person is verified.

3. As part of the counseling orientation process, the Internet counselor explains to clients the procedures for contacting the Internet counselor when he or she is off-line and, in the case of asynchronous counseling, how often e-mail messages will be checked by the Internet counselor.

4. As part of the counseling orientation process, the Internet counselor explains to clients the possibility of technology failure and discusses alternative modes of communication, if that failure occurs.

5. As part of the counseling orientation process, the Internet counselor explains to clients how to cope with potential misunderstandings when visual cues do not exist.

6. As a part of the counseling orientation process, the Internet counselor collaborates with the Internet client to identify an appropriately trained professional who can provide local assistance, including crisis intervention, if needed. The Internet counselor and Internet client should also collaborate to determine the local crisis hotline telephone number and the local emergency telephone number.

7. The Internet counselor has an obligation, when appropriate, to make clients aware of free public access points to the Internet within the community for accessing Internet counseling or Web-based assessment, information, and instructional resources.

8. Within the limits of readily available technology, Internet counselors have an obligation to make their Web site a barrier-free environment to clients with disabilities.

9. Internet counselors are aware that some clients may communicate in different languages, live in different time zones, and have unique cultural perspectives. Internet counselors are also aware that local conditions and events may impact the client.

Confidentiality in Internet Counseling

10. The Internet counselor informs Internet clients of encryption methods being used to help insure the security of client/counselor/supervisor communications.

Encryption methods should be used whenever possible. If encryption is not made available to clients, clients must be informed of the potential hazards of unsecured communication on the Internet. Hazards may include unauthorized monitoring of transmissions and/or records of Internet counseling sessions.

11. The Internet counselor informs Internet clients if, how, and how long session data are being preserved.

    Session data may include Internet counselor/Internet client e-mail, test results, audio/video session recordings, session notes, and counselor/supervisor communications. The likelihood of electronic sessions being preserved is greater because of the ease and decreased costs involved in recording. Thus, its potential use in supervision, research, and legal proceedings increases.

12. Internet counselors follow appropriate procedures regarding the release of information for sharing Internet client information with other electronic sources.

    Because of the relative ease with which e-mail messages can be forwarded to formal and casual referral sources, Internet counselors must work to insure the confidentiality of the Internet counseling relationship.

Legal Considerations, Licensure, and Certification

13. Internet counselors review pertinent legal and ethical codes for guidance on the practice of Internet counseling and supervision.

    Local, state, provincial, and national statutes as well as codes of professional membership organizations, professional certifying bodies, and state or provincial licensing boards need to be reviewed. Also, as varying state rules and opinions exist on questions pertaining to whether Internet counseling takes place in the Internet counselor's location or the Internet client's location, it is important to review codes in the counselor's home jurisdiction as well as the client's. Internet counselors also consider carefully local customs regarding age of consent and child abuse reporting, and liability insurance policies need to be reviewed to determine if the practice of Internet counseling is a covered activity.

14. The Internet counselor's Web site provides links to websites of all appropriate certification bodies and licensure boards to facilitate consumer protection.