Considerations for the Provision of E-Therapy
Overview

What is E-Therapy?
The provision of behavioral health services delivered interactively from a distance began as early as 1959, at the Nebraska Psychiatric Institute, when a television link was used to provide consultation (Maheu, et al., 2005; Maheu, Whitten, and Allen, 2001). Since the introduction of the use of technology in this manner, other forms of service delivery using electronic media have been developed and used in health care systems throughout the United States and abroad (Brown, 1998; Darkins and Cary, 2000; Maheu, et al., 2005). The development of electronic forms of behavioral health service delivery has also led to a multitude of terms used to describe this form of treatment. While E-health (also known as ehealth) is believed by many experts to be the preferred term for all clinical services administered via the Internet, E-therapy is among those names (in addition to e-counseling, cybercounseling, cybertherapy, and teletherapy) commonly used among professionals to describe services administered electronically (Maheu, et al., 2005). Similarly, there are a number of definitions to further explain the components and uses of E-therapy. The definition below serves as the conceptual framework for the information provided in this document:

E-therapy is the use of electronic media and information technologies to provide services for participants in different locations. It is used by skilled and knowledgeable professionals (e.g., counselors, therapists) to address a variety of individual, familial, and social issues. E-therapy can (1) include a range of services, including screening, assessment, primary treatment, and after care; (2) provide more accessible modes of treatment than the traditional ones to those who actively use the recent development of technology (i.e., adolescents and young adults); (3) help people access treatment services who traditionally would not seek services because of barriers related to geography, shame and guilt, stigma, or other issues; and 4) be provided as a sole treatment modality, or in combination with other treatment modalities, like traditional or existing treatments. 1,2,3

A variety of electronic media is used to conduct E-therapy and can be classified as either text-based or non-text-based. Text-based forms of communication include e-mail, chat rooms, text messaging, and listservs. Forms of communication that are not text-based include telephone and videoconferencing (Maheu, et al., 2005). Each form of communication has its advantages and disadvantages, which should be taken into consideration when determining the best methods for the service population, which may vary by health-related issues. These benefits and challenges are shown in Table 1.

In general, services administered via E-therapy are either synchronous or asynchronous. Synchronous communication is most easily facilitated through instant messaging, chat rooms, telephone, and videoconference (Castelnuovo, Gaggiolo, Matonavani, and Riva, 2003; Elleven and Allen, 2004). However, it should be noted that the quality of the equipment used in providing synchronous E-therapy

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3 Developed, revised, and finalized by CSAT E-Therapy Expert Panel Work Group Meeting participants, Aug. 28, 2006.
services is of utmost importance in maintaining the flow of communication (D. Albury, personal communication, Aug. 28, 2006). In particular, older equipment may result in sluggish transfer of information, while faulty equipment may be disruptive. An additional consideration for the use of synchronous text-based service delivery (i.e., via text messaging and chat rooms) is that it is most useful with clients who have typing skills (G. Stofle, personal communication, Aug. 28, 2006; Suler, 2000). For this reason, a user’s skills in communication and typing should be among the client characteristics considered when making decisions about the appropriateness of specific forms of electronic therapy.

### Table 1. Benefits and Challenges Associated with Modes of E-Therapy

<table>
<thead>
<tr>
<th>Mode</th>
<th>Benefits</th>
<th>Challenges</th>
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<tr>
<td>Text-Based Communication</td>
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<tr>
<td>E-mail</td>
<td>Conversation can be reviewed at a later date; Allows for more thoughtful communication.</td>
<td>Asynchronous; Does not allow for immediate response; Not completely secure (e.g., messages can be forwarded, copied, etc.); No nonverbal cues; Requires an e-mail account, Internet access, and computer.</td>
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<tr>
<td>Instant Messaging</td>
<td>Immediate response; Conversation can be reviewed at a later date.</td>
<td>Not completely secure (e.g., messages can be forwarded, copied, etc.); No nonverbal cues; Requires an e-mail account, Internet access, and computer.</td>
</tr>
<tr>
<td>Internet Chat</td>
<td>Group setting; Rapid response; Conversation can be reviewed at a later date.</td>
<td>Not completely secure (e.g., messages can be forwarded, copied, etc.); No nonverbal cues; Requires an e-mail account, Internet access, and computer.</td>
</tr>
<tr>
<td>Text Messaging</td>
<td>Immediate response; Conversation can be reviewed at a later date.</td>
<td>Not completely secure (e.g., messages can be forwarded, copied, etc.); No nonverbal cues; Requires a cellular phone.</td>
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<tr>
<td>Non-Text-Based Communication</td>
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<tr>
<td>Telephone</td>
<td>Immediate feedback; Low cost</td>
<td>Client cannot review conversations at a later date.</td>
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<tr>
<td>Videoconference</td>
<td>Immediate feedback; Can use nonverbal cues to support intervention.</td>
<td>Cost; Requires knowledge of equipment; Usually requires some travel.</td>
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<tr>
<td>Fax</td>
<td>Rapid feedback; Low cost.</td>
<td>Not secure; Information can be forwarded and copied.</td>
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Asynchronous communication allows for correspondence without simultaneous connection (Maheu, et al., 2005). Examples include postal mail, e-mail, facsimile, and voicemail. These forms of contact generally do not allow for immediate feedback or a consistent flow of conversation. As a result, the level of support offered via asynchronous communication is believed to be lower in comparison to synchronous forms of communication (M. Osborne, personal communication, Aug. 28, 2006). However, it is also important to note that asynchronous forms of communication tend to be less expensive, as they generally do not require the same degree of technological capacity as most synchronous forms of interaction. Further, asynchronous forms of communication allow the practitioner to prepare and revise responses to clients, thereby providing more thoughtful feedback (Castelnuovo, et al., 2003; Maheu, et al., 2005; G. Stofle, personal communication, Aug. 28, 2006; Suler, 2000).
When planning E-therapy implementation, it is important to acknowledge the distinction between forms of communication, so that clients’ needs can be readily addressed. For example, practitioners serving significant numbers of persons in crisis should consider the use of synchronous forms of communication, as a delayed response might place distressed clients in danger (Yager, 2002). However, as most service providers address an array of client challenges, having the capacity to use both synchronous and asynchronous forms of communication may be most appropriate (Maheu, et al., 2005; Stofle, 2004).

**When is the Use of E-Therapy Appropriate?**

E-therapy has the potential to be utilized throughout the continuum of care, for a variety of conditions. In particular, online counseling may be appropriate for psychoeducational purposes, issues requiring short-term treatment, self-help interventions, and cognitive-behavioral approaches (Mallen and Vogel, 2005). Also, persons who have endured trauma and are contending with feelings of anxiety, guilt, fear and shame as a result, are good candidates for E-therapy (J. Hoffmann, personal communication, Aug. 28, 2006; G. Stofle, personal communication, Aug. 28, 2006).

In addition, experts have identified specific groups of people for whom E-therapy may be suitable (e.g., International Society for Mental Health Online [ISMHO] Clinical Study Group, 2002; Mallen and Vogel, 2005; J. Shore, personal communication, Aug. 28, 2006; Stofle, 2004). For example, persons located in remote areas (e.g., rural, American Indian/Alaska Native territories) may benefit greatly from the flexibility of services delivered electronically (Brown, 1998; Gibson, Morley, and Romeo-Wolff., 2002). Other underserved populations, including ethnic and racial minorities, women with children, and people from low-income families may also experience improved access to substance abuse treatment services (Y. Choi, personal communication, Aug. 28, 2006). Adolescents and young adults have also been identified as a population that has the potential to benefit from E-therapy (Skinner, Biscope, Poland, and Goldberg, 2003). An added advantage of this group is their familiarity with computers and the Internet and their willingness to utilize technology in new ways (Skinner, et al., 2003; J. Wodarsky, personal communication, Aug. 28, 2006). However, according to Stofle (2001), populations inappropriate for online counseling include those with suicidality; borderline personality disorders, difficulty distinguishing reality from nonreality, or conditions that require face-to-face meetings for diagnosis (ISMHO, 2002).

**How Can Treatment Providers Use E-Therapy?**

An additional benefit of E-therapy is its versatility in terms of service delivery. E-therapy can be used to provide education, assessment and diagnosis, direct treatment, and aftercare services. In addition, providers can give and receive training and supervision using electronic forms of communication (Maheu, et al., 2005; Stofle, 2004). Each of the aforementioned uses is discussed in further detail below.

**Referrals**

Persons seeking treatment for substance abuse can obtain referrals via the Internet, e-mail, or telephone from credible resources (Maheu, et al., 2005; Stofle, 2004). A number of web-based directories, often maintained by insurance companies and service providers, give prospective clients practitioner information about available services, treatment specialties, types of insurance accepted, and location (Maheu, et al., 2005). Many of these websites are available for providers to advertise for a fee. However, fraudulent websites have been identified. Therefore, practitioners should thoroughly investigate any website before posting information and/or remitting payment (Maheu, et al., 2005). In addition, service providers must be aware that confirming the identity of a client referred electronically might be difficult. Additional
considerations related to confidentiality and identity confirmation are discussed further in the “Legal and Regulatory Issues” section of this document.

**Education**
The Internet has served as a source of information and education for a number of health-related issues through scientific journal articles available online, websites (e.g., WebMD, CyberDocs, and Metanoia), and listservs (Maheu, et al., 2005; Yager, 2002). Practitioners can also use the Internet to help clients feel more comfortable with technology, inform them of the treatment process, and assuage their anxiety about undergoing therapy. In addition, service providers can develop client education programs that are accessible via the World Wide Web. These programs can provide ongoing support, information, and treatment via the Internet. For example, Federal agencies, in their efforts to support substance abuse treatment efforts in communities, have developed several websites that target specific age groups. Specifically, the National Institute on Drug Abuse (NIDA) has developed a website to educate adolescents ages 11 through 15 years about scientific factors associated with drug abuse (see http://teens.drugabuse.gov/about.asp). Similarly, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has developed a series of interactive, Internet-based tools for college students to inform them of the dangers of alcohol use (see http://collegedrinkingprevention.gov). However, it should be noted that these programs should be immediately followed by treatment if necessary to prolong the effects of the information provided (Maheu, et al., 2005). Additionally, GetFit.SAMHSA.Gov (see http://getfit.samhsa.gov/) is an interactive website that provides information about physical health, mental health, alcohol and illicit drugs.

**Assessment and Diagnosis**
The Internet may also play a role in assessment and diagnosis. Several web-based screening tools are available for clients to assess their substance use. Many of these sites provide feedback and treatment resources for those who need assistance after taking an assessment (Copeland and Martin, 2004; Stofle, 2004). In addition, web-based questionnaires can be used to assess clients both before and during treatment (Maheu, et al., 2005). This practice establishes a baseline measure of the client’s condition and ongoing measurement of progress. Moreover, some studies suggest that psychological self-assessments conducted via the Internet are comparable to paper-and-pencil assessments (Vallejo, Jordán, Diáz, Comeche, and Ortega, 2007). However, as practitioners are commonly trained to incorporate observed nonverbal cues into their assessment and diagnosis, some experts (e.g., see Fenichel, 2000) argue that diagnosis is difficult without visual, olfactory, and aural cues to assist with the process. Grohol (cited in Ragusea and VandeCreek, 2003) argues that diagnosis is simply impossible online. Unfortunately, the ability to observe certain cues is not possible when administering a questionnaire via the Internet. There is some evidence to suggest that videoconferencing may alleviate some of the concern around the inability to fully view the client, but the findings are somewhat inconclusive to date (Elleven and Allen, 2004). For this reason, many experts agree that an initial in-person meeting should be held for assessment purposes and to determine the appropriateness of E-therapy for the client’s condition (Alleman, 2002; Stofle, 2004).

**Direct Care**
Substance abuse treatment may also be provided via E-therapy for clients deemed appropriate for service delivery in this fashion. A number of providers in private practice offer treatment, most often via e-mail or chat rooms as the method of delivery (Stofle, 2004). In addition, chemical dependency treatment programs are available online. Many of these programs, such as eGetgoing (www.egetgoing.com), provide Internet-based services, and are recognized by
major bodies of accreditation (Stofle, 2004). In addition, Internet-based brief interventions for substance use have yielded promising outcomes (e.g., Copeland and Martin, 2004). E-therapy may also be used as an adjunct to services provided face-to-face (Maheu et al., 2005). Practitioners may provide opportunities for communication through e-mail, chat, telephone, or videoconference. It should be noted that E-therapy might not be appropriate for all clients, as it may compromise the development of independence from the service provider. However, for some clients, it may facilitate communication that would not otherwise occur (Day, quoted in Maheu, et al., 2005, p. 360).

After Care
E-therapy may also be used by practitioners to support clients after treatment has been administered. Providers can use direct online contact as part of relapse prevention, particularly when using text-based forms of communication. These interactions serve as a reference for both the provider and client. In addition, self-help groups have resources available through the Internet (Stofle, 2004).

Training and Supervision
Communication conducted via E-therapy can also be used for training and supervision purposes. Text-based sessions provide records that can be reviewed directly (Maheu, et al., 2005). In addition, providers have offered continuing education to clinical staff in remote locations through videoconferencing. This method provides a low-cost, time-effective means for obtaining training and education (Gibson, et al., 2002).

How Effective is E-Therapy?
The array of services delivered via E-therapy provides opportunities for populations that would otherwise go without much-needed care (Brown, 1998; Gibson, et al., 2002; ISMHO, 2002; Mallen and Vogel, 2005; J. Shore, personal communication, Aug. 28, 2006; Stofle, 2004). Determining the degree to which E-therapy is effective should be based on both client perceptions of the care they received and on empirical research demonstrating a reduction in symptoms.

In terms of client perceptions, an informal survey conducted by Metanoia, a nonprofit clearinghouse for mental health websites, yielded the following results:

- Ninety percent of online clients who participated in the survey felt that E-therapy helped them.
- Many participants also felt that they would not have initially sought face-to-face therapy.
- A large percentage of those who sought online therapy later used face-to-face counseling (Alleman, 2002).

These results suggest that clients believe that they have been helped by services delivered through E-therapy.

Although the potential of E-therapy to provide quality services is frequently cited, there is insufficient empirical research to determine the efficacy of online therapy (Alleman, 2002; Barnett, 2005; Copeland and Martin, 2004; Ragusea and VandeCreek, 2003). Experts (e.g., Barnett, 2005) have emphasized the need for more research to thoroughly assess the delivery of mental health services via electronic media, citing methodological difficulties in designing studies to assess different types of online counseling and capturing the effects of practices commonly used with some forms of E-therapy (e.g., the use of emoticons to convey emotions using text). Additional methodological concerns include small sample sizes, high dropout
rates, and the lack of standards for comparison (e.g., Barnett, 2005; Copeland & Martin, 2004). These issues are discussed in further detail in the “Evaluation” section of this document.

While some argue that online therapy may be limited in its treatment efficacy due to the lack of nonverbal cues, some research suggests that humans find ways to express nonverbal cues in the absence of conventional “socio-emotional, nonverbal” cues. Further, some research findings suggest that levels of affect can exceed those of face-to-face situations in the absence of traditional nonverbal cues. For example, both children and adults seem to readily disclose much sooner when receiving treatment online versus in-person (Alleman, 2002).

The Efficacy of Specific Approaches
Castelnuovo and colleagues (2003) contend that the Internet can improve treatment delivery in two areas: individual therapy and self-help therapy. “Individual telepsychotherapy,” which is psychotherapy conducted remotely, might be used to access remote populations (Castelnuovo, et al., 2003). Findings from studies investigating the efficacy of individual telepsychotherapy with conditions including panic disorder, public speaking phobias, and agoraphobia have suggested that treatments administered electronically have significantly decreased most symptoms associated with those conditions (e.g., Botella, Banos, Villa, Perpiña, and García-Palacios, 2000; Bouchard, et al., 2000; Murdoch and Connor-Greene, 2000). In terms of self-help therapy, the effectiveness of online groups is generally high for the treatment of eating disorders and depression. However, it should be noted that the potential for ethical violations is also high, due to limited privacy, varied locations of participants, and the inability to confirm participants’ identities.

Although few studies exist examining the efficacy of Internet-based substance abuse interventions, there is some evidence that providing cognitive behavioral treatment (CBT) electronically may be as effective as face-to-face. For example, Hester and Delaney (1997) found that behavioral self-control training, a CBT intervention designed to help participants change their behavior around drinking, was equally as effective when delivered online (Copeland and Martin, 2004). Further, the reductions in alcohol use were maintained over a 1-year period.

Benefits and Challenges Associated with E-Therapy
Every form of treatment has benefits and challenges associated with its use, and E-therapy is no exception. As was previously mentioned, more research is needed to thoroughly assess the benefits and challenges associated with providing mental health services online. While there are many aspects of E-therapy that may be deemed either positive or negative, the following section focuses on three salient issues for each. Specifically, in terms of benefits, accessibility, cost, and continuity of care are discussed. The challenges discussed include demand for E-therapy, the “digital divide,” and confidentiality.

Benefits Associated with E-Therapy
In terms of access to services, research findings have suggested that online counseling may benefit clients who are isolated in rural areas or are underserved by conventional systems (Mallen and Vogel, 2005). That is, treatment providers may have the ability to make themselves more widely available to those in need, as compared to providers administering face-to-face treatment. For example, E-therapy services can be found in “rural clinics, military programs, correctional facilities, community mental health centers, nursing homes, home health care settings, and hospitals.” (Maheu, et al., 2005). More practitioners delivering services electronically will also improve treatment access for underserved populations. Further, practitioners can more readily provide interactive psychoeducational materials during
times when traditional services may not be accessible. These online materials can be used to dispel myths about mental health treatment, encourage treatment compliance, promote self-monitoring, and teach relapse strategies (Mallen and Vogel, 2005).

E-therapy is also associated with lower costs for care, particularly for rural programs (Alleman, 2002; Brown, 1998; Gibson, et al., 2002). For example, direct costs associated with E-therapy consultations have been as much as 50 percent less than face-to-face consultations in eastern Oregon’s RodeoNet telepsychiatry program (Brown, 1998). Although the initial costs for equipment may be prohibitive (Darkins and Cary, 2002), reduced travel for clients and practitioners, improved quality of care, and increased levels of monitoring and assistance have all been identified as factors related to the decrease in funds spent to provide care (Maheu, et al., 2005; Gibson, et al., 2002). Lower costs have also been attributed to reduced time spent per appointment for some areas of health care, such as dermatology (Darkins and Cary, 2002).

E-therapy may also allow practitioners to maintain consistent contact with clients who relocate or are highly mobile (Mallen, et al, 2005; Yager, 2002). The ability to access providers and clients from multiple locations vastly increases the continuity of care. Research findings suggest that continuity of care is important to the development and maintenance of the client-practitioner relationship. The strength of this relationship is, in turn, associated with client assessments of the quality and effectiveness of the care they receive (Castelnuovo, et al., 2003).

**Challenges Associated with E-Therapy**

Experts have identified a number of challenges associated with E-therapy. It is predicted that the overall demand for online treatment service delivery will increase over the next decade (Alleman, 2002; Castelnuovo, et al., 2003; Mallen, et al., 2005). However, according to Alleman (2002), mental health professionals are unprepared for this demand (Alleman (2002). Further, it is believed that practitioners are reluctant to investigate ways to incorporate E-therapy into their existing methods of service delivery (Mallen, et al., 2005). As a result, the accessibility of services offered through electronic means may not achieve its full potential over time. In addition, the demand for assistance will continue to exceed the availability of services, resulting in continued unmet need.

Another challenge associated with providing E-therapy involves maintaining client-practitioner confidentiality. This is a major concern, as regulations are imposed on the therapist, but not the client. Nothing prevents a client from forwarding correspondence between himself and his therapist to a third party (Alleman, 2002). In addition, the exchange of information conducted over the Internet creates records that can be infiltrated and are not easily deleted (Manhal-Baugus, 2001; Recupero and Rainey, 2005). Further, these records can be infiltrated easily if communication occurs over insecure connections (Maheu, et al, 2005; Terry, 2002). Maintaining the highest possible levels of network security is of paramount importance for practitioners to ensure the privacy of clients (Ragusea and VandeCreek, 2003). An additional challenge associated with the use of E-therapy concerns disproportionate access to electronic media. Mallen and colleagues (2005) identified “young, affluent, educated, and highly functioning whites as having the greatest access to the technology required” for E-therapy (Sanchez-Page, 2005). This “digital divide” may compromise the ability of E-therapy to reach underserved populations (Sanchez-Page, 2005; A. K. Burlew, personal communication, Aug. 28, 2006). The effects of the “digital divide” also include persons who are not computer-savvy or are fearful of technology.
Summary

- An array of media is used to conduct E-therapy. The advantages and disadvantages of each form of communication should be considered when determining the best methods for a service population. For example, a user’s skill level (e.g., communication, typing, and other media-related skills) should be among the client characteristics considered when making decisions about the appropriateness of specific forms of electronic therapy.

- E-therapy has the potential to be utilized throughout the continuum of care, for a variety of conditions. For example, E-therapy can be used to provide: (1) education; (2) assessment and diagnosis; (3) direct treatment; and (4) aftercare services. In addition, providers can give and receive training and supervision using electronic forms of communication.

- Although the potential of E-therapy to provide quality services has been examined extensively, there is a dearth of research findings to determine its effectiveness, especially for substance abuse intervention and treatment. Experts have emphasized the need for more research to thoroughly assess the delivery of mental health services via electronic media, citing methodological difficulties with study design.

Benefits associated with E-therapy include greater accessibility for hard-to-reach and underserved populations, lower costs as compared to face-to-face therapy, and the ability to maintain continuity of care when clients relocate or travel.

A challenge associated with E-therapy includes the “digital divide,” the term used to characterize disparities in access to computers and the Internet. An additional difficulty associated with E-therapy is maintaining confidential relationships with clients.
Cultural and Linguistic Competence

Unmet needs-to-services mismatches are evident among some ethnic and racial minority populations, who are far more likely to encounter problems in access to traditional substance abuse and mental health services and to receive lower quality services when they do receive care (Wells, Klap, Koike, and Sherbourne, 2001; Harris, Edlund, and Larson, 2005). Problem drinking and illicit drug use go untreated, yet E-therapy is expected to build substance abuse treatment capacity for such hard-to-reach and traditionally underserved groups. The treatment community is charged with providing effective substance abuse treatment modalities for all ethnicities. How do culture and race affect appropriate substance abuse treatment strategies for minority populations? What is the pivotal role of dialect and language when providing substance abuse treatment services to specific target populations? Each of these topics will be discussed in this section.

Knowledge of Culture and Ethnicity

There is limited research available that addresses the benefits and concerns surrounding E-therapy, culture, and linguistic competence (HHS, 2001). Defining cultural competence and examining the underlying factors that often prevent minority groups and other ethnic or racial groups from seeking effective treatment is critical for the adaptation and development of culturally appropriate treatment interventions. Castro, Proescholdbell, Abeita, and Rodriguez (1999) define cultural competence as “the capacity of a service provider or an organization to understand and work effectively in accordance with the cultural beliefs and practices of persons from a given ethnic/racial group.” Failing to customize E-therapy substance abuse treatment to accommodate the different cultural needs, experiences, and beliefs of the individual client can be a serious mistake.

Culture (e.g., norms, traditions, and religious rituals) plays an important role in clients’ lives (Maheu, 2001). For example, research indicates that minority groups often rely on cultural coping mechanisms within the community to address stress and perceived mental or substance use disorders. In African American and Latino communities, discussing challenging life events with a clergy member or traditional healer is readily accepted and often preferred to traditional treatment methods (Levin, 1986; Risser and Mazur, 1995). Young, Griffith, and Williams (2003) surveyed 99 African American pastors on the amount of time they spent counseling parishioners. The pastors averaged approximately 6 hours a week counseling members of the congregation, often addressing serious mental health and substance abuse concerns. Native American populations may more readily seek assistance from traditional informal service providers or tribal elders than from a licensed mental health professional (Walls, Johnson, Whitbeck, and Hoyt, 2006). Marbella, Harris, Diehr, Ignace, and Ignace (1998) interviewed 150 Native American adult clients at a Wisconsin Indian Health Center and found that 38 percent of the respondents would seek help from a traditional healer in conjunction with Western health care. In addition, 61.4 percent of the clients indicated they would follow the advice of the traditional healer if the advice given by the western-influenced physician differed from the traditional healer.

Linguistic competence is especially relevant in the delivery of services via electronic forms of communication (Maheu, 2001). Users may be native English writers or persons who use English as a second language. English-proficient providers also cannot assume that all persons accessing E-therapy services understand English as well as the clinician. Allowing the client to fully participate in developing treatment interventions by providing feedback has proven beneficial for the client and practitioner (HHS, 2001). No doubt, familiarity with colloquial expressions, idioms, and local variations of word usage is critical to that feedback. Maheu
(2001) also states that to offer behavioral health (substance abuse and mental health) care in the absence of such knowledge and understanding about specific patients can easily be considered outside the standard of care and can serve as major impediments to informed consent, clinical assessment, client education, and direct care. Therefore, it is important to be aware of cultural beliefs and communication nuances among minority groups, as they are important components for practitioners to incorporate during online counseling sessions. As a practitioner, it is essential to recognize that standard substance abuse curricula and general interventions may not necessarily provide the best treatment strategy for an individual from a minority group. Cultural competence is about adapting practices and interventions to meet the needs of diverse cultural groups (Davis, 1997). Studies conducted by Jerrell and Wilson (1997) indicate that ongoing training in cultural competence is crucial for providing minority clients with culturally appropriate services and treatment options. In that manner, a culturally engaged practitioner always considers a client’s cultural background and experiences, which may influence the utilization of E-therapy as a relevant form of treatment for substance abuse.

**Barriers to Cultural Competence**

Beliefs and attitudes about particular groups of people usually dictate individuals’ behavior toward that group, regardless of the accuracy of the perception (HHS, 2001). Mistrust of the medical community has been documented repeatedly, according to the Epidemiologic Catchment Area study conducted in the early 1980s (HHS, 2001). In the study, nearly 50 percent of the African Americans surveyed reported a fear of receiving mental health treatment, compared with 20 percent of whites. Current-day discrimination and racism coupled with historical mistreatment are real barriers that may contribute to a lack of trust toward mental health treatment and the medical community (HHS, 2001). In addition, a 1999 study funded by the Kaiser Family Foundation reported similar findings within minority populations. Results indicated that 12 percent of African Americans and 15 percent of Latinos, vs. 1 percent of whites, believed that they had received substandard medical care because of their race (HHS, 2001). Data from the Commonwealth Fund Minority Health Survey (1997) reported that 43 percent of African Americans and 28 percent of Latinos, compared with 5 percent of whites, perceived they were treated poorly by a health care professional because of their race and cultural background (HHS, 2001). Likewise, immigrants and refugees are also leery of the U.S. health care system. Consequently, the delivery of mental health and substance use disorder treatment services for undocumented people is in jeopardy because this population fears deportation and mistreatment (HHS, 2001). Few research studies examine the link between effective culturally competent substance abuse treatment services through electronic modalities for minority individuals. Sanchez-Page (2005) identifies and addresses four counseling inadequacies in delivering culturally appropriate mental health treatment online.

**Lack of culturally suitable evaluation tools.** Researchers and practitioners should design culturally suitable evaluation tools to measure the benefits of E-therapy compared with face-to-face counseling among minority populations and their white counterparts.

**Lack of awareness about communication styles.** Practitioners must understand the important impact of cultural communications styles among minority populations and how the absence of verbal and nonverbal cues associated with online counseling may negatively influence the relationship between the practitioner and client.

**Limited access to technology in communities of color.** Poverty and disproportionate access to technology within communities of color limit the use of E-therapy as a mainstream counseling option for minority groups. Consequently, further research is required to examine the usefulness of electronic therapy among minority populations.
Lack of culturally appropriate online interventions. Develop culturally appropriate online interventions that address the cultural beliefs and practices of individuals from specific ethnic/racial groups (Castro, et al., 1999).

By effectively addressing important cultural factors, clinicians may begin cultivating the opportunity to advance the integration of E-therapy among underrepresented and underserved populations (Sanchez-Page, 2005).

Shame Associated with Mental Illness and Substance Abuse

Members of minority communities often have critical views about mental illness (HHS, 2001). In these communities, individuals who suffer from mental illness are often ostracized and subjected to shame and embarrassment by family members (HHS, 2001). Documenting the intensity of this stigma is difficult because minority groups are reluctant to address issues related to mental illness and substance abuse (HHS, 2001). Few cross-cultural studies have examined the relationship between race and mental illness. Zhang, Snowden, and Sue (1998) conducted a study comparing Asian Americans and whites living in Los Angeles. Data indicated that more than twice the number of whites (25 percent) would consider talking about their mental health challenges with a friend, compared with 12 percent of Asians. Study reports also showed that only 4 percent of Asian respondents would seek assistance from a mental health professional, compared with 26 percent of white respondents. Thirteen percent of white participants found it acceptable to discuss mental distress with a doctor, compared with only 3 percent of the Asian participants found it acceptable (HHS, 2001).

In the 1970s, the National Opinion Research Center began to evaluate societal views of mental illness. This extensive analysis initiated the 1996 General Social Survey (HHS, 2001), which gauged respondents’ personal opinions about mental illness when presented with various short stories depicting people diagnosed with mental illness. Study results indicated that respondents labeled people with mental illness as a menace and unfit to handle personal responsibilities. Intense criticism was aimed at individuals with substance abuse problems and schizophrenia. However, researchers observed that neither the race of neither the respondents nor of the individuals portrayed in the short stories factored into the stigma associated with mental illness (HHS, 2001).

On the other hand, a second study assessing public bias toward individuals with mental illness captured how different ethnic groups respond to people with mental illness (HHS, 2001). After interacting with individuals diagnosed with mental illness, Native Americans and whites reported a greater tolerance of people with mental illness, while African Americans, Latinos, and Asians reported less tolerance. The self-worth of family members and individuals diagnosed with mental illness is directly affected by the stigma of being labeled “crazy.” Often, the intense stigma attached to mental illness prevents people, particularly those within minority groups, from receiving treatment for mental illness. However, cultural sensitivity and acknowledgment of cultural stigma associated with receiving mental health and substance abuse treatment services is helpful when relating to minority clients (HHS, 2001).

Culturally Appropriate Treatment Services

Integrating fundamental parts of ethnic group culture, including styles of communication, value systems, historical background, and religious and traditional beliefs, are believed to increase the use of mental health services among minority clients. Researchers recognize that by adapting mental health treatment services to a client’s familiar culture, potentially significant treatment outcomes may be realized (HHS, 2001). During the last decade, practitioners and other mental health care professionals began emphasizing the importance of delivering culturally competent mental health services while encouraging buy-in from minority consumers, families, and communities. For example, a noted culturally appropriate
mental health care service delivery model designed for children and adolescents with severe emotional disabilities concentrates on the strengths of ethnic groups’ culture for effective service delivery (Cross, Bazron, Dennis, and Isaacs, 1989). Principal components involved in adapting this mental health care service delivery model include policy, training, resources, practice, and research.

Linguistic competence is equally significant in developing culturally appropriate treatment services. The National Center for Cultural Competence at Georgetown University defines linguistic competence as the “capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences, including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served” (The National Center for Cultural Competence, 2006). For example, the bilingual website “Amigos” utilizes an electronic psychoeducational tool to help minorities access health-related resources (Guanipa, Nolte, and Lizarraga, 2002). Providing availability to computers, and educating the targeted community about mental health care and multiculturalism, was the objective of establishing “Amigos.” By implementing electronic modalities similar to the “Amigos” program, minority groups may cautiously utilize culturally and linguistically competent mental health and substance abuse treatment services. Continuing research by practitioners and further development of culturally appropriate online interventions may encourage the use of E-therapy by minority populations.

Summary

- Developing and testing the effectiveness of culturally appropriate online substance abuse treatment interventions requires buy-in from minority consumers, families, communities, and mental health professionals.

- Therapists should recognize that the historical discrimination that minority groups have experienced in encounters with the medical community and the resulting feelings of mistrust from these encounters may influence the willingness of individuals to seek mental health and substance abuse treatment.

- Poverty and limited access to technological resources may influence the utilization of E-therapy as a mainstream counseling option within some minority groups. In addition, consider that standard substance abuse curricula and general interventions may not necessarily provide the best treatment strategies for minority communities.

- Practitioners must recognize and emphasize the importance of providing culturally competent treatment services and integrate fundamental components of ethnic group culture, including communication styles and religious and traditional beliefs. Integrating these cultural components may increase the use of mental health services among minority clients.
Legal and Regulatory Issues

The past several years have brought rapid changes to service delivery through the use of E-therapy. However, the development of laws and ethics codes governing its practice has lagged behind (Alleman, 2002; Barnett and Sheetz, 2003). Practitioners are required to adhere to their professional associations’ codes of ethics. In addition, the license to practice necessitates following the requirements set forth by licensing boards. The increased use of E-therapy has led to many unanswered questions in terms of licensure, ethics, client protections, and practitioner protections. Each of these issues will be discussed in this section.

Licensure

In most cases, the delivery of substance abuse treatment is regulated by the State in which practitioners serve clients. Regulations vary depending on the type of practitioner and the jurisdiction of practice. For this reason, most practitioners must be licensed in each State or province where they provide services within the “scope of practice” of that jurisdiction’s license (Mallen, Vogel, and Rochlen, 2005). The conduct of E-therapy complicates this issue, as most forms of electronic service delivery can easily occur across jurisdictional lines. This presents legal challenges that have not been clarified to date (Barnett, 2005; Darkins and Cary, 2000). For example, practitioners providing treatment to clients outside of the State in which they are licensed may be practicing outside of the “scope of practice” for their licenses. As a result, these practitioners may be in violation of the rules set forth by their respective licensing boards and liable for any harm to clients (A. K. Burlew, personal communication, Aug. 28, 2006; Recupero and Rainey, 2005). In addition, with a practitioner-client relationships formed across jurisdictional lines, it is unclear which region’s regulations take precedence (Manhal-Baugus, 2001).

To date, California has passed the most comprehensive legislation related to the conduct of E-therapy (National Conference of State Legislatures [NCSL], 2005). According to a component of the California Telemedicine Act, only clinical psychologists or medical doctors licensed in the State of California can administer E-therapy to clients who are State residents (Manhal-Baugus, 2001). As of September 2005, approximately 18 States had enacted legislation related to the use E-therapy for treatment purposes. In addition, several of these states, including Arizona, Montana, Vermont, and West Virginia, had established laws similar to California’s in terms of the practice of E-therapy. In addition, Montana and Puerto Rico require a special license to practice E-therapy within their jurisdictions (NCSL, 2005).

The need for the clarification of jurisdictional licensing issues is evident. To alleviate complications, many practitioners specializing in substance use disorder treatment and E-therapy endorse the formation of a national licensing system or reciprocal licensing among jurisdictions (Alleman, 2002; Manhal-Baugus, 2001; G. Stofle and E. Singleton, personal communication, Aug. 28, 2006; Terry, 2002). In addition, some licensing boards are working toward license reciprocity, which would alleviate a number of issues related to practicing in multiple States (Mallen, et al., 2005).

Until such legislation is passed, field experts recommend that practitioners provide services only in jurisdictions in which they are licensed to practice (Barnett, 2005; Barnett and Scheetz, 2003; CSAT E-Therapy Expert Panel Work Group Meeting, Aug. 28, 2006). It is also important for practitioners to know where their clients reside, to ensure that they are not in violation of any regulations. Experts further advise that practitioners be completely aware of the parameters under which they are permitted to practice E-therapy in their respective
jurisdictions and the areas in which their clients reside (Barnett, 2005; Gluekauf, Pickett, Ketterson, Loomis, and Rozensky, 2003).

**Ethics**

Because E-therapy is a relatively new field, there are few ethical codes that relate specifically to providing services electronically. Further, there is no consensus as to whether or not separate ethical guidelines for online practice are necessary (Ragusea and Vandecreek, 2003). It should be noted that the potential for ethical violations is high due to limited privacy, varied locations of participants, and the inability (in many cases) to confirm the identity of clients (Castelnuovo, et al., 2003).

While a few organizations have ethics codes created specifically for E-therapy, others have adapted their existing codes of ethics to include electronic communication. For example, the American Counseling Association, the American Psychological Association, and the National Board of Certified Counselors have revised their ethics codes to include E-therapy (American Psychological Association, 2002; Manhal-Baugus, 2001). Specifically, the codes were changed to address concerns about confidentiality, informed consent, licensure, and emergency procedures.

In 2000, the International Society for Mental Health Online approved a set of suggested principles of practice for those providing E-therapy (ISMHO, 2000). These principles address informed consent, standard operating procedure, and emergencies and seek to mediate a number of ethical issues related to providing E-therapy.

**Client Protections**

Ensuring the protection of clients is key to successful service delivery. In terms of E-therapy, establishing and retaining such security requires the adherence to client privacy regulations, obtaining informed consent, and providing for clients in the event of emergency.

At the Federal level, the Health Information Portability and Protection Act (HIPAA) protects the transfer and sharing of client information. As most practitioners are keenly aware, this legislation requires client consent to release medical information, with some exceptions. This legislation also applies to the electronic transfer of medical records, and practitioners must adhere to specific guidelines when sharing client information (Maheu, et al., 2005). However, in some cases, State and local regulations may supersede HIPAA (McMenamin, personal communication, July 7, 2006). Practitioners should check the guidelines in their jurisdictions to verify their responsibility in terms of transferring client information.

An additional component to client protection is informed consent, which was established to protect the client’s right to participate in treatment (Recupero and Rainey, 2005). As is the case with any form of treatment, clients are required to be provided with the following information, in accordance with applicable regulations:

- The treatment process or procedure
- Benefits associated with the treatment or procedure;
- Risks associated with the treatment procedure;
- Actions taken to prevent client risk
- Procedures for emergencies.

It is recommended that practitioners provide this information to clients prior to initiating treatment. Further, clients should have the opportunity to assert their understanding of the information provided to them (Recupero and Rainey, 2005).
In addition, ISMHO offers the following considerations for the provision of E-therapy, to be shared with potential clients prior to administering treatment:

- The possibility of misunderstandings, particularly with text-based forms of E-therapy, because there are no nonverbal cues to inform the communication
- The increased response time involved in asynchronous forms of communication
- The average time needed to provide the client with a response for asynchronous forms of communication
- The counselor’s right to privacy and the possibility of restrictions on the client’s use of any communication with the practitioner;
- The name and qualifications of the practitioner and how to confirm the information provided
- Alternatives to receiving assistance via E-therapy (ISMHO, 2000).

Practitioner Protections
Practitioners of E-therapy must also be vigilant about their own protection. In particular, treatment providers must be aware of issues related to malpractice and privacy. In terms of malpractice, one of the biggest concerns is the inability to have consistent face-to-face contact with the client, except in cases where videoconferencing is used (Maheu, et al., 2001). Without initial face-to-face contact, inaccurate assessment or misdiagnosis is possible. For this reason, an initial face-to-face consultation is recommended to facilitate accurate assessment and to determine the client’s appropriateness for E-therapy (G. Stofle, personal communication, Aug. 28, 2006).

It is also important for practitioners to have malpractice insurance coverage in every jurisdiction relevant to their practice, as most clients will file a suit in their area of residence (Maheu et al., 2001). As was previously mentioned, most States require licensure in the State of practice and do not allow interstate treatment to occur on a regular basis. A malpractice suit filed in a State other than that of the practitioner would prove detrimental to further practice without the proper licensure and insurance coverage.

Practitioners have the right to privacy in a manner similar to clients, but they are not protected by regulations. The provision of E-therapy complicates the practitioner’s ability to maintain his or her confidentiality when using text-based forms of communication, as the client also has a record of the exchange (Alleman, 2002). Nonetheless, as was previously mentioned, the practitioner should inform the client of his or her right to privacy.

Summary

- Most practitioners must be licensed in each State or province where they provide services within the “scope of practice” of that jurisdiction’s license. The conduct of E-therapy complicates this issue, as most forms of electronic service delivery can easily cross jurisdictional lines.
- As of September 2005, approximately 18 States had enacted legislation related to the use of E-therapy for treatment purposes. Laws in Montana and Puerto Rico require a special license to practice E-therapy within their jurisdictions.
Experts recommend that practitioners provide services only in jurisdictions where they are licensed to practice and that they know where their clients reside to ensure that they are not in violation of any regulations.

Service providers should be completely aware of the parameters under which they are permitted to practice E-therapy in their respective jurisdictions, as well as the areas in which their clients reside.

In terms of E-therapy, establishing and retaining client protections requires adherence to local, State, and Federal client privacy regulations, obtaining informed consent, and providing resources for clients in the event of emergency.

Practitioners have the right to privacy in a manner similar to clients, but they are not protected by regulations.
Administrative Issues

Introduction
Traditional face-to-face therapy requires standard confidentiality and privacy measures (Maheu, et al., 2001; Stofle, 2001). Specifically, practitioners must ensure that HIPAA regulatory procedures and codes of conduct are followed. In addition, providing E-therapy services involves implementing electronic safeguards to prevent hackers from accessing patient records and to prevent computer viruses from corrupting electronic data (Zack, 2004). Several different security options are available to practitioners and clients for maintaining a secure computer network. For a licensed therapist practicing E-therapy, experts recommend securing clients’ electronic records by utilizing password protection programs, computer network firewalls, wiping software, and document encryption. Critical administrative responsibilities include maintaining accurate billing statements, properly secured client files, and reliable technical support (Zack, 2004). Each of these topics will be explored in this section.

Electronic Security Measures

Password Protection Programs
When selecting a password, computer specialists suggest using a short phrase that is at least eight characters long (Zack, 2004; Stofle, 2001). Randomly selecting a variation of numeric, nonalphanumeric, lower and uppercase characters will increase the degree of difficulty in guessing the password. Also, automatic screen savers provide additional security to password protection software by appearing within a few minutes on the computer screen when the computer is not in use. In the case of illness or disability, online therapists recommend writing down the computer password and storing it in a safe deposit box. Providing a trusted colleague with instructions on how to access the stored computer password if an emergency occurs is encouraged.

Computer Network Firewalls
Further computer network security measures are attainable by installing firewall software or specialized hardware equipment. Firewalls allow the computer owner to filter selected information from the Internet through their personal computer network. Unwelcome electronic solicitations are significantly decreased with firewall protection. In addition, a network router operating between the cable/DSL modem can be adapted to encode identified data from the Internet to the owner’s personal computer (Maheu, et al., 2005).

Wiping Software
Wiping software is designed to overwrite computer hard drives with a haphazard series of zeros and ones. Information technology experts recommend wiping the computer hard drive before selling a used computer and discarding used floppy disks and CD-ROMs. For therapists providing E-therapy services, “wiping” ensures permanent deletion of client files and an additional layer of computer security before disposing of a computer that was used for E-therapy (Zack, 2004).

Document Encryption
Another method used to protect online counseling transmittals is document encryption. Encryption involves deliberately scrambling the text of a document by devising a basic
mathematical equation and an unusual “key” and then applying the equation to the document. The scrambled text is readable after a second mathematical equation and unusual “key” are applied to the document.

Options include symmetric encryption and public key encryption. Both are used to encrypt confidential documents (Maheu, et al., 2001; Zack, 2004). Symmetric encryption requires one key to encode and decode a confidential file. Notably, symmetric encryption proves to be an effective security measure, because without the decryption key the message remains unreadable to a potential computer hacker. Public key encryption consists of a public and private key set. Anyone may access the public key necessary to e-mail a therapist an encrypted message; however, only the therapist may decrypt and read the message by using a private key. Public keys are posted on websites or e-mailed to clients, while private keys are password protected and located on the practitioner’s personal computer (Maheu, et al., 2005; Zack, 2004).

**Administrative Responsibilities**

**Billable Services**
Medicare deemed online videoconferencing billable in October 2001 (Maheu, et al., 2001). Similar reimbursement rates for face-to-face counseling would be applicable to synchronous or asynchronous videoconferencing. However, health insurance companies do not cover text-based therapy. Therefore, clients utilizing text-based counseling services must pay the practitioner directly, usually by credit card. To alleviate confusion over payment responsibilities, therapists should explain the reimbursement restrictions surrounding text-based therapy to potential clients (Zack, 2004; Stofle, 2001).

**Client Records**
Regulatory procedures require practitioners to obtain and securely store client paper records. Likewise, electronic client files and online communications are protected by similar stringent privacy and confidentiality polices (Zack, 2004). Undoubtedly, health care organizations report that the most obvious threat to electronic patient files is computer hackers. Within larger health care agencies, client records tend to be more vulnerable to security breaches. Unfortunately, careless employees pose a risk to exposing confidential patient information. Employees may print clients’ records on unsecured copiers, leave private records unattended, select easy computer passwords, or talk to coworkers about client information (Maheu, et al., 2005). However, practitioners and health care employees are responsible for practicing ethical behavior in the workplace and so they must ensure that patient information is properly secured.

**Technical Support**
Experienced online therapists recommend investing in a reliable, 24-hour computer technical support service. Usually, computer companies offer technical support services along with the purchase of the computer.

**Summary**

- Overall, the implementation of effective electronic security measures and administrative responsibilities is critical to ensuring a confidential and client-friendly online counseling atmosphere.
- Effective security measures to prevent unauthorized access to confidential information and to establish a secured computer network include installing firewalls, using wiping software to erase clients’ electronic records when disposing of an old computer, and utilizing document encryption.
- Choosing simple words, phrases, or names of family members for computer passwords is risky and does not provide the security that is required to protect clients’ electronic files. Selecting unusual words or odd groupings of numbers and letters offers an increased level of security.
- Maintaining strict confidentiality when handling client files is paramount. Observing HIPAA regulatory procedures and codes of conduct is essential when practicing E-therapy.
References


