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Etherapy: Ethical and Clinical Considerations for Version 7 of the World Professional Association for Transgender Health's *Standards of Care*

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Etherapy: Ethical and Clinical Considerations for Version 7 of the World Professional Association for Transgender Health's *Standards of Care*

Lin Fraser

ABSTRACT. This invited article provides background and exploratory material for the potential inclusion of etherapy in Version 7 of the *Standards of Care* (*SOC*). A brief overview of the literature, its applicability and extrapolation to transgender clients, the rationale for etherapy, and clinical and ethical considerations, both general and specific to transpeople, are described. Included in the discussion is an online psychotherapy case and commentary involving a Saudi-based American male-to-female transperson and a San Francisco therapist. The article concludes with specific content for a recommendation for the inclusion of etherapy (but not online evaluation and referral) in the next revision of the *SOC*.

KEYWORDS. Etherapy, e-therapy, Internet therapy, online counseling, online therapy, psychotherapy, Web-based therapy, telehealth, transgender

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DEFINITIONS/METHODS OF DELIVERY OF SERVICES

Etherapy (e-therapy, cybertherapy, e-counseling, online therapy, distance counseling, etc.) normally refers to the provision of mental health services through electronic media (American Psychological Association [APA], 2007) or "to the use of psychotechnologies to deliver therapeutic dialogues at a distance" (Maheu, Pulier, Wilhelm, McMenamin, & Brown-Connolly, 2005, p. 5). According to some researchers, the main differentiating factor from traditional face-to-face (f2f) is the medium by which the therapy occurs (Derrig-Palumbo & Zeine, 2005). In this case the medium is electronic, but the provider of services could be the same person. It is the method of delivery of service, rather than the service itself, that distinguishes etherapy from more traditional f2f.

Another perspective (Suler, 2008) suggests that cyberspace, defined as the notional environment in which communication over computer networks occurs ("Cyberspace," 2005), is a unique psychological space. Hence, cyberspace as a psychological realm might be quite different from f2f environments and traditional concepts and theories may need to be modified.

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The description of the distance-credentialed counselor on the Center for Credentialing and Education (CCE, n.d.-b) Web site is as follows:

> A Distance Credentialed Counselor (DCC) will be nationally recognized as a professional with training in best practices in Distance Counseling. Distance Counseling is a counseling approach that takes the best practices of traditional counseling as well as some of its own unique advantages and adapts them for delivery to clients via electronic means in order to maximize the use of technology-assisted counseling techniques. The technology-assisted methods may include telecounseling (telephone), secure email communication, chat, videoconferencing or computerized standalone software programs.

Technology-assisted methods can be either synchronous or asynchronous and can be supplementary as well as complementary to f2f. Synchronous delivery methods include such interactions as real-time chat, instant messaging (IM) and video chat, and text-based phone and/or telephone (Voice-over-Internet Protocol [VoIP] such as Skype). Asynchronous methods include E-mail, via the Internet, or by telephone. Although it is beyond the scope of this article to discuss technical considerations, it is presumed that any therapist providing these services will get the training necessary to be comfortable, knowledgeable, and ethical using any of these delivery methods.

THE CASE FOR ETHERAPY

Timing and Access

The proliferation of the Internet concomitant with the burgeoning worldwide transgender community online has set in place an ideal avenue to develop outreach and care online. One of our goals and missions is to advocate and provide care regardless of demographics (Brown, 2009). One problem for the transgender population has to do with access. Many are geographically isolated and live in places where they may be stigmatized or even criminalized. The Internet knows no boundaries and has the capacity to reach even the most inaccessible of people as long as they have electronic access. The infrastructure allowing fast, easy access is growing worldwide, including in developing countries. Emphasizing this advantage, the dedication page of a seminal handbook on online therapy states "for those who suffer from emotional distress and need better access to care" (Maheu et al., 2005). Moreover, even where therapeutic care is accessible, access to competent specialists providing transgender care may be limited. Via online connections, specialists can provide care virtually anywhere, either directly to the client or indirectly via training, consultation, or supervision to local therapists who may be providing the f2f care.

Readiness and Appropriateness of Transpeople for Online Therapy

Etherapy has been shown to appeal to and especially help a certain type of individual (Derrig-Palumbo & Zeine, 2005; Fenichel et al., 2004), attributes shared by some members of the transgender population. These attributes include (a) knowledge of and access to technology, (b) motivation to get help, (c) capacity for psychotherapeutic work and comfort with the written word, (d) geographic isolation, and (e) stigma and need for anonymity, among others.

Many transgender people are technologically educated and have already developed worldwide connections online. Technical knowledge, information, and delivery models are already in place to provide ethical online psychotherapy to an ever-expanding global trans community. The mechanisms exist to deliver services and provide training to local licensed clinicians and/or community-based mental health facilitators. The systems are already in place, and clinicians need to learn how to utilize them to expand their reach.

Moreover, many transgender people are highly motivated and want care from knowledgeable providers (Rachlin, 2002). Some will not access therapy due to concerns that uneducated providers might misunderstand, pathologize, or even harm them. Etherapy, with members of the World Professional Association for Transgender

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Health (WPATH), knowledgeable about transgender issues, could mitigate some of these concerns.

As candidates for psychotherapy, what is anecdotally known is that many transgender people are highly intelligent; psychologically knowledgeable, having examined themselves for years, often alone and in secret (Fraser, 2003); and may be excellent candidates for psychotherapeutic work with a competent therapist. Those who are quite comfortable with the written word could benefit from text-based therapy. Simultaneous translation of text is available online for those who speak a different language from the clinician. Moreover, Web therapy often appeals to those who are geographically isolated or stigmatized and might otherwise not reach out for services due to location, fear, shame, or need for anonymity (Dellig-Palumbo & Zeine, 2005). For these reasons, Web-based therapy may be appropriate for a subset of the transgender population.

Convenience and Flexibility/Increased Containment

An advantage of etherapy is that multiple modalities and delivery methods are available depending on preference of the client and creativity of the therapist. This offers possibilities to mix and match modalities, offering convenience, flexibility, and individualized treatment. Each delivery method has its advantages (Ainsworth, 2001; American Psychiatric Association Council on Psychiatry and Law, n.d.; CCE, n.d.-a, n.d.-b; Dellig-Palumbo & Zeine, 2005; International Society for Mental Health Online [ISMHO], 2000b) and the therapist can learn to utilize each most effectively depending upon preference, experience, and the needs of the client.

A definite advantage for both client and therapist is mobility and continuous connection. The provider and client are free to be mobile without disrupting the work. For those who are doing f2f in combination with etherapy, knowing that the therapist is somewhat accessible when either are away for long periods or even in between sessions (this is at provider's discretion and is part of the frame) can reduce acting-out behavior and other manifestations of anxiety (Suler, 2007). In this increasingly globalized society, a mobile therapist and client can maintain an ongoing connection, potentially containing sometimes difficult material. Moreover, online psychotherapy can be convenient and flexible. A client can contact the therapist on his or her own time from wherever he or she wishes. And the therapist can respond likewise within the agreed-upon frame.

Finally, online therapy provides accessibility to clients who may be of limited means due to a reduction in travel expenses, a not unimportant concern within the transgender population (Whittle, 2006), who often travel great distances to see trans-sensitive providers.

MYTHS AND REALITIES/CLINICAL AND ETHICAL CONCERNS

Concerns about etherapy tend to fall into one of two categories, clinical or ethical/legal.

Clinical

Clinical concerns about etherapy relate to concerns about connection, relationship, and the therapeutic alliance and issues of risk management (confidentiality, emergency, identity of client).

Connection, Relationship, and Therapeutic Alliance

The primary clinical resistance to etherapy relates to the inability of the clinician to actually see and be in the same room with the client, hence being unable to visually discern nonverbal communication and other nuances central to f2f therapy. Moreover, many clinicians believe that the mutual physical presence is necessary for the exploration of underlying considerations, not to mention the basic tenets of psychotherapy, such as the development of a therapeutic alliance and the intersubjective connection that allows the client to feel safe. It is believed that this connection can only occur in the physical office. Depth therapy considerations such as the development of a transference and immersion into deeper levels are presumed to only occur in the actual

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physical presence of a caring, nonjudgmental empathic other. Many people worry that somehow cyberspace seems limited and mechanical given the nature of the intimacy of an f2f psychotherapeutic relationship. The evidence, both from the literature (Fenichel et al., 2004; Suler, 2007, 2008) and in the case described below, does not support these concerns.

Some people may disclose more readily given the relative anonymity of cyberspace and in some cases, if geographically permissible, will progress to f2f (Dellig-Palumbo & Zeine, 2005). Some of these people might not have accessed any psychological services had cybertherapy not been available.

Moreover, as technology advances, more online work will include video either by phone or computer, alleviating the concern about lack of verbal cues (Maheu et al., 2005). Second, the efficacy of the written word should not be underestimated and text-based communications for certain clients (and providers) can be a powerful modality for the psychotherapeutic relationship. Concerns related to the therapeutic connection central to therapeutic alliance and moving to deeper levels are not borne out by those who have actually experienced the power of etherapy. (Fenichel et al., 2004; Suler, 2007). Due to the effects of online disinhibition (Barak & Suler, 2008), people make more, deeper and faster disclosures about themselves than they do to people in their physical environment (Barak & Suler, 2008).

As will be demonstrated in the case study in this article, this ongoing connection in cyberspace allows a protective and strong holding environment. Growth does not necessarily operate on a schedule and some of the deepest revelations may occur outside scheduled sessions. The felt experience for many is that the therapist is as close as the screen. People often experience cyberspace as an extension of their minds and personalities, a transitional space (Turkle, 1995) that is an extension of their intrapsychic world (Barak & Suler, 2008), and can feel connected to others in this liminal space. It is this sense of connection rather than the actual physical contact that seems to be important and is borne out by those who practice etherapy (Suler, 2007). This connection may remain between sessions, can contain difficult material, and may allow the client to go deeper in awareness and understanding more quickly. More discussion of this cyber connection is described in the "Case Study" section of this article.

A detailed discussion of clinical concerns is beyond the scope of this article. At this point, much of the literature is descriptive and often involves case studies (though not of transgender people, unfortunately) of this evolving practice, with the recognition that more data-based research is needed. Further resources addressing clinical issues may be found in the "How to Stay Current/Links to Further Information" section in Appendix A.

Risk Management

Another clinical concern has to do with risk management, issues such as security, confidentiality, emergency backup, and reliability regarding the identity of the client. These can be resolved via encryption, a plan for what to do in an emergency, providing links to local services, and the provision of an emergency local health care contact. Identity can be established via credit card payment and software. For people concerned with visible exposure prior to "coming out," confidentiality and security may be perceptibly increased utilizing online services.

Ethical/Legal

The primary ethical/legal issue under consideration has to do with who can practice and where one practices etherapy. Where is the therapy located? Where exactly is cyberspace? Much discussion concerns the legitimacy of crossing state, national, and international boundaries or whether boundaries even exist in cyberspace. The bottom line issue is how the consumer is protected.

This article has as an underlying premise that clinicians considering practicing etherapy will be certified, licensed, or otherwise covered by their regulatory boards to practice f2f therapy and etherapy (where the regulations are clear) and will provide this information to clients as part of the informed consent process. For example, the provider's Web site might include links to appropriate licensing and regulatory boards

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as a way to verify their credentials. It is also presumed that, as in f2f, the practitioner will have familiarity with the ethics of their respective practices. The practice of etherapy far exceeds the various state regulatory and licensing boards' abilities to keep up with its exponential growth. Hence, it falls upon providers not to only stay current with their respective regulations but to understand the thinking upon which ethical practice is based. Regulation is a complex issue (ERIC/CASS Digest, 2000). Problems of licensing reciprocity exist and the location of cyberspace is generally undefined. Telemedicine guidelines are clear in some states in the United States, but not all, and the international situation is even less defined (Maheu et al., 2005; Zack, 2007).

As an overarching principle, then, the reader is advised to stay current with his or her particular licensing board, professional association, and country's regulations as well as the thinking of those in the vanguard of this rapidly evolving medium. At a minimum, by keeping abreast of current information, a considered and knowledgeable decision about whether to participate can be made.

As an overview, the various regulations available today can be confusing, still unclear and contradictory. For example, M. Fenichel, in an April 13, 2007, e-mail to the ISMHO membership, addressed the "thorny problem of US licensing," saying that

> The short version of the topic is that the patchwork of 50 states sets of rules now in place does not seem like it can remain standing—it is anachronistic, so it seems, out of step with the reality of how people interact with the world these days, often facilitated by the Internet.

Moreover, one's particular state's or even country's governing body may not approve of what may be considered quite ethical from one's professional association.

Rules range from a commonsense approach such as the NCC's *Code of Ethics* from the 1990s that advises the clinician to use his or her best clinical judgment based on an extrapolation of ethics from f2f to online work or the American Psychiatric Association's position statement on the Ethical Use of Telemedicine:

> The APA supports the use of telemedicine as a legitimate component of a mental health delivery system to the extent that its use is in the best interest of the patient and is in compliance with the APA policies on medical ethics and confidentiality (American Psychiatric Association Ethics Committee, 1995).

to a highly restrictive regulation, where, under such and such a license, the clinician can only practice etherapy if licensed in the location where the client is physically located. Hence, in this latter case the location of the therapy is determined by the location of the client. Others are quite liberal, like Britain, for example, which offers reimbursement for etherapy services provided by clinicians living both inside and outside the UK as long as they hold a UK certification (K. Anthony, personal communication, 2007). The United States now has a Current Procedural Terminology code (0074T) for online consultation with an established patient (Kraus, 2004).

In the United States, a national counseling credential and a distance counseling certification exist and, although not licenses, provide some potential protection for a therapist practicing across state lines. Even so, their applicability in some locations remains unclear. Discussions are in place about a global credential (Clawson, 2007). Maheu and her colleagues have drafted papers including principles, statements, and philosophy for an international convention on telemedicine and telehealth (Maheu et al., 2005, Appendix D, p. 451).

In general, regulations are slowly catching up to practice. In the United States, rural states are in the forefront, because their consumers desperately need access to services, and the hope is that need will engender regulatory reform. "There are no national laws forbidding a therapist to treat someone outside of his or her state of licensure, though some state boards have taken a stand on where the therapy takes place" (Derrig-Palumbo & Zeine, 2005, p. 53). To date, no legal case has been tested or tried that might untangle the myriad regulations; hence, services

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are provided without any certainty as to how a lawsuit might be played out. One case in California (Zack, 2007) has recently emerged as a potential test case. A physician in Colorado prescribed medication (Prozac) online and across state lines to a person in California through a server in Texas without physically examining the person. The patient later committed suicide and was found to have had Prozac in his system. The writ petition against the doctor is a felony complaint about practicing without a license in California. It is unknown, whether this may become the test case with potential applicability to etherapy.

Another ethical concern involves the availability of liability coverage for online therapy. Readers are referred to their own carriers; however, a cursory review suggests that insurance is available if the therapist can show evidence of professional training. As an example, the author's insurer added the distance counseling credential to her liability policy for an additional $17.

The reader is referred to the ISMHO Web site (http://www.ismho.org/home.asp) for articles and interesting and ongoing international discussions about ethics, liability, and legality of providing etherapy. Most discussions of ethics and codes of conduct seem to concur on a few general principles. First, as an overview, is the importance of maintaining a clear understanding of the ethics statement of one's own professional organization, both in general and then specifically about etherapy if such standards exist. General considerations usually include maintaining licensure, providing informed consent, maintaining an ongoing consideration of what is in the client's best interest, providing access and nondiscrimination policies, and operating within one's level of competence and training. These are underlying ethical considerations for all therapy, including etherapy. The therapist needs to regularly ask whether what is being provided is in the best interest of the client and is he or she competent to provide it. Then, in terms of extrapolation to etherapy, for this particular client, given his or her particular situation, is etherapy the best available service? And is his or her condition within the therapist's area of expertise or could he or she access more effective services elsewhere? Certainly, given these universal ethical parameters, the case for etherapy exists for transgender clients due to the aforementioned accessibility problem and limited available expertise.

Aside from general ethical considerations, the therapist also needs to understand specific regulations and standards having to do with etherapy. Many professional associations provide versions of them. These are usually subsets of their ethics statements such as the American Psychiatric Association, American Psychological Association, National Certified Counselor, American Association Marriage and Family Therapists (in the United States). It is also important to check local and country laws and regulations to see whether any exist regarding etherapy. What may be found is a good deal of confusion, so each provider needs to consider carefully his or her own circumstances. A major question in the Distance Credentialed Counselor certifying exam involves knowledge regarding the ability to access information and knowledge of how to stay current. Links to useful Web sites and further information are included in Appendix A. Appendix B describes current legal opinion regarding disclosure, informed consent, and malpractice coverage for online therapy.

CASE STUDY

What follows is a case from the author's practice (written in the first person for readability) that addresses the issues and considerations, both clinical and ethical, described in the previous sections. No other transgender-specific clinical case material could be found in the literature.

From this single case review and the information herein presented, it is hoped that the reader might be able to extrapolate to his or her own practice and imagine the clinical possibilities inherent in the cyber therapeutic connection as well as the multiple modalities it affords to individualize treatment, offer choice, and potentially offer even more creative delivery of clinical services than may be afforded by traditional f2f.

SH has given permission to discuss her case: "You also have my full consent to use all relevant documents regarding our therapeutic

interactions, including handwritten notes and copies of E-mails in any future paper, presentation, or publication regarding our telehealth activities."

Case Summary/Initial Phase

SH, then MH, an American living in Saudi Arabia, contacted me via e-mail in March 1998 and asked for an appointment during his (she was living in a male role at the time) home visit to the Bay Area. I saw him in my office in May. He was experiencing rather intensifying progressive gender incongruence and needed therapy to sort out his conflicting struggles. Married and the father of two (almost grown) children, and working overseas with no contact with any kindred spirits, he was becoming increasingly depressed and agitated. The pressure on his psyche was intensifying and he was filled with guilt and shame. He was considering medical feminization, even though the consequences of a speedy transition could be quite dire from his perspective and potentially quite dangerous if he went out dressed in Saudi. We saw each other several times before his return to the Middle East and he asked whether we might continue the work via e-mail. This was my first introduction to etherapy in my own practice, although, over the years, I had worked with established clients over the telephone as time and distance considerations required. I had also recently joined a listserv about etherapy, so I had some sense of the issues and concerns involved. MH was seeing and had been seeing a psychiatrist in Saudi since 1996 and had been in therapy with others in the past, but his psychiatrist had no knowledge of gender issues. I felt that as long as he continued to see his local therapist, and if the local therapist agreed that ongoing e-mail contact between MH and me might be helpful, then I would be willing to work with him on a trial basis and evaluate its effectiveness as we went along. We discussed the tentative frame of the therapy, such as fee structure, my availability, response turnaround time of communications, contact information of his psychiatrist and next of kin, security of e-mail, etc., and agreed that these arrangements might evolve or change as the therapy progressed.

What I could not have known at the time was that this would be the beginning of a new kind of clinical experience, rich with depth and possibility. Although much less was available then in terms of knowledge regarding ecare, the thinking concerning how best to help from a distance has not really changed. The issues that were confronted are the same as would be confronted by anyone with his or her first eclient. Moreover, members of WPATH, used to being cutting edge and on the forefront of new and challenging theory and developing new standards and therapies to meet the evolving needs of transpeople, might be particularly suited to cyber psychology.

Due to a confluence of factors, this first case proved efficacious. SH turned out to be ideal for this kind of work. She is technically knowledgeable and knew how to encrypt our communications. She is intelligent and comfortable with the written word. She is psychologically oriented with the ability to connect experience and dreams to feelings as she wrote. She is literate and knowledgeable about symbols, attributes important to the kind of work that ensued. Moreover, she is capable of developing a transference, and we were able to create a holding environment in cyberspace, the latter being especially important given the very real danger of being a transperson in Saudi. These perspicacious factors were unknown, of course, in the initial phases of treatment. What was clear, however, was that we had developed an early therapeutic alliance and that responding to her request for online work would likely not harm her, given that she had local backup and support. After our first session, she (then he) e-mailed me an initial dream that contained strong imagery suggesting that his entire world was crumbling, that the status quo as he knew it was tumbling down and he woke up crying. So, the therapy began.

Ethics, Risk Management, and Informed Consent

For those contemplating online work in locations where regulations are evolving, my actions concerning ethics and liability at the time I accepted this case might serve as an introductory template. Little concrete or clear information was then available. I checked with relevant

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licensing, professional membership ethical standards, and codes of conduct and attended an APA Workshop on telehealth to learn more.

The National Certified Counselors Ethical Standards for online work, although no longer available, delineated a commonsense approach recommending that because this is a new modality, the counselor needs to apply the same ethical principles as he or she would to f2f and provided a listing of the commonsense principles.

By the time I attended the 3-day APA workshop on telehealth, I had been communicating online with SH several times weekly and was aware that the therapy seemed to be helping. I presented the case to the attendees and workshop leaders, including the group leader, Marlene Maheu, PhD, a psychologist in the forefront of the telehealth movement (see Maheu et al., 2005), and an APA attorney and APA ethicist. What they told me applies today and may help any new etherapist to learn how to think conceptually. First, what is most important as a bottom line (and this seems to be true in all clinical ethics; see "Links to Further Information" in Appendix A) is what is in the best interest of the patient. Is providing etherapy to this person at this time in his or her best interest? In this case, clearly the answer was yes because she could not find the expertise in transgender issues in Saudi. Second, does she have informed consent? And what does informed consent mean in etherapy? This may differ depending upon one's professional association. In the next paragraph, SH's informed consent is included and covers most bases. Third, the lawyer said that in terms of legal precedents, the best application would be the comparison to telephone therapy, which, according to the APA, requires an f2f visit before commencing ongoing telephone work. In terms of case law, an initial f2f visit puts one on solid legal ground. Current ethics do not require f2f contact; nevertheless, an introductory f2f still makes common sense, to exchange visuals and to establish a more conventional therapeutic alliance, although that may not always be feasible due to accessibility. In general, it is recommended to check one's own specialty ethics and legal and licensing (state or country) regulations regarding how to proceed. Although there has been no test case, according to the APA attorney, the defense or prosecution will refer to case law.

Fourth, the APA workshop leaders suggested good recordkeeping and ongoing consultation. With etherapy, one has a full transcription of the therapy. In the Bay Area, a specialist f2f consultation group (Bay Area Gender Associates) exists, but consultation may be less accessible in other areas. Online consultation with WPATH members may be a possibility.

After reporting the APA information to SH, then MH, he provided the following "informed consent"

> Dear LF,
>
> Please let this email be for whom it may concern verification that I, MH, an American citizen born on ———, 19— in ——, ——— do give fully informed consent to LF of San Francisco, California, to practice gender identity therapy with me as a client via internet email through a new and experimental process sometimes termed "telehealth." I understand that this is a new and somewhat unknown form of therapy, and that therapeutic outcomes are not guaranteed to be the same as might have occurred through the process of face-to-face therapy sessions. However, due to my remote living and working situation (in Dhahran, Saudi Arabia), and the complete lack of any alternative gender identity therapy in this country, nor any adjacent countries, I approached LF by email early in 1998 to set up an appointment for me at the end of May. During our first two sessions in her office I asked her if she would be willing to counsel me as her patient via email when I was back in Saudi Arabia. She agreed to this arrangement, and we have been communicating on a daily basis since the beginning of June. We plan to have face to face sessions whenever my presence in San Francisco is possible, but due to my living in Saudi Arabia, this may only be possible a very few times per year.
>
> Sincerely
> MH

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Case Summary—Client Reflection and Evaluation

The therapy progressed over the next 6 months with numerous e-mails back and forth, much struggle on her part, and a deepening of the internal work. Inclusion of the etherapy dialogue and progression is beyond the scope of this article, but the text was as powerful and in many ways more powerful than f2f. There was more time for thoughtful reflection, which allowed a savoring and settling of the work during and between communications. Per our initial agreement, I asked her to reflect upon and evaluate the work. Here are her words verbatim in December 1998:

> Dear L,
>
> This is a brief personal evaluation of the therapy relationship we have had from early June through today (December 4, 1998) and my personal feelings as to the effectiveness of the process, how I feel it has benefited me.
>
> I believe our tele-counseling process ("telehealth") has been extremely effective in my situation, more so than much of the counseling I have experienced directly with two different psychiatrists face-to-face during the past fifteen years or so. If nothing else, it certainly has put me in a "journaling mode" like I've never experienced before, knowing that you would be reading my thoughts within a few hours, most of the time every day during July and August and September when I was going through heavy identity problems. And now during a time the "problem area" seems to have shifted somewhat to the transition of our family unit, my relationship long term and future with my wife, TH, and both disclosure and the transition of my relationship with my son and daughter.
>
> As far as I know, there are no psychiatrists or psychologists in this country (Saudi Arabia) with experience or skills such as you have and are able to draw upon in working with gender issues like mine.
>
> You have been able to help me by being a constant and consistent listener and artful questioner. While I know you have often expressed some frustration at not being able to interact more directly and to visually see my body language as we dialogue, I also realize that there are some things that can be gotten into even deeper through writing words with feeling and care, sort of a verbal meditation, done in silence, fully focused. These include complex feelings and observations that are felt while being articulated. Not a whole lot different than face-to-face therapy, I suppose, where certainly over 50% of the process is verbal (some might disagree). We also of course should not discount the transpersonal dimensions, since I sit and meditate and think of you and my issues.
>
> I really believe that Internet email, which we are using as your communication medium between Dhahran and San Francisco, is highly effective in this dialogue, more so than traditional "snailmail". One knows that the other person in the dialog will likely read what you have just said within a few hours, sometimes within minutes. This makes it a real "conversation", almost like face-to-face but with the time-speed slowed down quite a bit.
>
> Anyway, to be more specific, I feel that the following developments have been highly important to me during the past six months of telehealth gender therapy:
>
> 1. I feel I have transitioned from a state of great doubt, confusion, anxiety and emotional turmoil due to conflicting "identity feelings" to a state of relative peace, clarity of objectives, and a strong new sense of a single identity (through acceptance of my conflicted female feelings).
> 2. I have arrived at a clearer understanding and feeling of self-identity than ever previously in my life, as I am more able to accept more of my male and female elements simultaneously

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and/or in sequence, as situationally appropriate.

3. I have learned that it is possible to "slow down" the speed of my transition (which always is pressuring my psyche to "accelerate" the changes), to consolidate them and pause and digest them, and only then to go forward, and to use the emerging, though highly inexperienced/immature feminine elements of my psyche to shift my concern from exclusively focusing on myself, to being able to think more about others and how they feel and how they are impacted by my gender shifting. Previously I was of course concerned, but with a much greater emphasis on fear (terror actually) and shame and tremendous guilt at "what I was doing to myself and how it would destroy both me and my family." Those feelings of fear/terror/guilt kept me paralyzed, unable to act with "skillful means". Now I accept S, and have experienced a vast polar shift from feeling "transgendered and damned" to feeling "transgendered and proud" (probably a sign of major immaturity here! But it feels good at this point!). And feeling at peace with myself internally, I feel I have the solid inner foundation upon which to take a firm, stable stand to nurture, rebuild where necessary, and preserve where appropriate, our previous family relationships (I mean the intimate emotional/marital relationship with my wife primarily, but am entering the process, with your help, of including my children in the transition which must proceed from disclosure).

I think that all I want to say on the issue that you asked me to comment on, i.e. "could I provide an evaluation of our telehealth gender therapy process?"

Of course there are additional side benefits from this telehealth that are obvious, particularly that of having the entire therapy dialog/process (or 90% of it) in electronic text files for present and future reference during therapy and possibly later for research, ability to scan electronically for issues and patterns of resolution, etc.

Hope that has been enough for an A grade in "evaluation reporting"!

Hugs and a warm smile and a simple "thanks Lin!"

"S"

After this quite comprehensive evaluation, the therapy continued via e-mail until SH returned to the United States the following spring, and we moved into a rather traditional f2f psychotherapy that was deeply enriched by the etherapy that had preceded it. Over the next few years, she did transition. She completed medical feminization, went through an ultimately amicable divorce, and is now happily partnered with another transwoman. She is close to both her ex-wife and children, is successfully employed, and sees me occasionally as needed. In her latest exchange (April 3, 2007) she talked about her happy relationships with her partner; her delight in her children, one married, one engaged; her upcoming retirement and move to a lovely new home; and her deepening spiritual commitment. Her only reference to her transgender identity was the following:

On Palm Sunday I led the procession with Fr. ——— at my side, the priest in front, as we sang a processional chant in Latin. A lot of irony here, as I first met Fr. ——— at the ancient monastery of ———, near ———, in ———, back in 1992 with my young family (I, as M, had a red moustache at the time). I don't think he realizes that S used to be M, but one never knows with these monks . . .

Lots of interesting times in the life of S, no! No end in sight. I wish you and your family a joyous Easter!

S

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COMMENTARY ON CASE

From the foregoing, it is evident that SH does indeed have a rich and fulfilling life. Given her situation when she first sought consultation, one wonders what the outcome might have been without etherapy. SH describes it as a "lifesaver." Although she was a particularly good candidate given her technical and verbal prowess, the issues that emerged in her case are perhaps typical of many transpeople living in remote areas where clinical expertise is unavailable.

Moreover, although the etherapy part of her therapy was from 1998 to 1999, conceptualization, ethical issues, and how to think clinically are the same today. Initial clinical issues would be similar for any beginning etherapist. For example, as the case evolved, ethical and clinical experts were consulted regarding pertinent information that was then available and ongoing clinical supervision was obtained, both group and individual. Even though the thinking was less evolved than today, the process is the same: checking with licensing and regulatory boards; keeping abreast of ethics; and maintaining consultation among colleagues, both more experienced and peer.

Moreover, more options now exist that allow synchronous communications, such as IM, text, or video chat, rather than just the asynchronous format available in 1998. Hence, etherapy can be multimodal and individualized, offering both the advantages of a real conversation as well as the slowed-down quality and time for reflection allowed by asynchronous e-mail.

An extensive discussion of clinical considerations as they apply to etherapy and specifically to this case as an illustration of distance work with a transgender client is beyond the scope of this article. What is presumed is that the reader can extrapolate the general clinical issues involving both the frame and the process. The following will only be a brief discussion of both.

The frame would include such things as screening. SH was a particularly good candidate for etherapy because she was highly motivated, comfortable with computers and text-based communication, and psychologically oriented and could connect her feelings to both her conscious and unconscious experience. Moreover, she had the capacity to reflect and journal. She was responsive to the type of therapy offered. Other therapists, of course, have other orientations, and the literature suggests that most orientations can be adapted to etherapy (Derrig-Palumbo & Zeine, 2005).

Other issues pertaining to the frame include informed consent (Griffin, 2006), security, confidentiality, encryption, and other technical considerations. Arrangements need to be made regarding emergency local backup, links to local services, payment and fee schedule, frequency and length of contact, etc.

In terms of the clinical process, SH's commentary actually says it best and points to the potential power of etherapy. There is little to add; she mentioned many of the points suggested in the literature, the power of written word, the deep meditative process that can occur, the unbroken intersubjective client–therapist connection, the potential for containment for unhealthy impulses, and the reality of the virtual office as a holding environment. What is inferred in the "evaluation" is the strong transference that can also develop, even without the therapist's physical presence. As an example, SH told me that she had kept for months, and referred to repeatedly (she put it on her mirror), an encouraging note that I had sent to help her through a particularly difficult day. She also imagined me in her daily meditations and still calls on my image during conflict. In terms of countertransference, I held her just as strongly as any of my people in f2f work, sometimes more so. I wrote to her, both in response to what I felt she needed, but also when the muse struck. The location of the therapy was both diffuse and everywhere yet felt boundaried and nonintrusive. I responded at my own pace, respecting what I knew to be her needs but also, because this had been discussed as part of the frame, in consideration of my own.

Basically, what her commentary describes is tentative clinical evidence for the extrapolation and application of what is known about the benefits of etherapy to a transgender client. Her descriptions of the benefits she received match descriptions in the general literature, with the addition of the benefits both typical and specific to transgender identities. These include the slow consolidation and integration of a unitary gendered self, a movement from conflict,

confusion, and guilt to clarity of objectives and relative peace, the development of a capacity to slow down the process to allow integration, a beginning sense of safety, and a greater capacity to consider the feelings of others.

She also mentioned the usefulness of having the complete record of the therapy available then as a written review as the case progressed, an identification and discussion of what has happened during the work, goals reached, and its potential use in the future. This complete record has been of obvious use in the preparation of this article.

It is important to recognize that information is evolving as more people practice and publish. The case study in this background paper on Version 7 is an addition to this tradition and is the first to my knowledge on the applicability of etherapy to a transgender client. No other case was found in the literature. Another case involving online therapy with a gay man was found, and the issues, though not identical, offer similarities that support the conclusions from this case review showing the efficacy of online therapy with a transgender client. This example from the ISMHO Study Group (Fenichel et al., 2004) offers a direct parallel and might sound familiar in terms of the issues presented:

> Several unique advantages exist in online work. Many have been described in the literature already, such as access for the homebound, geographically isolated, or stigmatized client who will not or cannot access treatment. One of our case presentations illustrated vividly not only the possibility but also the advantage of Internet-based therapeutic support. A pilot in the military, exploring sexual orientation and afraid of the potential impact of "coming out" and jeopardizing a military career, demonstrated how seeking help online was reassuring to the client in terms of confidentiality. The absence of geographic boundaries allowed the client to select a therapist who appeared to have the expertise and understanding needed in the client's particular situation.

ETHERAPY—APPLICABILITY TO THE SOC

Psychotherapy/Cybertherapy

This article argues that etherapy can be a useful modality for psychotherapy with transgendered people. Although the data are limited, a single case review, the argument for online counseling is compelling. What is already known about the efficacy of Internet therapy can be extrapolated to many in the transgender population. As outlined in this article, online therapy has been shown to be particularly useful for people who have problems with access to competent treatment and who may experience isolation and stigma.

The case review offers tentative clinical evidence for the application of what is known about the benefits of etherapy to a transgender client. As described earlier, SH's descriptions of the benefits she received match descriptions in the general literature, with the addition of the benefits both typical and specific to transgender identities.

The case for etherapy would be made stronger if we had more examples, and it will be up to the membership to provide them as the field progresses. Moreover, this case has some obvious limitations: the initial connection was made f2f and SH could hardly be described as typical; as one reviewer commented, she was a "poster child" as a case example.

Nevertheless, the case here does present a very good argument for the bottom-line ethical standard of what is in the best interest of the patient? And there are many more transgendered people worldwide with no access to competent services who could arguably benefit from the services of a knowledgeable, competent, and compassionate etherapist. Etherapy offers opportunities for potentially enhanced and expanded, creative, tailor-made delivery of services.

Although we need more data, based on this single case review, this article argues for the inclusion of etherapy in the next revision of the *SOC*, especially because the need is so great.

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SUGGESTIONS FOR FURTHER RESEARCH

Assessment/Hormone and Surgery Referrals

One issue that clearly needs further research is whether a clinician can ever make a competent assessment for a referral for medical masculinization or feminization without f2f work.

Though it is arguable that the trans population is ready and can benefit from the provision of etherapy by competent knowledgeable clinicians, what is not clear is whether evidence exists that can be extrapolated to assessment and referral for surgery and hormones. Although literature exists supporting Internet assessment (Hyler, Gangure, & Batchelder, 2005), the data do not offer enough of a parallel to draw conclusions for the *SOC*. Further research is needed in this area along with more data specific to the field. At this point, "relying solely on web-based contacts with consumers as the exclusive basis for evaluation or referral is risky at best for both providers and consumers and does not meet the minimum Standards of Care guidelines promulgated by this organization" (Brown, 2006). Therefore, this issue is beyond the scope of this article, which has been limited to the efficacy of psychotherapy.

Prior to inclusion in the *SOC*, more knowledge, more specific information, and more experience are needed, most likely gathered from the membership of WPATH. Once data are generated, limited inclusion might be considered. For example, possibilities might include at least one f2f consultations for a primary letter with a corroborating online second letter. Another possibility might be online consultation/supervision of the referring f2f clinician. It may be that as data are generated within the organization clinicians will be in a better position to consider hormone and surgery evaluation and referral.

Clinical

What could be interesting in terms of further clinical possibilities and research might be the impact on transgender people of online immersive environments such as Second Life, or the experience of virtual identities, online virtual real-life test, and immersive psychotherapies such as are already beginning in Second Life. One question to be studied might be what an identity is in cyberspace and how it relates to real life (Turkle, 1995) for the transperson's identity and gender identity. What effect if any do immersive worlds have on gender identity? If a person is trying on various experiences of his or her gender identity, for example, in social networking spaces such as Frenzo, where one can personalize virtual 3D characters, how would that impact identity in vivo? These and other questions might be of particular interest to people who are already on the cutting edge of fluidity in their physical gendered selves.

Etraining and Econsultation

This article has focused on etherapy, but next steps for WPATH might include setting up standards for etraining and econsultation as another way to improve access to competent, knowledgeable care.

RECOMMENDATIONS FOR THE SOC

Online Evaluation for Hormones and Surgery

The recommendation at this point is to wait until we have more data.

Etherapy

Etherapy has not been included in previous versions of the *SOC* (Meyer et al., 2001). This article recommends tentative inclusion of etherapy in Version 7 of the *SOC* either as a separate category or as a subsection of psychotherapy. The exact wording is to be addressed by the SOC Task Force at a later date, although it might include, but not be limited to, the topics explored and discussed in this article such as the suggestions below.

As an overarching principle for the *SOC*, WPATH members providing etherapy will stay current with their particular licensing board, professional association, and country's regulations as well as the thinking of those in the vanguard of

this rapidly evolving medium. At a minimum, by keeping abreast of current information, a considered and knowledgeable decision about whether to participate can be made.

The clinician providing eservices will:

1. Understand the rationale for providing etherapy to transgender people such as:
   - Demographics, geographic isolation, problems of access, and limited available professional expertise
   - Readiness and appropriateness of transgender people for this new method of delivery of services
   - Convenience and flexibility of delivery methods
2. Possess online clinical competence and efficacy regarding:
   - Frame of the therapy
   - Connection, relationship, and maintenance of the therapeutic alliance online
   - Risk management, confidentiality, emergency, recordkeeping
   - Culturally competent clinical knowledge and understanding
3. Apply ethical and legal provision of services including, but not limited to:
   - Use of the underlying ethical standard—Is this service in the best interest for this client at this time?
   - Provision of services within one's level of knowledge and competence
   - Certification to practice by regulatory boards and liability coverage where applicable
   - Agreement to stay abreast of relevant regulations and laws regarding etherapy specific to the therapist's location and specialty
   - Provision of informed consent
   - Competence to use electronic methods of delivery of service

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REFERENCES

Ainsworth, M. (2001). *E-therapy: History and survey.* Retrieved May 18, 2007, from http://www.metanoia.org/imhs

American Psychiatric Association Council on Psychiatry and Law. (n.d.). *Frequently asked questions e-therapy*. Retrieved May 4, 2007, from http://www.psych.org/psych_pract/clin_issues/etherapyfaqs.cfm

American Psychiatric Association Ethics Committee. (1995). *Position statement on the ethical use of telemedicine*. Washington, DC: Author. Retrieved May 28, 2007, from http://www.psych.org/edu/other_res/lib_archives/archives/199515.pdf

American Psychological Association. (2007). *APA Statement on services by telephone, teleconferencing, and Internet, a statement by the ethics committee of the American psychological association*. Retrieved May 4, 2007, from http://www.apa.org/ethics/stmnt01.html

Barak, A. (2009). *References related to the Internet and psychology*. Retrieved November 22, 2009, from http://construct.haifa.ac.il/~azy/refindx.htm

Barak, A., & Suler, J. (2008). Reflections on the psychology and social science of cyberspace. In A. Barak (Ed.), *Psychological aspects of cyberspace* (pp. 1–12). Cambridge, UK: Cambridge University Press.

Behnke, S. (2007). Posting on the Internet: An opportunity for self (and other) reflection. *Monitor on Psychology, 38*(1), 60. Retrieved November 22, 2009, from http://www.apa.org/monitor/jan07/ethics.html

Brown, G. R. (2006). *The ethics of online services*: *An opinion*. Retrieved June 25, 2006, from http://www.wpath.org

Brown, G. R. (2009). Recommended revisions of World Professional Association for Transgender Health's *Standards of Care* section on medical care for incarcerated persons with gender identity disorder. *International Journal of Transgenderism, 11*, 133–139.

Center for Credentialing and Education. (n.d.-a). *Distance counseling continuing education opportunities: Security strategies for distance counseling via E-mail*. Retrieved May 18, 2007, from http://www.cce-global.org/credentials-offered/dccrecert/edopp

Center for Credentialing and Education. (n.d.-b). *Distance credentialed counselor (DCC)*. Retrieved May 18, 2007, from http://www.cce-global.org/credentials-offered/dccmain

Clawson, T. (2007). Reflections on NBCC's first twenty-five years. *The National Certified Counselor, 23*(2), 4.

Cyberspace. (2005). In *New Oxford American dictionary* (2nd ed.) [Computer software]. Cupertino, CA: Apple, Inc.

Derrig-Palumbo, K., & Zeine, F. (2005). *Online therapy: A therapist's guide to expanding your practice*. New York: W.W. Norton & Company.

ERIC/CASS Digest. (2000). *Ethics and regulations of cybercounseling*. Retrieved October 28, 2006, from http://www.ericdigests.org/2001-3/ethics.htm

Fenichel, M., Suler, J., Barak, A., Zelvin, E., Jones, G., Munro, K., et al. (2004). *Myths and realities of online clinical work, a 3rd-year report from ISMHO's Clinical Case Study Group*. Retrieved May 18, 2007, from http://www.ismho.org/casestudy/myths.htm

Fraser, L. (2003, September). *The transgender phenomenon: Psychodynamic viewpoint*. Paper presented at the 18th Biennial Symposium of the HBIGDA, Gent, Belgium.

Griffin, M. (2006, September/October). Revisiting informed consent. *The Therapist,* 35–44.

Hyler, S. E., Gangure, D. P., & Batchelder, S. T. (2005). Can telepsychiatry replace in-person psychiatric assessments? A review and meta-analysis of comparison studies. *CNS Spectrum Studies, 10*(5), 403–413.

International Society for Mental Health Online. (2000a) Suggested principles for the online provision of mental health services (Version 3.1.1). Retrieved May 18, 2007, from http://www.ismho.org/suggestions.html

International Society for Mental Health Online. (2000b). *The online clinical case study group of the International Society for Mental Health online: A report from the Millennium Group*. Retrieved May 28, 2007, from http://www.ismho.org/casestudy/ccsgmg.htm

International Society for Mental Health Online. (n.d.) Assessing a person's suitability for online therapy. Retrieved May 18, 2007, from http://www.ismho.org/casestudy/ccsgas.htm

Kraus, R. (2004). *CPT code 0074T for online consultation—A revolution in healthcare delivery?* Retrieved March 8, 2007, from http://www.onlineclinics.com/pages/content.asp?iglobalid=44

Leslie, R. S. (2005). *At the intersection of law and psychotherapy, online therapy-insurance coverage*. Retrieved Nov 22, 2009, from http://www.cphins.com/LegalResources/BulletinArchive/tabid/66/cid/14/sid/13/Default.aspx

Leslie, R. S. (2006). *At the intersection of law and psychotherapy, online therapy-disclosure*. Retrieved Nov 22, 2009 from http://www.cphins.com/LegalResources/BulletinArchive/tabid/66/cid/14/sid/13/Default.aspx

Maheu, M. M. (2009). *Center for online counseling and psychotherapy.* Retrieved Nov 22, 2009 from http://centerforonlinecounseling.com

Maheu, M. M., Pulier, M. L., Wilhelm, F. H., McMenamin, J. P., & Brown-Connolly, N. E. (2005). *The mental health professional and the new technologies: A handbook for practice today*. Mahwah, NJ: Lawrence Erlbaum.

Meyer, W., III, Bockting, W., Cohen-Kettenis, P., Coleman, E., DiCeglie, D., Devor, H., et al. (2001). The *Standards of Care* for gender identity disorders—Sixth version. *International Journal of Transgenderism, 5*(1). Retrieved May 27, 2007, from http://www.symposion.com/ijt/soc_2001/index.htm

OnlineClinics. (1999). *Guidelines for mental health and healthcare practice online*. Retrieved May 18, 2007, from http://ethicscode.com/pages/698182/index.htm

Pew Internet and American Life Project. (2009). *Mission statement.* Retrieved Nov 22, 2009 from http://www.pewinternet.org/About-Us.aspx

Rachlin, K. (2002). Transgender individual's experiences of psychotherapy. *International Journal of Transgenderism, 6*(1). Retrieved January 27, 2007, from http://www.symposion.com/ijt/ijtvo06no01_03.htm

ReadyMinds. (2008). *Professional training*. Retrieved November 22, 2009, from http://www.readyminds.com/training/dcc_cert.asp

Suler, J. (2007). *The psychology of cyberspace*. Retrieved May 27, 2007, from http://www.rider.edu/~suler/psycyber.html

Suler, J. (2008). Cybertherapeutic theory and technique. In A. Barak (Ed.), *Psychological aspects of cyberspace*. (pp. 102–128) Cambridge, UK: Cambridge University Press.

Turkle, S. (1995). *Life on the screen: Identity in the age of the Internet*. New York: Simon & Schuster.

Whittle, S. (2006). *A future for online gender identity care services? An opinion*. Retrieved June 25, 2006, from http://www.wpath.org

Zack, J. (2007). *Ethics*. Retrieved May 18, 2007, from http://etherapylaw.com/?page_id=10

APPENDIX A

How to Stay Current/Links to Further Information

Even though clinical considerations may have changed little in the intervening years, much is evolving in terms of ethics, regulations, laws, etc. Online therapy is growing exponentially, information is evolving, and new ethical dilemmas are emerging (Behnke, 2007). As mentioned earlier, one requirement for any etherapist is the necessity of staying current. To keep up with this shifting information, information on the Web is regularly updated. The reader is here referred to several excellent Web sites and forums. These include links to online professional associations, current information on ethics and the law, information about how to get more education including continuing education units (CEUs), as well as general references in the field.

The links below include only a smattering of the many Web sites available, but the list is inclusive of those referred to in this article.

Two Web sites have been most useful; one is the International Society for Mental Health Online (ISMHO), which has links to several of the papers referred to earlier and other useful links regarding etherapy. One section includes a link to a members-only forum, which offers

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threads to many interesting discussions on topics of interest to etherapists. For those interested in practicing online therapy, membership in this organization is recommended.

An excellent resource is a series of white papers, developed by ISMHO's Clinical Case Study Group (ISMHO, 2000b), who presented a series of cases to each other over a 3-year period and then developed some conclusions about online therapy based on their shared experience and ongoing case consultation. These white papers, available online, contain valuable information, compiled by established leaders in the field. One article assesses a person's suitability for online therapy (ISMHO, n.d.), another suggests clinical principles for the online provision of mental health services (ISMHO, 2000a) and another, on the myths and realities of online clinical work, dispels such myths that therapy needs to be f2f, talking and/or synchronous (Fenichel et al., 2004).

Several pioneers, such as Michael Fenichel, PhD; Ron Kraus, PhD; and John Suler, PhD, have useful Web sites and also offer CEUs in the field. Suler's work has been particularly influential regarding the clinical/psychodynamic considerations described in this article. He has written a classic in the field, an online book, *The Psychology of Cyberspace* (Suler, 2007), and offers CEUs through multiple online providers located through search.

Kraus's company, OnlineClinics (1999) has a useful and general ethics code, *Guidelines for Mental Health and Healthcare Practice Online*, that covers many of the concerns articulated in this article. Information on the national credentialing process for online therapy is on the ReadyMinds counselor credential Web site.

An extensive list of articles on etherapy has been compiled by Azy Barak, PhD, (2009) an Israeli pioneer and member of the ISMHO Study Group, entitled References Related to the Internet and Psychology. For those interested in more technical articles, with comprehensive lists of journal articles, Marlene Maheu's 500+-page volume, titled *The Mental Health Professional and the New Technologies*, with 37 pages of tiny-font references, may be of interest (Maheu et al., 2005). She also has a good informational Website on telehealth and e-health (Maheu, 2009).

For those interested in general information about the Internet, the Pew Internet Project provides extensive information about Internet trends and their impact "on children, families, communities, the workplace, schools, healthcare and civic/political life" (Pew Internet and American Life Project, 2009).

APPENDIX B

Examples of Current Legal Thinking

As an example of current legal thinking about etherapy, included below is some commentary from an avoiding liability bulletin distributed by the author's liability carrier. It is written by Richard Leslie, JD, an attorney specializing in the intersection of psychotherapy and the law. The following is his prudent advice regarding online informed consent and insurance coverage.

Online Therapy—Disclosure

> . . . Whether or not required by state law or regulation, therapists who practice online therapy (e.g., intrastate) would be wise to make certain disclosures to the patient prior to the commencement of online therapy, and to obtain the patient's written and informed consent prior to such treatment. Of course, if there is an applicable state law or regulation, therapists must follow the law or regulation in all of its detail. Since it can be reasonably argued that online psychotherapy can be considered new, innovative or experimental, it would be wise and prudent to obtain written informed consent, even in the absence of a state requirement.
>
> Disclosure that is often required or, at a minimum, advisable, is a description of the potential risks, consequences, and benefits of online therapy. In one state, the telemedicine statute leaves it to the practitioner to determine what those risks, consequences and benefits actually are. Consequently, disclosures in that state and in

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other states will vary (where not specifically mandated) depending upon the technology used, the level of sophistication of the therapist and the patient/client, and the nature of the services being sought and rendered. Certainly a disclosure about how confidentiality will or may be affected by services being provided over the Internet, and what steps the therapist will take or has taken to make sure that the communications between patient and therapist remain confidential, would be important.

The patient should also be informed about how session records will be kept and how they may be retrieved or copied, to the extent that it differs from traditional record keeping practices. If therapy does not involve synchronous audio and video communication, but rather, written communication only, additional disclosures about the nature and process of the written communication should be considered. A therapist might also disclose the possible lack of certain clinical information about the patient because of the inability to see what might otherwise be seen in face-to-face therapy, and the possible consequences thereof. (Leslie, 2006)

Online Therapy—Insurance Coverage

> Therapists and counselors often ask whether or not their malpractice (professional liability) policy covers them if there is a claim or lawsuit for alleged negligence in the performance of online therapy sometimes called Internet therapy or e-therapy). Because the answer to the question may vary from insurer to insurer, therapists should review their policy to see whether or not there is any exclusion or limitation pertaining to online therapy. If there is no limitation or exclusion, then coverage should exist. (Leslie, 2005)

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