

See discussions, stats, and author profiles for this publication at: <https://www.researchgate.net/publication/282054935>

Online and Phone Therapy: Challenges and Opportunities

Article in *The Journal of Individual Psychology* · June 2015

DOI: 10.1353/jip.2015.0010

CITATIONS

16

READS

3,740

2 authors:



Alana Kingsley
Adler University

1 PUBLICATION 16 CITATIONS

SEE PROFILE



Janna Henning
Adler University

6 PUBLICATIONS 58 CITATIONS

SEE PROFILE

Online and Phone Therapy: Challenges and Opportunities

Alana Kingsley and Janna A. Henning

Abstract

This article reviews the existing literature on the potential advantages and drawbacks of therapy that is conducted when the clinician and client are not sitting in the same room. Specifically, forms of psychotherapy that are conducted via the telephone, e-mail, and video chat are addressed. As different researchers have reported contradictory findings on this topic, and the laws and policies that govern these types of therapy interactions are still being developed, it is suggested that clinicians use extra caution when providing treatment through these media.

Keywords: Individual Psychology, psychotherapy, online, distance counseling, Adlerian

In the earlier days of psychology as a distinct human activity, mental health treatment could be conducted only with face-to-face interaction between clinician and client. Modern technology has created the ability for clients and clinicians to be miles away from each other but still continue a therapeutic relationship.

There are many reasons an individual may be unable or prefer not to see a clinician in person. For instance, a client may move out of the city in which the client has been seeing a clinician for many years but nevertheless wish to continue treatment with that clinician, at least until he or she can find a new therapist (Neimeyer & Noppe-Brandon, 2012). This may be particularly relevant with rare diagnoses, with clients living in geographically remote areas, and in other cases for which qualified clinicians may not be easily and immediately accessible. In addition, temporary relocations or limitations in a client's physical mobility may pose obstacles to conducting face-to-face sessions. Finally, there is still some cultural stigma associated with seeing a psychotherapist, so an individual may feel more comfortable receiving therapy in a more discreet manner (Dwight-Johnson et al., 2011). In group treatment settings, non-face-to-face therapy can be advantageous, as participants may be less prone to feeling judged and have more courage to speak than if the group met face-to-face.

As a result of these changing modes of therapy, the American Psychological Association (APA) issued a statement regarding non-face-to-face treatment

in 1995, noting, the “Ethics Code is not specific with regard to telephone therapy or teleconferencing or any electronically provided services as such and has no rules prohibiting such services” (p. 1). Most recently, the APA acknowledged that “there is little consistent guidance across states on how psychologists should use these and other forms of electronic communication such as email, Skype and various forms of videoconferencing” (DeAngelis, 2012, p. 52). Unfortunately, in the 17 years between the two statements, little has changed in regard to clear dos and don’ts of e-therapy in the Ethics Code.

As psychologists are expected to “work based upon established scientific and professional knowledge of the profession” (APA, 2010, p. 5), it is necessary for psychologists to be well informed about approaches that are supported by scientific evidence, in order to be most effective in providing mental health services. Furthermore, “technology is pushing ahead at a rapid pace, and psychology licensing laws have not yet caught up” (DeAngelis, 2012, p. 52). For instance, DeAngelis (2012) noted, “Most state laws prohibit out-of-state psychologists from providing telepsychology services to consumers” (p. 52). As a result, a clinician would need to be licensed in his or her own state, as well as the state the client lives in, to provide treatment using electronic media. For these reasons, it is important to assess existing research on this topic so that psychologists are better able to determine if, when, and how to engage in e-therapy and are aware of the potential implications of practicing non-face-to-face therapy.

Therapy via Telephone

Before the invention of e-mail, the only way for a clinician and a client to speak without being face-to-face was through the telephone. Several studies analyzed whether this type of therapy was effective. A study by Turner, Heyman, Futh, and Lovell (2009) found that the 10 individuals in the research group who received telephone therapy as treatment for obsessive-compulsive disorder had a remission rate of 70%, a finding consistent at a follow-up at six months and again at one year post-treatment. Assessments of the participants’ current symptoms were compared to assessments conducted before treatment (Turner et al., 2009). A similar study conducted with 79 HIV-positive participants living in rural areas found that telephone therapy significantly reduced their self-reported “psychiatric distress” (Ransom et al., 2008).

The above-mentioned studies assessed whether teletherapy was an effective form of individual treatment for persons with psychological disorders. Goelitz (2003) sought to determine whether teletherapy was effective in groups. Most of the 24 group members who participated in the study reported that they found the groups to be beneficial. One of the explanations for success is that attendance in the telephone group averaged 78%

throughout the course of treatment, whereas participants in a face-to-face (treatment-as-usual) therapy group had a significantly lower attendance rate (Goelitz, 2003). These results support the claim that teletherapy can be just as effective as face-to-face treatment.

Other studies suggest that teletherapy is not as effective as face-to-face therapy. A study by Ricker (2002) compared two groups of participants, one that received face-to-face therapy and another that received treatment via telephone, for issues related to mental health, relationships, and/or job problems. The face-to-face group reported a 54% improvement in functioning, whereas the group that received telephone therapy reported a 31% improvement (Ricker, 2002).

A similar study found that although 10 patients with terminal states of cancer who received teletherapy reported an equal rate of satisfaction following remote, telephone treatment, when compared with face-to-face therapy, levels of anxiety and depression in the group did not decline significantly (Cluver, Schuyler, Frueh, Brescia, & Arana, 2005). This lack of significant improvement in anxiety and depression levels was reported through a post-treatment questionnaire. The reason for the lack of decline in distress levels in the participants who received teletherapy is unclear, but it can be hypothesized that a lack of face-to-face communication between the clients and clinicians may limit the establishment of a strong therapeutic alliance, which may lead to poorer treatment outcomes, as research shows a strong link between a therapeutic alliance and treatment outcomes (Krupnick et al., 1996).

Neimeyer and Noppe-Brandon (2012) assessed Neimeyer's personal experiences as a therapist and Noppe-Brandon's personal experiences as a client throughout the course of their teletherapy relationship. Neimeyer discussed the difficulties with this mode of therapy, reporting problems in deciphering the meaning of silence during the conversation and inability to comfort a client in a traditional way (by handing her a tissue when she was crying). From the client's perspective, and despite some advantages, Noppe-Brandon shared struggles with "trusting the security of a caretaker" she could not see (Neimeyer & Noppe-Brandon, 2012, p. 107).

Therapy via E-Mail

In recent years, non-face-to-face therapy has been conducted less often via telephone and more often via the Internet. This approach has been given many different names, such as "online practice, e-counseling, web-based therapy, web-based counseling, e-mail counseling, Internet therapy, and therap-e-mail" (Olasupo & Atiri, 2013, p. 277). Before video chat, electronic therapy could be conducted only via e-mail communication. As this mode of technology-facilitated therapy has been practiced for a longer

period of time than any other types, there is more research on the topic. In a 2008 study conducted by Robinson and Serfaty, 17 college-aged females with a diagnosis of bulimia nervosa (purging or non-purging) were treated with e-mail bulimia therapy (eBT) for three months. The methods used for e-mail treatment in the study were identical to those that have been successful in eating-disorder clinics for college-aged students. The only difference was that all correspondence between client and practitioner was through e-mail, rather than face-to-face (Robinson & Serfaty, 2008). As a result, 13 of the study participants no longer met the criteria for a diagnosis of an eating disorder as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). In 2006, Fingeld-Connett analyzed the success of e-mail-based treatment for alcohol abuse disorders, finding that this type of online intervention could, in fact, significantly reduce the amount of drinking reported by an individual.

Although it can be difficult to understand verbal cues via e-mail, Fenichel (2002) alluded to different methods of showing these cues via e-mail communication. For instance, both clinicians and clients can use smiley faces, capitalization (to emphasize meaning), and asterisks in place of the verbal cues and body language that are present in face-to-face communication.

At the same time, the primary negative issue with this type of therapy is evident: the client and practitioner cannot see each other; nor can they hear each other's voices. Therefore, there is an increased likelihood that communication by this method may be misinterpreted either by the clinician or by the client as a consequence of the lack of "tonal cues" in e-mail and instant messaging (King, Engi, & Poulos, 1998). For this reason, Shaw and Shaw (2006) strongly suggest that online therapists inform their clients about online counseling not being "a replacement for traditional face-to-face counseling" (p. 47).

Fingeld-Connett (2006) identified certain populations that are unlikely to find this type of treatment advantageous. Individuals with poor literacy, for instance, are unlikely to benefit from "therap-e-mail," as it may be difficult for them to understand the clinician's writing and to express their thoughts and feelings thoroughly in written media. Clients with fewer economic resources may need to access their e-mail through public computers, such as those in a library, which presents potential risks to privacy and confidentiality. In collaboration with a client, the clinician should assess which form of treatment would be most beneficial for the client.

Therapy via Videoconferencing

For many reasons, videoconferencing may be more effective than e-mail-based therapy. First, videoconferencing allows clinician and client

to see one another, providing access to a wealth of visual cues, such as facial expressions. Second, in this mode of therapy, the clinician and client can hear the tonal cues the other person is using, which are useful in deciphering nonverbal characteristics, particularly with respect to affect. Seeking to determine whether online video-chat therapy was able to “produce clinical outcomes that are at least equivalent to those achieved through face-to-face service” (p. 836), O’Reilley et al. (2007) found that not only were most of the 495 participants in their study equally satisfied with service in both groups (254 face-to-face, 241 teletherapy), but also the clinical outcomes were equivalent. That is, both groups showed significant improvements in functioning following the completion of the four-month study (O’Reilley et al., 2007). Similarly, but with a different clinical population, Kuulasmaa, Wahlberg, and Kuusimaki (2004) found that family therapy via videoconferencing can be as effective as family therapy conducted in the clinician’s office, as long as family members meet in person at least twice a year to help “the family improve interactions and strengthen the therapeutic alliance” and all therapy participants are always in view on the screen. Not being in view on the screen, participants likely do not feel included and “drop out of the discussion” (Kuulasmaa et al., 2004, p. 128).

One of the most substantial issues with videoconferencing e-therapy is that it is not as dependable as face-to-face therapy, as an Internet connection may not always be available at the time of a scheduled session. For instance, if a clinician is unable to establish an Internet connection, has an unstable connection, or has lost power in his or her office on a day of a scheduled e-session, the therapist has no choice but to cancel the session, thus preventing the client from receiving treatment (Olasupo & Atiri, 2013). Disruptions in connection and image or sound distortions can be unsettling to both parties and can undermine the therapeutic process. For these reasons, Kuulasmaa et al. (2004) believe that this mode of treatment is not a substitute for meeting in person and should be conducted only if absolutely necessary.

Still, with video therapy, even when technology works smoothly, and the video session progresses as planned, clients may feel a low level of connection with a clinician, and clinicians may feel that it is difficult to gain the “relational capital” needed for an effective treatment (Neimeyer & Noppe-Brandon, 2012, p. 118).

General Ethical and Legal Considerations in E-Therapy

Much of the literature on this topic addressed issues of confidentiality in both types of online therapeutic services. First, clinicians must obtain informed consent when conducting this type of therapy, just as they must

in traditional therapy (Kolmes, Merz Nagel, & Anthony, 2011). Clinicians should offer “clear and precise information that is accessible via the practitioner’s website,” and the signed informed consent should be sent back to the practitioner “via encrypted channels” (Keeley et al., p. 27). Second, as it is possible for determined individuals to “hack” computer programs, clinicians must ensure that the software they use to conduct therapy is at minimal risk for outside intrusion (Childress, 2000). Clinicians must also take precautions to ensure that their files and programs are not accessible by others, including any possible informational technology support staff (Childress, 2000).

Another confidentiality issue likely to arise with this type of treatment concerns the fact that many individuals share a computer with family members. As a result, it is not difficult for a person other than the client in treatment to have access to client–practitioner communication if a therapist does not have a password-protected account or if a family member has adequate information to access an account (Cartwright, Gibbon, McDermott, & Bor, 2005). Last, a few of the researchers who have studied this topic cautioned that it is very likely that either practitioner or client might accidentally address an e-mail to someone other than the individual intended to receive it. Childress (2000) warned that “inadvertently sending private information meant for the therapist to a friend or family member can result in embarrassing and painful situations for the client” (p. 7). It is crucial in these cases for the clinician and client to be aware of the potential concerns with respect to this mode of treatment.

As use of cell phones in professional practice becomes more popular, clinicians should be aware of the necessary measures that should be taken if they decide to allow clients to send them text messages. Kolmes and Monroe (2014) stated that they do not support client–therapist texting, because of the difficulty in deciphering the urgency of text messages and the inevitable misspellings or mistaken autocorrection in texts, as well as the common use of emoticons, all potentially contributing to mutual misjudgment, eroded boundaries, and other causes of clinical mistakes. If clinicians do decide to allow clients to text them, some precautions should be taken. Most important, Kolmes (2010) noted, is that text messages are included in “interactions that are a part of treatment,” and therefore need to be documented for legal purposes (p. 1).

Critique of the Literature

Ransom et al. (2008) recognized that most studies on the topic of e-mail and telephone-based therapeutic techniques are older (2003–2007), but

they did not revisit whether study participants were still seeing the benefits of therapy years after services were terminated. In addition to the absence of longitudinal research, the lack of published literature on this subject is also associated with a lack of information on which disorders are most treatable via the Internet and telephone.

Although most of the literature on this subject mentioned the probable clinical problems stemming from a lack of the ability to read body language in non-face-to-face therapy, several potential concerns have not been addressed. For example, the lack of face-to-face contact with a client may prevent the clinician from being able to recognize the side effects of psychotropic drugs. In addition, it is probably ill advised to conduct teletherapy or e-therapy with clients who are at risk of self-harm, or harm to others, as it may be very difficult to assess changes in stability or risk among these clients without reliable access to visual cues. Furthermore, it is likely to be very difficult to hospitalize a client who is geographically distant from the clinician, if this becomes necessary. Finally, most of the literature on this topic has not addressed gender, culture, religion, or any other factors that may affect the success of this mode of treatment.

Teletherapy, E-Therapy, and Adlerian Psychology

Alfred Adler strongly emphasized the importance of social interest in an individual's life. Social interest, he theorized, was a "feeling of community, an orientation to live cooperatively with others, and a lifestyle that values the common good above one's own interests and desires" (Guzick, Dorman, Groff, Altermatt, & Forsyth, 2004, p. 362). Social interest is an important aspect of one's life, as Adler believed that one's amount of social interest was correlated with overall psychological health.

By using digital therapy, the clinician may be able to assist a client (and especially a client who might be disconnected from a physical community due to his or her dwelling status or disability) in connecting with a community, thus allowing the individual to strengthen a sense of social interest, and therefore potentially improving the individual's psychological health.

From the Adlerian perspective, there may also be some disadvantages of teletherapy and e-therapy. For example, the Adlerian approach to therapy depends on a collaborative relationship between client and therapist, which may be more difficult to establish without the ability to read facial cues or body language. This lack of visual information may also impair the use of immediacy to reflect back the apparent match or incongruences between the client's verbal statements and body language or tone of voice.

Summary and Implications for Professional Psychologists

Most of the literature on this topic concludes that teletherapy, e-mail therapy, and videoconferencing therapy may be efficacious modes of conducting psychological treatment, and they often lead to positive outcomes. However, because not all analyzed studies reach this conclusion and there are varying views on the success of this mode of treatment, psychologists should proceed with caution when using technology in therapy. Psychologists must be very careful, for instance, to ensure that client confidentiality is maintained. It is very easy to reply to a client's e-mail, for example, and accidentally send it to another individual, who was not intended to receive the information. Clinicians must ensure that their clients are fully aware of the risks when this mode of communication is used.

As always, it is important that psychologists conducting treatment frequently check in with their clients to see whether the client feels the mode of communication being used is beneficial. Without doing so, there is a risk that the client and the psychologist may have different views about the efficacy and success of the therapy. Furthermore, psychologists should make sure that their insurance companies are aware that these types of services are being offered, so that the services are covered under the clinician's malpractice policy (DeAngelis, 2012).

As time goes on, more research will be published and more policies will be developed concerning non-face-to-face psychotherapy. Clinicians who engage in this type of treatment must keep up with the newest research on the topic. Furthermore, peer consultations would be beneficial for clinicians as they attempt to use new technology as a treatment medium.

References

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Arlington, VA: American Psychiatric Publishing.
- American Psychological Association. (1995). *American Psychological Association statement on services by telephone, teleconferencing, and Internet*. Retrieved from <http://apa.org/ethics/education/telephone-statement.aspx>
- American Psychological Association. (2010). *Code of ethics*. Retrieved from <http://www.apa.org/ethics/code/principles.pdf>
- Cartwright, M., Gibbon, P., McDermott, B. M., & Bor, W. (2005). The use of email in a child and adolescent mental health service: Are staff ready? *Journal of Telemedicine and Telecare*, 11(4), 199–204.

- Childress, C. (2000). Ethical issues in providing online psychotherapeutic interventions. [J Med Internet Res] 2000 Jan-Mar; Vol. 2(1), pp. E5. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1761841/>
- Cluver, J. S., Schuyler, D., Frueh, B. C., Brescia, F., & Arana, G. W. (2005). Remote psychotherapy for terminally ill cancer patients. *Journal of Telemedicine and Telecare*, 11(3), 157–159.
- DeAngelis, T. (2012). Practicing distance therapy, legally and ethically. *Monitor on Psychology*, 43(3), 52.
- Dwight-Johnson, M., Aisenberg, E., Golinelli, D., Hong, S., O'Brien, M., & Ludman, E. (2011). Telephone-based cognitive-behavioral therapy for Latino patients living in rural areas: A randomized pilot study. *Psychiatric Services*, 62(8), 936–942.
- Fenichel, M. (2002). *The here and now of cyberspace*. Retrieved from <http://www.fenichel.com/herenow.shtml>
- Fingfeld-Connett, D. (2006). Web-based treatment for problem drinking. *Journal of Psychosocial Nursing & Mental Health Services*, 44(9), 20–27.
- Goelitz, A. (2003). When accessibility is an issue: Telephone support groups for caregivers. *Smith College Studies in Social Work*, 73(3), 385–394.
- Guzick, D. T., Dorman, W. J., Groff, T. S., Altermatt, E. R., & Forsyth, G. A. (2004). Fostering social interest in schools for long-term and short-term outcomes. *Journal of Individual Psychology*, 60(4), 361–366.
- King, S. A., Engi, S., & Poulos, S. T. (1998). Using the Internet to assist family therapy. *British Journal of Guidance & Counselling*, 26(1), 43–52. Retrieved from <http://ezproxy.adler.edu/login?url=http://search.proquest.com/docview/205161784?accountid=26166>
- Kolmes, K. (2010). *Additional comments on documentation for clinicians*. Retrieved from <http://drkkolmes.com/2010/07/14/additional-thoughts-on-documentation-for-clinicians>
- Kolmes, K., Merz Nagel, D., & Anthony, K. (January 2011). Ethical framework for the use of social media by mental health professionals. *TILT Magazine*, 20–29.
- Kolmes, K., & Monroe, K. (2014). *Wickr: HIPAA-compliant SMS app tested by two psychologists*. Retrieved from <http://drkkolmes.com/writing/blog/>
- Krupnick, J. L., Sotsky, S. M., Simmens, S., Moyer, J., Elkin, I., Watkins, J., & Pilkonis, P. A. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology*, 64(3), 532–539. Retrieved from <http://psycnet.apa.org/journals/ccp/64/3/532/>
- Kuulasmaa, A., Wahlberg, K., & Kuusimäki, M. (2004). Videoconferencing in family therapy: A review. *Journal of Telemedicine and Telecare*, 10(3), 125–129.

- Neimeyer, R. A., & Noppe-Brandon, G. (2012). Attachment at a distance: Grief therapy in the virtual world. In C. J. Sofka, I. Noppe Cupit, & K. R. Gilbert (Eds.), *Dying, death, and grief in an online universe: For counselors and educators* (pp. 103–118). New York, NY: Springer.
- Olasupo, M. O., & Atiri, O. S. (2013). E-therapy: Contemporary tool in psychotherapy. *Ife Psychologia*, 21(3), 277–280.
- O’Reilly, R., Bishop, J., Maddox, K., Hutchinson, L., Fisman, M., & Takhar, J. (2007). Is telepsychiatry equivalent to face-to-face psychiatry? Results from a randomized controlled equivalence trial. *Psychiatric Services*, 58(6), 836–843. Retrieved from <http://ps.psychiatryonline.org/article.aspx?articleid=98152>
- Ransom, D., Heckman, T. G., Anderson, T., Garske, J., Holroyd, K., & Basta, T. (2008). Telephone-delivered, interpersonal psychotherapy for HIV-infected rural persons with depression: A pilot trial. *Psychiatric Services*, 59(8), 871–877.
- Ricker, J. (2002). Study shows telephone counseling can be effective. *Monitor on Psychology*, 33(4), 14. Retrieved from <http://www.apa.org/monitor/apr02/studyshows.aspx>
- Robinson, P., & Serfaty, M. (2008). Getting better byte by byte: A pilot randomised controlled trial of email therapy for bulimia nervosa and binge eating disorder. *European Eating Disorders Review*, 16(2), 84.
- Shaw, H. E., & Shaw, S. F. (2006). Critical ethical issues in online counseling: Assessing current practices with an ethical intent checklist. *Journal of Counseling and Development*, 84(1), 41–53.
- Turner, C., Heyman, I., Futh, A., & Lovell, K. (2009). A pilot study of telephone cognitive-behavioural therapy for obsessive-compulsive disorder in young people. *Behavioural and Cognitive Psychotherapy*, 37(4), 469–474. doi:<http://dx.doi.org/10.1017/S1352465809990178>

Alana Kingsley (akingsley@my.adler.edu) is a PsyD student at the Adler University in Chicago. Her focus is on children and adolescents, and she hopes to use e-therapy and teletherapy effectively throughout her career to help meet the needs of her clients. She is also an avid Instagrammer and Facebooker, and cannot wait to see what social media forum will be popular next.

Janna A. Henning (jhenning@adler.edu) is a clinical psychologist and educator specializing in traumatic stress, dissociative disorders, death, dying, bereavement, and loss in psychotherapy. She is an associate professor in the PsyD program at the Adler University in Chicago and the creator and coordinator of its Traumatic Stress Psychology Concentration. Although she is a “digital immigrant,” she actively uses social media for personal and professional purposes, and welcomes the opportunities for expanded patient care offered by teletherapy and e-therapy.