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14

Ethical Couple and Family E-Therapy

Markie L. C. Twist and Katherine M. Hertlein

Dr. Stellar holds a small private practice in a suburb of a large city. She has, on average, 15 clients per week and shares office space with two other family therapists. Because the office space she rents does not come with a landline phone, she and her co-renters have their clients contact them via each therapist's smartphone. Although several of her clients use the phone to make a call to confirm or schedule an appointment, eight well-established clients on her caseload routinely communicate scheduling with her via text message. Of those that schedule via text, about half of them also routinely communicate with her between sessions through e-mail and texts about what has happened since the last session, as well as ask questions about how to proceed. Her e-mail and text messaging practices with her clients have grown over time, and she has not really thought of them as e-therapy and consequently has not implemented an online communication agreement with her clients. Last month, Dr. Stellar conducted a session via Skype with one of her most well-established clients with whom she felt comfortable, because the client and his wife were desperately needing services while they were traveling out of state. Even though she recognized the video session as a form of e-therapy, because of the extenuating circumstances, her joined relationship, and the session going so smoothly, she does not recognize any potential ethical and/or legal problems.

Our case scenario with Dr. Stellar raises several questions. What constitutes e-therapy? What are the benefits and risks related to e-therapy? What are the legal and ethical issues of electronic practices? The purpose of this chapter is to address these questions, and provide guidelines to help couple and family therapists (CFTs) attend to common and potential ethical issues that arise in e-therapy. CFTs are integrating technology in their practices at a rapid pace, with an increasing number of articles and books on the topic (e.g., Dewan, Luo, & Lorez, 2015; Turvey & Myers, 2013). It is not uncommon for CFTs to use videoconferencing for treatment or supervision; they may have even participated in their own personal therapy via videoconferencing. There are, however, subtle ways in which technology enters treatment, such as text messages and e-mails between clients and therapists. CFTs may be unknowingly engaging in online practices, with minimal to no thought to potential ethical issues that arise when using these digital medium (Hertlein, Blumer, & Smith, 2014).

We consider e-therapy as *any professional interaction between clients, therapists, and/or supervisors that utilizes Internet and electronic media* (i.e., chatting, video calling, discussion boards, e-mailing, texting, websites, social network sites, etc.) (Blumer & Hertlein,

2012). Technologies are constantly changing, necessitating CFTs to understand how to work ethically within the dynamic framework of e-therapy. To that end, we propose guidelines to aid systemic therapists in e-therapy—termed the Couple and Family Therapy Technology Framework—which is an evolving framework that can be used by CFTs as a guide in working with individual, couple, and family systems in online clinical contexts (Figure 14.1) (Blumer, 2014, 2015; Hertlein & Twist, 2015).

The Couple and Family Technology Framework captures the interaction between technology and couple and family relationships (Hertlein & Blumer, 2013). Because technologies evolve at such a rapid pace, the strategies to for e-therapy practices presented in this chapter provide guidelines for the CFT, rather than specific practice suggestions, using the Couple and Family Therapy Technology Framework.

Couple and Family Therapy Technology Framework

The Couple and Family Therapy Technology Framework aids the CFT in understanding human–technology relationships directly applicable to e-therapy practices (Blumer, 2014, 2015; Hertlein & Twist, 2015). The framework explores how the ecological elements of the Internet (anonymity, approximation, accessibility, affordability, ambiguity, accommodation, and acceptability; Table 14.1) affect both the structure (roles, rules, boundaries) and process (phase of e-therapy, relationship between therapist and client) of one's practice. Additionally, as the components of new technologies change over time, therapists must revisit how these components affect the structure and process of their treatment so as to provide the same standard of care as they would in offline treatment. In this chapter we discuss ethical and clinical elements of e-therapy; readers are referred to Figure 14.1 and Table 14.1 for additional information.

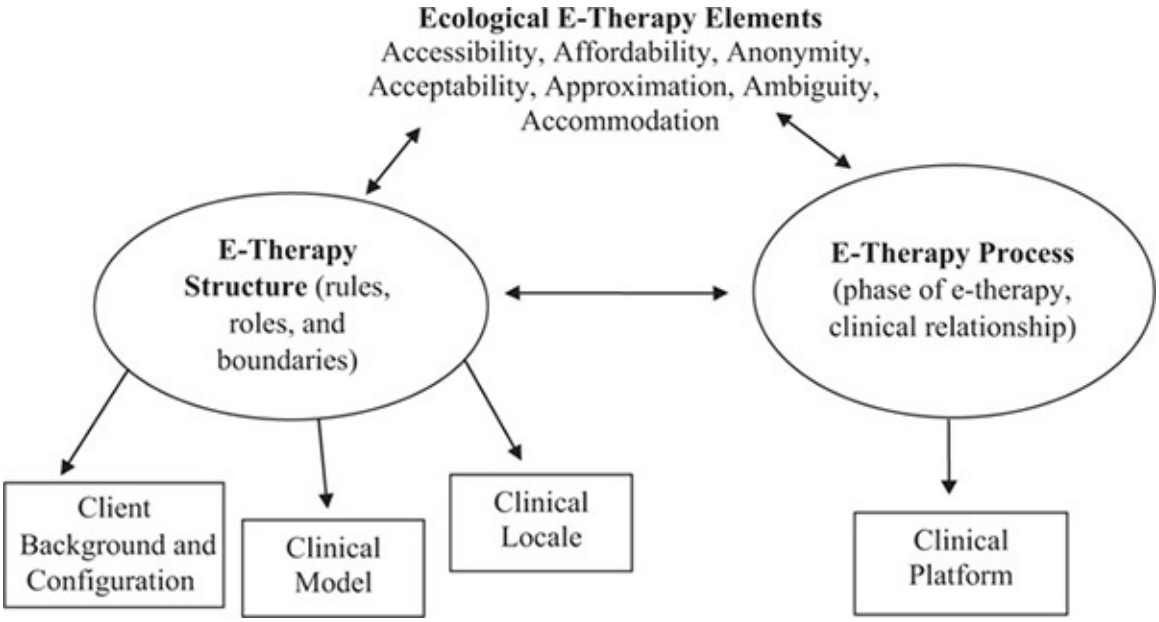

Figure 14.1 Couple and Family Therapy Technology Framework.

*Adapted from The CFT Framework (Hertlein & Blumer, 2013).

TABLE 14.1 Ecological E-Therapy Elements

Ecological Elements[a]	Recommendations[b]
Approximation – quality with which the Internet approximates offline, real-world clinical practices (Ross & Kauth, 2002)	**Closing the Approximation Gap** – Review similarities and differences between face-to-face therapy and e-therapy – Minimize the gap between face-to-face therapy and e-therapy by enhancing the online fields through measures such as ensuring technological clarity and quality
Affordability – degree to which the Internet and new media are widely available and affordable in clinical contexts (Cooper, 2002)	**Checking Affordability** – Consider financial costs of e-therapy for all relevant parties – Online payment transactions need to be secure and encrypted – Informed consent document needs to include payment information, specifically if occurs through provider or third-party platform and if the latter provide the merchant information
Ambiguity – lack of clarity and related difficulties in defining e-therapy technologically and relationally (Blumer & Hertlein, 2012; Hertlein & Stevenson, 2010)	**Reconciling Relational Ambiguity** – Agree on definition of e-therapy – Consider relational appropriateness (i.e., fit of population, presenting problem, platform, etc.) of relevant parties (e.g., clients, clinicians, supervisors) for engagement in e-therapy

	– Informed consent document that includes risks and benefits of e-therapy, geographical jurisdiction information, plans during technological breaks, management of emergencies, payment information, and management of boundaries around dual relationships online and offline (Anthony & Nagel, 2010) – Review and have parties sign contractual agreements around participation in e-therapy
	Reconciling Technological Ambiguity – Review the technological requirements (e.g., encryption, back-up systems, password protections, firewalls, back up protections, hardware, software, and use of third-party systems) for e-therapy participation – Consider technological appropriateness (i.e., technological literacy level, level of education and training, intergenerational experiences with technology, etc.) of relevant parties for participation in e-therapy
Accessibility – ease with which one has the opportunity and capability to access the Internet and new media on a daily and	**Managing Accessibility** – Management of boundaries with relevant parties is necessary, because with technology: one is virtually always accessible and visible,

unlimited basis from an array of locations (Cooper, 2002)	there is an expectation of availability being equated with this accessibility (Wilcoxon, 2015), there are differences on the experiencing of the therapeutic relationship based on phase of e-therapy and platform utilized, there is a high potential for work–family spillover (Chelsey, 2005) – Adhere to current state licensure regulations concerning e-therapy while in the same/different place as one's client – Include information about accessibility with regard to the handling of emergencies, expectations around frequency and timing of online communications, etc. in informed consent document – Scheduling and record keeping needs to be through secure and encrypted means
Anonymity – online users can present themselves in any manner, and in the context of being protected from being identified (Hertlein & Sendak, 2007)	**Managing Anonymity** – To ensure the relevant party is agreeing to participate in e-therapy, have them review and sign informed consent and contractual agreements in person or via videoconferencing – Do not search for clients via search engines or social media

	– E-therapy services need to be HIPAA-compliant – Attend to safety, and security around confidentiality in e-therapy practices, meaning for: • online practices: encryption measures, recognizing therapist as owner of online records, providing information on security of file storage, and having privacy policies in informed consent and on website (Anthony & Nagel, 2010) • face-to-face practices: keep smartphones out of sessions or if in session remove battery, and password protect phones
Accommodation – differences between the ways one presents in their offline therapy practices versus their e-therapy practices (Hertlein & Stevenson, 2010)	**Aligning Accommodation** – Presentation of one sense of self in offline environments and another sense of self (i.e., an electronic self or e-self) in online environments (Michikyan, Subrahmanyam, & Dennis, 2014) – Reconciliation of self and e-self is needed for all relevant parties and can be accomplished by focusing on: self-reflection, attainment of congruence between self and ideal self, ceasing to compare oneself online with others online, and being authentic and consistent across online and offline contexts

	Acknowledging E-Visibility Management – Visibility management is the degree to which minority identity individuals are "out" in varied contexts (Iwasaki & Ristock, 2007) – E-visibility management is the degree to which one's minoritized identity/ies is visible in online environments (Blumer, Bergdall, & Ullman, 2014) – Acknowledging visibility and e-visibility management practices is important in terms of monitoring the ability to protect relevant parties from cyberbullies, trolls, and other online predators
Acceptability – degree to which a multitude of functions once deemed inappropriate offline and/or online have now become accepted e-therapy practices (Blumer & Hertlein, 2011; King, 1999)	**Determining Acceptability** – Determine what is acceptable for online versus offline therapy. For example: for clients online practices are acceptable after completion of an assessment that involves gathering client identification, signing informed consent, completion of thorough mental, medical, and relational health history, and gathering information about daily health, hygiene, and living skills (Anthony & Nagel, 2010) – Determine the current state standards, ethics codes, and insurance regulations to follow – Display education and credentials, crisis intervention information, provider information, terms of use and privacy policy, ensuring of encrypted transmission, and a reflection of sensitivity to people of diverse backgrounds in one's online space (Anthony & Nagel, 2010) – Use acceptable e-therapy models and platforms

[a]Definitions of ecological elements adapted from Hertlein and Blumer (2013) and Blumer (2014).
[b]Summary of recommendations adapted from Blumer (2015).

Guidelines for the Structural Components of E-Therapy

There are many features of technology that are changing CFT practice. In addition to the effect of the ecological elements on the structure of e-therapy practices, it is important that therapists consider other structural elements such as client background and configuration, the clinical model, and the clinical locale (Godleski et al., 2008; Kramer, Mishkind, Luxton, & Shore, 2013). Clinical locale refers to the degree to which both the client(s) and the clinician have privacy, safety, and security while engaging in e-therapeutic practices. Because of the accessibility of e-therapy, CFTs facilitating e-therapy also need to consider management of e-therapy practices in relation to geographical location for both the client(s) and the clinician because interstate therapy is typically not supported by state licensing laws. A CFT practicing outside of the state(s) in which they are licensed is considered practicing without a license, which can bring misdemeanor and felony charges as well as substantial fines. Thus, a CFT must examine applicable state and federal laws and board regulations.

An essential step in structuring e-therapy is deciding who the client is, and who will be included in e-therapy, as is required in offline therapy. This means considering whether the e-

therapy will be with an individual, couple, and/or family client system, or some combination therein. Much of this can be managed with clear and appropriate paperwork (e.g., informed consent), describing who is to participate in therapy, rules about the structure of sessions, and both how and under what circumstances crises will be managed. Informed consent should address any and all electronic communications, no matter how insignificant that communication may seem (e.g., texts). In addition, therapists should implement a screening process to determine a client's fit for e-services. Akin to offline therapy, therapists need to evaluate the evidence for specific approaches on presenting problems seen in treatment and decide which clinical model is the best fit for the clients.

Guidelines for Process Components of E-Therapy

Establishing guidelines for the process of e-therapy is equally important to establishing structural guidelines. In terms of the process components of e-therapy it important to consider, once again, the effect of the ecological elements (i.e., anonymity, approximation, accessibility, affordability, ambiguity, accommodation, and acceptability) and the clinical platform, the relationship between the therapist and client(s), and the phase of e-therapy. For example, the clinical platform that the therapist works through in engaging online with the client(s) may vary based on the stage of the therapy, and the nature of the clinical relationship/therapeutic alliance. Thus, understanding the effect of communication platforms on the therapeutic alliance is essential. For instance, early on in a relationship, asynchronous and primarily text-based communications (e.g., e-mail) (Suler, 2000) tend to promote interactions characterized by higher amounts of self-disclosure, which in turn tends to build intimacy (in this case, intimacy in the form of a therapeutic alliance) more rapidly than other forms of online communication (Jiang, Bazarova, & Hancock, 2013; Twist & Hertlein, 2015). Asynchronous, text-based online communications, however, tend to create emotional distance in the therapeutic relationship over time, as the communications become shorter in length and more sporadic (Twist & Hertlein, 2015; Wilding, 2006). Thus, in terms of the maintenance stage of e-therapy, it might be more effective to make use of synchronous and interpersonal platforms. In addition, the ability for videoconferencing to approximate a real-time therapy session may be advantageous compared to other forms of media (such as e-mail), which do not as closely approximate an offline therapeutic situation.

Types of E-Therapy

The types of e-therapy that currently exist are typically conceptualized in two ways: (1) modalities of online therapy and (2) platforms used to engage in online therapy. Viewing e-therapy modalities and platforms through the lens of the Couple and Family Therapy Technology Framework, it is evident that the modalities one uses involve the structure of e-therapy, whereas the platform involves the process. Through both, the clinician is addressing the ecological e-therapy element of approximation (Ross & Kauth, 2002)—or the ability of the e-therapy experience to approximate the offline face-to-face experience.

Clinical Modalities

Common treatment modalities dispensed electronically include cognitive-behavioral therapy (CBT), integrative behavioral couple therapy (IBCT), structural therapy, support groups, self-help practices, and psychoeducation. Of these, the modalities that have received the most attention for use in online environments are CBT and psychoeducational programming (Blumer, Hertlein, Smith, & Allen, 2013).

Communication Platforms

There are several platforms available to conduct treatment or interact with clients online. The characteristics of these platforms include five overlapping dimensions: (1) synchronous/asynchronous, (2) text/sensory, (3) imaginary/real, (4) automated/interpersonal, and (5) invisible/present (Suler, 2000). The first dimension—synchronous/asynchronous—refers to timing. Synchronous online communication occurs between participants simultaneously, whereas asynchronous communications occur between participants at different times—in other words, there is a time lag (Suler, 2000). Examples of synchronous platforms include texting, chatting, videoconferencing, instant messaging, short-messaging systems, and telephony. Examples of asynchronous platforms include e-mail, discussion boards, weblogs, message boards, listservs, and recorded video and/or audio playback. This dimension has implications for therapists because clients may mistakenly believe that having accessibility (one of the ecological e-therapy elements) to the Internet makes all interactions synchronous and their therapist can and will respond immediately to any concerns raised through electronic platforms (Wilcoxon, 2015).

The text/sensory dimension breaks down into text communications (occurring via the Internet/media that are typed text only), and sensory communications (sight and sound) (Suler, 2000). Examples of text-only communication include: e-mail, message boards, discussion boards, newsgroups, short-messaging services, websites, and weblogs. Sensory communications include videoconferencing, telephony, sending pictures via the Internet, social media, avatars, virtual reality, and websites. The imaginary/real environment is the third dimension of the online and computer-mediated psychotherapy model. How closely the online environment can approximate (another of the ecological e-therapy elements) the offline environment is the degree of the realness of that online context. The closest we can get to offering encounters that approximate in-person interactions at present is through videoconferencing (Suler, 2000), through which most e-therapy is conducted.

The degree to which the online exchanges are with a computer or a human is the focus of the automated/interpersonal dimension (Suler, 2000). When a human is the primary entity that one interacts with online, then this interaction is thought to be interpersonal in nature (Suler, 2000). The bulk of e-therapy that is occurring at the moment is still in the form of interpersonal communications, primarily in the forms of virtual reality, videoconferencing, and personalized e-mails. Interactions are described as automated when a computer or a bot is the primary entity that interacts with one online. In clinical applications, programs can scan e-mails to determine one's mood, score inventories, and distribute e-mails automatically (Suler, 2000).

The fifth and final dimension is the degree to which users are visible versus present in online environments (Suler, 2000). When clients believe they are only talking with a computer, then the therapist is thought to be invisible. This can happen when a therapist watches clients interact in online messaging or discussion boards, or via an e-mail listserv. Clinicians can also hold office hours via instant messaging or chatting for clients who want to have brief check-ins; in this way, a therapist can be interacting with several clients simultaneously without them being aware of each other's presence. Clients may also appear to be invisible online because they can be in online support groups, discussion boards, and/or listservs without directly interacting with other participants, but instead just observing (Suler, 2000).

Clinical and Ethical Issues

Benefits of E-Therapy

Effective Treatment for Specific Problems

The benefits of e-therapy within the context of the Couple and Family Therapy Technology Framework are both a reflection and perpetuation of the growing acceptance of e-therapy practices. At one time, e-therapy was thought to be ineffective, unhelpful, inappropriate, and even unethical. Yet as the technology grows and changes and a growing body of empirical evidence mounts, suggesting that there are distinct benefits to e-therapy, the clinical community's acceptance of e-therapy practices propagates (Hertlein, Blumer, & Mihaloliakos, 2015; Hertlein et al., 2014). E-therapy is now an effective delivery method for a host of presenting problems such as anxiety and panic disorders (Rees & Maclaine, 2015), mood disorders, and posttraumatic stress disorder (Fortney et al., 2015), depression, maternal depression, long-term medical problems, childhood and adolescent anxiety (Eells, Barrett, Wright, & Thase, 2014; Hesser et al., 2012; Sheeber, Seeley, Feil, Sorensen, Kosty, & Lewinsohn, 2012), and eating disorders (Loucas et al., 2014). Early evidence suggests that treatment therapy has the same effectiveness as face-to-face therapy and, in some cases, demonstrates higher levels of efficacy (Fortney et al., 2015; Frueh, 2015; Morland et al., 2010).

Children and families also benefit from e-therapy, although with limited integration with family therapy theories. Families and children are more likely to adopt teleconferencing procedures than clinicians, potentially because it is easier for families to be coordinated to be together for the session (Goldstein & Myers, 2014). In the treatment of childhood depression, CBT delivered via videoconference fared the same as treatment delivered face-to-face (Nelson, Barnard, & Cain, 2006). CBT-based e-therapy has also been found to be effective for teaching parents the skills they need to better manage attention-deficit/hyperactivity disorder (Palmer, Myers, Vander Stoep, McCarty, Geyer, & DeSalvo, 2010; Xie et al., 2013). Systemic therapists have relied on using IBCT in online service delivery. For example, Doss and colleagues (2013) have developed a web-based version of the systemic-based model, IBCT, for use with couples experiencing relationship distress and who may be at risk of divorcing.

Bridging the Gap Between Service Needs and Delivery

In the context of the Couple and Family Therapy Framework, the ability to bridge the gap between mental and relational health service needs and therapeutic delivery at a distance is helpful to consider via the ecological e-therapy element of accessibility. Accessibility, or the ability to access others via technologies from virtually anywhere (Cooper, 2002), is another key benefit because it enables clinicians to provide services to people who would not be able to otherwise receive services, especially a rural population (Hertlein et al., 2014; Morland et al., 2010; Simms, Gibson, & O'Donnell, 2011). Early evidence shows great need for mental health services (Frueh, 2015) in rural locales, but the ability of e-therapy to reach those regions was far below what one would expect, thereby not closing the gap. The lack of use of e-therapy for bridging this gap is especially problematic considering other research has suggested that those in rural communities may be more likely to use mental health services if they were available (Harwood & L'Abate, 2009). E-therapy is also a timely way to get practitioners to provide services to those in areas affected by disaster (Augusterfer, 2013).

Offering therapeutic services online may also reduce costs for both clients and therapists compared to offering them solely face-to-face, which addresses the ecological e-therapy element of affordability (Cooper, 2002), or the degree to which e-therapeutic technologies are available and affordable in clinical contexts. Cost savings occur when the need for office space decreases, practitioners do not have to rent a specific office space, there is decreased travel time for clinicians, and when clinicians are able to see a greater number of clients (Glueck, 2013a). Likewise, clients also experience a cost-benefit via e-therapy services because they are able to take less time off from work for traveling to appointments and they spend less money on child care and other expenses associated with travel such as gas, car insurance, and mechanical maintenance (Glueck, 2013b). Cost savings also get passed on to clients in decreased treatment costs. For example, in a controlled study, Crow and colleagues (2009) found the average cost of the treatment of bulimia electronically was $7,300 compared to $9,325 for face-to-face treatment.

Risks (and Perceptions of Risk) in E-Therapy

CFTs who were asked to clarify their perceptions about issues that might arise in their technology practices listed five issues for consideration, which included: confidentiality, the perceived damage to the therapeutic relationship, liability and licensing issues, concerns around how to handle emergency situations, and training issues (Hertlein et al., 2015). With regard to informed consent, CFTs expressed that codes of other health professional organizations were helpful in making decisions about how to obtain informed consent in an ethical manner (Hertlein et al., 2015).

Confidentiality

CFTs are concerned about confidentiality in e-therapy (Hertlein et al., 2015). Specifically, there is concern as to who is on the other end of the computer and that security online is not guaranteed. First, there are any number of people who might have access to one's electronic

accounts and passwords. In one case, a patient's husband gained access to her passwords online by installing a key logging system on her computer. He logged into her e-mail accounts and was attempting to log in to her secure patient account where she journaled for her therapist. Upon discovery of the keylogging system and his disclosure of information that was only in her e-mail accounts, her therapist advised her to stop journaling in case he might also gain access to her secure patient account and cease any e-mail connection until such a time when she felt safe and was no longer being observed.

In other cases, confidentiality may be violated on the therapist's end, because e-mail addresses can be auto-populated with relative ease (Gamble, Boyle, & Morris, 2015). Additionally, it is impossible to guarantee confidentiality because clients open their e-mail on their phone, and mobile phones can be lost or stolen (Gamble et al., 2015). When considering confidentiality in e-therapeutic contexts via the Couple and Family Therapy Technology Framework, it is helpful to consider the ecological e-therapy element of anonymity, or the extent to which a client(s) can be protected from being identified in online contexts (Hertlein & Sendak, 2007).

Perceived Risk to the Therapeutic Alliance

The therapeutic alliance is one area in which practitioners' perceived risk in e-therapy situations is greater than the research on therapeutic alliance and e-therapy supports. Therapeutic alliance is a key concept in psychotherapy, as well as in the process of e-therapy. It drives, to some degree, client disclosures to the therapist, client responsiveness and execution of interventions, and the therapist's ability to accurately hypothesize and design interventions. Many perceive that the practice of e-therapy impairs the joining process; the therapist can be more likely to structure the session so it focuses more on tasks and less on process, which disrupts the therapeutic alliance (Simms et al., 2011). However, the consensus in the literature is that there are few differences, if any, in the therapeutic alliance when service delivery is performed online (Germain, Marchand, Bouchard, Guay, & Drouin, 2010; Glueck, 2013b; Morgan, Patrick, & Magaletta, 2008). These results seem to be consistently independent of presenting problem (Jenkins-Guarnieri, Pruitt, Luxton, & Johnson, 2015).

In some instances, the challenges of developing a solid therapeutic alliance can be even greater in online service delivery than face-to-face (e.g., Knaevelsrud & Maercker, 2006). For example, when there is insufficient bandwidth, there may be transmission issues such as delay in transmission of pictures or jagged movements or other technical issues (Jenkins-Guarnieri et al., 2015), which may affect the therapeutic alliance. In addition, therapists and clients need to have camera software that allows for the clinician to view the pertinent parts of the physical setting (e.g., other individuals in the session, client's setting) (Glueck, 2013b). Eye contact may be a challenge as cameras are often mounted in a place that does not allow for direct eye contact with the person on the other end of the camera; rather, cameras are mounted at the top of a screen and give the impression of the other person looking away. This might be viewed as a risk or a challenge to gain the same level of alliance for those participating in e-therapy in comparison to those in face-to-face therapy sessions.

In reviewing studies on the impact to the therapeutic alliance in e-therapeutic treatments, one

of the primary findings was the attitude of the clinician toward e-therapy may be a key factor in polluting the alliance findings (Simpson & Reid, 2014). Specifically, therapeutic bond is a key factor in the therapeutic alliance, which includes the therapist's attitude, abilities, and therapist anxiety. Therefore, therapists who are apprehensive or mistrustful of using videoconferencing technologies may communicate that apprehension through the technology, thus negatively impacting the bond, and relatedly the alliance (Simpson & Reid, 2014).

Perceived Risk of Increased Symptomatic Behavior

One area of risk sometimes introduced by the therapist is the inability to conduct a proper assessment without the person being face-to-face, such as when evaluating for psychosis. Part of this concern may be rooted in the ecological e-therapy element of accommodation, or the differences between the ways a client may present themselves offline versus online (Hertlein & Stevenson, 2010). Others are concerned that e-therapy enables those fearful of traveling or leaving their homes. However, researchers thus far have indicated that symptoms do not tend to increase because of service modality in these populations (Turvey & Myers, 2013).

Emergency Situations

Equally important is the issue related to potential risk of suicidality and self-harm in clients participating in online therapy (Kramer et al., 2013). Suicide assessments conducted via e-therapy have three main associated legal and ethical issues: licensing, involuntary commitment, and liability (Godleski et al., 2008). Licensing and involuntary commitment overlap when there is a need to detain a client with suicidal ideation or intent to harm self or others, but an inability to do so when the clinician is not licensed to practice in the state in which the client resides. This can be particularly problematic for veteran's administration practitioners who are only required to be licensed in one state to work agency-wide, but may encounter detainment issues when engaging in e-therapy practices (Godleski et al., 2008). Finally, liability is generally discussed as falling in two categories: abandonment (characterized by technology failing resulting in an inability to "meet" with the client) and negligence (characterized by a failure to provide medical attention to a suicidal client). Each state differs in its definition of what constitutes a client who is in danger of harming oneself, thus introducing more confusion for interstate practitioners.

Training Issues

Because CFTs are increasing their adoption of e-therapy practices, they are interested in receiving adequate training on how to provide the appropriate standard of care in their couple and family therapy technology practices (Blumer, Hertlein, & VandenBosch, 2015). Sunderji, Crawford, and Jovanovic (2015) conducted a literature review of telepsychiatry competencies and found that competencies to be included in training are those that address technical aspects of telehealth, ideas on collaboration, and competencies on how to perform specific administrative tasks. Alternatively, Nelson, Bui, and Sharp (2011) identified competencies as falling into two categories: clinical and outreach. Several states are working on developing and adopting core competencies of training for those who conduct telemental health (e.g.,

Areas of Competence for Psychologists in Telepsychology, 2013). Outside of the states, there are also professional organizations such as Association of Marital and Family Therapy Regulatory Boards (AMFTRB), American Psychological Association (APA), American Telemedicine Association (ATA), and National Association of Social Workers (NASW) who are working to develop core competencies and guidelines for their respective organization(s) (Blumer et al., 2015). One of the main challenges, however, is the lack of coordination on the part of the organizations in these efforts, which makes the development of a coherent frame for therapists difficult.

Privacy, Security, and Confidentiality

Security is such an issue that many of the e-therapy guidelines speak directly to the necessity for practitioners to understand the nuances about the system they use to provide the best security for clients. Security refers to the ways in which the practitioner would safeguard the information to prevent unauthorized disclosure. This differs from privacy, which refers to how one manages and distributes their personal information. Finally, confidentiality refers the ethical responsibility of the therapist to not share personal information shared. Therapists working in online environments need to ensure their client's electronic information is safeguarded—from the security provided by the system to the client during sessions to the way in which personal information and data is protected. The main point of both the issues of malpractice and protecting client information is that the standard of care "does not change with technology" (Vanderpool, 2015, p. 172). The Health Insurance Portability and Accountability Act (HIPAA) security regulations are of particular import here, and are discussed further in Chapter 4.

Informed Consent

It is essential that the ecological e-therapy element of ambiguity be addressed before and while engaging in online therapy. In the context of the Couple and Family Therapy Technology Framework, ambiguity is described as the lack of clarity and related difficulties associated with defining e-therapy, both technologically and relationally (Blumer & Hertlein, 2012; Hertlein & Stevenson, 2010). There are myriad authors who pose several independent considerations for managing such ambiguities in one's digital practice, with most advocating for thorough informed consent regarding the risks and benefits of e-therapy. Informed consent should address why e-therapy is being used, what to do when technological issues happen that may interfere with having a session, the basic nuts and bolts of the process of treatment (Glueck, 2013b), and assist clients in understanding how to promote the confidentiality and privacy of their therapeutic information (Sabin & Skimming, 2015). Wilcoxon (2015) also suggests therapists think critically and with forethought about any potential technology-related issues, clarify meanings of terms, develop policies around electronic communication and explain them to the client, keep updated on literature related to e-practices, identify whether e-therapy is covered by one's insurance, and avoid social networking with clients. The HIPAA security risk assessment as discussed in Chapter 4 will aid in this process. Cyber-insurance is

also available.

Legal Issues

Licensing and Credentialing

As previously mentioned, a significant advantage to e-therapy is the ability to serve populations who are at a geographical disadvantage for receiving services (Hertlein et al., 2014; Koocher, 2007). One of the primary challenges of e-therapy is that of licensure. Historically, the regulations regarding licensure dictated that mental and relational health professionals could only practice e-therapy in the states in which they were licensed (Vanderpool, 2015). As opportunities arose for practitioners to expand practices beyond their state lines, such as when clients resided in another state, legislation is being introduced that will enable therapists to participate in service delivery across state lines. At present, this is not the case, though some states will allow mental health professionals to obtain a temporary license to practice within their state for a maximum number of days or sessions per year (Kramer et al., 2013).

Malpractice

As previously mentioned, interstate practice without appropriate licenses can lead to misdemeanors, felonies, and fines. If harm has been generated when therapists practice outside of the purview of their license, they may find themselves facing malpractice suits. For many practitioners, their malpractice insurance covers to face-to-face interactions and says little about what happens when that contact is over the Internet. CFTs should look closely at their policy; for example, CPH and Associates Professional Liability Insurance does cover online therapy in those states that allow it, and encourages therapists to contact their state board to ensure they are practicing lawfully An additional malpractice risk to consider is that because e-therapists must expand their informed consent to cover e-therapy contingencies, they inadvertently have also expanded their scope of practice, and consequently their liability risks.

Application of the Couple and Family Therapy Technology Framework

Knowledge of ethical issues surrounding the structure and process of e-therapy is important as CFTs use technology to address client needs. Using the Couple and Family Therapy Technology Framework, CFTs can make more informed decisions regarding e-therapeutic practices. Returning to our case scenario at the beginning of this chapter, Dr. Stellar would likely alter her choices in terms of CFT technology practices. For instance, if she attended to the ecological e-therapy element of ambiguity and its effect on the structure and process of e-therapeutic practices, she would recognize the importance of agreeing with her clients on a definition of e-therapy for the sake of clarifying their online interactions. In addition, she

would likely recognize the need for having the clients review and sign a detailed informed consent document related to e-therapeutic treatment, aiding her in addressing safety and security issues, and other legal and ethical issues. Additionally, she would also be better informed as to which technological platform would be most appropriate to use with which clients, and during which phase of treatment, rather than just using various platforms for clinical work in what seems to be a haphazard and/or urgency-based manner.

Conclusion

CFTs face a myriad of issues in practicing e-therapy. E-therapy is evolving at a rapid pace, and we recognize that because of that, aspects of e-therapy that are not clear now will be clarified as technology practices become standardized. However, what becomes standardized can quickly become outdated, requiring the CFT to stay current how both therapeutic and technology issues advance. For ethical practice, we advise CFTs to continue to check with their state laws regarding the current standards of care, to stay up-to-date with the relevant scholarly literature, utilize knowledgeable attorneys as resources to e-practice, and participate in continuing education opportunities that are related to online therapy.

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