

Ethical and Legal Considerations for Internet-Based Psychotherapy

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Abstract. The provision of mental health services over the Internet is becoming increasingly commonplace as new technologies continue to develop. Evidence in support of the efficacy of many such interventions is accumulating. Given the potential global reach of Internet-based psychological services, the authors examine ethical issues relating to this growing area of practice through the lens of the *Universal Declaration of Ethical Principles for Psychologists* (International Union of Psychological Science, 2008). They also raise issues relating to potential liability risks and offer recommendations intended to guide mental health practitioners who are considering involvement in the provision of Internet-based services. *Key words:* *Internet-based psychotherapy; ethics; Universal Declaration of Ethical Principles; liability.*

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Internet-based mental health services have become increasingly commonplace over the past two decades. Just as in face-to-face therapy, Internet-based mental health services can be provided in a variety of styles and formats. Internet-based psychotherapy (IBP) has been provided through web pages and self-help materials and often involves varying degrees of therapist contact (e.g. via e-mail, videoconferencing, and telephone; see Anderson et al., 2008). With the advent of new and affordable technologies, such as Voice over Internet Protocol (VoIP) and videoconferencing, IBP is likely to increasingly expand from text-based interventions to more closely simulate face-to-face therapy (e.g. Bouchard et al., 2000; Manhal-Bangus, 2001).

Although several recent articles address controversies surrounding the provision of Internet-based services (e.g. Alleman, 2002; Koocher, 2009; Maheu & Gordon, 2000; Zack, 2008), we see no sign of a reversal in this trend. Around the world, professional organizations

associated with mental health care seem interested in closely monitoring Internet-based services, although only a few have taken strong policy positions opposing these practices. It seems highly unlikely that significant movement in opposition to IBP will arise, given the disadvantages such a decision could create for groups already well served by technology (e.g. individuals who would not otherwise have access to therapy for a variety of reasons, including financial strain, geographic location, work schedule, and tolerance of the social stigma associated with the experience of mental health difficulties; Alleman, 2002, Barak, 1999; Young, 2005). It would also be important to acknowledge that many mental health professionals view IBP as a complement to, as opposed to a replacement for, more traditional forms of psychotherapy.

In keeping with the nonprohibitive stance evidenced by psychology's professional bodies to date, the professionalization of Internet-based psychological services continues apace.

New regulations that seek to directly regulate IBP have begun circulating (e.g., the Telemedicine Development Act, 1996), and clinicians have begun to develop Internet-based services, including Internet-based treatment protocols for specific conditions (e.g. Kiro-poulos et al., 2008; B. Klein et al., 2009). The literature on efficacy and effectiveness suggest that many Internet-based treatments, despite ethical and legal concerns, are effective (Andersson, 2009; Pull, 2006; Spek et al., 2007) and inexpensive (Ritterband et al., 2009) methods of psychotherapy. As professional and regulatory bodies continue to evaluate their responses to IBP, psychologists must do the same. Psychologists must decide for themselves whether or not to make Internet-based service delivery part of their practice based on factors such as the advantages and disadvantages for the population they treat and consideration of legal and ethical issues related to Internet-based service delivery. Following a review of a number of universally accepted ethical principles with implications for IBP, we discuss ethical concerns about IBP as reflected in the professional literature and review general legal issues of particular concern to psychologists practicing over the Internet.

Professional ethics

Several psychological associations have been referring IBP practitioners to more general ethical principles intended to address all areas of practice. For example, the American Psychological Association (APA; 1997) issued a statement on the delivery of services by telephone, teleconferencing, and Internet, which points to existing ethics code standards that may be relevant, including Standard 1.04c, which states: "In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect patients, clients, students, research participants, and others from harm" (APA, 2002). Other national and international associations, such as the European Federation of Psychologists' Associations (2005), the Hong Kong Psychological Society (1998), and the Japanese Psychological Association (n.d.) also do not make specific reference to the provision of services via electronic

communication within their codes of ethics and conduct.

The decision to rely on existing ethical principles, values, and standards is reasonable in that it ensures the widest possible applicability of ethics codes (e.g. regardless of rapid changes in technology). However, it may not satisfy professionals who plan to offer IBP and seek an adequate understanding of specific ethical issues likely to arise in their practices. The Canadian Psychological Association (CPA; 2006) acknowledged this need by releasing a set of guidelines for the provision of services via electronic media (these are currently under revision, and the CPA has announced its plans to disseminate a future draft for consultation). The CPA guidelines are framed within the CPA's four ethical principles. For example, the guideline "Psychologists do not attempt to address a problem using electronic media unless they have demonstrated their competence to do it in in-person services" falls under the CPA ethics principle of "Responsible Caring". Although the CPA guidelines provide a useful frame of reference for Canadian psychologists who offer IBP, a need exists for similar guidelines on an international level. We seek to contribute to international discussion of ethical issues in IBP psychotherapy by considering these issues from an area of ethical common ground for psychologists in all forms of practice: the International Union for Psychological Science's (IUPsyS) *Universal Declaration of Ethical Principles for Psychologists* (2008).

The goal of IUPsyS is the development, representation, and advancement of psychology as a basic and applied science (IUPsyS, 2006). Currently, 72 nations are represented by IUPsyS. The *Universal Declaration* was adopted unanimously by the General Assembly of IUPsyS in Berlin on July 22, 2008, and by the Board of Directors of the International Association of Applied Psychology in Berlin on July 26, 2008. The *Universal Declaration*, constructed around the same four principles that form the basis of the CPA code of ethics and other similar codes (e.g. European Federation of Psychologists' Associations, 2005), was intended to provide "a moral framework and generic set of ethical principles for psychology organizations worldwide" (IUPsyS, 2008, p. 1). Because it was designed to have universal applicability, the *Universal*

Table 1. *Internet-based psychotherapy (IBP) and the Universal Declaration of Ethical Principles for Psychologists*

Principle	Issues pertinent to IBP
I. Respect for the dignity of persons and peoples	Consent Privacy Confidentiality Fairness and justice in the treatment of persons and peoples
II. Competent caring for the wellbeing of persons and peoples	Taking care to do no harm Developing and maintaining competence
III. Integrity	Avoiding incomplete disclosure Maximizing impartiality and minimizing biases Not exploiting for personal, professional, or financial gain
IV. Professional and scientific responsibilities to society	Responsibility to increase scientific and professional knowledge Responsibility to protect such knowledge from being misused Responsibility to adequately train its members Responsibility to develop ethical awareness

Note. *Although many issues relating to the four principles of the Universal Declaration of Ethical Principles for Psychologists may apply to the provision of IBP, only the most pertinent issues are listed here.*

Declaration provides a solid basis for a discussion of ethical concerns in the practice of IBP. Here, we discuss each principle of the *Universal Declaration* briefly and then summarize anticipated ethical issues specific to the practice of IBP. This has been summarized in Table 1.

Principle I: respect for the dignity of persons and peoples

This universal principle “recognizes the inherent worth of all human beings, regardless of perceived or real differences in social status, ethnic origin, gender, capacities, or other such characteristics” (IUPsyS, 2008, p. 2). Values associated with this principle include “a) respect for the unique worth and inherent dignity of all human beings; b) respect for the diversity among persons and peoples; c) respect for the customs and beliefs of cultures, to be limited only when a custom or a belief seriously contravenes the principle of respect for the dignity of persons or peoples or causes serious harm to their well-being; d) free and informed consent, as culturally defined and relevant for individuals, families, groups, and communities; e) privacy for individuals, families, groups, and communities; f) protection of confidentiality of personal information, as culturally defined

and relevant for individuals, families, groups, and communities; g) fairness and justice in the treatment of persons and peoples” (IUPsyS, 2008, p. 2). Although all of these values have relevance to IBP, as they do to traditional psychotherapeutic practice, the last four warrant special consideration as they apply to IBP.

Consent. This is a hallmark component of the practice of psychology. Consent represents a knowing, voluntary, affirmative decision that one makes on behalf of oneself, as contrasted with the concept of *permission*, when someone must act on behalf of a mentally or legally incompetent person, or of *assent*, when offering an individual (who is not legally authorized to provide consent) the right to veto participation. The validity of the consent process can be undermined by coercion or by failure to provide information relevant to consent (e.g. information regarding the assessment and therapy process, the psychologist’s credentials, and any potential benefits and risks). In all forms of therapeutic contact, the psychologist has an obligation to provide potential clients with information required to make an informed decision to undergo treatment; however, in the context of IBP, there are some special considerations. For example, potential clients should be informed

of the risks to confidentiality inherent in Internet-based communications (see Koocher, 2007, 2009, for examples of such risks), the measures planned to protect confidentiality, and methods clients can use to safeguard their own confidentiality (e.g. communicating through a virtual private network). Providing information about the advantages and disadvantages of IBP and other available alternatives will also help the clients make an informed choice. Furthermore, as part of the consent process, clients seeking IBP should receive information about the potential for technology failures and black-outs and should be provided with instructions to follow in the event of such a failure (e.g. ways to contact the therapist or seek any necessary emergency assistance; Midkiff & Wyatt, 2008). Internet therapists should also provide clients with a means of verifying their credentials (Manhal-Baugus, 2001), such as referral to licensing verification websites.

A practical issue related to the process of obtaining consent also warrants consideration. Psychologists typically use a signed consent form or, when appropriate, documentation of oral consent. For Internet therapists, these means of obtaining consent sometimes prove inconvenient or unrealistic; thus, Midkiff and Wyatt (2008) suggest two possible avenues for obtaining consent when conducting Internet-based assessments and psychotherapy. The first option involves printing and signing a consent form, which clients could then fax or scan and e-mail to their psychologist for insertion in their file. Alternatively, the therapist could ask clients to read a consent form online and click a box indicating that they agree to the terms of therapy, thereby providing an electronic signature. According to Midkiff and Wyatt (2008), this form of electronic signature is frequently used and constitutes a valid method of obtaining consent. If using VoIP or videoconferencing, the psychologist could request permission to capture a recording of the consent process electronically. However, in some jurisdictions (e.g. California), the law may require more traditional (written) consent procedures.

Internet therapists must also take steps to ensure that potential clients have the competence to provide consent to assessment and therapy. Although it is possible to place stipulations on the website that clients must

be at least 18 years old to receive services, these provisions do not guarantee that the individual consenting to therapy has attained the age of consent, so one would usually supplement attestation by other methods to confirm identity, including presentation of photo identification or birth certificate (in person or electronically). In addition, identity of the client can be ascertained through an initial in-person meeting with a therapist in or near the client's home town (Midkiff & Wyatt, 2008) or using the services of a third-party organization for verification (Alleman, 2002). *Privacy.* IBP can offer particular advantages with respect to enhancing some aspects of client privacy. Young (2005) found that privacy-related issues were the most commonly endorsed reason for seeking online counseling (e.g. respondents believed it was easier to participate in therapy without the knowledge of family and friends). On the other hand, online counseling can also raise privacy concerns. For example, Internet communications can be accessed by third parties, unless one takes special measures (e.g. encryption) to protect these communications (Koocher, 2007). Psychologists who offer IBP should act to ensure the privacy of their communications with clients to the extent possible, and several options exist. For example, many Internet chat sites use secured log-ins with pseudonyms to protect users' identities (Freeny, 2001). Encryption of therapist-client communications is also a commonly advised strategy to protect privacy. Alleman (2002) convincingly notes that encryption reduces the probability of the client's privacy being violated during therapy to about the same likelihood as a counselor's office being bugged. At least one research group has reported using a very secure client-therapist contact system that is similar to that used in Internet banking (Andersson, Carlbring, Berger, Almlöv, & Cuijpers, 2009). Even if therapists implement specific measures to ensure privacy, they should make clients aware that a risk of privacy violation always exists.

Confidentiality. Confidentiality is related to privacy and refers to assurances that a psychotherapist will not disclose certain information the client provides without that client's expressed authorization. Psychologists place a high value on confidential communication because the information psychotherapy

clients provide is often highly personal and provided in a context of trust. In IBP, transcripts of sessions, if saved by the therapist, require appropriate secure storage, with limited access, just as with other modes of therapy and record types. Electronic files are highly portable and more vulnerable to accidental or purposeful destruction; thus, one must take care to ensure access to the data as needed and only by those who are entitled to access it (by the client's consent or by law). Any limits to confidentiality imposed by the use of Internet technology must be frankly discussed with potential clients. For example, clients have a right to know which clinic personnel, other than the therapist, will have access to their records and what type of information will be released to third parties (e.g. for billing purposes). A substantial body of legislation concerning the confidentiality of Internet-based health services or Internet-based business transactions has existed for some time at both national and state/provincial levels (e.g. the Telemedicine Development Act, 1996; Health Insurance Portability and Accountability Act [HIPAA], 1996; Personal Information Protection and Electronic Documents Act [PIPEDA], 2000; Directive 95/46/EC of the European Parliament, 1995). Thus, in addition to considering ethical principles related to confidentiality, psychologists should refer to legislation related to topics such as the public funding and regulation of health services (e.g. Medicare/Medicaid), telehealth or telemedicine, and privacy.

Fairness and justice in the treatment of persons and peoples. IBP is often discussed in light of new ethical problems, but it also has several unique benefits. One such benefit involves the potential to promote fairness and justice in treatment by increasing access to service by underserved populations. For example, the Internet can reach people (a) who might not choose to present for in-clinic treatment (e.g. those with severe agoraphobia), (b) who live in rural or remote settings, (c) who do not find it convenient to attend face-to-face therapy (e.g. schedule conflict, transportation problems, or disability), or (d) who cannot afford the cost of face-to-face therapy (the per-session cost of text-based IBP is typically lower than that of face-to-face therapy; Manhal-Baugus, 2001). On the other hand, the cost of computer equipment and Internet

service may limit access for individuals at lower income levels (Child Trends DataBank, 2006; Dryburgh, 2001). In addition, although public computer access exists in many communities, client privacy and confidentiality may be compromised when public computers are used for psychotherapy. Although we do not believe that psychologists necessarily have an obligation to ensure that everybody has access to IBP, those who consider offering IBP to particular clinical populations or communities should consider issues such as these to maximize fair access to their services.

Principle II: competent caring for the wellbeing of persons and peoples

The second principle of the *Universal Declaration* (IUPsyS, 2008) emphasizes that psychologists should act to maximize benefit, minimize potential harm, and offset or correct any harm that has already occurred. Psychologists are encouraged to establish interpersonal relationships that benefit clients and to develop a base of self-knowledge that can help prevent harm. Values associated with this principle include "a) active concern for the well-being of individuals, families, groups, and communities; b) taking care to do no harm to individuals, families, groups, and communities; c) maximizing benefits and minimizing potential harm to individuals, families, groups, and communities; d) correcting or offsetting harmful effects that have occurred as a result of their activities; e) developing and maintaining competence; f) self-knowledge regarding how their own values, attitudes, experiences, and social contexts influence their actions, interpretations, choices, and recommendations; and g) respect for the ability of individuals, families, groups, and communities to make decisions for themselves and to care for themselves and each other" (IUPsyS, 2008, p. 3). Values that merit special consideration by those who practice IBP include items (b) and (e).

Taking care to do no harm. Psychologists should plan ahead to manage any problems perceived as having a higher potential to occur during Internet-based practice (e.g. violations of confidentiality) or problems they will manage differently in Internet-based practice (e.g. responding to a suicidal or homicidal client or potential client at a distance). For instance,

as already discussed, clients should receive information about risks to privacy and confidentiality during IBP, and providers must make special efforts to manage these risks. With respect to emergency situations, it is incumbent upon psychologists who practice over the Internet to expect occasional emergencies and to plan to manage them effectively. Some authors (e.g. Stoffe, 2004) have recommended limits on the scope of practice to reduce the risk that those who practice therapy over the Internet will have to manage mental health emergencies from a distance. Others have argued that emergency situations can be managed well using technology. For example, Barak (2007) discussed the implementation of a Hebrew-language website for mental health crises that includes multimodal information (e.g. textual information, videos, chat features) as well as support by telephone or e-mail on demand. This site is accessed approximately 10,000 times monthly, and about one-tenth of those who access it make personal contact (as opposed to accessing textual information only).

Technology can certainly be used effectively to facilitate communication, even in high-risk situations. The utilization of suicide hotlines is good evidence of this, and Barak's (2007) work suggests that the Internet may be similarly useful. However, psychologists conducting IBP may not encounter emergencies regularly; therefore, they should decide how to manage them during IBP. At minimum, they should collect emergency contact information from clients at the onset of therapy. They should also decide, in advance, what level of availability they are willing to provide in the event of an emergency and should discuss this with clients as therapy begins. For example, the psychologist might offer specific times for contact and recommend that, outside these times, the client go to the local emergency room or obtain assistance from an emergency telephone service. It may also be possible, in some situations, to prearrange contact with a therapist or physician in the client's home town in the event of an emergency. Alternatively, some psychologists may feel comfortable offering select clients 24-hour telephone availability in the event of an emergency.

Developing and maintaining competence. In addition to the basic competencies expected of licensed psychologists, some special areas of competence are required for IBP. First and

foremost, an understanding of the particular technologies used in IBP is essential, and there is no better way to acquire understanding than through direct experience. Before practicing independently, we recommend that those who intend to practice IBP undergo supervised training with any techniques and interfaces they intend to use. *Clinical* supervision is necessary because, in addition to mastering basic technical skills, psychologists must be able to use these skills to effectively develop a therapeutic alliance via e-mail, text-chat, VoIP, or videoconferencing interfaces. Each technology comes with its own set of communication challenges that may impact the development of the therapeutic alliance. In e-mail communication, for example, spontaneity of communication is reduced because of response delays, whereas text-chat communication can occur instantly. As technology continues to develop, psychologists who use VoIP and videoconferencing must also prepare for occasional interruptions and mild distortion of audio or visual data.

Psychologists who wish to develop additional competencies in IBP would need to familiarize themselves with professional literature on the subject of technology-mediated relationships, including psychotherapeutic relationships. A persistent concern about text-based (e.g. e-mail) psychotherapy, for example, focuses on the formation of a strong therapeutic alliance in the absence of nonverbal cues typically present in face-to-face therapy (Cook & Doyle, 2002). Although some research indicates that no difference exists in the quality of personal relationships formed in text-based communication and those formed face to face (e.g. Parks & Roberts, 1998), other evidence suggests subtle differences in the progression of relationships. Alleman (2002), for example, suggests that various text-based styles can act as a cue for emotion (e.g. the use of capital letters, font colors, smiley faces, punctuation). Moreover, some research suggests that individuals disclose personal information more quickly in text-based communication styles than in face-to-face interaction (e.g. Joinson, 2000). Psychologists practicing IBP will want to remain current with the developing literature, including the coverage of ethical issues. It is also important that IBP providers remain aware of any legislation governing their actions, both in their own and in their clients' jurisdictions.

Principle III: integrity

This principle emphasizes “truthful, open and accurate communications” and the avoidance of conflicts of interest that could result in harm or exploitation (IUPsyS, 2008, p. 3). According to the *Universal Declaration*, one should balance the need for complete openness and disclosure with the need to protect safety and confidentiality and a respect for cultural differences. Values associated with this principle include “a) honesty, and truthful, open and accurate communications; b) avoiding incomplete disclosure of information unless complete disclosure is culturally inappropriate, or violates confidentiality, or carries the potential to do serious harm to individuals, families, groups, or communities; c) maximizing impartiality and minimizing biases; d) not exploiting persons or peoples for personal, professional, or financial gain; and e) avoiding conflicts of interest and declaring them when they cannot be avoided or are inappropriate to avoid” (IUPsyS, 2008, p. 4). In our view, items (b), (c), and (d) may have special implications in IBP.

Avoiding incomplete disclosure. Full disclosure becomes important both during the consent process and in ongoing therapy. In IBP, full disclosure should include all of the information that might reasonably influence the client’s decision to participate. This would include information about the potential for a breach of privacy, information about any personnel or third parties that have access to personal information, and information about the advantages and disadvantages of Internet therapy (e.g. evidence about how it compares with other options, such as face-to-face therapy). In addition, therapists providing IBP should willingly provide appropriate information about their own professional identity; for example, the therapist’s or clinic’s website should clearly list professional credentials and clients should have the opportunity and ability to verify this information (e.g. Manhal-Baugus, 2001).

Maximizing impartiality and minimizing biases. IBP is an exciting development in the field of psychology. Although many studies have provided support for its use with several different populations (e.g. Andersson, 2009; Andersson et al., 2006; Andersson, Waara, et al., 2009; B. Klein et al., 2009; Litz, Engel,

Bryant, & Papa, 2007; Ritterband et al., 2009), this is a relatively new area of practice and, as such, it would be important to carefully monitor new data as the evidence base continues to develop. There is also a need for more evidence on the efficacy of approaches involving psychotherapy through videoconferencing and VoIP.

Not exploiting for personal, professional, or financial gain. IBP clinics can become a lucrative business option, judging by the success of several therapy websites (Manhal-Baugus, 2001). Although investments in security measures, identity verification, and confidential data storage may prove substantial, the cost of doing business can remain quite low (Koocher, 2009). In addition, IBP provides a convenient way for therapists to work (e.g. the potential to work out of one’s home and to set one’s hours; reduced concern about physical security). Psychologists must take care to consider their motivations for becoming involved with Internet-based therapy. Creating a profit-making sustainable business plan and choosing an approach to clinical practice that suits one’s preferences is perfectly ethical, so long as one fully informs the client of all relevant details and makes the client’s wellbeing the paramount concern.

Principle IV: professional and scientific responsibilities to society

According to Principle IV of the *Universal Declaration*, psychologists’ responsibilities to society include contribution to knowledge about human behavior and use of this knowledge to improve individual and social conditions. Values associated with this principle include the discipline’s responsibility to (a) “increase scientific and professional knowledge in ways that allow the promotion of the well-being of society and all its members”; (b) “use psychological knowledge for beneficial purposes and to protect such knowledge from being misused, used incompetently, or made useless”; (c) “conduct its affairs in ways that are ethical and consistent with the promotion of the well-being of society and all its members”; (d) “promote the highest ethical ideals in the scientific, professional and educational activities of its members”; (e) “adequately train its members in their

ethical responsibilities and required competencies"; and (f) "develop its ethical awareness and sensitivity, and to be as self-correcting as possible" (IUPsyS, 2008, p. 4). Items (a), (b), (e), and (f) are of special importance to IBP.

Responsibility to increase scientific and professional knowledge. Establishing the effectiveness of Internet-based psychology services is a priority for many (Alleman, 2002; Jerome et al., 2000; DeLeon, Crimmins, & Wolf, 2003), and the professional literature in this area is developing at a rapid pace. Pull (2006) notes that most Internet-based psychotherapies are structured as guided self-help programs, are designed to treat mood and anxiety disorders, and rely on a cognitive-behavioral approach to therapy. Randomized controlled trials (e.g. Andersson et al., 2005; Carlbring et al., 2005; Perini, Titov, & Andrews, 2009; B. Klein et al., 2009; Kiropoulos et al., 2008), reviews (Cuijpers et al., 2009; Pull, 2006), and meta-analytic work (Spek et al., 2007) demonstrate that Internet-based programs can reduce symptoms of anxiety and depression. Internet-based programs for smoking cessation, tinnitus, problem drinking, and insomnia also exist (e.g. Bewick et al., 2008; Cobb et al., 2005; Kaldo et al., 2008; Ritterband et al., 2009; Strom, Pettersson, & Andersson, 2004).

In addition to the dearth of information about treatment of disorders other than anxiety and depression, the evidence base for IBP has some other limitations. For instance, very few studies have directly compared IBP with face-to-face psychotherapy, although initial outcome evidence (e.g. Andersson, Carlbring, & Grimlund, 2008; Kiropoulos et al., 2008) suggests that the two modes of therapy seem comparable in many ways. Nonetheless, an understanding of the extent to which therapist support enhances the results of self-help programs delivered over the Internet is still developing. For instance, Kiropoulos and colleagues (2008) compared traditional face-to-face CBT with Internet-based CBT for panic disorder with agoraphobia. The Internet-based treatment consisted of a six-module treatment protocol guided by a psychologist via e-mail. Psychologists would respond to e-mails within 24 hours of their receipt. Results showed no differences in ratings of the therapeutic alliance between those in the Internet-based and face-to-face conditions. However, individuals in the

face-to-face format reported higher levels of enjoyment in communicating with their therapist and were rated by therapists as being more compliant with the treatment. The meta-analytic work of Spek and colleagues (2007) has also documented the direct contribution of therapist contact to therapy effect sizes.

Responsibility to protect such knowledge from being misused. It is easy to find both helpful and harmful information about psychological interventions on the Internet, depending where one looks. It is also easy to find treatment offered by licensed and unlicensed individuals who describe themselves as therapists. It is important that psychologists consider aiding the public in discriminating among the various providers based on meaningful criteria. In the meantime, helpful solutions have been promoted independently of professional organizations. For example, Manhal-Baugus (2001) discussed the use of an online database (<http://www.mentalhelp.net>), popular with professionals who offer Internet-based mental health services, that allows clients to search for details, including the names, specialty areas, and credentials of online practitioners. Metanoia (<http://www.metanoia.org>) is another site that provides useful information about Internet therapy from a client's perspective (Alleman, 2002; Metanoia, 2009). Perhaps with time, professional organizations will take on functions such as these in order to provide clients greater reassurance that the services they pay for are provided by qualified professionals bound by professional codes of ethics and conduct. Efforts of organizations such as the American Counseling Association (ACA), CPA, International Society for Mental Health Online (ISMHO), National Board for Certified Counselors (NBCC), and others to provide specific guidance to therapists who are considering practicing IBP are to be applauded in this respect, as are the efforts of clinical researchers who study the outcomes of IBP.

Responsibility to adequately train its members. A market for IBP clearly exists, and psychologists have not been discouraged from entering it. However, IBP requires a special set of competencies, including knowledge of new technologies, skills in developing relationships mediated by technology, and knowledge of special ethical and legal implications. Goss and Anthony (2009) provide a list of websites where practitioners can complete specialized

training; however, it is important that graduate training programs and professional organizations consider offering more training in this emerging area.

Responsibility to develop ethical awareness. Psychologists who practice IBP should pay close attention to emerging discussion of specific ethical issues in IBP as professional literature develops, and should also consider the specific guidelines and principles of organizations such as ACA (2005), ISMHO (2000), and NBCC (2009) or of professional organizations and regulatory bodies in their own jurisdiction.

Ethical advantages and disadvantages of IBP

As a document intended to represent the universal values of psychologists, the *Universal Declaration* provides a useful way to consider the ethical issues involved in Internet-based psychological services. An increasing market for IBP raises serious ethical concerns, including the importance of effectively using technology to ensure privacy and confidentiality, the importance of further discussion and study of the advantages and limitations of IBP, and the need for Internet therapists to develop special competencies and to have crisis management plans in place. The development of IBP services also has ethical advantages. For instance, it reflects psychologists' concern about underserved clients. It may also offer concerned clients some reprieve from the stigmatization sometimes associated with seeking traditional psychological treatment. Moreover, IBP allows individuals the freedom to extend beyond the limits of their geographic location to find a therapist with whom they feel comfortable, who has sufficient expertise treating their particular difficulty, or who shares the same cultural background. Finally, the development of IBP demonstrates psychologists' efforts to develop an appropriate professional knowledge base as new areas of practice emerge.

The regulation of Internet-based mental health services

IBP is increasingly regulated directly (e.g. by privacy legislation in many countries and, in countries such as the United States, by legislation specific to the provision of

telehealth services). IBP is also affected less directly by regulations related to the Internet and to provision of health and mental health services. Based on current professional discussions (e.g., Alleman, 2002; DeLeon et al., 2003; LeBourdais, 1997; Taylor & Luce, 2003), some of the most significant legal issues introduced by delivery of IBP include the lack of consensus regarding who regulates services when the client and therapist reside in different legal jurisdictions, the duty of care owed to the client (including concern about the level of difficulty for managing crises over the Internet), liability risks, and client privacy/confidentiality.

Direct regulation of Internet-delivered psychotherapy

In the United States, some states have enacted legislation to regulate telehealth services. For example, the Telemedicine Development Act (1996) regulates the actions of psychologists practicing IBP. Specifically, practitioners subject to this legislation must obtain patients' written consent before providing services, and services for patients living in California must be provided by practitioners who are licensed to practice in California, although it specifically excludes e-mail messages and telephone conversations. Procedures for the maintenance of clients' records and for client access to records are also specified by the Telemedicine Development Act (1996). Similar legislation may determine the direction of the growth of telehealth psychotherapy in the United States (S. R. Klein & Manning, 1995). Psychologists interested in determining the direction of practice standards should monitor these developments.

Licensure for Internet-delivered psychotherapy

To the best of our knowledge, questions about the jurisdiction of those practicing IBP have not been effectively addressed by legislation or professional licensing bodies to date. As we noted, some American states have legislated geographical limitations on telehealth practice (e.g. the Telemedicine Development Act, 1996). However, several licensing boards and professional organizations seem reluctant to follow suit by restricting IBP to the jurisdictions in which the therapist holds licenses.

This most likely relates to the belief expressed by Alleman (2002) that this restriction would undercut the advantages of IBP. Indeed, a survey by Maheu and Gordon (2000) suggests that most practitioners who deliver services over the Internet provide services to people who live outside their licensing jurisdiction.

In the absence of nationwide licenses or agreements, therapists who practice over the Internet with no license in the geographic region in which the client resides might place themselves at risk in the event of a malpractice or licensing board complaint. Decisions about in which jurisdiction (e.g. client's or therapist's) complaints will be adjudicated may vary across state, provincial, and country lines. In some jurisdictions, this could result in the complaint being forwarded directly to the courts. To address these concerns, some have proposed that psychologists obtain licenses both in their own geographic region of residence and in all geographic regions in which they offer Internet-based services (e.g. Midkiff & Wyatt, 2008; Zack, 2008); however, this solution seems unduly complicated. Although the Association of State and Provincial Psychology Boards has established a program to facilitate the professional mobility of psychologists (the Certificate of Professional Qualification) licensed to practice in the United States or Canadian provinces, the program is most suitable for psychologists who seek to relocate their practice from one jurisdiction to another or who limit their practice to a small number of jurisdictions. Alleman (2002) has proposed that a national licensing organization for Internet therapists could be created, or interjurisdictional enforcement agreements adopted, to facilitate interjurisdictional IBP. In the absence of an organized professional approach to this matter, legislation such as the Telemedicine Development Act (1996) will increasingly determine the limits of professional practice, perhaps in ways that create unneeded restrictions.

Management of crises: the duty to warn/protect

One of the most significant areas of case law concerning the provision of psychological services concerns psychologists' duty to warn and/or duty to protect. Legal precedent varies, to some degree, from jurisdiction to jurisdiction. The typical minimum expectation under

the law (clients should be informed of this expectation during the consent for treatment/assessment process) is that psychologists breach confidentiality with the client in very unusual circumstances involving risk of harm in order to protect certain identified individuals or groups (e.g. acutely suicidal clients, children suspected of being abused). Legal precedent concerning the duty to warn/protect probably seems to extend fairly directly to Internet service delivery; however, cases involving Internet-based service delivery may have more complexity in that the therapist is less available to intervene directly in an emergency situation. It seems likely that the courts will consider the hypothetical actions of a reasonable and prudent person as they decide whether any given psychologist took sufficient action to warn or protect those at risk of harm. For example, the courts might look to factors such as whether the psychologist recorded contact and emergency contact information, what plans the psychologist had in place to manage crisis situations, and what actions were actually taken during a particular crisis involving the possibility of serious harm.

Age of consent

Misrepresentation of age is a concern given that, under the laws of most states and provinces, minors may not consent independently to receive psychological assessment and treatment (except under specific conditions). As an attempt to safeguard against such problems, many websites state that clients must be 18 or older to receive IBP (Midkiff & Wyatt, 2008). Some potential methods of verifying that clients are of the age of consent have been reviewed previously. We can expect that the courts will take an interest in whether psychologists have measures in place to ensure that the individual receiving therapy has valid legal competence to consent.

Client privacy and confidentiality

Federal and state/provincial legislation governs the privacy of electronically-stored health records, including electronic communications. For example, Canada, several member states of the European Union, and the United States have all enacted legislation that regulates the privacy of electronic data. In the United States, the Health Insurance Portability and Accountability Act (HIPAA, 1996) protects

the privacy of medical information. This legislation applies to American psychologists who regularly conduct specific aspects of their business (e.g. claims, billing, referral, and regular provision of services) electronically. HIPAA (1996) includes limitations on the collection and disclosure of individually identifiable health information (i.e. third parties may collect protected health information [PHI] only to the extent necessary to accomplish a specified purpose) and requirements for the protection of PHI (e.g. the implementation of reasonable administrative, technical, and physical safeguards to ensure its integrity, confidentiality, and availability as well as to prevent inappropriate or unauthorised access, disclosure, or use). In addition, HIPAA requires the implementation of a written privacy policy and the appointment of a privacy officer, if the practice or institution's size warrants such a role.

In Canada, the Personal Information Protection and Electronic Documents Act (PIPEDA, 2000) applies to all organizations engaged in commercial activity. This law is similar to HIPAA in its emphasis on identifying purposes of information collection, limiting collection of information to the purposes for which permission was given, limiting the use of information by parties other than the party to whom it was given, ensuring accuracy of records, and ensuring access to records. In addition to federal privacy regulation (PIPEDA, 2000) affecting commercial organizations, including psychological practices, some Canadian provinces have enacted legislation specific to publicly-funded health care providers and other health care organizations (including mental health services). This legislation contains regulations similar to those enacted in PIPEDA (2000).

In the United States and Canada, as well as the European Union, the following principles seem paramount in organizational communication over the Internet: organizational accountability; disclosure of the purposes of information collection; informed consent; limiting collection of information to the disclosed purposes; limiting use, disclosure, and retention of data; ensuring accuracy of data; ensuring data integrity and confidentiality; and ensuring access to one's own personal information (Directive 95/46/EC, 1995; HIPAA, 1996; PIPEDA, 2000). Psychologists practicing IBP

must have familiarity with all relevant legislation concerning the privacy of personal information communicated or stored electronically and must comply with this legislation. If psychologists are uncertain whether privacy measures adequately address regulatory requirements, they should consult with experts in the areas of law and data security.

Liability concerns for Internet-based practitioners

Many liability-related concerns typically encountered in face-to-face treatment may often become intensified for practitioners providing psychotherapy via the Internet. Holmes (2008) suggests that some of the most predominant liability concerns among psychologists offering IBP include practicing in jurisdictions in which psychologists do not hold a license and in potential breaches of confidentiality inherent in Internet use. Banach and Bernat (2000), for example, suggest that practitioners offering online counseling may face liability for breaches of confidentiality of e-mails and text-based messages forwarded in error to individuals outside the therapeutic relationship. Moreover, it has been suggested that practitioners responding to a single e-mail may be held accountable for entering a fiduciary relationship with the client (e.g. Banach & Bernat, 2000; Terry, 2002), and that those providing online counseling may also face increased accountability for misdiagnoses or inaccuracies in assessment when basing diagnoses or treatment plans chiefly on Internet communications despite encouraging initial evidence about the accuracy of online diagnostic approaches (e.g. Chinman, Young, Schell, Hassell, & Mintz, 2004; Lin et al., 2007). Online practitioners may also face increased liability for difficulties in handling emergency situations as a result of increased geographic distance.

To minimize liability risks, practitioners should have safeguards in place, including but not limited to the use of tools to encrypt communications (i.e. thereby demonstrating an effort to protect privacy and confidentiality), familiarity with applicable legislation, competence in the use of technology, and use of disclaimers regarding the practitioner's responsibility on the website and on consent statements accepted by clients (Banach & Bernat, 2000).

Conclusions

Although legislation clearly relates to IBP both directly and indirectly, in a survey of behavioral e-health practitioners, 74% of US respondents either reported feeling uncertain or incorrectly answered questions about whether their states currently had any telemedicine or telehealth laws (Maheu & Gordon, 2000). We must emphasize that professionals who wish to practice in this area should become familiar with legal issues relevant to the manner in which they practice their profession (e.g. duty to warn/protect), should consider how to manage these issues during IBP, and should become familiar with the growing body of legislation that directly governs IBP or the management of electronic data and transactions in health care or for commercial purposes. We recognize as a limitation that, as one would expect from a report of this sort, we focused on several international and local guidelines and standards but were not able to capture every set of standards that may be available in different jurisdictions across the globe.

Specific guidelines for providing Internet-based therapy

Several organizations have published guidelines for individuals conducting therapeutic services via the Internet (e.g., ACA, 2005; CPA, 2006; ISMHO, 2000; NBCC, 2009). The CPA's (2006) statement has the advantage of linking ethical recommendations to an easy-to-remember ethical framework based on four key principles. The APA's (1997) statement has the advantage of linking to ethical standards that psychologists already have some familiarity with. The ACA (2005) Code of Ethics provides a detailed 11-step process for seeking clients' informed consent for Internet-based therapies. The ISMHO (2000) guidelines have a unique focus on practice issues relating to the provision of online mental health services, including guidelines for obtaining informed consent, standard operations, and strategies for dealing with emergency situations. Furthermore, the NBCC (2009) standards speak to the development of a strong therapeutic relationship when providing services online, with suggestions concerning the use of code

words or numbers to verify the identify of the client at the beginning of sessions, the determination of whether the client has the competence to provide consent for services (e.g. if the client has reached the age of majority), the possibility of technology failure, ways of contacting the therapist when offline, coping with the lack of visual cues when conducting text-based therapy or when using VoIP, identification of a local service provider who can assist the client in the case of an emergency, identification of services for clients who do not have the ability to pay for IBP, minimization of barriers for individuals with disabilities, and awareness that clients may come from different cultures and time zones.

The ACA, CPA, ISMHO, and NBCC have taken important steps toward the improvement of Internet-based mental health services through the publication of specific guidelines and standards of practice. These organizations have focused on several issues raised with regard to the provision of mental health services online, including obtaining free and informed consent, contracting for emergencies, and abiding by pertinent legislative documents. The general approach of several national professional organizations for psychologists has focused on referring psychologists to general, all-encompassing codes of ethics developed with expansion of services and technologies in mind. Mental health practitioners interested in providing online therapy may benefit from more specific guidelines outlining the potential ethical and legal implications of this practice.

Conclusion

Based on current evidence (e.g., Pull, 2006; Spek et al., 2007), IBP shows substantial promise as an efficacious and cost-effective method of providing mental health services. Although Internet-based therapies have a number of important strengths, this report has delineated some of the most pressing ethical and legal implications for Internet-based psychological treatment. In summary, we make the following recommendations regarding its provision:

1. Given the demand for IBP, professional psychology programs should offer optional training to enhance the competencies of

- psychologists and graduate students who intend to offer IBP.
2. Professional psychologists who provide IBP should keep pace with new technologies, including those used to provide services, protect confidentiality, and verify identity.
 3. Professional psychologists who provide IBP should develop a clear understanding of relevant legislation in one's own as well as the client's jurisdiction.
 4. Psychologists should outline clear boundaries and terms of services with clients receiving IBP, including (a) who to contact in emergency situations, (b) when the psychologist will be available, (c) expected response time to electronic communications, (d) fees, and (e) how missed sessions will be handled.
 5. If specific guidelines or codes of conduct for the provision of Internet-based therapies are not available from one's licensing body or national professional organization, mental health practitioners should ensure that their practice aligns with the more general codes of ethics by which they are bound and should become familiar with the professional ethics literature in this area of practice.
 6. Legal advice concerning policies and procedures related to IBP should be sought by those who provide it in order to minimize liability risk while providing high-quality services.

It is our hope that our recommendations will provide those interested in the provision of IBP with general guidance in their effort to develop and follow high standards of practice in this rapidly developing area.

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