

Informed Consent to E-therapy

PATRICIA R. RECUPERO, J.D., M.D. *

SAMARA E. RAINEY, B.A. **

E-therapy, the provision of mental health treatment through the Internet, poses many risks as well as benefits. This article addresses some relevant risks and benefits of e-therapy and discusses the practicality of using computers in the informed consent process. Although e-therapy has numerous proponents, no clinical trials have assessed its long-term effectiveness. To limit liability and to protect patients, e-therapy providers should disclose material risks as well as possible benefits and engage patients in an active dialogue. A thorough informed consent procedure enables patients to make an educated decision about whether e-therapy is right for them. In the future, e-therapy and informed consent online may become more common; in the mean time, clinicians must be prepared for e-therapy's uncertain legal status and allow patients to decide for themselves whether or not to seek counseling on the Internet.

INTRODUCTION

Advances in communication technology have begun to influence the physician-patient relationship and change the face of modern treatment. This change has manifested itself, in part, as e-therapy: the provision of mental health services over the Internet. Because e-therapy is a relatively new form of treatment with unique risks and benefits, this article describes some model content for informed consent between the e-therapy provider and patient.

While e-therapy may seem new-fangled, in that it utilizes the Internet for clinician-patient communication, its roots in correspondence therapy date back to the early days of medicine and psychotherapy. During the seventeenth and eighteenth centuries, physicians often relied on patients' written descriptions of symptoms, rather than on physical examinations, to make diagnoses (Spielberg, 1998). Freud corresponded with patients

*Department of Psychiatry and Human Behavior, Brown University, and Butler Hospital, Providence, RI **Mailing address:** President/CEO, Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906. e-mail: Patricia_Recupero@Brown.edu

**Butler Hospital, Providence, RI

through letters, and some commentators note the historical link between correspondence therapy and modern-day e-therapy (Pergament, 1998). Some e-therapists also offer “snail mail” correspondence therapy (Therapy Session Website, 2004; Dr. Franklin Online, 2004). Despite e-therapy’s antecedents, treatment through the Internet carries unique risks and benefits that warrant informed consent.

E-THERAPY: BACKGROUND

Scholars have compared e-therapy to radio psychology and advice columns (Pergament, 1998; Shapiro et al 1996), and some analogize e-therapy to the practice of media psychology, in which mental health experts offer advice and commentary to a public audience, sometimes responding publicly to queries by audience members (Pergament, 1998; Shapiro et al 1996; McCann, 2002). Because media psychology is commonly accepted as a form of entertainment rather than clinical treatment, no provider-patient relationship exists between a radio psychiatrist and an individual who calls in to discuss his problems on the airwaves. Furthermore, media psychologists “are the only clinicians allowed to practice outside of an established professional relationship” (Shapiro et al 1996), and they are not held to the same ethical standards as those followed by psychotherapists (APA, 2003). However, unlike media psychologists, e-therapists regard themselves as providing therapy and not entertainment (Pergament, 1998).

E-therapy may be analogous to telephone-based treatment (Terry, 2002), frequently referred to as telemedicine. Telemedicine also often utilizes video technology to enable participants to see one another. The American Telemedicine Association defines telemedicine as “the use of medical information exchanged from one site to another via electronic communications to improve patients’ health status” (American Telemedicine Association, 2005). When treatment is provided solely by telephone without accompanying video, the provider and patient cannot see one another; consequently, less information is exchanged. In 1985, the American Psychiatric Association opined that therapy provided almost exclusively by telephone was “unusual, inappropriate and not accepted medical practice.” (Justice Gangel-Jacob, 1989) If analogous to telephone treatment, e-therapy may face similar skepticism. However, much has changed since 1985; telemedicine and cybermedicine have grown more widespread, and videoconferencing software enables greater information exchange. It may be time to reassess the ethical status of e-therapy.

The popularity of health advice websites (Baker et al 2003; Open

Minds, 2003; Pies, 2002) and Internet support groups (Roberts, 1998; Houston et al 2002) has led, in part, to the development of e-therapy in the mid 1990s (Grohol, 2004). Currently, there is a range of scope for e-therapy; it may be conducted as the sole form of psychotherapeutic treatment, or it may be adjunctive (e.g Internet journaling “homework” for cognitive behavior therapy). E-therapists may use asynchronous communication, such as e-mail (Imperio, 2001; Murphy et al 1998; Yager, 2002), as well as synchronous communication, such as instant messaging or “chat” (Stofle, 2002), or videoconferencing technology (Gunter et al 2003; Liebson, 1997; Video-Counseling.com Website, 2004) to provide services to patients through the Internet. Currently, e-therapists range from unlicensed therapists and spiritual counselors to licensed social workers, psychologists, and psychiatrists (Maheu et al 2000). While some e-therapists claim that the services they provide do not constitute nor substitute for psychotherapy (HelpHorizons.com Website, 2004; Ask the Internet Therapist Website, 2004; Shrink-Me.com Website, 2004), the similarities between traditional psychotherapy and e-therapy are numerous.

INFORMED CONSENT TO E-THERAPY

The doctrine of informed consent for research is reflected in the Hippocratic oath (Jurevic, 1998). Informed consent is designed to protect patients’ rights to participate in the treatment decision-making process. As informed consent is required prior to provision of any treatment, some professional organizations note the need for informed consent to e-therapy (ISMHO, 2000) and other forms of cybermedicine and telemedicine (APA, 2001; Kane et al 1998; APA, 1997; AMA, 2003; FSMB, 2002; Medem, 2002). Telemedicine informed consent laws vary by jurisdiction; in Oklahoma (36 Okl. St. § 6804, 2004), California (Cal. Bus. & Prof. Code §2290.5, 2004), and Puerto Rico (20 L.P.R. Ann. § 6006, 2002), a provider must obtain a patient’s written informed consent before telemedicine begins; these jurisdictions require disclosure of statute-specified information. Texas requires informed consent but does not specify whether this must be written or may be obtained orally (Tex. Ins. Code art. 21.53F, 2004; Tex. Occ. Code §107.002, 2004). Finally, Arizona’s telemedicine statute allows for verbal consent, provided consent is noted in the patient’s medical record (Ariz. Rev. Stat. § 36-3602, 2004).

Informed consent is, ideally, a tripartite process: (1) conveyance of information from provider to patient, (2) the patient’s understanding of said information, and (3) the patient’s voluntary consent to a treatment plan. This article will address appropriate information for disclosure

during the informed consent process and some appropriate techniques to assure patient understanding and consent. This article aims to offer a starting point for reflection on the types of issues a provider may wish to disclose before conducting e-therapy, not a prescription for informed consent to e-therapy.

DISCLOSURE OF INFORMATION TO THE PATIENT

Prior to initiating treatment, the clinician has a duty to disclose relevant (“material”) risks, as well as possible benefits, safeguards, and alternatives: all information that would be deemed relevant by the reasonable patient to foster an educated decision. The risks and benefits of e-therapy vary from patient to patient, and clinicians should tailor disclosure to the patient’s unique situation, taking into account factors such as the patient’s diagnosis or symptomatology. The possible existence of undiscovered additional risks also warrants disclosure (Noah, 2002).

THERAPEUTIC RISKS

Text-based e-therapy carries unique risks. Internet communications experts have discussed what is now known as the “disinhibition” effect of the Internet (Suler, 2004). Without facial expression cues, text-based communication may lower individuals’ inhibitions; a shy patient may be more likely to disclose suicidal ideation in a chat room than in a therapist’s office. However, in such a scenario, the e-therapist must now be concerned with the safety of a patient who may be far away. To protect potentially suicidal patients, e-therapists may wish to restrict services to local patients to improve crisis intervention.

The lack of face-to-face interaction increases the risk of misdiagnosis and misunderstanding between the e-therapist and patient, thereby increasing the risk of uncertainty for the clinician (Shapiro et al 1996; Childress, 1998). Even the use of emoticons such as “:-)” may not resolve misunderstandings; therapists will be unable to assess whether a patient’s affect is in accordance with the emoticon. Psychotherapists traditionally rely on non-verbal clues, such as eye contact and tone of voice, in order to assess demeanor and make diagnoses. Crying and other “red flags” may go unnoticed in e-therapy where they could have been detected in traditional psychotherapy, although videoconferencing may lessen these risks. Additional risks arise when a psychiatrist prescribes medicine over the Internet. Harmful side effects of medication, such as tremor or akathisia, may go undetected. Moreover, regulatory authorities have taken swift action to end some Internet prescribing practices (Gunter et al 2003; Lerman,

2001); indeed, some psychiatrists refuse to prescribe medicine online. A provider may mitigate the risk of misdiagnosis by upgrading from text-based e-therapy to videoconferencing, or the therapist may request that all patients obtain a face-to-face psychiatric assessment.

SECURITY RISKS

Internet communication carries two categories of confidentiality risks: general security risks and risks specific to the content of the communications. With respect to general security risks, e-mails may be misdirected by typos in the “to” field or intercepted by hackers, resulting in inadvertent disclosure of highly sensitive health information. This poses significant risks for clinicians, as the number of lawsuits over breached confidentiality is on the rise (Terry, 2001). State laws often provide for higher standards of privacy protection for mental health information than for most other medical information. Computer programming errors may also cause inadvertent disclosure, as was allegedly the case when HealthNet sent patients’ psychiatric records to the wrong doctors (Wells, 2003). Patients may sue for inadvertent disclosure of sensitive health information (*Doe v. Community Health Plan*, 2000; *Behringer v. Medical Center at Princeton*, 1991) or use federal statutory remedies under HIPAA (42 U.S.C. 1320d *et seq.*). Therapists should notify patients of these risks and available safeguards, such as firewalls, encryption, audit trails, password protection, and authentication.

Patients’ privacy may be more limited than they realize. Employers may monitor e-mails sent through office networks; family members may read e-mail on shared home computers; and legal process may compel disclosure by therapists or staff of sensitive patient communications (*Menendez v. Superior Court of Los Angeles County*, 1992). The “unsanitized” nature of e-therapy communications complicates privacy risks through additional, content-specific risks. Unlike progress notes written by the therapist, e-mails contain an exact transcript. Like stored audiotapes, documents may remain available on computers even after a file has been deleted. Providers may forewarn patients of content-specific risks so that patients may choose carefully what information may be discussed through e-therapy and what is better suited for a face-to-face session.

LICENSURE RISKS

Both clinician and patient should be aware that substantial issues may arise with respect to licensure and malpractice insurance. Many states require providers to have state licensure or special certification for the state

in which a patient is located (Terry, 2002), except for incidental prescriptions. Although malpractice insurance underwriting varies, insurance is normally limited to the state(s) in which a provider is licensed to practice, leaving the provider uncovered in the event of an interstate malpractice suit (Nickelson, 1998). To reduce risks associated with licensure and state laws, a clinician may limit e-therapy to patients residing in states where the clinician is licensed, although some have argued that if the patient accesses the clinician's website, the patient has "traveled" to the clinician's state.

THERAPEUTIC BENEFITS

In response to criticism from e-therapy skeptics, some clinicians and patients have documented success stories of e-therapy (Murphy et al 1998; Wylie, 2000; Ainsworth, 2002). While positive patient outcome reports are available, little if any scientific research has assessed the effectiveness of Internet counseling (Maheu, 2001). Studies have found positive results for related technologies, such as telephone-based assessments (Aziz et al 2004; Paulsen et al 1988; Rohde et al 1997; Wells et al 1988) and treatment (Simon et al 2004), Internet support groups (Houston et al 2002), computer-based self-assessments (Chinman et al 2004), and videoconferencing telepsychiatry treatment (Ruskin et al 2004). So far, counselors have successfully integrated e-therapy in the treatment of eating disorders (Imperio, 2001; Yager, 2002) and weight loss programs (Tate et al 2003; Tate et al 2001) and in support groups (Colon, 1999).

A significant benefit to e-therapy may be patient preference (CNN.com, 2000). Computer-based patient education applications have been found to be effective with patients suffering from depression and schizophrenia. These patients reported that using a multimedia system for informed consent was less stressful than traditional processes (Jimison, 1998). The removal of a face-to-face interaction may increase self-disclosure and honesty; in a study of patients with severe mental illness, most patients preferred a computer-assisted self-assessment tool to the traditional face-to-face assessment conducted by a clinician (Chinman et al 2004). Some patients enjoy the opportunity to take their time to write carefully thought out messages and save replies for future reference (Slack, 2004). Despite the notable confidentiality risks discussed above, some patients feel that e-therapy affords them an *increased* perception of privacy (CNN.com, 2000; Scott, 2001). Furthermore, the absence of face-to-face communication may elicit increased transference, projection, and countertransference reactions (Suler, 2000), possibly adding clinical benefits to e-therapy (Childress, 1998).

While research has yet to determine the long-term effectiveness of e-therapy, Internet therapy may avoid some informed consent problems associated with telephone and correspondence therapy. Delays in the exchange of traditional “snail mail” correspondence may cause patients to neglect important questions they would ask in a face-to-face or e-therapy setting. Telephone conversations may allow for a thorough dialogue, but they are rarely saved for future reference. One commonly cited benefit is the absence of “phone tag” issues in asynchronous communication such as e-mail (McCann, 2002; Slack, 2004; Brand, 2004). E-therapy may be convenient when the clinician or patient is traveling, and some patients may use e-therapy as a first step towards obtaining face-to-face services (Ainsworth, 2002). Some patients who are unable or unwilling to seek face-to-face services may use e-therapy to receive treatment they would not otherwise obtain. Clinicians should advise prospective patients not only of risks, but also of these and other potential benefits to e-therapy.

In the field of mental health, the case of *Osheroff v. Chestnut Lodge* (1985) demonstrates the duty to disclose alternative methods of treatment (Mossman, 2002). In *Osheroff*, a patient sued a psychiatric hospital for failing to educate him about the option of pharmacological treatment in addition to or in place of the psychotherapy he was receiving. Similarly, when providing e-therapy, a clinician should inform the patient of alternatives to e-therapy and ensure that the patient understands that e-therapy’s long-term effectiveness has not yet been determined. Providers should disclose their own personal limitations, such as lack of training or experience in a particular diagnosis or treatment method, including e-therapy; patients should understand options for other sources of treatment.

PATIENT’S UNDERSTANDING AND INFORMED CONSENT

Internet communication may enable the clinician to enhance the documentation of informed consent. Many patients enjoy using the Internet to find medical information (Fox et al 2003), and computer applications have already been found to enhance the informed consent process (Rostom et al 2002; Rosoff, 1999), including significantly improved comprehension among psychotic patients (Dunn et al 2001). E-therapists may engage patients in a synchronous chat online about the process of and alternatives to e-therapy, questions the patient may have, and different risks and benefits to consider. The patient and clinician may then save and print the discussion for documentation of the patient’s understanding of the information. However, this type of informed consent could pose an additional risk. If the clinician were to forget to mention a particular risk, there would

be a written record to show exactly what had been disclosed. Providers may decide to use standardized forms of patient education in brochures or pamphlets and follow up through an Internet-based informed consent discussion. In the future, this type of informed consent may grow more common; a pilot study of one Internet informed consent program found that 95 percent of study participants found the online consent application strongly preferable to face-to-face interactions with physicians (PrivaComp, 2001).

While informed consent guidelines suggest maximal disclosure, it is unlikely that all clinicians use such a detailed procedure in practice (Schachter et al 1998). One scholar has noted the “informed consent gap” (Schuck, 1994), a discrepancy between the law in books and the law in action. When informed consent is designed merely to reduce provider liability (Hampton, 1985), the crucial phase of patient understanding (dialogue) is often omitted from the procedure, making the consent an *event*, rather than the *process* it ought to be (Appelbaum et al 1987). Event-oriented, canned informed consent procedures undermine the importance of shared decision making between provider and patient. As one commentator has remarked, informed consent in these cases has been “demoted. . . into just another issue. . . of risk management” (Terry, 1993, p.191).

In contrast to printed discussions, other methods of documenting consent may not demonstrate the patient’s understanding of the information. Signed consent forms, for example, elicit merely a signature from the patient, offering little assurance that the patient has understood what he or she has signed. Analogous to signed forms are click-wrap agreements, computer-based digital contracts in which a patient reads the terms of an agreement and indicates assent by clicking on a button saying “I accept” or “I agree.” Some websites use such click-wrap agreements to present the terms of their usage to site visitors. In some ways, click-wrap agreements resemble aspects of the informed consent process, in that they present information to a person and obtain the person’s assent. However, they do not enable a dialogue between the person clicking “I agree” and the person who is requesting consent. An ethical therapist cannot use a click-wrap agreement in place of an informed consent discussion; patients must be able to demonstrate understanding of the material. One option therapists may consider is to post to their website downloadable information so that patients may review it at their leisure; therapists may subsequently engage the patient in discussions about the material, thereby facilitating a process-oriented informed consent.

A complete and voluntary consent to e-therapy presents information in clear, consistent, simple language. Some e-therapy providers have adopted confusing disclaimers, perhaps believing that by labeling the services they provide “information” or “education” rather than “advice” or “treatment” (Scott, 2001), they will lessen their liability to the patient. On the contrary, misleading claims preclude informed consent. While some e-therapy providers offer ongoing Internet-based therapy with “licensed professional[s]” (HelpHorizons, 2004), many of these sites simultaneously state that they do not provide professional advice (Maheu et al 2000, p.486; HelpHorizons, 2004). In theory, the distinction between the provision of information and the provision of treatment is clear: the former constitutes an educational service, applicable to a wide public; the latter includes patient-specific advice sufficient to establish a therapist-patient relationship. In practice, conflicting claims and services offered through some Internet-based organizations blur this distinction (Shapiro et al 1996; Maheu et al 2000; Miller et al 2002). For many individuals, a crisis may be the impetus to seek psychotherapeutic treatment. Such patients will be less likely to read lengthy disclaimers; therefore, a continuing process of informed consent should be used.

CONCLUSION

Until a significant body of empirical research supports the effectiveness of Internet-based counseling, courts may view e-therapy as an experimental form of treatment, despite evidence of its utility (Board of Medical Regis. & Exam. v. Kaadt, 1948). Providers may choose to include a warning to patients about the evolving nature of e-therapy. To ensure that patient consent is valid, informed consent should be an *ongoing* process, re-evaluated periodically as new information becomes available. A patient’s consent may be questioned if it is obtained only at the outset of treatment.

Currently, e-therapy enjoys the support of many proponents in the mental health field. In 1997, professionals formed the International Society for Mental Health Online, a nonprofit organization designed to encourage the use of Internet technology in mental health (ISMHO, 2004). While “ISMHO does not endorse or hold any official position about the legitimacy or usefulness of e-therapy (or online counseling). . . [it] has, however, released a set of Suggested Principles for the Online Provision of Mental Health Services. . .” (ISMHO, 2004). Overall, ISMHO’s guidelines (ISMHO, 2000) call for a detailed informed consent procedure for the provision of e-therapy, consistent with other existing professional ethical

guidelines regarding mental health online (NBCC, 2001; APA, 2001; APA, 1997; AMA, 2003; FSMB, 2002; Medem, 2002). While informed consent may be obtained online, the clinician is cautioned that beginning e-therapy without an initial face-to-face assessment may incur other problems. Some jurisdictions may impose additional restrictions and requirements for informed consent to be recognized as valid, and some professional ethical guidelines suggest that treatment is unethical without an initial face-to-face assessment and in-person informed consent (APA, 2001; Medem, 2002).

By engaging a patient in an informed consent dialogue, the treatment provider allows the patient greater autonomy in the decision-making process (Schuck, 1994; Katz, 1994), protecting the best interests of the individual patient and possibly reducing provider liability. To discourage patient confusion, providers should disclose their qualifications and limitations prior to initiating a course of e-therapy and avoid characterizing their services as “educational” or “informational” when in fact they are psychotherapeutic.

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