Telepsychology in a Modern World: A Qualitative Study

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ABSTRACT

Computers and the Internet ushered humanity into a new era in the late 1990s – information on a variety of topics became widely available to the general public and it became suddenly possible for individuals to communicate with one another instantaneously regardless of each person's geographical location. According to some, the evolution of technology has outpaced humanity's ability to learn how to manage technology properly, and this appears particularly true in the field of psychology. Instant messaging, social media sites, and video conferencing have all influenced the ways in which therapists and patients can interact. Questions remain, however, about the use of this technology. This paper intends to address some of those questions by considering whether or not telepsychology is effective when it is used to conduct therapy and the circumstances under which a therapist might use a technological medium to provide such services. A review of some ethical considerations related to the use of technology in the service of providing therapeutic services is also included, as well as a discussion regarding embodiment and whether or not anything is lost in the therapeutic encounter when two individuals choose to interact with one another through the use of technology instead of face-to-face.

Keywords: Telepsychology, mental health services, efficacy, efficiency

Introduction

Telemedicine is a rapidly growing method of care delivery (American Academy of Dermatology and AAD Association Position Statement [AAD], 2004) across a variety of health care professions, including the field of professional clinical psychology. Under the umbrella of telemedicine is the area of telepsychology, which can be defined as the provision of psychological services using telecommunication technologies (Drum & Littleton, 2014; California Board of Psychology[CBP], n.d.). As many clinicians know, the phrase "psychological services" can mean any number of things – provision of therapeutic services, psychoeducation, consultation with organizations or other professionals, case management, and so forth. Likewise, telecommunication technologies can encompass a variety of methods of communication: telephone calls, video conferencing, instant messaging, email, and so forth. As the world becomes ever more connected through the use of these technologies and as behavioral health service providers face increasing demand from their patients and their patients' insurance companies to provide more cost effective services and more accessibility to these services, it is becoming increasingly important to operationalize these terms and understand how the use of technology affects the provision of psychological services and whether the quality of its provision are for better or worse.

There are various ways in which the delivery of health care services can be provided using technological means, including live, interactive methods and store-and- forward methods (AAD, 2004), but this paper focuses primarily on the use of the live, interactive delivery of services. When delivering services via live, interactive means, the participants are separated by distance but are interacting with one another in real time (AAD, 2004). Such use of technology can be considered synchronous, because both the therapist and patient are online and using technology simultaneously in order to communicate with one another. A good example of a technology that would be considered conducive to live, real time interactions would be video conferencing technology, such as Skype. This is in direct opposition to "store and forward" methods, where a patient is able to access data previously stored on a server, such as a podcast, and download it at his or her convenience without needing to interact with a mental health professional in real time. Store-and-forward methods are considered to be asynchronous, because information that might be therapeutically helpful is uploaded to the Internet in such a way that a patient can download it at a later time.

For the purposes of this paper, "telepsychology" can refer to the provision of any psychological services distributed over any technological mediums, including phone calls and video conferencing. This term is interchangeable

with the term "telemental health." As previously mentioned, telepsychology is considered a subfield under the over-arching and still emerging field of telehealth, also sometimes referred to as telemedicine (American Telemedicine Association [ATA], 2012) and e-health (Avey & Hobbs, 2013), which includes the provision of a wide variety of medical services via technological mediums, including phone calls and video conferencing. Telemedicine and telehealth are therefore considered to be the provision of any kind of healthcare service provided to a patient at a distance, while telepsychology and telemental health refer specifically to the provision of mental health, behavioral health, and psychological services at a distance (Yellowlees, Shore, & Roberts, 2009).

Efficacy

Contrary to the fears of some clinicians that it is ineffective (Kramer et al., 2010), telepsychology has already been successfully used to deliver behavioral interventions, psychological assessments, social skills training, and session evaluations to rural populations, the elderly, and patients with thought disorders (Hynes et al., 2009; Reese, Slone, Soares, & Sprang, 2015; Tuerk, Yoder, Ruggiero, Gros & Acierno, 2010). In addition, interventions implemented over the Internet have been shown to improve patient outcomes for populations suffering from both depression and anxiety disorders (Glynn, Randolph, Garrick, & Lui, 2010; Hailey, Roine, & Ohinmaa, 2008) and eating disorders (Hailey et al., 2008; Shingleton, Richards, & Thompson-Brenner, 2013). Data also suggests that the delivery of some interventions, such as manualized cognitive-behavioral treatments and treatment of posttraumatic stress disorder through the use of virtual reality is as efficacious when delivered via telehealth technologies as it is when it is delivered by a therapist who is in the same room as the patient (Frueh et al., 2007; Tuerk et al., 2010). Some studies have even shown that mental health patients treated using telepsychology continue to make gains even after treatment has terminated (Shingleton et al., 2013) and that, in some cases, telepsychology is more effective than traditional face-to-face therapeutic services (Hailey et al., 2008). This research indicates that, at least in some situations, specific disorders can be treated using various telecommunications mediums as effectively as they can be treated if the identified patient and the treating clinician are in the same room during a treatment episode, and that, at the very least, behavioral health treatment using a technological medium is better than no treatment at all.

One example of an institution that has pioneered the use of telepsychology services for the express purpose of reaching those individuals in rural and remote parts of the United States is the Alaska Psychiatric Institute (API), which holds the distinction of being the only psychiatric hospital in Alaska and the home of the Telebehavioral Healthcare Service Initiative, founded in 1997 (Avey & Hobbs, 2013). API offers direct care services such as psychoeducation and medication management to both children and adults in Alaska's frontier regions (Avey & Hobbs, 2013) and has conducted some research regarding their internal programs and processes. The Veteran's Health Administration (VA), an integrated healthcare provider within the Department of Veterans' Affairs in the United States, is another example of an organization actively pursuing the use of telepsychology. Much of the research conducted regarding the practice of telepsychology has been conducted at various VA offices and more research regarding the delivery of telehealth within that system in the future is planned.

Some of the research being conducted regarding the use of telepsychology has focused on therapists' abilities to conduct therapy successfully through the use of a technological medium. The focus of this research has been slightly different than the research mentioned above. While the research mentioned above indicates the effectiveness of providing psychological services via the use of telecommunication mediums from the perspective of the identified patient in each study, the research by Frueh and his colleagues (2007) measured therapist competency based on the research team's analysis of the clinician based on a rubric developed by the team that could be analyzed separately from subjective experience of the identified patient. Frueh et al. (2007) measured several components of therapist competence when comparing the results of manualized cognitive-behavioral therapy delivered through the use of technology against the results of that same therapy delivered by a psychologist present in the same room as the patient. The components measured by Frueh and his colleagues (2007) included the therapists' ability to structure session time, implement session activities, provide feedback, deal with difficulties, develop rapport, and convey empathy.

According to their findings, both therapist competence and adherence to manualized practices was similar for therapists conducing sessions via a

technological medium and therapists working face-to-face with a patient. Additionally, Frueh and his colleagues (2007) found that conducting therapy through the use of technology did not compromise the therapist's ability to structure sessions or build rapport, which can be interpreted to mean that conducting therapy via the use of technology may not compromise the therapeutic relationship in the way that some clinicians fear that it would. Frueh et al. (2007) discovered that neither therapist competence nor rapport building was compromised when psychological services were delivered through the use of a technological medium and, while there may be differences regarding how comfortable some populations are with using technological mediums to connect with other individuals, Wilson, Onorati, Mishkind, Reger and Gahm (2008) discovered that the participants in their study were already experienced in using the communication tools provided in the study.

Empirical data suggests that psychometric interviews completed via telehealth technologies allow clinicians to obtain the same amount of information regarding patient symptoms as interviews conducted in traditional, face-to-face encounters and that patients actually report high levels of satisfaction with services provided in this manner (Avey & Hobbs, 2013; Frueh et al., 2007; Glynn et al., 2010; Reese et al., 2015). These findings suggest that it may be possible to conduct quality therapy with patients who are unable to meet with a therapist face to face. As mentioned above, this is especially important for certain at-risk populations, such as military personnel, missionaries, students studying abroad, rural communities, and the homebound. These findings also suggest that it may be possible to provide more cost-effective mental health services to populations with low socioeconomic status, allowing them unprecedented access to care for their mental health needs. The opportunity to engage with a therapist through the use of telepsychology allows a patient to access mental health services without having to worry about costs associated with transportation, lost work time, or childcare, all of which have been identified as barriers to mental health care (Dyck & Hardy, 2013) but which may more negatively affect individuals without the resources to pay for items or services that mitigate those barriers (Reese et al., 2015). At the same time, a therapist engaging with his or her patients through the use of telepsychology may be able to communicate with patients from a home office, reducing the need to rent office space and incur all of the expenses associated with running a private practice. A therapist who finds him or herself in such a

position may have less overhead to contend with, which might allow him or her to charge lower rates than a therapist who finds him or herself needing to pay for office space, electricity for the office space, and so forth. Lowered rates might create an environment in which more patients can afford to pay for the services of a psychologist, allowing access to mental health care to individuals who might otherwise not have been able to afford to see a psychologist in a private practice setting. That being said, because individuals considered to be low SES might have more trouble accessing technology, psychologists wanting to interact with this population might need to carefully weigh both the benefits and draw-backs of setting up a practice intended to use technology to interact with these individuals. While this paper does not address the importance of ensuring that individuals living in all tax brackets have adequate and appropriate access to technology, such a concern is important for researchers investigating all aspects of health care and social justice, particularly as access to technology is becoming more and more crucial to survival in the 21st century.

Just as research has been conducted on the use of telepsychology to treat individuals struggling with mental health issues, research has been conducted on the efficacy of telepsychology interventions for the family members of these individuals (Glynn et al., 2010). The study conducted by Glynn et al. (2010) found that technology based interventions for the family members of individuals suffering from mental disorders does not seem to affect the prognosis of the individual with the mental health diagnosis, that is, the identified patient. It can be inferred, then, that it might be best for therapists wanting to engage in telepsychology to limit the interventions they deliver through the use of technology directly to the identified patient rather than to the patient's family members, even if the therapist in question prefers to use a family systems approach. Glynn et al. (2010) hypothesized in their discussion that although the use of technology to support the relatives of individuals living with schizophrenia lowered overall stress in the family system, it was not possible to replicate the effects that might be found in more traditional, informal gatherings that are common to multifamily groups. They (Glynn et al., 2010) also stated that their results may have been more significant if they had included the identified patients in their group interventions instead of simply working to support the family members of these individuals.

Efficiency

There are multiple benefits to developing and encouraging the use of telepsychology services. Patients in need of psychological services but to whom psychological services are not available due to geographic constraints, financial constraints, or medical conditions may be able to access such services when such services would otherwise be outside of their reach. For example, telepsychology would make psychological services available to potential patients living outside of the country or in remote areas (Avey & Hobbs, 2013; Luxton, 2013), such as members of the armed forces, missionaries, members of the Peace Corps, or other potential patients abroad who happen to be abroad for extended periods of time in countries where psychological services may not be readily available. Telepsychology could allow these potential patients to contact therapists in the United States or the country of their preference via a means such as video in order to find support at the moment that they need it instead of having to wait until they return home. Access to psychological services is also an issue for populations living within the country, such as those in rural areas (Avey & Hobbs, 2013; Frueh, et al., 2007; Reese et al., 2015) and the homebound, such as those too elderly or ill to drive. This is especially true for those individuals living in areas so remote that they are unable to reach urban centers or seek assistance from individuals in urban centers without boarding a plane or boat (Avey & Hobbs, 2013) and individuals facing round trips in excess of 200 miles if they feel the need to meet with a therapist (Reese et al, 2015). Those individuals who are either too ill or too impoverished to make a trip to the office of a psychologist (Glynn et al., 2010) may also find it difficult to have their mental health needs met without access to telepsychology. Glynn et al. (2010) have also found that some patients and their support groups do not attend therapy simply because their schedules do not fit with the schedules of their clinicians (Luxton, 2013).

While it may be easy to dismiss potential patients who have not yet attended therapy because of scheduling conflicts as being unmotivated or uncommitted to therapy, in major metropolitan areas where average commute times range from one to two hours, it can be legitimately difficult for a potential patient to arrange his or her schedule so as to make it to the office of a therapist before six, seven, or eight o'clock at night. An additional benefit associated with the provision of telepsychology is that if a patient does indeed miss a session because of a scheduling conflict, he or she may be able to watch a recording of the session

after the fact if the session missed was a skills building group or psychoeducation presentation (Reese et al., 2015). There is also the case of patients with diagnosed disorders that require highly specialized care, such as patients with eating disorders, who may not be able to find specialists in the areas where they live (Shingleton et al., 2013). Some research has also found that there is a belief among mental health professionals that offering telepsychology services might allow for more culturally competent care, as patients in crisis in remote or rural areas could engage with a mental health professional using telecommunication technology instead of being removed from their community and taken to an urban center (Avey & Hobbs, 2013) where they would have to manage their symptoms and heal without the benefit of being surrounded by friends and family members. For these potential patients, and for many other potential patients, telepsychology is a way of accessing mental health services in situations where it might otherwise be difficult to access such services. Several other fields, including the field of professional dermatology, have already made the delivery of their services available through the use of technological delivery methods for such populations (AAD, 2004) and video conferencing is already leading the way in rural areas as the preferred method for delivering telehealth services (Avey & Hobbs, 2013).

The American Telemedicine Association (ATA, 2012) agrees, arguing that improved access to healthcare along with the massive financial savings available to both healthcare providers and managed care providers are just two of the fundamental benefits of using telehealth technology, including telepsychology services. Decreased organizational costs are just one of the many benefits for healthcare providers interested in the use of telehealth technology (Avey & Hobbs, 2013) and it would be hoped that decreased organizational costs might translate into lower costs for patients in need of services.

That being said, while there are several benefits to adopting the use of telehealth technology for both patients and providers, there are also several drawbacks to take into consideration before taking the leap into the world of telehealth, including telepsychology. Avey & Hobbs (2013) identified several struggles identified by health care providers interested in engaging in the use of telehealth services, including barriers to provider and support staff education regarding the use of telehealth technology and questions about how to bill appropriately for such services. There are also some issues with the research regarding the

use of telepsychology itself, and these issues are addressed in the following section.

Research Methodology

As is the case with many kinds of research in new and emerging fields, there are some issues with the research that has been published regarding the administration of telepsychology services. A major limitation with the majority of the studies that have been done regarding the use of technological mediums in the delivery of mental health interventions is that most of the studies (e.g., Glynn et al., 2010; Frueh et al., 2007; Reger et al., 2011; Tuerk et al., 2010; Wilson et al., 2008) have been focused on active or retired military personnel and have had extremely small sample sizes (e.g., Glynn et al., 2010; Frueh et al., 2007; Reese et al., 2016; Reger et al., 2011; Tuerk et al., 2010; Wilson et al., 2008), which makes it difficult to apply the findings of these studies to the general population. Because the sample sizes have been so small on so many of the research studies conducted, and because cluster sampling has often been used in order to determine research participants (both identified patients and therapists), one must, again, question whether or not the sample sizes selected have been representative of the general population and, if not, whether or not the results can be applied to the general population. Many of the samples appear to be convenience samples, which makes it difficult to generalize the results of the current research to the target populations that one would hope to be able to support by using this technology. It is also impossible to ignore the fact that a handful of studies have shown telepsychology to be less effective than traditional face-to-face therapy (Hailey et al., 2008).

Also, only Frueh and his colleagues (2007) have simultaneously measured therapist competence and the efficacy of treatment, which means that the findings regarding therapist competence have not yet been replicated and could therefore be invalid if other therapists cannot achieve the same results using the same rubric used by Frueh and his colleagues (2007) in their study. Another issue is that several of the studies that have been conducted have focused on small pilot programs where one very specific aspect of the program has been measured (Avey & Hobbs, 2013), as opposed to the program as a whole. In order to be able to generalize the findings of the researchers who have been involved in studying the delivery of mental health care services through the use of technology, more studies using far larger sample sizes need to be conducted and therapist competence needs to be measured at the same time that the efficacy of the treatment being offered is measured. The best case scenario would be a large scale experiment using a stratified random sample taken from the target population where each subject in the study has an equal chance of being assigned to the control group or to the experimental group. A larger sample size, constructed in such a manner, might improve the external validity of the study which may create a space for practicing clinicians to accept the general use of telepsychology, which may in turn encourage managed care providers to pay for such a system. It may also be beneficial to conduct thorough program evaluations for those institutions already offering telepsychology services so that the scientific community could gain a better understanding of the systems required to run a successful telepsychology service, what patient outcomes and satisfactions surveys indicate regarding progress made in therapy and the therapeutic alliance, and what lessons can be implemented to ensure that services offered in such a manner are continually improving.

Luxton (2013) points out that there are also problems with the research conducted regarding economic value of telepsychology. As he describes in his 2013 paper regarding this topic, economic evaluations of telepsychology are complex because they include aspects of both the healthcare field and the world of technology and therefore require that additional factors be taken into consideration. In his literature review, Luxton (2013) found that several of the problems reported with regards to the research concerning the efficacy of telepsychology are also true about the research regarding its economic value – the studies have all focused on short term pilot programs and there is a dearth of research conducted using random control trials. Additionally, while there has been research into the efficacy of telepsychology and research conducted into its cost-effectiveness, there has yet to be a study that looks at efficacy and cost-effectiveness simultaneously, which means that the scientific community is missing a vital piece of information with regards to telepsychology's overall effectiveness. The effectiveness of a technological medium, after all, has to do with more than its end result – it has to do with the cost associated with its implementation and maintenance and whether or not it is possible to maintain its infrastructure over the long term.

A recommendation made by Reese et al. (2015) with regards to addressing the dearth of robust research regarding telepsychology is that clinicians and researchers use a benchmarking strategy, particularly in situations where randomized, controlled trials are not possible. They

recommend benchmarking as a way to evaluate the effectiveness of a given treatment as compared to reliable effect sizes found in clinical trials or through the process of meta-analysis (Reese et al., 2015). It should be noted that while Reese et al. (2015) made the recommendation to use benchmarking as a way to address some of the issues with research in the area of telepsychology, their own sample size was fairly small, indicating the small *n*'s seem to plague the research field in the area of telepsychology even when the researchers in question have noted that small sample sizes are an issue. In order to be able to generalize the results found in the current literature to the demographic groups most likely to benefit from the use of telepsychology, much larger sample sizes comprised of randomly selected members of the target populations are needed.

Embodiment

As noted above, even with some of the problems associated with the research into the intersection of psychology and technology, there are cases that suggest that the use of technology to deliver psychological treatment is effective. When given the choice between having no contact with a therapist and communicating with a therapist via a technological medium, the evidence seems to indicate that, for at least some patients, communication via a technological medium is preferred. One must also consider, however, the issue of embodied presence. In at least one study, participants indicated that they missed the person to person interaction that they would have received from an in vivo experience, even when they reported being satisfied with the interventions and information provided to them via video conferencing (Reese et al., 2015). Are there aspects of traditional, face-to-face therapy that do not translate to telepsychology? Is there anything lost when two people communicate with one another's images rather than with one another directly? One cannot discount that, while some patients prefer to obtain behavioral health services via a technological medium, there are some who do not (Shingleton et al., 2013). As Paul Stepansky (2010) writes in the preface to Bodies in Treatment: The Unspoken Dimension, any struggling individual choosing to enter therapy is "a body in treatment" – how can we then, as clinicians, discount the somatic dimension to the work done in the therapy room, particularly when somatically centered experiences can be richly informative? If our bodies are how we engage with the world and the primary tool we use to interpret and understand our environments, it seems that something meaningful

would be lost by removing either a patient's body or a therapist's body from the therapy room.

Nonverbal communication is essential to the ways in which human beings exchange ideas and stories, and while many nonverbal cues are expressed through the movements of the face, body postures are another necessary and perhaps even more primal means of communication (Wilbarger, Reed, & McIntosh, 2011). Body posture opens a window to the emotions and intentions of others (Wilbarger et al., 2011), allowing us to understand them better even when no explicit communication has been shared. Because the ability to see and then reflect body posture and even facial expressions is limited when a therapist uses a technological medium to conduct therapy, one must wonder about the change this causes, if any, in the felt experience of either the therapist or the patient. In at least one study, therapists engaging with patients through the use of telepsychology noted that they felt some differences when communicating with patients through video conferencing as compared to their interactions with patients during in vivo sessions (Reese et al., 2015). This same study confirmed that nonverbal communication such as making eye contact and nodding was indeed more problematic when using telepsychology to deliver mental health services than during in vivo psychotherapy sessions (Reese et al., 2015). This piece of information is perhaps especially important with considering how well a therapist might be able to perceive the emotions of his or her patient when engaging in telepsychology, particularly as there has been support in the literature that indicates that one's own body is often used to recognize the emotional expressions of others (Cornell, 2010; Wilbarger et al., 2011).

Shingleton et al. (2013) ask this same question, wondering how much information, if any, is lost in the evaluation and diagnostic process when a clinician interacts with a patient solely using a technological medium as opposed to meeting with a patient face to face. Luxton, Pruitt, and Osenback (2014) state that much is indeed lost when a clinician and a patient or prospective patient choose to engage in telepsychology rather than traditional face to face psychotherapy. Luxton et al. (2014) state, for example, that the lack of olfactory information available to a clinician when he or she chooses to engage in telepsychology with a patient can limit the observations a clinician may make regarding a patient's hygiene practices as well as the patient's potential use of alcohol and/or other substances. Another potential problem that may arise when using technology to conduct psychotherapy is the issue of eye contact, or,

perhaps, the lack thereof. The term "eye gaze angle" refers to the angle between the camera on a computer and the eye of the person using the computer and the eye of that user and the center of the computer's display. As Luxton et al. (2014) point out, consumers who frequently use video-conferencing systems tend to keep their vision fixed on the image of the person with whom they are video-conferencing, rather than keeping their eyes on the camera.

This causes each person to experience the person with whom they are conversing as looking down and away from them rather than at them (Luxton et al., 2014), and this problem is difficult to remedy, because even if both users simply looked into their cameras, all they would see is a camera staring back at them. While camera adjustments and picture-in-picture technology may, in some cases, alleviate this issue, it is possible that it will remain difficult to replicate the felt sense of shared eye contact and intimacy when using technology to communicate over distance.

While the answers to the above stated questions are not the focus of this paper and therefore cannot be explored as thoroughly as might be preferred in pursuit of understanding both the benefits and drawbacks of telepsychology, there are many psychologists who firmly believe in the power of mutual regulation within the context of a therapeutic relationship and, sadly, much of that which is mutual about a therapeutic relationship can feel different or nonexistent when two bodies are not present with one another while doing the important work of therapy. If implicit memory forms the core self (Cornell, 2010) and if the purpose of therapy is to help the patient make the implicit explicit, it seems as though there would be something lost in the therapeutic encounter if the therapist is kept from being able to experience fully the presence of the patient and thereby all of the nonverbal clues and gestures that might have helped him or her gain some insight into the patient's unconscious processes. One must wonder if, in a zeitgeist where the connection between the mind and the body is again gaining prominence, a move towards embracing telepsychology might undo some of the progress made regarding holistic care so that therapists again focus on the mind and the body as two separate aspects of a person rather than as an integrated whole.

Ethics

As mentioned at the start of this paper, one of the aspects of telepsychology being considered here concerns the ethics of using such technology to provide patients with mental health services. While most of this paper can be thought of as a philosophical argument regarding the use of such technology based on the evidence both for and against it, it seems imperative to review the ethical standards related to the use of such technology. The state of California recently developed a set of recommendations meant to guide psychologists as they begin to think about this issue, particularly as there are so many components of telepsychology that are not at all relevant to the provision of traditional psychotherapy services. This portion of the paper attempts to acquaint the reader with both the standards being developed in California and an analysis of those standards.

As is always the case in the provision of psychological services, the two most important components to consider when thinking about the implementation of telepsychology are the level of training the therapist involved has received in the provision of telepsychology and the level of understanding the patient has with regards to the associated risks (CBP, n.d.). With regards to the therapist's level of training, it is important for the therapist to understand the technology used, how to use the technology, and how to repair the technology should the technology fail him or her while in the midst of providing services using the technology. Research shows, after all, that it is easy for a patient to find technical issues distracting to the therapeutic process and frustrating to contend with (Reese et al., 2015). Therapists should, for example, be trained in various technological means of communication and also know basic information regarding wireless and wired networks so that they can engage in simple troubleshooting in the event of a network failure. This knowledge would also be important so that the therapist in question could provide his or her potential patient with the appropriate information required by the patient in order for the patient to be able to give his or her informed consent. This issue of informed consent is of paramount importance when delivering any kind of psychological services but becomes even more important when one considers the additional risks involved with communicating via various technological means. Many of the ways in which individuals communicate with each other daily are not secure, but most individuals remain unaware of the risks associated with their use of technology.

Cell phone calls, text messages, video conferencing, Skype, and so forth, are all fairly easy to access, if one knows how to do so, and certainly do not meet HIPAA requirements for confidentiality and the protection of private health information. Before engaging in telepsychology using any of these means, or any other means of

communicating via technology for that matter, it is important for a patient to understand such risks and in order for the patient to understand the risks, the therapist must be able to explain them. Therapists must also understand that the technology they use to provide mental health services may fail them from time to time and should explain the possibility of this to patients while in the process of obtaining informed consent. Therapists should also be able to work collaboratively with patients in order to develop contingency plans in the event that technical difficulties interfere with a session and should ensure that access to technical support will be available to them in a timely fashion.

To that end, the California Board of Psychology has recently compiled a set of guidelines for those clinicians who choose to engage in the practice of telepsychology. These guidelines encourage practitioners to be familiar with relevant laws and regulations when providing psychological services across jurisdictional and international borders and to comply with such laws (CBP, n.d.). Much like the ethics code published by the American Psychological Association (APA), the guidelines for the use of telepsychology in the state of California are "aspirational in intent" (CBP, n.d.; APA, 2010) and are meant to serve as exactly what they are called – guidelines, not enforceable rules, and not laws, but guidelines. According to the California Board of Psychology, they are meant to facilitate the continued systematic development of the profession and help ensure a high level of professional practice by psychologists. This stated intention of the as-yet-to-be- published guidelines is of paramount importance, particularly since so much of the technology used in the world today is relatively new, especially when compared to the history of clinical psychology.

Ethical Guidelines

Guideline #1

The first of the ethical guidelines proposed by the California Board of Psychology (CBP, n.d.) addresses exactly this issue, stating that psychologists who provide telepsychology services should strive to take reasonable steps to ensure their competence with regards to the technologies they employ in the provision of these services. The knowledge required to use telepsychology tools lies outside of the scope of professional psychology practice, after all, and requires a special skill set (Johnson, 2014) not generally communicated in graduate psychology programs. That same guideline states that psychologists using such technologies should take reasonable steps to understand the impact of such technologies on their patients, supervisees, and other professionals (CBP, n.d.). The American Telemedicine Association echoes this, stating that health professionals engaging in telepsychology must have the necessary education, training/orientation, and continuing education/professional development to ensure they possess the necessary competencies for the provision of quality health services through the use of technological mediums (Yellowlees et al., 2009). Because the technologies used to provide telepsychology services are relatively new and most graduate programs do not train their students specifically in the use of such technologies, psychologists have been left to learn about these technologies on their own and to pass on what they know to their patients and supervisees. Some health care professionals have begun to investigate the various technologies available for the use of delivering healthcare via technological means and have made recommendations regarding the systems and networks that can be used. Dermatologists have, for example, ascertained that a minimum connection speed of 384 kbps be used when engaging in video conferencing (AAD, 2004). The American Telemedicine Association also recommends that practitioners engaging in any kind of telemedicine service provision use technology able to reach a connection speed of at least 384 kbps and also state that audio settings should be set to 7 kHz full duplex with echo cancellation so as to eliminate background noise in the rooms on each side of the connection (Yellowlees et al., 2009). The American Telemedicine Association also recommends that flat conference-style microphones be used for video-conferencing and that participants in a telepsychology session be sure to conduct each side of the session in a "quiet room," a room equipped with carpeting and soft furnishings, as such surroundings improve the audio quality of a conference call (Yellowlees et al., 2009).

Consider the following example: a therapist living in a large urban center receives a request to provide treatment to an adolescent experiencing behavioral issues associated with the loss of a parent. The adolescent lives in a small rural community and the therapist therefore assumes that he or she is the best provider to work with the adolescent, particularly as there are few therapists in the adolescent's area able to provide treatment. While there might be several cultural factors that eventually come into play in the above- described therapeutic alliance, some of those cultural factors might be associated with the differences found between living in a city

and living in the country. A therapist not accustomed to rural life or to working with patients in rural settings might become frustrated by the lack of resources available to the patient and might even become frustrated with the patient's seeming complacency regarding what the therapist experiences as a lack of resources. If the adolescent happens to come from a small community where the expectation is that each member of the extended family be included in the adolescent's treatment and care, the therapist might have to come to terms with including large groups of people in the video-conferencing sessions every once in a while and might have to figure out how to explain why release of information documents are needed, especially if the inclusion of family members in sessions seems completely common and necessary to the adolescent and his or her family members. Communication about differences in opinion might need to be even more explicit than what is generally found to be the case in a therapeutic alliance and the therapist and adolescent would both have to actively work to understand the assumptions that each of them, being from very different environments, might bring to the treatment. Such would be the case in any therapeutic dyad where the therapist is in one environment while the patient is in another, and so these issues would need to be addressed.

Yet another issue related to multiculturalism has to do with potentially differing attitudes regarding the use of technology in and of itself. Older adults are much less likely than younger adults to use computers and the Internet (Czaja et al., 2006) for a variety of reasons, and might find less value in the use of technology due to having less exposure to it. Individuals who have spent most of their lives engaging with others in vivo might have very different beliefs about technology, its usefulness, and its appropriateness and may therefore dislike the thought of interacting with a psychologist or any health care provider in such a way. The same could be said for communities that believe in restricted use of technology, such as the Amish, or individuals who believe that constant exposure to technology can be harmful, such as those who report feeling pain or discomfort when near certain types of technology.

Guideline #2

The second ethical guideline proposed by the California Board of Psychology states that psychologists choosing to serve their patients via telepsychology means must make every effort to ensure that ethical and professional standards of care and practice are met at the outset and throughout the duration (CBP, n.d.) of therapy. The American Telemedicine Association echoes this standard, stating that appropriate staff must be available to meet patient and provider needs before, during, and after telehealth encounters of all types (Yellowlees et al., 2009) and that clinicians choosing to participate in any kind of telemedicine provision should ensure that the standard of care delivered via telemedicine is equivalent to the standard of any other type of care that can be delivered to the patient, considering the specific context, location and timing, and relative availability of in-person care (Yellowlees et al., 2009). This standard conveys the message that ethical guidelines and state laws should be adhered to equally well whether the patient is being seen by the psychologist in person or whether they are being served via telepsychology, but, perhaps more importantly, that standards of patient care should remain equally high regardless of the mode of service delivery. This means that if a therapist is given to providing 50-minute sessions to patients who come to his or her office, 50-minute sessions should be offered to patients wanting to engage the therapist in telepsychology, that outcome measures be administered to patients engaging in telepsychology if they are being administered to patients pursuing care in vivo, that initial paperwork for telepsychology patients be filed in the same way that paperwork for in vivo patients is filed, and so forth. In order to ensure that the patient care delivered to patients via telepsychology means remains of the highest caliber, the California Board of Psychology, through the Guidelines for the Practice of Telepsychology, encourages practitioners to conduct an initial evaluation with a patient who is requesting telepsychology services prior to the start of therapy to ensure that delivery via such means is appropriate when the patient's presenting problem is taken into account.

Just as a potential patient and therapist might meet in person in order to conduct an initial evaluation, discuss the patient's presenting problem, and get to know one another in order to ensure that they are a good therapeutic fit before starting therapy, a psychologist providing services via technological means should ensure that he or she and the potential patient are a good fit. During this initial evaluation, the psychologist can also weigh the benefits of the particular patient engaging in telepsychology versus the risks associated with the particular patient receiving therapy via such means (CBP, n.d.). The California Board of Psychology even goes as far as suggesting that this initial

evaluation be conducted face to face, prior to the start of telepsychology services even being agreed upon.

In a traditional therapeutic relationship, both the therapist and the patient are fully responsible for the work that is done in the therapy room. The therapist must do his or her best to apply his or her theoretical knowledge and clinical experience and judgment in such a way that allows the patient to find relief from his or her symptoms, and, at the same time, the patient must be honest about his or her symptoms and do his or her best to comply with treatment in order for his or her symptoms to be reduced. In much the same way, both the psychologist and the patient are fully responsible for therapy conducted via telepsychological means. As previously mentioned, in telepsychology, the therapist conducting therapy via such means has some additional responsibilities that he or she might not have to take upon him or herself in a traditional therapeutic relationship, such as being familiar with the technology being employed and ensuring that the patient is aware of the risks and potential breaches of confidentiality inherent to the use of any telecommunications equipment. The California Board of Psychology suggests that a patient receiving care via such means also has some additional responsibilities with regards to the care being received, such as ensuring that he or she is in a comfortable setting while receiving care and that sessions will not be interrupted (Drum & Littleton, 2014; CBP, n.d.; Luxton et al., 2014). It might be helpful, for example, for a patient interacting with a therapist from a work environment to ensure that there is a private office with a door that closes that he or she could use during the session and that the office is equipped with whatever technology is necessary for the session to run smoothly. A patient interacting with a therapist from his or her home might want to ensure that partners, children, and relatives know that the patient needs some time during which he or she will not be interrupted, that pets will not need to be walked or cared for in the middle of the session, that doing chores while interacting with the therapist may not be appropriate, etc. It may also be conducive for a patient to ensure that he or she will not be overheard during the session and that confidentiality on his or her end of the line, so to speak, is his or her responsibility, as no psychologist providing telepsychological services can control the environment that the patient is in and the security of that environment when the patient is in a location that differs from the psychologist's location. The American Telemedicine Association goes as far as saying that

all persons in the rooms at both sites must be identified to everyone participating in the consultation taking place (Yellowlees et al., 2009). They recommend that disclosing persons who are attending the consultation be done by panning the camera from one end of the room to the other, or at a minimum, announcing the presence of individuals present and asking everyone's permission for additional persons to be in the room (Yellowlees et al., 2009). They also state, however, that such precautions are not necessary if the clinician believes it necessary for the identified patient to have someone in the room with him or her due to safety concerns (Yellowlees et al., 2009).

Guideline #3

As previously mentioned, perhaps the most important component to consider when providing telepsychological services has to do with the level of informed consent that a patient is able to provide at the outset of therapy. The third guideline proposed by the California Board of Psychology references this and states that psychologists must strive to obtain and document informed consent that specifically addresses the unique concerns related to the telepsychology services they provide (CBP, n.d.) and that they are aware of not just the laws and regulations that might govern their use of such technologies, but that they are aware of the internal requirements of their specific organizations as well (CBP, n.d.). The American Telemedicine Association further states that organizations and practitioners need to have agreements in place to assure licensing, credentialing, training, and authentication of patients and practitioners as appropriate according to local, state, and national requirements (Yellowlees et al., 2009).

This requirement to obtain proper documentation regarding informed consent that specifically addresses the particular issues related to telepsychology appears to be easy to comply with, at first glance, but complications arise when one begins to consider how to deliver initial paperwork to a new patient and how to receive back the signed forms. For example, if a psychologist typically has new patients complete an intake form, an informed consent form, and a form detailing cancelation and financial policies, it seems rather simple to add one more piece of paper to the packet of a patient asking for therapy via telepsychological means. All the psychologist needs to do is draft a form outlining the inherent risks to privacy and confidentiality associated with telepsychology. The issue becomes complicated when the psychologist needs to send the forms to the patient. The forms could be mailed, or faxed, or emailed, but mail is

slow, which would cause there to be a delay in the start of therapy, most email servers are not secure enough to be considered HIPAA compliant, and unless the patient has a secure fax machine, there exists the possibility that someone in the patient's home or office might accidentally pick up the fax before the patient sees it. Once the patient has the paperwork and signs all of the required forms, the same issues arrive upon the patient attempting to return the documents.

Another issue that may arise in the process of procuring such documentation has to do with the consent needed from a parent or legal guardian when the telepsychology being requested is for a minor. While a minor is able to assent to therapy, a minor is not legally able to give consent for therapy services in most states, which is fundamental to the process of obtaining informed consent. While it may be easy to distinguish a child from an adult, it is less simple to distinguish a 17-year-old from an 18-year-old, and in many parts of the United States, the age of consent is 18. A psychologist being asked to provide telepsychology services for a minor or for a potential patient who might be a minor might then find him or herself in the position of needing to verify the age of the potential patient by requesting a copy of the potential patient's driver's license or passport and might then need to obtain the consent of the potential patient's parents or legal guardians before therapy can ensue. Issues related to age arise even when the age of consent in a given state is under 18. In Pennsylvania, for example, the age of consent needed to obtain therapeutic services is 14. This means that young adolescents can seek therapeutic services without the consent of their parents, but situations regarding access might arise if such young adolescents attempt to obtain telepsychology services. Such young adolescents may encounter more difficulty accessing the items they need to obtain services, sending paperwork back and forth, and so forth. Entwined with this issue is the question of whether or not specific technologies have age limits prescribed by their developers and manufacturers and, if so, how these issues can be navigated. Does Skype set an age limit for its users, for example? Does someone creating a GoToMeeting account have to attest to being a certain age in order to proceed with the creation of an account? How is a psychologist to respond or proceed if he or she becomes aware that someone has lied about his or her age in the process of procuring mental health services from the psychologist in question? Each of these situations should be thoroughly thought through before a psychologist delves into the world of telepsychology.

Because of the complex nature of delivering mental health services via telepsychology, the California Board of Psychology suggests including information on what patient information will be stored, how that data will be stored, how the data will be accessed by the psychologist, how secure the chosen technological medium of communication is considered to be, and any potential risks to confidentiality and privacy in the consent form pertaining to the provision of services via telepsychology (CBP, n.d.). This is especially important when providing telepsychology services, even more important than when providing general telehealth services, because of the enhanced requirements for privacy and confidentiality afforded to patients receiving mental health care in the United States (Yellowlees et al., 2009). For example, if the psychologist is willing to communicate with a patient via email, he or she should explain that emails sometimes travel through multiple servers and that it is therefore difficult to assess how secure email communication might be. Another option might be for a psychologist engaging in telepsychology to use an encrypted form of email. Therapists engaging in telepsychology should also ensure that their computers and email are password protected and/or encrypted. Furthermore, psychologists may want to consider developing agreements with their patients so that the patients assume some role in protecting the data and information (CBP, n.d.) they receive from the psychologist. In the case of email, for example, the psychologist may ask the patient to agree to refrain from forwarding any emails the psychologist sends him or her (Drum & Littleton, 2014); in the case of a phone call or video chatting, the psychologist may ask the patient to use headphones or a headset when communicating with the psychologist or to refrain from using a speakerphone. Whether a patient agrees with such requests is, of course, up to the patient, but a clinician practicing telepsychology should provide the patient with information about privacy concerns related to such considerations in order to support the patient in making the decision he or she feels is best.

Guideline #4

The fourth guideline set forth by the California Board of Psychology echoes APA ethics code 4.01 and states that psychologists who provide telepsychology services must make reasonable efforts to protect and maintain the confidentiality of information pertaining to their patients (APA,

2010; CBP, n.d.). This same guideline reiterates the need to communicate to patients the increased risk regarding the loss of confidentiality inherent to the use of telecommunication technologies and goes a step further to remind psychologists that any activity on the Internet on their behalf has the potential of being seen by their patients and could therefore compromise the therapeutic relationship (CBP, n.d.).

Engaging with social media has become normative in much of the world, particularly in the western world, and psychologists living in the United States are no exception to this trend. Billions of people access social media every day, whether it be Facebook, LinkedIn, Pinterest, or Instagram, and these sites often allow others to see what a user posts on his or her page or site even if the user is not connected to that specific person on social media sites. It is entirely possible, especially in small or tight-knit communities, for a patient to be a friend of a friend or the acquaintance of an acquaintance and stumble across his or her therapist's social media activity without meaning to do so. It is also possible for a patient to search for his or her therapist by name or email address in the search bars of any of the above mentioned sites or even on Google and every precaution should therefore be taken by psychologists to hide their activity online so as to avoid compromising their therapeutic relationships with their patients.

Issues related to the interconnectivity available through the use of the Internet and how psychologists should manage their online presence are related to ideas about boundaries and how boundaries should be managed within the therapeutic relationship.

As Drum and Littleton (2014) point out, psychologists engaging in the provision of telepsychology services might find themselves in relatively novel situations with regards to boundaries and may need to develop additional plans and processes to ensure that they are maintaining appropriate and professional boundaries. They (Drum & Littleton, 2014) argue that because telepsychology is a relatively new practice, neither psychologists nor patients may have clear ideas about what boundaries should look like in such a nontraditional setting, which makes it more likely that boundary challenges will arise. Drum and Littleton (2014) state that because idiosyncratic boundaries can be harmful to patients, a psychologist engaging in the use of telepsychology should know how he or she plans to manage boundaries prior to engaging in the provision of such services.

Drum and Littleton (2014) also note that when therapists have the flexibility to manage therapy sessions from home, they themselves may act in a less formal manner and make the mistake of acting more like a friend and less like a therapist. Another concern presented by Drum and Littleton (2014) related to potential boundary issues is that psychologists engaging in the provision of services via telepsychology might be susceptible to succumb to working while ill, while traveling, or while on vacation. When engaging in traditional psychotherapy, such temptations are less likely to turn into boundary issues because the psychologist is out of the office and the patient is more likely to have learned that he or she cannot access the clinician in non-emergency situations when the clinician is out of the office. In their 2014 article, Drum and Littleton make several recommendations to help psychologists maintain appropriate boundaries when working with patients through the use of telepsychology, including maintaining traditional business hours and setting expectations with patients about how and when it is appropriate to communicate with the psychologist in question. Setting clear boundaries at the outset of telepsychology might be the best way of ensuring that boundary crossing is kept to a minimum. They (Drum & Littleton, 2014) also recommend that psychologists engage in telepsychology that includes a video component from a consistent environment and that engaging in such services from a consistent environment might help the psychologist to communicate safety, privacy, and stability, all of which are components of maintaining healthy boundaries in therapeutic relationships.

Guideline #5

The fifth guideline set forth by the California Board of Psychology continues with the theme of the fourth guideline and states that psychologists who engage in the provision of mental health services through the use of telepsychology must take appropriate security measures to ensure that the information they receive from their patients is secure from unintended or unauthorized access (CBP, n.d.). The American Telemedicine Association echoes this, stating that health organizations and practitioners engaging in the use of telepsychology need to determine processes for the documentation, storage, and retrieval of telepsychology health records (Yellowlees et al., 2009). This means that both the physical telecommunication devices used by psychologists in the provision of telepsychology services and the means by which these devices are used must be secure. HIPAA regulations and the ingenuity of

programmers can assist psychologists with ensuring that they are compliant with this particular portion of the guidelines for the practice of telepsychology.

Just as a behavioral health provider is responsible for securing patient information in his or her possession, so too is that provider responsible for doing his or her best to protect patient information transmitted to him or her via various technological mediums, or, at the very least, providing a prospective patient with information regarding the risks to his or her privacy should he or she choose to engage with his or her attending clinician via electronic methods. As mentioned previously, most clinical psychologists – most behavioral health experts, in general – are not trained in the provision of telepsychology services and, therefore, must integrate their personal knowledge of technology with their professional training in the field of mental health. The trouble with such a proposition is that the majority of the general public, behavioral health professionals included, have access to a limited amount of information regarding the true nature of Internet security and so may place themselves or their patients at risk simply for a lack of knowledge. Some behavioral health providers, for example, use Skype as a way of providing services to patients in distant locations without realizing that Skype encryption protocols do not meet the minimum requirements set forth by HIPAA standards governing patient privacy. HIPAA laws require a 128 bit encryption (Yellowlees et al., 2009), a standard which Skype technology does not meet, and yet behavioral health providers use the technology because it is well-known, free, and easily accessible.

Yet another level of security possible for cellular phones involves the installation of a security system on the cell phone, such as the Lookout Mobile Security application available in the Google Play store. The Lookout Mobile Security application allows the owner of a cell phone to control the phone or find the phone if it is ever lost or stolen by interacting with the cell phone's environment through the phone itself. For example, if a cell phone requires that a PIN be entered in order to access the phone and the PIN is entered incorrectly too many times, the Lookout Mobile Security application takes a photograph with the front-facing camera on the phone, capturing the culprit's face, and then sends that photograph to the email address that the owner of the cell phone has registered with the application. The application also stores information on the phone's location and uploads it to the Lookout Mobile Security website and allows the owner of the phone to reset the

phone to factory settings from a remote location, thereby erasing all of the information on the phone, in the event that the phone cannot be recovered. All of these capabilities could be of monumental importance to the owner of a cell phone, especially if the cell phone has been lost or stolen, especially if the owner of the cell phone happened to be a psychologist who had been using the phone to store patient information, such as contact information or recordings of sessions.

As the California Board of Psychology points out in their document, Guidelines for the Practice of Telepsychology, theft and loss are not the only potential threats to the security of information stored on a computer or cell phone. Other threats include viruses, hackers, damage to the devices, the failure of an installed security system, flawed software, or malfunctioning or outdated technology (CBP, n.d.). While some of these factors may be out of the direct control of the psychologist using electronic devices for the provision of psychological services, good electronic hygiene, such as the security measures listed above along with regularly updating software and old hardware, can prevent or at least limit unintended or unauthorized access to patient information stored on electronic devices.

Conclusions and Future Study

The last several decades have been remarkable in terms of the advances made in the fields of science and technology, and nowhere is that more true than with regards to the methods of communication used by human beings to communicate over vast distances. There was once a time where making a simple phone call or sending a telegram was considered to be the leading edge of telecommunication – now, human beings have access to the Internet, video-conferencing, smart phones, text messaging, instant messaging, social media applications , etc. It is just as possible today to make a phone call from a private home as it is to send an email from the middle of the Atlantic Ocean as it is to upload a video to the Internet from a cave in the middle of the desert. Human beings have raced to keep pace with the speed at which technology has been advancing and several fields have struggled to keep up with all of the changes rapidly occurring, including the field of psychology, which is just now beginning to consider the ways in which advances in telecommunications may benefit a variety of patient populations.

While a substantial amount of progress has been made in the field of psychology with regards to telepsychology and its benefits and risks, there is still much to be discovered. As mentioned, while there are certainly some institutions leading the way with regards to the implementation of telepsychology, all of the studies conducted thus far in pursuit of understanding telepsychology have had small sample sizes, which make it harder to extrapolate the results of those studies to the general population, no matter how encouraging those studies might be. None of the studies mentioned during this paper's literature review included conditions in which either subjects or treatment conditions were randomly assigned, which is another area of concern insofar as extrapolating the included data is concerned. There have also been few studies that assess both the efficacy of treatment delivered via telecommunications means while at the same time objectively measuring the clinician providing such services against an agreed- upon standard. It would certainly be beneficial for both the field of psychology and its prospective future patients for such studies to be conducted, on a large scale, so that the field can begin to consider both the benefits of telepsychology and its inherent risks from a broader prospective. Because at least one study reviewed for this paper found that patients being served via telepsychology seemed to prefer Internet and telephone-based interventions to video-conferencing services (Hailey et al., 2008), it might also be interesting to investigate whether practice standards should be developed to govern each method available for the provision of telepsychology services in order to ensure that patients are receiving quality care regardless of the way in which they are interacting with their therapists.

One way in which mental health professionals can learn how to manage their use of technology in the provision of psychological services is for the profession to formalize training in the provision of telepsychology. Psychologists who choose to engage in telepsychology can be required to complete a certain number of continuing education units regarding the topic each year, for example, in much the same way that licensed psychologists providing supervision to unlicensed psychologists are required to complete a certain number of continuing education units regarding supervision. The resources listed in Appendix A include organizations and websites that are leading the way with regards to how such training might be provided. Doctoral programs can also begin to provide training to their students regarding their

use of technology. Such training can include information regarding online security and basic knowledge of secure videoconferencing software. An entire course need not be necessary for the delivery of this information – a lecture delivered as part of an ethics course or a one-day seminar may be sufficient for communicating the points the psychologist providing the training believes relevant. More in-depth training might be necessary if a psychologist decides to use telepsychology as his or her primary means of service delivery. In that case, it may be best for the psychologist to receive training from an expert in the mode of technology that he or she has chosen to use. This would support the psychologist in providing the best care possible to the clients he or she is serving by allowing him or her to know enough about the technology to provide his or her patients with accurate information during the informed consent process. Johnson (2014) argues that training in the use of telepsychology should include supervised experience in the provision of telepsychology as well as additional training in ethics and the kinds of evidence-based practices most suitable to telepsychology. He also argues that specialized training in communicating with patients and evaluating patients might be necessary to help the telepsychology practitioner accomplish these tasks as smoothly as possible even in the face of technical difficulties (Johnson, 2014). This level of advanced training would also afford the psychologist interested in telepsychology to understand the benefits and pitfalls of using the medium he or she has selected, how to use the medium with professionalism and fluency, and how to troubleshoot any issues that might arise in the course of providing a patient with telepsychology services.

At the end of the day, perhaps that is the most important and salient piece regarding the conversations that have arisen around the topic of using technology to assist in the delivery of psychological services: do patients know what they are consenting to when they agree to receive psychological services via a technological medium? Do they know that there may be greater risks to their privacy? Do they know that information communicated via video-conferencing and email is much more likely to be lost or obtained by unauthorized sources than information that is discussed between two people face to face? Perhaps the question is not about whether or not to video conference with a client, or about whether therapists should communicate with patients via text message, or about whether or not an organization should use electronic records, rather,

the question is about whether or not our patients know what they are consenting to when we invite them to engage with us through the use of telepsychology. It may be sufficient, from both a legal and ethical perspective, to provide a prospective patient with accurate information and allow the patient to decide whether or not he or she would like to continue to pursue telepsychology. As clinicians, we offer such choice points to patients at other critical junctions – patients are informed that confidentiality will be breached if they plan to hurt themselves, if they plan to hurt another, if they know of a child or dependent adult being abused – and allow them to decide what information they will reveal to us regarding such matters. It is possible for telepsychology to be administered in a similar way – for a clinician to inform a prospective patient that he or she truly has no control over information communicated via email or video-conferencing, but that such treatment may still be efficacious and then allow the patient to decide whether or not he or she will

continue to pursue such treatment. Similar information can be shared with patients about potential differences in the felt experiences of patients being offered telepsychology versus in vivo therapy. For some prospective patients, knowledge of the additional risks and differences inherent in the delivery of such services may prove to be too much for them and they may choose to forgo services or wait until they can determine the best way to receive such services face to face. For other patients, such risks and differences may appear inconsequential in the face of the potential benefits of such services.

Ultimately, the question is whether or not we, the clinicians responsible for providing the services or not providing the services, as it may turn out, will be able to provide patients with a fair and balanced assessment regarding the risks and benefits of telepsychology and then allow patients to make their own choices with regards to the provision of care.

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