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Internet Psychotherapy: Current Status and Future Regulation

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NOTE

INTERNET PSYCHOTHERAPY: CURRENT STATUS AND FUTURE REGULATION

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I. INTRODUCTION

The client is living and working in a native village in the Arctic Circle. And is depressed. The psychologist is in Maryland. They're meeting for counseling sessions—on the Internet. Over time, they've worked out how to meet regularly by e-mail, ar-

> ranged how to pay for therapeutic sessions [and] found an electronic manner to explore treatment for someone in a place that's about as remote as they get.[1]

THIS VIGNETTE IS NOT a science fiction prediction of the psychotherapeutic treatment of the future, but an event that may be happening as you read this Note. It is part of the social revolution sparked by the use of the Internet to conduct rapid global communications unencumbered by the limitations created by territorial borders and time zones.[2] This ability to transcend time and geographic boundaries is creating new realms of human activities[3] in the virtual world of "cyberspace."[4]

With Internet psychotherapy it is now possible to live in the Arctic Circle or "Small Town, U.S.A." and receive psychological assistance from a therapist in Philadelphia, Pennsylva-

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1. Terry Schwardon, *Postcard from Cyberspace: Personal Technology: Not All Therapy May Be Net-Worthy*, L.A. TIMES, Mar. 31, 1997, at D5 (discussing the development of Internet-based practice guidelines).

2. Recent estimates suggest that 40 million people are now connected to the Internet and that as many as 20 new users log on every 30 seconds. *See* John Simons, *Waiting to Download: Only Market Forces Can Unclog the Internet*, U.S. NEWS & WORLD REP., Dec. 30, 1996, at 60. The government estimates that the number of Internet users may grow to 200 million by 1999. *See* American Civil Liberties Union v. Reno, 929 F. Supp. 824, 831 (E.D. Pa. 1996) (challenging on constitutional grounds provisions of the Communications Decency Act of 1996 by various organizations and individuals associated with the computer and/or communications industry, or who publish material on the Internet), *aff'd* 117 S.Ct. 2329 (1997). The Internet is a world-wide system of computer networks. *See* Barry M. Leiner et al., *The Past and Future History of the Internet: The Next 50 Years: Our Hopes, Our Visions, Our Plans*, COMMUNICATIONS OF THE ACM, Feb. 1997, at 102. The Internet was originally called ARPANET (an acronym for Advanced Research Projects Agency Network) when U.S. Department of Defense researchers created it in the late 1970s as an experiment to determine how to build computer networks resistant to nuclear damage. *Id.* at 103. As researchers developed more sophisticated technology and new applications, the network was then gradually extended to other government departments, academic settings, and various global sites. *Id.* In the late 1980s, the public gained Internet access through commercial on-line services. The introduction of the World Wide Web (WWW or Web) in the early 1990s was instrumental in the rapid expansion of the number of users. *See* Milton P. Huang & Norman E. Alessi, *The Internet and the Future of Psychiatry*, 153 AM. J. PSYCHIATRY 861, 863 (1996) (describing the structure of the Internet). The Web provides users with a graphical browser that allows them to view pages containing text, graphics, and links to other cites. *See id.* (describing basic elements of WWW documents). In addition to the Web, the Internet allows users to communicate via electronic mail or other forms of electronic transmission that allow for the instantaneous exchange of information or visual images. These technologies and their applications to Internet mediated psychotherapy are described in Section II.

3. *See* David R. Johnson & David Post, *Law and Borders — The Rise of Law in Cyberspace*, 48 STAN. L. REV. 1367, 1367 (1996) (describing how the absence of physical barriers in cyberspace challenges present legal constructs).

4. *See id.* at 1367, 1370-74 (describing how the proliferation of computer technology is creating a distinct arena for human interactions not limited by geographic boundaries or controlled by traditional legal constructs).

nia;[5] Redondo Beach[6] or Fortuna,[7] California; Kobe, Japan;[8] the United Kingdom;[9] or Rochester, New York.[10] Currently, it is difficult to estimate the exact number of licensed and unlicensed individuals offering some form of psychotherapeutic assistance over the Internet.[11] The costs of Internet- based services vary from a few dollars for a response to a question[12] to charges that are slightly lower than the costs of a psychotherapy session in a major metropolitan area.[13]

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5. Wired Senses, based in Philadelphia, offers a variety of on-line psychotherapy services ranging from one time e-mail exchanges or ongoing e-mail exchanges to telecounseling sessions. *See Wired Senses* (visited Feb. 14, 1998) <http://www.revisions.com/meet.html>.

6. Gary Breese, Ph.D., a California licensed psychologist and marriage, family, and child counselor, offers "inexpensive, immediate short term intervention for those who may never have otherwise had the opportunity to have their problems addressed." *See* Gary Breese, Dr. G Psych-Link (visited Feb. 14, 1998) <http://www.drgpsychlink.com>.

7. Adriane St. Clare, R.N., M.A. has offered on-line therapy from Fortuna, California, since December, 1997. *See* Psychotherapy Online (visited Feb. 14, 1998) <http://www.psychotherapy-online.com>.

8. Dr. Masayuki Ohta and Miss Mihoka Nishida, C.P., based at the Akashi Tsuchiyama Hospital, are offering e-mail therapeutic exchanges as "The Counseling Room." *See* Masayuki Ohta & Mihoko Nishida, *The Counseling Room* (visited Mar. 18, 1998) <http://www.kobe-net.or.jp/counseling/index-e.html>.

9. The Pink Practice, offering e-mail mediated psychotherapeutic services to gays and lesbians, is based in the United Kingdom. *See The Pink Practice* (visited Jan. 15, 1998) <http://www.pinkpractice.co.uk>. Although the Web page states that this service is available only in the U.K., it is conceivable that an individual could circumvent this restriction through the use of technology designed to disguise a user's actual location.

10. Richard St. Pierre, C.S.W. offers therapy via e-mail from Rochester, New York. *See Turning Crisis into Positive Change* (visited Feb. 14, 1998) <http://www.frontiernet.net>.

11. The difficulty estimating the exact number of Internet-based "psychotherapy" services is a result of the fleeting nature of many of the activities conducted on the Internet and the occasional communications difficulties that interfere with connections to websites advertising these services. During the research, writing, revisions, and editorial process undertaken for this Note, the author observed the demise of numerous sites. For example, Shrink-Link, a company that offered e-mail exchanges about human behavior and psychological issues, has ceased business. *See* Shapiro & Schulman, *infra* note 15, at 107-08. Dr. David I. Sommers, an early practitioner of Internet psychotherapy, ended his on-line practice because of unresolved concerns regarding ethics, fees, confidentiality, and legal issues. Sommers, however, maintains his website as a resource for those interested in on-line treatment modalities. *See Legal and Fee Stuff* (visited Feb. 14, 1998) <http://www.dcez.com/~davids\>.

12. The standard fee for most e-mail questions is $20. *See* Richard M. Perloff, *Freud Faces the Internet*, PLAIN DEALER, Sept. 7, 1997, at 1, 4-J (describing Internet psychotherapy services). However, there are some services that offer lower fees for responses to questions to entice individuals to use their services. *See Wired Senses, supra* note 5 (offering "e-mail sessions" for $12).

13. It is difficult to gauge the standard fees for Internet psychotherapy, other than e-mail exchanges, because most practitioners' web pages do not list session changes and only divulge this information to actual clients. However, those practitioners who list prices typically list session charges slightly lower than the charges for psychotherapy sessions in the geographic region in which they practice traditional (face-to-face) psychotherapy. *See, e.g.*, St. Clare, *supra* note 7 (charging $50.00 for a one-hour interactive session and $65.00 for an hour of traditional

Some dismiss these services as a novelty that will be short-lived because they are pale imitations of traditional psychotherapeutic treatment[14] or relegate psychotherapists to the status of newspaper advice columnists or radio "psychologists."[15] Although it is unlikely that Internet psychotherapy will completely replace traditional forms of psychotherapeutic treatment, on-line self-help groups that populate the "information superhighway" already are described as the "self-help route of the 90s"[16] and are a signal that Internet-mediated psychological assistance is growing in popularity. As the "on-line culture" proliferates, Internet psychotherapy may become an appealing form of treatment to those who are frequent users of Internet services.

Moreover, with growing efforts to control health care costs and improvements in technology making real-time voice and visual capabilities a part of Internet services, these treatment modalities could become an integral part of mental health care. Internet psychotherapy presents managed care companies[17]

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psychotherapy). St. Clare, a California-based marriage and family therapist, charges fees that are comparable to the cost of individual psychotherapy offered by marriage and family therapists in western states receiving direct payment from patients. *Cf. 1997 Fee, Practice and Managed Care Survey*, PSYCHOTHERAPY FINANCES, May 1997, at 3 (listing most frequently paid fees by region).

14. Dr. Donald Bernstein, the Director of Professional Affairs for the New Jersey Psychological Association, states, "The basis of what constitutes psychotherapy is the relationship between the patient and the practitioner .... For the therapist to operate as effectively as possible, there are all kinds of physical cues that he or she needs .... I question the whole thing .... They ask people to say what their problem is; well, a lot of time people don't even know what their problem is." *See* Robert Gebeloff, *On the Net, is Mental Health Just a Click Away?*, BERGEN RECORD, Feb. 18, 1997, at A1.

15. *See* Daniel Edward Shapiro & Charles Eric Schulman, *Ethical and Legal Issues in E-Mail Therapy*, 6 ETHICS & BEHAVIOR 107, 117 (1996) (arguing that if services like the defunct Shrink-Link and Help-Net are not significantly altered and expanded, psychologists will inevitably become similar to advice columnists).

16. *See generally* Mark Ehrman, *Reaching Out for Virtual Therapy*, L.A. TIMES, June 25, 1995, at E1 (describing the popularity of on-line self-help groups). *See also* Laura Spinney, *A Virtual Shoulder to Cry On: Depressed and Disillusioned People are Turning to the Net for Comfort Asks if it can Ever Provide a Practical Alternative to Conventional Therapy*, NEW SCIENTIST, Dec. 9, 1995, at 37 (describing the British group "The Samaritans" which offers free counseling via e-mail).

17. Although no managed health care organization has announced an Internet psychotherapy scheme, there has been evidence of a willingness to use computer-based treatment and assessment modalities. In fact, Cigna Health Plan was a partner in the development of the Therapeutic Learning Program (TLP), a computer-based brief therapy system and provided clinical services using the TLP system. *See generally The Computer as "Co-Therapist,"* BEHAV. HEALTH MGMT., Jan. 1994, at 11 (describing the development of TLP and Cigna's use of the program.) More recently, mental health researchers at the University of Wisconsin conducted research assessing the validity and clinical utility of a telephone-assisted computer-administered

with an opportunity to offer mental health care at significantly reduced savings. With Internet psychotherapy the costs associated with running a traditional psychotherapeutic practice are sharply reduced because the overhead associated with maintaining offices is eliminated. In addition, managed care companies could provide psychotherapy services throughout the world because the geographic barriers imposed by traditional treatment are eliminated.

Furthermore, these services have important applications for difficult-to-treat populations. Patients who are too phobic to leave their houses, individuals with mental illnesses or disabilities that make face-to-face interactions difficult,[18] people who reside in communities underserved by mental health professionals,[19] or individuals who are too busy to maintain a regular schedule of traditional psychotherapeutic appointments will likely benefit from Internet-based treatment or medication monitoring.

This Note is one of the first attempts to examine the legal implications of Internet psychotherapy[20] and argue for regulations that protect the consumer, but permit psychotherapists to explore the advantages, disadvantages, and efficacy of Internet-based treatment modalities. Part II of this Note places Internet-mediated psychotherapy within the context of the evolution of popular culture and psychoanalysis and psychotherapy. Part III

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version of Primary Care Evaluation of Mental Disorders (PRIME-MD). This comparison of diagnoses obtained by computer over the telephone using interactive voice response (IVR) technology to those obtained by a clinician over the telephone using the Structured Clinical Interview for DSM-IV involved participants drawn from not-for-profit and for-profit HMOs. *See* Kenneth A. Koback et al., *A Computer-Administered Telephone Interview to Identify Mental Disorders,* 278 JAMA 905 (1997).

18. *See also* Harvey Blume, *On the Net: Autistics Freed From Face-to-Face Encounters Are Communicating in Cyberspace,* N.Y. TIMES, June 30, 1997, at D6 (describing the development of on-line "communities" by groups of autistic Internet users and their preference for e-mail when conducting social interactions).

19. Approximately 15% to 25% of the U.S. population lives in nonurban areas or in areas underserved by medical services. *See* E. Andrew Balas et al., *Electronic Communication with Patients: Evaluation of Distance Medicine Technology,* 278 JAMA 152, 152 (1997) (concluding that "distance medicine technologies" enable greater continuity of care by improving access and supporting the coordination of activities by a clinician).

20. Shapiro and Schulman have provided the first analysis of the legal and ethical implications of Internet psychotherapy. However, their work only discusses e-mail exchanges and does not consider the use of other Internet-based treatment modalities. *See generally* Shapiro & Schulman, *supra* note 15.

is an analysis of the legal challenges created by Internet psychotherapy. This section explores the complex liability, licensure, and confidentiality issues that surround Internet psychotherapy and justify regulating Internet psychotherapy. Part IV is a series of recommendations for the creation of a national Internet health care infrastructure designed to ensure that consumers of Internet health care services, such as Internet psychotherapy, receive the same legal protections available to individuals who seek more traditional health care.

II. BACKGROUND

A. The Historical Antecedents of Internet Psychotherapy

When many lay people think about psychoanalysis or psychotherapy they conjure up images of an elderly bearded psychiatrist sitting out of sight of a patient reclining on a couch. The patient prattles on while the psychiatrist makes the occasional terse comment marked by a heavy Viennese accent. This stereotypical image is an obvious association with Sigmund Freud and the practices he developed as the first psychoanalyst.

A cursory examination of Internet psychotherapy would indicate that it is a dramatic departure from the practices and values that form the origins and nature of psychoanalytic treatment. Freud and his followers living in *fin de siécle* Vienna could not conceive of a world altered by the telecommunications and computer revolution. However, Internet psychotherapy is clearly an outgrowth of four important elements within the history of psychoanalysis and psychotherapy. Two of the elements are a part of the Freudian tradition: Freud's and other early psychoanalysts' use of correspondence to provide and to discuss psychological insights and their willingness to condone deviations from orthodox analytic technique. The other elements are a result of the popularization of psychoanalytic theories. These elements are the fascination by popular culture with psychotherapy and the use of mass media to provide access to psychological insights.

1. The Psychoanalytic Tradition of Correspondence

Freud conducted a vast correspondence.[21] Letters were the cornerstone of Freud's interactions with others and were more important to him than actual encounters with people.[22] For Freud, "[l]etters were a means of access to the soul without the sometimes irritating presence of the other person, and the possibility of the other person's interrupting one's train of thought."[23] The vast bulk of Freud's correspondence was focused on exchanges with professional colleagues.[24] However, Freud also responded to letters about emotional problems from private citizens. Several of these letters survive and provide important insights into Freud's theories and supplement formally published materials delineating Freud's views on crucial psychological issues and concepts.[25] Later, other analysts also conducted correspondences with former patients that often augmented more formal treatment or generated additional material for publications based on that particular case.[26]

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21. *See* PETER GAY, FREUD: A LIFE FOR OUR TIME xvii (1988).

22. *See* PHYLLIS GROSSKURTH, THE SECRET RING: FREUD'S INNER CIRCLE AND THE POLITICS OF PSYCHOANALYSIS 25 (1991) (documenting the history of Sigmund Freud's "secret committee" — the group of his followers formed to ensure Freud's continued dominance over psychoanalysis).

23. *Id.*

24. *See id.*

25. One of the most famous of these letters is described by historians of psychoanalysis as "The Letter to an American Mother" and has been used to buttress arguments that homosexuality is not a mental illness. In this letter, Freud responded to an unknown American woman's concerns about her homosexual son. Freud also discussed psychoanalytic theories regarding homosexuality and the possibility of the young man undergoing analysis. Letter from Sigmund Freud to Unidentified American Woman, Apr. 9, 1935 (original on file at the Kinsey Institute for the Study of Sex, Gender, and Reproduction, Indiana University) (photocopy on file with the author). *See also* RONALD BAYER, HOMOSEXUALITY AND AMERICAN PSYCHIATRY: THE POLITICS OF DIAGNOSIS 27 (1987) (reprinting "Letter to An American Mother").

26. One such correspondence that had a significant impact on the development of psychoanalytic theory was the one conducted by Muriel Morris Gardiner and the patient identified in psychoanalytic literature as the Wolf-Man (Sergei Constantinovich Pankejeff). The Wolf-Man was the son of a rich Russian landowner who underwent psychoanalysis with Freud because of a severe neurotic disturbance that originally manifested itself as a wolf phobia and in dreams involving wolves. *See* MURIEL M. GARDINER, *Introduction*, THE WOLF-MAN BY THE WOLF-MAN v (Muriel Gardiner ed., Basic Books 1971) (providing background information on the Wolf-Man's life and psychoanalytic treatment); SIGMUND FREUD, *The Case of the Wolf-Man, in* THE WOLF-MAN BY THE WOLF-MAN 154, 161 (Muriel Gardiner ed., Basic Books 1971) (describing the Wolf-Man's neurotic disturbance and the Wolf-Man's dreams). Until the Wolf-Man's death in 1979, he sent letters that formed the basis of Gardiner's reports which other analysts as well as Gardiner's scholarly work related to the Wolf-Man's case. *See* Muriel M. Gardiner, *The Wolf-Man's Last Years*, 31 J. AM. PSYCHOANALYTIC ASS'N 867, 867-68 (1983) (describing the nature of the correspondence and relationship between Gardiner and the Wolf-Man). This correspon-

2. The Tradition of Experimentation with the Analytic Setting

Freud described the analyst's role with such metaphors as "[t]he physician should be opaque to the patient and, like a mirror, show nothing but what is shown to him."[27] Freud encouraged early analysts to treat patients within the carefully defined parameters of the analytic setting and "the rule of abstinence" as a way to encourage the development of a mode of treatment that would be regarded as scientific.[28] Although Freud attempted to inculcate his followers with austere technical precepts,[29] his own behavior in the analytic setting did not often reflect the rigidity, abstinence, and anonymity that he advocated in his writings.[30] Moreover, the history of psychoanalysis is replete with numerous examples of analytic pioneers experimenting with analytic technique and transcending the restrictions designed to create the analytic setting. Freud conducted informal analyses in some astonishing settings, including analyzing Max Eitingon during evening strolls through Vienna.[31] Melanie Klein conducted training analyses in her hotel rooms during vacations,[32] and Donald Winnicott conducted "analysis on demand" including prolonged two-hour or three-hour sessions.[33] Despite these departures from the strictures of the analytic process, most psychoanalytically oriented therapists regard such deviations from standard practices as the

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dence, along with the case histories by Freud and Ruth Mack Brunswick, made the Wolf-Man's case unique in psychoanalytic literature because it allowed analysts to study the psychological development of an analysand from infancy to old age. *See* MURIEL GARDINER, *supra*.

27. GAY, *supra* note 21, at 303 (quoting Sigmund Freud, *Recommendations to Physicians Practicing Psycho-Analysis, in* 12 STANDARD EDITION OF THE COMPLETE PSYCHOLOGICAL WORKS OF SIGMUND FREUD 115, 118 (James Strachey et al. eds, 1953-74).

28. *See id.* at 244-45, 292-305 (describing Freud's efforts to impart a cohesive general methodology of psychoanalysis through the publication of papers on psychoanalytic techniques).

29. *See id.* at 267.

30. *See* Scott H. Johnston & Barry A. Farber, *The Maintenance of Boundaries in Psychotherapeutic Practice*, 33 PSYCHOTHERAPY 391, 392 (1996) (arguing that the history of psychotherapy "reflects a tension between boundary firmness and flexibility" as evidenced by differences in Freud's writings and his behavior with patients).

31. *See* GAY, *supra* note 21, at 303.

32. *See* PHYLLIS GROSSKURTH, MELANIE KLEIN: HER WORLD AND HER WORK 189-90 (1986).

33. *See* ANTHONY BATEMAN & JEREMY HOLMES, INTRODUCTION TO PSYCHOANALYSIS: CONTEMPORARY THEORY AND PRACTICE 156 (1995) (discussing deviations from classical analytic technique).

province of "mavericks and masters."[34]

However, like many complex intellectual movements, psychoanalysis has developed numerous factions and schools of thought. Today, there are over 400 modalities of mental health treatment that have evolved from the Freudian tradition and that are employed by mental health professionals providing psychotherapeutic treatment.[35] Psychotherapy via the Internet appears to be the most recent addition to the wide spectrum of treatment modalities that have purported to employ psychoanalytic precepts and techniques to ameliorate emotional suffering. Yet unlike other forms of psychotherapeutic treatment, Internet psychotherapy appears to mix the intellectual traditions of psychoanalysis and mass media exploitation of psychotherapy as entertainment.

3. Psychoanalysis and Psychotherapy as a Popular Culture Phenomenon

Although the roots of psychoanalysis and psychotherapy are central European, the popularization of psychoanalytic theory and mass media psychological activities that are the cornerstones of Internet psychotherapy are purely American. After the rise of Nazism and the forced exile of many psychoanalysts,[36] the United States became the focal point for psychoanalysis.[37] With this shift, analytic culture and practices took on a decidedly American and popular flavor.

The beginning of mass media interest in psychoanalysis dates to 1909 when Freud visited America for the first and only time to deliver a series of lectures at Clark University.[38]

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34. *Id.*

35. *See* Erica E. Goode & Betsy Wagner, *Does Psychotherapy Work?*, U.S. NEWS & WORLD REP., May 24, 1993, at 55, 59 (discussing how psychoanalysis "introduced during Freud's visit to the United States . . . [has] burrowed deeply into the American culture").

36. *See* LAURA FERMI, ILLUSTRIOUS IMMIGRANTS: THE INTELLECTUAL MIGRATION FROM EUROPE 1930-41 (2nd ed. 1971) 142, 145 (describing how the rise of Nazism and the development of anti-Jewish racial policies fueled the exodus of psychoanalysts from continental Europe).

37. *See* BATEMAN & HOLMES, *supra* note 33, at 11. "In 1925, 22% of the members of the International Psychoanalytic Association were from North America." *Id.* "By 1952 the figure had risen to 64%." *See id.* Psychoanalysis also became the dominant force within American psychiatry in the 1950s and 1960s. *Id.* Bateman and Holmes attribute these changes to the emigration from Europe and also because of "the fertile soil for new ideas typical of the USA." *Id.*

38. *See* NATHAN G. HALE, JR., FREUD AND THE AMERICANS: THE BEGINNINGS OF

Despite the attention the visit garnered, most Americans learned about psychoanalysis through mass circulation women's magazines and newspapers that presented glorified and simplified versions of psychoanalytic theories.[39]

The height of media interest in Freud came in 1924 when Colonel Robert McCormick, publisher of the *Chicago Tribune*, offered Freud $25,000 or "anything he name [sic]"[40] to come to Chicago and "psychoanalyze" Nathan Leopold and Richard Loeb,[41] and movie mogul Samuel Goldwyn set sail for Europe to offer Freud $100,000 to serve as a film consultant.[42] Although Freud never responded to McCormick and pointedly rebuffed Goldwyn,[43] these offers exemplified the growing media fascination with psychoanalysis.

Despite Freud's refusal to involve himself in popular culture activities, the popularization of psychoanalysis did not abate and it became a central element of American popular culture. Psychoanalysis was an influential enough theme in popular culture by 1941 that a singing analytic patient and her dreams starred in a hit Broadway musical called *Lady in the Dark*.[44] Quickly, psychoanalytic themes and depictions of psychotherapeutic treatment became, and remain, a popular theme of films,[45] plays,[46] songs,[47] fiction,[48] and television shows.[49]

PSYCHOANALYSIS IN THE UNITED STATES 1876-1917, at 397-411 (1971) (discussing the popularization of psychoanalysis).

39. As Peter Gay points out, "The number of people who would read, let alone fully grasp, esoteric texts like BEYOND THE PLEASURE PRINCIPLE or THE EGO AND THE ID was bound to remain small.... Yet [Freud's] name, and his photograph showing a stern, carefully dressed elderly gentleman with penetrating eyes and the inevitable cigar became known to millions. GAY, *supra* note 21, at 454.

40. *Id.*

41. *See id.*

42. *See id.*

43. Freud's terse reply to Goldwyn's request was reported in *Die Stunde*, a Viennese newspaper: "I do not intend to see Mr. Goldwyn." *Id.*

44. MOSS HART ET AL., LADY IN THE DARK (1941). The play ran in New York for 467 performances and in 1944 was made into a film. *See* KIRN GABBARD & GLEN O. GABBARD, PSYCHIATRY AND THE CINEMA 7 (1987).

45. There is an extensive filmography of films with psychoanalytically inspired themes or depictions of therapy including John Huston's melodramatic "biopic" of Freud's life starring Montgomery Clift and originally scripted by Jean-Paul Sartre. *See* FREUD: THE SECRET PASSION (Universal 1962). For a psychohistorical analysis of the film, see Peter Gay, *Freud, in* PAST IMPERFECT: HISTORY ACCORDING TO THE MOVIES 170 (Mark G. Carnes et al. eds., 1995). Psychotherapy continues to serve as an important theme and plot element in commercially and critically successful films. *See generally* GABBARD & GABBARD, *supra* note 44 (documenting the history of psychiatry in American Films from 1906 to 1986). One such film, most noteworthy for its commercial success was THE PRINCE OF TIDES (Columbia Picture 1991) directed by Barbra

These popular depictions of psychotherapy have fueled an interest in media-based psychotherapeutic-oriented activities that have also served as an attempt to bring the benefits of psychological insights to the masses. The most influential of these activities include well-known psychoanalysts or analytically oriented pediatricians and psychologists writing books about child-rearing and serving as magazine columnists and radio and later television commentators on child develop-

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Streisand and based on the best-selling novel of the same name. See CONROY, *infra* note 48. *See also* Maitland McDonagh, *Psychiatrists Analyze Dr. Lowenstein*, N.Y. TIMES, Jan. 19, 1992, § 2 at 24 (including interviews of psychiatrists and psychoanalysts commenting on films depicting therapists). In addition, no explanation of psychoanalytically oriented films would be complete without mentioning the work of Woody Allen. *See, e.g.*, ZELIG (Orion 1983) and DECONSTRUCTING HARRY (New Line Cinema 1997).

46. In addition to LADY IN THE DARK, there have been several Broadway and Off-Broadway productions featuring psychoanalytic themes or depicting psychotherapy. Recent examples, produced in the last twenty years, include William Finn's MARCH OF THE FALSETTOS, featuring a psychiatrist singing "Yes I feel guilt. Yes I'm annoyed. So was Jung. So was Freud." WILLIAM FINN, THE MARVIN SONGS: THREE ONE-ACT MUSICALS 146 (1981). Other examples include Stephen Sondheim and George Furth's GETTING AWAY WITH MURDER, which depicts a group of neurotic Manhattanites in group therapy who together discover that their therapist has been murdered; Terry Johnson's HYSTERIA, a farce in which Freud matches wits with Salvador Dali; and Nicholas Wright's MRS. KLEIN, which depicts pioneering child analyst Melanie Klein's tortured relationship with her children.

47. One clever example of lyrics mocking popular culture's obsession with psychoanalysis was *Twisted*, which has become a standard of the Vocalese jazz style. LAMBERT, ET AL., *Twisted, on* THE GREATEST NEW GROUP IN JAZZ (Columbia 1959).

48. The first American novel with a psychoanalytic theme was published in 1918. *See* JAMES HAY, JR., MRS. MARDEN'S ORDEAL (1918). Since then psychoanalytic themes or therapist characters have been a staple of American fiction. Some works of this genre are a part of the canon of classic American literature. *See, e.g.*, F. SCOTT FITZGERALD, TENDER IS THE NIGHT (Macmillan 1934) (1933) (telling the story of a psychiatrist whose career is thwarted by marrying a wealthy woman); SYLVIA PLATH, THE BELL JAR (25th anniv. ed., Harper Collins 1996) (describing the emotional breakdown and psychiatric hospitalization of a young college student). The 1950s were the heyday of literature with psychological themes or therapist characters. Many of these works were pulp novels. Recent examples of therapeutically oriented fiction in the pulp tradition include the popular "Alex Delaware" novels, featuring a child-psychologist turned sleuth, written by former child psychologist Jonathan Kellerman. *See, e.g.*, JONATHAN KELLERMAN, WHEN THE BOUGH BREAKS (1985); SILENT PARTNER (1989); DEVIL'S WALTZ (1993); BAD LOVE (1994); SELF-DEFENSE (1995). *See also* PAT CONROY, THE PRINCE OF TIDES (1986). More serious recent works with therapeutic themes that have received popular and critical acclaim include the following: ON THE COUCH: GREAT AMERICAN STORIES ABOUT THERAPY (Erica Kates ed., 1997) (a collection of short stories by a number of prize winning authors); IRVIN D. YALOM, LYING ON THE COUCH (1996) (depicting the troubles of a young psychiatrist over sexual relationships between therapists and patients); and SUE MILLER, FAMILY PICTURES (1990) (portraying the experiences of a Chicago family coping with an autistic sibling and a psychiatrist father).

49. These include the current hit *Frasier* (NBC) (depicting a Seattle radio psychiatrist and his family and friends); cartoon cult hit *Dr. Katz: Professional Therapist* (Comedy Central) (portraying the tribulations of an animated therapist); and, in the 1970s, *The Bob Newhart Show* (CBS) (depicting a Chicago psychologist).

ment.[50]

Although the 1950s is considered the Golden Age of positive depictions of psychotherapy,[51] throughout the 1960s and 1970s, popular fascination with psychoanalytic themes and psychotherapeutic solutions to social and personal problems did not wane.[52] However, popular discourse became increasingly less Freudian and moved further away from the precepts enunciated by traditionally trained mental health professionals as interest in self-help and New Age movements grew.[53] During the same period, mass media representations of psychotherapy shifted from using therapy as a plot device or theme to the exploitation of real people's emotional and interpersonal difficulties for entertainment purposes.

4. Radio Therapy

"Radio therapy" is the media activity most closely related to Internet psychotherapy. Beginning in the 1950s, psychologist Dr. Joyce Brothers began chatting on the radio about a range of sexual topics.[54] However, it was not until the 1970s, when psychologist Toni Grant began taking live calls on the air in Los Angeles, that psychologists began broadcasting interactions with individuals.[55] Call-in radio "therapy" became a fixture of American life and allowed people to eavesdrop on a variety of human dramas.[56]

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50. *See generally* Nathan Cobb, *The Baby Gurus: There's No Shortage of Experts on Bringing Up Baby, But Standing Head and Shoulders Above the Crowd are T. Berry Brazelton, Penelope Leach, and (of course) Benjamin Spock*, BOSTON GLOBE, June 17, 1990, at 14 (describing the media activities of three leading authorities on child development and their influence on child-rearing practices).

51. *See* GABBARD & GABBARD, *supra* note 44, at 3.

52. For a popular history of New Age therapies and other therapeutic fads, see STEPHEN FARBER & MARC GREEN, HOLLYWOOD ON THE COUCH 279-317 (1993).

53. *Id.* at 294-95, 300-03, 304-06 (describing the genesis of various New Age and self-help improvements).

54. *See* Nora Zamichow, *The David Viscott You Didn't Know*, L.A. TIMES, Jan. 26, 1997, (Magazine), at 10 (describing the development of radio therapy and the downfall of a nationally syndicated radio psychiatrist).

55. *Id.*

56. *Id.* Radio "therapy" is now so popular that Laura Schlessinger, a Los Angeles-based self-described "shrink," hosts an internationally syndicated show. *See* Janet Wescombe, *I Don't Do Therapy*, L.A. TIMES, Jan. 18, 1998, (Magazine) at 10 (describing Schlessinger's personal and professional life). Although Schlessinger often states, "I don't do therapy" and is not a psychologist, she refers to herself as a shrink and provides advice about a range of emotional difficulties. *Id.* However, Schlessinger's abrasive and flippant style, her willingness to upbraid callers and

The therapeutic value of radio psychology is questionable and the ethical standards promulgated by the American Psychological Association advise that a therapeutic relationship cannot be formed based on contact over the radio.[57] This standard is easy to maintain because interactions over the radio do not offer any illusions of privacy and the rational caller understands that entertainment is the primary purpose of the show.[58] Moreover, radio therapy does not promise sustained contact and the development of a therapeutic alliance[59] between therapist and patient, or the emotional experiences of transference,[60] countertransference,[61] and resistance[62] that are the cornerstones of traditional psychotherapeutic treatment.

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offer opinions on moral issues, and the commercial focus of her program are indicative of the entertainment and not the therapeutic emphasis of her program. Yet the nature of the dialogue between Schlessinger and her callers is clearly rooted in the tradition of the radio "therapy" format. Schlessinger is also exploiting the emerging popularity of the Internet with a website that includes "Dr. Laura's On-Line Column," which allows individuals to submit questions and receive answers through publicly posted responses. *See* Laura Schlessinger, *The Official Site For Dr. Laura*, (visited Feb. 13, 1998) <http://www.dr.laura.com>.

57. *See* AM. PSYCHOL. ASS'N'S ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT § 3.04 (1992) (prohibiting media psychologists from encouraging individuals to infer that a personal relationship has been offered).

58. *See* Shapiro & Schulman, *supra* note 15, at 111 (comparing media psychologists and e-mail therapists).

59. *See* Stephen C. Scheiber, *Psychiatric Interview, Psychiatric History, and Mental Status Examination, in* TEXTBOOK OF PSYCHIATRY 163, 172-73 (John A. Talbot et al. eds., 1988) (describing the therapeutic alliance as a trusting relationship and as a process whereby the patient's mature, rational, and observing ego works in conjunction with the therapist's analytic abilities to advance their mutual understanding of the patient).

60. *See id.* at 171 (describing transference as the process whereby the patient "unconsciously projects [her own] emotions, thoughts, and wishes" onto the therapist). *See also* BATEMAN & HOLMES, *supra* note 33, at 95-109 (placing the concept of "transference" within the frameworks of various psychoanalytic theories). *See also* ANTHONY STORR, THE ART OF PSYCHOTHERAPY 70-82 (2d ed. 1990) (discussing the transference phenomenon within the context of psychotherapy).

61. *See* Scheiber, *supra* note 59, at 172 (describing countertransference as "a process whereby the [therapist] unconsciously projects her emotions, thoughts and wishes from [her] past... onto the patient's personality or onto the material that [she] is presenting, thus [demonstrating the therapist's] unresolved conflicts and/or gratifying [the therapist's] needs"). *But see* BATEMAN & HOLMES, *supra* note 33, at 111 (viewing countertransference as a demonstration of "affective attunement, empathy, appropriate mirroring, and a sense that certain aspects of all relationships are based on emotional identifications that are not solely projections") and 111-17 (discussing various theoretical positions on countertransference).

62. *See* BATEMAN & HOLMES, *supra* note 33, at 164 (defining resistance as "the myriad of methods a patient uses to obstruct the very process he is relying on to help him") and 164-166 (describing various theoretical views of the role resistance plays in psychotherapeutic treatment).

B. Internet Treatment Modalities

Internet treatment modalities, like radio "therapy" employ a communications device that is accessible to people in the privacy of their own homes and attempts to provide psychological insights to large numbers of people. Internet therapy is also comparable to radio "therapy," in that the interactions are aimed at the "worried well," not individuals with serious emotional disabilities. However, the disclaimers that accompany radio shows by therapists that state that the interactions with listeners are solely for entertainment purposes rather than therapeutic ones are largely absent from the web pages of Internet therapists. The vast majority of Internet psychotherapy services are not characterizing their activities as an extension of the interactive entertainment services that constitute a growing segment of Internet activities.[63] Instead, the web pages tout Internet treatment modalities as an application of traditional psychotherapeutic principles to a new form of human communication or describe the services as a legitimate replacement for traditional psychotherapy.

1. E-mail Therapeutic Exchanges

The most frequently advertised form of Internet psychotherapy service involves electronic mail (e-mail).[64] These services involve clinicians offering brief responses to short ques-

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63. Besides communication, information, and commercial activities, a growing segment of Internet activities includes interactive entertainment. One of the most controversial forms of Internet-based interactive entertainment are web sites devoted to the virtual equivalent of lottery scratch tickets, blackjack, and lotto games. Several states attorneys and the Senate Judiciary Committee are exploring ways to regulate or prohibit these activities. *See Tribe Starts New Business: Gambling Site On Internet,* N.Y. TIMES, July 5, 1997, at A8 (discussing state governmental opposition to an Internet gambling site established by the Coeur d'Alenes Tribe). *See also* Internet Gambling Prohibition Act of 1997, S. 474, 105th Cong. (1997). The proposed bill amends 18 U.S.C §§ 1081, 1084, which governs the wire transmission of gambling information. The amendment would allow the transmission of wagers and bets via the Internet if they originate from a state or country and are received in a state or foreign country that permit such wagers and bets. *See* Internet Gambling Prohibition Act of 1997, S. 474, 105th Cong. §3(b)(1)(B)(i-ii) (1997).

64. E-mail users have an electronic mailing address that can receive typed text messages from other users. The messages are transmitted along telephone lines to a university computer network or communication service like America Online. From there the message is forwarded through a network of linked computers to the receiver who can read the message the next time she turns on her computer and connects with the service that she uses to access e-mail.

tions for a nominal fee[65] or sometimes for free if the customer has not benefitted.[66] Typically, users are asked to categorize their problems using checklists of diagnoses (i.e. depression, panic attacks, or eating disorders) or respond to a series of questions about their emotional state and describe their problem in 200 words or less. Responses from therapists are usually sent within twenty-four to seventy-two hours.

The Web pages advertising the first e-mail services overtly stated that the service was not psychotherapy while implying that the service would be effective for the clients.[67] However, the advertisements also stressed that the service providers were psychiatrists and psychologists and compared the low cost of e-mail communications to traditional psychotherapeutic treatment.[68] The early services did not discourage repeated use, but they claimed that if a user frequently sent queries the practitioners would encourage the user to seek traditional therapy.[69]

2. On-going E-mail Therapy

Increasingly, individual and group practitioners are advertising their services as an alternative to traditional face-to-face therapy and are encouraging potential clients to use the service on an on-going basis. Proponents of on-line psychotherapy argue that it could have significant clinical advantages over traditional psychotherapy.[70] Despite the lack of efficacy stud-

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65. *See* discussion *supra* note 12.

66. Leonard G. Holmes, Ph.D. offers "psychological consultations" via e-mail. His website states that these consultations are not therapy. *See* Leonard G. Holmes, *Shareware Psychological Consultation* (visited Feb. 14, 1998) <http://www.netpsych.com>. Although Holmes calculates a charge for each consultation, he does not expect to receive payment unless "you feel that you have received value for the consultation." *Id.*

67. *See* Shapiro & Schulman, *supra* note 15, at 108-09 (discussing the now-defunct Shrink-Link service).

68. *See id.* at 109.

69. *See id.* at 112.

70. These claims are based almost wholly on conjecture or anecdotal information. Internet psychotherapy is too new a treatment modality to have generated any assessments of its clinical efficacy. It is likely that any literature emerging from clinical experiences or formalized studies of Internet psychotherapy will focus on the efficacy of using e-mail for therapeutic interactions and the impact on patients of engaging in therapeutic experiences via computer. Already, there is a limited body of literature reporting the efficacy of correspondence-based psychotherapy as part of traditional treatment modalities or as augmenting attempts at behavior modification. *See, e.g.*, M. Honoré France et al., *Letter Therapy: A Model for Enhancing Counseling Intervention*, 73 J.

ies and concerns that most Internet psychotherapy patients do not receive formal clinical assessment for diagnostic purposes,[71] proponents argue that on-line psychotherapy does allow patients to experience many of the elements of a therapeutic relationship including transference.[72] In addition, advocates of

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COUNSELING & DEVELOPMENT 317 (1995) (describing the use of letter writing in conjunction with face-to-face counseling); Leon Sloman & Joseph Pipitone, *Letter Writing in Family Therapy*, AMER. J. FAMILY THERAPY, Spring 1991, at 77 (exploring the use of letter writing to facilitate family therapy involving divorcing families); James V. Wojcik & Elizabeth R. Iverson, *Therapeutic Letters: The Power of the Printed Word*, J. STRATEGIC & SYSTEMATIC THERAPIES, Summer-Fall 1989, at 77 (discussing the value and organization of letters written to clients to facilitate the accomplishment of therapeutic goals); Geraldine Faria & Nancy Belohlavek, *Treating Female Adult Survivors of Childhood Incest*, SOCIAL-CASEWORK, Oct. 1984, at 465 (describing journal and letter writing in the cognitive therapy oriented treatment of an incest survivor); and Peder Terpager Rasmussen & Karl Tomm, *Guided Letter Writing: A Long Brief Therapy Method Whereby Clients Carry Out Their Own Treatment*, J. STRATEGIC & SYSTEMIC THERAPIES, Winter 1992, at 1 (describing a systemic approach to guided letter writing (GLW) that is designed to desensitize clients to painful conflicts and traumatic experiences). Similarly, there is limited literature on the use of computers in psychotherapeutic treatment. For example, there are reports of experiments utilizing ELIZA, a computer simulation of psychotherapy introduced in 1960s. *See, e.g.*, Jerry W. O'Dell & James Dickson, *ELIZA as a "Therapeutic" Tool*, 40 J. CLINICAL PSYCHOL. 942, 942 (1984) (describing interactions with ELIZA by seventy undergraduate students). There are also studies reporting that some psychiatric patients prefer computerized interviews to live therapists and may tend to reveal more to the machines than to human interviewers. *See generally* John H. Griest et al., *A Computer Interview for Suicide-Risk Prediction*, 130 AMER. J. PSYCHIATRY 1327 (1973) (establishing the feasibility of using computers to interview suicidal patients and finding that patients preferred the computer interview to talking with a physician) and Michael L. Zarr, *Computer-Mediated Psychotherapy: Toward Patient-Selection Guidelines*, 38 AMER. J. PSYCHOTHERAPY 47, 58 (1984) (describing the potential for computer-based treatment with avoidant, paranoid, masochistic, or depressed patients who might regard a typical doctor-patient relationship as too threatening). The popularity of the Internet among high-functioning individuals with autism lends further credence to the argument that Internet treatment modalities may make psychotherapeutic treatment for these individuals easier or more tolerable. *See* Harvey Blume, *On the Net: Autistics Freed From Face-to-Face Encounters Are Communicating in Cyberspace*, N.Y. TIMES, June 30, 1997, at C6 (describing the development of on-line "communities" by groups of autistic Internet users).

71. *See* Shapiro & Schulman, *supra* note 15, at 116-17 (criticizing e-mail facilitated therapeutic communications).

72. *See Metanoia Guide, Directory of Internal Mental Health Services* (visited Jan. 26, 1988) <http://www.metanoia.org>. The Metanoia Guide includes a discussion of the benefits of Internet psychotherapy including an anecdote from an anonymous satisfied patient. She states:

> I am fairly knowledgeable about psychotherapy (for a layperson), and was fortunate to work with a very talented psychotherapist for several years, experiencing the full depth and richness of that experience. I also had the experience of corresponding by e-mail with another psychotherapist for over a period of about six months .... I experienced deep emotions while reading and writing — grief, anxiety, joy, love, rage, you name it — and explored some very deep issues. You should know what happened: I learned to trust and depend on this person. The therapist was usually able to sense my feelings from changes in my writing. Transference happened. The relationship was reflected in my dreams. I was challenged, comforted, and empowered. The experience was profoundly healing, and my life changed for the better.

Id. at <http://www.metanonia.org/imhs/alliance.html>.

on-line therapy claim that Internet treatment may provide advantages over face-to-face treatment. Supporters argue that on-line treatment is easier than face-to-face treatment for patients with significant problems relating to others,[73] it may have value as an initial step in encouraging prospective patients to seek more traditional treatment,[74] reduces physical or geographical impediments,[75] and it permits a complete permanent record of every interaction.[76]

Unlike face-to-face psychotherapy, e-mail exchanges do not allow clinicians to interpret facial expressions, body language, or vocal intonations in assessing or diagnosing a user's condition responding to the material she shares. This removes a significant portion of the nonverbal information therapists use to discover the underlying meaning of a patient's statements and nonverbal behavior. Moreover, these exchanges only permit users and clinicians to work with material that captures a brief portion of an individual's thoughts and do not allow patients and therapists to engage in the dialogue based on the patient's free associations that is the hallmark of psychoanalytic psychotherapy.

3. Therapy via Talk and Internet Relay Chat (IRC)

Although e-mail therapy is the most widely advertised service, practitioners are also utilizing other Internet technologies to provide therapeutic services. By using Internet Talk and Internet Relay Chat (IRC) practitioners can circumvent the inability to conduct sustained dialogue imposed by e-mail and participate in an exchange that is an approximation of free association. Using Internet Talk, users can connect with each other and chat back and forth. IRC allows Internet users to participate in a party-line type of conversation. This is already a popular format for self-help groups that conduct on-line meetings using commercial on-line service "chat rooms."[77]

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73. *See* Fred Cutter, *Virtual Psychotherapy?*, PSYCH. NEWS INT'L., June 1996; Fred Cutter, *Virtual Psychotherapy*, (visited Feb. 26, 1998) <http://netpsych.com/virtual.htm> (describing Internet psychotherapy available on the Internet and outlining the psychotherapeutic value of online encounters).

74. *Id.*

75. *Id.*

76. *Id.*

77. The number and variety of on-line support groups utilizing chat rooms is constantly

Currently, several practitioners utilize this technology and offer services that allow individuals to schedule appointments, enter passwords at the scheduled time, and begin communicating live with a therapist.[78]

4. Psychotherapy via Internet-Based Tele-Conferencing

Therapists seeking to develop Internet-based therapy modalities that replicate the conditions of traditional psychotherapy have recently begun to experiment with two-way tele-video.[79] These services require that practitioners and patients have computers equipped with a digital camera and special software. This equipment costs a few hundred dollars and is still rather primitive. Although it does not provide the same level of intimacy experienced by individuals sitting in close physical proximity, tele-conferencing allows therapists and patients to conduct sessions that approximate face-to-face treatment since the visual and audio capabilities of tele-conferencing make it is possible to respond to changes in vocal intonation and facial expressions.

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changing. However, there have been efforts to compile and to update a guide to the over 400 groups oriented towards emotional support. *See* Steve Harris, *Emotional Support on the Internet* (visited Mar. 7, 1998) <http://www.compulink.co.uk./~net-services/care/>; <ftp://rtfm.mit.edu/pub/usenet/news.answers/support/emotional/resources-list>. For access through e-mail, see mail-server@rtfm.mit.edu (message must read "send usenet/news.answers/support/emotional/resources-list").

78. Examples of this type of service are Silicon Prairie Ventures, Inc., *CounseLine* (visited Mar. 7, 1998) <http://www.counseline.com/> and *Wired Senses* (visited Feb. 19, 1998) <http://www.revisions.com/wiredsenses.html>.

79. Wired Senses is attempting to offer therapy using two-way tele-video. Called "CU-SeeMe Telecounseling Sessions" the cost is $25 for a half-hour session. *See* <http://www.comcat.com/~gulreg3/cuseeme.html>. CUSeeMe offers real-time video by using a video board and a video camera connected to the computer, and bouncing audio-visual messages off of Internet "reflectors" or machines running the enabling software to other machines with CUSeeMe hardware. *See* Lynn Paul, *What will Cyberspace be Like in the Future?* FIN. POST, Mar.23, 1996, at N5 (describing emerging Internet technologies).

III. THE LEGAL AND CONSUMER CHALLENGES CREATED BY INTERNET PSYCHOTHERAPY

A. An Overview of the Issues

Internet activities challenge existing definitions of legal jurisdiction.[80] The Internet "radically subverts the system of rule-making based on borders between physical spaces."[81] The first challenge facing Internet psychotherapists and consumers of Internet psychotherapy services is how to determine what laws govern the therapists' actions and protect the consumer from harm. The primary question for psychotherapists concerns licensure laws: must they be licensed in the states in which their patients live or is licensure in the psychotherapist's own state sufficient? A related issue is which states' laws must be obeyed concerning the special duties psychotherapists have to their patients and communities. In addition, the geographic distances between some Internet therapists and their patients creates unique challenges in the fulfillment of these professional duties.

The primary issue facing potential consumers of Internet psychotherapy is similar to the one facing an individual contemplating entering traditional psychotherapeutic treatment: how to ensure that the therapist is a competent professional and the treatment being offered is indeed efficacious. Although many tout the Internet as creating a new form of communities that allow users to become "netizens"[82] of distinct communities formed around interactions in cyberspace,[83] these communities lack the regulatory and communal resources that traditionally protect consumers. Therefore, unlike consumers of face-to-face therapy, it is extremely difficult for Internet psychotherapy patients to avail themselves of the community and

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80. *See* Johnson & Post, *supra* note 3, at 1370.

81. *Id.*

82. *See generally* Robert D. Hof, *Internet Communities,* BUS. WK., May 5, 1997, at 64 (describing as "netizens" individuals who develop a sense of community through their use of the Internet and participation in various on-line fora). *See also* William S. Byassee, *Jurisdiction of Cyberspace: Applying Real World Precedent to the Virtual Community,* 30 WAKE FOREST L. REV. 197, 198-99 (1995) (discussing the development of cyberspace communities).

83. *See* Hof, *supra* note 82.

governmental resources that provide information and consumer protections for consumers of health care services. Furthermore, Internet psychotherapy patients face a problem that is unique to them. Typically, the records of a traditional therapist are based on notes made during or immediately after a session. In contrast, Internet psychotherapeutic treatment results in a verbatim record of *all* therapy sessions.

B. Professional Duties and Internet Psychotherapy

1. Duties to Individual Patients

The establishment of a therapist-patient relationship creates the professional duty of care owed to a patient. As a general rule, a therapist in private practice may choose whomever she wishes to treat.[84] The expressed or implied acceptance by the therapist to treat a patient creates a recognizable relationship and duty.[85] Psychotherapists are expected to practice within the ethical boundaries of the medical or allied health professionals. These include providing services that utilize the appropriate means of assessment and diagnosis,[86] informed consent,[87] and termination.[88]

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84. *See, e.g.*, COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, CURRENT OPINIONS 9.12 (1989). The American Medical Association's ethical standard on the patient/practitioner relationship asserts that the relationship is essentially contractual in nature, but one in which the practitioner has special responsibilities. The standard states:

> The creation of the physician-patient relationship is contractual in nature. Generally, both the physician and the patient are free to enter into or decline the relationship. A physician may decline to undertake the care of a patient whose medical condition is not within the physician's current competence. However, physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, or any other basis that would constitute illegal discrimination. Furthermore, physicians who are obligated under pre-existing contractual arrangements may not decline to accept patients as provided by those arrangements.

Id.

85. *See* RESTATEMENT (SECOND) OF TORTS § 323 (1965) (stating that one who undertakes to render services gratuitously or for consideration is liable for the negligent performance of the undertaking).

86. *See id. See also* STORR, *supra* note 60, at 6-15 (discussing the importance of the initial interview for establishing a good working relationship between psychotherapist and patient); and Scheiber, *supra* note 59, at 164 (describing the importance and essential elements of assessment to understand a patient with a psychiatric disorder).

87. Obtaining truly informed consent for traditional psychotherapy remains a complex challenge. It is difficult to warn patients of the risks of a proposed method of psychotherapy because treatment and outcomes are idiosyncratic. Transference reactions, regressive dependency states, and worsening clinical conditions are difficult to predict. Moreover, to the extent that

Courts have clearly held that a physician-patient relationship and the duty that arises from it can be sustained via telephone contact.[89] This principle has even been applied to the continuation of psychotherapeutic treatment begun in the traditional manner and later conducted almost solely by telephone and audio-cassette tapes.[90] It is likely that courts would consider Internet psychotherapy a legitimate alternative to traditional treatment and hold Internet psychotherapists to the same standards as more traditional therapists. However, the application of this principle is not as straight-forward as it first appears.

Unlike traditional psychotherapy, Internet psychotherapy treatment modalities typically do not include the establishment

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psychotherapeutic modalities can produce benefits, they may also cause harm. Therefore patients need to be informed about the benefits and risks. Generally the standard of care is to give prospective patients a realistic and cautious prognostic assessment, expected outcome with and without treatment, and available alternative treatment, including risks and benefits. The discussion of the latter issue is especially important because the treatment of a psychiatric disorder exclusively by psychotherapy when proven, effective biological treatments exists can be deemed negligence. *See* Osheroff v. Chestnut Lodge, 490 A.2d 720 (Md. 1985), *cert. denied*, 497 A.2d 1163 (Md. 1985) (outlining the elements of a viable negligence action as allegations of negligent failure to diagnose a true condition, negligent treatment, and providing inappropriate treatment for a condition). *See also* Gerald L. Klerman, *The Psychiatric Patient's Right to Effective Treatment: Implications of Osheroff v. Chestnut Lodge*, 147 AM. J. PSYCHIATRY 409 (1990) (arguing that *Osheroff* is an example of malpractice caused by favoring psychotherapy instead of psychopharmacological treatments). *But see* Alan A. Stone, *Law, Science, and Psychiatric Malpractice: A Response to Klerman's Indictment of Psychoanalytic Psychiatry*, 147 AM. J. PSYCHIATRY 419 (1990) (challenging Gerald L. Klerman's theory on patients' legal rights in psychotherapy).

88. The patient has the right to leave treatment at any time and without notice. The therapist has the right to withdraw from a case as long as proper notice is given to the patient so that she may find a suitable substitute. What constitutes sufficient notice depends on the locality. *See* John Mains, *Medical Abandonment*, MED. TRIAL TECH. Q., Spring 1985, at 308, 308-21.

89. *See* Grondahl v. Bulluck, 318 N.W.2d 240, 243 (Minn. 1982) (determining that telephone consultations may constitute proof of a continuing physician-patient relationship and evidence that the physician is attending and examining the patient); Shane v. Mouw, 323 N.W.2d 537 (Mich. Ct. App. 1982) (holding that a telephone conversation between plaintiff and his physician subsequent to treatment may constitute part of the treating or otherwise serving of the plaintiff necessary to provide a basis for a claim for medical malpractice for the purposes of determining the running of the period of limitation); Miller v. Sullivan, 625 N.Y.S.2d 102, 104 (N.Y. App. Div. 1995) (citations omitted) (finding that "[a] telephone call affirmatively advising a prospective patient as to a course of treatment can constitute professional service for the purpose of creating a physician-patient relationship only when the advice, if incorrect, would be actionable).

90. *See* Porter v. Commissioner of Internal Revenue, 51 T.C.M. (CCH) 477, 484 (1986) (holding that a psychiatrist could deduct as business expenses the cost of psychotherapy sessions and telephone charges associated with receiving treatment via the telephone and audio-cassette after his therapist relocated to Costa Rica, and finding that this method of treatment was therapeutic).

of a traditional patient-practitioner relationship that is then continued via the Internet. Moreover, Internet treatment affords practitioners very limited opportunities to diagnosis or assess patients.[91] In addition, the inherent difficulties of obtaining informed consent for psychotherapy patients are magnified by the limited experiences of using this form of treatment and the absence of studies evaluating the efficacy of Internet therapy.[92]

2. Duties to Third Parties and to Vulnerable Populations

When psychotherapists agree to treat a patient, the therapist legally takes charge of the patient. This action forms a "special relationship" between the therapist and patient. When a "special relationship" exits between two people, there is a duty to control the other's behavior or warn third parties of the other's dangerousness.[93] In addition, it is generally recognized that in cases where a defendant "in fact has knowledge, skill, or even intelligence superior to that of the ordinary person, the law will demand of that person conduct consistent with it."[94]

These principles have been examined and in some cases elaborated on by courts in numerous jurisdictions. *Tarasoff v.*

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91. The lack of opportunity for assessment is especially troublesome when the Internet psychotherapist is a psychiatrist. As a medical specialist, a psychiatrist owes a higher duty of skill and care toward patients than a non-psychiatrist. *See* East v. United States, 745 F. Supp. 1142, 1149 (D. Md. 1990) (finding that "the government doctors did not breach the standard of care by failing to provide or arrange psychiatric care"). "The psychiatrist's primary responsibility is to evaluate and treat the patient's mental condition. Since many psychological problems have an organic basis, this responsibility includes determining whether there might be an organic etiology for the psychological problems." *Id.* at 1160-61 (assessing whether or not a psychiatrist is required to perform a thyroid function test on all patients complaining of depression). The current forms of Internet psychotherapy do not include provisions for psychiatrists to conduct comprehensive clinical examinations that include physical and gross neurological exams or laboratory tests that could determine whether the psychiatric complaints are emotional manifestations of an underlying physical illness. This limitation and the lack of efforts by Internet practitioners to make provisions for such evaluations is especially troubling given the evidence demonstrating that medical illness is a major cause of psychiatric morbidity. *See* Erwin K. Koranyi, *Undiagnosed Physical Illness in Psychiatric Patients*, 33 ANN. REV. MED. 309, 311 (1982).

92. *See* discussion *supra* note 70.

93. *See* RESTATEMENT (SECOND) OF TORTS § 315 (1965). *See also* RESTATEMENT (SECOND) OF TORTS § 319 (1965) (stating "one who takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the third person to prevent him from doing such harm").

94. W. PAGE KEETON ET AL., PROSSER AND KEATON ON THE LAW OF TORTS § 32, at 185 (5th ed. 1984).

Regents of the University,[95] as the leading case on this issue, provided the foundation for the development of more specific standards concerning the duties of psychotherapists to third parties.[96] Since *Tarasoff,* a majority of courts examining the issue of the responsibility a therapist has for the acts of violent patients have concluded that the relationship between the psychotherapist and a psychotherapy outpatient constitutes a special relationship which imposes upon the psychotherapist an affirmative duty to protect against, or control, the patient's violent propensities.[97]

These courts have also recognized that the duty is imposed by virtue of the relationship, not by the professional's status.[98] Therefore, psychologists, social workers, other mental health professionals who know, or should have known, of their patient's violent propensities are required to warn third parties of potential danger.[99] The courts do not impose a uniform formulation as to what steps must be taken to alleviate the danger.[100] Depending on the particular situation, a psychothera-

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95. 551 P.2d 334 (1976).

96. In *Tarasoff,* a psychotherapy patient at a University of California hospital killed his former girlfriend. He had previously confided this intention to his therapist. In the lawsuit, brought by the victim's parents against the University and several therapists employed by the University, the California court held that a psychotherapist owes a duty of reasonable care to third parties who may be endangered by the therapist's patients. The court engaged in a two-part analysis. First, the court drew an analogy to cases which have imposed a duty upon physicians to diagnose and give warnings about their patient's contagious disease, and concluded that "by entering into a doctor-patient relationship the therapist becomes sufficiently involved to assume some responsibility for the safety, not only of the patient himself, but also of any third person whom the doctor knows to be threatened by the patient." *Id.* at 344 (citations omitted). Second, the court examined various public policy concerns, concluding that the public interest in safety from violent assaults outweighs the countervailing interests of safeguarding the confidential character of psychotherapeutic communications and the difficulty in forecasting dangerousness. *Id.* at 344-48. The *Tarasoff* court specifically held:

> When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more various steps, warn the intended victim or others likely to appraise the victim of the danger, to notify the police, or take whatever other steps are reasonably necessary under the circumstances.

Id. at 340.

97. *See* Estates of Morgan v. Fairfield Fam. Counseling. Ctr., 673 N.E.2d 1311, 1320 (Ohio 1997) (summarizing cases based on a *Tarasoff* analysis).

98. *See id.* at 1320-21.

99. *See id.* at 1321.

100. *Id.*

pist may or may not be required to perform a number of acts, including prescribing medication, developing a program for treatment, using whatever ability she has to control access to weapons, persuading the patient to voluntarily enter a hospital, issuing warnings or notifying the authorities and, if appropriate, initiating involuntary commitment proceedings.[101] Although some courts have limited the overall duty of therapists, generally the courts conclude that the interests of society to be protected against the violent acts of patients outweigh the concerns of confidentiality, overcommitment, and difficulty of predicting violent acts.[102] Moreover, the duty to warn has become such an intrinsic part of the legal responsibilities of psychotherapists that states have incorporated the duty to warn in the statutes licensing mental health professionals and provided immunity from liability for those practitioners who disclose confidential information while discharging the duty.[103]

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101. *See id.*

102. *See* Brady v. Hopper, 751 F.2d 329 (10th Cir. 1984) (holding that Colorado recognized a psychotherapist's duty to warn the foreseeable victims of his patients, but finding that the victims of John W. Hinckley, Jr. were not reasonably foreseeable victims); Jabolinski v. United States, 712 F. 2d 391, 397 (9th Cir. 1983) (finding that imposing a duty to warn foreseeable victims of a patient at a veterans' hospital would not undermine important governmental programs); Hamman v. Maricopa Cty., 775 P.2d 1122 (Ariz. 1989) (limiting the duty of psychiatrists to third parties only in those instances in which a specific threat is made against them, and holding that the duty extends to third persons whose circumstances place them within the reasonably foreseeable area of danger where the violent conduct of the patient is a threat); Bardoni v. Kim, 390 N.W.2d 218 (Mich. App. Ct. 1986) (discussing a psychiatrist's duty to protect a readily identifiable person endangered by his patient); Lundgren v. Fultz, 354 N.W.2d 25 (Minn. 1984) (finding that a cause of action upon which relief could be granted existed based on allegations a psychiatrist was negligent when he recommended to the police that handguns be returned to a patient that the patient later used to commit murder); McIntosh v. Milano, 403 A.2d 500 (N.J. 1979) (establishing precedent in New Jersey that psychiatrists have a duty to warn the foreseeable victims of their violent patients); Peck v. Counseling Serv. of Addison Cty., Inc., 499 A.2d 422, 426 (Vt. 1985) (holding that a mental health professional has a duty to take reasonable steps to protect third persons from threatened physical harm posed to them by his or her patient); Schuster v. Altenberg, 424 N.W.2d 159 (Wis. 1988) (holding merely that there are no compelling public policy reasons to prevent a claim for relief that would impose liability upon psychotherapists for harm resulting from the dangerous acts of their patients); *but see* Lipari v. Sears Roebuck, 497 F.Supp 185, 193 (D. Neb. 1980) (stating that in Nebraska, therapists have a duty to protect even unnamed victims from harm). *See also* John C. Williams, Annotation, *Liability of One Treating Mentally Afflicted Patient for Failure to Warn or to Protect Third Persons Threatened By a Patient,* 83 A.L.R. 3d 1201 (1996) (analyzing "cases which have determined the liability of one treating a mentally afflicted patient for failure to warn or protect a third person threatened by the patient").

103. *See, e.g.,* ALA. CODE § 34-17A-23 (Michie, LEXIS through 1997 Sess.) (delineating marriage and family therapists' duty to warn reasonably identifiable victim or victims of a serious threat of physical violence communicated by a patient and providing for immunity from monetary liability if confidences are disclosed to third parties in an effort to discharge the duty); MASS.

However, there is not a national consensus about the validity of the duties enunciated under *Tarasoff*. A minority of courts have concluded that the typical psychotherapist-outpatient relationship lacks a sufficient element of control necessary to establish a special relationship. These courts reason that the duty to control is corollary to the right, power, or ability to control and courts have criticized *Tarasoff* for not specifically addressing the issue of a psychotherapist's control over the outpatient.[104] Moreover, some of these courts have found that public policy does not justify the imposition of a duty in an outpatient setting.[105]

In addition to the "*Tarasoff*" duties, treating children, and in some states the elderly, imposes specific professional duties on psychotherapists to report instances or suspicions of abuse involving these vulnerable populations. Most statutes require specific information to be included in a child abuse report. Typically, these statutes require the name of the person making the report, the name and address of the child, the extent of the child's injuries, the child's present whereabouts, and the identity of the individual(s) responsible.[106] However, definitions of

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ANN. LAWS. ch. 112, § 129A (Law. Co-op. 1997) (outlining exceptions to the confidentiality of psychologist-patient communications created by an "explicit threat to kill or inflict serious bodily injury" by patient against himself or another reasonably identified person); NEB. REV. STAT. ANN. § 71-1, 206.30 (Michie, LEXIS through 1997 First Sess.) (specifying psychologist's duty to warn reasonably identifiable victim or victims of a serious threat of physical violence communicated by a patient and providing for immunity from monetary liability if confidences are disclosed to third parties in an effort to discharge the duty); N.H. REV. STAT. ANN. § 330-A:22 (Michie, LEXIS through 1996 Sess.) (delineating licensed mental health professional's duty to warn and take reasonable precautions to provide protections from a client's violent behavior when the client has communicated a serious threat of physical violence against a clearly identified or reasonably identifiable victim or victims or a serious threat of substantial damage to real property); N.J. STAT. § 2A:62A-16 (LEXIS through P.A. 1997, Second Ann. Sess.) (providing for medical or counseling practitioners' immunity from civil liability for discharging the duty to warn against a patient's threats of violent behavior and outlining when those duties are incurred); UTAH CODE ANN. § 78-14a-102 (Michie, LEXIS through 1997 First Spec. Sess.) (specifying when a therapist has a duty to warn or take precautions to provide protection from any violent behavior of his client or patient and providing for immunity against causes of action for breach of trust or privilege or for disclosure of confidential information in discharging the duty to warn).

104. *See* Estates of Morgan v. Fairfield Fam. Counseling Ctr., 673 N.E.2d 1311, 1322 (1997).

105. *See, e.g.*, Boyton v. Burglass, 590 So.2d 446 (Fla. Dist. Ct. App. 1991) (declining to recognize the rule announced in Tarasoff v. Regents of the University of California); Currie v. United States, 836 F.2d 209, 210 (4th Cir. 1987) (holding that the North Carolina Supreme Court would not hold a competent therapist to a duty of affirmatively seeking control over his patient through involuntary commitment).

106. *See, e.g.*, N.Y. SOC. SERV. LAW § 415 (McKinney 1992); TENN. CODE ANN. § 37-1-

what constitutes a child,[107] abuse and neglect,[108] and the individual who can be accused of child abuse[109] for purposes of the statute, differ. Most importantly, there are significant differences in the designation of what type of professional is a mandated reporter.[110]

403(c) (1996); WASH. REV. CODE ANN.§§ 26.44.020-.040 (West 1996).

107. A child for abuse reporting purposes is not always synonymous with minor under state law. For example, in Massachusetts, child abuse reports must be filed for all persons under 18 years of age who satisfy other criteria for reporting. MASS. GEN. LAWS. ANN. ch. 119, § 51A (Law. Co-op. 1996). However, in New York, an abused child may be older than 18 in some cases. *See* N.Y. SOC. SERV. LAW § 412(1)(c) (McKinney 1997).

108. Some states define an "abused and neglected" child as a single term. *See, e.g.*, FLA. STAT. ANN. ch. 415.503(1) (West 1997) (stating what conditions to which a child must be subjected to be an abused or neglected child); and HAW. REV. STAT. § 350-1 (1993) (stating the definition of "child abuse or neglect"). Other states distinguish "abuse" from "neglect." *See, e.g.*, LA. CHILD. CODE art. 603 § 1, 14 (1996); TEX. FAM. CODE ANN. § 261.001(1)(A)-(J), (4)(A)-(C) (West 1996 & Supp. 1998); *but see* N.Y. SOC. SERV. LAW § 412(1)-(2) (McKinney 1997) (defining "abused child" and "maltreated child" separately). Some states provide specific definitions of related terms such as "sexual abuse." *See, e.g.*, CAL. PENAL CODE § 11165.1 (1997) (defining the terms "sexual abuse" and "sexual assault"). These definitions of abuse generally include both physical and mental harm or threats of harm caused by the acts or omissions of certain persons. Sexual abuse, unusual punishment, or other unexplained physical injuries constitute abuse under most laws. *See, e.g.*, FLA. STAT. ANN. § 415.503 (West 1993) and HAW. REV. STAT. § 350-1 (1993) (providing an example of a statute that defines abuse as acts or omissions that cause physical or mental harm to the child and listing some examples of injuries that require a justifiable explanation); TEX. FAM. CODE ANN. § 261.001(1)(C), (E) (West Supp. 1998). Impairment of the child's ability to perform or function and other signs of emotional or psychological distress indicate potential abuse in many states. *See, e.g.*, HAW. REV. STAT. § 350-1 (3) (1993) (stating that an "injury to the psychological capacity of a child as evidenced by an observable and substantial impairment in the child's ability to function" indicates an act or omission constituting child abuse or neglect); TEX. FAM. CODE ANN. § 261.001 (1)(A) (West Supp. 1998). Elements of neglect may include failure to provide adequate food, clothing, shelter, or health care. *See, e.g.*, TEX. FAM. CODE ANN. § 261.001(4)(B)(ii-iii) (West 1996).

109. Some states refer to abuse by a child's parent or other person responsible for the child's welfare. *See, e.g.*, FLA. STAT. ANN. § 415.503(1) (West 1993); HAW. REV. STAT. § 350-1 (1993) (defining "child abuse or neglect" as "acts or omissions of any person who, or legal entity which, is in any manner or degree related to the child, is residing with the child, or is otherwise responsible for the child's care"); *See, e.g.*, LA. CHILD. CODE art. 603 § 1, 14 (1996). Other statutes address abuse or neglect of a child caused by "a" person. *See, e.g.*, TEX. FAM. CODE ANN. § 261.001(1), (4) (West 1996 & Supp. 1998).

110. Some states impose mandatory report obligations on specific categories of people, including designated health care professionals. Practitioners and other health care workers subject to mandatory reporting may be listed directly in the child abuse reporting provisions and/or may be cross-referenced to the state health care professional licensing statute. *See, e.g.* HAW. REV. STAT., § 350-1.1(a) (1993) (stating that Hawaii requires certain professionals to report suspected child abuse); MD. CODE ANN., [FAM. LAW] §§ 5-701(h), 5-704(a) (1991); WASH. REV. CODE ANN. § 26.44.020(3) (West 1997). Most child abuse reporting requirements are mandatory for health practitioners: only a few laws are permissive. *See, e.g.*, MISS. CODE ANN. § 93-21-25 (1994) (providing that written reports *may* be made if abuse is suspected) (emphasis added). In some states, the list creates a fixed group of professionals subject to reporting. *See, e.g.*, N.Y. SOC. SERV. LAW § 413 (McKinney 1997). In other states, the list is merely illustrative, stating that individuals who provide health care services, including those listed, must report. *See, e.g.*, FLA. STAT. ANN. § 415.504(1)(a), (b) (West 1993); HAW. REV. STAT. § 350-1.1(a) (1993) (listing those

Several states have extended abuse reporting requirements to cover the known or suspected abuse of vulnerable adults such as senior citizens, institutionalized persons, nursing home residents, and persons suffering from physical or mental impairments.[111] Like child abuse statutes, laws on the abuse of adults typically define terms such as "abuse" or "neglect"[112] and require various health practitioners to report instances that create a reasonable basis for believing abuse has occurred and provide information about the victim's condition, location, and the abuser.[113]

The challenges for Internet psychotherapists attempting to fulfill their professional duties to third parties go beyond the question of which state law governs the therapist's professional responsibilities. As currently practiced, Internet psychotherapy does not allow therapists any means to evaluate patients' violent potential. Moreover, therapists using treatment modalities other than tele-conferencing cannot rely on vocal intonations or body language to assess the veracity of their patients' reports of violent ideations or abuse.

Furthermore, the very acts required to fulfill professional responsibilities to third parties are made more difficult by the technological and geographic barriers created by Internet communications. The Internet grants individuals a level of anonymity and potential for disguise[114] that is impossible for tra-

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who must report suspected instances of child abuse or neglect as including, but not limited to, "physicians, including physicians in training, psychologists, dentists, nurses, osteopathic physicians and surgeons, optometrists, chiropractors, podiatrists, pharmacists, and other health-related profession"); MD. CODE ANN., [FAM. LAW] §§ 5-701(h), 5-704(a) (1991); WASH. REV. CODE ANN. § 26.44.020(3) (West 1997).

111. *See, e.g.*, CAL. WELF. & INST. CODE § 15610 (West 1996) (describing abuse with references to various sections of the Penal Code and as unreasonable constraint or deprivations or punishments, and describing neglect as negligent failure to provide reasonable care); FLA. STAT. ANN. §§ 415.101-415.114 (West 1993); IOWA CODE §§ 235B.1-235B.16 (1996) (creating an adult abuse reporting system); MINN. STAT. ANN. § 626.557 (1), (3) (West Supp. 1997) (defining relevant terms and who is mandated to report suspected abuse).

112. *See, e.g.*, CAL. WELF. & INST. CODE §§ 15600-15657.3 (1996); FLA. STAT. ANN. §§ 415.101-415.114 (West 1993).

113. *See, e.g.*, MINN. STAT. ANN. § 626.5572 (2), (17), 626.557 (3) (West Supp. 1997) (requiring immediate reporting).

114. *See* Edmund Lee, *Who Are You?*, VILLAGE VOICE, Feb. 18, 1997, at 30 (describing individuals "masquerading" on the Internet by taking on the identity of specific organizations or people). An additional layer of geographic confusion can be created by using Telnet. *See* Dan L. Burk, *Federalism in Cyberspace*, 28 CONN. L. REV. 1095, 1112 (1996) (describing the use of Telnet). An Internet address may indicate the location of a given machine but not an actual user,

ditional psychotherapy patients.[115] Even if psychotherapists decide that they have a *Tarasoff* duty, the limited ability to exercise the kind of control over a violent patient imposed by the duty would be severely hampered by geographic distance and the possibility the patient is using a false identity or is concealing her true identity.

This challenge of fulfilling professional duties to vulnerable populations becomes even more troubling when the possibility of a child or adolescent communicating with an Internet psychotherapist is considered. Although most Internet psychotherapy requires the use of a credit card to receive services, possession of a credit card is not an effective surrogate device for obtaining proof of age.[116] It is quite possible that a curious or emotionally desperate minor would use a parent's card to seek psychological assistance over the Internet. Not only are Internet therapists limited in their abilities to effectuate therapeutic measures designed to ameliorate the effects of abuse, but they would be acting without a firm sense of which jurisdiction could provide the social services necessary to intervene in an abusive situation because the therapist may not know where her patient really lives.[117]

C. Challenges to Protecting Consumers of Internet Psychotherapy

It is unlikely that the primary concerns of most Internet psychotherapy patients are the abilities of therapists to fulfill their professional responsibilities to third parties or to comply with statutes governing the reporting of child abuse. Instead,

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since telnet allows users to access an Internet account based at one computer domain through another. *Id.* at 113. In addition, anonymous remailers, another Internet-based software device, can be used to channel an Internet transmission through a third-party. *See* LANCE RODE, NETLAW: YOUR RIGHTS IN THE ON-LINE WORLD 183-84 (1995) (describing anonymous remailers). By using an anonymous remailer, a user can totally obscure her identity. *Id.*

115. *See* American Civil Liberties Union v. Reno, 929 F. Supp. 824, 845 (E.D. Pa. 1996) (discussing the fact that an e-mail address provides no authoritative information about the addressee, and the ease with which an individual may develop an e-mail "alias"), *aff'd* 117 S.Ct. 2329 (1997).

116. *See id.* at 845 (stating that there "is no effective way to determine the identity or age of a user accessing material through e-mail, mail explorers, newsgroups, or chat rooms").

117. *Cf. id.* at 118 (analyzing the jurisdictional problems created by e-mail therapy and the difficulty in determining what state law applies to causes of action resulting from Internet communications).

Internet psychotherapy patients are more likely concerned with the questions that all psychotherapy patients have about a potential therapist's training, practice experience, and ability to help with the difficulties an individual is experiencing.[118] In addition, with the increasing presence of managed care systems and efforts to computerize health care records, psychotherapy patients are also concerned about the privacy of their records, as well as notes and observations recorded by their therapist.[119]

1. The Absence of Community Standards and Resources

The Internet is often described as a new kind of community formed through interactions in cyberspace.[120] Although users may develop feelings of trust and affinity for another, unlike traditional communities, the Internet lacks communal structures that regulate the practice of the healing arts and protect consumers from incompetent practitioners. Unfortunately, it is all too easy to lure unsuspecting users through blatantly false Web pages[121] that advertise the services of a "psychotherapist" who lacks the training or experience to work with patients as a psychotherapist, let alone to cope with the limitations imposed by Internet treatment modalities.

Unlike patients seeking treatment from traditional psychotherapists, Internet consumers cannot completely rely on the licensure requirements and practice regulations imposed by states on mental health professionals. Internet psychotherapy patients may not know from what state their therapists are transmitting interpretations. Therefore, they could not investigate the therapist's licensure or report violations of professional standards to the appropriate authorities.

Although there have been efforts by proponents of telemedicine[122] to develop a system of medical licensure that

118. *See generally Mental Health Does Therapy Help?*, 60 CONSUMER REP. 734 (1995) (discussing the concerns by psychotherapy patients about the qualifications of their therapists).

119. *See* Maggie Scarf, *Keeping Secrets*, N.Y. TIMES, June 16, 1996, (Magazine) at 38 (describing how managed care is threatening therapist-patient privacy).

120. *See supra* note 82.

121. Georgia has attempted to address this issue by prohibiting false identification when using on-line services. *See* GA. CODE ANN. § 16-9.9.1 (1996).

122. Telemedicine is defined as "the practice of health care delivery, diagnosis, consultation,

would allow physicians to conduct interstate telemedicine consultations,[123] no state has revised its professional regulations to incorporate provisions that govern Internet mental health services provided by psychiatrists or non-physician therapists. In fact, California, the state at the forefront of telemedicine licensure, explicitly rejects characterizing electronic mail communications between physicians and patients as telemedicine communications.[124] Therefore, under existing state licensure laws, even if a dissatisfied or harmed patient complained to the appropriate state agency in the controlling jurisdiction, the absence of a specific professional regulation would make it difficult for that agency to assert regulatory control over Internet therapists.

Moreover, Internet psychotherapy patients are limited in their ability to access the type of referral information that protect savvy consumers of traditional health care services. Traditionally, prospective therapy patients are advised to find a potential psychotherapist by seeking information from their physician, a mental health professional organization, and/or knowledgeable and trustworthy friends.[125] Additionally, pa-

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treatment, transfer of medical data, and education using interactive audio, video, or data communications." *See, e.g.*, CAL. BUS. & PROF. CODE § 2290.5 (West 1998). Typically, telemedicine projects focus on providing rural populations with access to consultations with medical specialists typically located in large urban areas or affiliated with major medical institutions. *See, e.g.*, Paul M. Orbuch, *A Western States' Effort to Address Telemedicine Policy Barriers*, 73 N.D. L. REV. 35, 35-36 (1997) (describing solutions to the various public policy and regulatory challenges impeding the development of telemedicine); Dena S. Puskin, *Telecommunication in Rural America: Opportunities and Challenges for the Health Care System*, 670 ANNALS N.Y. ACAD. SCI. 67, 71, 74 (1992) (describing telemedicine projects connecting rural health care providers to consultation and education services).

123. Almost every discussion of telemedicne includes an analysis of the problems created by the lack of national uniform medical licensure standards. A review of all issues involved and an analysis of various solutions that address licensing requirements for interstate medicine is beyond the scope of this Note. For an excellent summary of these issues and information on various statutory schemes for licensure of medical practitioners providing interstate services, see generally THE CENTER FOR TELEMEDICINE LAW, TELEMEDICINE AND INTERSTATE LICENSURE: FINDINGS AND RECOMMENDATIONS OF THE CTL LICENSURE TASK FORCE, 73 N.D. L. REV. 109 (1997). *See also* CAL. BUS. & PROF. CODE § 2060 (Deering 1997) (permitting nonresident practitioners licensed in another state to participate in telemedicine consultations with physicians licensed in California).

124. *See* CAL. BUS. & PROF. CODE § 2290.5 (West 1997) ("Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient constitutes 'telemedicine' for purposes of this section").

125. *See* Mary K. Williams, *Therapeutic Approach: Choosing Mental Health Care to Fit Your Needs*, CHICAGO TRIB. Jan. 10, 1997, at C1.

tients have often turned to referral and clinical services conducted by community mental health services, university programs that train therapists, psychoanalytic institutes, and teaching hospitals to find a reputable psychotherapist.

Although there are Internet-based services that list descriptions of therapists' backgrounds and credentials,[126] these efforts are just the beginning. The need for screening services and information is made especially acute by the fact that Internet psychotherapy and the avoidance of travel it affords patients is appealing to individuals who are made extremely vulnerable to exploitation because of their psychopathology. It is easy to imagine a pathologically embarrassed or phobic person too afraid to leave her house, turning to an Internet psychotherapy service for solace, and being exploited and harmed by an unscrupulous Internet "therapist."

2. Privacy and Internet Psychotherapy Records

Increasingly, psychotherapists and their patients are losing the right to privacy for psychotherapy records. Psychotherapists who are under contract with managed care organizations are particularly vulnerable to demands for disclosures of previously private patient information to justify psychotherapeutic treatment.[127] Not only are therapists required to give detailed diagnoses, but they are also called upon to provide extensive descriptions of patients' problems and specific treatment plans.[128] Additionally, the use of computer systems that allow physical medical and nonmedical personnel to access psychotherapy records and session notes demonstrates the erosion of the privacy rights of patients receiving traditional forms of psychotherapy.[129]

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126. *See, e.g., Credential Check* (visited Feb. 19, 1998) <http://www.cmhc.com/check/> (providing a listing and credentialing service for Internet psychotherapists).

127. *See* Scarf, *supra* note 119, at 39 (discussing the pressures experienced by psychotherapists to release information that under normal circumstances they would not release in order to justify patients' continued treatment).

128. *See id.*

129. *See id.* at 38. The National Coalition of Mental Health Professionals and Consumers documents cases involving the invasion of privacy by managed care organizations. One of the most striking examples of the dangers of allowing nonmedical personnel ready access to psychotherapy records was reported by an employee of a self-insured organization. This man reported that after being denied a promotion he learned from a subsequent employer that he had

The governmental response to this issue is a pressing concern of mental health consumer advocates.[130] Recent passage of federal statutes calling for the standardization of computerized medical information compiled by doctors, hospitals, health plans, and insurers may serve to create a national medical databank.[131] Although electronic links among health-care providers may facilitate the provision of emergency medical services by making it easier for medical personnel in emergency situations to access a patient's complete record, it is feared that this system may contribute to the further undermining of the privacy afforded psychotherapy patients.[132]

The threat to Internet psychotherapy patients is even more significant than the one facing traditional patients because Internet psychotherapy sessions result in a verbatim record of a session that can be downloaded and easily transmitted to third parties by hackers[133] satisfying their voyeuristic curiosity, or those with a more legitimate claim to the information. The only privacy protection Internet psychotherapy patients have are the promises extended by practitioners to protect patients' records and encrypt transmissions.[134] Since the development of Internet psychotherapy is still at the embryonic stage, the effectiveness of this self-regulation has not been subject to widespread testing.

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become a subject of office gossip and ridicule after clerks in the company's insurance office had read and discussed his therapist's reports. *See id.*

130. *See id.* at 40 (describing the efforts of consumer and legal rights groups to oppose federal efforts to encourage the establishment of a computerized medical information network).

131. Standards for Information Transactions and Data Elements, 42 U.S.C.A. § 1320d-2 (1997) (discussing standards to enable electronic exchange).

132. *See generally* Scarf, *supra* note 119.

133. The Electronic Communications Privacy Act of 1986 covers voice communications via the telephone and digital communications including text and digitized visual images. *See* 18 U.S.C. § 2510 (1997). It also prohibits the unauthorized interception of messages in transmission and accessing of information stored in a computer system. *See id.* § 2511(1).

134. Encryption is a method for users to insure the privacy of their transmissions. *See* RODE, *supra* note 114, at 181. Users transmit their messages as encrypted files without giving anyone but the intended recipient the decryption key in an attempt to protect the privacy of the message. *Id.* The majority of Internet psychotherapists offer encryption for the transmission of credit card information and others encourage its use for the transmission of material being shared for therapeutic purposes. However, the sanctity of encrypted messages is not fully guaranteed. *Id.* at 181 (outlining the limitations of encryption programs). In addition, the federal government may succeed in establishing measures that would allow investigatory agencies access to encryption keys to facilitate investigations of crimes. *Id.* at 182.

Currently, Internet psychotherapy practitioners advertise their services as a way to avoid the expense and intrusiveness associated with managed care. However, it is not inconceivable that managed care organizations would seize the potential cost and time-saving benefits of Internet psychotherapy. The need to provide specific regulations to protect Internet psychotherapy records may become a pressing issue as the use of these treatment modalities expand and managed care companies enter the Internet psychotherapy market.

IV. RESPONDING TO THE CHALLENGES

The overarching challenges created by Internet psychotherapy are how to ensure that therapists can fulfill their professional responsibilities to both patients and third parties and guarantee that patients receive beneficial treatment without imposing such stringent regulations that the development of Internet treatment is stifled. Moreover, there is a pressing need to develop measures that protect the privacy of Internet psychotherapy sessions and records.

This section discusses the rationale, benefits, and limitations of the existing efforts to address these issues, and proposes the development of a national Internet health care infrastructure to address the challenges created by Internet psychotherapy and other health care services that may be conducted via the Internet in the future.

The national Internet health care infrastructure is premised on two specific arguments about the nature of Internet psychotherapy. First, although Internet psychotherapy may have resulted from the evolution of media-based therapeutic activities, it should not be dismissed as merely entertainment. Instead, it must be regarded as a health care service requiring regulation. Second, and more importantly, Internet psychotherapy represents a significant expansion of the interstate practice of the healing arts. This change in the nature of health care practices justifies the involvement of the federal government in regulating activities traditionally the province of state governments.

A. Self-Regulation

Currently, the only guidelines and regulatory practices explicitly addressing Internet psychotherapy are the ones being promulgated by professional organizations or initiated by individual practitioners. Recently, mental health professional groups began to establish guidelines for Internet psychotherapy[135] or adapt already existing standards for traditional face-to-face treatment[136] to Internet treatment modalities. Individu-

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135. *See* Schwardon, *supra* note 1 (discussing the development of Internet-based practice guidelines).

136. In 1995, the American Psychological Association (APA) Ethics Committee adopted a 1993 statement regarding "Psychotherapy by Telephone" to include treatment via the Internet. ETHICS COMMITTEE, AMERICAN PSYCHOLOGICAL ASSOCIATION, SERVICES BY TELEPHONE, TELECONFERENCING, AND INTERNET (1995) *rev. by* Ethics Committee, American Psychological Association, *Services by Telephone, Teleconferencing, and Internet* (visited Mar. 3, 1998) <http://www.apa.org/ethics/stmnht01.htm>. The guidelines express concern about Internet modalities that do not include a visual component, and caution psychologists contemplating offering such services to consider the relevant ethical standards and legal requirements concerning the interstate practice of psychology. *Id.*

In addition to APA guidelines, Shapiro and Schulman have developed a model ethical standard that adds specificity to the existing guidelines. Although Shapiro and Schulman recognize that the Internet offers a number of different modalities of communication, they focus solely on therapeutic exchanges via e-mail. The Shapiro and Schulman standard states:

> Psychologists offering e-mail facilitated therapeutic communication encourage clients to ask general questions that do not refer to a specific individual. Psychologists advertising such services include in advertisement all information necessary for clients to understand (a) the modality is experimental and its usefulness may be unrelated to the success of traditional therapies, (b) the communication is not confidential, (c) no therapist-client professional relationship exists, (d) repeated communications with the same professional are discouraged, and (e) records of the interaction may be stored with no report of such storage available to the client. Psychologists using e-mail to communicate with new clients encourage clients to seek more traditional therapies. Psychologists do not transmit confidential information, including payment information such as credit card data, by e-mail without encryption programs considered the standard.

Shapiro & Schulman, *supra* note 15, at 122-23.

In September, 1997, the National Board of Certified Counselors (NBCC) adopted Standards for the Ethical Practice of WebCounseling. The Standards encourages "WebCounselors" to:

> 1) Review pertinent legal and ethical codes for possible violations emanating from the practice of WebCounseling and supervision. Liability insurance polices should also be reviewed to determine if the practice of WebCounseling is a covered activity. Local, state, provincial, and national statutes as well as the codes of professional membership organizations, professional certifying bodies and state or provincial licensing boards need to be reviewed. Also, as no definitive answers are known to questions pertaining to whether WebCounseling takes place in the WebCounselor's location or the WebClient's location, WebCounselors should consider carefully local customs regarding age of consent and child abuse reporting.
>
> 2) Inform WebClients of encryption methods being used to help insure the security of client/counselor/supervisor communication. Encryption methods should be

used whenever possible. If encryption is not made available to clients, clients must be informed of the potential hazards of unsecured communication on the Internet. Hazards may include authorized or unauthorized monitoring of transmissions and/or records of WebCounseling sessions.

3) Inform clients if, how, and how long session data are preserved. Session data may include WebCounselor/WebClient e-mail, test results, audio/video session recordings, session notes, and counselor/supervisor communications. The likelihood of electronic sessions being preserved is greater because of the ease and decreased costs involved in recording. Thus, its potential use in supervision, research, and legal proceedings increases.

4) In situations where it is difficult to verify the identify of WebCounselor or WebClient, takes steps to address imposter concerns, such as by using code words, numbers, or graphics.

5) When parent/guardian consent is required to provide WebCounseling to minors, verify the identity of the consenting person.

6) Follow appropriate procedures regarding the release of information for sharing WebClient information with other electronic sources. Because of the relative ease with which e-mail messages can be forwarded to formal and casual referral sources, WebCounselors must work to insure the confidentiality of the WebCounseling relationship.

7) Carefully consider the extent of self disclosure presented to the WebClient and provide rationale for WebCounselor's level of disclosure. WebCounselors may wish to ensure that, minimally, the WebClient has the same data available about his/her service provider as would be available if the counseling were to take place face to face (i.e. possibly ethnicity, gender, etc.). Compelling reasons for limiting disclosure should be presented. WebCounselors will remember to protect themselves from unscrupulous users of the Internet by limiting potentially harmful disclosure about self and family.

8) Provide links to websites of all appropriate certification bodies and licensure boards to facilitate consumer protection.

9) Contact NBCC/CEE or the WebClient state or provincial licensing board to obtain the name of at least one Counselor-On-Call within the WebClient's geographical region. Further, WebCounselors have contacted that individual to determine his or her willingness to serve as a Counselor-On-Call (either in person, over the phone, or via e-mail) should that WebClient need emergency counseling services. Local crisis intervention hotline numbers, 911 and similar numbers may also be suggested when local Counselor-On-Calls are unknown or unavailable.

10) Discuss with their WebClients procedures for contacting the WebCounselor when he or she is off-line. This means explaining exactly how often e-mail messages are checked by the WebCounselor.

11) Mention at their websites those presenting problems they believe to be inappropriate for WebCounseling. While no conclusive research has been conducted to date, those topics might include: sexual abuse as a primary issue, violent relationships, eating disorders, and psychiatric disorders that involve distortions of reality.

12) Explain to clients the possibility of technology failure. The WebCounselor gives instructions to WebClients about calling if problems arise, discusses the appropriateness of the client calling collect when the call might be originating from around the world, mentions differences in time zones, talks about dealing with response delays in sending and receiving e-mail messages.

13) Explain to clients how to cope with potential misunderstanding arising from the lack of visual cues from WebCounselor or WebClient. For example, suggesting the other person simply say, "Because I couldn't see your face or hear your tone of voice in your e-mail message, I'm not sure how to interpret that last message." STANDARDS FOR THE ETHICAL PRACTICE OF WEBCOUNSELING, (National Board for

al psychotherapists are also attempting to practice self-regulation by limiting their practice to patients who do not seem to have a propensity for dangerous behavior,[137] or by refusing to treat actively suicidal individuals, while providing information about emergency intervention services for people with suicidal ideations.[138]

1. The Advantages of Self-Regulation

Self-regulation of Internet psychotherapy has distinct advantages. These efforts are consistent with the social attitudes that have arisen with the proliferation of Internet culture and communities. Many "netizens" are fearful of government involvement in Internet activities[139] and advocate that the Internet remain a bastion of unregulated communications and a

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Certified Counselors) (1997). These standards address some of this issues raised in this Note and by other critics of the current state of Internet psychotherapeutic practices. However, the standards are voluntary and they do not provide for the implementation of the suggested safeguards. Therefore, the NBCC standards should be considered purely aspirational goals and demonstrate the need for specific regulations governing the licensure and practice of Internet psychotherapists.

137. One of the most legalistic disclaimers is provided by PSYCHCARE a service run by a Colorado-based licensed, clinical neuropsychologist. *See* Richard Cook, *Psych Care* (visited Mar. 7, 1998) <http://www.psychcare.com/>.

The disclaimer states:

> PSYCHCARE, the electronic, interactive, Internet psychological practice is an alternative modality for the treatment of various psychological issues and disorders. It is not intended, nor does it replace, other psychological treatment regimes. It is not intended for the treatment of psychotic disorders or suicidal or homicidal ideation. In the event that suicidal or homicidal ideation is assessed by the treating clinician to be of imminent risk, the appropriate authorities will be contacted per State and Federal statutes in accordance with the Ethical Code of the American Psychological Association. In such cases, you are encouraged to contact your local medical or mental health professional. Similar contact will be made in the event of suspected child abuse or domestic violence. All records are entirely confidential, with the exception of those situations delineated above. No guarantees are stated, nor implied, with respect to the results of the treatment.

Id.

Although this disclaimer specifies some of the parameters that govern an Internet therapeutic relationship, it is questionable whether a lay-person could understand the statement. The lack of clarity indicates the need for more specific guidelines and access to consumer resources to protect individuals undergoing Internet psychotherapy.

138. *See Wired Senses, supra* note 5 (describing the need for suicidal individuals to seek immediate assistance from a local mental health professional or suicide prevention organization).

139. *See* Jonah Sieger, *Communications Decency Act is Defeated: Landmark Victory for Netizens,* COMMUNICATIONS OF THE ACM, Aug. 1996, at 13-15 (describing the efforts of the Citizens Internet Empowerment Coalition (CIEC) to defeat the Communications Decency Act of 1996 and advocating continued political activity to prevent government regulation of the Internet).

forum for the free exchange of information.[140] They advocate the continuation of the frontier mentality that characterized Internet activities prior to the explosion in the number of users that occurred during the 1990s.[141] This view is also in keeping with the policies concerning the Internet recently announced by the Clinton Administration. Although the Clinton Administration originally opposed self-regulation, with the recent Supreme Court decision[142] finding the Communications Decency Act of 1996[143] unconstitutional, the Clinton Administration has embraced a policy of minimal government intervention in Internet transactions and activities.[144] Self-regulation of Internet psychotherapy can also be considered a continuation of the psychoanalytic tradition of permitting the development of technical innovations by those practitioners who are daring enough to experiment with the accepted canon of therapeutic techniques.[145] Strict regulations or measures that discourage the exploration of Internet treatment modalities might deter those therapists willing to conduct treatment via the Internet. Moreover, it may have a negative impact on what could potentially become an important aspect of modern psychoanalytic culture. Imposing overly stringent regulations might interfere with the use of the Internet as a way to revive the psychoanalytic tradition of correspondence[146] in the computer age. Most importantly, hampering the development and practice of Internet psychotherapy might prevent patients unwilling or unable to consider traditional psychotherapy, but willing to participate in Internet-based treatment, from experiencing the benefits of psychotherapeutic assistance.

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140. *See id.*

141. *See* RODE, *supra* note 114, at 120 (comparing early Internet activities and the mentality of Internet users to the frontier justice of the American west).

142. Reno v. ACLU, 929 F. Supp. 824 (E.D. Pa. 1996), *aff'd* 117 S.Ct. 2329 (1997).

143. 47 U.S.C. § 223 (1994) (criminalizing the "knowing" transmission of "obscene or indecent" messages to any recipient under 18 years of age).

144. *See Hands Off the Internet,* ECONOMIST, July 5, 1997, at 15 (discussing President Clinton's "minimal governmental intervention" approach to Internet regulation).

145. *See* discussion *supra* Part I.A.2.

146. *See* discussion *supra* Part I.A.1.

2. The Disadvantages of Self-Regulation

Self-regulation does, however, have some significant disadvantages. Obviously, self-regulatory schemes created by professional organizations are limited in their protective value because they are not legally binding. The use of disclaimers as means to limit Internet treatment to patients who appear not to create the need to alert third parties or report abuse is not a guarantee that a patient might not share the kind of information that would require action by the therapist. Moreover, the legality of these disclaimers is questionable. The validity of a release from liability for future negligence imposed as a condition prior to the rendering of a health service is not likely to survive a court challenge because it is contrary to the public interest to allow health care providers to require prearranged exculpation from negligence for the provision of services.[147]

B. Civil Actions that Establish Practice Guidelines

The impact of civil litigation on the practice of psychotherapy is significant. *Tarasoff* and its progeny are the clearest examples of how case law develops into standards that guide therapists in recognizing specific legal duties. It is possible to rely on the adjudication of a cause of action against an Internet psychotherapist for the establishment of specific professional responsibilities that govern the practice of Internet psychotherapy.

This method of regulation would allow Internet psychotherapy to develop unfettered by potentially rigid regulatory schemes. However, this approach is not without significant disadvantages. The most important is the fact that an individual would have to sustain enough damage from the negligence of an Internet psychotherapist before any guidelines are established. In addition, potential consumers of Internet psychotherapy services would remain unprotected until the completion of the typically lengthy legal process.[148]

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147. *See* Tunkl v. Regents of the University of California, 383 P.2d 441 (Cal. 1963) (holding that a release from liability imposed as a condition for admission to a charitable research hospital was invalid under California law).

148. The adjudication of any Internet-related issue is complicated by the question of jurisdiction, minimum contacts, and other procedural issues. The courts have only recently begun

Most importantly, a tort remedy is not a guarantee that practice guidelines designed to extend protection to individual consumers would be established. Furthermore, relying on a court to establish standards of care for a psychotherapeutic treatment modality has the potential of establishing a precedent that would allow courts the opportunity to interfere with the development of psychotherapy and other health care practices.

C. Creating an Internet Health Care Infrastructure

The most effective way to ensure the development of efficacious Internet-based psychotherapy is to construct a federally administered regulatory infrastructure[149] that replicates the licensure and consumer protections available to patients of traditional psychotherapy and encourages psychotherapists to fulfill their professional responsibilities. The creation of such a system would also serve as an important model for the development of an Internet health care infrastructure that would govern and facilitate the development of the growing number of Internet services currently providing information to patients suffering from physical illnesses[150] or seeking information

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to address procedural questions raised by the Internet. However, these issues are beyond the scope of this Note. For an overview of the procedural challenges created by litigation stemming from Internet activities with a particular focus on jurisdictional issues, see generally Burk, *supra* note 114, at 1095.

149. The term infrastructure is used in the metaphorical sense and is borrowed from earlier discussions of the limitations created by the lack of a cohesive telecommunications infrastructure in the practice of telemedicine. *See generally* Dena S. Puskin & Jay H. Saunders, *Telemedicine Infrastructure Development,* 19 J. MED. SYS. 125 (1995) (discussing the technical and regulatory barriers to developing an adequate infrastructure for telemedicine). The ever-increasing sophistication of Internet technologies and the federal government's commitment to expand the use of the Internet is making a moot issue of the need to focus on the development of a physical infrastructure to facilitate the development of Internet health care services. However, the lack of a legal infrastructure to govern the provision of health care services via telecommunication and computer communications remains a pressing concern. Although there have been efforts to address licensure issues for physicians providing telemedical services, it must be remembered that these services are typically provided within the context of medical services offered by hospitals and other strictly regulated institutions. Moreover, efforts to expand licensure for telemedicine have explicitly excluded internet-based communications. *See supra* notes 124-26 and accompanying text (discussing the practice of telemedicine and licensure for telemedicine practitioners). Therefore, an Internet health care infrastructure that would benefit and protect Internet psychotherapy patients must include more specific consumer protection provision because an Internet psychotherapy treatment dyad does not benefit from the supervision that protects patients who receive treatment within the confines of an institutionalized and regulated health care system.

150. *See* Cynthia N. James-Catalono, *Doctor's Advice,* INTERNET WORLD, Feb. 1997, at 30 (describing burgeoning Internet services offering personalized medical advice via chat rooms and

and referrals to health care providers because of a possible genetic condition.[151]

1. Uniform Licensure

The first step in the creation of an Internet health care infrastructure is the development of uniform licensure standards. The primary goal of such measures is to ensure that mental health practitioners offering services over the Internet have achieved a minimum level of competency. The most efficient method for the administration of this system is to grant an Internet license to individuals who already held licenses to practice as a physician, psychologist, social worker, or mental health counselor in a specific state. To acquire an Internet license, mental health professionals would be required to obtain additional training through course work and conducting treatment under supervision that would be specifically focused on Internet treatment modalities.

a. Existing Models

Fortunately, there are existing models for this kind of professional regulation. Although the healing art professions are traditionally regulated by states as an exercise of police powers, both the healing art and legal professions provide models for standardized national licensure schemes. All fifty states require aspiring physicians to pass the three-step U.S. Medical Licensing Examination administered by the National Board of Medical Examiners and the majority of states require attorneys to pass the Multi-State Professional Responsibility Examination (MPRE) and Multi-State Bar Examination (MBE)

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e-mail and predicting the proliferation of these services).

151. In 1996, the National Cancer Institutes awarded the Robert H. Laurie Cancer Center of Northwestern University a grant to develop and conduct education and training programs on the genetics of cancer for health professionals and the public on the Internet. *See* Grant Application, Cancer Genetic Education/Training Programs on Internet, Submitted to National Cancer Institutes of the National Institute of Health, May 13, 1996 (on file with the author). The web-site created for this project is now operational. *See* Robert H. Lurie Cancer Center, *The Genetics of Cancer* (visited Mar. 23, 1998) <http://www.cpragmatics.com/genetics/>. This project may eventually be expanded to include genetic counseling and/or referrals for genetic testing via the Internet. *See* M. Kathleen Roth, Analysis of Internet-based Genetic Counseling (1997) (unpublished M.S. thesis, Northwestern University) (on file with the author) (creating a model for Internet-based genetic counseling).

administered by the National Conference of Bar Examiners.

b. The "Holdout" Provision

"States have the inherent power to safeguard the health and safety of their citizens, and to protect them from fraud and deceptive trade practices."[152] Because these powers are an inherent part of the balance between the powers of the federal government and state governments, to avoid a constitutional challenge to the creation of a national Internet health care infrastructure, a state must be granted the right to "hold out" from allowing Internet psychotherapists to treat citizens in a particular state.[153] It would then be the responsibility of individual states to prosecute therapists who violate the state-imposed ban.[154]

However since the success of a national infrastructure would be dependent on the participation of the majority of the states, financial and other incentives to encourage participation must be a part of any legislation designed to create a national medical infrastructure.

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152. Burk, *supra* note 114, at 1124-25 (discussing state policing powers regarding on-line communications).

153. *But cf.* Shapiro & Schulman, *supra* note 15, at 123 (arguing that the current trend away from federalism makes federal guidelines for Internet psychotherapy unlikely).

154. The best example of this approach is the vigorous effort the Minnesota Attorney General's office is making to warn individuals who engage in certain illegal activities over the Internet. The Minnesota Attorney General's office has posted a warning that, "PERSONS OUTSIDE OF MINNESOTA WHO TRANSMIT INFORMATION VIA THE INTERNET KNOWING THAT INFORMATION WILL BE DISSEMINATED IN MINNESOTA ARE SUBJECT TO JURISDICTION IN MINNESOTA COURTS FOR VIOLATIONS OF STATE CRIMINAL AND CIVIL LAWS." *Statement of Minnesota AG On Internet Jurisdiction* (visited Feb. 25, 1998) <http://www.webcom.com/~lewrose/article/minn.html> (discussing the legal basis for the warning and specific activities covered by the warning). Similar warnings could be employed on Internet psychotherapists' web pages to alert potential patients of the ban in particular states. *Cf. supra* note 63 (discussing similar provisions regulating Internet gambling). It must be noted, however, that the effectiveness of this regulatory scheme would force states to end their hesitation to prosecute practitioners licensed in one state for practicing in another state without a license. The right to prosecute exists under most state statutes, but survey articles show that states rarely invoke these. *See* Stacey Swatek Huie, Note, *Facilitating Telemedicine: Reconciling National Access with State Licensing Laws*, 18 HASTINGS COMM. & ENT. L.J. 377, 398-401 (1996).

2. The National Internet Practitioner Data Bank

Since one of the primary goals of the national Internet health care infrastructure is the replication of the consumer protections available to patients of traditional psychotherapy, the National Internet Practitioner Data Bank is a central element to these efforts. Although modeled on the National Practitioner Data Bank,[155] the Internet Data Bank would be designed primarily to benefit consumers of Internet-mediated health care services.[156] The Internet Data Bank would list the educational credentials and licensure status of individual practitioners. In addition, it would allow potential patients access to information concerning any complaints registered against the practitioner reported to both the Data Bank and state licensure boards.[157] Naturally, this system will benefit from the new medical data standards recently signed into law[158] and could be expanded to include practitioners other than psychotherapists.

3. Professional Responsibilities and Additional Consumer Protections

The most significant goals of the national Internet health care infrastructure are to ensure that health care providers can fulfill their professional responsibilities and consumers receive the same types of protection afforded individuals undergoing

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155. Malpractice and disciplinary actions taken by state licensure boards and medical institutions must be reported to the National Practitioner Data Bank established by the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 (1994).

156. Access to the National Practitioner Data Bank is strictly controlled and not granted to consumers. *See* 45 C.F.R. § 60.13 (1996) (explaining access to the Data Bank).

157. The most effective way to organize the Data Bank would be to require Internet practitioners' web pages to have links to the Data Bank and other relevant web sites with licensure and other relevant information. By simply clicking on the applicable icons for these links, potential Internet psychotherapy consumers could view a psychotherapist's Data Bank listing and/or view additional information to evaluate the services being offered. Fortunately, a model already exists for the use of the Internet for posting licensure information. *See* CAL. BUS. & PROF. CODE § 2027 (a-b) (West Supp. 1997) (requiring the posting of licensure and disciplinary information for all California licensed physicians and surgeons on the Internet and permitting the posting of links to sites providing information on health care service plans, insurers, hospitals, facilities, and other sites providing information or the affiliations of licensed physicians and surgeons). Obviously, this type of service would have to be expended to cover the entire nation and include a mechanism for Internet health care patients to register complaints with the government agency overseeing the national Internet health care infrastructure.

158. *See supra* note 131 and accompanying text.

more conventional treatment. Unfortunately, the current level of technology, and government attitudes regarding the privacy of psychotherapeutic records, make these the most difficult challenges.

a. Identity Verification

Although it is possible to require that individuals undergoing Internet psychotherapy accurately represent their identities,[159] the absolute enforcement of these regulations is impossible. As an aspirational goal, Internet psychotherapists will most likely consider treating only patients who truthfully identify themselves and their states of residence an aspirational goal. However, by requiring specialized training for Internet psychotherapists, coupled with Internet specific licensure, Internet psychotherapists will likely have a greater understanding of the challenges created by the Internet to fulfilling *Tarasoff* and abuse-reporting duties. This awareness will encourage the development of methods of patient evaluation and assessment as well as definitions of standards of care and professional responsibilities unique to Internet treatment modalities. Awareness of these issues may also stimulate the development of professional networks for the referral of patients to more traditional services, to facilitate access to traditional psychotherapy services or appropriate diagnostic services,[160] and to ensure the interventions often required by psychotherapists' professional responsibilities.

b. Privacy Provisions

The current level of technology makes it impossible to ensure the absolute privacy of Internet psychotherapy sessions. By requiring licensed Internet psychotherapists to conduct treatment via encrypted exchanges, Internet psychotherapy patients would be guaranteed a modicum of privacy. Violation of these requirements would be reported to the National

159. *See supra* note 121 and accompanying text.

160. The ability to refer patients to diagnostic services is an especially important consideration for psychiatrists conducting Internet psychotherapy. *See supra* note 91 (discussing the additional professional duties psychiatrists have as medical doctors).

Internet Practitioner Data Bank to encourage compliance with these provisions.

Currently, the privacy of stored verbatim records generated by Internet sessions is not as pressing an issue as it will become after managed care and insurance companies recognize the validity and potential of Internet treatment modalities. The existing laws designed to address computerized medical records do not provide any protection to Internet patients. Therefore, mental health consumer advocates and psychotherapists will have to intensify their efforts to establish greater protections for computerized mental health records. Fortunately, a model exists to strictly limit the amount of clinical data third-party payers can require of a therapist. Under a new Massachusetts measure, insurers can demand no information other than the patient's name, diagnosis, and date and type of treatment until a nondisclosure ceiling is reached.[161] In addition to this measure, to truly protect Internet psychotherapy patients, measures requiring informed consent from patients before their medical information can be downloaded and transferred to a third-party must be incorporated into the national electronic medical infrastructure. Furthermore, this regulatory infrastructure must prohibit the penalizing of health care providers and their patients who refuse to provide unduly sensitive data or do not want their Internet treatment sessions filed in data networks.

c. Informed Consent

The most important legal construct protecting health care consumers is the doctrine of informed consent. The national Internet health care infrastructure must include provisions that duplicate the measures patients receiving conventional health care are provided. Given the inherent difficulties in obtaining informed consent for conventional psychotherapy, this too

161. Massachusetts, in response to a controversy surrounding the Harvard Community Health Plan's practice of storing detailed psychiatric session notes in computerized format and permitting anyone working for the Plan (including nonmedical personnel) to access the records, passed a law prohibiting insurers from demanding detailed information about subscribers' life situations and psychiatric status before granting them mental health benefits. However, the law only covers the state-mandated benefits (i.e. $500). After the $500 nondisclosure ceiling is reached, an insurer can demand additional information to determine if treatment is justified. *See* MASS. GEN. LAWS ANN. ch. 175, § 47 B (c) (West Supp. 1997).

could be regarded as an aspirational goal. However, by allowing Internet psychotherapy patients access to the information contained in the National Internet Practitioner Data Bank, a foundation for the obtaining of informed consent for Internet psychotherapy will be constructed. Efforts to obtain informed consent will ultimately help promote and facilitate the further development of Internet psychotherapy treatment modalities and potentially the provision of psychotherapy assistance to those individuals who could not or would not avail themselves of traditional psychotherapeutic treatment.

However, the development of the information needed to obtain truly informed consent (i.e., studies comparing the efficacy of traditional and Internet-based treatment modalities) is not an inexpensive or simple procedure. The success of the national Internet health care infrastructure in promoting and regulating Internet psychotherapy, and perhaps later, other medical treatments, is dependent on the allocation of resources to fund studies on these treatments. The National Institute of Mental Health would be well-advised to duplicate and to expand the National Institutes of Cancer's efforts to explore the efficacy of Internet-based services providing medical information and treatment referrals.[162] The national Internet health care infrastructure's cornerstone could be the federal legislation implementing such a study of the efficacy of Internet psychotherapy, establishing Internet psychotherapist licensure, and creating the National Internet Practitioners Data Bank.

V. CONCLUSION

During Sigmund Freud's only visit to America, William James greeted Freud by exclaiming "Yours is the psychology of the future."[163] Internet psychotherapy is unlikely to have the same revolutionary impact as the original psychoanalytic treatment. However, Internet-based interactions are beginning to play important roles in all facets of modern life and may make Internet treatment an important and attractive psychother-

162. *See supra* note 151.

163. HISTORY OF PSYCHOTHERAPY: A CENTURY OF CHANGE 37 (Donald K. Freedheim ed., 1992).

apeutic treatment modality for individuals either unable, or unwilling to access traditional mental health assistance or those who prefer to interact via the Internet.

Clearly, Internet psychotherapy is generating challenges to the existing theoretical paradigms and the laws and ethical considerations that structure modern psychotherapeutic treatment. In addition, the absence of protections for consumers of Internet psychotherapeutic services, specific guidelines for the fulfillment of professional responsibilities for practitioners of Internet psychotherapy, and the lack of privacy protections for Internet psychotherapy records mandate development of a cohesive, national infrastructure to regulate the provision of health care services via the Internet.

Although consumers of Internet psychotherapy may be protected through self-regulation or traditional tort remedies, a national Internet health care infrastructure would ensure that Internet psychotherapy consumers are as protected as those individuals utilizing more traditional psychotherapeutic treatment. More importantly, this system would allow psychotherapists to explore the therapeutic value of Internet treatment modalities to provide treatment to individuals in need of solace, support, and insight.