

E-therapy as an Adjunct to Face-to-Face Therapy in the Treatment of Patients Suffering from Chronic Psychiatric Disorders

Hildegard Löhr, Rolf Wynn*, Jan Rosenvinge[§]

Psychiatric Centre for Tromsø and Karlsøy, University Hospital of Northern Norway, *Department of Clinical Psychiatry and [§]Institute of Psychology, Tromsø, Norway.

ABSTRACT

Objective: To explore the benefits and problems with the use of e-mail as an adjunct to face-to-face cognitive behavioural psychotherapy for patients with chronic psychiatric disorders.

Methods: The study involved 4 patients (2 men and 2 women, aged 21–31) with a history of chronic psychiatric disorders. All patients met diagnostic criteria for various combinations of affective disorders and anxiety disorders and all met the criteria for social phobia. Two patients also suffered from one or more personality disorders. Patients initially received face-to-face treatment after which e-mail was added as an adjunct treatment modality.

Results: The results of the study demonstrated that e-mail can be an effective supplement to face-to-face therapy for patients with complex psychiatric disorders. E-mail may be used in different ways, and these can be varied depending on the specific needs of each patient. The particulars of how the use of e-mail functioned in each of the cases are discussed.

Conclusions: E-mail may contribute positively to therapy especially for patients that express an interest in the use of this type of technology and those that have problems concentrating, expressing themselves verbally, or have high levels of anxiety in face-to-face settings. A good working alliance should always be established prior to the introduction of e-mail in therapy, in order to reduce the chance of misunderstanding occurring.

BACKGROUND

Although face-to-face therapy is the cornerstone of psychiatric treatment, not all patients benefit fully from this form of treatment. In particular, patients with concentration or memory problems, emotional inhibition (like anxiety and shame), or impulsiveness or rigidity, may find it difficult to participate in face to face treatment. In addition, patients who have problems travelling, e.g. due to long distances, may also not be able to fully participate and benefit from this form of treatment^{1,2}. With

Correspondence and reprint requests: Hildegard Löhr, Psychiatric Centre for Tromsø and Karlsøy, University Hospital of Northern Norway, Tromsø, Norway. Norway E-mail: Hildegard.lohr@unn.no.

advances in information and communication technology, the question inevitably arises as to whether these technologies could be used to improve the quality of treatment for certain groups of patients.

One possibility is e-mail^{3,4}. Using e-mail to write about emotional experiences could have a positive effect on mental health, in the same way as has been shown for other types of writing⁵. It has been suggested that e-mail, as an adjunct to face-to-face psychotherapy, may increase the therapeutic alliance, increase compliance, and give greater flexibility and opportunity to access cognitive resources and reflect on feelings and attitudes as well as on the content of therapy^{2,6,7}. Using e-mail may also allow for more precise interventions⁸. One study that conducted therapy completely without face-to-face contact suggested that some patients suffering from panic disorder may favour e-mail therapy in preference to face-to-face therapy⁹. Other reports on the use of e-mail as an adjunct to face-to-face therapy have indicated that e-mail can improve communication between therapist and patient and also suggested that some patients may favour e-therapy above conventional face-to-face therapy. Some have, however, expressed concerns regarding psychotherapy mediated by e-mail. One objection is that non-verbal aspects of communication which can be important to the therapeutic process may be lost in e-mail communication^{4,10}.

Cognitive Behaviour Therapy (CBT) is a type of psychotherapy that has a strong emphasis on teaching patients about psychiatric problems and possible ways of resolving them. CBT is manualised, and has been proven efficacious for the treatment of a range of psychiatric disorders, including anxiety disorders, depression, and eating disorders¹¹.

Few studies have examined how CBT or other types of psychotherapy may be enhanced by e-mail communication between patients and therapists^{1,4}. Qualitative and explorative studies may give important information regarding the use of e-mail therapy as a supplement to face-to-face therapy including its effects and whether different approaches are required for patients with different diseases. In this study, we examine the role of e-mail as an adjunct intervention to face-to-face therapy for patients with chronic psychiatric disorders. In particular we aim to explore the particulars of how the use of e-mail functioned in each of the cases.

METHODS

Four patients (2 men and 2 women, aged 21–31) were recruited to the study by their therapists at a psychiatric outpatient clinic. All patients had finished high school, were single and at the onset of the study were on some form of disability allowance due to their psychiatric problems. Each had been in different types of psychiatric treatment for a period of 1 to 5 years prior to joining the study, and two patients had previously been hospitalised for mental disorders. Permission to carry out the study was obtained from the Regional Ethics Committee as well as from the Norwegian Social Sciences Data Services. All patients gave written informed consent.

Patients were initially systematically assessed with diagnostic instruments, including the Mini International Neuropsychiatric Interview¹², the Structured Clinical Interview for DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition) personality disorders¹³, and the Beck Depression Inventory¹⁴. At the start of the study period, all patients met diagnostic criteria¹⁵ for various combinations of affective disorders and anxiety disorders. All met the criteria for social phobia. Two patients also suffered from one or more personality disorders. As the focus of the study was to examine the details of how e-mail could be used with this group of patients rather than to systematically examine therapeutic progress, a decision was made not to collect further patient data. This decision was also supported by the fact that as the study was small and qualitative it would not be possible to make any statistical analyses regarding therapeutic progress. Hence, psychometric data is not reported in this study.

The first phase of the study (without e-mail) was from April 2004 to February 2005. In phase two (February 2005–October 2005), e-mail was added as an adjunct treatment modality. Prior to being admitted into the study the patients were informed that e-mail would be introduced following a first phase. During the first phase, patients were given CBT in a face-to-face setting for 45 minutes per session, weekly or every two weeks, depending on the needs of each patient. As the conditions and needs of the patients varied considerably, a general CBT approach was chosen, and the techniques used were in each case adapted to the specific needs of the individual patients. Although a specific treatment manual was not followed, the treatment offered included but was not restricted to the following elements:

1. Story-telling and validation of emotions. The patient told his or her story, focusing on difficult thoughts and feelings and the therapist validated the patient's emotional experiences.
2. Goal definition. The patient and the therapist collaborated in defining the patient's problems, resources, and desired changes.
3. Working on core beliefs and assumptions by the patient about himself or herself.
4. Problem solving and behaviour change. The therapist guided the patient in using specific techniques, in order to help him or her recognise different ways of understanding a critical situation, and thereby coping more effectively.
5. Relapse prevention. Negative core beliefs were discussed and new situations and problems dealt with as they occurred.

E-mail communication was introduced in the second phase. It was used for most types of situations, but was supplemented with telephone and face-to-face interaction in more serious crises¹⁴. While there were, prior to the initiation of the study, ideas and plans regarding how e-mail could be used as an adjunct to face-to-face therapy, the actual use of e-mail in this setting evolved as the study progressed. This exploration of the use of e-mail was consistent with the qualitative design of the study chosen. After the introduction of e-mail, the frequency and duration of the face-to-face sessions varied considerably between the cases, as the use of e-mail

functioned differently for the different patients (these findings are described in more detail in the Results section). All e-mails were responded to promptly by the therapist who was an experienced clinical psychologist with a specialisation in CBT.

Technical Equipment

All patients possessed and were familiar with the required technical equipment, a personal computer (PC) with Internet access, an e-mail account and a cellular phone. To address legal and ethical concerns and to preserve confidentiality, all participants used a programme for secure (encrypted) e-mail communication (PatientLink, Well Diagnostics).

RESULTS

Case 1

Patient A was in her early thirties. She had previously been a student, but ended her studies when she became ill and subsequently hospitalised. She had tried working, but had not managed to hold a job because of repeated crises.

A was offered a comprehensive cognitively-oriented treatment focusing on techniques for helping self-regulation (i.e. how to manage basics such as sleeping, eating and recreational activities), social phobia treatment, and network management. Initially, when she attended face-to-face sessions without e-mail, she often became very upset when dealing with difficult issues. This led to a strong urge to talk and subsequent difficulties for the therapist in structuring the session. She was well motivated for treatment and eager to practice, and she quickly understood the essentials of self-regulation and CBT.

Initially A used e-mail primarily when in crisis. She then wrote down her worries and tended to express feelings of hopelessness and anger. Writing appeared to have clear therapeutic benefits as she reported that just writing down her thoughts gave her relief, even before she got any feedback from the therapist. Moreover, writing made it easier for her to discuss her own thoughts and feelings (meta-cognition), and writing was a useful tool in helping her change (cognitive restructuring).

It was a clear positive effect of the use of e-mail that A did not have to wait for the next face-to-face session before she was able to express her feelings. Moreover, the use of e-mail had the benefit of helping both the patient and the therapist in structuring their thoughts. They found that the use of e-mail was better than the use of plain paper, as the use of e-mail allowed more time for reflection and systematisation. Another benefit of the use of e-mail as compared with plain paper, was the capacity to respond to the patient's comments and concerns by using colours in the text, thus emphasising issues of particular importance. The therapist also used e-mail to sum up sessions, which offered further possibilities for clarification and discussion. A gradually learned to understand her feelings as natural and meaningful signals. As treatment advanced, she used e-mail in a more reflective manner, describing her

feelings and reflecting on their origin and on how various problems could be solved in a constructive way. Gradually, A's autonomy increased and her need for face-to-face sessions gradually decreased. At the final phase of the study, she communicated with the therapist only by e-mail. After half a year of comprehensive treatment, A felt sufficiently balanced to start in an occupational program. After another six months, she was coping well and in full time employment.

Case 2

Patient B was in her twenties. Despite a range of mental problems, she was able to finish high school, but at the time of entering the study was on disability allowance. She had received a combination of pharmacological and supportive therapy for several years, as well as a period of group CBT before being admitted into the study.

B received individual CBT as well as psychosocial skills training in a group¹⁶. After a while, she also received occupational and social training with personal assistants. Before the introduction of e-mail into her therapy, B did not seem to profit much from the individual CBT sessions. She had problems concentrating and was easily confused and overwhelmed. The therapist introduced the use of a PC as part of the therapy by exploring topics in writing during face-to-face sessions. For instance, B described a main topic, such as 'I am afraid of going outdoors'. The therapist would then type the topic in large letters. This helped B and the therapist to focus and reflect constructively on the issue. Following the session, the therapist e-mailed B the text that they had created and focused on during the therapy. As B became more familiar with using the computer as a part of therapy, she was given assignments, such as e-mailing any worries to the therapist. She could also contact the therapist by e-mail if she experienced unexpected problems between sessions. The use of e-mail appeared to help structure B's thoughts. Moreover, the use of e-mail allowed the therapist to sort and discuss her worries systematically. In addition, this procedure made it easier for B to learn from the exchange, as she could read her lists of worries and the therapist's responses repeatedly. While B clearly benefited from the use of e-mail in therapy, she needed weekly face-to-face therapy sessions throughout the study-period.

B was also offered family therapy. In order to keep her parents updated on the progress of her individual therapy, she showed them parts of her e-mail correspondence with her therapist. B and her parents reported that seeing the interaction in writing increased their knowledge and understanding and also their support of B's therapy.

Case 3

Patient C was a male in his twenties who did not respond positively to traditional psychodynamic face-to-face treatment. He expressed a strong interest in communicating by e-mail and was therefore included in the study. In the first phase, he received face-to-face CBT, and in these sessions he expressed difficulties in

discussing his emotions. He avoided difficult issues, as they easily made him upset and triggered panic attacks and even resulted in him fleeing sessions. C was highly motivated to use e-mail as a part of his therapy, as he had previous experience with using e-mail and chat-rooms to talk to other patients with similar problems and found that these had helped him. He stated that working on difficult topics would be easier and less anxiety-provoking in the safety and comfort of his own home.

C used e-mail to request appointments, to discuss therapy, and interestingly to send the therapist pictures of objects of emotional importance to him. Of particular interest was the fact that C was far better in expressing everyday worries and feelings and even more emotionally sensitive issues through the use of e-mail than he was in face-to-face sessions. The therapist used e-mail to validate C's feelings, to perform guided discovery, and to aid C in practical problem solving. The therapist found that it was considerably easier to carry out and involve him in these activities by e-mail compared to face-to-face. After working with e-mail for a while, it became easier for C to discuss his emotions and work on difficult issues, and it also became possible for him to approach these emotions and issues even in face-to-face sessions. As therapy progressed, C was able to manage with gradually less frequent face-to-face sessions, and at the end of the study period he only required face-to-face sessions every two months.

Case 4

Patient D was a male in his early twenties and was given CBT combined with a network oriented approach. In the first phase, when only face-to-face sessions were offered, D missed some appointments when he did not feel like travelling to the clinic. He usually said little during sessions and preferred the therapist to focus on psychoeducation. However, as D was quite passive during the sessions, the therapist was uncertain to what degree he had understood the cognitive model and whether he was able to make use of the model. The therapist suspected that a high level of stress and anxiousness and lack of concentration made it difficult for D to express his thoughts during face-to-face sessions. However, when e-mail was introduced, it became clear that D had understood the cognitive model and also that he was able to make use of it. The main reason for lack of a treatment effect in the face-to-face sessions was identified as D's lack of ability to concentrate in this setting. The therapist helped D prepare for face-to-face sessions by asking him to e-mail a short text about a problematic issue prior to the consultation. While the therapist acknowledged receipt of the e-mail, the main work was done during the face-to-face sessions, as D was able to make use of his e-mailed text as a point of departure for further discussions with the therapist. In this way, D was better able to participate in the face-to-face sessions, and was also more in control of the content and direction of therapy. Attempts were made at reducing the frequency of face-to-face sessions. However, it became clear that he needed face-to-face sessions when in crisis. At the end of the study period, D still needed face-to-face sessions every two weeks. With e-mail as a

therapeutic adjunct to face-to-face CBT, D's condition gradually improved, and he subsequently started in occupational rehabilitation.

DISCUSSION

The 4 cases in this study demonstrate a range of issues pertaining to the use of e-mail as an adjunct to face-to-face therapy for psychiatric treatment. Based on the cases and our clinical experience with e-mail in psychotherapy, we would like to focus on the following points which we believe may be of particular importance to the use of e-mail in clinical practice:

- Benefits of written communication as a part of therapy
- Structuring therapeutic e-mail interaction
- Advantages over paper-based writing
- Implications for the therapist-patient relationship
- The consequences of lack of face-to-face interaction

In addition we will also briefly discuss two other points that may be of concern to practitioners: liability and reimbursement.

Benefits of Written Communication as Part of Therapy

Prior studies^{5,16} have suggested that writing may be a useful part of therapy. Through writing, particularly when dealing with highly emotional issues, patients may vent feelings, experience emotional relief, distance themselves from problematic issues or see issues from a different perspective⁶. The process of writing as part of CBT involves the patient describing concrete problematic situations, feelings, automatic thoughts, and behaviours. Many patients also benefit from writing down their life-stories. The actual process of writing the e-mail may itself be therapeutic. This was illustrated by patient A who expressed considerable relief just by writing down her thoughts. Our study also indicates that e-mail communication may be a particularly valuable adjunct to face-to-face therapy in patients, suffering from high levels of social anxiety and lack of concentration, e.g. patient D.

A key benefit associated with using e-mail is the fact that patients may write in the safety of their own homes, whenever they want and as much as they want. They are also not bound by the limited time of a usual session or restricted by the therapists' questions, or disturbed by their presence. As a consequence patients may more easily follow their inner mental dialogue, rather than be distracted by a real dialogue. Having put down their thoughts on a computer, patients may send the material as e-mails to their therapist, who can help by reading and responding to their ideas and thoughts. Validation is a central part of therapy and balancing it with suggestions for change is important, particularly in complex cases¹⁷. With the use of e-mail, the process of validation can be performed more carefully, as the therapist has more time to consider the matter at hand as well as the possibility of reflecting on options for interventions and providing more conscious and explicit responses.

Structuring Therapeutic E-mail Interaction

The use of e-mail in therapy creates new possibilities for structuring interactions. Situations with strong negative emotional loadings represent a crucial challenge in CBT. With e-mail, a patient can send the therapist a lengthy story recounting an important event and the therapist has the advantage of reading the entire story before responding. This offers a better opportunity to identify and respond to issues of particular relevance in the ongoing therapy. Moreover, letting the patient tell the entire story before responding allows the patient to work on and to more independently apply skills acquired in therapy.

This point is illustrated by the case of patient A when she was in an advanced therapy phase and had been showing good coping skills for a while. During the first 80 percent of her e-mails she had been expressing strong feelings of helplessness, anger, and even hopelessness. However, under the process of narrative and reflective writing, as a consequence of the mood-stabilising skills she had been taught in therapy, the mood of her e-mails eventually lightened. It is important to consider that if she had been expressing such strong negative affect in a face-to-face session as opposed to an e-mail, the therapist probably would have responded prematurely, disturbing A's autonomous process of problem solving. This may indicate that contact by e-mail may be especially appropriate in the later phases of CBT treatment.

The use of e-mail between sessions may be carried out in different ways. For instance, when the patient sends the therapist an e-mail, the therapist may vary the type of response, depending on their evaluation of how critical the situation is. If there is no ongoing crisis, the therapist has the advantage of being more informed when meeting the patient in the next session, thus allowing for a more effective use of the face-to-face session. If the patient is experiencing a minor crisis, the therapist may coach the patient by e-mail between the face-to-face sessions, focusing on how to cope with the problem at hand in an effective way. To obtain information in a written format may be an advantage in a crisis. The problematic issue may be described more precisely, and the patient may read the therapist's responses as often as they want. If the situation is judged as being very acute, the therapist may call the patient or invite the patient to an emergency face-to-face session, if the matter cannot be handled by e-mail communication alone.

Advantages Over Paper-based Writing

The use of a computer and e-mail offers a range of pedagogical advantages compared to traditional face-to-face therapy supplemented by hand writing. In particular the analysis of more complex relapses which lead to crisis¹⁷, appears to be more easily done on a computer than directly on paper. In these cases, both the patient and the therapist focus on the screen. Either the therapist or the patient can do the typing. As in the case of patient A, different colours can be used to mark important issues or connections, and the language (dialect) can be adjusted to a personal style. Some

patients report that the whole setting induces an atmosphere of co-operative work. The screen inspires them to look at the critical scene as if it were a film, whilst maintaining an emotional distance. Using writing as an external therapeutic approach, patients reported that they could detach themselves, and see the situation in a new and clearer way, compared to “just talking about it” face-to-face with the therapist, which often provoked shame and fear. After the session, the patient is able to receive the document that is the outcome of the session by e-mail, allowing for continuous reflection and further work on the same document at home. Patient B appeared to profit substantially from this procedure. Another good opportunity for drawing on the pedagogical advantages of using a PC, is by giving feed-back to the patient by e-mail. For instance, the therapist, drawing on the patient’s text, may create tables (as in an ABCD-analysis). Other devices may also be used in order to emphasise important points, such as preparing posters with “my resources”, that the patient may print and put on their wall.

Another point worth emphasising is that in traditional CBT patients are often asked to write down their life history on a form or as a letter, whereas the therapist usually gives his or her feedback by talking to the patient in the session. Using e-mail, the therapist may work on the life-story document in different ways, for example by writing validating commentaries in between, thus strengthening the therapeutic relationship, or by writing commentaries in the margin, making suggestions for further work, or by colour-marking different parts of the text to reflect the same cognitive schemas or core-beliefs.

Use of E-mail and Implications for the Therapist–Patient Relationship: Reduced Formality and Increased Transparency

Traditionally, therapy is offered in an office and within a particular time-frame, thus providing clear frames and boundaries for therapy and also underlining the therapist’s formal authority. The use of e-mail is not restricted to a particular location or time, and the therapist has to establish his or her own frames and boundaries and authority^{10,18}. This may require a larger effort on the part of the therapist, but appears to make the interaction more formal and, in a sense, more on equal terms. It may indeed be regarded as somewhat paradoxical that written rather than verbal communication facilitates informality and equality. Moreover, by demonstrating how interaction can be carried out in a less formal setting, the therapist may be a good role model for the patient. The negotiation of frames and boundaries and the lack of formalities may contribute to a more truly interactional type of therapy, as the therapist and the patient must both contribute in working out how e-therapy should be performed.

The use of e-mail can increase the transparency of the interaction, in the sense that the written interaction reveals and documents the therapeutic process. Although this obviously may have positive effects, as the process now is more controllable, it can also potentially increase the vulnerability of both parties. To minimise the risk

of this a good working alliance should be established prior to the introduction of e-mail in therapy, to avoid misunderstandings, both parties inadvertently offending each other or choosing strategies of self-protection and concealment instead of more constructive strategies that may lead to a positive outcome.

The Lack of Face-to-Face Communication: Advantages and Disadvantages

Some patients clearly profit from not always having to meet their therapist in person. For instance, patients suffering from social phobia, such as Patient C find it easier to work on difficult and anxiety-provoking issues in the comfort of their own homes. On the other hand, the lack of face-to-face communication also involves some challenges. Implicit, non-verbal feedback, e.g. nodding the head or smiling, and sometimes more explicit feedback is typically given in face-to-face interaction and in traditional therapy. This feedback is important on a micro-level in the interaction as well as on a larger level, i.e. with respect to the working alliance¹⁹. When e-mail is used for therapy, the parties must be more conscious and explicit with regard to feedback, as everything has to be done in writing.

Liability and Reimbursement

While liability is still a minor worry for Nordic therapists, therapists in other countries such as the USA have expressed concern regarding the legal ramifications of the use of e-mail in therapy^{4,20-22}. It has been emphasised that practitioners using e-mail have the same ethical and legal responsibilities to their patients as they do during other encounters^{20,21}. Issues of privacy and confidentiality that do arise, can at least in part be addressed through the use of appropriate encryption systems⁴. E-mail consultations are reimbursed in some countries and in some USA states, but this practice is not universal^{20,22}. Concerns regarding liability and lack of reimbursement may be two of the key reasons why practitioners have been slow to introduce this technology into routine clinical practice²².

CONCLUSIONS

In the present study, we have demonstrated the various ways in which e-mail can function as a part of CBT and the potential benefits. Some of the benefits of using e-mail as an adjunct to face-to-face therapy are listed in Table 1.

Our research is qualitative and explorative and further work is required to quantify the specific therapeutic effects of e-mail, preferably through randomised controlled studies. Further work is also required to systematically examine the particular effects of different e-mail techniques.

Despite concerns voiced by some authors⁴, regarding the appropriateness of performing e-therapy, the cases presented and discussed above suggest that e-mail may in fact be an effective supplement to face-to-face CBT. E-mail may be used as a supplement in different ways, varying on the specific needs of each patient.

Table 1. *Some benefits of using e-mail as an adjunct to face-to-face therapy*

Using e-mail as an adjunct to face-to-face therapy may make it easier to:

- Vent feelings, obtain relief and perspective, overcome distance problems
 - Be concrete and work with a patient's life-story
 - Concentrate and follow inner mental dialogue
 - Structure and validate therapy
 - Participate in therapy
 - Work with emotionally loaded topics
 - Reduce formality, increase equality and transparency
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However, this tool is not suitable for therapy with all types of patients or for all types of treatment. We believe it is a prerequisite for efficient therapy by e-mail that the patient and the therapist are well acquainted and have established a satisfactory working alliance. If patients are very ill, face-to-face therapy sessions may be more appropriate than e-therapy. For instance, patients that are suicidal need the direct and immediate attention and observation that can only be offered in a face-to-face setting. Another group of patients that may find it difficult to take advantage of e-mail in therapy, are those who have problems that prevent them from actively participating in psychotherapy, for example certain patients with severe depression, psychotic disorders, or dementia. People suffering with reading or writing problems are also likely to favour face-to-face therapy above e-therapy.

Based on our experience with e-therapy for patients with complex psychiatric problems, we believe that e-mail should supplement rather than replace face-to-face therapy. Although the need for face-to-face sessions may decline when e-mail is introduced, regular face-to-face sessions should be scheduled in order to secure the quality of therapy and uphold a good working alliance. E-mail appears to be particularly useful for patients who express an interest in communicating by e-mail, and who have problems concentrating, expressing themselves verbally, or have high levels of anxiety in face-to-face settings.

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REFERENCES

- 1 Castelnovo G, Gaggioli A, Mantovani F, Riva G. From psychotherapy to e-therapy: the integration of traditional techniques and new communication tools in clinical settings. *Cyberpsychol Behav* 2003; **6**: 375–82.
- 2 Yager J. E-mail as a therapeutic adjunct in the outpatient treatment of anorexia nervosa: illustrative case material and a discussion of the issues. *Int J Eat Disord* 2001; **29**: 125–38.
- 3 King R, Sponner D, Reid W. Online counselling and psychotherapy. In *Telepsychiatry and e-Mental Health*. Edited by Wootton R, Yellowlees P, McLaren P. London: Royal Society of Medicine Press, 2003, pp. 245–64.
- 4 Silk KR, Yager J. Suggested guidelines for e-mail communication in psychiatric practice. *J Clin Psychiatry* 2003; **64**: 799–806.
- 5 Pennebaker JW. The effects of traumatic disclosure on physical and mental health: the values of writing and talking about upsetting events. *Int J Emerg Ment Health* 1999; **1**: 9–18.
- 6 Murdoch JW, Connor-Greene PA. Enhancing therapeutic impact and therapeutic alliance through electronic mail homework assignments. *J Psychother Pract Res* 2000; **9**: 232–37.
- 7 Yager J. Monitoring patients with eating disorders by using e-mail as an adjunct to clinical activities. *Psychiatr Serv* 2003; **54**: 1586–88.
- 8 Childress CA. Ethical issues in providing online psychotherapeutic interventions. *J Med Internet Res* 2000; **2**: 5.
- 9 Calbring P, Westling BE, Ljungstrand P, Ekselius L, Andersson G. Treatment of panic disorder via the internet: a randomized trial of a self-help program. *Behav Ther* 2001; **32**: 751–64.
- 10 Rothchild E. E-mail therapy. *Am J Psychiatry* 1997; **154**: 1476–77.
- 11 Butler AC, Chapman JE, Forman EM, Beck AT. The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clin Psychol Rev* 2006; **26**: 17–31.
- 12 Sheehan DV, Lecrubier Y, Sheehan KH, Amorim P, Janavs J, Weiller E, Hergueta T, Baker R, Dunbar GC. The Mini-International Neuropsychiatric Interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *J Clin Psychiatry* 1998; **59** (Suppl 20): 22–33.
- 13 First MB, Spitzer RL, Gibbon M, Williams JBW, Benjamin L. *Structured Clinical Interview for DSM-IV Axis II Personality Disorders*. New York: Biometrics Research Department, New York State Psychiatric Institute, 1994.
- 14 Beck AT, Ward CH, Medelson M, Mock J, Erbaugh J. An inventory for measuring depression. *Arch Gen Psychiatry* 1961; **4**: 561–71.
- 15 World Health Organisation: *International Classification of Diseases, 10th revision (ICD-10)*. Geneva: World Health Organisation; 1990.
- 16 Löhr H, Rosenvinge JH, Gammon D, Johnsen JAK. Can Internet be helpful for individuals with serious mental disorders? User experiences from a clinical perspective. [In Norwegian] *Journal of the Norwegian Psychological Association* 2002; **39**: 514–19.
- 17 Rizvi SL, Linehan MM. Dialectical behavior therapy for personality disorders. *Curr Psychiatry Rep* 2001; **3**: 64–69.
- 18 Bailey R, Yager J, Jenson J. The psychiatrist as clinical computerologist in the treatment of adolescents: old barks in new bytes. *Am J Psychiatry* 2002; **159**: 1298–1304.
- 19 Wynn R. *Provider–Patient Interaction*. Kristiansand, Norway: Norwegian Academic Press, 1999.
- 20 Seeman MV, Seeman B. E-psychiatry: the patient-psychiatrist relationship in the electronic age. *CMAJ* 1999; **161**: 1147–49.

- 21 Bovi AM. Ethical guidelines for use of electronic mail between patients and physicians. *Am J Bioeth* 2003; 3: W-IF2.
- 22 Meyer M. Physician use of e-mail: the telephone of the 21st century? *J Med Pract Manage* 2004; 19: 247-51.

