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Contemporary Media Forum

The Future of Online Clinical Work

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Allow me to begin this article with a joke that I sometimes tell at conference presentations and in other articles I write. I made it up myself, so be forewarned. It may not be terribly funny. But I do think it's an interesting joke:

How many clinicians does it take to do computer-mediated psychotherapy?

None. The computer can do it all by itself.

OK, so I'm not Jerry Seinfeld or Rodney Dangerfield. Why then do I think this joke is interesting? For two reasons. First, like many jokes, it points to a sensitive issue. Are we worried about computers taking over and ruining human relationships? Will really poor computer-mediated psychotherapy replace the tried and true methods of traditional psychotherapy? We could certainly make those arguments and it's something we should be on the lookout for. On the other hand, the joke suggests that big and interesting changes are coming right at us. Will computers someday actually do psychotherapy? Even if we insist that this isn't plausible, what will be possible given all this new technology? People are already doing psychotherapy in cyberspace right now. So what's next? Where is this all heading?

That's the question I'd like to address here. I'm going to take out my crystal ball in order to predict the future of online clinical work. Now, my fortune-telling skills are probably about as good as my ability to write a good joke, so maybe I should modify that statement. I'm going to talk about what I think might happen in the future, or maybe what I'd like to see happen. To a large extent I'm basing these predictions—or expectations—on issues we discuss in the Clinical Case Study Group of the International Society for

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Mental Health Online (www.ismho.org/ccsg.htm). It's a group that Michael Fenichel and I created three years ago—a think-tank, research, and peer supervision group devoted to in-depth discussions of online clinical work of all shapes and sizes.

Here's the first word that appears in my crystal ball. It probably comes as no great surprise to anyone who understands psychotherapy—**SPECIALIZATION**. We are going to see people specializing in different types of online clinical work. Right now the focus is mostly on individual psychotherapy conducted via e-mail. This is what many people call "e-therapy." It can be a very important, sophisticated method, usually based on a short term, psycho-educational model. There are obvious as well as quite subtle pros and cons. The e-mail specialist is going to fully understand those pros and cons and know how to work with them. There may even be specializations in different therapeutic approaches conducted via e-mail—cognitive, behavioral, humanistic, as well as various styles of psychoanalytic work.

People also may specialize in an interesting intervention that we discuss frequently in the ISMHO case study group—the single e-mail reply to people whom request help. If you're a clinician with an online presence, for example, you have your own professional web site—you're going to get requests, perhaps many requests out of the blue from people who want help and advice, sometimes desperate people. How do you reply to them in just one e-mail message? Skeptics say that this isn't psychotherapy, that it's more of an "Ann Landers" approach to helping people. Maybe so. Personally, I'd like to speak to Ann Landers to find out how she does it. I'm not sure that we online clinicians would intervene the same as she does, but I do know that it's not as easy as some might think. It takes quite a bit of clinical skill to reply effectively. Then there's also the challenge of helping people in two, three, or four e-mail exchanges—a message-limited approach that is being adopted by some online clinical centers. How do you boil down clinical work to these packets of highly concisely written interventions? It's surely an area of specialization.

Other than e-mail work, we're going to see many other types of text-based specializations. For example, there's chat therapy, which isn't asynchronous like e-mail, but rather synchronous. At first glance it seems like a small difference, but the real-time aspect of the interaction between client and therapist dramatically changes the expertise required. There also are mental health message boards that require a special knowledge of support groups, group therapy, and community psychology. Group therapy via e-mail or chat are other possible specializations. People love to role play and experiment with their identity in cyberspace, so yet another expertise will be the creation of imaginary, text-based environments in which people participate in therapeutic fictional scenarios, for example, some online versions

of Post-Modern Therapy (see www.california.com/~rathbone/pmth.htm). There are thousands of online communities with different formats, philosophies, and purposes. They weren't specifically intended to be psychotherapeutic, but for many people they are. In those communities people experiment with relationships, try out new ways of behaving, and explore new dimensions to their identity. These are potential gold mines for clinicians who want to specialize in consulting with and guiding clients in using their lifestyles in cyberspace as a personal growth experiments. In what looks like a kind of narrative therapy, people are publishing personal journals or diaries online. They create web sites where they reveal and explore themselves. They get and give feedback to other people who also are publishing these online logs of their life and thoughts. Might clinicians develop an expertise in learning how to use this phenomenon therapeutically with their clients?

Almost all of these specializations I have mentioned so far involve mostly text-based communication. The Internet offers more than just that. Obviously, there's video-conferencing, which is an attempt to recreate the in-person, face-to-face psychotherapy session. We also have this fascinating ability to create imaginary, multimedia environments. We already see VR being used in exposure therapy and in designing relaxation procedures. Might we also use VR in helping clients work through trauma? Could we do dream work in VR, or reconstruct and explore memories, or behavioral modeling and role playing, or psychodrama scenarios? Let's say a client relives a childhood scene at the dinner table, or experiments with telling off the boss at work, or lives inside Madeline Albright, Tony Soprano, or Bart Simpson for a day. All of these fantasy-based scenarios will be possible and such applications of VR might involve different specialty areas.

Here's where my crystal ball gets hazy—hazy because it is clouded by countless numbers of possibilities. We can't even imagine what might happen down the road in computer and Internet technology. As creative clinicians looking for new opportunities, we may not even know what is possible in the technical realm.

Emerging from that haze inside the crystal ball, a word does appear very clearly. It's the word **INTERDISCIPLINARY**. We can't rely on our own efforts in designing new computer-mediated approaches. We need to consult with experts in cognitive psychology, communications, human factors engineering, and Internet technology. They have knowledge we need. The computer and Internet experts will be able to tell us what technology is available. The communication and cognitive experts will help us understand some of the essential nuts and bolts of computer-mediated experience, like "immersion" and "presence." In fact, somewhere in the not too distant future, the most effective model of a cybertherapy program might involve an interdisciplinary team that helps decide what psychotherapy theory, with

which clinician, and in what communication environment, would work best for a particular client. Might the treatment for that client involve a package of several types of online interventions and experiences with the package designed and conducted by the interdisciplinary team?

Right behind the word "interdisciplinary" in my crystal ball, I see another word forming—**NETWORKS**. The Internet is all about connecting people and resources. If we're going to create these interdisciplinary teams, then obviously the members are going to be working with each other via the Internet, through e-mail, message boards, chat, and most likely person-to-person systems. The therapeutic environments they construct for their clients will be part of that network. I know this is a very tall order, but hopefully, ideally, we'll see cooperation among different clinical networks rather than competition. One important feature of these networks will be the linking of online and in-person services. Cyberspace therapy is great, but let's face it: in-person treatments will be best for many clients and some treatments will only be possible face-to-face. Here's a scenario that illustrates a perfect marriage of the face-to-face and online clinical worlds:

> Mr. Smith, who lives in Denver, emails an online clinical center that operates out of Sydney. The case manager from Atlanta working at that center does an intake with Mr. Smith. He interviews him via email, conducts a video-conferencing session with him, and does some online psychological testing. He decides that Smith might really benefit from therapy based on self psychology. He sends Mr. Smith to some web sites with information about self psychology, as well as other types of psychotherapy. After visiting the sites, Smith is interested in following through with self psychology. The case manager checks the network directory and finds seven clinicians in Denver who do this type of work. In an asynchronous user-to-user meeting, the case manager and the seven clinicians share information and video clips about the case. Three of them are interested in working with Mr. Smith. The case manager sends the web site addresses of the three clinicians to Smith. He checks out their site and decides to phone one of them. Soon thereafter, he begins face-to-face work with that clinician, who also happens to use intersession email and VR in his treatment.

That's the kind of scenario I'd like to see in the future. And in it I see another theme emerging from my crystal ball—**EMPOWERING OF THE CLIENT**. The Internet enables us to easily, efficiently offer information to clients. It enables us to easily and efficiently present the client with choices. Mr. Smith receives a little bit of an education about therapy. He participates in the decision-making process. In some cases, the empowering of the client may go even further. In traditional forms of therapy the clinician is placed at the center of the healing process. Clinicians administer a treatment or play a crucial role in creating a therapeutic experience. Many forms of online psychotherapy will similarly place the therapist in a strategic position for controlling the treatment process, but in other cases the professional may serve more like a consultant who helps a client design and navigate through a therapeutic activity or collection of activities. In cyberspace there are a wide

variety of mental health resources, including support groups, informational web sites, assessment and psychotherapeutic software, and comprehensive self-help programs, as well as the potentially therapeutic nature of online relationships and communities as social microcosms. In the role of consultant, the professional might help a client design a program of readings, activities, and social experiences that addresses his or her needs. Rather than being the "therapist" who directly controls the transformative process, the professional instead helps launch the client into this program, offers advice when needed, and perhaps assists the client in interpreting and assimilating the experience.

A THEORY OF CYBERTHERAPY appears next in my predictions. I think this means not just a specific theory of e-mail therapy, or the VR treatment of phobia, or how to manage a mental health message board, but rather a global theory—a meta-theory if you wish—providing an overarching framework for understanding the many fascinating facets of computer-mediated clinical work. I believe strongly in this need to develop a Big Picture theory of cybertherapy. In an article about computer-mediated psychotherapy (truecenterpoint.com/ce/cybertherapy.html), I describe this theory as one that looks at the elemental features of computer-mediated communication. It's a theory that deconstructs the therapeutic relationship or experience into its intrinsic components and helps us understand the pros and cons of those features. These are the kinds of questions that will guide us in that analysis:

- Does the relationship or experience occur in real time or in an asynchronous frame? If it's asynchronous what are the effects of varying the delay between exchanges?
- Does the relationship or experience involve communication via text, or are visual images exchanged, or combinations of the two?
- Does the relationship or experience involve auditory stimulation? If so, what types? Voice? Other sounds?
- Does the therapeutic relationship or experience rely on real identities and real environments or imaginary ones?
- How strong is the presence of the clinician in the therapeutic experience? Might the therapist in some respects be invisible? Might the client in some respects be invisible? For example, if the communication involves video-conferencing, might the therapist NOT see the client or the client not see the therapist?

These are just some of the elemental features. I think we need a theory that guides us in understanding when, how, and for whom these features are therapeutic, as well as what combinations of these features are therapeutic for which people. We're looking for a theory that helps us analyze the

potentially curative ingredients of different communication environments or communication pathways and for deciding what environments or pathways are therapeutic for which clients.

I should emphasize that this theory does not replace traditional theories of psychotherapy, but rather acts as a supplement to them. In fact, this theory of cybertherapy could be used to help reexamine those theories in terms of the elemental features of communication. For example, why does the analyst sit behind the patient and therefore become partially invisible? In behavioral rehearsals, Gestalt dialogues, or psychodrama, what are the pros and cons of using imaginary versus realistic scenes? In the many forms of therapy that work with mental images, what are the advantages and disadvantages of focusing on these sensory experiences compared to dealing with language, verbalizations, and text?

There is one final word that my crystal ball wants to offer up—**AUTOMATION**. Here's where I circle back to that joke about how many clinicians are needed to do computer-mediated psychotherapy. Might it be none? Can computers do it alone? One important elemental feature of clinical work in the next millennium will be this potential for automation. A wide range of clinical tasks might be conducted by software alone—assessment and psychological testing, structured behavioral and cognitive interventions, and self-help approaches. Many of these programs already exist. Here's a very simple example. A new version of the e-mail program Eudora has a "mood watch" function. It detects your use of harsh language in your outbox mail, sets off a warning, and asks you if you want to reconsider editing the message before sending it off. A very simple automated task, but think how therapeutic it might be as a component of a treatment package for someone with impulse control problems.

We're going to see more and more of this kind of software, which is only going to get more and more sophisticated. We can laugh at the old "Eliza" program and how clumsy it was at conducting a talking-cure therapy. But artificial intelligence technology is becoming very sophisticated. AI programs are getting much better at detecting subtle aspects of human language. Will an AI therapist be as good as face-to-face therapy with a flesh and bones clinician? In most cases, no. No matter how sophisticated they are machines will have a very hard time replicating the subtle human eye for understanding the complexities of human experience. But these machines can be very helpful as adjuncts and supplements. In some cases they may even take the lead role in basic counseling with a human clinician supervising them.

As my joke suggested, there's a tendency to worry that as we get further and further into technology, humans will become more like machines. Hopefully the reverse is true. Maybe machines will gradually become more human.