ISMHO Clinical Case Study Group: Half a Decade of Online Case Study

Fenichel,M., Jones,G., Meunier,V., Munro,K. and Walker-Schmucker, W.

Overview

The ISMHO Clinical Case Study Group is composed entirely of advanced-level clinicians who have been using Internet-facilitated and Internet-based communication in our daily work. Now engaged in our 6th year of continuous clinically-focused discussion, we endeavor to share with you the flavor of our daily dialogue and to highlight some of the important areas we have found ourselves frequently revisiting as experienced online clinicians.

A half decade of discovery and observation has led us to appreciate the tremendous benefits of a clinical case study approach which combines the scientist-practitioner's hands-on "learning laboratory" model, with multi-disciplinary, cross-cultural, cross-specialty consultation, sharing and providing invaluable support and feedback in the finest tradition of peer supervision.

In sharing this 1/2 Decade Report, we especially hope to provide a sense of "being here" and what our experience has been like for the many who we would have liked to have with us on this journey. For you we would like to recap some of our 1/2-decade-long history while also providing what we hope will be a useful road map for those who may find this model a viable and valuable way to hone online skills.

Key to our success at providing both ongoing clinical support as well as consensus in the observation of phenomena which have yet to be fully researched systematically, is our maintaining a collegial environment which fosters a team-oriented approach to the benefit of everyone involved, as we can tap into our diversity -- as people and as mental health professionals -- to our mutual benefit and for the benefit of our clientele. Thus we each learn from others' areas of experience and specialty, and benefit from the collegial feedback of experienced professionals, while together growing in our collective understanding of the types of challenges and approaches which are specific to online clinical work.

History

ISMHO's Clinical Case Study Group (CSG) was founded in the last century and

nurtured into the new Millennium and the new age of Internet-facilitated communication by co-leaders John Suler and Michael Fenichel, both clinical psychologists. The group was born at a time when very little was truly known, and even less publicly shared, in the area of clinically oriented work online.

Over the first 3 years, the group followed a traditional case study/grand rounds model of presenting actual ongoing "cases" for peer supervision, brainstorming, information-sharing, and hypothesis-testing. It was clear that new modalities were offering powerful options and new possibilities, while at the same time facing challenges and skepticism as well. Through case studies--where the focus ranged from providing supportive counseling around relationship issues, to working with identity crises, severe pathology, suicide intervention, child treatment, addiction issues, and more-- this group identified and affirmed over time some of the key factors which facilitate or impede online communication and relationships.

From some of the earliest discussions around disinhibition, effective communication styles, use of online resources, and technical (web) issues, to more advanced and nuanced discussions about ethics, treatment strategies, conjoint treatment, cognitive styles (e.g., ease with multi-tasking; preference for one modality over another), integrated online-offline approaches and more, the group documented our investigation and our conclusions, and evolved. Some members left, new members joined. For the past 3 years we have been a small, stable group of advanced practitioners who are virtually "on call" for each other 365 days a year, for both professional consultation and cordial, collegial support. After so many years, of course we get a sense of each other's work, our styles, our preferences for resources, strategies, and tools, our use of humor, of different modalities... all becomes, as our favorite photo illustrates, grist for the mill. It is hard to imagine a more supportive, informative, professional group of people.

In the first years, the ISMHO CCSG encountered and focused on a variety of cases and the issues they raised in terms of online treatment, the individual cases often serving as springboards to further exploration of the dynamics and phenomena we had been seeing and discussing. Our first report, "The Millennium Group" described this initial exploration, while in the new century (2001) the 2nd year group shared its conclusions about "Assessing a Person's Suitability for Online Therapy", published both online and in the journal *CyberPsychology and Behavior*. Drs. Suler and Fenichel presented some of this work at APA convention symposia as well (see http://www.fenichel.com/APAlive2001.shtml). In 2002, the group was at its largest size, and case presentation length was now expanded to allow for greater depth of exploration, and discussion of both process and theme. That summer the group's co-founders (Suler and Fenichel) presented an invited plenary session on Cyberspace Travels at the APA convention, with fellow panelists Azy Barak and APA's David Nickelson. At year's end the CSG synthesized some of the most often-discussed process and treatment issues into a discussion of "Myths and Realities of Online Clinical Work".

In 2003, several members of the group collaborated in the writing of 2 books, one theoretical and the other being the first graduate-level textbook on Internet-facilitated treatment approaches. The group leader published a book chapter entitled "The supervisory relationship online" (in *Technology in Counselling and Psychotherapy*, Goss & Anthony, eds., Palgrave) while another member presented the group's *Myths and Realities* paper in the UK, to the annual research conference of the British Association of Counselling and Psychotherapy [5-16-03].

Finally, the 2003-2004 (5th Year) Case Study Group, with a smaller group of well-seasoned participants, moved forward in its journey towards less of a single-case presentation model to an exploration of themes around theory and treatment issues which confront advanced-level practitioners. Increasingly, our shared discussion of ongoing treatment dynamics began to include previously-presented cases which the group had been following over an extended period of time, in some cases years. We remained online clinical consultants for each other, sharing our individual perspectives and areas of expertise, having already proven that long-term Internet-facilitated mental health services are not only a possibility but increasingly a method of choice. We also demonstrated beyond question the value of online treatment teams working with each other for the sake of both skill development and appropriate professional consultation to provide practical input and feedback, while working in the still relatively uncharted waters of online mental health practice.

Over time we came to appreciate specific strategies, techniques, and lines of inquiry which seemed to have the greatest diagnostic and/or therapeutic value. After a half decade of this ongoing intensive experience, we would now like to share some of what we have been exploring and illustrate some of the important concepts and issues which tend to arise in online clinical work specific to mental health professionals.

Reflections of the CCSG

Through presentation and analysis of ongoing cases within our group, a primary purpose has been to identify key clinical issues that appear to play a role in our daily work as clinicians who utilize web-based communication in working with clients. Our goal continues to be to hone our own skills, provide mutual support, and describe what we find in ways which are helpful to the patient, client, practitioner, and student. After half a decade of continuous work, study, and discussion, the CSG hopes as in the past that this paper may serve as a valuable source of information as well as an inspiration to others embarking on similar journeys.

Here then are some glimpses into some of the threads which reflect repeated themes which arose often enough to become, after years of CSG work, our individual and collective focus areas. It is our pleasure to share this with you.

Ongoing Threads

This paper represents a summary of several sets of topics and concerns which the Case Study Group has focused upon in the past year or two, in the context of cases that group participants brought to the online group for consultation with colleagues. Most of the cases discussed were taken from our daily work with mental health services both online and f2f. The Case Study Group provided an excellent forum for direct case study, peer consultation, and peer supervision, sometimes offering near-instantaneous feedback or suggestions from fellow group members during a crisis or emergent situation with clients. Several members reported periodically on long-term cases which had been presented previously, so the group was able to offer feedback and perspective on the growth and changes seen in treatment over the course of time, in some cases over several years of treatment.

Case Study Group members used this forum to receive consultation and support from each other on a host of professional issues, ranging from issues of online conflict [see Munro, 2002] and "toxic colleagues", to adolescent online social behavior, individual online-offline treatment plans, group consultation models, addiction diagnosis/treatment/support, challenges to the "therapeutic boundaries", and more. This latest contribution builds upon on our previous reports while reflecting another year of exploration in some of areas where still not much has been written. It is our earnest wish that our sharing of our experience -- insofar as is possible to condense 5 solid years into a brief paper -- may at the least serve to broaden the descriptive literature about online clinical work. It is a great pleasure to present a model which adheres to "best-practice" while proving itself to be particularly *effective* professional model, in providing support to both clients and fellow mental health professionals working in this new frontier.

We hope that you the reader finds useful and comfortable this effort to share a flavor of how a group such as ours can work. As in our *Myths & Realities* paper, we tried to present a slice of the issues we face as online clinicians, and a look at how some of the most experienced practitioners have come to regard the opportunities, challenges, and questions facing those who choose to follow this path. The discussions and themes revolve around both short and long-term case presentations which were presented alongside the many "one-shot calls for help or reassurance" which online clinicians with web sites typically receive each day in our inbox.

While it is not easy to organize a year, or 5 years, of clinical work into a few summary themes or "typical" cases, here are some of the most recent themes and presentations, some new and some of which have been echoing for the past half decade of clinical case study.

Borders and Boundaries

This was a year in which one of the group presented an illustrative case involving the balancing of boundaries and borders, while simultaneously utilizing both telephone sessions and a message board environment. In this year too, one of our members presented a case of medication management where one of the best indices of deteriorating thought processes was seen first online, and a combination of office visits and email dialogue between sessions helped to clarify priorities and monitor response to situational and medication issues. Finally, treatment of a pre-adolescent face-to-face, combined with online email consultation with parents proved to be equally valuable for both the "official" client as well as the conjoint client, the parent. Importantly, in this case the parent expressed explicit relief at having a place to simply journal and share her day-to-day stresses while slowly becoming able to gain distance from the minutia and anxiety about family circumstances. She reported feeling less anxious herself, as a result of the chance to organize and discharge her anxiety, in turn leading to dramatic decreases in anxiety in the child who was the focus of (f2f) treatment. As this process unfolded, input was provided by the group with regard to relevant cultural issues and parenting practices, by colleagues with particular expertise in these areas.

The additional aspect of boundaries, with regard to "who the client is" emerged a few times, along with questions about how to respond to emails from a concerned spouse or the parent of a client. One presentation this year involved a couple who were seen by a CSG member in a f2f diagnostic session. Each member of the couple was asked to send the therapist an email talking about their specific experience in the relationship. Using a combination of f2f sessions with the information provided using email, the therapist was able to address, in a more specific as well as empathic manner, each individual's concerns within the relationship. The CSG forum provided the therapist with the ability to use suggestions from multiple therapists to integrate the email material with the f2f sessions for the couple and to maintain empathy for both partners while maintaining a clear focus on the larger dynamics of the relationship.

After the initial couples session, during which the therapist recognized some difficulty with English as well as a reluctance to speak openly about their conflict, she suggested to the couple that both of them send emails describing their experience of the difficulties in the relationship. This suggestion turned out to introduce more complexity rather than clarity because the female partner in the couple sent an email that contained content suggesting paranoid ideation, and some possible thought disturbance. These symptoms were difficult to assess just from the email because of the client's native language not being English. However upon further f2f sessions as well as referring the woman in the couple to another colleague for individual therapy, it became clear that the relationship was in some ways "crazy making" for her in that she became disorganized in her thinking when trying to articulate her experiences with her partner. However, the referral for individual treatment, upon follow-up, appeared to have been very helpful and this

may not have happened without first reaching out for help online, and having the benefit of assessment and referral.

As such complex cases were ongoing, the group would simultaneously focus on content and process seen via sessions, while theoretical and practical discussions mingled as the group focused on the challenges and strategies one might consider, in this case working with couples online. In this way our group, already comfortable consulting on new case presentations, constantly was called upon for collegial feedback when complex or novel situations arose, be it conducting an appropriate online "intake", exploration of possible referral, or "assessing suitability for online treatment". [Suler et al, 2001]. Over the years it became clear to those of us who receive a great deal of mail seeking help or advice or ideas for term papers, that many people write with the expectation of quick, easy, and above all free, "one-shot advice" or reassurance. In the past issues of logistics (use of computer, separate communications, etc.) and issues of confidentiality were raised as possible reasons to avoid having separate discussions with each member of a couple outside the couples session. This year there was some more explanation of what such a treatment approach -- perhaps in addition to f2f or other modalities -- might entail in working online with couples:

Call me old fashioned (it won't be the first time!) but... it's not difficult to think of quite a few obstacles, ranging from practical to theoretical to logistical, in working online with couples or families in particular. I know we all would like to think of ourselves as rather expert in using our online and offline skills to allow us to establish a communicative, empathic dialogue perceived accurately by both participants -- as described for example by John Suler in his discussion of "text talk" skills... But beyond the absence of vocal tone and facial cues, and the work entailed in learning to communicate "naturally" and accurately online, in general, are there not additional cues we rely upon when working with *couples* f2f, which may go beyond word content, and making gestures or faces? I'm thinking posture, cutting each other off mid-sentence, sarcasm, out-shouting each other, etc.... Not necessarily easy to replicate online, though of course there may be other golden opportunities not easily replicated in a clinic. :-)
What would you, the reader, consider as important clinical factors in approaching online work with couples? Is it viable? Desirable?

Broadening our understanding of online countertransference reactions

This is an area which, as in graduate schools and psychoanalytic training, is demanding and requires some deep soul-searching at times. It requires professional/personal flexibility to look introspectively at how our personal attitudes and predilections may contribute to our reactions to clients' words and actions. We may also have additional countertransference issues around the treatment modality itself, or the client's presentation using the chosen medium. Just as clients may demonstrate rapid disinhibition, they may quickly demonstrate

limited skill with the technology, or with typing, or with textual communication. If there is a phenomenon of e-transference, it stands to reason there may be e-countertransference as well!

There were ample opportunities to observe the group's shared reactions -- to case content or situations presented to the group -- and to look at our individual reactions to our clients' words. Having a trusted group of mental health colleagues, whose working style and feedback style were now quite familiar to each other, allowed powerful and immediate feedback as to what might or might not be an accurate interpretation of a client's communication, or if countertransference (from the midst of the case) might be exaggerating a perception or leading to over-interpreting nuance in an email, for example.

Only after working with each other in this group format for a period of years did we evolve into a more intimate as well as mutually challenging supervision group. Having had long standing familiarity with each other's work, back channel communication, sharing of personal information about each others' lives, as well as f2f meetings at conferences, we had now reached a stage of becoming more of a cohesive working group that could provide more growth-producing feedback. This would clearly not have been possible if this was an open group with changing membership each year.

As always, in sharing reactions to a client's communication, there were several levels of interpretation and reflection, with a focus on both clarity of understanding the client and considering how a significant event or communication might advance the treatment goal(s). Did the therapist accurately and empathically understand the message -- the emphasis, the pain, the nuance? Is a client's change of response style significant enough to explore in depth? Does a change in font, in word count, or emoticon use have several meanings -- including the integration of what a therapist models into one's own online repertoire? Can this be an effective gauge of "positive transference"? These questions are ripe for research.

Many clinicians are reluctant to initiate use of acronyms or emoticons so as to minimize the risk of inadvertently baffling or alienating a client who does not understand the meaning. To what extent is a shared level of familiarity with "e-lingo" among client and counselor a key factor in establishing and maintaining effective and comfortable online communication? How would this impact across differing treatment approaches, for example for those who think within an object relations or psychodynamic framework, versus those who use journaling or homework assignments or those who embrace a CBT or social learning framework? Is it not a worthy goal in and of itself, in some cases, to teach social skills by example, rather than simply being a sounding board, when there are presenting problems specifically around social relatedness?

In a multi-disciplinary, professional-level supervision/consultation group such as

this, a simple one-line statement from a client sometimes suggests different meanings and possibilities to different clinicians. The therapist, sensitized through this feedback, is able to become more self-aware as well as flexible in his or her own reaction to the client's statement. Through reflecting on what her/his reaction suggests regarding his/her countertransference, as well as from hearing how others may construe a different meaning to the client's communication, the clinician can better understand how the response to the client might be tailored in order to make room for more than one meaning to the words. This underscores the importance of ongoing peer consultation when practicing in a new modality of service such as online work, a practice strongly encouraged in the ethical standards of APA.

Related to our understanding of online transference issues is the critical issue of recognizing and addressing countertransference. This is especially important, and thus far not adequately addressed in the literature specific to online psychotherapy or e-counseling. Yet there is ample reason to anticipate and work with it, not only in the traditional sense, but also with a goal of understanding how uniquely online situations may present challenges in *recognizing* it, as practitioners encounter barriers to accurate communication beyond what is typically encountered in traditional (f2f) office practice. In some ways the lack of many contextual cues makes online work not only a prime source of projection and fantasy for the client but may also provide the same benefit/disadvantage to the therapist.

One example, which has not been discussed elsewhere that we have seen, is the frustration which may be encountered by Internet-savvy clinicians in response to the varied levels of technical skills which clients bring to the online relationship. Inability to negotiate community boards, lists, or chat software seamlessly for example, is experienced by some as a hindrance to some people's online experience. It is not productive, of course, to "blame the victim", nor to become upset and frustrated because another person is not up to therapist's expectations or standards. In some cases -- see for example, *Assessing a Person's Suitability for Online Therapy* -- it seems professionally, ethically, and pragmatically appropriate to steer clear of online work with a given client or situation, altogether. One of our group members decided, after recognizing both the countertransference reaction and the real limitations of the client, to facilitate an improved situation for such clients, as well as the therapist:
"For example, some people can't seem to manage the basics of an online community board navigation. I have done a few things to simplify that process, create FAQ sections, and be as patient as possible with 'slower learners'".

There are times when it may become clear that the best approach for an individual presentation is to recommend f2f consultation, due to the risk involved or the difficulty in utilizing online modalities. To be fair (and honest) in the real world we live in now, there may be clients whose online skills far surpass that of a given practitioner, which raises the issue then of whether the online therapist

needs to be at least as comfortable, conversant, and natural with Internet-facilitated communication as is the client. Countertransference might be an issue here as well, or might signal that in this case it is the therapist who may not be suitable for this modality of clinical work.

In this case "technical skill" frustrations may be a source of much grist for the mill in helping the client understand their reaction to the therapist not "taking care of them" technically as a replay or mirroring of other caregivers who were not there to fix things for them. Similarly, a client who seems inarticulate more because they are not able to participate in a sophisticated manner with online work might stimulate for the therapist issues around resistant clients, self-blame for failure with the client, etc.

One of the first cases this year (discussed in the section below) dealt with both structural and counter-transference issues as a client moved between individual sessions with the therapist and posting to a message board where on occasion she made pointed comments about the therapist to other potential clients. This engendered a great deal of reflection on the part of the therapist about issues of boundaries and borders -- a topic which continues to demand consideration by online therapists -- as well around countertransference issues in response to what was said, and considerations for the atmosphere within the online forum community as well.

Transitions, Borders and Boundaries

Some of the advanced clinical issues which are addressed in graduate school, on internships, and through supervised practice involve recognizing and facilitating healthy transitions and working towards successful termination of treatment. Sometimes along the way one may encounter transitions or acting out where online disinhibition combines with a tendency towards destructive transgressions of the "therapeutic frame", where sometimes the clinician is forced to confront pathological blurring of personal boundaries and client-therapist roles. A number of cases which the CSG had followed long-term had successfully reached a point where transitions and termination were healthy and positive events, while a few times the group was asked for input in cases of unhealthy acting out, or where the level of apparent distortion or disorientation was great enough to cause concern about the current level of functioning, and perhaps a new effort at eliciting additional suggestions regarding referral or treatment strategies.

Managing Termination and Countertransference Issues:
(What if it is the therapist who must leave?)

One clinician who is both a therapist and long-time moderator of an online support board (on a volunteer basis) brought this case to CSG after deciding to resign from an active, full-time role on the MB. This decision came as a surprise to everyone-- including the clinician -- because the therapist had always held the

board's development as a community in such high esteem. But the time demands, not to mention demands of dealing with a very intense group process, eventually led to the decision to "leave" the group, or at least the position.

In this as in other case presentations, within the supportive context of the CCSG, clinicians felt safe enough to elicit feedback as to counter-transference reactions relating to a range of situations ranging from missed appointments to personal reactions in response to very strong, sometimes frightening content which came up in sessions. Often hearing from others led to affirmation, suggestions for additional lines of inquiry, and support for development of a strategy which a consensus felt to be the most effective and safe approach when issues of safety or stability emerged. Colleagues offered, as always, honest and non-judgmental feedback, both general (e.g., about the type of presenting problem) and specific to elements of the case, in this case orienting around being both direct and structured in dealing with the forum, and anticipating the reaction of the community.

Later that same day, the clinician shared this post with the group:
"God, they're good! There is now a thread that's started about my reduced presence at the board, they wonder what's up, they miss me and wonder what I have in mind...."
Here, a basic trust in group dynamics and an ability to maintain trust and honesty even while somehow "separating" (for healthy reasons) was a powerful lesson.

What would you do in this situation? Imagine the value of having peer support and perspective here, as needed, when needed. Of course we highlighted how important this community beacon had clearly been to their group, but also needed to recognize and focus on the fact that the clinician's goal *for herself* was a separation from this group, on several levels. Suggestions generated within the CSG included provision of an adequate clarification and "termination" period, a change in perspective from clinician to group facilitator and finally to consultant as the community sustained itself. There were also lengthy discussions about countertransference -- for example how it could be used positively to address the counselor's concerns about the fears and anger which would might emerge on the MB after the changes were announced -- as well as discussion of referral and treatment options and issues of boundaries and expectations.

In addition to receiving valued peer supervision on addressing some clinical issues among the MB population, this online therapist also felt supported while personally struggling with guilt and frustration in trying to establish a positive outcome for everyone, while intent on making the shift of role and being less of a presence within a community accustomed to having the counselor's full time presence. Concrete suggestions for a manageable, clearly delineated termination calendar and some techniques to leave the group with a positive "inner voice" which can be maintained by community leaders helped to support the therapist while hopefully making it easier for the forum community as well.

A new discussion emerged about the ways in which therapists work with conflict in groups, be they message board or f2f or within an e-mail list. Clearly there are many similarities, and differences too. Yet another countertransference issue generated discussion, and that was related to hearing clients complain about another provider, which at times led to anger and occasional advocacy, and at other times led to self-restraint despite feeling upset at what appeared to be unprofessionalism at best. But conflict and aberrant behavior is another subject -- one of many which is ripe for research!

The Case of Jeff
(Can I stay with you?)

Speaking of challenging situations, one member of the group was recently confronted with yet another, completely unexpected testing of boundaries and borders, following the re-emergence of the patient mentioned above, receiving both f2f and online support for severe (paranoid) ideation. Following the death of a parent, which stimulated some intense feelings followed by a period of withdrawal, the client contacted one of the treatment team he was seeing (for pharmacological as well as therapy support) and announced that he was now back among the living, but had been thinking it was now time to begin working for the therapy office, as he was sure it was in need of additional staff. Imagine the delicacy needed here as he was simultaneously declaring his newfound freedom while wanting to virtually move in with his therapist and nurse practitioner. The latter immediately went to our group of colleagues, already familiar with the ongoing work and past client experience. There she sought some advice/consultation on how to handle the boundary issues here without shattering the newfound feeling of being healed and ready to work, despite years of debilitating inability to do so.

Within minutes of posting a message to the group (with the subject head "Yikes!"), and throughout the day as colleagues checked mail across several time zones, the practitioner was provided with concrete suggestions for how to respond in an affirming but not rejecting way, while supporting the positive news of feeling ready to return to work. Members role-played, discussed options for supported, or "transitional" work programs, and provided some suggestions as how to tactfully explain the difficulties with having a client in charge of other clients' records. The counselor in turn used some of the suggestions and reported back to the group feeling greatly relieved and supported, after being faced with what seemed a very imminent and possibly scary situation, not to mention one where the client would be at risk of jeopardizing what had been a very long-term, and very productive client-provider relationship.

Note: Client communication is in black; First CSG member's comments are in blue; and a second CSG member's comments are in red, so the reader can get a sense of how there was an ongoing, dynamic dialogue.

Thought I'd touch base and get your opinion on something as well.

....I'm doing better than I thought I would. Some issues I had before are no longer there. There were things I wouldn't do because I felt that if I did certain things it would somehow result in my father passing away. It happened anyway and now I don't have to worry about those things. I won't go into what the things were other than to say it affected my hygiene and other daily activities. Now it doesn't matter.

I'm a little worried that I may [be] becoming desensitized to death. I miss my father and I loved him very much but I've had so many losses in the past three years that it seems normal.

Two weeks ago we had to put my mothers cat to sleep. The cat was very ill with a liver ailment and probably wouldn't have lasted another week....

[Describing a neighbor]: I'm not really sure what happened to change his mind but he decided that I wasn't the devil worshiping perverted psychopath he thought I was. In fact when I see him around now I wave like I always have and he waves back. His wife still doesn't wave back though.

There is something I want to talk to you about. I was going to say something last time I was in to see you. I've noticed that you do not have anybody behind the desk in your waiting room and nobody answers the phone when I call. I would like to offer my services. Before I became ill I was studying bookkeeping and along the way I picked up skills that would help in general office work. It has been many years since I've studied it but I'm sure that once the bong-resin clears out of my brain it will start to come back. There are things you'd have to show me but I think I can do it. I will of course bring a log book in so I can keep notes on how to do things. You wouldn't have to pay me much either. I'm going to start looking for work as it is. I'm not in any financial trouble or anything but all I've done for the past decade and a half is sit around smoking dope, listening to rock music, and watching the occasional movie. I want to do more than that with my life. I can't guarantee that it would work out but I wouldn't feel right if I didn't ask. I mean what's the worst that can happen? If you were to say no I would be no worse off than I am now and if you say yes there is a good possibility it would work out. Please discuss it with [your colleague]. It has been a long time since I've taken any kind of risk and it is driving me nuts....

It is getting late and I should go to bed. Please consider my offer. Thanks for listening.

The first reaction by another CSG member came within minutes, in the form of a (role played) response offering some suggestions on how one might respond:

Jeff-

I think it's great too, that you're thinking about comfortable places where you could be back into a work routine, and it's very kind that you've thought of me! I am sure you could be a great help doing office-management etc. and I am sure having something to anchor you to a daily routine of work might help keep you functioning "normally" and happily, even if it's not just for the money.

Unfortunately, after in fact giving your offer a bit of thought -- and feeling both flattered and happy for you because you seem ready to take on some new and productive activities -- I have to tell you honestly that I cannot use a new staff person just now, and there are some rather complicated reasons which don't have anything to do with your ability. First of all, you can imagine how confidential all our patients' records are, including your own. (You can understand, I'm sure, why I keep your records very private; I must be careful with all my client records and the insurance companies and all would have a fit if they knew that one of my own clients had access to others' records!) Secondly, although I'm sorry if you've had occasion to find the reception desk empty or not get an immediate response on the phone. That's my fault, and it's great that you're thinking about both me and my clients and offering to help yourself. But we've already been planning for better office coverage and I'm going to have more time to be working in the office myself very soon.

I'd also point out that we've also had an important (professional) relationship over the years, and I think that's important to maintain too, especially now that it sounds like you are going to take a more active position about going out and doing things, including maybe working part-time. I hope I can be here for you now to support the part of your life which has to deal with the stresses and struggles which are very much part of "normal" life.... I hope you can balance out not having to do things in a certain way out of worries about your father, with keeping yourself fit and healthy (including good hygiene, etc.) so that you really can find some work and fun activities and -- like with your neighbor -- learn how it's possible to turn some bad situations into good ones as long as you are thinking positively. It's good you felt like sharing this all with me, and again -- I'm here for you in that capacity, and hope you'll consider (even if I can't offer a job myself) that I'm here to support you as you try some new and positive activities.

Thanks again for the update, and your kind offer too. I will share your good news and your interest in working with A too, of course, when she returns. I'm sure she can help you with ideas and support as you continue to try some new and positive directions.

A 2nd CSG member replied within hours as well, beginning by focusing on the issue of Jeff's work readiness, in general, apart from his having just offered to be office manager for his therapist. She also addressed -- and beautifully described -- the important issue, and process, of grieving:

Do you and your colleague fear he's not ready/in a good enough place/etc. to

make a start yet? If he's been unemployed for a while (that's my impression) I wonder if there's some voluntary work he can do somewhere locally, just to get him back into the setting of being a work colleague? In UK voluntary agencies abound and they are great places for easing people back into the workplace - if you're not earning money people don't grumble as much if you take time off! Also, here, the volunteer workforce is generally a more caring and nurturing environment than the normal office setting because the people who attracted to it tend to want to 'care' for others by giving their services free.

Perhaps you have somewhere similar near you?

The loss issues around his father's death (feeling numb?) are normal for grief aren't they? The most common 'cornerstones' of grief follow a pattern usually - numbness, denial, then a turbulent period of strong emotional output swinging between anger grief and yearning whilst they adjust to the changed situation and finally, once they have adjusted and the dead person is securely held in their memory, letting go and moving on. I suspect your client hasn't yet moved to this adjustment period and when it comes, he may find these emotions frightening - especially if his father was a significant figure in his life (unless the drugs are keeping his emotions under tight control). Guess his therapist will find out how he's coping with his grief.

If he were my client I would affirm his intention (to return to the workplace), thank him for his offer of working of you but say you prefer to have direct contact with your patients (or whatever) and if possible, direct him towards some gentle voluntary environment where he will be accepted and his moods/absences may be tolerated. I think I would also sympathize with the loss of his father and suggest that it is early days for grief and he may find himself feeling a lot of strong emotions about his father's death in the weeks to come.

[Jeff wrote again, prior to his scheduled f2f appointment the next week; His primary therapist had been away for the week and he has not yet received a response to his job offer, as the 2 partners in the clinic need to discuss how to react. He repeats his "pitch" and seems increasingly hopeful and invested in his plan.]

Unfortunately I have no real experience. That is what I hope to gain. As long as I make enough money to pay for the gas there and back I'm happy. I must be honest though, except for one other person, I'm not going to inquire about any other employment at this time. I will only move as my heart guides me.

It occurs to me, that you could do a grand rounds or case conference on just this paragraph. It's so rich, and so ripe for exploration. This is the crux of it. There are issues of observing ego and reality testing, seeing some grandiosity on one hand but also a sense of needing/wanting to be surrounded by therapists throughout the day, ostensibly helping them while helping himself through having work. Clearly, at the least he seems eager to share all the thoughts he's grappling with

at the moment, and the explicit message is that he wants to move forward, even where it involves, in his words, "taking risks".

Btw, do you share his emails with your colleagues? [It's a group practice.]

On one hand, he is looking now for work experience, that's the (conscious) goal. "Job training". Here, I think our colleague's concern....is well taken, he may need some prevocational training or psychological preparation. As some of us discussed the last time round, in response to his first letter, we don't actually know his level of functional ability at the moment (or emotional stability between the death and his ending pot smoking, and who knows what else)...

And I'm concerned that he may discard realistic suggestions if his 'grandiose' plan doesn't come off. He may only want to pursue unrealistic goals because they are the ones he's decided (with God's help?) are what he needs to do.

As long as he makes gas money to get to YOU, he's happy. That's not such an appropriate treatment goal, actually, but if you send something like I suggested before he would have to grapple with Plan B.

His recognizing that a Plan B could exist seems unlikely from this later email. I'm not sure I understand his intentions behind Plan A (working for counselor) in the same way as [the first CSG member] described - i.e. his goal is to get close to counselor because she's 'good for me', she listens to him, reads his emails so he's decided he will go and work for her and have her attention whenever he wants it, there in the office with her. (Is that how you see it?)

My take on his intentions are that firstly he wants to step outside his home and go to work - clinic office is a safe place; [Therapist] is a safe person who knows all about him, therefore going to work for her is a way of getting back to work as well as thanking(?) her for her help. My concern is how he deals with counselor's decision not to have him work for her. My guess is that the longer he is without her response, the more he's making plans around putting it into action.

I definitely agree... with all of this! I think there are both conscious and unconscious wishes at play, and both psychological and vocational aspects to address. I agree [as did a 3rd member] the response to his "job application" will need to be carefully considered in order to be both supportive and helpful, rather than a powerful rejection in the face of his growing optimism.

And we don't know how he'll understand the issues of client confidentiality, boundaries etc. Though to his credit he did not stay riveted on that target in his mail, but gave a well-formed essay (like a political speech) -- key phrases, repetition, 'and in closing... I still need help and I hope I can move into your life in a big way'. Or... "as my heart guides me". Well, ok, that's sweet.... But you really do want to be able to take care of him, and the goal is for him to be able to take

care of himself, not his taking care of you. :-)

As it happens, Jeff was very resilient in hearing that there was not an opening for the job he'd envisioned. Perhaps on some level he knew this, but still wanted to make an effort at finding safe and beneficial employment. He is continuing in treatment, with work and emotional regulation remaining ongoing areas of focus.

Becoming an Online Clinical Treatment Team

One of the most profound and positive experiences among group members, who have now in some cases been available to each other for more than half a decade-- around the clock, throughout the year-- is that of both professional and collegial cohesiveness. In an atmosphere of mutual respect, group members share their expertise in a number of areas which benefit both case study and a unique blend of peer supervision and collaborative consultation. Among our members, the Case Study Group has included a multi-national, multi-lingual, multi-cultural, cross-disciplinary contingent of psychologists, counselors, professors, writers, researchers, a psychiatrist, nurse practitioner, family/marriage therapists, counselors, social workers, addiction specialists, pharmacology experts, anger management consultants, parenting consultants, supervisors, trainers, and others all engaged in the various aspects of online mental health. It is impossible to overstate the value of having, available as needed, a group of trusted clinicians who can provide feedback and consultation from within their perspective and specialty area. The group has clearly evolved over the years, from pioneers working together to understand the basic "nuts and bolts" of online communication and relationships, to scientist-practitioner study of specific strategies and paradigms, all the while rooted in actual case presentations of ongoing clinical work. Members also shared resources, research and personal anecdotes as additional supplements to discussion of specific case material.

Perhaps inevitably, over time the group has become such a powerful resource for each of its members that there has been a sense of wanting to "bottle it" and replicate it for others, as is in fact one of the reasons we have continued to make our work public and share our findings and ongoing discussions through these annual reports. It is gratifying to see how in fact some of our "graduates" and readers have implemented similar training components for online practitioners. We believe such endeavors require oversight/supervision by clinicians with significant first-hand experience, familiarity with the literature, and access to multi-disciplinary support by experts in their field, some of the key components we have been fortunate enough to maintain over the years. We are happy to have become a virtual "open source" of material which has been both cited and reiterated in corroborative ways in a growing number of recent books and articles.

The Clinical Case Study Group was founded for the express purpose of

broadening our understanding and supporting our skills with online clinical work, for the benefit of all, under the auspices of ISMHO, whose mission and principles have guided us from the beginning. Our co-leaders and members have given countless hours without any cost for members nor reimbursement for the leaders, though we have become aware of recent efforts by past members to develop paid consultation practices. Of course even altruistic scientist-practitioners have an interest in leisure time and income, but in terms of our work as the CSG our main reward has been in having the opportunity to grow as online clinicians, and a forum to present our ongoing work to the field as a whole in the hope of promoting informed online clinical practice. Another benefit is that group members are among the most experienced online clinicians to be found, and the skills being developed and shared can be useful -- and marketable -- in our professional lives beyond the CSG.

That said, one of CSG threads which developed recently focused on member experiences with marketing services, tools, publications, and other online-accessed materials. In discussion among the group, we discovered a variety of ways in which services and materials can be packaged and sold, ranging from traditional fee-for-time paradigms (chat, phone, or email primarily) to a combination of self-help materials bundled with interactive access to a clinician, to billing for f2f time (which is insurance reimbursable, most commonly) tied with email as a supplemental means of obtaining information or holding supplemental sessions. In part this appears to be determined by one's profession and the relationship to insurers (at least in the U.S.).

After over half a decade, members of the CSG have evolved from a group of investigators exploring basic principles and processes into a seasoned and savvy group of cross-disciplinary professionals who are familiar with each others' practices and way of working. We have often commented on how we seem to be blessed by a unique situation which feels increasingly like a group practice combined with constant access to peer consultation as well as collegial support. While we are not sharing fees nor routinely referring clients to each other, we have collectively been a presence whereby one can reliably consult with another trusted colleague in an allied profession, for example about a therapy strategy, or medication issue, or a question of addiction issues, or adolescence, or anger management, or working with online communities, to name a few of our specialty areas. This has been in no small part due to the mutual respect, acceptance of differences in culture, practice, and style, as well as a sense of cohesiveness that comes from knowing this is perhaps the only place where "everyone knows your name" and the intricacies of what you are trying to do with a brand new modality of practice.

We have become accustomed to such an ideal situation, and to having colleagues who (due to being in different time zones) might be available around the clock for a simple consultation as to opinion or definition of a culture-specific term, or a concern about a breaking situation. Moreover, we can usually respond

to a client with not only a reply to requests for information (should they be made) but often with a measured response which draws upon collective expertise and a pool of shared resources, a true bargain for the client and clearly a boon for each clinician in the group. Thus, while we have not been charging a fee for the "group practice" coverage some of our individual clients enjoy, we also have not had to pay fees ourselves to access expert opinion in an allied field, or from someone more knowledgeable about a particular presenting problem (e.g., trauma, gender identity issues, Asperger Syndrome, family dynamics, medications, addiction, etc.). In fact, we may have evolved into a nearly perfect-world model of an Internet group practice, albeit without being designed specifically to be profitable.

While others may emulate and replicate this model, we welcome this but caution that for most credentialed mental health practitioners, legal and professional constraints continue to be real. We can attest, too, that it may take years to build a cohesive virtual peer consultation model such as this, with a group committed to professional growth, continuing education, and peer supervision/support. It not only benefits the practitioner but more importantly, it benefits the client. When clients have given informed consent for CSG members to share clinical material and consult with colleagues who have expertise in a given client's area of concern, *clients have typically reported that they felt themselves to be beneficiaries when their professional provider was able to consult with a specialist on their behalf and took the time to do so*. There are certainly several levels of implication yet to be explored through research and practice -- in terms of positive transference, hope, reassurance, placebo effect, halo effect, cognitive dissonance, professional development, etc. Having a multi-disciplinary group to observe and explore client-counselor dynamics, both in terms of client experience and therapist experience, as shared in virtual real-time using the Internet for communication, has in itself been quite enlightening and empowering.

Perhaps it is too much to ask, as it is not specifically profit-driven, but we do feel this model of peer consultation/supervision/CE can serve as a paradigm which may in fact be of tremendous value to for-profit organizations and educational institutions as well. We would like to think, as the CSG winds up a half dozen years of around-the-clock list-based communication, and continues to be reborn through presentations and new ISMHO forums, we may leave a useful legacy which reflects our cumulative clinical experience. One of our most important legacies may well be the evolution of a model which meets both professional needs for supervision and continuing education, while serving as a viable model for a multi-disciplinary group practice, taking full advantage of the Internet in forming and maintaining a group such as this while serving online clients simultaneously.

Integrating Internet Communication with f2f treatment (Refrain)

Often one can gain special insights and information by introducing an online

component to an existing f2f relationship. Sometimes it can be helpful to ask a face-to-face client to send a journal by email or to keep a web log to which you have access. This allows them to put into words their concerns at the time they are being strongly experienced, and thus is un-rehearsed and often (thanks to online disinhibition) uncensored. Sometimes a client/patient is simply afforded an invitation to share additional experiences or concerns which spring to mind after the traditional therapy hour or medication consult ends.

Several of the cases presented in recent years involved work with children and adolescents. In one instance a girl (diagnosed with ADD/anxiety disorder) was seen f2f for therapy while parent consulted with psychologist via email. What evolved was a situation where the client, a pre-teen girl, became calmer and calmer as the mother sent daily journals of her own anxiety, detailing cultural, work, and parenting issues -- all spontaneous and unsolicited in this case. The parent, after some weeks, began writing about how much better *she* felt, simply by having the opportunity to reflect on her own anxiety. The therapist, rather than replying to a daily deluge of tiny details (shopping trips, dinner menu, etc.) sought to selectively reinforce the parent's sense of increased mastery and self-awareness while also sharing how in fact the daughter was becoming more self-assured too, even as she complained about parental anxiety. This case highlighted how conjoint work with a child and parents, where one or another segment utilized online communication, could be extremely valuable and productive. Interestingly, while this parent in this case was quite computer literate and sought often to communicate as a form of relaxation, the daughter had little interest in email, but was quite busy with cell phone and f2f socialization. Mother, due to cultural and personal background, was the opposite -- shy and preferring email to f2f socialization -- which led to some discussion in the group as to how best to balance communication, as well as the value of providing psycho-educational resources to help reinforce parenting skills and the need for information about "normal" parent-adolescent issues.

One note additional about the girl (seen f2f) and Internet: It was observed, as with several other teens and preteens, that she was very responsive to a visit with A.L.I.C.E., said to be the most (artificially) intelligent chat robot on earth, a friendly and patient presence with excellent eye contact (blue eyes) and great tolerance for adolescent insults. The girl's positive response to A.L.I.C.E. -- was so interesting that the psychologist shared this session with the group and has since used this online resource to address social skill deficits, as well as teaching positive social skills and frustration tolerance!

Another pre-teen, also seen f2f by a CSG member, had a totally different set of circumstances. She was diagnosed with Asperger Syndrome and presented as a prodigy with computers, having developed an international web log (blog) by the age of 11. In her case, she lived and breathed Internet, while parents did not. For her, a big "hook" in becoming engaged in counseling was the therapist's ability to empathize with her exasperation about spam, html coding, and message boards.

The content which she shared on her own forum (including talk of boredom and sadness) served as discussion points for f2f work, and was thus a very important factor in the relationship, with relationships in general being the treatment orientation, and one goal being to personalize the online experience rather than just discussing the site itself. This case speaks to the growing importance, or even need, for therapists to be web savvy when working with adolescent and young adult clients whose social and personal world may be intimately connected to their online experiences.

Borders & Boundaries Part 2 -
Technical/Practical Concerns - Maintaining the "Online Therapeutic Frame"

Another basic consideration in dynamic interpersonal therapies, aside from transference-countertransference, is that of the "therapeutic frame". Just as in f2f therapy, the client and counselor being able to work online within defined boundaries and frames plays a very important role. Time and again, having the opportunity to benefit from feedback and perspective from others within our group has proven to be tremendously valuable and validating. Aside from this, the immediacy with which our group has been able to respond to new communications and issues has been an extraordinary benefit shared by all participants.

The Case of Adam: Client Privacy versus Input from Spouse
(Who is the client? What can I say?)

Here is a brief example of how fast email responses can assist members of the group. It also is a case where one's professional concerns as well as countertransference may have understandably been at issue, when suddenly one hears (speaking of boundaries!) from the spouse of a client, via email. The following extracts from CSG emails show how a group member used the group after receiving such an email from a client s wife.

Email from therapist to CSG

"Adam is a long-term (2 years) f2f client who arrived following a failure to return to work due to panic disorder . He has recently started to extend his f2f visits with emails between sessions (f2f sessions fortnightly and emails in between) .I have had no previous contact with his wife, Betty, but received the email below from her in my post today. My questions are, do I respond? If so, should I copy my response to Adam (who may discover the correspondence anyway if they share a computer)? There's a boundary issue here. Adam is my client, I would not normally engage with anyone else without his knowing."

From wife of client to therapist

[Dear Therapist,] "Next time you speak to Adam please could you mention his drinking again, which is getting out of hand. Several binges (too many to mention)

and I am finding it very difficult to live with him in this current state. In the last week he has come to bed once - the other nights just sleeping where he has fallen i.e. lounge floor, sofa, office. Thank you. Betty (worried wife)"

From CSG to therapist

"   I am not comfortable with deception, but I also appreciate the bind you're in. The good news' is she is not asking for a response, only help -- 'fix him, please, he's destroying our family life'. Maybe you could see him more quickly, respond more quickly.... You don't know if wife removed the email from the 'sent' box or not. If he asks you if wife said anything, then I think you'll have a stickier dilemma, but I think his state and sobriety will be a big factor which will determine how he's going to approach you. If he can 'do this' to his wife and kids, he may avoid reality with you too. And I've no idea how bad his functioning has deteriorated..."

" My inclination would be to NOT answer her email unless you have a compelling reason (like advice on hospitalization if there's a real life/death issue) and you've decided the urgency warrants your breaking the therapeutic frame to go past him to his wife."

From therapist in response to CSG feedback

"Thanks for the speedy gut reaction. I was really interested to see you hanging back from responding to Betty. You are quite right, she's not looking for a response from me and my worries about that are my personal counter-transference interfering. But you've touched the centre of my dilemma when you say 'If he asks you if wife said anything, then I think you'll have a stickier dilemma...."

I am not yet sure how to respond if he asks me if Betty has been in touch - I could fall back on the old psychodynamic technique and say 'that's a very interesting question, I wonder why you feel it is important to know.....' etc. but I think that would compromise my professional approach which is to model honesty and openness. I guess I'll wait for him to broach the subject, meanwhile, doing as you suggest, enquiring how he enjoyed Easter with the children. Next dilemma (I can just see them adding up) is how do I deal with him if he lies? Confront him with Betty's version of events and how I learned of them says my internal supervisor.

Thanks, you've helped me begin to think this through."

Additional from CSG

"Is the man on any medication for his Panic Disorder?? if so the drinking is adding to his problems a great deal."

" I have had this experience where a spouse knows my e-mail/web site and has

contacted me regarding their mate ... I don't know in the UK what the confidentiality laws are but in the US in my state (each state has different specific laws) I can't even acknowledge that the spouse is a patient. It really would depend on your laws I think but I often treat unauthorized spouse communication as 'I can neither confirm nor deny that X is under my care'."

Response from therapist to CSG

" .I am now (thanks to thinking it through by email) quite clear in my own mind that I won't respond to Betty direct. ..The content of Betty's email has put a new light on the work I do with Adam (I can use it to measure the level of his honesty with me) but I won't engage in any dialogue with her direct. ."

With both these responses confirming her own gut instinct and received within 24 hours the therapist made an informed decision not to respond to Betty but to hold the information as a benchmark against which to measure Adam s own description of his drinking.

"And in my mail....."
How do we (or don't we) respond to inbox requests for help?

After several years of fielding requests from out of the blue -- including some serious calls for help, some requests for suggestions or advice, and some defying characterization as they seem unsure of what they are asking for, other than to be heard -- there are some ongoing themes which were observed by the CSG co-founders which seem as true now as ever before. First, it must be said that the number one request in our inbox - those of us with enduring web sites which offer information and an email address -- is for advice or reassurance. Advice, and reassurance. Together these comprise perhaps what the public at large seeks most (along with specific information). Students, self-helpers, concerned parents and spouses, and those without the ability to seek professional help even if they are aware they need it: These are the people who write.

The senior author has experienced years of letters from students asking "what is a good subject to write about", interspersed with personal accounts of terrible family/relationship situations (unsolicited and without any intent to pay for services or consultation), anxious students worried about their ADD, anxiety, siblings, parents, or roommates. Family members looking to end a dispute by asking an expert. The Internet's disinhibition, its always-open-for-business availability, and worst-that-can-happen-is-nobody-replies dynamic invite constant outreach to the mental health professional with an online presence. Some of us already consider it our ethical and moral obligation to offer some help pro bono where we can, and some go beyond this minimum level of public service. Some have developed guidelines to help separate out who is really writing an individual call for help versus a mass mailing or a hoax.

One of the ongoing threads which entered the mix was the "in my inbox" treat

which was illustrative of this genre, a true call for help easily supported, the bizarre and even scary message; the genuine but unanswerable (in 1000 messages or less) query as to what has become of one's life, or what is wrong with a loved one, or a pet. Being accessible online goes far beyond just being listed in the phone book. We are accessible to the world, and will be called upon for help from a diversity of sources, sometimes respectfully and genuinely, other times not. Finding ways to help the truly needy while protecting our own privacy, boundaries, and time, is part of the territory, and something to consider when one becomes easily found online.

One of the most fascinating, and sometimes challenging, aspects of offering web resources to the general public is responding to the constant mail which comes in, ranging from pitches to advertise products, to praise for the site, to open-ended calls for help or complaints about a significant other. All unsolicited. In past years there was a frequent sharing of inquiries and requests, and discussion of how to best assess the validity of an email, the nature of the communication, and the type of response which seemed most appropriate. While having an FAQ page, and developing an intuitive sense of what is a mass-mailing rather than a genuine call for help specific to the recipient both can help relieve the burden of responding to mountains of mail, still the online clinician does find her or himself frequently in the position of fielding unsolicited requests for (free) assistance.

The most common types of mail received, at least among those of the group with a mental health related web site receiving a fair amount of visitors, seem to be divided up into three major categories: (1) Requests for help (2) Requests for information/referral (3) Requests for reassurance.

Over our years together some of these shared inquiries presented to the group resulted in brainstorming over a concise "one-shot response" which would steer the writer towards online resources, a treatment source (online or f2f), or some combination. Occasionally one of our group had a particular expertise and/or cultural familiarity with specific issues, and this would help in responding both sensitively and practically, sometimes resulting in a referral, other times in a brief clarification of what the most salient "problems" seem to be, providing some possible action plans. Sometimes it is clear the letter one receives has been sent to massive numbers of people and is either a broad call for help or an impersonal request for assistance without regard to the recipient's particular area of expertise. But over nearly a decade of constant mail, it seems to be the case that very often what is sought more than anything else, at the moment someone sits down to pen a letter to a mental health professional, is *reassurance*. ("Is what I am experiencing 'normal'? Is there hope for me?")

One might argue that this concept is not new, that the notion of "transference cures" and placebo effects can attest to the power of hope and putting one's belief in another's calm reassurance that things will resolve and the future will become brighter. Yet time and again, it has been the case that an individualized response

to a student seeking ideas for a paper, or to a partner in a relationship feeling his/her world is falling apart, or to someone guilt-ridden or frustrated by work issues or problems balancing many life demands, a calm and informative and reassuring letter back to the writer seems to be experienced as a powerful help.

Providing at least some public service *pro bono* is something most ethical codes encourage practitioners to engage in at times. We all have offered a great deal of free services over the years, and having the chance to share some of these unsolicited "cases" has helped us sharpen skills in accurately determining the essence of self-submitted "case presentations". We have also learned, when there is a consensus, which specific requests seem most likely to be genuine, and something we can be helpful with, and which may be pranks or widely-broadcast calls for help made to 100's of people, rather than mail sent specifically to us.

The Case of the "Blanket Lady"

While providing a short and simple response to letters which seek advice, information, or help can become an acquired skill, there are other times when it is difficult to discern if someone is writing for free consultation or is in fact thinking about engaging in treatment. This is often a question which must be asked if it is felt that there is a bona fide value in getting professional help. In one instance this year, a young woman wrote with a long story about a rather aloof and dysfunctional family life, and some seemingly phobic behaviors she had developed which were preventing her from regularly attending her university classes. Instead, she would stay home because all day her thoughts were on returning to her blanket.

Some energy by the group went into clarifying the issues as presented, and it was clear that there were family dynamics as well as ingrained personality issues and some pathological coping styles at play. The psychotherapist who received the letter, after a discussion with the group about referral options -- this person lived far from any of us and English was her second language -- and after some discussion of the dynamics (blanket serving as transitional object, and seemingly phobic avoidance of leaving the house for very long) sent a letter back to this student expressing an understanding of her discomfort, and encouraging her to visit the university counseling center (as there were issues of her parents traveling abroad and having no money, aside from her being unwilling to ask the parents for help). We even researched the healthcare system in that country to find out about private services which were available, and in the end tactfully and respectfully made a strong recommendation to seek help so she could function more normally again. We suggested she share the burdens of her plight with a local resource who could help her get what she needed in the way of both counseling and perhaps medication to address her severe anxiety. Of course we praised her for reaching out as a first step, her situation being so compelling that we did try our best to help with suggestions, reassurance, and in this case a strong message that she really needed to take some action before it got worse (failing university, having to deal with that when parents returned, etc.).

Other items "in the mailbox" ranged from simple requests to help with a term paper in the area of expertise of the recipient, to "what do you think about what this horrible person said or did to me?" to lengthy autobiographies about struggles feeding the family and coping with having to work abroad, or dealing with a spouse's family, or with gender identity issues which were starting to impact on work or family relations. A few times we felt that one of us might be able to help directly, and this was offered (in one case very fortuitous in that one of our members was intimately familiar with both the writer's homeland and culture, and worked in the specific area where the writer was having a problem). Other times we referred to local practitioners or organizations. An anonymous email sent from someone apparently using a public library's Internet connection suggested that the writer was a runaway who felt in danger. We immediately counseled her to call 9-1-1, the local (free) emergency telephone for the police and emergency services, reassuring her that their first responsibility would be to protect her from danger, and we also provided some phone numbers and web addresses for Hotlines who could work with her anonymously and steer her to safe haven and protected shelter.

A great volume of mail is received, from the urgent to the obscure, from people simply looking to engage in treatment to those looking for advice and/or reassurance. Having an online presence and especially one which presents the clinician as available for consultation is a relatively new but increasingly common phenomenon. It is to be expected that once one has an established "online office" or interactive forum, there will be regular calls for help, referral, and reassurance. The value of being able to share some of the inquiries with a respected group of online-savvy colleagues is immense.

Epilogue

We would like to extend a tip of the hat to all the Case Study Group members past and present, over half a decade, some with us still and others going on to spawn training and practice projects of their own. All these clinicians contributed to our collective understanding and our sense of mission. Each contributed unique and rich perspectives, from across differing professional, personal, and cultural situations, with differing client populations. It is the cumulative, collective experience which we have sought to share in past years, as now, and each of our members has been a vital building block in the enduring and still-growing phenomenon known as the Online Clinical Case Study Group.

Members of the Group

Azy Barak (1999-2002)
Peter Chechele (1999-2001)
Tom Crain (1999-2001)
Kym Dawson (2000-2001)

Michael Fenichel (1999-2005)*
Betsy Frier Walker (1999-2000)
Robert Hsiung (1999-2001)
Ron Huxley (2003-2005)
Jim Jarvis (1999-2001)
Gill Jones (2001-2005)
Jim Maguire (1999-2001)
Vagdevi Meunier (2000-2005)
Kali Munro (2001-2004)
Gayla Novitsky (1999-2000)
Pamela Rudat (1999-2000)
Lois Shawver (2001-2002)
Gary Stofle (1999-2001)
John Suler (1999-2002)*
Clay Tucker-Ladd (2000-2001)
Mark Vardell (2000-2001)
Willadene Walker-Schmucker (1999-2005)
Elizabeth Zelvin (2001-2004)

***Group leaders**

As we drift into history (one way or another), we continue moving forward in our individual and collective projects, with long-time leaders and members becoming a presence in new contexts such as forums for advanced topics in online therapy as well as general discussions based online or in live presentations. We hope to be involved with continuing education modules, research projects, education, training, and special events, as well as in continuing to contribute to print projects such as articles and books. All this may be accelerated as ISMHO spawns new educational and professional skill development initiatives, through email, web forums, and live conference presentations.

We sincerely hope that these series of reports have contributed to the narrative history of online clinical service delivery in a meaningful way, and that our writings will offer a testament to the power and utility of the Case Study format. It would be our greatest reward to affirm that we have succeeded in advancing the clinical dialogue around online clinical work through sharing our experience - the challenges, successes, and the continuous spirit of pioneering - while maintaining and honing our professional skills in accordance within the rich tradition of the scientist-practitioner model.

A half decade of online clinical case study has been presented as best as we know how. It is gratifying to see not only replications of our model, but also increasing space in the literature devoted to discussing the issues and themes we have reported on, with discussion points highlighting past, present and future directions in online clinical practice, research, and education. Our case study experience and the discussions represented in our written work will hopefully set the stage to inspire and inform both experienced and aspiring online mental

health practitioners. Today's students and beginning practitioners will no doubt utilize new venues and techniques, and will continue to develop new insights into the basic principles of Internet-facilitated online mental health practice. "Online mental health" is itself a diverse and still-ripe area for exploration and utilization, and includes a wide diversity of components, from "normal" social communication to support groups, self-help sites, counseling and therapy services, education, and research projects and portals. We envision great strides in all of these areas.

While we have focused on direct clinical services, communication, and online experience, we believe the model we employ has great potential across a vast array of online mental health endeavors. It has been our honor and pleasure to share with you what we have learned.