PREDICTORS OF LICENSED CLINICIANS’ ATTITUDES
TOWARD E-THERAPY

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By
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CERTIFICATION OF APPROVAL

PREDICTORS OF LICENSED CLINICIANS’ ATTITUDES
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Signed Certification of Approval Page is on file with the University Library

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DEDICATION

I would like to dedicate this research to Mara and Jay. Mara, you were my inspiration to explore the connection made with another human being through an electronic device. I am grateful to have you in my life. To my son Jay, thank you for your patience and support throughout these past three years. You have been a trooper and I could not have done it without your help. To my father, thank you so very much for encouraging me and supporting me in every way on my journey. To my mother, thank you for being here for me when I needed you most. To my brother, thank you for opening my mind to education as I watched you exploring knowledge. To my adult children, Zethrey and Cheyenne, it has kept me motivated to hear your encouraging words. I hope to inspire all of you to experience higher education and follow your dreams. I love you all!
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ABSTRACT

Predictors of licensed clinicians’ attitudes toward e-therapy was investigated. This article discusses trends of electronic tools used in the field of psychology. The factors that may predict attitudes toward utilization of e-therapy practices were explored. A survey was administered to 141 licensed clinicians in United States. The survey included an e-therapy experiences questionnaire, the self-efficacy with computer technology scale, and the online counseling attitudes scale. Significant results from the study identified self-efficacy with technology and influences of e-therapy experiences as predictors of attitudes toward e-therapy. Psychoanalytic orientation and age were not found to be significant predictors of attitudes toward e-therapy. These findings lend support to the notion that training and exposure could increase positive attitudes toward e-therapy.
CHAPTER I

INTRODUCTION

Herbert Spencer, an English Philosopher, once wrote “There is a principle which is a bar against all information, which is proof against all arguments and which cannot fail to keep a man in everlasting ignorance – that principle is contempt prior to investigation” (Alcoholics Anonymous, 2001, p. 568). This statement comes to mind when thinking of the ever-changing electronic culture of our time. There are many critics who feel members of society are losing connection with others face-to-face and relying on electronic devices to communicate. Some feel the computer age is impersonal and artificial (Allemen, 2002). However, the fact remains that many services are provided and received over the internet successfully (Brottman, 2012; Himle et al., 2012). One of these newer services is psychotherapy.

The quote above captures the motivation behind the current study which has investigated factors which can be seen as increasing or decreasing interest in, and contempt or support of, delivering psychotherapeutic services by electronic devices in different ways other than face-to-face interactions. The factors included characteristics of participants, licensed clinicians’ comfort with technology, and the influences they had experienced which may be defined as exposure to, familiarity with, and encouragement by others to use e-therapy.

As psychotherapy enters a new era of electronic communication, there is an even greater need to understand the range of possibilities for providing services (Baker & Ray, 2011). Although mental health services provided through electronic
devices via internet is a more recent phenomenon, mostly occurring in the past twenty years, many therapeutic interactions other than “in person” therapy have already been established (e.g., Chester & Glass, 2006; Finn & Schoech, 2008). For example, many mental health services are delivered through telemedicine by psychiatrists. For many more years, emergency services have been delivered for mental health crisis situations by telephone, such as suicide hotlines, which continue to be used successfully today.

Another practice other than non-traditional “in person” therapy includes services provided by mail. Psychoanalyst Sigmund Freud communicated with his clients through postal mail (Kanin & Regehr, 2003). Effective therapeutic results have occurred from other than “in person” practices (Brottman, 2012; Calbring, et al. 2007; Heimle, et al., 2012; Peterson & Beck, 2003), but research is sparse at this point in evaluating the effectiveness of current “other than in person” practices.

Psychologists and therapists are utilizing electronic tools to communicate therapeutically through telephone, e-mail, instant messaging (texting), and videoconferencing, solely, or as an adjunct to “in person” therapy sessions (Castelnuovo, Gaggioli, Mantovani, & Riva, 2003; Haberstroh, et al., 2008). Such availability allows for supportive follow up and replacement of services when “in person” therapy is not an option.

Some may argue that these online interactions are not consistent or equivalent with what occurs in a face-to-face session. However, there is research which supports that many successful interventions are experienced by “crisis lines” and emergency
services provided via telephone (Kalafat, Gould, Munfakh, & Kleinman, 2007). This study found seriously suicidal individuals reached out to telephone crisis services and significant decreases in suicidality were found during the course of the telephone session, with continuing reduction in hopelessness and psychological pain in the following weeks.

Researchers have explored the use of integrating new communication tools with traditional “in person” therapy techniques (e.g., text, phone and video-conferencing). Some research findings indicate that other non-traditional practices should only be added to “in person” practices, but not be the sole therapeutic interaction (Boschen & Casey, 2008; Grohol, 1999). However, more current research (Finn & Schoech, 2008; Himle, et al., 2012) has introduced results to the contrary, in which delivery of therapy solely by electronic device has been shown to be effective. This will be discussed later in more detail.

The opinion that online treatment, which is sparsely documented to be effective, should not be used at all, or only in addition to traditional face-to-face treatment, is what the present researcher hopes to examine. The present researcher hopes to explore the influences current practitioners have that may have an impact on their attitudes toward the use of e-therapy.

**E-therapy Defined**

For the purpose of this paper, electronic therapy (e-therapy) is defined as a “non-face-to-face” interaction that occurs between two or more individuals, in which the service provider is a licensed professional, and services are provided via an
electronic instrument in which personal information is exchanged for the purpose of enhancing the mental health of the client. Different types of electronic instruments include computers and phones. Information can be exchanged through video, voice, and text. This can be done by telephone through a call or text, and/or by computer through teleconferencing, e-mail, and chat or instant messaging.

**Current Online Trends**

In 2001, the ONS reported, 70 million to 100 million Americans were seeking health information online. In 2011, the Office of National Statistics (ONS) reported 77% of households having internet access. A study released by Pew Internet and American Life Project found that 80 percent of Internet users, or about 93 million Americans, have searched for a health-related topic online (Pew Internet and American Life Project, 2012). That’s up from 62 percent of Internet users who said they went online to research health topics in 2001. This number has surely increased. The availability of mental health information to consumers will likely accelerate the pace of innovations in clinical practice as well. As consumers find more comfort in navigating electronic devices.

Lee (2010) describes Americans as increasingly relying on the use of the web to improve their overall well-being. Due to technological advancements, a cultural shift has occurred towards the acceptance of internet-based communication; therefore, increasing the acceptance of e-therapy. This dramatic rise in the availability of online mental health care has led to a need for information and guidelines for consumers and
providers interested in receiving/providing mental health services via the Internet (Lee, 2010).

Grohol (2003), an online mental health pioneer, discussed in his book, *The Insider’s Guide to Mental Health Resources Online, 2002/2003 Edition*, the usefulness of the online modality for conducting therapy. Although there is much research needed still at this time, he states that, “emerging research is providing empirical support for using the internet to conduct electronic therapy…” and “so far, the results look promising that this new type of therapeutic modality is potentially safe and effective” (p. 231).

Grohol (2003) mentions several websites (i.e., ismho.org, metanoia.org, and psychcentral.com) that can be used by practitioners to gain current information and he offers guidelines to those who may be thinking of doing online therapy. Some websites that were accessible on the Internet in 2003 continue today to give support, but many websites come and go. These services include setting up an online practice, providing open forums, making technology services available like secure encrypted e-mail, chat rooms and videoconferencing. These websites also provide record keeping, marketing and bookkeeping services for practitioners. The websites he described are developed and maintained by founding members who practice online therapy, and a growing membership that includes national and international professional associations and companies.

Heinlen, Welfel, Richmond, and O’Donnell (2003) provided information on the prevalence of several internet-based treatment modalities. This study revealed the
modalities being used by 44 online therapy websites that are run by psychologists. Eighty-four percent of those psychologists provided services via e-mail and about half via online chat. Only nine percent communicated via video conferencing.

Castelnuevo et al. (2001) found that of mental health providers surveyed, e-mail is the most widely used electronic communication modality between patients and health care providers. This finding shows a trend in which professionals have utilized online tools in psychotherapy that were not delivered “in-person”, revealing increasing acceptance of integrating electronic communication into the practice of therapy.

Today, there are numerous sites offering mental health information as well as private e-therapy clinics such as Find-a-Therapist.com and OnlineClinics.com. The growth in online counseling and mental health services has led to the development of the International Society for Mental Health Online. The practitioner who needs more information in considering the use of online therapy in his/her own therapy practice could access these sources if he/she is aware of them.

**Concerns about E-therapy**

Past research has focused on the limitations and ethical issues of e-therapy (Abbot, Klein, & Ciechomski, 2008; Graff & Heckler, 2010; Lee, 2010). There are many concerns and criticisms of e-therapy that may cause psychotherapists to hesitate to use e-therapy due to fear of the unknown. The lack of experience and absence of formal training in e-therapy for many practitioners may be enough to reject the
thought of providing such services (Finn & Barak, 2010; Haberstroh, 2009; Well et al., 2007).

Concerns about e-therapy include the possibility that visual cues are lost in the process of e-therapy that could have detrimental consequences for the client. There are difficulties with determining age and location of clients, adequately protecting confidentiality, and disclosing proper verification of professional credentials just to name a few. (Barnett, 2005; Finn & Barak, 2010; Mora, Nevid, & Chaplin, 2008).

Ethical issues of e-therapy are discussed by Lee (2010) in which she sees accurate assessment, in some modalities of e-therapy, as problematic. When high risk clients use e-therapy for services, the loss of visual, non-verbal cues can increase the incidence of not accurately assessing for suicide. This has been a concern of crisis phone interventions as well, in which high risk clients are treated without in person contact and are often limited to no contact or identity information. Telephone contact has also been commonly used as an adjunct to in person therapy and does not allow for visual, non-verbal cues. However, it is considered acceptable interaction with clients by many therapists.

Past research has belabored the strengths and weaknesses of e-therapy (Abbot, Klein, & Ciechomski, 2008; Allemen, 2001; Fisher & Fried, 2003; Graff & Heckler, 2010; Hall, 2004; Lee, 2010; Rochlen, Zack, & Speyer, 2004). The identified pros and cons are well defined, and have not appeared to change much over the years. The current study presented these in a general way in order to focus on an area of research that is less studied: the current attitudes of therapy providers.
Other concerns are the loss of interpersonal quality and the physical closeness of face-to-face therapy when it takes place over an electronic device. The therapeutic alliance, the building of the therapeutic relationship between client and therapist may be seen as hindered with e-therapy in which client and therapist are not face-to-face. Another concern is that privacy can also be compromised when access can be gained to personal computers and phones by others (Abbot, Klein, & Ciechomski, 2008; Brottman, 2012; Haberstroh, 2009).

**The Utility of E-therapy**

The utility of e-therapy is the convenience in which accessibility is only a key stroke or a phone call away. Therapy can occur from the comfort of one’s own home or anywhere one chooses, at any time that is convenient to the individual.

For some potential clients, the specific services needed are not accessible for them due to their location, their physical ability, or their comfort in seeking services. Treatment offered other than in-person, delivered by electronic communication, can be an option if one seeks e-therapy (Alleman, 2002; Baker & Ray, 2011; Haberstroh, 2009).

The cost of providing services is also reduced for the therapist who can work from the privacy of home have billing and scheduling handled by a website, and create electronic records which can reduce time spent on documentation. This reduction of cost can be passed on to the consumer (Cook & Doyle, 2002).

The privacy of the individual can also be perceived as more protected by receiving services in the client’s chosen environment. For example, for many clients
who suffer from severe anxiety, the opportunity to receive services without being face-to-face, may seem to them to be their only option. Researchers found that providing online therapy services and supplemental weekly phone contact with patients with social phobia resulted in 93% completing the treatment protocol and one year later all improvements were maintained (Carlbring, et al., 2007).

Another accommodation is the ability to review the interaction in text or video by both therapist and client. This allows the client a record of the interaction that can be used as repeatedly reinforcing, therapeutic, or thought provoking. For psychoanalysts, this may be intriguing due to the heightened transference and countertransference that occurs in text-based interactions (Suler, 2004)

**Recent E-therapy Research**

Current research is limited, but exploration of e-therapy practices has increased significantly in recent years. More recent research has assessed the characteristics of consumers, the skills and training of providers, and the attitudes and perceptions of both consumers and providers.

A study by Vogela et al. (2012), looked at the client’s perception of receiving services and found videoconference and cell phone-based cognitive-behavioral therapy, used exclusively, was effective in the treatment of obsessive-compulsive disorder. Participants had significant decreases in symptoms and gains were sustained after follow-up three months later. This study also evaluated the participants’ perceptions of their experience and found that all participants rated the quality of the working alliance as high and the treatment format as acceptable.
Himle, Freitag, Walther, Franklin, Ely, and Woods (2012) conducted a study comparing videoconference and face-to-face delivery of behavior therapy for childhood tic disorders. The results of this study found that both treatments were effective with significant tic reduction in participants. The therapist-client alliance ratings were strong for both treatment modalities, indicating higher agreement on goals of treatment, agreement on how to achieve goals, and therapist-client bond. The results of this study suggested that the treatment used can be effectively disseminated by electronic device. This example of effective use of one specific treatment suggests that other therapeutic treatments could also be delivered effectively, and should be studied.

Other research focuses on the practitioner’s perception of providing therapy by electronic devices. Wangberg et al. (2007), conducted an exploratory study in Norway of psychologists’ use of and attitudes toward the practices of using email and mobile text messaging in interactions with therapy clients. They developed a two-dimensional scale of positive and negative attitude items for measuring attitudes of 854 Norwegian psychologists towards e-therapy and found that 45% had used e-mail or mobile text in their interactions with clients. The data also revealed that on average participants reported attitudes towards e-therapy was neutral, with 3% finding these practices unacceptable. Thirty-one percent believed that e-therapy, solely, could work as the only form of communication in therapy, and 64% believed that it would only work as a supplemental or an adjunctive tool to traditional face-to-face therapy.
Overall, the findings of the Wangberg study indicate that Norwegian psychologists, on average, appear to be open but cautious toward therapy practices other than “in person” interactions. The “neutral” attitude found appeared to reflect that research regarding e-therapy is in its infancy and much is still unknown.

Mora, Nevid and Chaplin (2008) conducted a study in which 138 U.S. psychologists were surveyed by mail to evaluate their endorsements of four internet-based treatment modalities based on evaluating client needs in a vignette. These modalities were described as email, individual chat, group chat, and video conferencing. The findings were that psychologists provided low levels of endorsement of internet based services. Video conferencing received the highest endorsement ratings as an alternative to face-to-face therapy. E-mail was also highly endorsed as an adjunctive tool with face-to-face therapy.

Other research has found support of e-therapy as an adjunct to face-to-face therapy. Finn and Barak (2010) conducted a study by online survey of 93 e-counselors providing online therapy. These e-counselors had at least a master’s degree and were invited by e-mail to participate in the study. Seventy-nine percent of the participants were female, and 80% of them resided in the United States. The questionnaire included demographic information and Likert-type scales related to extent of practice, theoretical orientation, training and supervision, attitudes about appropriate practice, referral, legal and ethical issues, practice difficulties, and therapist satisfaction.
Overall, e-counselors are satisfied with their practice and believe their practice to be effective. Generally, e-counselors do not have formal training or supervision of their online practice. This study found e-counseling to currently be a supplemental practice with little overlap with face-to-face practice. Amongst those e-counselors surveyed, there was little agreement made between them concerning attitudes, practice, ethical issues, and knowledge of regulations relating to e-counseling.

These findings indicate the need for formal training and safe practices education of mental health services over the internet. Practitioners and consumers need more information about these unique services. Finn and Barak (2010) believe that there is a need for stricter laws and regulations, as well as institutionalized and mandatory education and training for providers. This study clearly identified the individualistic perceptions and practice of online counseling by practitioners that lacked formal training and did not practice by the professional guidelines established.

**Theoretical Approaches and E-therapy**

The consideration of theoretical orientation of therapist was also explored by Mora et al. (2008). Cognitive-behaviorally-oriented practitioners were found to more strongly endorse internet-based interventions than psychoanalytically-oriented practitioners. The participant’s theoretical orientation will be surveyed in the current study.

Cognitive-behavioral therapy (CBT) focuses on what people think with less emphasis on what they do. They believe that dysfunctional thinking leads to dysfunctional emotions and behaviors. The behavioral component focuses on learning
and its role in developing normal and abnormal behaviors. It is believed that behaviors are conditioned through reinforcement and punishment through associative learning. The focus is on changing the client’s thoughts to change how he/she feels and behaves.

Recent research by Sucala et al. (2012) reviewed 840 studies and found cognitive-behavioral therapy to be most commonly identified as the theoretical orientation in studies on e-therapy. This may be due to the psychoeducational component of CBT that is more innovative and receptive to exchange of information between the therapist and client. Education is an area in which the use of computers has been accepted as a valid and effective mode of transmission for the student and teacher.

Boeschen and Casey (2008) reviewed the existing literature and found cell phone use as an adjunctive tool in providing cognitive behavioral psychotherapy to be a promising avenue for both clinical practice and research. Although telephone has been used for years to deliver therapeutic interventions adjunctively, little has been studied to evaluate its effectiveness. There are many factors which need to be considered in providing ideal therapy with use of a cell phone as an adjunctive tool.

A humanistic approach emphasizes the client’s capacity to make rational choices and develop to their maximum potential. Client-centered therapy arose out of the idea that the client is the authority on their own inner experiences, and that the therapist’s role is to facilitate change by emphasizing the therapist’s concern, care and interest in the client. For client-centered therapists there may be concern of loss of
intimacy between client and therapist in a non-face-to-face interaction. It is believed by many that the rapport between client and therapist is built in the interpersonal setting of their physical proximity. The non-verbal cues and moments of silence may be better observed in person, which would be a concern in other than face-to-face practices.

Psychoanalytic therapy focuses on changing problem behaviors, feelings and thoughts by discovering their unconscious meanings and motivations. Clients learn about themselves by exploring their interactions in the therapeutic relationship. Studies have found that psychoanalysts are the least supportive of online therapy (Wangberg et al., 2007). There are concerns for psychoanalysts who see potential problems for e-therapy: therapy becoming conversational, problems of transference and countertransference, and the effects of client's control and immediacy of contact (Savege-Scharff, 2013). However, it could also be said that free association might be more easily produced by a client in text than in speech. (Suler, 2000)

Brottman (2012) provided some explanation of the findings that psychoanalysts are commonly opposed to e-therapy. He summarized research that found the average age of psychoanalysts’ is 65 years old, and adults ages 64 and over have a significantly lower rate of Internet use. Brottman concludes that adaptation of e-therapy by psychoanalysts’ may be the result of discomfort with technology.

**Future of E-therapy**

Research continues to reveal the increasing use of e-therapy and the need for more information and training for providers. Many pioneers of e-therapy have come
together with their experience and education to create support for those interested in
the field of e-therapy and to provide formal training to those who would like to
provide e-therapy (Kraus, Zack & Stricker, 2004).

In the book, Ethics and Professional Issues in Couple and Family Therapy,
Graff and Heckler (2010) wrote a chapter entitled “E-therapy: Developing an Ethical
Online Practice,” which outlines the current elements of e-therapy and they report
that evidence-based research on the effectiveness of e-therapy is starting to emerge.
They also report that e-therapy should be regarded as experimental treatment with
uncertain risks and benefits at this time. With this cautious stance they continue to
inform readers of the movement toward utilizing electronics in providing therapy
services.

These authors also provide guidelines for e-therapists and questions that an e-
therapist would want to answer before providing services. The authors acknowledge
that enthusiasm for e-therapy by mental health providers may be affected by their use
of technology to boost their practices. Their comfort with technology is considered to
influence the attitude of providing online services.

They point out the convenient use of sending intake information and
assessments to a client prior to session and computer-assisted instruction for
homework assignments. The convenience of couple and family therapy sessions via
video-conferencing, when all participants can’t be in the same location at time of
service, is also another viable option. They conclude by saying, “There are many
configurations in which e-therapy can augment practice” (p. 253).
Ofer Zur (2013) offers online resources, including continuing education courses in providing online therapy which gives current information about legal and ethical practices. There are citations of recent research which support the success of therapy delivered online. This website also offers formal training and certification to practitioners who choose to learn more and/or practice therapy online.

Another resource for learning for the practicing therapist is the textbook “Online Counseling: A Handbook for Mental Health Professionals” authored by Kraus, Zack, and Stricker (2004). This textbook is designed to be used in formal training. The contributors are among pioneers and current researchers of e-therapy.

**Present Research**

Wilkins (2012) completed a master’s thesis at the University of Nebraska at Omaha that investigated the Midwestern counselor’s attitudes towards online counseling and self-efficacy with online tools. A survey was administered to 59 licensed professional counselors in the Midwest. The survey used in this study consists of three sections: a demographic questionnaire, Online Counseling Attitudes Scale (OCAS), and a Self-efficacy with Computer Technologies survey (SCT).

Significant results from the study showed counselors who possessed a positive attitude towards online counseling also had high self-efficacy with online tools. Similarly, those who possessed a negative attitude towards online counseling had low self-efficacy with online tools.

In the statement of the problem for his study, Wilkins described that online counseling has the potential to expand the counseling field, but that current
practitioners are apprehensive for a number of reasons. These include, but are not limited to: graduate training programs not providing experiences utilizing online tools, governing bodies not endorsing online counseling, and the limited number of online counseling licensed professionals who are available to provide supervision for online practitioners while they are being trained in providing online services (Alleman, 2002; Haberstroh et al., 2009; Mallen, Vogel, & Rochlen, 2005).

This led Wilkins to investigate the self-efficacy of using online tools and its connection with attitudes toward the use of online counseling services. The purpose of Wilkin’s study was to examine this relationship to create awareness and hope that future research would focus on the role attitudes toward e-therapy and level of self-efficacy with online tools can influence the counselor’s use of computer technologies in their practices. Wilkins found that counselors who possess a positive attitude toward online counseling also have high self-efficacy with online tools. Those with negative attitudes toward online counseling also have low self-efficacy with online tools.

The purpose of the current study was to examine the current attitudes of licensed clinicians toward online therapy by gathering data about the exposure they have experienced concerning e-therapy, the level of confidence the therapist has with technology, their age, and their theoretical orientation. It is anticipated that these factors will have an effect on the licensed professional’s attitude toward the use of e-therapy.
**Hypotheses**

Based on the literature reviewed, the following hypotheses were developed:

1. Licensed clinicians will be more likely to have positive attitudes toward e-therapy if they are confident with technology. This hypothesis is based on research cited earlier by Wilkins (2012) in which he found those with greater confidence using technology have more positive attitudes toward e-therapy practices. Confidence with technology will be assessed with the Self-efficacy with Computer Technology Scale (SCT). Participants’ attitudes will be assessed with the Online Counseling Attitudes Scale (OCAS).

2. Licensed clinicians will be more likely to have positive attitudes toward e-therapy (OCAS) if they have had favorable influences (experiences or exposure) related to e-therapy. Exposure and experience will be assessed with the E-therapy Experiences Questionnaire (EEQ).

3. Those surveyed are more likely to have positive attitudes toward e-therapy (OCAS) if they have had positive influences/experiences related to e-therapy (EEQ) and are more confident using technology (SCT).

4. Those clinicians who have a psychoanalytical orientation will be less likely to have positive attitudes toward e-therapy (OCAS) as compared to licensed clinicians who have a cognitive-behavioral orientation. This prediction is based on research by Wangberg (2007) in which psychoanalytic practitioners were found to have more negative attitudes toward e-therapy.
CHAPTER II

METHOD

Participants

Data were collected from 141 licensed clinicians in the United States. There were 41 (29%) male participants and 100 (71%) female participants. Participants ranged in age from 28 to 81 ($M = 54.27$, $SD = 12.22$). Each participant’s attitudes toward online therapy, personal experience, and influence of others, as well as self-efficacy with computer technology, were measured using self-administered surveys. Fifteen hundred e-mails were sent to licensed clinicians across the United States who are listed as members of the American Psychological Association (APA), California Association of Marriage and Family Therapists (CAMFT) and/or American Association of Marriage and Family Therapists (AAMFT). Twenty-five paper surveys were given out to licensed clinicians in Modesto, CA at a CAMFT workshop. There were 120 (85%) surveys completed via e-mail with an attached survey link of the 1500 e-mails sent giving an 8% return rate. However, 21 (15%) paper surveys were completed and returned through postal mail of the 25 given out giving an 84% return rate, by participants who were also listed as licensed members of the APA, CAMFT, and/or AAMFT. The overall return rate for all participants was 11.5%. Paper copies were distributed as an attempt to include participants who may not currently use online technology. Demographic information is presented in Tables 1 and 2.
Table 1

*Participants’ Descriptive Statistics*

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<tr>
<td>Female</td>
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<td>2 – 12%</td>
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<tr>
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Table 2

Participants’ Age and Year of Licensure

<table>
<thead>
<tr>
<th>Age</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
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<td>3</td>
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<tr>
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<td>0.7</td>
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<tr>
<td>No response</td>
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<td>0.7</td>
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<tr>
<td>Year of Licensure</td>
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<td>23</td>
<td>16.3</td>
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<tr>
<td>No response</td>
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<td>3.5</td>
</tr>
</tbody>
</table>

Measures

Demographic questionnaire (Appendix A). The demographic questionnaire consisted of nine items including gender, ethnicity, age, graduate degree and year obtained, license and year obtained, percentage of online courses taken to acquire degree, theoretical orientation, current practice status, and online continuing education participation.

E-therapy Experience Questionnaire (EEQ) (Appendix B). This instrument was developed for this study to measure experiences that may influence attitudes regarding online therapy. For this study, a questionnaire was developed that consists
of 17 items aimed to assess the personal influence of professional educational and personal experience of the participant that may have determined the participant’s attitudes developed toward online therapy. The EEQ measures participants’ level of experience using a 6-point Likert scale with anchors at 1 (strongly disagree) and 6 (strongly agree). An example of an item is “My peers/colleagues consider online therapy to be effective”. The range of scoring is 1-6. A higher score indicates more experiences and a lower score indicates less experiences. Items 8, 11, and 12 were reverse coded to consistently score more or less experiences. Internal consistency was calculated for all items in this scale. The analysis yielded Chronbach’s alpha of .83.

**Self-efficacy with Computer Technologies Survey (SCT)** (Wilkins, 2012)(Appendix C). This survey is intended to measure self-efficacy of computer technology. This measure assesses confidence of use with internet tools that would apply to online counseling. The original Self-efficacy with Computer Technologies (SCT) was developed by Kenzie and Decourt (1991) and has continued to evolve to measure relevant technologies as technologies have advanced. Permission was obtained from the publishers by Wilkins (2012) to use and adapt each scale. Wilkins made modifications to the scale and tested them on a group of counseling professionals prior to its use. The SCT is a 52- item questionnaire measuring confidence using a 6-point Likert scale with anchors at 1 (strongly disagree) and 6 (strongly agree). The scoring range for this scale is 1-6. A higher score indicates higher confidence with using technology. A lower score indicates less confidence with technology use. In order to reduce the length of the survey, Wilkins (2012) modified the scale to 49
items removing questions not relevant to online tools. This researcher added an additional three questions to obtain information that was not collected in the previous study by Wilkins (2012). A higher score indicates more confidence in computer technology use and a lower score indicates less confidence in computer technology use. No items were reverse coded. Internal consistency was calculated for all items in this scale. This analysis yielded a Cronbach’s alpha score of .98.

**Online Counseling Attitudes Scale (OCAS)** (Wilkins, 2012) (Appendix D). This instrument measures attitudes toward online counseling. The original questions on the OCAS (Rochlen et al., 2004) were modified by Wilkins (2012) to shift the focus from a client perspective to a counselor perspective. The OCAS originally consisted of 26 items aimed to assess attitudes toward online counseling services. Rochlen et al. (2004) found that the OCAS showed strong evidence of internal consistency on all subscales across two studies (.77 to .90) and test-retest score reliability (.77 to .88) over a 3-week testing period. The scale modified by Wilkins (2012) has two factors termed “Value of Online Counseling” (VOC) and “Discomfort with Online Counseling” (DOC). After deleting items that did not load on these two factors, Wilkins obtained a VOC subscale with 12 items (α = .96) and a DOC subscale with 5 items (α = .84). Together, analysis of these subscales yielded a Chronbach’s alpha score of .98. These 17 items were used in the current study as a single scale. The modified OCAS uses a 6-point Likert scale measuring attitudes anchored at 1 (strongly disagree) and 6 (strongly agree) yielding a range of score from 1-6, with higher scores indicating a more positive attitude toward online counseling and lower
scores indicating less positive attitudes. Items 1, 2, 3, 9, and 12 were reverse coded. Internal consistency was calculated for all items in this scale yielding a Cronbach’s alpha of .95.

**Procedure**

An e-mail list of licensed clinicians was accessed from APA, AAMFT, CAMFT licensed clinician directories. Informed consent and surveys were sent by e-mail to addresses with an attached survey link. Paper surveys were given to licensed clinicians attending a CAMFT workshop in Modesto, California, by signing the informed consent at that time and then completing the survey to be returned by U.S. Postal mail with return postage-paid envelopes. Paper surveys were used to include participants who might not have been accessible through e-mail.

The online survey, including the informed consent (Appendix E), and debriefing (Appendix F) were available through Qualtics. Qualtrics allows users to send out a link to the survey through e-mail. By clicking on the survey link, participants were brought to the informed consent page. If consent was agreed upon, participants were then prompted to complete the survey. Upon completion, participants were brought to the debriefing page which they could print out for future reference. The surveys were presented in the following order to first explore factors of influence prior to evaluating attitudes: Demographic questionnaire, influences questionnaire, modified SCT with additional items, and modified OCAS.
Data Analysis

All statistical analysis was performed with the Statistical Package for Social Science 21 (SPSS). Means and standard deviations were calculated for the variables as well as correlations, t-test, and multiple regressions between variables were analyzed.
CHAPTER III

RESULTS

Means and standard deviations were calculated for each measure (see Table 3). The hypothesis that licensed clinicians would have more positive attitudes toward e-therapy if they had higher self-efficacy with technology was supported. A Pearson correlation was found to be statistically significant $r(123) = .360, p = .000$. This indicates that as comfort with technology increased, positive attitudes toward e-therapy also increased.

Table 3

*Means and Standard Deviations of Measures*

<table>
<thead>
<tr>
<th>Measure</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-therapy Experiences Questionnaire</td>
<td>2.74</td>
<td>.95</td>
</tr>
<tr>
<td>Self-efficacy with Computer Technology</td>
<td>4.18</td>
<td>.96</td>
</tr>
<tr>
<td>Online Counseling Attitudes Scale</td>
<td>3.47</td>
<td>1.00</td>
</tr>
</tbody>
</table>

The hypothesis that licensed clinicians would have more positive attitudes toward e-therapy if they experienced more favorable influences was also supported. A Pearson correlation was found to be statistically significant $r(124) = .413, p = .000$. This indicates that as participants experienced more favorable influences, positive attitudes also increased.

Multiple regression was also used to test the hypothesis that self-efficacy and increased experiences would predict positive attitudes toward e-therapy. Confidence with technology use and experiences explained an amount of variance in OCAS...
scores, $R^2 = .208$, $F(2, 121) = 17.16$, $p = .000$. As scores increased in e-therapy experiences, favorable attitudes scores also increased, $\beta = .405$, $t(121) = 3.81$, $p = .000$. As scores of self-efficacy with computer technology increased, more favorable attitudes increased as well, $\beta = .087$, $t(121) = 2.81$, $p = .006$. This indicates that increased experiences and higher self-efficacy of technology significantly predicted more positive attitudes toward e-therapy.

A t-test was utilized to analyze the hypothesis that licensed clinicians who have a psychoanalytic orientation would have less positive attitudes toward e-therapy than cognitive behaviorally oriented participants. This hypothesis was not supported, $t(78) = -.471$, $p = .403$. Psychoanalytic participants ($n = 27$) scored an average of 3.58 ($SD = .87$) on the OCAS, while cognitive behavioral participants ($n = 53$) scored an average of 3.47 ($SD = 1.04$) on the OCAS. This indicates no statistically significant difference between these theoretical orientations regarding attitudes toward e-therapy. Further exploration of this variable can be found in the correlation matrix in Table 4.

Other analyses were run to explore other possible relationships among variables in this study. A statistical regression was run to explore if licensed clinicians would have negative (less favorable) attitudes toward e-therapy if they were older in age and less self-efficacious with technology. Self-efficacy was statistically significant as a predictor of attitudes toward e-therapy, $\beta = .134$, $t(120) = 4.241$, $p = .000$. However, age was not found to be a predictor of attitudes toward e-therapy, $\beta = .045$, $t(120) = -.349$, $p = .728$. Self-efficacy with technology explained variance in OCAS attitudes scores, $R^2 = .131$, $F(2, 120) = 9.018$, $p = .000$. Self-efficacy with
technology was found to be consistent with more favorable attitudes toward e-therapy.

A correlation matrix was also calculated to explore possible relationships among the variables (see Table 4). There were no additional significant findings identified.

Table 4

<table>
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<tr>
<th></th>
<th>Age</th>
<th>Year Graduated</th>
<th>Year Licensed</th>
<th>Theoretical Orientation</th>
<th>OCAS(^a)</th>
<th>SCT(^b)</th>
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<td>.104</td>
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<td>.092</td>
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<td>-.005</td>
<td>.060</td>
<td>.038</td>
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<tr>
<td>SCT(^b)</td>
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<td>-.147</td>
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<td>.011</td>
<td>.357**</td>
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<tr>
<td>EEQ(^c)</td>
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<td>-.009</td>
<td>.016</td>
<td>-.100</td>
<td>.413**</td>
<td>.392**</td>
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</tbody>
</table>

\(^a\) Online Counseling Attitudes Scale  
\(^b\) Self-efficacy with Computer Technology  
\(^c\) E-therapy Experiences Questionnaire  

* Correlation is significant at the 0.05 level (2-tailed)  
** Correlation is significant at the 0.01 level (2-tailed)
CHAPTER IV
DISCUSSION

The current study’s main goal was to explore predictors of clinicians’ attitudes toward e-therapy (OCAS). Variables explored were self-efficacy with use of technology (SCT) and experiences including exposure to e-therapy (EEQ) through social, education, literature, and media influences.

The author was interested in what factors might predict positive or negative attitudes of clinicians toward e-therapy. Current trends indicate rapid increase and usage of the internet to access mental health resources and a growing number of e-therapy websites (Ofer Zur, 2013). Yet, even with this increasing trend in the field, clinicians surveyed have had somewhat neutral attitudes toward e-therapy (Wangberg, 2007) and in this current study somewhat neutral attitudes and limited experience with e-therapy.

Although formal training was not explored in this study, Finn and Barak (2010) found that master’s degree level e-counsellors considered their online practice to be effective, yet had little or no formal training. The current study findings indicate that approximately one third of the participants currently use electronics in their e-therapy practice, have similar formal training of little or none, yet have somewhat neutral attitudes toward e-therapy. The difference in attitudes may be due to the practitioner’s definition of e-therapy.

With increased numbers of students obtaining their education online, this trend indicates an acceptance of learning and connecting with instructors and peers in
other-than-face-to-face forums (Allen & Sellman, 2009). The current study found 67% of clinicians had taken online courses in the last two years which may indicate acknowledgment and acceptance of effective communication and transmission of information online. However, obvious differences between learning and therapy need to be considered.

The findings of this study revealed predictors of attitudes toward practicing e-therapy that may help to explain clinicians’ hesitation in providing e-therapy. One predictor was identified as self-efficacy with technology. The results indicated clinicians who had higher self-efficacy with technology had more favorable attitudes toward e-therapy. These findings were consistent with Wilkins (2012) study in which participants’ mean score was 4.04 (SD = .94) on the Self-efficacy with Technology scale and mean score on the Online Counseling Attitudes Scale (calculated by averaging the measure’s two subscales) was 2.94 (SD = .99) While these findings do not imply a causal relationship, they may indicate that clinicians’ level of confidence using the tools needed for e-therapy may increase positive attitudes toward doing so.

In the past, self-efficacy with computer technology may have been more necessary to conduct e-therapy. Today there are many resources for interested practitioners (Ofer Zur, 2013; Grohol, 2003). These resources are accessible to provide a clinician with little knowledge of technology, or effort by the clinician, to set up what is necessary to provide privacy secured e-therapy services (encryption, billing, etc.).
The influences of experience, peers, mentors, education, literature, and media were also explored as predictors of attitudes. Participant’s attitudes toward e-therapy were positively correlated with increased influential experiences. This indicates that some of these factors may predict the attitude of clinicians and should be acknowledged and further explored.

Limited exposure to e-therapy practices in the field may be the greatest barrier to understanding its’ use and utility. This could have detrimental effects on consumers and practitioners who are not fully trained and knowledgeable of e-therapy practices (Finn & Barak, 2010). Providing or receiving e-therapy services by naïve people could result in harm to consumers and liability to providers.

In the past, it has been found that people older in age had lower self-efficacy with technology. Age was not found to be a relevant factor. Participants older in age were similar in scores on the SCT and OCAS as younger participants. The current study’s participants ranged in age from 28 – 81, with an average age of 54. This sample had a broad range of age with 60 of the participants over the age of 60.

As part of a follow up analysis, the correlation between age and self-efficacy with technology was examined. That correlation in this study was extremely low ($r = -.133$). These findings were not consistent with Rainie’s (2009) findings that older age was correlated with lower self-efficacy of technology. However, Rainie (2009) surveyed the general population and the current study participants may have increased exposure to computer technology. Increased exposure to computer usage
was evident in this study by data indicating 101 participants (67.8%) had taken online continuing education courses in the past two years.

The predictors of self-efficacy with computer technology and e-therapy experiences were found to be influential in attitudes toward e-therapy. This finding may indicate that clinicians who have the opportunity to gain knowledge in support of e-therapy and those who use computer technology may be more likely to have favorable attitudes toward and may even utilize e-therapy in his/her own practice or personal life. This evolution of attitudes would be consistent with trends of increased e-therapy usage (Baker & Ray, 2011).

In previous research by Wangberg et al. (2007), a psychodynamic theoretical orientation was considered as a predictor of negative attitudes toward e-therapy. Psychoanalytic orientation was also presented as the least supportive of e-therapy practices in recent studies, although it was predicted that this trend was currently changing (Brottman, 2012; Mora, 2008). The current study found there was no significant difference in attitudes toward e-therapy between the two most common orientations of cognitive behavioral and psychoanalytic as shown previously in Table 4. It may be useful to explore attitudes of other orientations beyond psychoanalytical and cognitive-behavioral in future research.

Limitations of the Study

There are a number of limitations of the current study. The first limitation was the recruitment process. More than 85% of the participants were recruited online through e-mail. The remaining participants were recruited in person at a local
professional workshop and paper surveys were returned by postal mail. This may have resulted in a sampling bias. It is not known how many potential participants did not have online access. Collecting data from those clinicians who do not currently use computer technology would be important for comparison of attitudes.

Recruitment was also unbalanced between disciplines and geographical locations because MFT’s were primarily recruited in California through the CAMFT members listing and all paper surveys were received by CAMFT members in California. Psychologists were recruited across the United States through the APA members listing. There was minimal response from AAMFT members. This may have biased the study by sampling different levels of clinician’s from specific areas. Clinicians were not asked to identify the state in which they currently practice which could have provided more information about current practices.

Another issue of the current study was the loss of a paragraph defining e-therapy within the online survey. This paragraph clearly defined the researcher’s meaning of e-therapy and was included on the paper survey for those participants. This was an oversight by the researcher and was discovered at the end of data collection, after receiving a request from a participant asking for clarity. This may have affected the responses of participants by leaving them to define e-therapy in ways not consistent with researcher’s definition, and should be corrected in future research.

The Self-efficacy with Computer Technology scale (SCT) was used to measure confidence in use of those electronic tools assumed to be needed for
providing e-therapy. Providers can now utilize websites to manage and set up needed transmission software. Some of the items on the SCT were also outdated as new technology continues to evolve.

**Implications**

The current study focused on understanding some of the factors that affect attitudes of clinicians toward e-therapy. One finding is that age was not a factor in self-efficacy of computer technology. This indicates that trends are changing and people, at least licensed professionals, are becoming increasingly self-efficacious with computer technology. This may also increase the possibility that clinicians and clients may provide or receive psychotherapeutic services via electronic devices.

The predictor of e-therapy experiences was supported and provides new areas to investigate further. The sources of influence were defined through social interaction, education, literature, and media. These questionnaire items were not analyzed separately to identify which area might be more influential than others. Further research should explore these findings.

Psychoanalytic theoretical orientation was not a predictor of negative attitudes toward e-therapy. This may indicate an evolving openness to utilizing e-therapy in the field of psychology that was once strongly criticized. As more research reveals positive outcomes of e-therapy, the attitudes of clinicians may continue to evolve.

Clinicians surveyed indicated generally positive attitudes regarding the use of electronic devices as an adjunct to face-to-face therapy. Future research should explore if specific therapeutic approaches use these tools (Skype, e-mail, etc.). If
some general positive attitudes are being expressed regarding the use of e-therapy by some therapeutic approaches and are viewed as being more efficacious than others, it should be explored further.

An important benefit of the present study was that it exposed participants to information concerning e-therapy that could elicit interest and further exploration of clinicians' attitudes and practices related to e-therapy. In addition, participants may have become aware of the existence of mental health services being provided through electronic devices.
REFERENCES


APPENDICES
APPENDIX A

DEMOGRAPHIC QUESTIONNAIRE

This survey has four sections that consist of a demographic section, influence section, comfort with technology section, and attitudes section.

Section 1: Please answer the following demographic questions to the best of your ability.

Gender__________

What culture do you most identify with? ________

A. Hispanic or Latino
B. White or Caucasian
C. Black or African American
D. Asian
E. American Indian or Alaska Native
F. Pacific Islander or Native Hawaiian

Age____________

Graduate Degree_______ Year Licensed _________

A. LMFT
B. PsyD
C. LCSW
D. EdD
E. PHD
F. LPCC
G. Other__________

What percentage of online courses for this degree? __________

A. 0%
B. 1% – 50%
C. 51 – 100%

Please indicate the theoretical orientation do you most identify with? ________

Are you currently practicing? __________

In the last 2 years, have you taken any continuing education courses online? _____
APPENDIX B

E-THERAPY EXPERIENCES QUESTIONNAIRE

Online therapy/counseling will be used interchangeably throughout this study to refer to therapy or counseling that: a) involves direct communication between a licensed therapist and client(s) using electronic tools such as e-mail, chat, instant messenger, video web camera, and text by phone and b) the communication between counselor and client is inherently therapeutic and treatment focused, similar to face-to-face counseling. Online counseling is commonly referred to as e-therapy, e-counseling, e-psychotherapy, internet counseling, internet psychotherapy, and web counseling.

Section 2: Please rate the following statements to the best of your knowledge, based on your personal experience.

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<thead>
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<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIRCLE ONE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. I have provided online therapy successfully.  
   1  2  3  4  5  6

2. Someone I know has provided online therapy successfully.  
   1  2  3  4  5  6

3. I have received online therapy successfully.  
   1  2  3  4  5  6

4. Someone I know has received online therapy.  
   1  2  3  4  5  6

5. I have discussed online therapy with my peers/colleagues.  
   1  2  3  4  5  6

6. My peers/colleagues consider online therapy to be effective.  
   1  2  3  4  5  6

7. My mentors/educators/supervisors encourage me to learn more about online therapy.  
   1  2  3  4  5  6

8. My mentors/educators/supervisors do not believe online therapy is effective.  
   1  2  3  4  5  6

9. I have participated in webinars/CE classes providing information about online practices in therapy.  
   1  2  3  4  5  6

10. Instructors discussed the use of online therapy in many of my graduate classes.
11. My educational textbooks had little information in them concerning online therapy.

12. I have read nothing about online therapy.

13. I have seen/heard advertisements for online therapy.

14. I have seen continuing education courses are offered to me regarding online therapy practices.

15. I have extensive knowledge of online therapy.

16. Do you currently use any electronic tools to conduct therapy sessions with a client?

17. If yes, please list which electronic tools you use?
APPENDIX C

SELF-EFFICACY WITH COMPUTER TECHNOLOGY (SCT)

Section 3: Please answer the following questions about your confidence with online computer tools to the best of your ability.

Please indicate the extent to which you feel confident carrying out each task by circling the degree to which you believe the statement to be true.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

I feel confident…

1. working on a personal computer.  
2. getting the software up and running.  
3. understanding terms relating to computer hardware.  
4. troubleshooting computer problems.  
5. exiting a program.  
6. copying an individual file.  
7. adding or deleting information from a file.  
8. copying a compact disk.  
9. using the computer to analyze data.  
10. learning to use a variety of programs.  
11. assessing a chat room website.  
12. downloading chat encryption software.  
13. creating a chat room User ID.  
14. logging into a chat room

CIRCLE ONE
I feel confident…

15. finding a specific ‘friend’ in a chat room.  
16. sending text to a specific chatter in a chat room.  
17. in my knowledge of internet abbreviations such as LOL, JK, OMG, etc…(Laugh Out Loud, Just Kidding, Oh My Gawd)  
18. saving chat logs from online chat sessions.  
19. in my ability to provide empathy in a chat session.  
20. I can facilitate a welcoming environment when conducting chat sessions.  
21. downloading an instant messenger.  
22. creating a User ID.  
23. running the instant messenger program.  
24. adding friends to your instant messenger.  
25. sending an instant message.  
26. sending a file through an instant message.  
27. saving messages form instant messaging sessions.  
28. in my ability to use emoticons to convey feeling.  
29. downloading an instant messenger encryption program.  
30. in my ability to convey feeling in writing.  
31. creating an email account.  
32. composing an email.  
33. sending an email.  
34. sending an email with an attachment.
I feel confident…

35. replying to an email.  
36. forwarding an email.  
37. downloading email encryption.  
38. installing a web camera in my computer.  
39. installing web camera software.  
40. downloading web camera tools to enable counseling sessions.  
41. adding contacts into a web camera tool.  
42. calling a contact via web camera tool.  
43. sending text via web camera tool.  
44. send a file via web camera tool.  
45. transferring my face to face skills to online web camera counseling.  
46. creating a therapeutic environment via web camera  
47. troubleshooting problems that may occur with web camera technologies.  
48. in my ability to call a client by phone.  
49. in downloading an encryption program to secure phone texting.  
50. conducting a counseling session over the phone.  
51. to attach and send therapeutic tools to clients via e-mail.  
52. responding to clients through electronic devices.
## Section 4: Please answer the following questions about your attitude towards online counseling to the best of your ability.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

1. I think clients would feel uneasy discussing emotional problems with an online counselor.
2. I think clients would dread explaining their problems to an online counselor.
3. Most clients would never seek out the help of an online counselor.
4. I might encourage someone to use an online counseling service.
5. My clients would feel safe using the services using an online counselor.
6. I would enjoy conversing with clients online.
7. Consulting with a client via online counseling is a good idea.
8. I think clients would follow the advice of an online counselor.
9. I think clients would be afraid to discuss stressful events with an online counselor.
10. I think an online counselor would be a good resource to help clients resolve their personal problems.
11. Using online counseling would help clients learn about themselves.
12. Participating in an online counseling session would be intimidating.
<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
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<td>3</td>
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<td>5</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
</tr>
</tbody>
</table>

13. If a friend had personal problems, I might encourage him/her to consider online counseling.  
   CIRCLE ONE

14. I would confide my personal problems in an online counselor.  
   1 2 3 4 5 6

15. It could be worthwhile for clients to discuss their personal problems with an online counselor.  
   1 2 3 4 5 6

16. If online counseling were available at no charge, I would consider trying it.  
   1 2 3 4 5 6

17. I would feel comfortable counseling online.  
   1 2 3 4 5 6
APPENDIX E

CONSENT FORM

I am a student at California State University, Stanislaus, seeking to complete my master’s of science degree in psychology, counseling. I am inviting you to participate in a study that will assess the attitudes of licensed clinicians toward e-therapy. It is my hope that by conducting this study, I will find information that will explore current influences on the development of attitudes toward e-therapy within the profession of psychotherapy. You can be assured that all information provided will be anonymous and confidential; your name, address, or any other type of identification are not requested, and your responses will only be used for research purposes.

Enclosed you will find a questionnaire that contains questions regarding opinions and knowledge of computer technology, professional experiences, and e-therapy services. The questionnaire can be completed in approximately 10-15 minutes. It is requested that you answer every question to the best of your ability to ensure that I can derive an accurate conclusion. When the questionnaire is completed, please mail it back within two weeks in the self-addressed, stamped envelope that you have been provided, or follow link online to complete survey.

You are free to discontinue your participation at any time without penalty. You may also skip any survey questions that make you feel uncomfortable.

Participation in this research study does not guarantee any benefits to you. However, possible benefits include the fact that you may learn something about how research studies are conducted and you may learn something about this area of research. If you do wish to receive more information regarding the results of the study, it will be provided to you at your request. You will be provided with a blank, unsigned consent form for your information.

Thank you for your time and participation, and for your responses regarding this important issue. If you have further questions, please feel free to contact me (Sheilena Roberts) by e-mail (sheilenaroberts@yahoo.com) or by phone at (209)969-4094.

If you have any questions about your rights as a research participant, you may contact the campus compliance officer of California State University, Stanislaus at IRBadmin@csustan.edu.

By signing below, you attest that you are 18 years of age or older.

By signing below, you are indicating that you have freely consented to participate in this research study.

___________________________________                  ____________________________
Participant Signature                  Date
APPENDIX F

DEBRIEFING

Thank you for participating in this study! We are interested in understanding licensed clinician’s attitudes about e-therapy. Understanding what professionals think about e-therapy is important to explore in this current trend of mental health services being provided through electronic devices. Prior research shows that many factors may predict positive or negative attitudes toward the use of e-therapy. Our aim is to explore these influencing predictors. Our purpose in this study is not to judge professionals on their attitudes, but to explore these factors that may lead licensed clinicians to practice e-therapy, or not.

Please note that all the information we collected in this study will be kept safe from inappropriate disclosure, and there will be no way of identifying your responses in the data archive. We are not interested in anyone’s individual responses; rather, we want to look at the general patterns that emerge when all of the participants’ responses are put together. We ask that you do not discuss the nature of the study with others who may later participate in it, as this could affect the validity of our research conclusions.

If you have any questions about the study or would like to learn about the results of the study you may contact me, Sheilena Roberts, through my research supervisor, Dr. Kurt Baker, at (209) 664-6681. If you have any questions about your rights as a research participant, you may contact the Campus Compliance Officer of CSU Stanislaus at IRBadmin@csustan.edu.

If you would like to learn more about this topic, we suggest the following references:
