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Guidelines for the Clinical Use of Electronic Mail with Clients Diagnosed with Severe Dissociative Disorders in Private Practice.

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Introduction

Today's focus on client centred care and accessibility means that e-mail can become a key method of communication. Technically minded, electronically equipped health-care consumers have accelerated the demand for e-mail access to their health care therapists. This trend correlates with the advent of low-cost Internet access, mass-marketed online services, and employer-provided e-mail accounts for employees.

In many MH settings, consumer-driven demand is urging health care therapists, both individuals and institutions, to establish a mechanism for e-mail exchanges.

The intent of this guideline is to provide guidance concerning computer-based communications between therapists and clients, specifically within a contractual relationship within the context of active therapy being provided. The guidelines address two interrelated aspects: effective and safe interaction between the therapist and client, and observance of medicolegal prudence. Recommendations for site/clinical area-specific policy formulation are included.

This document will guide therapists in the use of e-mail communication with a particular sub-group of clients. This will ensure that this method of communication might *enhance the value of,* rather than introduce complications into, *the therapist—client relationship*. It is focussed on the use of e-mail with clients with severe dissociative disorders, such as Dissociative Identity Disorder, a condition whereby a person may dissociate into separate identities (commonly known as alters), with or without amnesia for this, who may at times dissociate into alters during the course of

therapy and these parts may seek to communicate with the clinician. On some occasions, alters may want to communicate directly with the clinician, but feel unable to do this in face-to-face settings as a result of shame, for example, and e-mail provides an opportunity for them to do so safely.

Definition

Therapist-client electronic mail is defined as: computer-based communication between therapists and people within an active therapeutic context. This guideline does not address communication between therapists and people in which no contractual relationship exists, e.g. as within an online discussion group in a public support forum, such as social media sites.

Background

Although there is some literature in praise of electronic messaging between therapists, there is a paucity of published research within the field of complex trauma and dissociation on the subject of therapist-client e-mail, and no apparent long-term studies were discovered. In addition, we are aware that there can be particular concerns and governance issues with clients with a diagnosis of DID, and communication from parts/alters to therapists. Hunt, Shochet and King (2013) outlined the usefulness and pragmatic considerations of e-mail as an adjunct to therapy in clients with attachment difficulties, drawing on established knowledge from the use of therapeutic letters.

Citing previous papers outlining the history of therapist-client correspondence, Hunt et al describe how it can be "a vehicle to expand the therapeutic relationship, offer interpretations or hypotheses, empower clients, send messages about self-esteem, provide encouragement, or to strategise, and it acts to maximise the client's sense of participation and collaboration in therapy" (2005, p11)

It has been traditionally accepted that clients are not routinely given access to therapist e-mail addresses in NHS settings, this is often different within private practice, where it appears more prevalent, and often necessary for making contact for self-referral. A separate set of guidelines has been prepared for the use of therapeutic e-mail in NHS settings

The Nature of E-Mail – the benefits

It's easy to understand the attraction of e-mail. It is quick and flexible and, unlike telephone communication, it provides a chain of correspondence that can be stored for reference. Parties do not need to be simultaneously available, and an increasing body of evidence suggests that many clients prefer e-mail for certain types of correspondence, such as the sharing of creative activities, photos, web-links etc

It is more spontaneous than letter writing and offers more permanence than oral conversations. Words in e-mail can be more carefully chosen than in telephone conversation, and utilised at all hours of the day, for example when a client may be up during the night and wishing to make contact. While unencrypted electronic messages may, in theory, provide less privacy than postal mail or telephone calls, in practice e-mail replaces and is used more like the telephone but with less urgency. Because of

its asynchronous nature (volleying back and forth over hours or days), e-mail helps prevent “telephone tag” and avoids interruptions associated with telephone calls.

E-mail follow-up allows retention and clarification of advice provided in clinic. Often clients under the duress of illness forget to ask important questions. Self-care instructions might not be fully understood or retained. E-mail creates a written record that removes doubt as to what information was conveyed. It can also augment the stabilisation phase of therapy, potentially reducing delays in the process and building up of resources and trust that is critical to the therapeutic relationship. The use of e-mail with this particular client group is especially important if there is dissociative amnesia (a common symptom found in Dissociative Identity Disorder). Being able to e-mail session notes / reminders about homework, for example, can be useful after sessions.

The use of e-mail in long-term therapies can also be useful in maintaining a contact with the therapist when the therapist is not present. The therapeutic relationship is critical to the success of therapy with clients carrying complex trauma and dissociative presentations, developing trust between the client, the alters and the therapist. Being able to connect in a virtual sense to the therapist at any time of day or night can promote stabilisation of emotional difficulty. For example, many people with dissociation experience night-time as triggering due to traumatic experience; being able to communicate and share feelings via e-mail at night can de-escalate such stress.

E-mail is especially useful for information the client would have to commit to writing if it were given orally. Examples include addresses and telephone numbers of other facilities/resources to which the client is referred; service-user forums and self-help resources; standardised psychometric test results with interpretation (only if appropriate) and other forms of client-related psychoeducation. Some frequently used educational handouts can be ported to an e-mailer template or formatted for the therapist's website. Anonymised / coded questionnaires can also be provided via e-mail, reducing time delays in posting.

E-mail messages can embed links to educational materials and other resources on websites. In some electronic mail applications, clicking on a “live” universal resource locator (URL) link inside a mail message launches a web browser and takes the user directly to the indicated resource. Therapists can provide lists of URLs on particular topics, such as dissociation, depression, and trauma symptoms and could create e-mail reply templates with pointers to frequently used reference sites.

In contrast with telephone conversations, e-mail is self-documenting: Copies of e-mail can be printed or attached to the client's notes.

Finally, since many complaints or concerns can be traced to faulty communication, good communication is part of good governance.

Arguments for and against the use of e-mail as part of the therapeutic process have been set out by Pelling (2009), recommending candidates for using such technology become aware of the pros and cons of its use.

Guidelines

Guidelines for using e-mail in therapy settings address two interrelated aspects: effective interaction between the therapist and client (Table 1), and the observance of medicolegal prudence (Table 2).

Section 1: Effective interaction

In private practice, the way in which a client initially contacts a therapist often sets the tone for the ongoing relationship (phone, e-mail, for example). If a therapist needs to contact a client, the use of e-mail, telephone, voice mail, or postal exchange should be agreed and documented in the notes (consent). Clients might choose e-mail, telephone or voice mail, personal meeting, or the postal route at different times for different purposes. Any changes to standard communication should be documented.

Appointment reminders and routine follow-up inquiries are well suited to e-mail. It also provides the client with a convenient way to report home health measurements, such as goal directed bespoke measurement.

Issues of a time-sensitive nature, such as risk-related information, threats of self-harm, or threats to others, **do not** lend themselves to discussion via e-mail, since the time when an e-mail message will be read and acted upon cannot be ascertained. Sensitive and highly confidential matters should not be discussed through most e-mail systems because of the potential for interception of the messages and transmission of messages to unintended recipients. With this client group, it is also important to state that use of e-mail is an adjunct for therapy and not a replacement. It is to be used for the passing of information rather than being routine therapy in of itself, unless there is a specific reason for doing so, for example, to replace a session that would otherwise be cancelled.

Therapist-Client Agreement

In general, the use of e-mail depends upon negotiation between therapist and client. Negotiation should focus on the following issues:

Turnaround time. Ascertain how often both parties retrieve e-mail and establish a maximal turnaround time for client-initiated messages. In some messaging cultures, natural selection has evolved a one-business-day turnaround for non-urgent phone calls, and a 2-3 business-day turnaround for e-mail. As e-mail gains ascendancy as a preferred medium, messages may need to be checked and sorted by priority (triaged) daily. It can also be agreed that lengthy e-mails may not be immediately read, rather acknowledged within reasonable time-frames. Out of Office can also be utilised to let clients know e-mails have been received but will not be read until a specified date. Issues of abandonment and rejection may be present, so ensuring there is a system by which either the client or their alters emails and knows that messages have been received and given reassurance on general response times is important.

Often, the context of the client's message will indicate the expected turnaround time.

- *Privacy*. If there is an administrative / office e-mail provided, indicate whether the admin staff will triage messages, or whether mail addressed to the therapist's direct e-mail will be read exclusively by the therapist. Content received via e-mail from alters

may need to be communicated to the client (they would be present in the 'sent folder' of the client anyway). Explicit agreement needs to clearly state that all e-mails are part of the therapy notes and should be kept according to standard guidelines of maintaining notes.

- *E-mail addresses*. In addition to knowing who may be reading any e-mails sent, agreements need to be made regarding the sharing of any specific content sent by alters, as this may include information that the client is unaware of (for example, history not accessible to them due to dissociative amnesia). For this reason, it is recommended that only one e-mail address is used by the client. Alters having their own e-mail addresses is not recommended as this can lead to complications regarding whether the therapist should forward or divulge any information from these sources. A single e-mail address means that the client has access to anything from the 'sent folder', thus reducing issues of requested secrecy in any communications.

- *Permissible transactions and content*. This area is particularly important to discuss with this group of clients. If other staff (e.g. the admin team) will be processing e-mails from clients, therapists will need to establish the extent of action permitted over e-mail — e.g. appointment scheduling — and the topics. Certain topics, such as risk-related behaviours should not be discussed via e-mail. Issues such as complaints could be e-mailed as this would be useful for any legal intervention should this be necessary.

    - In relation to clients with DID, there are certain times in the therapy journey during which it can be helpful to communicate with parts/alters, for example: if the alter finds it less distressing to communicate a piece of past trauma-related information as part of building their trauma narrative, or if it helps to understand a relationship between particular parts. Reflections or observations from parts following therapy sessions can also be shared via e-mail.

    - Communicating current risk-related information would not be a permissible transaction in e-mail, nor would the expectation of support from the therapist outside of designated working hours. This type of communication needs to be discussed within the confines of the therapeutic face to face session. Should the rule on not communicating risk-related information (for example, intent to self-harm) be ignored, the availability of e-mail access can be withdrawn

    - It may be useful to make available contact numbers, for example, crisis teams, Samaritans, helplines, both locally and nationally, in the event of a client needing to express risk-related information. Contact numbers could be imbedded into either response 'out of office' messages or as part of the contracted agreement

- *Categorial subject headers*. Instruct clients to specify a transaction type in the "Subject:" field of their messages. This convention will facilitate redirection of messages to the therapist by the admin team if appropriate. Since many e-mail addresses consist of nicknames, clients should also be asked to write their name in the body of the message.

- *Discreet subject headers*. Therapists should use discretion in their outgoing message titles. Clients may have fewer safeguards on their desktops than they need for their own privacy.

Handling of Messages

- *Automatic reply to incoming messages*. If available, e-mail software can be configured to send automatic replies in response to incoming messages from clients should the therapist be unavailable for a period of time (such as holidays, sickness absence). Such messages should include the therapist's estimated date of return and instructions on whom to contact for immediate assistance if appropriate. The use of 'read receipt' communication should be considered carefully and agreed with or rejected in collaboration between the therapist and client. While this can assist each to know a message is read, the immediate timing of the receipt delivery can be off-putting as it informs the other of when the message is read, reducing the possibility of privacy.

  Some e-mail programs have sophisticated filtering mechanisms that trigger different automated replies for clients, colleagues, and unknown correspondents. It may also be necessary to check spam/junk folders to ensure that messages are not being lost.

- *Archiving of e-mail transactions*. E-mail exchanges constitute a form of progress note. Therapists with electronic client record can include e-mail messages, but if not, either e-mail messages could be printed in full and a copy placed in the client's paper record or archived on the e-mail server (timescale for maintenance is according to standard guidelines on note-keeping).

- *Acknowledgment of messages*. For messages containing important information, such as cancelling sessions, clients should be instructed to acknowledge messages by sending a brief reply. In the absence of such confirmation, it cannot be assumed that the client has received, much less read, important instructions. When in doubt, confirm by telephone.

- *Group mailings*. Group-addressing, where those in the group see each other's names, should never be used to send mail to clients. Even the fact that a person sees a particular health care therapist is confidential information. If sending out group mailings, e.g. in the case of a message to members of a therapeutic group, use the "blind cc:" (blind carbon copy, or blind courtesy copy) software feature to keep recipients invisible to each other. When using this feature, enter the therapist's own name in the "To:" field and place the list of recipients in the "bcc:" field.

- *Emotional content of e-mail*. Whilst it is very unlikely in a professional setting, irony, sarcasm, and harsh criticism should not be attempted in e-mail messages. The impersonal nature and ambiguity of e-mail often results in real or imagined exaggeration of animosity toward the recipient. Therapists must realize that ill, anxious, or angry clients might indeed express stronger sentiments with e-mail than they would face-to-face or over the phone. Therapists should make an effort to restrain their language despite their own stress and fatigue. In the case of therapists managing any serious incidents within client e-mails, e.g. intimidation or harassment, it is recommended that all such e-mails are discussed with legal/insurance providers. The possibility of misinterpretation is especially important when considering e-mail content

to alters, some may be young in nature and easily confused by technical or overly 'collegiate' tone. Reading messages carefully before sending to ensure that clarity has been achieved is recommended. Pelling (2009) suggests the use of 'emotional bracketing' to facilitate the difference between information and emotive reflections.

Therapists should be aware that e-mail messages that are deleted may be maintained on backup servers from the e-mail provider. Deleting e-mails does not necessarily permanently erase a message.

Section 2: Medicolegal Issues

Aspects of electronic messaging of particular interest to risk management and legal departments concern data security and liability for advice. Medicolegal anxiety, however, should not be allowed to disable open communication as the basis for a healthy therapist—client relationship. If clients consent to the use of e-mail, provided that guidelines are met elsewhere in this document, medicolegal standards for therapy should be maintained throughout use of e-mail.

Additional Recommendations

- *Forwarding*. Never forward a client's message or client-identifiable information to a third party without the express permission of the client. Even if consent is given, text forwarded to a colleague for the purpose of consultation should not contain the client's name or e-mail address.
- *Mailing lists*. Never use a client's e-mail address in marketing schemes or supply such addresses to third parties for advertising or any other use i.e. all standardised GDPR policies will apply to how any e-mail address is provided.
- *Headers*. Consider the use of a banner at the top of each e-mail message such as:
    - This is a CONFIDENTIAL communication.
    - *Offsite processing of client mail*. As with other parts of the medical record, client-identifiable e-mail must not be taken out of the office. If therapists answer e-mail from home, they must take special precautions to prevent other household members from intercepting messages from clients. Therapists must not share e-mail accounts or passwords with friends, family, or co-workers. Therapists who communicate with clients should have their own accounts for professional use. Therapists must see to it that e-mail processed off site on home systems or portable computing devices is subsequently printed in the office and included in the notes.

Outcomes evaluation. How will the efficacy and usefulness of e-mail with clients be evaluated? Will it be possible to determine utilities based on a monetary cost-benefit analysis, client satisfaction, therapist perception, or clinical outcomes? It may be worth conducting a short survey to determine whether clients feel that therapeutic e-mail access is a worthwhile part of their therapy.

Insurance. Ensure that therapist insurance covers any e-mail communications if applicable

Cost. It may be necessary to include the use of e-mail as part of the fee for therapy, or as an additional cost depending on use / frequency if appropriate.

Table 1 Summary of communication guidelines

- Establish turnaround time for messages. Do not use e-mail for urgent matters.
- Inform service users about privacy issues. They should be told:
    - Who, besides the therapist processes or views e-mail messages:
        - during business hours
        - during illness leave or annual leave
- It is important to establish with clients the types of permissible transactions (for example appointment scheduling, provision of psychoeducation information or web addresses), and the sensitivity of clinical content permitted over e-mail.
- In the case of alters/parts seeking to communicate with the therapist, the content of the communication must be conducive to the therapeutic contract and enhance the therapeutic work, rather than add complications. For example, information about the trauma narrative, or level of communication between parts is permitted if parts find it helpful to communicate in this way
- However, it should be made clear to clients that urgent requests, information about current risk related behaviours, or information related to a deterioration in mental health are not permissible transactions. Continued use of e-mail for these non-permissible transactions will result in the option of e-mail communication being withdrawn from the therapy contract.
- Ask clients to put the type of transaction in the subject field, for example appointment scheduling, asking a question, request for information etc
- Ask clients to put their name in the body of the message.
- Consider an automatic reply ('read receipt') to acknowledge receipt of the communication.
- Therapist to have a system of archiving e-mails to become part of the client's notes
- Maintain a mailing list of clients, but do not send group mailings where recipients are visible to each other. If you absolutely need to use a group mailing, use blind copy feature available in your e-mail software
- Avoid all anger, sarcasm, harsh criticism, and libellous references to third parties in messages.

Table 2 Summary of Medicolegal considerations

Obtain client's informed consent for use of e-mail for therapeutic purposes and enter this data onto the notes.

- Use password-protected screen savers for all desktop workstations in the office, hospital, and at home.
- Never forward client-identifiable information to a third party without the client's express permission.
- Never use client's e-mail address in a marketing scheme.
- Do not share professional e-mail accounts with family members.
- Use encryption for all messages when encryption technology becomes widely available, user-friendly, and practical.
- Do not use client-identifiable information.
- Double-check all ''To:'' fields prior to sending messages.

References

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