Archives of Psychiatry and Psychotherapy, 2008; 1 : 55–65

Perspective of the use of electronic communication in the psychotherapy of eating disorders

Małgorzata Starzomska

Summary

Current research on using adjunctive e-mail in psychotherapy of eating disordered patients is still in its infancy. Some authors underline potential benefits of this form of intervention, and, to prove it, they quote very enthusiastic opinions of their patients. Obviously, this medium of e-mail may help some patients with eating disorders, especially these who are shy, timid and harm-avoidant or who for various reasons have hindered access to treatment. Paradoxically, anonymity which is considered to be one of advantages of e-mail, may become the most serious danger for privacy of patients. Additionally, this feature may appear fatal in the case of self-destructive behaviours of disturbed patients. Cautious optimism of most patients about this form psychotherapy should be, aside from clearly cognitive reasons, an additional motivation for researchers, for a thorough empirical verification of it.

eating disorders / psychotherapy / electronic communication

INTRODUCTION

Latest computer technologies, especially the internet and electronic communication through e-mail create new perspectives for contemporary psychology. The use of computers in the therapy of psychological disorders such as depression, general anxiety disorder, or compulsive- obsessive disorders, was proposed as an alternative to the face to face therapy with a therapist (mostly cognitive-behavioural therapy – CBT, sometimes interpersonal therapy and family therapy) [1]. During the period of intensive development of the Internet, in the 90's computerization of the CBT packages and their use without a therapist were introduced. However, it was immediately criticized. The withdrawal of direct contact with a therapist from the treatment of psychological disorders was described as lacking the interpersonal contact, which seems to be a very important part of the therapeutic relation. In the end it was limited to experimental research into efficacy of adding e-mail contact to the classical face to face therapy. Currently, the researchers agree that this type of therapy which treats electronic communication as an "extra" to the traditional therapy [1] is still in the experimental phase and it is just starting to develop [1, 2]. Due to the currently unclear status of such therapy, different terminology is used for its description, which shows that the terminology is probably temporary. This inconsistency mostly refers to the description of the degree to which e-mail is used. Besides the names used by the clinicians and researchers suggest prudence (c.f. "useful addition to therapy" [2], "therapeutic addition" [1], "addition to ambulatory treatment" [1]) one can also notice an appearance of very courageous terms such as "adjunctive e-mail therapy [1], "e-mail associated psychotherapies" [2], or "use of e-mail in psychotherapy" [2]. Howev-

Małgorzata Starzomska: The Institute of Applied Psychology Academy of Special Pedagogy Warsaw, Poland; Correspondence address: Małgorzata Starzomska, Academy of Special Pedagogy, 40 Szczęśliwicka St., 02-353 Warsaw. E-mail: eltram@life.pl

er, even though some inexactness still exists, it is out of doubt that among the various propositions of interventions with the use of electronic communication in helping people with psychological disorders we can distinguish a one time consultation and electronic communication supporting a face to face therapy.

This text is mostly about all pros and cons of psychotherapy supported by electronic communication and about the evaluations of the effectiveness of such a contact in helping persons with eating disorders. Before discussing the above mentioned topics the criteria for diagnosing anorexia, bulimia and compulsive overeating as well as a specific use of electronic communication in one time electronic consultation will be presented.

DIAGNOSIS AND CONSEQUENCES OF ANOREXIA NERVOSA

Anorexia, bulimia and compulsive overeating are considered as eating disorders. The major symptoms are the fear of weight gaining and concentration on weight loss. For better understanding, we present below the diagnostic criteria for bulimia and anorexia.

In DSM-IV-TR [3] there are four criteria for anorexia:

- refusing to maintain a minimally normal body weight and height for a given age, for example a weight loss that leads to the weight 15% below the expected level, stopping gaining weight and growing which keeps the weight 15% below expected level;
- strong fear of gaining weight, even when underweight;
- a significant disturbance in the perception of the body shape or size, for example a person may claim that he or she feels fat even if he or she is gaunt, or claim that a given part of the body is "too fat", even if clear underweight exists;
- postmenarcheal females lacking at least three consecutive menstrual cycles; women with this disorder are amenorrheic, if menstruation occurs only as a result of taking hormones such as oestrogen; men lose libido;

As far as the bulimia goes DSM-IV-TR [3] states five diagnostic criteria. The first criterion is recurring binge episodes. Binge episodes are characterized by:

- eating in a given time period, for example in two hours, a significantly larger amount of food than a healthy person could eat in the same time and similar situation;
- feeling a lack of control during the episode which relates to a feeling in which one cannot stop eating or feels the lack of control over what and how much one eats.

The second criterion for bulimia are reoccurring inappropriate types of behaviour preventing weight gain, such as provoking vomiting, overuse of laxatives, diuretics, enemas or other medical means, intensive physical exercise, restraining from eating. The third diagnostic criterion of bulimia is occurrence of binge attacks and the above mentioned types of inappropriate behaviour at least twice a week for three months. The fourth criterion of this illness is the influence of body shape and body weight on self-esteem and the fifth is excluding the above behaviour as one of the symptoms of anorexia.

According to DSM-IV [3] the major diagnostic criteria for compulsive binge eating disorders are:

- consumption of very large amount of food in a short period of time, which is accompanied by a feeling of lack of control over eating during an episode;
- assertion that episodes of overeating are connected with at least three of the following factors:
  - eating in a very fast and rapid manner,
  - eating to the point in which a person feels that he or she has overeaten to the point of discomfort,
  - eating large amount of food even if a person does not feel hungry,
  - eating alone due to the fear that somebody will notice atypical eating pattern, which exists in a given person;
- the feeling of disgust at oneself, depression or sense of guilt after overeating;
- a major stress associated with the fact of overeating;
- occurrence of binge episodes at least twice a week for a period not shorter than 6 months;
- lack of compensation behaviour typical for bulimia.

Anorexia, bulimia and compulsive eating disorder have very serious consequences for the whole body. From 4 to 20 % patients with anorexia die as the result of loosing weight, although the direct cause of death are emaciation of the organism, acute circulatory failure and cardiac arrest [4, 5]. Another, less common cause of death in people with anorexia is suicide [6, 7]. 1 – 2.4 % patients with bulimia [8, 9, 10] die of medical complications due to attacks of compulsive overeating and rapid purge [11, 12] and due to suicide [13, 14]. The consequences of compulsive overeating are: obesity and serious diseases of the digestive system and cardiovascular system.

Literature shows a major role of electronic communication in the help for people with eating disorders both in the sense of one time consultation for the patients and for the people from their environment, in the way of psychotherapy supported by regular exchange of e-mails between the patient and his or her therapist. Below, two methods of the use of electronic communication in the case of anorexia and bulimia are discussed.

ONE TIME CONSULTATION WITH THE USE OF E-MAIL IN THE HELP FOR PATIENTS WITH EATING DISORDERS AND PEOPLE IN THEIR ENVIRONMENT

The German Internet site: "Information and Consulting Server for Eating Disorders" [15], is a good example of a therapist's action aiming mostly at one time consultations considering eating disorders. In the firsts months of its existence it was visited by thousands of readers. Analyses of 615 e-mails which were sent to specialists who were co-authors of that page disclosed that society has a great demand for this type of sites [16]. It was shown that the main motivation for using this type of site was the guarantee of anonymity.

Among 615 e-mails, 346 were from people with eating disorders (333 women, i.e. 54.1% of all the respondents and 13 men, i.e. 2.1% of all the respondents). Among them:

most people had bulimia (212 people, i.e. 63% of the respondents with eating disorders);

54 people with a compulsive overeating disor der, which constitutes 16.2% of the respondents with eating disorders);

27 people with anorexia (8.1% of the respond ents with eating disorders);

8 people with obesity (2.4% of the respondents with eating disorders);

29 persons with eating disorders not otherwise specified, which constitutes 8.7% of all the respondents with eating disorders.

It should be stressed out that the discussed web page was addressed to all the people interested in eating disorders, including people with anorexia. However, most reaction came from people with bulimia, which is consistent with the following statement by Martina Grunwald and Juliane C. Busse: "In opposition to people with anorexia, people with bulimia have very painful experience due to their illness and limitations that go with it. Because of that, mostly people with bulimia are aware of the fact that they need help and actively search for consultation and help. However, people with anorexia reach such a critical view of their own illness only after years of psychotherapy" [16].

Besides people with eating disorders help through Internet was sought by:

- friends of sick people (more men – 73 , which constitutes 11.9% of all the respondents, than women – 57, which constitutes 9.3% of all the respondents);
- parents of ill persons sick people (17 persons, which constitutes 2.8% of all the respondents);
- siblings of ill persons (19 persons, which constitutes 3.09% of all the respondents);
- people interested in the problems of eating disorders (for reasons not specified) (53 persons, which constitutes 8.6% of all the respondents);
- doctors (13 persons, which constitutes 2.1% of all the respondents).

In their e-mails' persons with eating disorders, especially patients with bulimia, asked for information about biological consequences of inappropriate types of behaviour concerning eating and about the possibilities of treatment of the illness (also abroad) and about a way of overcoming the illness without therapy. They also often asked the consultant for a decision whether or not their eating behaviour meant to be "abnormal". It needs to be stressed that the e-mails coming from people with eating disorders were

usually their first contact with a professional help giver at the beginning of the disease. It is worth mentioning that even though persons with bulimia search more willingly for help than patients with anorexia, inadequate social support and cases (currently sporadic) of misunderstanding by general physicians, to whom these persons talk before searching for psychological help [17, 18] are the cause a number of the so called "silent patients", who even when having strenuous symptoms probably will never decide to seek professional help [19]. It is obvious that in such cases the response to the first e-mail from such a distrustful person should be very honest and well balanced. Additional difficulty of such situations rests in the fact that it is not easy for a professional to evaluate the problem on the basis of a spontaneous, often very short statement, which in the same time masks feelings.

Because of the above mentioned problems the advocates of consultation through e-mail work on finding techniques for reliable evaluation of patient's state based on such statements and search for a method of a practical and at the same time non-intrusive consultation.

As it was mentioned above, help through the Internet is also sought by persons from the patients' environment, especially by family members. They often feel helpless and admit that they wish to have at least a "tolerable" life [16]. Most of all, they want to persuade the patient to seek a treatment. However, surprisingly these people have very little knowledge about the essence of the illness in the people to whom they feel close. For example, very often they do think that the problem can be solved by a change in the patient's behaviour and because of that they search for fast and practical advice. Also, they seem not to notice the psychological side of the illness, thus the patient's feelings and a specific way of perceiving reality goes unnoticed. It is not uncommon that in despair these people decide to break off the contact (most often this happens in the case of friends, couples or fiancées) even though their decision is accompanied by a tremendous feeling of guilt. It needs to be stressed that very often families and friends of people with eating disorders also wish to understand themselves, especially the nature of strong tension that accompanies their contact with the patients.

Yet, in other cases, physicians search through the Internet for information about methods and means in the treatment of eating disorders.

The research done by Grunwald and Busse [16] showed that the method of consultation described above, with the use of Internet and e-mail is fully accepted by persons, who decided to use this way to seek help. However, it seems that the success of this form of consultation is a matter of good cooperation between psychologists, psychiatrists and general physicians [16].

PSYCHOTHERAPY ASSOCIATED WITH REGULAR EXCHANGE OF E-MAILS BETWEEN THE PATIENT AND THE THERAPIST

Form

The form of psychotherapy associated with regular exchange of e-mails between patient and therapist is usually as follows. In the course of 3 to 7 months of psychotherapy, the patient comes for weekly therapeutic face to face sessions and these sessions are supported by e-mail contact. At the beginning of the therapy, during the determination of contract between therapists and the patient, both sides negotiate what the frequency of the e-mail contact should be, but usually they agree to send one or a few e-mails a week from each side. If the therapist does not receive any e-mail, he or she sends to the patient an e-mail reminding about the contract [20, 21].

Advantages [1]

Empowerment

The literature of the subject shows that each year the number of persons with depression, phobias, and different eating disorders, especially bulimia, increases. However, they are not treated because of fear and resistance towards contact with people who can offer help in such cases. Although, as it was mentioned earlier, contrary to persons with anorexia, patients with

[1] Advantages and disadvantages of therapy assisted by e-mail have been described by Paul H. Robinson and Marc A. Serfaty as "clinical implications" [20, p. 192].

bulimia want to get better [16]. Paradoxically, a lot of them do not get help, because they very seldom go to see specialists. There are many reasons. One of them is depression, which accompanies bulimia [22] and very often negative experience in searching for help, for example underestimating the seriousness of the situation in a given person by a general physician (it needs to be mentioned that persons with bulimia usually are not obese or extremely thin so their look does not suggest an illness) [20, 23]. Electronic communication through the Internet gives a chance to avoid these obstacles in search for help by people with eating disorders, especially bulimia [21]. It has been shown that patients with bulimia that agreed to go through therapy with e-mail communication would not find courage to go through traditional psychotherapy [21]. It is worth mentioning that most respondents, as indicated in the research done by Robinson and Serfaty, who attended e-mail supported therapy, expressed desire in further face to face therapy. Therefore electronic communication often encourages distrustful people with bulimia to get help, to search for contact with therapist and traditional psychotherapy [21]. It's worth mentioning that contact with a therapist through a computer, compared to face to face contact, does not cause such big difficulties as the ones that these patients may encounter in direct contact. During the latter contact, even subtle changes in the eye contact or tone of voice may cause reserve in the expression of thoughts or emotions and even termination of the session or therapy. Additionally, when a patient is characterized by shyness or even timidity and avoidance of hurting feelings, which very often are characteristics of a person with eating disorders especially with anorexia, he or she may feel resistance towards keeping the eye contact with the other person in this case the therapist. In such situations the monitor screen seems to be the optimal medium for expression of the patient's feelings, and that is why many patients welcome the contact with a therapist through e-mail with "enthusiasm" [1].

This is even though, the use of e-mail in psychotherapy as a method lacks direct interdisciplinary contact between a therapist and a patient and because of that it is often criticized by clinicians and researchers. Nevertheless, this method is considered by persons with eating disorders, at least in the early phase of treatment, as the only possible choice of treatment among many other options [21].

Accessibility and egalitarianism

A big advantage of the e-mail contact between a therapist and a patient during psychotherapy of eating disorders (and other) is the accessibility of help for patients regardless of geographical distance, which is important not only for people living far from therapeutic centres, but also for patients who have problems with getting to the therapeutic centres due to agoraphobia or problems with moving [20, 21]. It is worth adding that eating disorders most often concern young people, among whom, many are advocates of the Internet and electronic communication [1].

Other important advantage of e-mail communication is its egalitarianism, which means minimization of the psychological distance between a physician or a psychologist and a patient [1, 20, 21].

Monitoring the patient and the therapists

The additional advantage of electronic communication comes from the possibility of monitoring the patient's physical state, equally for somatic consequences of eating disorder as for diseases which may accompany these disorders (such as diabetes, asthma or high blood pressure) [20].

The e-mail assisted therapy gives also a chance to monitor competence of the therapists, who may and should send a copy of their e-mail to their supervisors, who upon making annotations on them send, the modified versions back to therapists [21].

Anonymity

Robinson and Serfaty list "privacy" among the advantages of electronic communication in psychotherapy by which they understood its protection [21]. However, "anonymity" seems to be a better term here (due to reasons, which will

be described in the part describing limits of this type of intervention). The therapy with the use of electronic communication can be adequate for patients who, for different reasons, want to stay anonymous, for example patients who are ashamed of their illness symptoms [21].

Tension reduction

E-mail contact reduces the emotional burden to a significant degree in patients, because the computer kindly, gently, simply "blandly" [1] approves, without any objection, of everything the patient wants to say, including confessions, threats, or strange ideas. The above mentioned computer's characteristics cause the patient to relax more than he or she would be during a direct contact with a therapist, when he or she must pay attention to the clinician's remarks or to his or her own body language, which significantly decreases sincerity of the statement. It needs to be emphasized that during e-mail contact, the patients use informal language and use it also to abbreviate the physician's name (usually Eng. "e-doc") [21, 1]. It turns out that on the base of electronic communication, in spite of its impersonality, very beneficial and authentic relations between patient and his or her therapist may be created.

Involvement in the contact with the therapist

Patient's access to the therapist's e-mail ensures the constant feeling of support for the patient. This medium significantly increases the frequency of therapeutic contacts and extends their time, and in consequence the time of the therapy. Receiving feedback information from therapists in between sessions insures the patient about the fact that the therapist is present, listens to, and thinks about him or her. It also gives the feeling of being in direct, almost physical contact with the therapist and being under his or her care. This type of contact also ensures comfort of unlimited access to e-mail (and indirectly to the therapist) [1, 2]. At the same time, this characteristic of communication is described as "the synchronic nature of e-mail" [1], and Yoel Yager called the discussed type of contact "semi-everyday therapy" [1]. It is necessary for the success of a therapy, that the therapist will be very serious about the duty of informing the patient how often he or she reads the correspondence and replies to it. This information may help avoid many misunderstandings, because patients know when they should expect an answer. It needs to be emphasized that the time which patients spend on considering and writing e-mails to the therapist, judged on the seriousness of their thoughts, shows strong involvement in the relation with the therapist (the time which a therapist spends on answering to a single e-mail of one patient is of course a lot shorter) [1]. Patients' e-mails are often very emotional, especially those initiating the contact if it is needed (of course in accordance with the contract) [1] and the patients are not afraid that they may invade the privacy of the therapist, because it is the therapist who always decides when he or she will read the mail. This special emotionality contradicts popular opinion about "coldness" [21] of the e-mail therapy. However, the above mentioned "semi-everyday" contact in a subtle but firm way requires from its participants constant involvement in the therapeutic process also during the period between sessions. The research shows that patients do not betray the trust in this aspect and respect requirements for the frequency of e-mails sent to the therapist [21].

Advantages of therapy with the use of e-mail communication from the patients' perspective

Below there are cited statements of patients who positively evaluated therapy with the use of e-mail, in which they participated.

"I would never admit my problems face to face", "I would never answer if it weren't for the anonymity of e-mail therapy", "Anonymity of contact through e-mail cause that later I dare search for help (this time face to face)", "E-mail contact gives more time to think through the answer than a direct contact", "During e-therapy I felt trapped, but a month later I noticed that my problem disappeared" [21]. "Therapist's remarks are very accurate and I feel that somebody is concerned about my problems" [21]. "…I had an impression that the therapy occurred more

often than only once a week (…). It is a good way to communicate what one is thinking in a given moment and what for sure I would have forgotten during a visit. It's a good way to think about what I am doing and a moment for reflection" [1]; "…e-mail is a good way of contact, because there is a distance here. I think that e-mail may be effective in the process of getting better. It's fast and so simple to use. You can get in touch in such an easy and fast way" [1]. "(…) e –mail gives me a feeling of security because I know that if I have such a need, at any moment the door between me and somebody that will offer me help is open. Getting the feedback on the things I do is very beneficial (…)" [1]. "(...) e-mail causes that communication with the therapist is better (…). Instead of weekly or bimonthly visit it's possible to have everyday contact (…). During e-mail therapy the trust is growing (…)" [1].

In conclusion, the research showed that for many patients with eating disorders adding the e-mail contact with the therapist to traditional therapy constitutes a beneficial alternative to the latter one. The use of e-mail does not exclude and even supports the use of cognitive-behavioural and eclectic psychotherapy [20, 21, 24]. Of course, such a therapy needs to be offered by well schooled clinicians [21, 24]. There is a need for further research on the efficacy of e-mail assisted therapy [21, 25]. Especially in Poland, this area is still an untapped potential in the use of computer technology.

Disadvantages

In spite of the above described advantages of enrichment of a traditional therapy by e-mail contact, reports of serious limitations on the therapy modified in such a way come to fore. Or even of the threats of its use. The most important objections to the e mail supported psychotherapy will be shown below as well as arguments pro and against such accusations, if such do exist in scientific literature.

Many objections to the use of e-mail in psychotherapy boil down to one major question, and that is: is such modified therapy safe [21] and may it have negative consequences [1, 2]?

Lack of face to face contact between a therapist and a patient

The critique of e-mail contact as a relation lacking direct contact, which is understood as lack of warmth, empathy, protectiveness during such a contact, results probably from the misunderstanding by its critics of the real role which e-mails play in psychotherapy. E-mails, which were mentioned at the beginning of this article, are treated only as an addition to the traditional ambulatory treatment and not as a basic treatment. Of course there are cases in which e-mail contact serves as a basis of psychotherapy, but this type of initiatives are not supported by ethic committees which define rules of psychotherapy.

Although the opponents of e-mail contact as a part of psychotherapy criticize it for the lack of warm contact, which as already mentioned in this article is false, the major danger of such contact lies in the misunderstandings between therapist and patient, which may result in serious consequences for the therapeutic process. Sometimes the therapist's remarks which would be very appropriate during face to face therapy are not always appropriate in the electronic communication [21]. The standard response should contain a commentary to the patient's letter, discussion of the problems appearing and encouragement for further work on oneself and for continuation of contact. However, even if the therapist knows those rules he or she may fail in the situation of psychological tension in the patient. Robinson and Sergaty described the case of a patient who complained to the therapist about the fact that her mother was going to send her a box of chocolates even though she knew that her daughter was bulimic. When the therapist wanted to analyze this complaint and asked in the e-mail to the patient about her relation with her mother, she received a fierce negative reaction and the negation of any problem in this relation. Probably the failure of this contact was caused by the fact that electronic communication lacks the nuances in the tone of the expression and of the body language, which obscured the identification of the patient's emotions and their understanding [21]. So the lack of direct contact may cause many misunderstandings, which would probably never take place in the face to face contact. Robinson and Serfatuy [21] also described

the behaviour of one of the patients, who wrote a letter in Spanish describing his anger towards the therapist which was caused in his opinion by his neglecting him. According to the patient the therapist disappointed him by not answering his letters. After some time it became clear that an error occurred. The patient's letter did not get to the therapist who was long awaiting it. After clearing the misunderstanding further correspondence – in English – developed correctly [21].

Lack of therapist's control over disturbing patient's behaviours

According to the critics of the e-mail assisted psychotherapy, such a form of intervention is not appropriate in the case of patients whose behaviour shows the risk of self-mutilation or suicide. Opponents of such indirect therapeutic contact stress the fact that therapists who gain most information about patients from e-mail have practically no knowledge about the patient's behaviour or control over it. According to them, e-mail contact is by definition connected with the lack of direct access to the patient who very often may take actions that can be dangerous to his or her health and life. Of course such behaviour may appear also during traditional therapy, but in this case definitely there is a better access to the patient [20]. The critics of e-mail as an addition to traditional therapy, point also to difficulties with a "distant" diagnosis of simulation of the allegedly "sick" [21]. The UK General Medical Council indirectly confirms the above mentioned accusations towards e-mail contact by stressing that such contact is not recommended in the case when the patient is not known to the therapist [21], the "therapist did not even see the 'patient' " [21], there was no examination of the patient before starting the intervention with the use of e-mail and a reliable monitoring of the patient's state is not possible after the end of consecutive therapy phases [21]. Agreements of The UK General Medical Council are without a doubt necessary for the protection of the patient's well being, especially that according to Yager [1] the clinician may sometimes recognize the patient's communicates wrongly, which may prove to have fatal results. Such situations may take place when his or her state requires immediate face to face contact or at least a phone conversation. Unfortunately, in such cases, e-mail contact cannot guarantee the patient's help or safety. In extreme situations, some therapists, when they think that the patient is in a weak psychological condition, use the so called virtual hug [1] which is basically calling the patients and talking to him or her or signing the patient for an additional session. When the patient goes to school or studies, in order to prevent the worsening of his or her condition, the therapist gains access to the patient through a teacher or friends [20].

Inattention of form in the therapeutic contact

A major threat to the efficacy of e-mail supported therapy is negligence coming from the patients but also from the therapists. A special challenge for therapists using e-mail assisted therapy come from patients who keep distance towards therapy and neglect the task of e-mail writing. Also there are problematic patients who write dozens of e-mails weekly, and also who send e-mails that are in no way related to their psychological problem. It is worth mentioning that spontaneity may bring some positive and negative sides to it. In this case we mean spontaneity which crosses the borders of therapeutic relation [1]. A totally different group consists of patients who, according to Yager: "Simply do not like e-mails" [2]. In such situations motivating them to the unpleasant task seems to be pointless. The reasons for misunderstandings in the therapeutic contact may originate also from the therapists, especially those who have nasty habits of answering the e-mails with a large delay, which may result in the patient's distrust or even cessation of the therapeutic contact altogether [1].

Confidentiality of information

As it was mentioned in this article, the word "privacy", which appeared in the text of Robinson and Serfaty [21], was treated there as an advantage of e-mail supported therapy. However, this term used there by these researchers should

be considered unfortunate, because on the following pages of the same article, the authors describe the risk of threat of the above mentioned privacy by patients. Yager [2] lists this danger among the most serious risks of the use of electronic communication in psychotherapy. The most common case of the loss of confidentiality by patients participating in the therapy is the access of the third party to the e-mails, by for example, using one computer by all family members without setting a password. Sometimes the therapist mistakenly includes in the answer information that he or she received from the patient [21] and this way undesired people inquire about the patient's problem. Of course the risk of such incidents may be minimized by, for example, setting a password to the e-mail box [20] or by discretion resulting in not attaching patient's e-mails to the send out information [1]. Very often before starting therapy, the e-mail exchange patients are informed by the therapist about the need of using a private e-mail addresses and about avoiding sending information via e-mail that they would never want a stranger to read and which may be shared during a meeting [1]. Such a personal but lacking most embarrassing secrets message is called a safe text [1]. Patients should also be informed that their e-mails may be used in scientific work, of course while maintaining the rules of total confidentiality. Without a doubt, before starting a therapy with the use of electronic communication, the patient should be informed that the e-mails are not the safest way to communicate [1], and his or her permission for such a form of therapy should be in the written form of declaration. It should be mentioned that probably in the near future, patients will also pay for e-mail contacts, which together with regular visits (face to face contact) form an integral part of psychotherapy [1, 2].

Flaws of e-mail assisted therapy in the patient's eyes

Below the statements of patients who negatively evaluated the therapy combined with e-mail exchange in which they took part have been shown.

"Writing is basically evenly difficult as talking", "E-mail therapy is easier to ignore", "During e-mail therapy one loses personal contact with the therapist", "E-mail assisted therapy is a bit cold", "During e-mail contact misunderstandings are more common" [21]. "During such therapy I lose to some extent personal contact, which is difficult to establish through computer", "The commentaries were helpful and accurate, but….I missed a direct contact", "Direct emotional involvement with person, who may directly engage in an interaction may be important and less "anonymous", "E-mail is a pretty cold way of communication, because by definition the verbal communication is impossible, so also the tone of voice in which some words are pronounced" [21].

RESULTS OF THE RESEARCH ON THE EFFICACY OF E-MAIL CONTACT BESED ON EXAMPLES OF PATIENTS WITH BULIMIA, ANOREXIA AND COMPULSIVE OVER EATING

One of the first studies done, whose purpose it was to define the efficacy of electronic communication in the case of patients with eating disorders was by Robinson and Serfaty. The research had some limitations. One of them was the fact that it did not address e-mail assisted psychotherapy but only pure electronic communication, which in this case constituted the base for therapeutic intervention. The research was done after receiving approval for the procedure from the Scientific Ethic Committee. The participants were informed about minimal frequency with which they should send e-mails to the therapist. It was two, twice a week. At the beginning, the research group consisted of twenty three women with bulimia and compulsive eating disorders from one of London's colleges. However, due to resignation of four persons during the research, the final group consisted of nineteen participants. The therapeutic e-mail intervention lasted for three months and was done by two therapists. One of them worked in the cognitive –behavioural convention, the other represented a more eclectic school of therapy [20]. The research participants were randomly assigned to one of the two groups. However, in the data analysis the efficacy of a given therapy was not taken into consideration, which definitively is a second limitation of the described research.

The evaluation of the efficacy of e-mail use as psychotherapeutic method was done by taking two measurements of patient's weight (at the beginning and at the end of intervention; the tool used was the Body Mass Index - BMI), the intensity of depression (tool: Beck Depression Inventory- BDI) and the strength of bulimic symptoms (tool: Bulimic Investigatory Test Edingurgh- BITE).

The results showed a lack of change in the BMI and a decrease in the number of symptoms of depression and bulimia [21]. The statistical analysis of the results showed also a moderate positive correlation between the number of words contained in patients' e-mails and the results of the BDI and BITE questionnaires. The r-Pearson's coefficient of correlation for BDI was 0.44 and for the two subscales of BITE it was 0.42 and 0.41 respectively [21]. It is worth mentioning that meta-analyses of many research studies done by Robinson and Serfaty did not show a statistically significant difference between traditional intervention and the e-mail interaction in respect to drop-out from therapy [20].

The qualitative analyses of responses showed less encouraging results. Most respondents answered that this e-mail contact helped them in a way to reduce some eating disorder symptoms or helped them to reach a decision to undertake therapy in a clinical setting. However, many opinions were characterized by a big dose of caution. In spite of the fact that there were enthusiastic commentaries and many patients approved of this type of intervention [20], after detail analyses of their responses upon terminating the therapy, 53% of the patients chose a face to face therapy and only 26% chose the one through e-mail [21]. According to Robinson and Sarfaty it may be said that the patients' opinion about e-mail use was balanced, which means that there was about the same number of positive as well as negative opinions [21]. And although the patients' commentaries were full of excited declarations to continue the treatment in the face to face setting in reality only few patients did so [21]. There was yet another very serious limitation to this research: the lack of a control group. The group should without a doubt consist of persons with eating disorders who participate in traditional psychotherapy. In summary, Yager's statement [2], according to which we cannot talk about negative consequences of e-mail contact, should be considered as true. However, the lack of negative consequences does not mean that we can talk about this type of contact, especially when it is treated as a base for psychotherapy, only in superlatives.

CONCLUSIONS

The use of electronic communication as an element enriching the traditional psychotherapy has many advocates but even more opponents. The purpose of this article was a theoretical analysis of potential shortcomings and merits of such a form of psychotherapy. Its efficacy, as it was stated before, is in the experimental research phase, and the results of the research done so far may be described at most as preliminary due to inconclusiveness and methodological problems. So, even the statement that "potential advantages of this approach surpass in large the dangers" [20], seems to justify use of the word "potential". One should not forget the advantages of electronic help for patients that are withdrawn or those having difficulties with a physical access to a therapist. However, taking into consideration that this medium carries some risk factors such as the lack of monitoring during a crisis or a loss of privacy, one should distance oneself from a very enthusiastic evaluation of this type of intervention. It should not be forgotten that reliability of data considering real merits of the e-mail assisted therapy is still a matter of future research and the temptation to replace the traditional face-to-face therapeutic contact by e-mail contact may prove to be a serious challenge to the contemporary ethics of psychotherapy.

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AMERICAN JOURNAL OF PSYCHOTHERAPY

OFFICIAL JOURNAL OF THE ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOTHERAPY, INC.

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