marked distress, impairment in functioning, or both" (Corey & Corey, 2002, p. 15). Psychotherapy groups are typically used in conjunction with inpatient or outpatient treatment of people with severe mental illness.

The group becomes the forum for analyzing maladaptive social behaviors that are exhibited by participants. Group members assist the leader by observing behaviors and trying to intervene to help each person express deep feelings, gain insight, and alleviate emotional distress. The hoped-for outcome is for participants to develop socially positive behaviors. The group serves as the context for members to practice those behaviors with the goal of using them in everyday life. The role of the group leader is to use psychotherapeutic skills in a group context. This involves a fluidity between guiding individuals and facilitating a group as a trained psychotherapist.

LO 6 **Online Therapy** Many things are now being done online, and therapy is increasingly becoming one of them. Online therapy, also known as cybertherapy, has been around for a number of years. As people's access to the Internet has grown and new technologies have been developed, increasing numbers of people are taking advantage of therapy services online. It is difficult to know exactly how many people are engaged in some type of online therapy. There are, however, a number of indicators that suggest that the numbers are high. There are cybertherapy conferences and a journal of cybertherapy, and there were even five seasons of a TV show called *Web Therapy*. A growing number of websites and apps list available online therapists and facilitate the therapy process. In addition to improved access to the Internet, new technology is available to facilitate online sessions. Therapy sessions are being held using Skype, FaceTime, and other videoconferencing software that allows people to see and hear their therapist from a distance. Therapy is also being conducted using asynchronous messaging and live, online chat sessions. Technology also allows for online group counseling sessions.

A growing body of research suggests that online therapy can be as effective as in-person therapy for certain populations and certain problems (Deen, Godleski, & Fortney, 2012; Richards & Vigano, 2013; Shore, 2013). Research has shown that it can improve access and provide services at a lower cost than face-to-face therapy (Anderson & Titov, 2014). It is convenient for people who live at a distance from a therapist who is a good fit for them and for people who have mobility issues. It may be particularly useful for people living in rural areas, including many returning veterans, without easy access to therapists or adequate transportation. Online therapy can allow for increased anonymity for people who might be embarrassed to see a therapist.

In spite of the growth of online therapy, there are still questions about its appropriate use. How can therapists protect client confidentiality and client information? This might be particularly challenging when therapy is conducted via e-mail or text. Do clinicians need different types of training to be effective when working online? Have online providers prepared for high-risk situations, such as a suicidal client? In an online situation, it would be hard to locate the client and report it to police. Can interventions be done as effectively without the therapist witnessing body language and other verbal cues? As social workers and other professionals increasingly use online therapy, they will continue to grapple with these questions.

Culturally Responsive Practice

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During the 1960s and 1970s, community mental health programs that attempted to serve diverse groups were developed in low-income communities. However, traditional services and therapies used primarily on white middle-class clients were not always effective with people from different cultures and classes (Roglet, Malgady, Constantino, & Blumenthal, 1987). Culture affects how people display and describe their symptoms, how they cope with those symptoms, and whether they are willing to seek treatment (Eshun & Gurung, 2009). Culture of the therapist is also important. It can shape how the clinician understands the problem and the direction of treatment. Today's mental health professionals are developing more culturally relevant services and becoming more culturally sensitive and competent. Social workers need to understand cultural beliefs about mental illness and ways of coping with it to understand behavior and plan interventions that meet the needs of all groups of consumers.

The role of culture in mental health has been known for many years. A study conducted in the late 1980s by the World Health Organization (WHO) found that sadness, anxiety, tension and low energy were common symptoms of depression in countries around the world. However, guilt was only reported as a symptom of depression in the West, whereas people in eastern countries instead reported more physical complaints (Draguns, 1990). Other cultural differences in mental health exist as well. Members of some Asian American cultures believe that people should not dwell on morbid thoughts and should be taught to use willpower to avoid emotional upset (Yeung & Kam, 2006). This belief makes the use of psychosocial interventions problematic. Haitians experience something called *S'eizisman*, which is a condition caused by strong emotions. It results in headaches, loss of vision, high blood pressure, stroke, and even death. To reduce the likelihood of it occurring, Haitians try to mute strong emotions (Green, 2009). In some cultures, mental illness is viewed as a spiritual concern, and religious leaders may be the first source of help. **Culture-bound syndromes**—patterns of aberrant or problematic behavior unique to a local culture—may appear more commonly among people who are older or less acculturated. Culture-bound syndromes are not well understood within the parameters of *DSM* diagnoses.

As discussed in Chapter 5, members of nondominant groups are less likely than members of dominant groups to seek help from human service professionals. This may be a result of lack of trust in government-operated institutions. Other reasons may include lack of affordable treatment, lack of experience of the clinician, or previous experiences of inferior or ineffective treatment (Daley, 2005).

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When nondominant consumers do enter the treatment system, they may receive discriminatory care and differential diagnoses, causing them to drop out before completion. People of color are significantly more likely to drop out of mental health treatment after the first session than Caucasian clients (Montalvo, 2009). Social work practitioners can significantly impact the dropout rate by using empathy to understand clients' ethnoracial point of view and allowing them to tell their story.