

# **Myths and Realities of Online Clinical Work**

## **3<sup>rd</sup>-Year Report of the ISMHO Clinical Case Study Group**

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### **Introduction**

The phenomena of online experience and therapeutic relationships continue to be a central focus of the Clinical Case Study Group, sponsored by the International Society for Mental Health Online. \*

Over the past three years, the Case Study Group (CSG) has explored some of the many ways in which online mental health professionals engage in clinical online practice, either as the primary treatment modality or in combination with traditional face-to-face (f2f) office practice. <sup>1</sup>

As practitioners and clients become more comfortable with, and knowledgeable about, online relationships and the many available options for synchronous and asynchronous communication, there has also been a blossoming of “non-traditional” approaches which have, under the microscope of peer group study, been demonstrated to have remarkable “therapeutic” potential in ways that have not been widely recognized or understood.

What do most people believe about the possibility of engaging in the type of online work that we have in fact been doing? We have observed and discussed many new and exciting activities with great therapeutic potential, among us and between us. The Case Study Group (CSG) has provided, through peer support and feedback, a laboratory for expanding our understanding of clinical online phenomena (Suler, 2001a). In detailing some of our experiences we hope to describe how effective our interventions can be in facilitating positive changes through guided online mental health activities.

Through this paper, we hope to illuminate the potential for online clinical work, and to share our evolving understanding of what is truly possible, despite the prevalent myths and realities which shape our thinking about online “therapy” and the nature of Internet-facilitated communication and behavior.

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<sup>1</sup>See, for example, Suler, J., and Fenichel, M., (2000). The online clinical case study group of the International Society for Mental Health Online. A report from the Millennium Group; and Suler *et al* (2001). Assessing a person’s suitability for online therapy.

## **Myths of Internet-Based Counseling**

Even among mental health professionals who may be otherwise very like-minded about concepts and principles which guide traditional counseling/psychotherapy approaches, there are some specific areas of concern which continue to be hotly debated with regard to Internet-facilitated mental health services (e.g., Fenichel, 2000; Maheu & Gordon, 2000; Manhal-Baugus, 2001). Clearly there does need to be thoughtful consideration about professional, ethical practice, with particular concern about risk management for particular types of client situations. Our direct experience among a group of diversely trained mental health professionals, all with experience offline as well as online, suggests that there is even more potential than we had imagined for creative and therapeutic uses of Internet-facilitated communication. Moreover, the entire group acknowledges that what we have observed through the case presentations, and shared through a peer-supervision model, has convincingly demonstrated that some things we may not have thought possible clearly are (e.g., Suler, Barak, Chechele, Fenichel, Hsiung, Maguire, Meunier, Stofle, Tucker-Ladd, Vardell, & Walker-Schmucker, 2001).

At the same time, we have become still more acutely aware of the realities which are well-known in translating f2f therapies into digital versions, and the complexities involved in employing sound therapeutic and ethical judgment when situations arise “between sessions” online.

### ***MYTH #1:*** **“Online therapy” is impossible, period**

“What is therapy? What is therapeutic?” Asking these questions in academic and clinical settings generally leads to debates about the nature of psychotherapy and counseling quite apart from the setting in which treatment takes place.

However we define traditional therapy processes and outcomes, the evidence we have seen regarding therapeutic online relationships suggests that clients have reported self-perception of increased autonomy, improvement in decision-making and interpersonal relationships, and more taking of responsibility for self-help and interpersonal engagement. Other benefits included such additional things as improved *online* relational skills, within groups and individual e-mails.

Some contend that regardless of the successes which have in fact been experienced and reported, the nature of online work carries too many unique risks to justify beginning it at all (e.g., Baur, 2000; Griffiths, 2001; Maheu & Gordon, 2000). Therefore such work is, or should be, “impossible”. Is this a myth, or reality?

Among the most pervasive misconceptions regarding the Internet not being suitable for clinical work is the belief that verifying a client's identity or guaranteeing privacy is completely impossible online (e.g., Bloom, 1998; Robson & Robson, 2000). However, that is clearly not the case, given the potential to employ such tools as secure chat rooms, digital signatures, encrypted e-mail, and other safeguards.

It is important to note that personal computers are relatively easy to break into and obtain information saved in them, including sensitive reports on clients. On the other hand, however, this possibility is not greater than breaking into a therapist's office or a locked file cabinet. Responsible online therapists, aware of problems of breaking into computers and the easiness of 'copy & paste,' take special measures to secure information, including the use of access authorization by secret passwords, as well as other advanced technical means.

Informed consent is a basic requirement for mental health researchers and practitioners, both online and f2f (Hsiung, 2001). Online practitioners are careful to provide the public with a means of evaluating their own qualifications and describe the limits and risks associated with a given online treatment modality.

Some would argue that with such stringent precautions, ranging from sophisticated technological safeguards to using only personal, password-protected computers, in fact the online client may enjoy a level of personal privacy which extends beyond what telephone and even face-to-face treatments in busy office practices can offer.

The issue of establishing identity, positively and absolutely, is one that continues to be intensely discussed and debated. We have seen examples of online services that, like telephone hotlines, provide life-saving services to those who might not have reached out at all were there not a promise of anonymity. At the same time, it is understood that one needs to assess the risk of a client's misrepresentation of identity in any contracted professional relationship. For the online therapist, payment is made via means that ensure it's an adult who is paying, though of course for a session or two (until the adult credit card holder receives the bill) it is possible for a minor to misrepresent him or herself. Not only the provider, by the way, is likely to be concerned about who he or she is addressing. It is extremely important to recognize that the consumer has a legitimate interest in being able to verify the identity and qualifications of the mental health professional.

There are in fact several extant ethical codes -- for example the statement of principles of the National Board for Certified Counselors (2001) and the Suggested Principles for the Online Provision of Mental Health Services of ISMHO/PSI (2000) -- that address the need to be cognizant of risks, particularly to the consumer. From the practitioner's perspective, the rarity of examples where intentional deceit is used to procure online mental health services by no means outweighs or negates the potential for providing help to the many adults

(or even children and teens, with permission) who might benefit from remote access to a mental health professional. This is likely to become an increasingly important area of interest, as the ubiquitous use of computers, cell phones and PDAs among teens already demonstrates. Their first response in seeking help or information may now be to turn on the computer. Using the Internet is an easy way to find help, advice, or peer support, so why not seek a counselor online rather than f2f?

Several unique advantages exist in online work. Many have been described in the literature already, such as access for the homebound, geographically isolated, or stigmatized client who will not or cannot access treatment locally (Grohol, 1998; Stofle, 2001). One of our case presentations illustrated vividly not only the possibility but also the advantage of Internet-based therapeutic support. A pilot in the military, exploring sexual orientation and afraid of the potential impact of “coming out” and jeopardizing a military career, demonstrated how seeking help online was reassuring to the client in terms of confidentiality. The absence of geographic boundaries allowed the client to select a therapist who appeared to have the expertise and understanding needed in the client's particular situation.

There are numerous examples of other particular types of clients who benefit from having access to mental health services via the Internet. Hearing disabled people, celebrities, business travelers, people who are shy and introverted, clients concerned about stigma, or socially phobic, also might find unique advantages to seeking therapeutic activities, self-help materials, and a diversity of mental health professionals, all easily accessible online.

Online clinical work is not only possible, but offers a unique "elasticity of communication" that includes several factors, such as flexibility of location and of time, varying levels of synchronicity, and flexibility to employ various online channels of contact (Suler, 2000). Online therapy has shattered three of the basic premises of therapeutic interaction, which is that it must always, by definition, be based on

- (a) visible (f2f) contact
- (b) talking
- (c) synchronous (“real time”) interaction

Therapies not based on these foundations cannot rely on old conceptions.

Online therapies, experienced as such, not only can be but are being offered and increasingly accepted and sought after.

**MYTH #2:**

**“Online therapy” consists almost exclusively of e-mail exchanges**

Online clinicians, while they frequently work with e-mail (Murphy & Mitchell, 1998), often use other channels to communicate with their clients -- instant messaging, chat, phone calls, and in some cases occasional face-to-face meetings. For some clients, combining different communication modalities may prove to be a very synergistic strategy. People express themselves differently when communicating with voice, text, and visuals. Unique aspects of identity and self emerge in those different modalities. Moving from one modality to another sometimes proves to be a very important event in the therapy. For these reasons, clinicians may design treatment plans involving combinations of different channels of communication or transitions between different channels.

Although text-based communication currently is the most common method for conducting online psychotherapy, clinicians have begun to experiment with multimedia approaches as well. In addition to using video to simulate an in-person meeting, clinicians may also utilize virtual environments in which the client and therapist create visual representations of themselves ("avatars") in order to interact with each other (Suler, 1999; Ookita & Tokuda, 2001). In the future, this "avatar psychotherapy" may be very effective in psychotherapies that rely on techniques involving fantasy, imagination, and role-playing.

Some clinicians already employ multimedia virtual reality (e.g., Wiederhold & Wiederhold, 1998), and it is possible that components of their interventions may be conducted online. Even simply incorporating pictures, graphics, and video or sound files into the communication between client and therapist can be a very effective addition to text-based therapy. No doubt, the future of online clinical work will entail a variety of creative approaches for mixing and matching text, sound, and visuals.

Among the cases which were presented during the 3<sup>rd</sup> year of ISMHO's Case Study Group (2001-2002) were some very dramatic and vivid examples of how a therapeutic relationship can span several modalities and/or "channels" of online experience, such as integrating the use of synchronous chat sessions with between-session e-mail and/or using a web-based Message Board to share experiences with others seeking information and support for common problems and concerns. In some cases, utilizing online bulletin boards as well as e-mail, clients were also provided with hypertext links (URLs) to access additional sources of relevant information and support.

There are a number of therapists whose preferred modality is chat, as opposed to e-mail. One such case, presented to the group, demonstrated the potential for establishing an online relationship with such poignancy and immediacy that a review of the case session transcripts was, to our amazement, quite difficult to imagine as having taken place via the Internet rather than face-to-face (or on the couch).

Among the many useful techniques which were demonstrated and validated through our case studies, powerful therapeutic relationships were recognized and clarified, replete with transference and countertransference, deep and immediate emotions expressed by the client, and the possibility of long-term engagement even with an ambivalent client. We often observed how this was facilitated by establishing the benefits of true synchronicity through the chat medium – especially with good technology and two fast typists -- and then marveled at the similarity between a text-based transcript and a comparable office session, as well as the expressiveness and depth of text-based communication.

A chat room is an efficient way to use the therapeutic here & now principle online, with a limited number of pre-screened participants, led by a well-trained facilitator working according to pre-established rules (Barak & Wander-Schwartz, 2000).

Internet users whose experience is limited to public, unfacilitated chats tend to think of chat as superficial, elliptical, and limited in structure, authenticity, and emotional intensity. It is as if, having seen classrooms used only for drop-in social groups for teenagers, the observer concluded that serious learning cannot take place in a classroom. Therapeutic chat is a text-based, synchronous therapeutic encounter facilitated by a skilled therapist whose interventions are designed to help the client move toward treatment goals.

The more flexible the use of online media, the more different from face-to-face communication it becomes, the stronger the case for working online. For example, a hard-of-hearing person may be more expressive typing text in a chat room than speaking with a hearing therapist or using a sign language interpreter. A client who travels frequently and whose schedule is irregular can form a stronger therapeutic relationship with a therapist who can accommodate to a need for unscheduled sessions and week-to-week changes in availability and time zone.

It is important to note that some client-therapist dyads may in fact decide to embrace a more “traditional” approach of scheduling a chat session at a given time, and in a few cases where routine and boundaries may play an important role, this too is an option to use and integrate into the counseling regimen. One should not necessarily interpret a client’s preference for lack of structure as “resistance” to treatment; rather, seeking online help may help facilitate the ability to engage in the first place.

In another of our case presentations, a face-to-face weight management group was combined with online support group and message board and included experts in both mental health and nutrition, meeting both online and off. This group demonstrated the value of using online work as a supplement to f2f didactic instruction. Members of this group were invited to use a secure message board to share information about their backgrounds, stress levels, and

any “emotional” issues that were affecting their eating behavior. Because they also met f2f each week, the facilitators were able to monitor each member’s progress both through their online participation as well as f2f behavior, to learn more about each person’s unique struggles (often there was not sufficient time for such detailed personal information to be shared in person), and to provide more customized / personalized attention to each member’s needs. Members reported being able to share more openly with each other online than in f2f meetings due to feelings of shame, fear of rejection, and avoidance of intimacy or emotional expression in person (all of which was made easier online). The online components in this group provided a valuable flexibility as well as familiarity with each member that a face-to-face group alone would have. Message boards (also referred to as “bulletin boards”) can be used as a valuable adjunct to online or f2f therapy. One CSG member had a face-to-face client join the bulletin board that she moderated on her website. This resource helped the client to make the transition from discussing her feelings and problems with only her therapist to discussing them with others (at the board) and later with people in her life. Observing the client in this medium gave the therapist new and valuable information about how her client interacts with people. Issues of transference and counter transference arose in this context and were then addressed in f2f therapy. For example, the client became jealous of the attention her therapist gave to other members, which led to a deeper exploration of those feelings in f2f therapy. The therapist experienced counter transference when she felt hurt by a few angry messages that her client posted about her in the public forum. Because the client’s words were posted online, the therapist was able to copy and paste the post verbatim and send to the CSG’s e-list to receive collegial feedback and support almost immediately before responding.

The Message Board (MB) has been successfully used in a variety of self-help and support communities, and in other activities ranging from counseling to teaching (Hsiung, 2000; King & Moreggi, 1998). One advantage of using MB’s when teaching university courses online has been that they provide a point of contact for the students and professors which develops in line with the students’ use of “e-mail loops” (group e-mails to which individuals elect to “reply to all”). Such message boards thread the thoughts of the group together and provide a point of reference, while students discuss and develop ideas through the e-mail loops. Another function of the message boards is to house the more permanent thoughts of the group, while students may discuss and develop such thoughts through use of the loops.

A further use for the message board is seen in such practical applications as providing college students with a place for class registration, especially useful when the online group is not housed on a single campus. Message boards can be used for purely informational purposes as well as to foster social interaction. One CSG member offered students an online “Chill Out Room” for jokes, fun contact, informal messages, etc. This was particularly well used as the course ended and students left each other messages of farewell.

One great advantage of a MB, or forum, is the very easy use of embedded pictures and links. It allows members to permanently and easily view all accumulated messages and, very important, to use an internal search engine.

Members of the Case Study Group used threaded e-mail subject heads in a similar manner, during vacation times, to maintain the continuity of contact in a non-stress environment between presentations. The group found this an effective way of maintaining cohesion and contact. In such ways, health and tele-health professionals are integrating ongoing care and peer support into our 21<sup>st</sup> century lives.

**MYTH #3:**

**Text-only is inadequate to convey a richness of human experience**

Why do people continue to argue that words alone cannot convey the breadth of human experience? The whole body of human literature from Homer to hip-hop renders this frequently stated myth absurd. It is widely believed that Shakespeare saw as deeply into the human heart as Freud.

In fact, Sigmund Freud himself treated some patients exclusively through written text, from a distance rather than in person, and he “saw” others on the couch rather than face-to-face. Freud’s psychoanalytic technique was designed to foster the very disinhibition which naturally occurs so easily on the Internet.

Why, then, is it so hard to believe that a client cannot be emotionally authentic and a therapist empathic and insightful in text? Our experience as online clinicians, as well as our personal experience with relationships on the Internet, demonstrates that some individuals are more honest, more uninhibited, and more expressive in writing than face-to-face. Certain literary forms, letters and journals in particular, have always been characterized by the skilled practitioner’s ability to be just as authentic, as fully oneself, in text as in person. Nor does the writer have to be a literary sophisticate. Within the past 50 years, literally millions of readers have been moved by a candid and artless piece of writing that was not intended to be read by anyone: the diary of Anne Frank.

Humans are curious creatures. When faced with barriers, they find all sorts of creative ways to work around those barriers, especially when those barriers involve communication. Experienced e-mail users have developed a variety of keyboard techniques to overcome some of the limitations of typed text -- techniques that almost lend a vocal and kinesthetic quality to the message. They attempt to make e-mail conversations less like postal letters and more like a face-to-face encounter. Some of these strategies include the use of emoticons, parenthetical expressions that convey body language or “sub vocal” thoughts and feelings (sigh), voice accentuation via the use of CAPS and \*asterisks\*, and trailers.... to indicate a transition in thought or speech. Use of “smileys” and other

commonly used symbols can convey not only facial expression but also a variety of emotional nuances.

As with all things, practice makes perfect, so people tend to fine-tune and enhance their text expressiveness over time. As a text relationship develops, the partners also become more sensitive to the nuances of each other's typed expressions, and together may develop their own private language and style of communication that contains many rich subtleties not immediately obvious to an outsider (Fenichel, 2002; Murphy & Mitchell, 1998; Stofle, 2001).

While the therapeutic relationship may in some ways be made more complex by the absence of some sensory cues, in many ways we are in fact learning to work with the presence of new additional (text-based) data and the power of the word.

Practitioners even among our own small group of clinicians report remarkable responses to many modes and mediums of self-expression, from synchronous chat to sharing of photographs, poetry, and autobiographical web pages. All these become "grist for the mill" in the ongoing therapeutic process. Such activities are easy to share and to facilitate as the home computer is increasingly integrated into our every day lives. Supplemental materials, which may also include logs, diaries, works of art, memorials, and self-help/support group communities, may provide cumulatively more of an all-encompassing therapeutic experience than heretofore imagined in the non -"text-only" therapy session.

#### **MYTH#4:**

#### **Suicide prevention and crisis intervention are impossible online**

Assessment of risk and initiation of appropriate suicide intervention is an area which many mental health professionals do not believe can (or should) be addressed via the Internet. Some conclude it is impossible to do by virtue of not being able to see a client face-to-face, in order to take advantage of visual and other cues in assessing the client's state of mind. No doubt there were similar critics when telephone hot lines were established, which today we consider a necessary part of the crisis intervention continuum of services especially with teens, runaways, domestic violence, rape, and other human tragedies. The reality is that online counseling and support for suicidal people and those in crisis can be very effective. A groundbreaking program in Israel, for example, has been so successful that many lives have been saved. It is now impossible to conclude that such work is "impossible".

MYTH: Through Internet-based professional interaction, counselors cannot actually observe clients; hence their impressions are limited to verbal messages. Therefore, risk assessment is highly restricted and apparently invalid. Moreover, because of easy escape and remote communication, online clients in a dangerous condition, who may need immediate or emergency care, cannot be followed, detained, hospitalized, or treated.

REALITY: Online counseling and support for suicidal people and those in crisis can be very effective.

Despite the lack of visibility and consequent nonverbal communication cues, people in severe emotional distress can effectively be approached and emotionally touched through synchronous online communication devices. Also, many people in crisis situations tend to share their experiences and feelings with anonymous, unseen partners on the Net, as personal inhibitions diminish. Therefore, a professional crisis intervention service, managed by specifically trained personnel, can be of much help, as surfers in crisis and distress are drawn to such virtual places, frequently eager to share their painful experiences. Moreover, as suicidal notes are being posted in public online environments -- such as personal websites, blogs, message boards (forums), and chat rooms -- it becomes easier to identify and approach individuals in crisis.

There are quite a few websites that pertain to suicide prevention and include valuable information and self-help resources that might be of help to people who contemplate suicide. Surfers in distress may use these sites directly and independent of human mediation. This exposure to available resources may be an incentive for seeking further help.

The Internet can be used in conjunction with face-to-face counseling or telephone hotlines in a number of ways, from referring people to relevant online readings to providing the opportunity of writing and sharing their difficulties through emails, to engaging in an online virtual community constructed and aimed to help people in a similar emotional condition (an online support group). The Samaritans organization in the United Kingdom, for example, (<http://www.samaritans.co.uk>) offers nonstop hotline service for suicidal people, in conjunction with email service. In the year 2000, over 37,000 emails were received and replied as a part of The Samaritans' emotional support system.

The Internet can be used specifically to offer support for people in crisis and those who consider suicide, through direct, synchronous communication as well as closely watched asynchronous communication devices.

Internet chat and instant messaging (IM) are similar to telephone hotlines in that they enable direct and immediate communication between people. Unlike the telephone, they provide enhanced anonymity, opportunity for self-expression through writing, increased ambiguity of counselors, ease of escape, and enhanced aloneness, thus facilitating depth of self-disclosure and exposure of personal materials, as well as accelerating the speed of opening up. That is, the disadvantages of invisibility become advantages, especially in extreme and

emergency situations, where time and depth of confession are essential.

Especially trained counselors or paraprofessional helpers may offer emotional support online, much as they can do so offline. Nonetheless, the online environment has the special advantage of integrating several methods of communication (individual or group, synchronous or asynchronous), together with effective use of relevant reading materials, as well as convenient referrals to help resources by hyperlinks or classified list posted on a website. Unlike the client seen f2f or on a telephone hotline, a person in crisis or severe emotional distress who contacts an online crisis center may consequently be approached with an offer of a “tailor-made support suit” that provides a perfect fit, optimally meeting his/her personal desires, needs, and capabilities.

The use of online support groups is known to have significant impact on people in various types of distress, including medical diseases, depression, relationship problems, or other kinds of personal difficulties. As such, online support groups -- easy to approach, with no threat of identity exposure -- are efficient means of crisis intervention and prevention of suicide. In combination of these measures, SAHAR, the Israeli online free crisis service (<http://www.sahar.org.il>), has proven that suicide can effectively be prevented and people in crisis and severe distress be helped through entirely online activity. In its 15 months of operation, SAHAR has provided online support to thousands of Israelis, and helped in preventing the suicide death of many of them, sometimes in last-moment detection of people who delivered farewell notices (Barak, 2001).

Not only has SAHAR thus proven the value of such a program for the suicidal client with web access, but also an additional benefit has developed, in that Israelis who reside abroad contact SAHAR regularly for personal support. Internet-based support is borderless, and asynchronicity allows convenient interaction from a distance.

***MYTH #5:***

**Effective online counseling for serious disorders is not possible**

Aside from concerns about safety, confidentiality, and other aspects that are well-known in f2f clinical practice, accurately understanding and responding to a client’s communication becomes more problematic when a significant psychopathology emerges during the treatment. In working with severe personality disorders, for example -- where clients may demonstrate lapses in impulse control and judgment, and when it becomes difficult to maintain therapeutic boundaries -- it is sometimes felt that the challenges of managing the course of treatment online are so overwhelming as to preclude such treatment.

Ongoing clinical experience online reveals many instances in which avoiding the addressing of serious issues is unnecessary at best, and at worst an ethical failure to act in the client's best interests. Depressed clients may lack the determination to make and keep a face-to-face appointment with a clinical professional, yet seize a moment of willingness to reach out by clicking for online help. Initial assessment may reveal either that the client is completely unwilling to seek help within his or her community or that none is available. With appropriate safeguards, such as contracting for a crisis plan and affirming the client's commitment to seeking local medication evaluation and management, the online therapist may provide essential support (Bouchard, Payeur, Rivard, Allard, Paquin, Renaud, & Goyer, 2000; Klein & Richards, 2001; Lange, Schieken, van de Ven, Bredeweg, Emmelkamp, van der Kolk, Lydsdottir, Massaro, & Reuvers, 2000; Robinson & Serfaty, 2001).

Addictions, as another example, seldom appear as the initial presenting problem online, but the experienced addictions professional may pick up cues in the course of ongoing work that the mental health generalist might miss, such as recurrent mention of heavy drinking or partying associated with adverse consequences, the client's embarrassment about something he or she said, or a regretted sexual encounter. It then becomes the therapist's obligation to reflect these connections over time and, perhaps without actual confrontation, provide some substance abuse education, until the client becomes ready to acknowledge and address the problem.

There were several occasions during our case presentations when it was suspected that further (f2f) assessment might be beneficial, or that motivation to change and persevere through emotionally demanding situations was inadequate to justify continuing treatment online. Once again, however, with patience and consistency, along with limit-setting and some strategies offered by the peer supervision group, it was demonstrated to our satisfaction that some types of clients, who might well be difficult to treat f2f, in fact did respond well to online work, demonstrating some increased insight into self-defeating behaviors and using the "disinhibition" of online work (Suler, 2001) to share painful and intimate experiences which might not have been possible to address so immediately or quickly in traditional office practice.

An advantage of online work with severely disturbed clients is that clients can choose to use emails, chat scripts, and other online exchanges (that can be saved) to rehearse, review, and reinforce therapeutic messages in a way that can be grounding, affirming, and increase reality testing. Also, the therapist's empathic words can function as a transitional object that can be internalized over time at the client's pace. Additionally, having access to an International group of online colleagues has proven very useful in making rapid, appropriate referrals, sometimes in single-session correspondence or very short-term consultation.

**MYTH #6:**

**Geography doesn't matter when providing mental health services online**

To be sure, there are practical considerations which impact on a counselor's ability or willingness to provide synchronous communication across time zones. In some geographic locations, notably the United States, there may be legal restrictions on mental health treatment offered by licensed professionals whose license is limited to practice in the therapist's particular state. Some states have a regulatory policy which suggests that cyberspace is not a geographic location and insists that counselors will be construed to be practicing professionally in the state where the services are received. For the licensed U.S. practitioner who is worried about the risk entailed, whether tangible or not, or for whom insurance will not cover Internet-based interventions or liability outside the state, geography may be a clear and real factor to consider.

While some practitioners may be deterred from crossing state lines for legal reasons, others may be reluctant to engage clients from other regions due to the concern about lack of adequate experience within a given culture, or where there is a language barrier. It must be acknowledged that geography is a relevant consideration in such endeavors as providing professional therapy services, and this consideration is part of most ethical guidelines for mental health professionals, which require that clinicians practice only within their bounds of competency and experience. Working with someone from a completely different culture, time zone, and social system clearly can be problematic, and this is something to consider before concluding that "anyone can practice world wide" in any circumstance.

On the other hand, long-distance, cross-cultural training and practice are being conducted and some very exciting opportunities are emerging due to our ability to shift time and still be able to focus effectively and respond to another person as if in a shared "here and now" (Fenichel, 2002). The Internet clearly presents entire major new opportunities that are proving to have great potential in ways never before thought possible.

Asynchronous e-mailing is a rich, culturally diverse, time-unlimited method of communication. It allows all its participants to contribute in their own time (the previous text is there for reference) and from their own cultural - geographical - time-zone perspective. Moreover, with growing sophistication in translation software, the ability to communicate across language barriers is also enhanced.

While there are obvious barriers to communication in synchronous "real-time" between two people in discrepant time zones, it was our experience that with some effort and acclimation, one can effectively use asynchronous communication to participate in ongoing discussion in a meaningful way. Where a method of shared experience can be maintained, there are distinct benefits not only with clients but also in participating meaningfully in "asynchronously live" professional and educational dialogues across time and space.

The issue of time-zone differences was made quite real to CSG members personally, as participants included mental health professionals from 4 countries, in 5 time zones. Often those 3 or more hours away from the majority (located in the US) were either experienced as being delayed in response by several hours, or leading a topic far in advance, while others were asleep or at work away from the computer, and vice versa. Here is the experience of a group member in the U.K.:

Working in a different time zone requires its own skills. At first I felt I was left out of discussions because they all seemed to be happening at a time when I wasn't online – most of the discussions were taking place between 1:00 and 5.00 a.m. UK time. However, I re-read the notes about contributing to discussion threads and decided that my own contributions (whether they repeated what had already been said or not) were of value to the group since they could confirm what was being said, and also offered a culturally and geographically different perspective. Once it was my turn to present a case, the time zone issue changed completely as I found I was generating the discussion threads and therefore at the head of the trail rather than the back.

In this case, once the participants acclimated to the characteristics of the time-based realities, communication across time and geographic distance became less of an obstacle, and more of an enriching experience for the entire group. The implication for such larger endeavors as improving communication and understanding between peoples of different cultures and nationalities is profound.

**MYTH #7:**

**Online clinical work always involves one counselor or therapist working with individuals and groups**

Traditional models of psychotherapy -- especially individual psychotherapy -- usually place the clinician at the center of the therapeutic process. The clinician administers a treatment or plays a crucial role in creating and facilitating a transformative experience. So too in many cases of online therapy. However, in other cases the professional may serve more like a consultant who helps a client design and navigate through a therapeutic activity or collection of activities.

In cyberspace there are a wide variety of mental health resources, including support groups, informational websites, assessment and psychotherapeutic software, and comprehensive self-help programs -- not to mention the potentially therapeutic nature of online relationships and communities as social microcosms. In the role of consultant, the professional might help a client design a program of readings, activities, and social experiences that addresses his or her needs. Rather than being the "therapist" who directly controls the transformative process, the professional instead helps launch the client into this program, offers

advice when needed, and perhaps assists the client in evaluating and assimilating the experience.

Group work is also emerging as a potent online activity for both education and therapeutic growth (McKenna & Green, 2002). Co-leaders may participate f2f, online, or both, such as in the case presentation of a face-to-face weight management group that also had an online component. In this case each therapist was able to provide “group as a whole” interventions as well as individual attention to each member. Members in turn had the benefit of simultaneously interacting with three professionals with different but complementary specialties. This experience provided a unique opportunity to integrate group and individual work, online and off, through the collaboration of allied health and mental health professionals.

Even a short-term intervention or one-time request for help can involve the sharing of information between colleagues (Bai, Lin, Chen, & Liu, 2001). In one case presentation, the client was writing -- from another country -- for “advice” about some serious problems. The recipient of the call for help was unfamiliar with that country's health care system and was also concerned about the presenting symptoms. As this client was requesting one-shot advice and gave permission to consult colleagues, the practitioner was able to provide a brief consultation (pro bono) which included knowledgeable referral information from a colleague in that country and also some excellent suggestions which were generated through the almost-synchronous discussion on the CSG list-serv, day in and day out.

In this case, the client was able to access a multi-disciplinary, multi-national consultation from the comfort and perceived safety of her home, and was directed to the appropriate local services that she could effectively utilize.

***MYTH #8:***

**Online principles are the same as offline principles**

Clearly, “people are people”, whether talking f2f, on the telephone, or via the Internet. Clients seeking help online, however, are faced with a computer monitor rather than a receptionist, and do not have the benefit of immediately seeing all the diplomas and licenses on the wall, nor experiencing through their own eyes a therapist's warmth or smile or sense of humor. Nor can they necessarily experience beforehand a counselor's typing speed or style, nor anticipate e-mail frequency or response speed. The first task for a potential client may be to determine if the therapist is able and willing to address their individual need, but then it is important for the therapist to provide a basis for making a decision about compatibility, or “fit”, and the potential to work together in a therapeutic alliance. Many people are now turning to clinicians they can find online, with the expectation of a therapist who is knowledgeable and well experienced with the unique nature of online work (Holmes, 1998).

As mentioned earlier, online clinical work can entail a variety of creative approaches for mixing and matching text, sound, and visuals. In fact, such work offers us the opportunity to examine more carefully the elemental components of face-to-face therapy that often are taken for granted. It allows us to alter those features. Does the relationship exist in real time or in an asynchronous frame? If it is asynchronous, what are the effects of varying the delay between exchanges? Does the relationship or experience involve communication via text, or are visual images exchanged, or combinations of the two? Does the relationship or experience involve auditory stimulation? If so, what types? Voice? Other sounds? Does the therapeutic relationship or experience rely on real identities and real environments, or imaginary ones? How strong is the presence of the clinician in the therapeutic experience? Might the therapist in some respects be invisible? Might the client in some respects be invisible?

The online therapist needs to develop not only skills but also sensitivities. Aside from the well-known challenges and adaptations relating to text-only communication, it must be recognized that even within the same language (e.g., English) there are differences in meaning and nuance across countries and cultures. Also consistent with general concern for accurate communication is accurate understanding of one's client's general circumstances. For example, the spelling of a name may lead to a false assumption about gender. This actually happened within the group, leading to a misunderstanding that lasted for months. Again, it becomes important for online practitioners to be careful in making conclusions about names, idiomatic expressions, and so forth when working across oceans, cultures, and languages.

As with more traditional f2f therapies, online work calls for a relevant set of principles -- a theory of cybertherapy -- that guides us in understanding when, how, and for whom these various possibilities are therapeutic. Online clinicians search for principles that will inform us about what combinations of text, sight, sound, and virtual presence are therapeutic for which people. We are in the process of developing a theory that helps us analyze the potentially curative ingredients of different communication environments or communication pathways and for deciding what environments or pathways are therapeutic for which clients.

Online practitioners need to understand the immediate environment and experience of the client, at the time they are writing, to have an accurate perception of the "tone" and circumstances at that time. Therapists need to understand and master some characteristics of online work. For example:

Working online at your own computer means you will be working in a more isolated setting than you might face-to-face. Preparation for such work will help you to avoid some of the pitfalls and dips in confidence you could otherwise

experience and will be beneficial for those clients whom you plan to work with online.

There is no doubt that therapists who use the Net to provide therapy should get specific training in several aspects, including technology, theory, applications, and ethics. Internet based mental health services should be seen as a new and emerging form of treatment in which case each practitioner is ethically bound to seek out and participate in appropriate training and ongoing supervision in order to develop and maintain their competency.

The online mental health practitioner needs to develop skills that derive from training and experience in a professional discipline such as psychology, psychiatry, or clinical social work. The clinician must also learn effective techniques for using text to work synchronously and asynchronously with individuals and groups. In addition, experience in working with particular issues, groups, or types of disorders must be readily harnessed in ways which make the therapist's services most accessible and beneficial to the client.

Keeping in mind the unique nature of online clinical work, it appears that there are now new opportunities for clients to seek, and increasingly find, someone well acquainted with their particular area of concern. One can now find online any number of therapists who work in both cyberspace and f2f with particular populations and who can now share their expertise as specialists with others -- clients, students, and colleagues -- via the Internet. In fact, whole new possibilities for safe and knowledgeable support and treatment now exist. Some populations, for example, lesbians and gay men, sexual and ritual abuse survivors, and people with problems related to sexuality or sex may be more likely to ask for and be able to access therapy when it is available on the Internet.

These populations can have a number of issues in common that may be more readily addressed online, at least in the initial stages of therapy. For example, people who are struggling with issues of isolation, secrecy, disclosure, hyper-vigilance, shame, vulnerability, sexuality, and intimacy may be more comfortable making contact and engaging with a therapist online. (An article addressing these themes faced by sexual abuse survivors and lesbians and gay men is available at: <http://www.atlantapsychotherapy.com/articles/struve4.htm>.)

For individuals whose issues of shame, fear, and secrecy are significant, the anonymity and privacy of therapy online make it easier and therefore more likely that they will access therapy. People who are afraid of being judged, or who worry that there is something terribly wrong with them -- something many lesbians, gay men and survivors feel -- find online therapy way less threatening. Frequently, clients who need to talk about a problem related to sex feel uncomfortable meeting in person, but are comfortable discussing the topic with a therapist online (Barak & Fisher, 2001; Ochs & Binik, 2000).

Many sexual abuse survivors report that they feel too frightened to see a therapist in person, at least in the initial stages of their healing. It is much less frightening for many such people to receive therapy online from the safety of their own home.

If a gay person has a high level of concern about confidentiality, receiving therapy online may be more confidential than walking into a therapy office where they can bump into acquaintances they know, or could be identified as gay simply by seeing a therapist who specializes in working with gay clients. Many lesbians, gay men, and child sexual and ritual abuse survivors find that there are no therapists in their area who understand their unique needs, or if there are, they are not accepting any more clients. For them, particularly those who live in rural areas or small cities, accessing therapy online may be a lifesaver

**MYTH #9:**

***Online training and peer supervision are ineffective***

Offerings for formalized training are now beginning to appear in university settings across the globe. For example, training for counselors to work online is enthusiastically offered in the UK. There are several courses offering training in Internet skills as well as online counseling skills. Online counseling is also being offered as a module in many face-to-face training courses, in the U.K. as well as in the U.S. and elsewhere, while counseling via the Internet is an increasingly popular research topic for graduate students.

In one online training module, students initially collaborate in supporting each other while they get used to the variable reliability and performance of Internet and computer technology. They compile lists of useful websites, along with tips and tricks for dealing with their computer/ISP/Internet connection, and compare experiences and notes on what works/doesn't work when troubleshooting. This need to come to terms with an unreliable technology strengthens the closed group which has formed for the duration of the course. The impact of such group strength can also extend to the role-plays they engage in and some students comment on the powerful opportunity they have had for personal growth as a result.

Another interactive training program presented in the Case Study Group incorporates students working across modalities, creating an online web project and utilizing a variety of online resources in a guided "quest" of self-exploring a psychosocial topic.

Increasingly, not only in the training of mental health professionals but in higher education generally, use of forums, "whiteboards", bulletin boards, and so forth is proving to be a useful and motivational supplement to conventional classroom lectures (e.g., Vandervert, Shavinina, & Cornell, 2001). As noted above, it can also improve social cohesion among students, as in the case of the "Chill Out

Room”. Another professor has reported equally good results through the similar strategy of offering students a forum described as “the cafeteria” which has stimulated positive social interaction.

Such work with students, using online groups and multi-modal resources, only hints at the great potential of these resources for various populations of clients and colleagues in the fields of mental health. There is clearly vast potential and immediate need for bringing online training, education, and supervision opportunities into line, and up to speed (Kanz, 2001; Oravec, 2000). In some circumstances such as that of rural practitioners, therapists with physical disabilities, and perhaps therapists who would like to be supervised by a specialist in another country, online supervision and training may offer the most viable and ideal form of learning for the therapist in training.

The work of the CSG itself is a testament to the power of peer support and supervision (Suler, 2001a). It dramatically illustrates the power of such an endeavor to stimulate a steep learning curve and promote enhancement of technical skills, cross-cultural awareness, and familiarity with the many new issues that have arisen in ethical and professional practice. Rapid sharing of references and resources through hyperlinks and instant access to peers has also been of great value for the members of this group.

In terms of advanced clinical training, the value of online peer group supervision has proven itself to be tremendous. One long-term client was working with the therapist exclusively via chat and presented to the Case Study Group over a 2-week period, as the case continued “live”. Another case was presented where there was a very serious call for help via e-mail, and the group shared online resources, suggestions, support, and personal experience with various treatment providers local to the client.

It might be noted that during these case presentations, there was almost always one or another colleague present, online, for consultation or assistance with any urgent situation. This turned out to be tremendously helpful in a number of cases. Several effective, rapid, and knowledgeable interventions would not have been possible were it not for the opportunity to utilize both synchronous and asynchronous communication channels, to consult with respected peers, around the clock, and in some cases around the planet.

***MYTH #10:***

**Any clinician experienced in ftf work can do online work**

Anyone who has been practicing in an office and dreaming of “doing the easy thing” and working online, will soon find new meaning in the understanding of “the therapeutic relationship”. Even if the therapist is a quick typist and wonderful online technician, perhaps the client is not. Or conversely, we have seen examples of clients using font color, emoticons, and abbreviations suggesting

more natural ease with the medium than many counselors who offer services but may be newly appearing online. Aside from one's own skills, and the client's, in order to have a "transparent", natural relationship, which allows for communication, understanding and empathy, there must be a good "match" between client and clinician, and an ability and willingness among each to employ the various online modalities and channels that are available.

It is clearly a myth, or perhaps a wish, that "doing online therapy" is easy and uncomplicated. There are definitely some very enjoyable benefits, along with some areas for concern:

Working online from your own home has numerous advantages:

- You can walk the dog more or less when you need to
- You can wear whatever you are comfortable in
- You can stop and make a cup of coffee when you want to
- You can switch off and do something else if you wish

However, online practice can be even more isolating than working face to face (particularly if the latter is conducted in a practice setting where you are part of a team). Therefore being comfortable with certain practical skills is important, if the therapist is to avoid tears of technological frustration.

Working online requires a love of, and respect for, language and words. It is useless to embark on text-only therapy if the therapist struggles to find the right word to express him or herself or relies on the computer's thesaurus when writing a letter. When you work in text only, words are your only therapeutic tools and must be chosen and used with skill. Time also has a different meaning online: the immediacy of the communication system encourages instant response, and even asynchronous e-mails can fly back and forth in what becomes almost a conversation. It may be important for the client and/or therapist to take sufficient time to process what is happening before making another contact. Drawing attention to this requires special tact and diplomacy to avoid appearing "hostile" or "punitive" to the client. The impact of words used alone may be more powerful than in f2f communication. The online therapist may need to choose words that are warmer, more sensitive, more caring than might be necessary face-to-face. The disinhibition effect can equally affect the therapist as well as the client, so training and self- or peer-monitoring of one's clinical work may become an important component of online work.

It can be lonely at the computer. The client may trigger the therapist's own feelings about loneliness and it may sometimes become difficult to retain a professional distance. At these times, the therapist's confidence in his or her ability to work online will be put to the test and it will be important to have access to others who can be trusted with these doubts. Supervision of online work either in a peer group or with a supervisor would seem to be one way of addressing

these issues. If supervision is available online, the therapist can take advantage of the Internet to seek support and guidance when needed, via e-mail to the supervisor or group, and not have to wait for a scheduled supervision session.

Some of the skills employed by online practitioners are subtle, while others are quite basic. Some examples follow:

### ***Required therapist Skills for effective online communication***

#### Practical skills

- Fast or touch-typing
- Comfort with Internet modalities and software programs (IM, chat, email)
- Curiosity and courage to investigate and alter parts of your computer you might not normally bother with (e.g. adjusting the configuration, downloading the latest browser, etc.).
- Comfort responding swiftly when necessary (or tolerating delays between messages)
- Ability to accumulate, store, and use appropriate web links
- Ability to receive, store, and protect communications from clients
- Knowledge of encryption and other privacy technology
- Expressive writing, facility with both language and other available visual cues
- Training/expertise as mental health professional, with a theoretical base to draw upon

#### Emotional skills

- Comfort describing own and others' feelings in text
- Comfort in a text-only environment
- Ability to make effective therapeutic interventions only using text
- Awareness of how client perceives therapist online
- Skill at clarifying accuracy of online communication
- Love being online
- Experience with online relationships (synchronous and non-synchronous)
- Flexibility in approach and conceptualization of therapeutic relationships (e.g., believing it's possible to form therapeutic relationships without visual cues or employing traditional psychodynamic, frameworks, concepts, and techniques)
- Confidence with technology, role as online authority
- Tolerance for computer glitches
- Ability to move between modalities (virtual and f2f) in response to client need and circumstances
- Ability to handle acting-out behavior and intensity of emotion as expressed in client messages (ranging from frustration and anxiety to client projections, anger, boundary and abandonment issues, etc.)

### Required client characteristics

- Has a computer
- Comfortable online
- Ability to contract and maintain a shared working relationship online
- Ability to clarify miscommunications, in both directions
- Motivated
- At least moderately fast typist (or has voice technology)
- Reasonably expressive writer, adequate reading/comprehension skills
- Credit card, willing to use it online

Research suggests that working online is only suitable for experienced face-to-face therapists. However, that may well change in the next year or two as using the Internet and working online becomes more widespread. As Internet usage grows, newly trained therapists will want to develop an online practice (perhaps with little or no face to face experience) and will want to concentrate on the skills of working online during their training. It is therefore very important that attention is paid to best practice for training therapists in this new medium.

As we move further into new possibilities for online clinical work, training will become not only more necessary, but also more complex. Clinicians will train to specialize in different types of text-based, multimedia, and virtual reality interventions. Even relatively experienced online clinicians cannot rely solely on our own efforts in designing these new computer-mediated approaches. We need to consult with experts in cognitive psychology, communications, human factors engineering, and Internet technology. In fact, somewhere in the not too distant future, the most effective model of a cybertherapy program might involve an interdisciplinary team that helps decide what psychotherapy theory, with which clinician, in what communication environment, would work best for a particular client. Might the treatment for that client involve a package of several types of online interventions and experiences, with the package designed and conducted by the interdisciplinary team? Members of such interdisciplinary teams are going to be working with each other via the Internet, e-mail, message boards, chat, and most likely person-to-person systems. The therapeutic environments they construct for their clients will be part of that network.

All of these possibilities, many of which already are a becoming reality, mean that a face-to-face clinician cannot simply step into cyberspace and immediately open a practice—not, at least, if that clinician expects to be as effective as possible. Newcomers will need to educate themselves about the complex techniques of online clinical work, as well as about the culture and resources of the online mental health profession.

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