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ONLINE COUNSELING: THE INTERNET AND MENTAL HEALTH TREATMENT

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The author asserts that the mental health profession is unprepared for the likely growth and related implications of mental health therapy delivered over the Internet. Clinical, ethical, and economic issues are addressed. Conclusions are that therapy can be done online, that it can be done ethically, and that online services might not be a serious threat to face-to-face therapy. Regulatory and professional organizations are strongly advised to cooperate with each other. Suggestions include how practitioners and educators might develop skills, how ethics and legislation might be coordinated, how research might be facilitated, and how certain support systems might be established.

The mental health profession is unprepared for the possibility that within a few years there may be as many people seeking professional counseling over the Internet as there are looking for it face-to-face. In 1995, Martha Ainsworth went searching for a therapist on the Internet because her travel requirements made it difficult to attend face-to-face appointments. At the time, she found fewer than a dozen sites offering online therapy, but one of those met her needs quite well. Later, to share her story and to help others find and evaluate online services, she founded Metanoia, a nonprofit clearinghouse for mental health Web sites (Metanoia, 2001a). By 2000, Ainsworth's database had grown to 250 private practice Web sites as well as a number of online clinics through which another 700 therapists could be contacted (Metanoia, 2001b). In an informal survey conducted by Metanoia, 90% of online clients who responded felt e-therapy had helped them. Many also indicated they would not initially have sought face-to-face counseling. Of considerable interest are preliminary findings indicating that a large percentage of these online clients later went on to use face-to-face counseling (Metanoia, 2001b). These are not rigorous scientific findings, but they might be indicators with potentially important implications for the future. Universities, social agencies, and mental health practitioners, like so many other parts of our society, need to assess their readiness for the changes being driven by the Internet. Attitudes about whether professional therapy can be done without face-to-face interaction, ethical issues involving client protection, and unclear legal jurisdiction are all areas of ambiguity that leave would-be cybertherapists treading into the apparent unknown (Koocher & Morray, 2000; Maheu & Gordon, 2000; Shapiro & Schulman, 1996).

Some think it is important to differentiate what they call *e-therapy* or *webcounseling* from psychotherapy (Grohol, 1999; Maheu & Gordon, 2000; Metanoia, 2001a). Such disclaimers are understandable because circumscribed therapeutic claims and careful use of terminology might ward off unfounded expectations, professional criticism, or even possible legal liability. For this discussion of interactive online mental health services, however, I do not differentiate between the terms *counseling* and *psychotherapy,* nor do I attempt to differentiate these terms from others, like *e-therapy*, *online counseling*, *cybertherapy*, *webcounseling*, and *computer-mediated psychotherapy*. Though there are undoubtedly meaning-

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ful distinctions, it is my undocumented assumption that if prospective clients differentiate at all, they do so on the basis of perceived credentials of the practitioner rather than on what he or she calls the treatment. By online or Internet therapy or counseling, I refer to ongoing, interactive, text-based, electronic communication between a client and a mental health professional aimed at behavioral or mental health improvement. The generally preferred online mode for this kind of therapy is asynchronous (e-mail exchanges) as opposed to synchronous (real-time chatting; Metanoia, 2001c). E-mail may not be the way we as therapists prefer clients to get their counseling, but it appears to be the way many are going to seek it in spite of our disapproval, so we may as well understand it a little better. As with other effects of the Internet, these forces of change simply have no way to slow themselves down out of courtesy to the status quo.

Current Attitudes: Can Therapy Be Done Online?

Despite growth in the number of online counseling Web sites, there are still very few therapists or potential clients for whom the Internet comes to mind when they think about mental health counseling. It does not fit the image. Counseling online does not involve two people who are in each other's physical presence while they communicate. Communication by e-mail appears to completely lack the nonverbal cues most of us consider an integral part of traditional therapy. Indeed, some highly experiential approaches may depend so heavily on use of real-time nonverbal cues, they simply could not be adapted for delivery in any mode other than face-to-face. Similarly, approaches that invest greatly in front-end diagnoses requiring direct observation would need to be fundamentally redesigned or used only in videoconference rather than purely text formats. For other traditional talk therapies and brief therapies, however, it is possible to speculate how effective treatment could be delivered in the absence of the face-to-face milieu. Although there are a growing number of cases of computer-mediated therapy showing positive outcomes (Cohen & Kerr, 1998; Jedlicka & Jennings, 2001; Jerome, 1997; King, Engi, & Poulos, 1998; Stevens & Lundberg, 1998), there is still an inadequate body of empirical research to reliably evaluate the effectiveness of online therapy (Barak, 1999).

Communication that conveys high levels of affect does not require being face-to-face, however. Some researchers have suggested that when humans are deprived of traditional socioemotional, nonverbal cues through one sensory source, they create and substitute new ones (Rice & Love, 1987). Bradac, Bowers, and Courtright (1979) identified variations in language intensity, content immediacy, and lexical variation not dependent on being face-to-face that make substantial impact on a communicator's perceived competence, affect, and anxiety. The kind of words people use and the way they put them together in print can say a lot about how they feel even when they cannot hear or see the person with whom they are communicating. Those of us who have visited an online chatroom (America Online, 2001) or written a love letter know that being limited to text does not mean being deprived of expressiveness. Beyond the mere words we choose in chatrooms, colors, ALL CAPS, smiley ;-) faces, rrrrepeated llletters, `fonts`, sizes, *typefaces*, difrunt spellin, ?????? punctuation !!!!!!!!, spacing between l e t t e r s, between words, and between

lines

can be used to help convey the speaker's feelings, personality, and message context. Furthermore, cumbersome English spelling can be dramatically simplified without much loss of meaning. This can work to the benefit of those who are less fluent in traditional written English. Cld it b u r c-ing a globl, ritten languij b-ing formd?

Although some theorists initially concluded that communication over the Internet would be an inadequate replacement for face-to-face intimacy (Robson & Robson, 1998) others have not. Walther (1992), who evaluated formation of affect in business e-mail communication, concluded that given sufficient time and exchange of messages, "relational valences in later periods of CMC [computer-mediated communication] and face-to-face communication will be the same" (p. 62). Following up on these findings, Walther (1996) continued to study CMC and later identified what he called hyperpersonal interaction, in which levels of affect can exceed those of face-to-face situations. Some clients might create an idealized mental image of a therapist they believe can help them. There also may be a disinhibition effect, whereby people say things online (positive or negative) they would not say face-to-face (Suler, 2001). In what appears a related phenomenon,

both adults and children have disclosed higher levels of personal information sooner on a computer than face-to-face (Joinson, 2000, cited in Young, 2000; Romer et al., 1997). Such dynamics might make online counseling different, but they do not necessarily keep it from being real therapy. And in the hands of a creatively skilled and ethical professional, they might make working online even more efficient and just as effective as face-to-face treatment.

It seems reasonable to assume that in a face-to-face environment, nonverbal communication can either reinforce or detract from the accuracy and usefulness of two-way verbal information. Appearance, posture, tone, inflection, pace, and eye contact either can give the therapist useful, additional information or can mislead, distract, overload, confuse, or intimidate. This is also true of the way the therapist's nonverbal behavior affects the client. With some clients or some problems, there might well be circumstances when all of the nonverbal noise accompanying a face-to-face session nets very little positive contribution.

In the 1980s, one of my jobs was as a corporate group process facilitator. When work groups or project teams were having a particularly difficult time, I was sometimes called in as a neutral, third-party facilitator. Frequently, there were interpersonal problems involved. The task was likely to be enmeshed in issues of power, control, and differences in personality and communication style. In such a context, the volume of task-related information that had to be processed by the team often seemed overwhelming. My world changed when I discovered group decision support software (GDSS). With GDSS, I could bring most of the participants into a conference room where each of them had a computer terminal. Participants in remote locations were linked electronically to the same little, private network. When assembled, we would attack the task through our keyboards. Much of the power of this approach was in its ability to get rid of the usual face-to-face interference. Because everyone could type simultaneously, the process displaced time and eliminated the substantial inefficiency and control issues of conversational turn taking. When I asked participants to identify the most serious priorities, they had time to reflect on the question and share their thoughts honestly. Each person's ideas appeared anonymously on everyone else's screen. People had no need to withhold good ideas or fail to critique bad ones because of insufficient airtime, self-censorship, fear of retribution, or lack of interpersonal assertiveness. A massive amount of information was shared in a fraction of the time it would ordinarily take. Each person's idea carried the same status as everyone else's. Each contributor knew that his or her idea was not being summarily evaluated in the context of how important he or she looked or what perceived power he or she had over others. Using rating and ranking tools included in the software, we would usually have consensus on our priorities by the morning break. By afternoon break, we could have an action plan with contingencies, assignments and deadlines. At the end of the session, we generally had time to type our thoughts and feelings about the process. People were almost always upbeat about their sense of joint progress, and it was not unusual to see previously intractable personal rivalries recede to the background. Sometimes I would recommend we use the software to rate our confidence in success or our commitment to the plan before we all signed off. When all was done, everyone had access to a written transcript of the entire process for later reference. Others have documented similar observations in working with GDSS (Dennis, George, Jessup, Nunamaker, & Vogel, 1988; Jessup, Connolly, & Galegher, 1990).

Although there are substantial differences between individual therapy and a task-oriented GDSS session, some of the same elements could help an online counselor turn loss of being face-to-face into a therapeutic advantage. In the popular press, clients of online counseling have reported they feel less self-conscious, less inhibited, and better able to express themselves than they would sitting in someone's therapy room, and therapists have reported they feel more focused and that their responses are more powerful when they have time to reflect before responding to a client's input (Hamilton, 1999; "Seeing a Virtual Shrink," 2001). People meet and fall in love on the Internet. Why would a therapeutic relationship not also be possible?

Perhaps one thing that makes traditional therapists uncomfortable, beyond having to learn a new set of lexical cues, is that the online client has more discretion as to which supplemental cues the therapist gets. Having control of these communication techniques, clients could manipulate cues to mislead if they do not want (or are unable) to use them honestly. In other words, it is still probably easier to lie if the other person

cannot see your posture or your face or hear your voice. On the other hand, if a client is genuinely seeking help and willing to pay for it, there is little to be gained from intentional dishonesty. Acknowledging the client's control over disclosure and honesty could turn out to be part of the treatment in online therapy. Backing up this client-centered control is the assumption that a typed e-mail message also gives a client more time to reflect and to strive to make each message convey exactly what he or wants to communicate. Inevitable misunderstandings, properly worked through, could also be therapeutic.

Even if we concede that some problems probably could be treated online, logic dictates that there are also some we ought not even try to treat without being face-to-face. Gary S. Stofle (2001), secretary of the International Society for Mental Health Online, has been treating patients online since 1996, and he advises that crisis situations such as suicidality; disordered thinking, where someone has difficulty separating reality from nonreality; borderline personality disorders, where a person probably needs to interact with a tangible human being; and diagnostic requirements for which direct observation of the person's physical condition is important, such as anorexia nervosa, not be treated online. As particularly good candidates for online treatment, Stofle specifies people seeking personal growth and fulfillment, adult children of alcoholics, those with body image or shame and guilt issues, and persons suffering from agoraphobia, anxiety disorders, and social phobias.

Although more research is needed, it seems plausible that people could communicate effectively online even when the content of their communication is fraught with affective intensity. It seems a relatively small step to conclude that effective individual therapy, using an appropriately adapted and theoretically sound methodology, could be transacted online as well. In fact, Cohen and Kerr (1998) found no difference in the effectiveness of computer-mediated and face-to-face counseling when treating clients suffering from excessive anxiety. Their randomized outcome study went even further to demonstrate no difference in the way clients rated their counselors on expertness, attractiveness, or trustworthiness.

Ethics: Is It Safe to Practice Online?

As another indicator that Internet-based therapy is here, several major mental health organizations have now issued ethical guidelines for online counseling (American Counseling Association [ACA], 1999; American Mental Health Counselors Association [AMHCA], 2000; National Board for Certified Counselors [NBCC], 2001). A 1997 statement by the Ethics Committee of the American Psychological Association (APA, 1997) is among the least specific of available guidelines. It asserts that principles underlying existing standards already provide much of the needed guidance. The statement affirmed that existing APA codes did not prohibit electronically provided services but warned about the need to consider local laws and licensure board rules.

In October 1999, the ACA issued a special message called *Ethical Standards for Internet On-Line Counseling* (ACA, 1999). These guidelines addressed specific issues related to Internet counseling by telling members their Web sites must be secure, messages should be encrypted, and clients need to identify themselves and provide alternative means for emergency contact. Everyone at the counselor's site who has access to client messages must also be identified to the client. The known limitations and difficulties in receiving counseling online must be clearly disclosed to the client as part of an informed consent process. If the client will not execute a formal acknowledgment and waiver concerning the limitations of online counseling, the counselor must refer the client to more traditional services (ACA, 1999).

With the exception of some specifics, like the emphasis on encryption, the *Code of Ethics* of the AMHCA makes similar requirements (AMHCA, 2000). Although not foolproof, encryption is a powerful tool for online confidentiality. It uses software to scramble a message when it leaves the sender. The receiver, with a special key and compatible software, can unscramble it to make it readable. Though any computer or server can be hacked or otherwise violated, with 2.1 billion e-mails sent daily in the United States, if both therapist and client use encryption, the probability of someone eavesdropping on a client's message probably falls to about the same probability of someone putting an electronic bug in a face-to-face therapy office or breaking into office files. Computer security concerns did not begin with online counseling. Regardless of how therapy is delivered, if a managed health care company is involved, sensitive client information

is likely being stored on a computer server somewhere anyway (Alleman, 2001).

Even if security technology like encryption is available free of charge, clients will still sometimes perceive it too inconvenient, preferring to use less rigorous methods such as a disguised screen name. A case using this technique was recently described in a popular therapy magazine (Freeny, 2001). A good explanation of online treatment limitations and an easily understood, written disclaimer (Banach & Bernat, 2000) will be essential for Internet practitioners. Ultimately, much of the confidentiality issue may come to rest on the degree to which the practitioner is willing to grant a fully informed client autonomy to choose the level of electronic security he or she desires. It will also be critical to make sure that the client knows how to keep his or her own files secure and that he or she should not seek confidential treatment on a machine belonging to someone else, such as a school or an employer. A note of further caution for the therapist is in order. Although confidentiality requirements are automatically imposed on a therapist, there are typically no such restrictions on a client. Once a text message is sent, the therapist's words are captured for all time. A client can print them, duplicate them or forward them to untold unintended audiences. These attributed words may turn up in a lawsuit, in a publication, or in an attempt to undermine efforts of a fellow therapist. Practitioners should make a practice of discussing mutual ground rules with all online clients.

To someone familiar with e-mail and Web site technology, most of the ACA guidelines related to confidentiality seem rigorous but doable. Two other ACA requirements, however, become problematic when working with clients on the Web. The first, limiting one's practice to the geographical area in which one is licensed, seems to undercut a major advantage of operating online for both clients and practitioners. The second, requiring verification of client identity, is difficult to achieve with absolute certainty.

Section 3d of the ACA code states that "counselors . . . do not provide on-line counseling services to clients located in states in which counselors are not licensed" (ACA, 1999, p. 4). Given its strong ties to state licensing authorities, the ACA understandably includes this restriction, but in the long term it might prove a futile attempt to impose traditional geographical parameters in a way that will be difficult to justify or enforce. Given the nature of the Internet, should clients be told they may not use a counselor outside their home state or should counselors be told the only clients they may accept are those within their local area? It seems a prescription destined for violations that will be difficult to police. A survey of U.S. state attorneys general showed little consistency on whether states claim regulatory authority over practitioners residing outside the state's boundaries (Koocher & Morray, 2000).

A new professional organization, formed in 1995 explicitly to serve e-therapists, treats this jurisdictional issue in a more equivocal fashion. The rapidly growing International Society for Mental Health Online (ISMHO) has published its own set of guidelines for practice, *ISMHO/PSI Suggested Principles for the Online Provision of Mental Health Services* (ISMHO, 2000). According to Section 2b, "The counselor should meet any necessary requirements, for example licensure, to provide mental health services *where he or she is located* [italics added]" (ISMHO, 2000, p. 3). These principles go on to warn, "In fact, requirements *where the client is located* [italics added] may also need to be met to make it legal to provide mental health services to that client" (ISMHO, 2000, p. 3). This leaves more judgment, if not less risk, in the hands of the provider. The Internet counseling standards adopted in November 2001 by the NBCC state that "as varying state rules and opinions exist on questions pertaining to whether Internet counseling takes place in the Internet counselor's location or the Internet client's location, it is important to review codes in the counselor's home jurisdiction as well as the client's" (NBCC, 2001, p. 1). The NBCC code follows this up by requiring its members to have links on their Web sites to their own licensing entities and by requiring counselors to obtain contact information for at least one on-call counselor near the client's location (NBCC, 2001).

Availability of medical and mental health counseling over the Internet makes quick and easy verification of provider credentials essential. This should not be a problem. Validating someone's current professional status by clicking on a hyperlink seems at least as easy as and probably more informative than surreptitiously squinting at a printed diploma on someone's office wall. What needs to be strengthened in the ethics codes is absolute assurance that the person answering the client's message is the person the client thinks

it is. Severe penalties should be imposed for violation of this assumption.

Another difficulty inherent in Internet communication involves verifying the age and identity of clients. Counselor diligence in this regard can certainly be demanded, but what should be done when clients do not want the counselor to know who they are or when they are dishonest about it? Whereas a computer makes it easier for a troubled 13-year-old to reach out for help from the dark corner of a bedroom, it also makes it easier for such a child to lie about his or her age. Should we refuse online help on the basis of such a possibility? Some practitioners may choose to go so far as to accept no online client until the client has visited a face-to-face clinic to have identity established, sign an informed consent in person, and designate local emergency resources. Clients who resent such inconveniences will simply look for a different Web site. Requiring documentation of attempts to verify age and identity are realistic, but judgment and thus some risk will always remain. Reasonable legislation might help. Until protective guidelines are established, each therapist will balance his or her willingness to help others with the need to protect himself or herself. The difficulty in identifying a client's age also applies to determining a client's location. Today's crazy quilt of state and local laws pertaining to age of majority, abuse-reporting requirements, and duty-to-warn case law will strain a therapist's legal research capabilities even if the client is willing to disclose where he or she lives. Local statutes and district court decisions are typically not recorded or stored for easy Internet retrieval.

After reading relevant ethical guidelines, if a professional believes the risks are too great to allow the practice of ethical psychotherapy online, he or she should not attempt to provide it. This does not change the fact, however, that other professionals have already arrived at a different conclusion. Nor does it in the least influence the fact that potential clients will continue searching for counseling online. As Stofle put it, "If the ethical therapist is not online, who is?" (cited in Metanoia, 2001a, p. 9). Going forward, the greatest ethical risk we may face is that we will write rules or enforce local laws in such a way that competent, principled professionals are forced to exclude themselves from online availability. It cannot possibly be ethical to create such a trap for potential clients who are merely seeking help through technology that is available to them.

The Marketplace: Can Traditional Therapy Compete?

Online therapy may prove itself to be a strong competitor in the counseling marketplace. From a market perspective, price and convenience both exert great influence on purchase decisions even when it comes to health care services. Price is a factor whether fees are being paid by the consumer or paid on behalf of the consumer by a third party, such as an employer or insurance company. As with any product or service, a number of variables can influence a purchase decision, but there are typically only a couple that make the critical difference (Cady & Buzzell, 1986). If online counseling is seen as desirable because of a lower price or more convenient access, it would still need to be perceived safe and legal and be expected to work.

Consider a prospective psychotherapy client, lying awake at 3:00 a.m. staring at the ceiling of his bedroom, overwhelmed by his problems and finally ready to admit he needs help. If he is aware of it, this client has a new option. He can get up and walk a few feet to his computer. After a brief search, using words describing his problem or words such as *online therapy* or *Internet counseling*, he will almost certainly find Web sites offering professional counseling online. The site he chooses might have basic information about his kind of problem as well as links to more detailed information. In the privacy of his home or apartment he can read about counseling fees, the process and requirements of online therapy, the kinds of problems appropriate and inappropriate for online treatment, limits of confidentiality, and the therapist's qualifications and credentials. Because an initial e-mail exchange is either free or very reasonably priced, he may choose to fill out a contact form. The form asks for age and background information as well as alternative ways to contact him in case of emergency. Then, it gives him space to talk. At 3:30 a.m., without leaving his home, he can tell someone about the fears and frustrations that are making him reach out for help. When he has said what he wants to say in exactly the way he wants to say it, he clicks the "send" button and goes back to bed to await a response, promised within 24 hours.

Contrast this option with one that requires our client to wait until the next morning and hope he still feels the same motivation. He will need to get his phone book, find a clinic or therapist in his area (if there is one), examine his own time restrictions and call to make an appointment several days off. Fees are steep, but if the pain is still felt, he may persist. At the scheduled time, with considerable anxiety, he will get in his car or go to the bus stop and travel to a strange waiting room where he will wait, uncomfortably, for someone he may or may not like, who may or may not be able to help him.

Consider further this client's managed mental health care company. Face-to-face therapy costs more than online therapy to provide, and what little research has been done shows they may both be effective (Cohen & Kerr, 1998; Jedlicka & Jennings, 2001; Klein & Richards, 2001; Lange et al., 2000; ISMHO, 2001). Two decades of debate over managed care give us some powerful precedents to consider when it comes to economic forces in the managed mental health care market. When expensive, long-term psychotherapy was unable to prove that it produced substantively better outcomes than shorter term therapy (Howard, Kopta, Krause, & Orlinsky, 1986; Kopta, Howard, Lowry, & Beutler, 1994; Koss & Shiang, 1994), the managed care market began using that information to move toward the more economical, time-limited alternatives. With online therapy, the burden of economic proof will not be on the cybertherapists. It will be on traditional, face-to-face therapy. The cost of maintaining a brick-and-mortar operation that provides meeting rooms, receptionists, parking, groundskeepers, custodians, and counselor offices will almost certainly be higher than the cost of an online practice that ties therapists together at a Web site through computers already in their homes. If face-to-face therapy is unable to produce outcomes better than those of online therapy, markets will begin to respond and we should not be surprised, before long, to find the considerable weight of managed care behind some of the movement.

An important counterbalancing market variable might also be operating, however. In the surveyed user information I mentioned earlier, a large percentage of online clients said it was their first experience with counseling and that they would not have considered seeking face-to-face counseling. This suggests these clients constitute a new counseling market segment that has not previously been reached. Furthermore, after breaking the ice by using counseling over the Internet, almost 65% said they later went on to see a face-to-face provider (Metanoia, 2000b). If these preliminary data are even partially supported by further research, growth in online counseling could help the face-to-face market rather than hurt it. There are only four classical routes to market success and profitability. One can decrease costs, increase prices, increase the number of customers by taking them away from competitors, or increase the number of customers by growing the size of the underlying market (making the pie bigger for everyone; Cady & Buzzell, 1986). As someone who used to train market strategists, I believe from this scenario that the most competitive individuals and organizations will offer both online and face-to-face counseling as a planned product mix. Some clients may use exclusively one or the other, whereas others will benefit from some blend of the two.

As already reviewed, there are still unanswered legal, ethical, and public policy questions, but in a free market, there are always some entrepreneurs willing to take the initial risks. If they experience enough success, bigger players will begin to take interest by either lobbying to shut online therapy down (probably unsuccessfully) or investing in serious research and market planning to help open it up and make it safe to practice. Whether or not an individual practitioner ever plans to be a provider on the Internet, it would be wise to remain informed and involved out of simple self-interest.

Getting Ready

Current Practitioners

Established practitioners will probably look first to fellow practitioners, publications, licensing bodies, and their professional organizations for guidance as they seek to understand online therapy and/or develop their own online therapy skills. At the very least, debates and seminars discussing the theory, methods, ethics, and practice of online counseling should be considered wherever conference agendas are being planned. Nonprofit Web sites and electronic mailing lists such as Metanoia (www.metonia.org) and the ISMHO Web site (www.ismho.org) are already flowing with information and discussions.

Generally, when there is a perceived training need, entrepreneurs (qualified and unqualified) can be counted on to appear. There is at least one Web site in the United Kingdom offering online training for online counselors (www.onlinetraining4counsellors.com; see Counselling Online Ltd., 2001). Professional organizations could proactively serve members by helping evaluate such offerings. Credentialed therapists who are first to gain online experience will become logical sources for training, consultation, and supervision. Many of these will likely be in a position to offer professional services either online or face-to-face. Everyone should encourage quality research to get underway quickly through special sponsorship, funding and awards. Collective learning will accelerate when conferences and journals become venues for lively, constructive policy debate based on good empirical findings. Koocher and Morray (2000, pp. 507–508) recommend attention to seven specific areas for practitioners who decide to offer telepsychology services. These include a realistic assessment of competence, a review of insurance coverage, written guidelines for client emergencies, thoughtful documentation and consultation, a statement for clients on limitations of confidentiality, explicit specification of what kinds of services are offered and not offered, and open disclosure to third-party payers of services that were delivered electronically.

New Therapists

The Association for Counselor Education and Supervision (ACES, a division of the ACA) has published 10 technical competencies as guidelines for educational program development. Knowledge of relevant legal and ethical codes related to counseling online and knowledge of the strengths and weaknesses of providing counseling over the Internet are already included in these guidelines (ACES, 1999). Graduate programs for clinicians, counselors, and counselor educators should include discussions on Internet-based counseling in classes on theory, methods, ethics, and career development. To do so, some faculty members are going to need to become a little more technologically literate, and some will need to become a lot more open minded.

Students who want to develop actual online counseling skills will need incremental training beyond that of most existing counselor education programs. First, they will need knowledge in real-time use of the Internet. Knowing how to use the Internet for electronic messaging, to set up chatrooms, to find resources and referrals for clients, and to help verify client identity or locate emergency resources should be included. A second necessity would be technological knowledge of Web site quality, security, and interactive capabilities. Whether a practitioner builds his or her own site, pays to have one built, or decides to join an online clinic that has an existing site, he or she must be competent enough to evaluate Web site design and security. Third, students need a way to realistically assess their online written communication skills. If their basic skills are good, they then need to experience difficulties in accurately perceiving meaning from others in the absence of voice tone, facial expression, body posture, hand gestures, and eye contact. Some counselors-in-training may find themselves immediately effective interacting through text alone. Others may find that their current skills are not up to the task.

Counseling programs and clinical psychology departments may want to recruit some computer-literate faculty or find ways to leverage computer classes and technicians in other departments to jump-start a technical training elective in their curriculum. A relatively easy way to simulate the experience of online counseling would be to conduct computer-based role-plays using faculty, advanced students, or student peers as stand-in clients who communicate with counselors-in-training via e-mail. In debriefing and evaluating such role-plays (conveniently transcribed on computer printouts), students could experience how text-based therapy differs from traditional face-to-face therapy. For schools with on-site practicums, faculties could consider whether to assemble the competence, technical resources, and insurance coverage to offer supervised, online counseling to real clients through the relative security of the school's Web page and within the manageable licensure jurisdiction of the campus counseling center.

Licensing

As growing numbers of U.S. medical and mental health professionals include an online presence in their practices, they will press professional organizations to lobby for more standardization and portability of licensure across state jurisdictions. The Internet has already shown its

power with regard to at least one public policy issue. In 1998, and again in 2001, Congress imposed a moratorium on taxation of Internet sales because of the potential chaos that would result if every state and local entity tried to collect its own sales tax. If states are ever to be allowed access to the potentially huge tax revenues associated with Internet transactions, unprecedented cooperation in standardization of rates and collection procedures will likely be required (Association of American Universities, 2001; NYT Syndicate, 2001).

Local licensing boards may still feel obligated to protect only those Internet users who live within their jurisdiction, but the practical ability to police cyberspace through enforcement of local laws may turn out to be limited and such parochial isolation should be questioned. This issue is even more obvious from an international standpoint. Interjurisdictional cooperation and standardization is a place to start. If the laws and licensing requirements where the client is located are compatible with those where the service provider is located and if interjurisdictional enforcement agreements have been worked out, it will be easier for a practitioner to work on the Internet and easier for an injured client to redress a grievance.

Another way to look at professional licensure as it applies to the Internet is to acknowledge that providing services online requires new and different competencies. Perhaps a nationwide authority should be established to license online mental health practitioners. To acquire and hold such an Internet counseling license, practitioners would have to meet credentialing requirements of their home jurisdictions, demonstrate technical computer skills, be trained in text-based counseling, show that they know how to locate emergency resources, and show that they know how to research relevant local laws concerning age of majority and abuse reporting. Mental health Web sites, regardless of where practitioners reside or where servers or computers are geographically located, could also be licensed by this single authority. With establishment of a single Internet grievance board, clients would have a single place to file complaints and a meaningful way to influence the continuing status of both practitioners and Web sites with their grievances.

Research

Online mental health therapy is still very new, and empirically we know almost nothing about it. Yet the computer, the medium over which it is being delivered, is by far the best tool there is for gathering, organizing, analyzing, and disseminating data. With online counseling still in its infancy, Internet clinicians should cooperate to begin research on a coordinated footing.

Consider a secure, certified research service accessible through a link on each cybertherapist's Web site, sponsored by one or more of the practitioners' research networks and managed by one or more of the established professional mental health organizations. Standardized symptom checklists as well as pre- and posttreatment questionnaires could be provided for both online clients and therapists. Without identifying clients by name, information from both clients and therapists could be collected, matched, summarized, and analyzed systematically across many practicing Web sites. This could be done on a scale large enough to provide statistically useful information much more quickly and less expensively than if such research were dependent on the resources or initiative of individual clinicians. Confidentiality for both clients and therapists would have to be rigorously ensured, but all participants are already using computers, and it would seem a missed opportunity if application of systematic, computer-based research were not explored. Once established, this online database could be made available to researchers and clinicians for more creative research or simply for comparison with data gathered from their own practices.

The Public

If we assume potential clients will continue to seek counseling services online, and if, in the language of the ethicist, we believe they will receive the greatest beneficence and lowest risk of maleficence by using a trained, credentialed professional, we need to make it easy for clients to evaluate online resources. In addition, we need to be careful that we do not make using qualified professionals so difficult, inconvenient, invasive, or threatening that it drives clients by default to the unqualified or unprincipled practitioners. As implied earlier, the competition for professional online counseling may not be professional face-to-face counseling. The more immediate competition may be nonprofessional online counseling, and the clearest immediate challenge is to help those who use the Internet to understand the difference.

The media are already seeing online therapy as something of interest to the general public. There have been features on television and in popular magazines about online counseling (ISMHO, 2001; Metanoia, 2001a). Most of this recent publicity makes a point of including the views of experienced mental health practitioners who warn about shoddy or unqualified providers (Hamilton, 1999; "Seeing a Virtual Shrink," 2001). On their Web sites, professional counselors need to advise potential clients how to evaluate the credentials of online counselors. In addition, local licensing boards should be working hard to make it easy for online practitioners to provide a direct link to the board's Web site, which can be used to verify not only the credentials of a counselor by name but also the status and reputation of known Web sites. This implies the need to develop routine ways for grievance boards to investigate and evaluate Web sites that offer what appears to be therapy or counseling. Such efforts would best begin in cross-jurisdictional conferences aimed at standardization and ongoing coordination.

Finally, regardless of product, service, or location, the public needs to know that those who use the Internet to victimize or defraud online consumers are being identified and prosecuted. Whether transactions involve toys in auctions, real estate in Wyoming, medicines from drug companies, or mental health counseling, protection for the public when the public is transacting business on the Internet needs to stay prominent on the political agenda.

Support Systems

The last time I bought something at an online auction, I was offered the option to go to a secure, third-party Web site where I could pay for the item with my credit card. The seller of the item never knew who I was or what my credit card number was, I never knew the identity of the seller, and the third-party billing service did not know what I was paying for. The only thing we knew in common were e-mail addresses. As proposed earlier, entrepreneurs can usually be counted on to find unmet market needs. Online therapists could use intermediary services like these not just for confidential billing but eventually to help verify client identity and to locate emergency services or face-to-face referral resources nearest a client's zip code. A complete counselor's service package might even include age of majority, mandatory reporting requirements, and Tarasoff-type court precedents in the client's state of residence.

Closing Comments

Though I have not attempted to hide my biases, my objectives have not been to advocate online therapy. My objective has been first to inform and then to identify some issues needing action. In a review of Internet liabilities for social work practice, Banach and Bernat (2000) wrote, "The practitioner should not forego using the Internet for service delivery just because the medium is new and the method of service delivery is still undergoing development" (p. 160). Online mental health therapy is already here. It is likely to grow. It is undoubtedly going to have an impact on the helping professions, and many of us who do traditional mental health therapy have not thought much about it. Change is seldom entirely good or entirely bad, but it always comes and it hardly ever makes things feel more comfortable. We may not be fully prepared for mental health counseling to be delivered over the Internet, but there are some things we can do individually and collectively—not only to get caught up but to help lay a purposeful foundation for the future as well.

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