

Therapy over the Internet? Theory, Research & Finances

Laszlo, J.V. , Esterman, G. &, Zabko, S. (1999). Therapy over the Internet? Theory, Research & Finances. *CyberPsychology & Behavior*. 2(4), p.293-307 (Also: [Online]. Available: <http://www.geocities.com/HotSprings/Resort/7579/internet.htm> [today's date].)

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Behavioral telehealth, the use of telecommunications and information technology to provide access to behavioral health assessment, diagnosis, intervention, consultation, supervision, education, and information across distance (Nickerson, 1998), is more and more often cited as alternative mode of providing mental health services to individuals, families and groups. These services are sought out by individuals who have relationship issues (Colon, 1999; Powell, 1998; Sommers, 1997), depression (Powell, 1998; Sommers, 1997), family issues (Barak, 1999; King & Moreggi, 1998; King, Engi & Poulos, 1998; Powell, 1998; Sommers, 1997), substance abuse (Powell, 1998; Sommers, 1997), anxiety (Powell, 1998; Sommers, 1997), sexual problems (Powell, 1998; Sommers, 1997), eating disorders (Powell, 1998), bereavement/grief (Colon, 1999), phobias (Sommers, 1997), need career counseling (Barak, 1999; Tait, 1999), have medical illnesses (Colon, 1999; Childress, 1998), post-traumatic stress (Sommers, 1997), "mood swings" (Sommers, 1997) and are gay/lesbian (Powell, 1998). Others that are thought to benefit from on-line counseling are autistic clients, anti-social personality individuals (Polauf, 1998), as well as those suffering from generalized social phobia, avoident personality disorder and agoraphobia (King & Poulos, 1998; Sommers, 1997). Individuals requiring mental health services that live in remote areas, which are home bound due to illness, disability or old age would at least get services when they would not otherwise be available (Cutter, 1996; Powell, 1998, Sommers, 1997; Suler, 1998Aug; Sussman, 1998). King & Moreggi (1998) considered some to be counter-indicated for such services: those having sexual abuse as a primary issue, being in violent relationships, have eating disorders, individuals with psychotic disorders that involve distortions of reality as well as anyone having suicidal ideations.

The focus of this paper will be to evaluate the provision of mental health services via the Internet, and more specifically the provision of such services through a text-based mode of communication (such as e-mail). Terms such as on-line therapy, Internet counseling cybertherapy and telehealth will be used interchangeably for simplicity's sake as well as to get the reader familiarized with different terminologies in use. We will look at suggested theoretical modalities for on-line therapy, will evaluate the research available on the subject as well as assess financial implications to providing mental health services over the Internet.

THEORETICAL MODALITIES

A rather controversial question posed about behavioral telehealth is whether the provision of on-line mental health services constitutes psychotherapy. In the traditional sense, it is not, but in a transcended context it may very well be. Due to the lack of face to face contact, there naturally needs to be an improvising or an adaptation of the psychotherapeutic concepts and theories to this medium. A number of writers proposed viable practice possibilities and theoretical modalities that can potentially be tailored to on-line counseling so as to equip on-line therapist with a set of tools to utilize and deliver quality therapeutic services.

Polauf (1996-99; 1998) suggested that Crisis Intervention Theory could be an effective framework within which to intervene via e-mail. He termed it *e-mail based crisis intervention*. Crisis intervention is

" a process for actively influencing psychosocial functioning during a period of disequilibrium in order to alleviate the immediate impact of disruptive stressful events and to help mobilize the manifest and latent psychological capabilities and social resources of persons directly affected by the crisis" (Parad & Parad, 1990, p.4).

As such it requires rapid response, easy accessibility and quick effectiveness whose goals are to return the individual to pre-crisis functioning. Such counseling is time limited and entails concrete goals and problem solving exercises that can be conducted via e-mail. He suggested that the problem gets framed during initial messages by the individual as a disruption in otherwise steady state and is then taken through the same treatment stages undertaken in traditional agency-based crisis intervention.

Polauf (1996-99; 1998) further describes the process that would follow. Upon receiving initial e-mail from the client, therapist should explore the problem and reframe it in cognitive terms thus instilling hope, reducing client's anxiety, developing trust and allow for ventilation so as to make the client feel listened to and understood. Shortly after, the formulation of concrete and doable goals should be collaboratively agreed upon, promoting client's autonomy and sense of competence. These should encompass symptom reduction, restoration of functioning, insight into stressors and an increased repertoire of problem solving skills. A specific time frame is then set up within which goals can foreseeably be met and during which structured and active interventions are used.

Cognitive-Behavioral intervention would be very compatible with the text-based medium as well, as they rely heavily on conscious processes and thinking. Cognitive theory (Beck, 1976) works on examining the individual's thought processes, detecting cognitive error and helping the individual develop alternative and more flexible understanding about self and environment via re-framing and other techniques. Gabriel & Holden (1999, lecture) proposed a possible adaptation in text-to-text intervention. They suggested looking for emergent patterns in text to intervene on. These are 1. Overgeneralization (where individual uses frequent "always", "never" or good/bad, right/wrong), 2. Excessive responsibility (I should've done this, I must do that), 3. Predicting without sufficient evidence, 4. Making self-referential statements minimizing or maximizing the significance of the behavior ("anyone could've done it"), or 5. Catastrophizing situations and only focusing on the negatives (world will fall apart if I don't do it). Questioning such statements would serve to begin restructuring this individual's thought process and hence

foster change. Childress (1999, Mar) also spoke about behavioral interventions holding promise for online work, but he didn't give details.

Cognitive behavioral approach to treatment by Ellis (1994), known as rational-emotive behavior therapy, assumes that every person has a number of 12 possible self-defeating beliefs that underpin dysfunctional behavior. Treatment consists of uncovering these irrational beliefs, admission to having them, recognizing their irrationality and their replacement with more functional beliefs. Ellis (1997) proposes to address these irrational beliefs with techniques that ask the following questions: What self-defeating irrational belief do I want to dispute and surrender? Can I rationally support this belief? What evidence exists of the *falseness* of this belief? Does any evidence exist of the *truth* of this belief? What are the worst things that could *actually* happen to me if I don't get what I think I must (or do get what I think I must not get)? What good things could I make happen if I don't get what I think I must (or do get what I think I must not get)?

Narrative therapy (White & Epston, 1990) and solution-focused approaches (deShazer, 1988) have also been suggested and used in on-line therapy (Murphy & Mitchell, 1998; Childress, 1999 Mar). These approaches work on building trust and respect for clients and are oriented toward finding and building on their strengths and already possessed resources (Walsh, 1997).

Narrative therapy is based on a theory of interpretation and holds, as its main focus, people's expression of the experiences of their lives (White, on-line). As individuals tell the "story" of their problem, the therapist explores the individual's interpretation of these experiences, brings forth the contradictory or ambiguous experiences of their subjective reality and works on externalizing and re-framing the problem in a manner that is more enabling and empowering to its resolution. In time, individuals resolve their problems by attributing alternate meanings to event in their life and thereby "re-author the story" of their life. Although this process generally occurs face to face, it can just as easily happen through writing, and therefore via e-mail. In fact, Murphy & Mitchell (1998) consider the writing process to actually enhance the externalization of problems (as the individual sees their issues in print on their computer screen) and thereby promote therapeutic change. In addition, the individual will be able to note more readily the contradictions they hold in belief and attempt to make sense of it without even the therapist needing to point them out.

Solution-focused therapy also searches for exceptions to the individual's problem and when certain solutions were working. It focuses on current successes and desired future conditions in an effort to maximize them. This is predominantly done through solution focused questioning and exploration.

Task-centered approach (Reid, 1992), which draws selectively on empirically based theories and methods from compatible approaches such as problem-solving, cognitive-behavioral, cognitive and structural, could also be feasible for use in on-line counseling. Dr. Naleppa (1999), Assistant Professor at School of Social Work at Virginia Commonwealth University and host of www.task-centered.com web site, stated that "the clear structure of the [task-centered] model and its step-like approach lend themselves more to internet based intervention than many other approaches". This short term, problem-solving approach views problems as "unmet wants" that are resolved when

the client successfully completes empirically proven tasks. As recording of problem baseline and progress is essential, client's self-recording can be easily monitored via e-mail.

Other suggested modalities are the use of bibliotherapy (Barak, 1999), journal writing (Childress, 1999 Mar), and aspects of psychoanalytic models of treatment (Colon, 1999; Suler, 1998Aug; Uecker, 1997). Little is written, however, on how exactly they're implemented but rather are talked about on various listservers. Colon (1999) stated "I use psychoanalytic psychotherapeutic models in my work [on-line]. It has been a challenge to take what I know and apply it to this other medium...[but] repetition, recollection, transference, resistance, conflict, and acting out are all there" (p.80-81).

The most often cited psychotherapeutic behavior is transference (Colon, 1999; Cutter, 1996; King, 1994; Childress, 1998; Polauf, 1998; Suler, 1996May; Suler, 1998Mar). Suler (1998, Mar) summarized transference phenomenon by saying:

"The basic premise is that we tend to recreate in our current relationships the patterns of thinking, feeling, and behaving that were formed early in our life, most importantly in the relationships with our parents and siblings when we were children... Based on our relationships with them, we created models or templates in our mind about what constitutes the expected ways in which people behave in relationships." (p.1)

And due to the lack of visual cues in this medium, individuals are left to make formulations of people they communicate with on the only available information: their own experiences. As situations tend to be ambiguous, they lend themselves greatly to unconscious projections of various wishes, fantasies, hopes and fears onto the other person. The risk of this projection lies equally for the clinician, hence making it countertransference. These are neither good nor bad, but it is important for a clinician to be aware of them and how they differ from face to face interactions.

One possibility is that since the client has nothing visual to form an opinion, narcissistic projection may occur where they will ascribe everything that is pure and good to the interactions (Polauf, 1998). Although this may initially aid in the formulation of a therapeutic alliance, it may be detrimental to treatment when the client realizes the therapist is only human and also makes mistakes. Colon (1999) also noted that since the clinician is unseen and "mysterious", anger and frustration could be more easily directed at him/her. Suler (1998, Mar) went even further and classified transference as falling into one four groups: 1. You as you, computer as parent. 2. You as parent, computer as you. 3. You as you, computer as wished-for parent. 4. You as wished-for parent, computer as you. In the first, one experiences the other person as being like their parent and themselves as the child they once were. The computer is seen "as seductive, as a sex object, a satisfier of desire, as a symbol of sexual power and prowess" (Suler, 1998Mar). In the second, the roles are reversed. The computer is seen here as the individual's baby and treated according to the childhood experience (or it's opposite) of the individual - nurturing or abusing it. In the third transference, individuals project onto the computer the qualities and characteristics they always wished for of their parent. They may be of predictability, reliability and being non-judgmental when the parent was anything but, or experiencing the computer as benign, responsive, passive and compassionate when the parent was demanding and bossy. In the last

transference, the individual becomes the wished-for parent of its computer. This may evidence itself in various ways such as making sure his/her computer is safe & healthy, over-worrying about viruses and possible damage thereby not allowing anyone to use it, being so interested in the computer that he/she learns everything about it, or getting so invested in the technology that it becomes an obsession.

A concept closely related to this is Internet regression (Holland, 1996; Cutter, 1996; King, 1994; King & Moreggi, 1998). As regression is an instinctual return to an earlier mode or object of gratification (Brenner, 1973), it is once again not surprising that in absence of visual cues and heightened ambiguity that individuals resort to what is familiar. Holland (1996) talked about the above transferences in terms of regression as that's what underlies the transference reaction, particularly emphasizing the drive theory i.e.: sex and aggression. He noted three major signs / symptoms of this regression to be aggressive "flaming", sexual harassment or attack, and extraordinary generosity and openness on the Internet. The first being an expression of anger and rage at someone at the slightest provocation, the second being crude invitations by strangers for sexual activities, and the last being a sense of openness, sharing and tolerance by mere strangers.

Cutter (1996) suggests that there is an implicit permission granted by the computer to regress. This being the case, clinicians may choose to utilize it for psychotherapeutic gain. And being that clients who receive information via computer tend to believe it (Sampson et. al. 1997 in King & Moreggi, 1998), clinicians can find themselves in more powerful positions for making change.

Resistance to treatment is just as likely to occur on the internet as in face to face contact, but naturally will evidence itself in modified ways. Colon (1999) evidenced it in the forms of textual aggression, joking, silence and other forms of acting-out. Avoidance of salient material can also occur via hyperpersonal communication (King & Moreggi, 1998)

This exciting concept is the investigation of how computer-mediated communication can be "*hyperpersonal*" - that is, "to exceed face-to-face communication" (Walther, 1996; p.5). It is a complex discussion that bears reading in the original, but in summary, suggests that the computer-mediated communicators can create a mutually reinforcing "intensification loop" fostered by "selective self-presentation, idealization and reciprocation" (p.28). As for why people would be attracted to such distortion, Walther suggests the appeal of having an idealized self confirmed rather than challenged, and the potential of this type of interaction to strengthen ego functioning.

Walther's "intensification loop" theory seems credible as far as explaining the attraction of computer-mediated communication for many people, and the view that meaningful relationships can develop online, an argument that can be used to support the efficacy of online therapy. Although King & Moreggi (1998) also see the positive aspect of it with earlier disclosure of personal information to online therapist, they also foresee the opposite being just as likely. Walther adds that not having to worry about maintaining social appearance and cues allows more attention to message meaning. He does not address how the increased ability to deliberately conceal or enhance aspects of one's character(istics) allowed by computer-mediated communication could contribute to, or detract from, a therapeutic relationship. It is possible that the reduction of external cues may support a focus on the internal object world that could be

useful in therapeutic work. Alternatively, an object relations perspective would say that if the individual has not achieved sufficient object constancy, this inner focus might not be available for therapeutic use.

Although it is clear that personality assessment is difficult to ascertain, Suler (1998, Aug) proposed modified assessment method at figuring out the individuals on the other side of the screen. He noted that compulsive individuals would strive for well-organized and logically constructed messages. Those with a histrionic flair would have a more dramatic written presentation with neatness playing a back seat to expressive use of spacing, caps, and language. Pithy and concise writing could best recognize schizoid tendencies while disorganized, spelling-challenged messages with emotional phrases highlighted would point to a more compulsive individual. A narcissistic individual would be likely to produce length blocks of unbroken text for seemingly endless screens of longwinded descriptions of what the writer thinks and feels. This is not to imply that seeing such writing styles is representative of a personality disorder, but rather attune the clinician as to the character tendencies that predominate for any of us.

Finally, a significant amount of literature has been written about the therapeutic value of asynchronous messages (Uecker, 1997; Suler, 1998Aug; Suler, 1999Mar). Uecker (1997) wrote about the effect of delayed emotional response being enhanced in cyberspace. She postulated that communicating over the Internet disinhibited individual's unconscious defense mechanisms. This not only allows for more clear communication, but also allows for greater disclosure and the processing of "soul" issues needing to be addressed. In addition a psychological space is created with distinct context and boundaries (Suler, 1998Aug; Suler, 1999Mar). The asynchronous nature allows for a "zone of reflection" in order to think, evaluate and compose the desired reply (Suler, 1999). And finally, it provides consciously or subconsciously a "place" or "space" that one enters and that is filled with a wide array of meanings and purposes that reflect that individual's tastes, attitudes and interests (Suler, 1999Mar).

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REVIEW OF LITERATURE

While speculation and strong feelings are plentiful, research related to the effectiveness of and methods used in online counseling is sparse, reflecting both the newness of the field and also the difficulty in monitoring and measuring transactions in cyberspace. The research that exists tends to be descriptive, one-shot efforts based on extremely small samples.

In addition to research directly related to online counseling, which will be reviewed below, there are other theoretical perspectives that can contribute to the development of a theoretical foundation for cybertherapy. Computer-mediated communication has its roots in the military, business, and academic realms (Kraut et. al., 1998; Kiesler, Siegel & McGuire, 1984; Sampson, Kolodinsky & Greeno, 1997; Walther, 1996) and to date has been examined more closely for its usefulness in those contexts than for therapeutic purposes. A good example is a 1984 study by Kiesler, Siegel and McGuire that examined how computerization affects business communication, especially the ability of groups to reach consensus. This study compared two

forms of computer-mediated group process (simultaneous conference and email) with face-to-face group process.

While many discussions of computer-mediated communication emphasize the advantages of speed, information sharing, and reduction of prestige differences, this study found that computer-mediated work groups took longer to reach consensus than face-to-face groups. One explanation for the difference was the lack of social cues in the computer-mediated group that made it harder to deal with nuanced communication. Other factors that were believed to have reduced efficiency were the increase in equality of participation among those of different statuses in organizational hierarchies and changes in degree of influence among group participants due to anonymity.

The authors hypothesized that the depersonalization and increased equality of computer-mediated communication might foster greater creativity in group communications, and therefore positively influence outcome despite the more lengthy deliberation. However, they found that although there was less inhibition, more extreme representation of views, and more "choice shifting," the quality of decisions in computer-mediated communication groups were not significantly different, and in some cases, were inferior to those made in face-to-face groups. They suggest that the lack of an obvious leader and the absence of clear feedback about ideas may have increased frustration and may account for the difficulty in decision making.

Kiesler, Siegel and McGuire speculated about how the lack or existence of prior relationships affected among those communicating by computer, but did not report findings. They cite a previous study (1983) in which they found that "although people felt more embarrassed meeting one another face-to-face, they ended up liking each other better" (p. 1131). Greist et al. (1973, cited in Zarr, 1984) found that many people feel more comfortable describing socially deviant behaviors, like suicide, to a computer because it is nonjudgmental. It is possible that a perception of non-judgmentalism is retained in email since the writer has some anonymity, even though there is a sentient human receiving the message, (Galinsky, Schopler & Abell, 1997).

Walther (1996) suggests that, rather than debating whether or not computer-mediated communication is useful, technology can be adaptively used to either "dampen" interpersonal communication or to "heighten" intimacy and solidarity. Functions for which "dampened" affect could be desirable are brainstorming, increasing democratization, and minimizing fears of criticism due to status concerns.

Community or Isolation?

Research about whether online use increases isolation or builds community also bears relevance to how cybertherapy may or may not be effective. Kraut et al. (1998), in a two-year study of 73 families, found that "greater use of the Internet was associated with declines in participants' communication with family members in the household, declines in the size of their social circle, and increases in depression and loneliness" (p. 2). They noted that it is difficult to determine the causal direction of the relationship between computer use and social involvement, since many people use computers in order to maintain already existing strong social ties. On the other hand, they posit that had their sample included more isolated individuals, use of the Internet may have increased social participation.

Mickelson (cited in Frabotta, 1998) believes that Kraut's results are inconclusive. In a study of the Internet's effect on parents of special needs children, she found that participants' use of Internet support groups corresponded with times of conflict in their family. It suggests that it is the "isolation, loss of social activities and failure to address conflicts with the immediate family" (p. 4) that results in depression, not the use of the Internet itself. She and Kraut do agree that "The Internet tends to replace strong family ties with weak ties" (p. 4).

Childress (Behavior Online, 1999) suggests that computer-mediated communication can be used for social skill building and to increase social networks. Others champion the benefits of the expanded global community made possible by the Internet (Robin Sircus, NetPsy listserv participant, 1999). Kraut et al. (1998) and Michaelson (1996) suggest that computer-mediated communication can and should be used to enhance already-existing communities, e.g., neighborhoods, schools, local volunteer networks, etc. Kling (1996) advocates that more research examine how the social design/organization of electronic forums strengthens or weakens group life in workplaces and communities.

Research on Computer-based counseling

As noted above, empirical studies of computer-based counseling are few and far between. Extracting the theoretical framework used in the computer-based counseling approaches that have been studied reveals a variety of modalities and approaches, including cognitive-behavioral, journal writing, narrative, solution-focused, and self-help therapies/support. One site (www.cyberanalysis.com) offers "a combination of the most effective elements of several different schools of psychotherapy, including Cognitive Analytical Therapy, Client-Centered Therapy, Freudian Psychoanalytic Therapy, Transactional Analysis and Personal Construct Therapy." (Note: the approaches in the research literature do not seem to represent the vast array of those used in the many "therapeutic" sites available, some of which are discussed in the previous section of this paper).

Computer-mediated groups

Clawson, Bostrom and Anson's (1993) study of Group Support Systems (GSS) in the business environment found few differences between facilitation of face-to-face groups and computer-mediated groups. Using a broad definition of facilitation as "helping to make an outcome easier to achieve" (p. 549), they found that face-to-face and computer-mediated facilitation require similar skill sets comprised of 9 dimensions: "provides structure; provides support; develops relationships; builds rapport; creates open, participative environment; uses individual differences; emphasizes outcome; clarifies roles; and recognizes and demonstrates self-awareness" (p. 551). Successful computer-based group facilitation was found to require an additional three dimensions: "having conceptual understanding of technology and its capabilities; having ability to appropriately select and prepare the technology; and engaging in behaviors that create comfort and understanding of the technology and its outputs with the group" (pp. 559-560). Though the context of this study was business facilitation, not therapeutic or supportive counseling, the identification of technology skills as necessary for effective practice of online group facilitation can clearly be transferred across settings.

Online support groups for a variety of mental health issues/symptoms such as eating disorders, sexual abuse, suicide, breast and other cancers, caregivers, HIV, and substance abuse/addiction have been studied. Most used extremely small sample groups which limits their external validity. Our interest was in groups that are moderated in some way by a counseling professional (as opposed to self-help support groups in which individuals post and read messages without any intervention by a professional). However, because literature in this area is scarce, we have included some findings from non-facilitated groups that could influence a discussion of a theoretical framework for online therapy.

One line of research has focused on the question of what benefits are obtained from online groups and how these benefits compare to those offered by face-to-face groups. Finn and Lavitt (1994) state that because there has been no systematic study of online support groups, it is not really known which elements are beneficial. Elements of interaction that have been observed in studies of online support groups are the exchange of information, the extension of personal support (in the forms of sympathy, empathy, universality, hope, group cohesion, catharsis, altruism, validation, and acceptance), and the provision of feedback (Finn, 1995; Miller & Gergen, 1998; Weinberg, Schmale, et al., 1995; Weinberg, Uken, et al., 1995; Winzelberg, in press, cited in DeAngelis, 1999). These researchers as a point of comparison for online groups have relied on face-to-face group theory, (e.g., Yalom, 12-step principles), without the addition of other elements specifically related to online communication.

Winzelberg analyzed the content of 300 messages in an online eating disorders group, most of who were teens. They found that the messages reflected similar patterns as those found in face-to-face groups, but noted that 12 percent of the messages included inaccurate or unhealthy information, without the immediate corrective feedback that would be more likely in a face-to-face group. Lebow (1998) also expresses concerns that such groups may support problematic or mistaken belief systems without a trained therapist who influences the client toward therapeutic ends. He suggests that others who share the feeling may reinforce helplessness felt by members, and that the Internet is more appropriately used for psychoeducational purposes as an adjunct to face-to-face therapy.

Miller and Gergen (1998) found that exchanges over an 11-month period in an unmediated online suicide support group were extremely supportive, but only rarely was there an exchange that they would characterize as "change-inducing" (p. 189). They concluded that online interchanges are more "sustaining than transforming" (p. 189). This conclusion seems limited, in that it relies on an outsider's evaluation of whether or how an exchange between others contributes to "change."

In a separate study, Winzelberg and Taylor (in press, cited in DeAngelis, 1999) created a psychoeducational intervention package that included information, email, and a moderator who "facilitated group discussion, provided information, and directed participants on ways to effectively use the program" (pp. 2-3). Although the moderator was a psychologist, the researchers state that she did not act as a therapist because they did not know enough about the efficacy of online psychotherapy. They do not expand on their definition of "acting as a therapist." They found that while participants disclosed concerns and made significant progress in body image compared to a control group who did not receive the intervention, supportive

messages directed at other participants was low. A third study in process by the same authors is attempting to add more structure and model supportive feedback through using weekly assignments and a more active moderator who alerts the group to requests for feedback and encourages sharing. The use of assignments suggests a cognitive-behavioral or narrative approach, but details were not provided.

Weinberg, Uken et al. (1995) also found, in their study of an online support group for six women with breast cancer, that a more active leadership role was indicated. For example, group members did not respond to a member who expressed fears related to death. Galinsky, Schopler, and Abell (1997, p. 187) provide the beginnings of a theoretical framework for online group practice:

Although active intervention can be important in face-to-face groups, depending on the goals, and other variables, it may be essential more often and for longer periods in telephone and computer groups because of the decrease in visual and auditory cues. ... Structured systems for tracking patterns of communication and assessing silence and anxiety can be helpful.

In 1994, Finn found no studies on participant satisfaction with computer-based self-help groups for sexual abuse survivors. He suggests (1994, 1996) that the rapid proliferation of such groups indicates satisfaction and that the phenomenon is market driven. In 1996, however, he notes that more than half of all users of an addiction bulletin board only used it one or two times, and found that while online group membership may be high, interchanges tend to be dominated by a subgroup. Similarly, Miller and Gergen (1998) found that one quarter of the 24 participants on an online bulletin board related to suicide posted 61 percent of all entries, and a sub-subgroup of 10 posted 41 percent of the total messages. Miller and Gergen also found that respondents to a survey about the group expressed satisfaction, but noted that those who had negative experiences may not have tended to respond. A question for future research is whether users of such groups are, as many have suggested, those who do not have access to other services due to geography, stigma, or other limitations.

Lebow (1998) asks whether online users may use cyberservices instead of therapy, and thus miss out on the "constructive benefits of professional guidance" (p. 204). Virtually all the studies reviewed noted issues of limited computer access for the poor, children, elderly, and disabled. While there are clear advantages to online services over no service at all, we believe that caution is warranted before advocating that cyberservices become a replacement for society's investment in face-to-face services for underserved populations.

Finn and Lavitt (1994) raise the issue that sexual abuse survivors are not likely to present for treatment of sexual abuse, but instead present with symptoms such as depression, substance abuse, eating disorders, sexual dysfunction, mood disturbance or dissociative states. They raise the concern that some professionals may not know enough about sexual abuse to make the connections between symptoms and cause, and that targeted services, such as computer-based self-help should be available for the survivor. They champion online services for the advantage of receiving support and information from a wider variety of individuals than might present to face-to-face support groups. However, the availability of such groups does not address their stated concern about those who may not be aware of their need for support around specific issues

in the first place. Research to find out whether their hypothesis that users of computer-based support groups might be more diverse than face-to-face groups, would also be useful.

Finn and Lavitt (1994) found that moderators of online support groups tend to be people with personal experience of the problem, and not counseling professionals. They suggest that the role of professionals is to educate themselves about cybersupport in order to refer clients responsibly. Others (online chat, 1999) worry that nonprofessionals will take over the turf of therapy. Some see the role of online professionals as being available to do assessment and referral. For example, Finn & Lavitt (1994) relates an anecdote about a woman who said her participation in an online support group facilitated her attendance at an in-person AA meeting. However, he also reports an anecdote about someone who felt the computer-based group was more helpful than a face-to-face group. In an early entry into the discourse, Barnett (1982) describes an incident in which he publicly referred to himself as counselor on an interactive university computer system and soon after was contacted by a young man hundreds of miles away who had serious suicidal ideation. They "talked" for 2 hours while Barnett located a crisis center near to the young man and persuaded him to call the center. Barnett uses this incident to sensitize psychologists to issues of liability and responsibility in computer-mediated conversation. While that topic is not the subject of this paper, the anecdote is included to make the point that even those who use the Web for psychoeducational or referral purposes only may find themselves in need of practice guidelines for dealing directly with individuals in crisis who contact them.

Zimmerman (1987, cited in Walther) studied 18 clinically disturbed 13- to 20-year-olds who communicated via asynchronous computer conferencing for 30 minutes twice weekly over 11 months. She found that the computer-mediated communication was more egocentric, less stressful, and had more positive evaluation of self and others, and concluded that such communication might be a new resource for eliciting more related communications among this population.

Sander (1996) reports on the use of a therapist-led computer "chat" experience that developed spontaneously as a means to extend support to couples who had already been together in a face-to-face group. The couples found technology limiting and frustrating and felt that the sessions paled in comparison with their in-person sessions. Sander observed a selfconsciousness around the presentation of self through text, i.e., fear of judgement about inadvertent misspellings and typos. In retrospect, he felt he could have used more interpretation with the group, noting his discovery of what he considered to be a Freudian slip in the exchanges of text. In contrast to Lebow (1998) who suggests that psychoanalytic techniques would not be effective in online communication since it does not capture the whole person, Sander reports that he experienced a continuity between his in-person role of observing and commenting on patient resistance and interpreting latent content of messages, and how he interacted online. Sanders also cites personal communication with "an analytically-oriented therapist" who conducted a six month, time-limited asynchronous group that had never met before. This therapist reportedly found that "the anonymity and absence of nonverbal communication facilitated personal revelations and the rapid development of transference feelings" (p. 309)

King, Engi & Poulos (1998) report on the use of the Internet to assist family therapy, providing one real-life case example and a hypothetical example. They state that, "There are no studies yet

that show whether [these] efforts at individual cybertherapy are effective" (p. 2). They suggest that a therapist must have specialized knowledge about email therapy to know whether it may be effective in a given case. Examples of skills needed include familiarity with guidelines that offer suggestions for how to minimize misunderstanding in email communication, and use of a pre-therapy orientation to the hazards of email. They also explore ways of using therapeutic writing, and how it can also serve as a form of resistance.

Childress (1999) is currently conducting research on the effectiveness of email consultation as a new model for helping parents effectively manage children with moderate behavior problems. The pilot study involves families in California with children ages 5-12, and includes a structured behavior program and consultation weekly and as needed with a parenting skills specialist. Childress includes the following note in the research protocol:

As a text-based communication medium, e-mail alters the traditional dynamics of face-to-face communication and may impact communication in ways seen and unforeseen. For example, text communication often sounds harsher and more critical than face-to-face communication and without non-verbal cues such as body language, tone of voice, and facial expressions, it may be easier for misunderstandings and miscommunications to develop. It is therefore important that both parties in this current research, the consultant and the parent, check out with each other any communication which sounds harsh, cold or critical as this may not have been the intended meaning.

This seems to be a good beginning model for a pre-intervention orientation to online counseling services.

Limitations in the Research

As noted above, the existing research on the efficacy of online therapy is extremely limited at this point. This is part is due to the newness of the technology, but also reflects some of the limits of comparison possibilities. For example, Walther notes that because it is not possible to study asynchronous face-to-face communication, there is no way to truly compare face-to-face therapy with online therapy. It also is hard to monitor whether group members have simultaneous private communications and how much of the perceived benefits of groups might be attributed to those relationships (although this is also a concern with face-to-face groups). Also, as is true with face-to-face individual services, many providers have private practices and researchers cannot easily access users or providers. Finally, it is important to re-state that virtually all the studies we reviewed noted the issue of access to online technology — that the elderly, poor, female, and undereducated who have least access to face-to-face services also tend to lack online access. Therefore, any practice theory is likely to have limited applicability.

Areas for Future Research

Murphy and Mitchell (1998) suggest the need for studies that look at the impact writing has on clients. Chafe and Tannen (1987) in a discussion of oral and written communication find that "different conditions of production as well as different intended uses foster the creation of different kinds of language." Gender differences in response to different online approaches and

styles of work could be useful, especially given Powell's (1998) finding that men are the majority consumers of online therapy services.

The studies reviewed seemed to rely on existing, face-to-face theory as a framework from which to compare online therapy. Few researchers posed the need for developing a new theoretical framework that uses the special features of cyberspace for therapeutic intervention. If people do tend to reveal selves more to computer, how can that be used? Does that mean such individuals are also more quickly receptive to confrontation and interpretation? The very characteristics of online communication that make it appealing for a therapeutic relationship can be viewed as detractors from another perspective (e.g., anonymity/depersonalization, acceleration of information exchange / asynchronicity of information exchange). Practice guidelines that encompass the complexity and variety of consumer/patient needs would be an important foundation for providers to determine the appropriateness of the modality for potential clients.

FINANCIAL FACTORS

Currently in the reimbursable market for text to text therapy, it has been limited to the private pay sector. We conducted a survey of a recent sample of 40 Internet sites offering text to text therapy. This sample was obtained by using the search engine Yahoo and the key words therapy, business and online. As of 4/17/99, this data source can be accessed at the following website location [http://dir.yahoo.com/Business_and_Economy/Companies/Health/Mental_Health/Clinics_and_Practices/Online_Therapy/]. Of those sites, e-mail was used by 75% of the practitioners and real time chat was used by 52% of them.

The fee's per e-mail exchange ranged from no cost to \$50.00 per transaction with an average cost of \$18.00. Fifteen percent of the sites for real time chats were for groups and their fee's ranged from \$15.00 to \$40.00 per session with an average charge of \$26.00 dollars for a 35-minute session. Individual real time chat fee's ranged from \$25.00 to \$90.00 with an average charge of \$45.00 for a 45-minute session. Out of the 40 sites sampled, 45% of the sites were administered by Ph.D's, 35% by MS/MA's and 25% by MSW's.

The trend for reimbursement from a third party payer has been on the interactive technology of teleconferencing. Text to text very well may be the next wave of reimbursement of technological services if it follows the current trends. TeleHealth and TeleMedicine are used interchangeably through out the current literature and legislation. TeleHealth, as previously stated by Nickelson (1998), provides access to health assessments, diagnosis, intervention, consultation, supervision, education and information across distances. TeleMedicine, according to the Department of Health and Human Services / Health Care Financing Administration (1999), is generally described as the use of communications and equipment to link health care practitioners and patients in different locations.

The federal government gave TeleHealth and TeleMedicine a big push for third party insurance through the legislation of the Balanced Budget Act (BBA) that was introduced to congress on March 3, 1997 (Balanced Budget Act, 1997). According to the Federal Register (1998):

In section 4206 of the Balanced Budget Act of 1997, the Congress required that, not later than January 1, 1999, Medicare Part B pay for professional consultations by a physician via interactive telecommunications systems. Under section 4206(a) of BBA payment may be made under Medicare Part B, provided the teleconsultation service is furnished to a beneficiary who resides in a county in a rural area designated as a Health Profession Shortage Area (5E).

The Act included a Clinical Social Worker or a Clinical Psychologist as a referring or consulting practitioner, thereby being able to receive federal reimbursement for tele communication exchanges (Federal Register, 1998). However, once the hearings were conducted on how to implement this ruling it was brought to the committees attention that Medicare does not currently make payments for consultations for Clinical Social Workers or Clinical Psychologists therefore these practitioners were not able to receive reimbursement for consultation services (Federal Register, 1998). Nickelson (1998) states that there has been several surveys on health care providers that use this technology and that Clinical Social Workers and Psychologists are the top users.

The professions that are able to bill for consultations are limited in their fee's that are able to charge. The stipulations regarding fee's that could be billed are they can not exceed the current fee schedule, no charge can be included for reimbursement of telephone lines and equipment, no charge can be included and for the use of the facility, and no telephone, fax or e-mail consultations can be included (Federal Register, 1998).

The fee structure for TeleMedicine was broken down into 75% of the set fee would go to the professional doing the consultation and the other 25% would be for the referring practitioner (Federal Register, 1998). The Clinical Social Worker and the Clinical Psychologist would be eligible to collect the fee as the referring practitioner. For example, a Clinical Social Worker in a Health Profession Shortage Area has a client who needs psychiatric services. The Social Worker could make a referral to a Psychiatrist who has this technology and assist the client with accessing help. Psychiatry is a covered service under Medicare Part B so both parties would be reimbursed (Health Care Financing Administration, 1999).

An important factor of this legislation is that new technology is being looked at and reimbursement is being established to provide these services. This technology can assist different professions in reaching people who are unable to access service. Using and learning this technology can open new doors and opportunities for the Social Work profession. As the federal government to authorize reimbursement for these types of services, third party and private insurance's are obligated to pay the co-payment on these services and begin looking at creating policies that cover these services.

On the state level, 14 states have already adapted their Medicaid program to cover telehealth services (Health Care Financing Administration, 1999). Out of those 14 states, 4 states cover mental health services and all of the states except Kansas, reimburse both the "consultants hub" and the "referrers hub" (Health Care Financing Administration, 1999). The table below summarizes the information obtained from the Health Care Financing Administration on TeleMedicine benefits (1999):

TeleHealth services have the capacity and ability of making numerous services available on a local level (Kincade, 1996). Medicaid programs can have the advantages of using this technology to reduce patients travel time and expenses, improve access to rural health care systems and improve patient access to Mental Health providers (Health Care Financing Administration, 1999).

California's Governor, Pete Wilson, signed a landmark reimbursement bill that was meant to increase access to quality health care in under served areas of California (Jones, 1996). Thompson (1996) states the act's major provisions ensure that providers of TeleMedicine services are reimbursed for their efforts. This bill reimburses costs associated with TeleMedicine and it prohibits payers (private insurance's) from requiring face to face contact as a condition of payment (Jones, 1996). California's Kaiser plan has begun looking at using TeleHealth in new online services (TeleMedicine Report to Congress, 1997). Using Online services points to the possibility of text to text reimbursement again as a logical next step in the use of technology.

Oklahoma's TeleMedicine Act became effective as of July 1997 (Dakins, 1997). All insurers in the state are not required to have in person contact for reimbursement to occur (Dakins, 1997). Texas, also, has had three bills passed since 1997 that provide reimbursement of TeleMedicine services (Neuberger & Scott, 1997).

Residents of Kentucky have had greater access to mental health services through their telecommunications system (Burton, 1997). In a 20 month period of time over 250 patients were served through this technology in a Child and Adult Psychiatry program (Burton, 1997). One aspect of this program uses interactive video that links primary care providers with local mental health agencies (Burton, 1997). During 1995 Kentucky's Medicaid program paid \$28 million dollars in travel expenses for their recipients. (Contrill, 1997). The intention of telehealth would reduce those costs for transportation and allow that money to be used differently.

Minnesota's Omnibus Health Care Bill was signed into law in May, 1996 which includes TeleMedicine services in the homecare arena (Jones, 1996). This again is taking this technology into the patients' home to allow the practitioner to better services their patients. Blue Cross and Blue Shield of Kansas have funded over \$1,000,000 in research with home health care and Visiting Nurse Services (Neuberger & Scott, 1997).

Nebraska, North Dakota and Arkansas have grant programs set up for mental health services through TeleHealth (Neuberger & Scott, 1997). Nebraska's program has used video conferencing with psychiatric and chemical dependent patients (Neuberger & Scott, 1997). North Dakota's Senator, Kent Conrad, introduced the TeleMedicine bill to Congress as early as 1993 (Conrad, 1999). Senator Conrad has had an active role in getting TeleMedicine included in the BBA of 1997 (Conrad, 1999).

Michigan's Upper Peninsula TeleHealth Network has been looking at applications for support groups and telepsychiatry for prisoners through grant money (Neuberger & Scott, 1997). Montana is also using grant money to explore using telepsychiatry (Neuberger & Scott, 1997). Hawaii's Department of Health has been developing a plan to use this technology to improve the delivery of Mental Health services in their state (Neuberger and Scott, 1997).

The top 10 TeleMedicine and TeleHealth programs for 1998 included Public Mental Health and Psychiatric services as a new theme (Freeman, 1998). Northern Arizona Behavioral Health Authority and South Carolina's Department of Mental Health were mentioned in this article as experts in providing Mental Health services through TeleMedicine (Freeman, 1998).

TeleMedicine has the potential to improve the delivery of health care in the United States by bringing a vast array of services such as mental health services to under served communities (TeleMedicine Report to Congress, 1997). TeleMedicine, TeleHealth and technology in general has the potential for increasing access to quality health care, including mental health for all. The future of this technology and its capabilities are being created everyday.

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**We'd like to especially thank
Dr. Gary Holden & Dr. Martha Gabriel from New York University
for the encouragement and opportunities in this exciting field.**

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Revised 9/25/99