



# **The University of Sydney**

## **Internet Therapy for Problem Gambling: A Literature Review and Environmental Scan**

**Sally Monaghan & Alex Blaszczynski**

School of Psychology  
The University of Sydney

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### Contact Information

Sally Monaghan  
School of Psychology  
Brennan MacCallum Building A(18)  
The University of Sydney NSW 2006  
Australia  
[@psych.usyd.edu.au](mailto:@psych.usyd.edu.au)  
Tel: +514 803 3665 (Canada) +612 9969 8039 (Australia)

Prof. Alex Blaszczynski  
School of Psychology  
Brennan MacCallum Building A(18)  
The University of Sydney NSW 2006  
Australia  
[@psych.usyd.edu](mailto:@psych.usyd.edu)  
Tel: +612 9036 7227

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## ABSTRACT

Technological advances, liberalized legislation, and popularity have resulted in the increased availability of gambling opportunities and a corresponding increase in the incidence of problem gambling. Current treatment modalities include a reluctance to seek help, high drop out rates, and absence of empirical evidence that clearly demonstrates the efficacy and effectiveness of existing treatment interventions. Internet therapy offers inherent advantages over standard treatment formats including privacy and convenience, cost-effectiveness and accessibility (70% market penetration) to those unable or unwilling to access traditional services. Internet therapy is also particularly relevant for youth and Internet gamblers, groups identified as at-risk for the development of gambling problems. Currently little is known about the effectiveness of online therapy for problem gambling, although Internet-based gambling assistance programs have been established in several countries. Internet counselling is also available for other mental health problems including mood, anxiety and health-related disorders. This report will review the available evidence on online Internet therapy in general and for problem gambling specifically. The report will discuss and make recommendations on the most effective program content and format, program delivery, legal and ethical considerations including cross jurisdictional responsibility and licensing, management of suicidality and comorbid conditions and options to enhance compliance and interest. This report aims to inform key stakeholders including governments, regulators, researchers and treatment providers, of the utility of Internet therapy for problem gambling and how such an intervention should be best implemented.

**Key words:** Internet therapy, online counselling, problem gambling, treatment

## INTRODUCTION

Initially developed to connect four universities in 1996, the Internet has increased exponentially from a network of 37 nodes in 1972 to a world wide web by the late 2000s connecting millions of users (Ellerman, 2007). Approximately 70% of households in developed nations have access to the Internet with uses ranging from information gathering, communication, commerce and banking, entertainment, multi-player interactive gaming, gambling and education (Gackenbach, 2007). Advances in the wireless and telecommunication have expanded its market penetration to hand-held devices; mobile/cell phones and gaming devices such as Sony PSP, X-Box and Nintendo. The Internet is now a central feature of contemporary technological society.

Given its capacity to facilitate access to health information and expertise, health professionals are increasingly utilizing the Internet to deliver counselling services, treatment interventions, foster support group networks and offer programs for self-directed therapy (Houston, Cooper, & Ford, 2002). However, within this context both benefits and harm may be associated with Internet use; for example, the dissemination of instructions on how to self-harm, how to be a “better” anorexic (Bessell et al., 2002), or the provision of questionably effective interventions offered by unqualified counsellors.

The aim of this report is to review the potential effectiveness, benefits and difficulties of providing online therapy either in individual, group or guided-self-help therapy format for problem gamblers. The primary focus will be on cognitive behaviour therapy (CBT), as this is an empirically validated psychological treatment (Norcross, Karpiak, & Santoro, 2005) that has been translated into self-help formats (den Boer, Wiersma, & Van den Bosh, 2004). In the field of problem gambling, CBT has been demonstrated to be highly effective delivered either by clinicians (Ladouceur et al., 2001; Ladouceur et al., 2003; Petry et al., 2006) or through self-help manuals (Hodgins, Currie, & el-Guebaly, 2001; Hodgins, Currie, el-Guebaly, & Peden, 2004). Given the recency of this field, there is limited empirical research to fully elucidate the strengths and benefits of Internet therapy and even fewer studies investigating Internet-based interventions for problem gambling. Therefore, this report will begin by discussing common issues relating to online therapy before focussing on subjects specific to Internet treatment options for problem gambling.

## RATIONALE

There are significant problems with existing treatments for problem gambling. Firstly, the majority of problem gamblers (approximately 90% - 97%) do not engage in treatment (Evans & Delfabbro, 2005; Ladouceur, 2005; National Gambling Impact Study, 1999; Petry & Armentano, 1999; Productivity Commission, 1999). For example, while a telephone survey conducted between 2006 and 2007 in Ontario (N=8,467) found 3% met criteria for lifetime at-risk, and approximately 2% for lifetime diagnosis, of problem or pathological gambling (Suurvali, Hodgins, Toneatto, & Cunningham, 2008), of these only 6% sought any type of service; a figure that reduced to 3% if self-help materials were excluded. Data further suggests that the likelihood of ever accessing treatment

services increases significantly with severity of gambling problems with 25% of problem gamblers reporting the use of treatment services inclusive of self-help resources. Gamblers who accessed help for gambling were most likely to have chosen self-help, either on the Internet or as printed material. The proportion of gamblers with lifetime treatment use in this study were higher than those found in other North American survey studies, although still representing a low penetration of the population possibly benefiting from treatment.

There are two possible reasons accounting for this finding; either the vast majority of gamblers in the community address their problems without professional assistance, or they are reluctant to seek help. Some evidence suggests that a significant proportion either cease on their own volition, or are unwilling to admit to their problems and consequently are typically reluctant to seek help until they experience a significant life crisis (Clarke, Abbott, DeSouza, & Bellringer, 2007; Evans & Delfabbro, 2005). Reluctance may be due to fear of stigma, shame and denial (Clark, et al., 2007; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000), or to a lack of understanding of the treatment process and wariness about seeking professional help because of a perceived or previous negative experience (Clark, et al., 2007; Hodgins & el-Guebaly, 2000). A comparison of self-recovered former problem gamblers and treatment-recovered former problem gamblers found that the primary reasons for not seeking formal treatment included a desire for unassisted improvement, denial or problem minimisation, and embarrassment or anxiety (Marotta, 2000). The low degree of treatment uptake and reported barriers suggest that the majority of problem gamblers remain untreated.

A further significant problem with existing treatments is the high attrition rate, reported to range between 17%-76% depending on the treatment modality (Westphal, 2006). This high attrition rate may be accounted for by inconvenience, time constraints or geographical distances preventing easy access to face-to-face services.

Consequently, a major challenge facing clinicians is how to increase the accessibility and affordability of evidence-based psychological treatments for problem gambling. One solution is the use of online (Internet) brief interventions and guided self-help programs. Randomised controlled trials have demonstrated support for the effectiveness of brief interventions using CBT based self-help books coupled with therapist support (Hodgins et al., 2001; Hodgins et al., 2004). As an increasing proportion of the population becomes familiar and comfortable with using the Internet, combined with ease of access due to cheaper broadband technology and costs, online modalities represents an effective medium to reach problem gamblers who would not otherwise seek help.

## **HISTORY OF INTERNET COUNSELLING**

The practice of non face-to-face therapy is not new; for instance, Sigmund Freud heavily relied on letters to conduct therapy (Brabant, Falzeder, & Giampieri-Deutsch, 1994). Since the advent of electronic communications, other distance technologies, principally the telephone have been used to deliver therapy. Reasons given are those of geographical

distance (Coman, Burrows, & Evans, 2001), unwillingness or inability to visit a therapist's office (Coates, 2000) and technical appropriateness (Flynn, Taylor, & Pollard, 1992). The telephone has been found to be acceptable (Reese, 2001) and effective (McNamee, O'Sullivan, Lelliott, & Marks, 1989; Reese, Conoley, & Brossart, 2002).

It is not surprising that Internet therapy is now an emerging modality given its capacity to connect individuals and to foster the discussion and information exchange on a host of personal issues. Mailing lists, newsgroup, bulletin boards and forums have long been popular as a way for individuals to obtain advice from others experiencing similar difficulties (Rheingold, 1993). Furthermore, there is emerging evidence that individuals are also increasingly seeking help for a variety of medical as well as personal problems through the Internet; data suggest four in ten adults and one in four adolescents have used the Internet to access health information in the previous year (Baker, Wagner, Singer, & Bundorf, 2003; Lenhard, Raini, & Lewis, 2001; US Department of Commerce, 2002). Furthermore, Internet users living with disabilities or chronic conditions, or newly diagnosed, are more likely than other users to conduct and benefit from online health searches (Pew Internet & American Life Project, 2008a). Individuals suffering depression, anxiety, stress or mental health issues are significantly more likely to search for mental-health related information online (Pew Internet & American Life Project, 2007). Similarly, individuals who have experience with a condition or illness are active in posting advice online about managing a certain condition as well as advising people on how to seek help (Pew Internet & American Life Project, 2008a).

Online self-help support groups, the precursor of Internet therapy and Internet-based support groups for mental health began as early as 1982 (Kanani & Regeher, 2003). Their enduring success established the potential for computer-mediated communication to foster discussion of sensitive personal issues (Skinner & Zack, 2004) with evidence of resulting symptomatic improvement (Houston et al., 2002; Humphreys & Klaw, 2001). Furthermore, the success of online support groups demonstrates that consumers are willing to seek help in an online environment as the first step toward change (Grohol, 2004).

The earliest known organised service to provide mental health advice online was Ask Uncle Ezra, a free service offered to students of Cornell University ([ezra.cornell](http://ezra.cornell)). Started in 1986, this service is still available and well utilized by students. Topics vary from the factual (when are prospective students notified of acceptance?) to the emotional (e.g., is it ever too late to say sorry?). Fee-based mental health services began appearing in the mid-1990s with only a few dozen therapists offering online services. By 2002, this figure had grown to over 250 private practice Internet counselling sites and over 700 therapists contactable through online clinics (Alleman, 2002). The advent of Internet therapy clinics marked a significant development in online therapy (Skinner & Zach, 2004). These clinics offer resources to prospective Internet therapists in the form of online security, payment methods and practice management tools including screening clinicians and active marketing of services. Therapists join these clinics for a modest monthly fee and are offered a generic Web template page through which they may conduct their own Internet therapy practice. Consumers who visit the sites are provided

with a list of therapists to choose from, all of whom have been carefully screened to ensure they are qualified professionals. Examples of Internet clinics include HelpHorizons.com (www.helphorizons.com), MyTherapyNet.com (www.mytherapynet.com), and the U.K. based PsychologyOnline ([.psychologyonline.co](http://.psychologyonline.co)).

## **TYPES OF INTERNET THERAPY**

Internet-based therapy involves the interaction between client and therapist via the Internet and incorporates the use of a structured, web-based treatment programs in conjunction with therapist assistance (Abbott, Klein, & Ciechomski, 2008). The interaction between therapist and consumer most frequently occurs via time-delayed or asynchronous communication, such as email, but can also include simultaneous communication (synchronous), such as chat-based exchanges or instant messaging, and video conferencing (Skype).

Multiple options have emerged to facilitate Internet therapy (see Table 1). Online therapy can be practiced through various communication channels, which differ in terms of synchronicity, mode (individuals or group communication), type of communication (typed text, pictures, videos or voice) and the degree of on-site human interaction (direct, indirect through instructions on websites, or online interactive software) (Barak, 2004). Internet therapy may use a mixture of multiple mediums; for example webcams, chat sites, or email and group discussion boards. Additionally, Internet therapy may be practiced as an adjunct to face-to-face therapy through email “booster” or other Internet-based sessions following introductory face-to-face sessions. The most popular form of Internet therapy is conducted by email (Alberta Alcohol and Drug Abuse Commission, 1999; Chester & Glass, 2006; Shaw & Shaw, 2006).

<b>Mode of Therapy</b>	<b>Advantages</b>	<b>Disadvantages</b>
Email – A specified number of emails sent per week between client and counsellor.	<ul style="list-style-type: none"> <li>• Emails can be written at a time convenient to the client or when in a heightened emotional state.</li> <li>• Reliable feedback as therapist responds within a specified time-frame (e.g. 24-48 hours) or set-time per week.</li> <li>• Emails can be stored and revised by both client and therapist.</li> <li>• Wording of sessions can be carefully considered.</li> </ul>	<ul style="list-style-type: none"> <li>• Issues may be lost or not addressed between sessions due to possibility of complex and high-content emails.</li> <li>• Miscommunication possible due to difficulty communicating emotion.</li> </ul>
Chat/Instant Messaging – Predefined period of time where client and therapist conduct real-time text-based online conversation.	<ul style="list-style-type: none"> <li>• Allows online version of traditional therapy session with conversation and immediate feedback.</li> </ul>	<ul style="list-style-type: none"> <li>• Clients and therapists must be able to type sufficiently quickly.</li> <li>• Pre-set session times must be arranged, limits flexibility.</li> </ul>
Internet discussion/bulletin boards – Organised forum where various members can post discussion points and responses, typically moderated by an experienced therapist	<ul style="list-style-type: none"> <li>• Enables support and discussion from a group of people who may be geographically distant.</li> <li>• Members can post messages at their convenience and when they have something to contribute.</li> <li>• Therapist needs minimal intervention, providing support and information where appropriate.</li> </ul>	<ul style="list-style-type: none"> <li>• May allow ‘lurking’ where individuals can read others posts without contributing to the discussion.</li> <li>• Must be carefully monitored to prevent ‘flaming’ where a member posts an unsupportive and negative comment.</li> </ul>
Video conferencing – a face-to-face session achieved online through the use of real-time webcams	<ul style="list-style-type: none"> <li>• Allows non-verbal cues for enhanced communication.</li> <li>• May facilitate greater therapist alliance as client and therapist can relate to each other.</li> <li>• Allows immediate feedback</li> </ul>	<ul style="list-style-type: none"> <li>• Prevents anonymity in therapy sessions.</li> <li>• Some individuals may wish to avoid face-to-face contact due to difficulty communicating in this fashion.</li> <li>• Requires equipment.</li> <li>• Pre-set sessions times are required.</li> </ul>

*Table 1: Modes of Internet Therapy and their Advantages and Disadvantages*

It is important to differentiate Internet therapy from other types of Internet-based mental health services: that is, information websites, self-guided treatment, support groups/online chat forums, and online screening and assessments. Abbott and colleagues

(2008) distinguished Internet therapy from Internet counselling on the basis of differing treatment modalities. According to these authors, Internet counselling generally involves the provision of advice and support via textual communications relayed between therapist and client, usually in real time, and rarely including a structured “treatment” program. This type of counselling does not require sets of written texts or self-help manuals but allows direct one-to-one discussion on a range of topics. Internet counselling may be beneficial by enabling distressed individuals to rapidly and easily consult anonymously with counsellors during an immediate crisis. Additionally, one-time question and answer services can be offered where clients post questions anonymously to therapists such that others may also benefit by viewing the exchange. This form of Internet counselling may be best suited to individuals seeking help but not experiencing clinical difficulties or ready to commit to therapy.

Internet therapy, on the other hand, incorporates email communication between therapist and client, with directive treatment-oriented communications, and the addition of a structured program for the treatment of specific disorders (Abbott et al., 2008). Internet-based therapy most frequently incorporates CBT principles, has a well defined structure, an evidence base and includes an assessment procedure prior to the commencement of treatment. The latter is to ensure that the consumer meets the relevant criteria for the targeted clinical disorder.

The allocation of labour intensive clinical resources are markedly reduced in Internet therapy compared to traditional psychological treatments. Typically, the intervention consists of one or two emails per week in response to directed client exercises and questions. However, while the clinician’s time is reduced, time spent by the client in therapy is not less and can be greater than in traditional therapy as it involves directed homework assignments with the requirement for the client to continuously report on progress for immediate feedback. Balanced against this resource allocation advantage, is the absence of non-specific therapist effects. For example, in an ongoing study, evidence is emerging that therapist factors do make a difference in Internet therapy (Andersson et al., 2008). As more effective Internet training programs for clinicians evolve, the influence of non-specific therapeutic effects may become greater, and thus may not represent a disadvantage for this form of treatment medium.

It is important to emphasize again that there is a paucity of research specifically on Internet therapy. As a result this review will cover research on Internet counselling and Internet support groups for problem and pathological gamblers in addition to including of the use of Internet therapy for other specified clinical disorders. While Internet-based counselling and support may be useful for providing brief interventions (e.g., motivation, support, booster sessions, and crisis counselling) for problem gamblers and significant others, our focus is on Internet therapy directed to the more serious end of the spectrum where more structured interventions are required. It is acknowledged that Internet counselling be offered by laypersons, or counsellors with minimal training; for example, providing encouragement/motivation to change, emotional support, and referrals to further treatment and services. More formal Internet therapy for severe problem and pathological gamblers should be conducted by properly trained, qualified and licensed

psychologists equipped to assess, diagnose primary and comorbid conditions, understand theoretical frameworks, and to respond effectively to psychological crises. Expertise is also required for monitoring and planning emails and real-time Internet discussions.

## **ADVANTAGES OF INTERNET THERAPY**

Traditionally therapists provide a range of face-to-face counselling services for individuals, couples, families, and significant others. However, recent advances in technology and cheaper and wider coverage of broadband Internet access have prompted consumer demand for therapy to be provided online, particularly for rural and geographically isolated clients. For example, over an eight month period in 2001, Relationships Australia, Queensland received 119 requests for Internet counselling from clients accessing their website despite the absence of an advertised online counselling service (Hunt, 2002). In response to such demands, pressure has been placed on clinicians to develop, implement and evaluate Internet counselling services.

The following section reviews the advantages of online counselling:

### **Consumer Demand**

Computer access to the majority of community members is more the norm than the exception as a result of decreased costs and advances in computer technology and agencies (libraries) and commercial enterprises (Internet cafes) providing computing facilities. Currently, increasing numbers of individuals are using the Internet for purposes of work, seeking information and help, conducting online business/banking/shopping transactions and for entertainment. Wireless is also contributing to this expansion rise through mobile phone and Wi-Fi platforms extending its penetration beyond the home and office to the open public; for example, some local governments are providing free city-wide wireless hot-spots. Given the extent, reliance and expectation of Internet use in virtually all aspects of domestic, government and business interactions, it is only reasonable to anticipate that more and more public health and medical services will be delivered via this medium.

### **Convenience and Accessibility**

Internet therapy is convenient to deliver and is not limited to locality and time. It allows individuals to seek treatment when they may not otherwise have access to face-to-face counselling services due to time constraints, transport problems, physical disabilities, work commitments, and/or have child care problems. This applies equally to individuals living in rural, remote and metropolitan areas (including military personnel and prison inmates). One Canadian study reported that 45% of Internet users reported that they were from rural areas (Brethour, 2001). The increased use of computers indicate that more people are accessing and using computers for communication purposes and may therefore take up the option of online counselling if offered. Recent estimates indicate that 84.3% of Canadians have Internet access and in 2003 Canada ranked fourth worldwide in terms of the proportion of households who had broadband access (Internet World Stats, 2008).

Internet therapy avoids the need for scheduling and appointments (although for chat-based counselling this may still occur), enabling both therapists and clients greater flexibility in conducting session. For example, consumers at an Internet-based therapy unit based at Swinburne University, Australia, reported that the convenience of not having to leave home for treatment was an important factor when registering their interest in attending (Klein, Shandley, Austin & Nordin, 2008). This convenience may result in increased client retention and completion rates.

As Internet-based therapy can be provided from any location, online therapists may offer a greater variety of opening hours, allowing working individuals to schedule appointments after traditional working hours. This is a major advantage for those constrained by working hour commitments. At the same time, immediate assistance can be provided for those in crisis, or who may need extensive care (e.g., 24/7 online crisis counsellors).

The convenience and accessibility of Internet therapy enables clients to express feelings and thoughts when emotionally distressed, as opposed to prearranged sessions under different emotional states. Furthermore, at termination of Internet therapy, clients may be allowed to email Internet therapists as necessary and give permission to be contacted by the therapist, providing a convenient and easy form of aftercare and follow-up for professional and research purposes.

Another advantage of Internet-based interventions is that they lend themselves to a shared-care model of treatment delivery by involving general practitioners/family physicians (GPs) and/or other allied healthcare providers. Internet-based CBT self-help programs or those with minimal therapist contact may provide an appropriate adjunct to routine GP care without substantially increasing consultation times, providing that GPs are adequately trained.

### **Providing Services to Remote Areas**

Counselling in remote areas is difficult for several reasons. Firstly, limited numbers of therapists are available, their session frequency and duration are subject to demands on services, and often lack sufficient time and resources. Secondly, in remote locations individuals typically know one another and therefore are reluctant to disclose material to professionals with whom they may have social contact. Cocksedge (1989) argues that counselling is best undertaken with clear personal boundaries in a confidential and anonymous relationship by a counsellor who lives away from the locality, a difficulty for those in rural settings. Thirdly, in a remote or rural setting it may be difficult for clients to see therapists without others knowing. Finally, some areas are so remote that clients may not be able to access any counselling services on a regular basis.

Internet counselling addresses these problems by providing appropriate, private format by which individuals can access psychological services without encountering stigma experienced in local contexts. Therefore, Internet therapy offers significant benefits to geographically isolated clients by enabling treatment to be provided to those avoiding or unable to access face-to-face services.

### **Cost-Effectiveness**

Internet therapy is cheaper than traditional face-to-face therapy due to reduced costs of office space, secretarial support and related overheads thereby enabling therapists to set up less costly services resulting in the treatment of more clients. Additionally, more clients within geographical regions are able to access therapy online due to reduced costs involved with travelling to sessions. High quality and high speed Internet access and necessary technology (computers, webcams, etc) are becoming more affordable and increasingly accessible to the public through educational institutes, cafes and libraries. This reduces the potential technology-divide that limits online therapy to those who can afford the necessary technology equipment.

There is some discrepancy in reports regarding the financial cost of providing Internet therapy. While Beel and Court (2000) claim that fees quoted on psychology websites are typically less than regular face-to-face sessions, Barak (2004) claims that this is not always the case. He suggests that costs related to the purchase of technology and continuous upgrades, security measures and extensive time needed for counsellors to type (as opposed to talk) may increase the overall costs of Internet therapy. It is likely that Internet therapy involving therapist-assisted programs with minimal therapist interaction is less costly compared to Internet-based intensive and individually orientated counselling sessions; the latter direct and indirect costs are probably equivalent to traditional therapy. This may result in skilful clinicians avoiding intensive sessions in preference to face-to-face interactions on the basis of direct therapy contact and higher remuneration. As a consequence, skilled therapist may gravitate toward traditional methods while less skilled therapists and those early in their training therapists may prefer Internet therapy.

Another consideration is the question of health-care providers, regulators and insurance companies accepting Internet therapy as legitimate sessions for purposes of health rebate, and the formulae on which to calculate session duration for purposes of making claims; can clients legitimately submit claims for an email to a therapist?

Overall, preliminary research into the delivery of Internet therapy in Australia tends to support the assertion that Internet therapy is less expensive compared to face-to-face therapy (Klein, Richards, & Austin, 2006; Mihalopoulos et al, 2005), with costs estimated to be between one third and one sixth less than other psychological treatments (Crone et al., 2004). Interventions can be updated centrally (at the host site) relatively easily in response to new knowledge, client feedback or research data, avoiding costs associated with printing new handbooks or materials. Setting aside initial capital set-up costs, Internet-based interventions are potentially more cost-efficient compared to face-to-face interventions.

### **Perceived Anonymity & Disclosure**

As mentioned, the majority of problem gamblers do not engage in treatment and major barriers to seeking help include fear of stigma and feelings of pride, shame, and problem denial (Clark, et al., 2007; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000; Marotta, 2000). Email or interactive communication increases the potential for clients to

self-disclose online, particularly where sensitive or embarrassing material is addressed (Murphey & Mitchell, 1998). Research has consistently shown that the Internet has a disinhibiting effect on users and reduces social desirability (Joinson, 1998). Research also shows that both adults and children disclose higher levels of personal information sooner on a computer than face-to-face (Joinson, 2000) interactions. The Internet is a non-face-to-face environment, perceived by many users to be anonymous and non-threatening. Therefore, online services are attractive to clients who wish to remain anonymous (Grohol, 1999).

Kids Helpline statistics from Australia reveal that there is a high demand for online services and counselling emails related to topics such as suicide, sexual assault, pregnancy, family relationships, and mental health (Kids Help Line, 2000). There is some evidence to suggest those who benefit the most from online therapy are those who have experienced the negative effects of social stigma with high online participation in support groups correlated with stigmatizing health and social conditions (Davidson, Pennebaker, & Dickerson; 2000). Similarly, McKenna and Bargh (1998) found that marginalised social groups benefited when anonymous online communication shrouded the influence of physical appearance. In an exploratory study of the use of online support for problem gambling, Cooper (2004) found a correlation between higher levels of concerns about stigma and the absence of treatment utilisation. Furthermore, 'lurking' (i.e., visiting but not registering presence to other users) at a problem gambling support group website reportedly led a proportion to seek subsequent help for gambling problems including face-to-face help (Cooper, 2004). These results suggest that individuals at the precontemplation phase (Prochaska & DiClemente, 1982; 1992) may move towards the action stage after exploring the nature of helping interventions without the need to disclose personal information. It is important to note that while online support groups may offer anonymity, Internet-based therapy may require clients to disclose their real identity and location for the purposes of satisfying jurisdictional requirements and ensuring appropriate crisis care. However, the lack of face-to-face contact may still enable the benefits of perceived anonymity and increased disclosure while satisfying legal and ethical requirements of therapy.

## **Therapeutic Benefits**

### **Communication and Reflection**

Asynchronous written communication (e.g., emails) enables Internet therapy to improve therapy since both clients and therapists are able to devote more thought and clarity to written communications (Kanani & Regeher, 2003). Internet therapy provides a thread for all text-transcripts including written material (less prone to being misplaced or lost compared with hard copies), allowing clients to revise previous sessions more easily than recalling material presented in face-to-face sessions. Having the opportunity to read previous exchanges enhances a client's capacity to reflect and process interactions to augment gains made from each session. Similarly, the opportunity for clinicians to read-over client's emails is beneficial and may enhance more accurate communication, and to review sessions throughout therapy to detect any potential issues overlooked.

### Therapeutic Benefits of Writing

There is emerging evidence to support the effectiveness of narrative therapies (Murphy & Mitchell, 1998) that involve clients writing details of personal stories to achieve greater clarity and distance from overwhelming thoughts and emotions. Some evidence has been found to support the notion that the use of positive emotive words in written description of difficulties and experiences improves client outcomes (Pennebaker & Francis, 1996). Narrative therapy has been used as an intervention for problem gambling (de Jong, 2005; McGowan 2003a; 2003b). While there is currently little empirical evidence available demonstrating the efficacy of this treatment for problem gambling, client feedback has supported the benefits of online written communication is aiding changes in gambling behaviour (McGowan, 2003a).

### Comfort

Online counselling has the advantage that it may demystify counselling processes and shift perception about counsellors (Barak, 1999) in a more positive direction, that is, counsellors are readily, easily and conveniently accessible. Clients may benefit from greater flexibility and capacity for timely responses by interacting with clients from multiple locations beyond the confines of their office. This feature may foster faster rapport building resulting in increased positive outcomes.

### Ease of Communication

Online counselling allows organisations to fully meet their duty of care to clients by providing online (a) education material; (b) details of the terms and conditions of online counselling services; (c) details of qualifications of staff and their skills and areas of expertise; (d) details relating to client confidentiality; and (e) the advantages/disadvantages of online counselling. The availability of this information online provides clients with an opportunity to read and refer to this information across time and allows organisations to inform clients of their rights and responsibilities, and to retain records of having provided such material in cases of complaints (Grohol, 1999).

CBT may be easily adapted to email counselling with daily homework be set for clients delayed by circumstances in seeing counsellors (Childress, 2000). In these cases counsellors may have greater consistency and influence in changing clients' behaviour(s); there is a growing body of evidence indicating that this is the case (Carlbring, Westling, Ljungstrand, Ekselius, & Andersson 2001; Klein et al., 2006).

### **Motivation & Treatment Completion**

Given that Internet therapists and clients are physically distant from one another compared to face-to-face interventions, clients require greater motivation and self-management ability to successfully engage in and complete Internet therapy treatment (Abbott et al., 2008). However, the opportunity for self-directed pacing and attendant sense of empowerment has the capacity to increase motivation, particularly when stimulating and engaging graphics, pictures, video and audio files in online manuals, exercises and homework activities are displayed to capture interest (International Society for Mental Health Online, 2000; Manhal-Baugus, 2001). In addition, Internet therapy

treatment programs are generally well structured and guidelines are provided enabling client to understand the nature and framework of therapy (Abbott et al., 2008).

Evidence suggests an acceptable completion rate for Internet-based therapy for a variety of clinical disorders (Abbott et al., 2008). Specifically, the attrition rates of Internet therapy programs are reported to be as low as 5%, compared to 28% for information-only program, and 17% for those using print-based self-help program (Klein et al., 2006). Studies are also beginning to emerge showing that the inclusion of an Internet therapist enhances treatment outcomes with a recent meta-analysis of anxiety and depression showing that Internet interventions with some level of therapist support obtained larger treatment effect sizes than those that were purely, or primarily self-help (Spek, Nyklicke, Cuijpers, & Pop, 2007). However, it is still unknown how much therapist assistance is actually required for beneficial outcomes, and, in addition, what the predictors of completion and non-completion are.

### **Supervision & Accountability**

Internet counselling communication records can be made available to supervisors and managers within an organisation thus increasing accountability and enabling quality control of practice within an organisation. Additionally, this would assist supervision, an important aspect of ongoing therapist training and enable detailed feedback from senior therapists.

### **Research**

Internet therapy increases the ease with which treatment evaluative research can be conducted. As all sessions are transcribed electronically and questionnaires completed online, data can be readily checked for missing data, extracted in de-identified form and analysed on a regular basis to assess the continued efficacy of therapy and progress compared to sample or normative means. Within this format, treatment interventions can be efficiently assessed and modified according to the client's response and progress.

The capacity for de-identified linked data bases to be compiled allows an ideal platform for multi-site outcome evaluation studies that reduces the cost and minimizes errors associated with scoring and data entry, and rapid analysis of outcomes within and across sites.

## **PROBLEMS & ISSUES REQUIRING CONSIDERATION**

### **Financial Limitations**

While Internet therapy may be more cost effective than traditional face-to-face therapy, the financial viability of providing such a service needs to be carefully considered. In the late 1990s several mental health companies attempted to launch online therapy clinics; however, these typically offered a relatively low fee-for-service rate and did not recruit sufficient clients to sustain viability. More recent business models are revising the structure and operation of Internet clinics that require therapists to pay a monthly fee in exchange for standard tools, templates and related infrastructure to conduct Internet

therapy. Potential clients are offered the opportunity to select therapists from those available at the Internet clinic. However, it is still uncertain whether the number of potential clients makes this a financially viable option in comparison to face-to-face therapy.

Traditional therapy is open to clients with private health insurance or Medicare coverage. Although online therapy has the potential to reduce operating costs for the clinic on the one hand, its use may increase given its accessibility and convenience thereby increasing costs to insurance companies. This may impose a monetary incentive for insurers to minimize usage of this form of therapy (Skinner & Zach, 2004). Once Internet therapy is validated as an effective treatment protocol, pressure will be placed on third party providers to reimburse clients; however, until such time individuals are required to cover costs incurred.

Increasing coverage in the popular media suggests that there is some public interest in Internet therapy, but research suggests that consumers' lack of awareness continues to relegate it to a second choice (Rochlen, Beretvas, & Zach, 2004). For Internet counselling to be financially viable there needs to be increased consumer and professional awareness and consumption of Internet therapy.

In addition to the financial viability of Internet counselling, other costs must be considered. There may be significant start-up costs involved in purchasing new technology, design and implementation of necessary software and systems for encryption, secure storage of files and payment. Treatment programs must be designed and evaluated and staff must be trained in the use of Internet technology and text-based counselling. Recurrent costs include maintenance of security systems and upgrades of both software and hardware, and continual improvements/adjustments to treatment programs based on client feedback and research data. To enhance the quality of the treatment, the program should be continually evaluated, which is easier than evaluation of traditional therapy as all data is already computerised. Additionally, to maximise the benefits of Internet therapy, staff may be required to be available outside traditional business hours, which may increase salary costs. While Internet therapy certainly has the potential to be more cost-effective than traditional therapy, the initial and ongoing costs may offset gains.

### **Potential Technology Impediments**

Individuals with limited computer experience and knowledge may be less suited to online therapy (Suler, 2001). With regards to this issue, it is a prerequisite that therapists ensure that clients can regularly access a computer and the Internet and, if required, technical assistance (Mallen, Vogel, & Rochlen, 2005; Suler, 2001). In early trials of Panic Online (an Internet-based therapy provided by the Etherapy Unit, Swinburne University) a proportion of participants reported experiencing technology difficulties, primarily due to lack of skills; however, adequate support from project managers and/or allocated Internet therapists, overcame this problem (Richards, Klein, & Carlbring, 2003). Reportedly, issues relating to a lack of computer skills, experience, and anxiety have become less common over the past five years (Abbot et al., 2008). Conversely, therapists must have appropriate expertise and knowledge to manage technical difficulties in order to offer

assistance to clients. Some older therapists less familiar with Internet and technology may be resistant to change and/or are not suited to Internet therapy.

### **Literacy Issues**

An important issue is how well the consumer is able to read and write in text-based communications, especially those from a differing cultural background. It is advisable that the written material should be set to a maximum reading age of grade eight (14 years) as a means to increase readability and comprehension (Abbott et al., 2008). In contrast, successful Internet therapy treatment outcome (for Panic Disorder) was not found to be related to educational level on any post-assessment variable (Richards et al., 2003), which may indicate the success of this program in tailoring written material to an appropriate education level to maximise benefits for all clients.

### **Professional Boundaries**

Due to the immediacy, accessibility and convenience of the Internet, there is a potential for clients to abuse client-counsellor relationships through numerous, inappropriate and constant emails. Counsellors may be exposed to harassment with traditional lines and boundaries of therapeutic relationships becoming easily blurred. As therapy can be conducted from multiple locations, clients accessing the Internet from Internet cafes may not concentrate, may be distracted, or may not take the therapy seriously.

Organisations and therapists that provide Internet-based therapy should develop guidelines and provide information and expectations for client conduct in seeking online counselling on websites. Therapeutic boundaries expectations should be discussed at the commencement of therapy to ensure that clients are ready for therapy and understands what is required of them. Any misconceptions should be clarified, similar to that that takes place in face-to-face relationships. Therapists should meet client's needs by ensuring they reply to emails within a previously specified timeframe (e.g., at a set time each week or within 24-72 hours depending on the mode of therapy).

### **Duty of Care and Organisational Safety**

Organisations may not have adequate human and financial resources or skills to deliver online counselling leading to the risk of inadequate or inappropriate responses. In addition, potential obstacles may arise from technological delays and malfunctions that inhibit timely client/counsellor communication. Internal guidelines, policies and procedures and a Code of Ethics and Standards of Practice should be developed to set clear boundaries regarding online counselling services and to protect counsellors and the organisation from legal obligations. Furthermore, online counselling as a form of service delivery can be added to insurance policies and disclaimers can be incorporated into web sites to reduce liability. Additionally, the development of policy and procedures and a cultural shift is required within the organisation to assist those counsellors who are either resistant to online counselling or not computer literate.

### **Miscommunication**

Text-based counselling poses the potential problem of miscommunication due to the lack of non-verbal cues and possibility that the meaning of written words is misinterpreted

(Abbott et al., 2008; Australian Psychological Society, 2004; Barak, 1999; Childress, 2000; Rich, 1999). Text-based communication can be harsher than verbal communication, in part because the non-verbal cues, such as tone of voice and body language, are missing from the communication (Hunt, 2002). Such miscommunications or misinterpretation of text may result in the premature termination of counselling and negative or traumatic experience of counselling. The adverse outcome is that clients become reluctant to pursue further treatment with any other therapist or modality.

To address these issues, staff training in text-based communication for counselling represents a critical component of online service delivery, together with the provision of adequate supervision for counsellors. Both therapists and clients need to discuss and acknowledge the potential for miscommunication and implement steps to minimize its potential and to establish procedures to deal with it should the need arise (Abbott et al., 2008). Clinicians should respond to emails promptly (within 24-72 hours) to ensure speedy resolution of such misunderstandings. On a positive note, in practical experience, serious misunderstandings between Internet therapists and clients are reported to be relatively rare (Abbott et al., 2008). Steps taken to avoid miscommunications and increase the value of written communication, for example by:

- Carefully using the richness of language and especially simile and metaphor (Bayne & Thompson, 2000).
- Compensating for the lack of non-verbal cues by bracketing emotional content behind the words e.g., “I haven't heard from you in a month and I'm wondering if you're okay. (Feeling concerned, hoping you're okay)” (Collie, Mitchell, & Murphy, 2000).
- Use of emoticons, semi-pictorial symbols for specific emotions, reactions, or facial expressions, and other techniques specific to online communication, e.g., acronyms ROFL for ‘Rolling On Floor Laughing’ or ‘:(’, for crying.
- Internet-based video counselling may also provide contextual information in conversation and can influence interpretation of meaning in communication (Childress, 2000).

### **Social Justice**

There exists an ethical concern that persons of lower socioeconomic status will be denied benefits of Internet therapy because of affordability (Childress & Asamen, 1998; Oravec, 2000). This may be particularly true for problem gambling interventions as problem gamblers are often unable to afford or reluctant (that is, exhibit a preference to allocate money to maintain gambling habits) to purchase technology. Furthermore, some clients may not be skilled in the use of computer technology and/or may be found by counsellors to be ‘not suitable’ for online counselling and therefore will be unable to benefit from Internet therapy raising the ethical issue of equity in access to health resources. This may include individuals who are illiterate, elderly, or suffering certain medical conditions such as dyslexia, mental illness (paranoid schizophrenia), and/or cultural groups, for example, Indigenous people, people from non-English speaking backgrounds (Hunt, 2002).

In response to these issues, while it is possible that some people will be unable to take advantage of Internet therapy, as previously mentioned, potential clients living in remote areas or people who have transport and child care issues so cannot access face-to-face counselling would benefit from the provision of online services. Furthermore, free and low-cost Internet is increasingly available in libraries, schools, and other public facilities.

Email and chat services are relatively easy to use and the young appear to be particularly technology savvy, which may eventually reduce further any difficulties with using technology. In terms of client suitability, a standard registration form should be developed to seek details of a client, including age and cultural background. Other counselling options including face-to-face therapy should be made available for those who are not suitable for, or prefer not to be involved with Internet therapy.

### **Cultural Sensitivities**

It is essential for therapists to be sensitive to the culture of their client, which requires knowledge and understanding of the client's cultural background. While this is also an important element of face-to-face therapy, Internet therapy also removes visual cues, consists of text-based communication and allows therapists to treat clients from any geographic location. Therefore, special attention should be allocated to the cultural sensitivities in written text since negative reactions to statements may not be readily identified by therapists. Therapists should include in their assessment procedures questions about a client's cultural background to assist this process and online client guides should suggest that potential clients disclose their cultural background to potential therapists to minimise any potential misunderstandings and inform their therapist immediately when misunderstandings occur.

## **ETHICAL ISSUES**

### **Confidentiality**

Client privacy and confidentiality is an important concern, as it is in face-to-face therapy, but additional concerns may apply in the case of Internet therapy. Potential violations to the privacy of online therapy may occur due to breaches by hackers, viruses and other persons (e.g., spouses, parents, employers) intentionally or unintentionally gaining access to, downloading, or corrupting online counselling session records. Care must be taken to ensure that emails are not forwarded or copied to the wrong recipient (Childress, 2000; Grohol, 1999). As with all case and therapy notes, therapists should be mindful that these may be subpoenaed.

As with all forms of therapy, clients should be informed of the limits of confidentiality and other ethical and legal requirements before commencing Internet therapy. Encrypted messages can be used to prevent hackers from accessing online counselling sessions and passwords between client and counsellor can be used to maximize protection of client data and confidentiality. Clients should consider who may have access to their emails including family members, employers who may have a legal right to access and monitor employee emails, and email administrators/ISP providers. Clients using certain email ISP

providers should be aware that deleted from files may nevertheless be retained on the primary server and open to access by the ISP administrator. Accordingly, clients can be informed about policies and procedures regarding record keeping and should be given advice to assist them in managing their own emails and secure file storage.

Professional associations should develop policy and procedure regarding Internet counselling services to guide Eclinics and therapists who wish to provide online therapy. For example, the Canadian Psychological Association and the Ontario College of Psychologists should include online counselling services in their Code of Ethics as have others including the American Counselling Association (1999), the Australian Psychological Society (2004); the British Association for Counselling (1999), and the National Board for Certified Counsellors (2000).

### **Informed Consent**

It is vital to provide sufficient information for consumers to be able to provide their informed consent to take part in Internet therapy (Abbott et al., 2008). As such, therapists should disclose details of their qualifications, professional affiliations, full name and additional contact details including a physical address, contact phone number and location of the Internet site. Clients should be informed prior to the commencement of Internet therapy about the potential risks and benefits of online therapy, the limits of confidentiality, possible safeguards, and what they can expect from the therapy and therapist (Australian Psychological Society, 2004; Suler, 2001).

Although an advantage of Internet therapy is that it is more anonymous than face-to-face therapy, there is also a potential for consumers to misrepresent themselves. For example, a minor may incorrectly report their age, making it difficult to know whether parental consent is required. This may be overcome with initial assessments conducted over the telephone and/or proof of age, location and identity.

In some ways, however, the Internet offers advantages in developing an informed consent process (Childress, 2000). Professional web pages allow for multi-faceted and multi-layered discussion of relevant issues which remain constantly available on the Internet for clients to review. Web pages can address issues such as the potential risks involved with online treatment and the theoretical underpinnings of the treatment. The discussion of informed consent through email also allows for a documented record of the informed consent process.

### **Unprofessional Behaviours**

Anybody can host a website and increasingly, consumer-authored sites appear credible in terms of their content and professional appearance. The lack of current regulatory procedures concerning the provision of Internet therapy means that there exists the risk of unprofessional, unlicensed and untrained therapists/services being offered (Childress, 2000; Barak, 1999). Many jurisdictions do not have quality assurance mechanisms to ensure that those claiming certain levels of competency are indeed practicing or competent at that level. A further risk is the ability of sites to shut down with minimal notice resulting in the loss of therapist contact leaving clients without support.

Unscrupulous Internet gambling operators may also use embedded phrases to direct users searching for “problem gambling, etc” to an online gambling site. By advertising sites as containing links to problem gambling information, online gambling operators may lead problem gamblers through a series of pages and pop-up screens before reaching the problem gambling information and links provided.

However, while individuals appear to be highly engaged in seeking health information online, there also appears to be an understanding that the Internet is not a cure-all. Some 60% of Internet users in the U.S. agreed with the following statement: “The Internet is full of misinformation and propaganda that too many voters believe is accurate” (Pew Internet & American Life Project, 2008a). A December 2007 study found that medical professionals were the dominant source for people with urgent health questions, which is not the case for topics extending to education, taxes, Medicare, or changing job status (Pew Internet & American Life Project, 2008a). These results suggest that individuals have some insight into the unreliability of Internet sites and would respond to information directing them to legitimate sites recommended by authorized or credible organisations. There is also evidence to suggest that the majority of individuals seeking help online for health-related issues find this significantly helpful. Only 3% of health seekers say they or someone they know has been seriously harmed by following the advice or information found online (Pew Internet & American Life Project, 2008a).

Credible organisations can reduce the risk of individuals using unprofessional online therapy by providing Internet therapy themselves, or providing regularly updated links to approved websites. Furthermore, organisations can provide information to assist individuals in deciding whether Internet therapy is suitable for them and if so, how to find a suitable online counsellor. Professional organisations need to recognise the dishonest behaviour of unlicensed and unqualified treatment providers and unscrupulous behaviour of online gambling sites and take action against these where possible. Professional counsellors need to advise potential clients on how to evaluate credentials of online counsellors or links to verify qualifications and registration with professional bodies. In addition, local licensing boards should make it easy for Internet counsellors to provide a direct link to the Board’s website enabling them to verify the credentials of counsellors and the status and reputation of known websites (Alleman, 2002). This necessitates the need to develop routine ways for grievance boards to investigate and evaluate websites that purport to offer therapy or counselling.

### **Effectiveness of Internet Therapy**

There are few rigorous evaluation studies determining the effectiveness of Internet therapy. However, there is emerging support for its effectiveness compared to waitlists and face-to-face groups, and some support for online therapy for problem gambling. These will be discussed in the following section.

It is important to note that Internet therapy is not suitable for all clients or clinicians. Some client’s problems may be too severe to be dealt with over the Internet. Therefore, it is essential that clients are screened carefully before commencing online therapy to ensure this mode of therapy is beneficial and does not expose them to risk of harm.

Individuals who may not be suitable for Internet therapy include those with psychiatric disorders in which they experience distortions of reality, suicidal ideation, are currently a victim of violence or sexual abuse, or are experiencing high rates of comorbid psychiatric disturbances (Australian Psychological Society, 2004; Mallen et al., 2005; Manhal-Baugus, 2001; Rochlen, Zach, & Speyer, 2004; Suler, 2001). Established centres that provide Internet therapy manage client suitability by conducting a 90 minute structured telephone interview for each potential client prior to the commencement of Internet therapy (Andersson et al., 2008; Klein et al., 2006).

One of the most important aspects online therapists should take into consideration is the criteria determining when to terminate or advise against the use Internet therapy with particular clients, or to recommend a shift to face-to-face sessions (Oravec, 2000). Online counsellors should develop sets of 'warning signs' including indications of increasing social isolation, delusional ideation, withdrawal from reality and computer dependence. Often nuances and seemingly minor problems can expand into major misunderstandings online (Oravec, 1996; Turkle, 1995). Clients who have been negatively affected by such misunderstandings may be best served by shifting to face-to-face interaction, at least for a period of time.

There are further limitations of Internet therapy in comparison to face-to-face therapy including greater difficulty in establishing trust and client rapport and a lack of non-verbal cues often necessary in therapy, particularly when clients have difficulty expressing thoughts and emotions. The lack of interpersonal interaction may limit beneficial effects of face-to-face therapy in assisting individuals trust others and communicate in an open fashion. Individuals may "hide behind the Internet". Non-verbal cues are extremely important in therapy as clients often have difficulty expressing emotions and directly communicating problems and cognitions. Clients may avoid negative issues more easily online than in face-to-face counselling. Furthermore, the convenience of online therapy should be viewed with caution so that clients do not come to rely on therapists and instead develop their own support mechanisms. ,

As evidence suggests below, these difficulties are not insurmountable and if therapists are mindful and effective programs are created, evaluated and routinely adjusted to suit clients needs, Internet therapy may be beneficial for a proportion of clients.

### **Technological Failures**

Technology is always accompanied by the risk of error or failures. This may be particularly true in remote areas where problems with transmission and temporary service disruptions from Internet service providers may occur. However, these problems are becoming less frequent and even rural areas are largely able to access the Internet. Different hardware will have its own potential problems that the therapists will need to be aware of (Beel & Court, 2000). For example, data loss (e.g., client records) through hardware failure is a possibility, impacting on the ethical and legal requirements to maintain client records for several years after consultation. This should be managed by creating password protected back-up copies of client files. Clients should be instructed on

how to manage a temporary disruption to services for technical reasons and be given alternative contact details to call therapists and continue sessions.

### **Crisis Situations**

Online therapy is faced with similar difficulties as telephone therapy in that if clients are geographically remote, or their location unknown, it is difficult to protect them in emergency situations. For example, if a therapist does not know the identity and location of their client it is impossible to provide emergency care under conditions of suicidality or threat of harm to others. Such issues can be solved by appropriate intake procedures that establish and verify a client's identity and location, and informing clients that therapists are legally and ethically bound to intervene if they suspect a risk of harm to the client or others. For example, at the Etherapy Unit, it is mandatory that the contact details of participants and their general practitioner are provided. In instances where a participant failed to respond to Internet therapists emails, the therapist would then telephone the client to ensure that they were safe. During trials of Internet therapy, this procedure was necessitated in approximately 5% of cases (Abbott et al., 2008).

## **LEGAL ISSUES**

In addition to ethical considerations, there are a variety of legal issues that must be considered in the provision of Internet therapy.

### **Session Transparency**

Legal limitations to client confidentiality include the possibility of text-based counselling sessions being subpoenaed. The level of detail provided in contrast to case notes in face-to-face counselling sessions could leave organisations/practitioners vulnerable to prosecution. This could result in an increase in cost of professional indemnity insurance. However, this problem may not be greater than the same issue regarding case notes. The main issue is about whether or not case notes/email transcripts are written in a factual, professional, ethical manner, so that if email transcripts are subpoenaed individuals and organisations are not sued or subject to criticism. Adequate training in case note writing and record keeping as well as supervision of practice regarding Internet counselling can prevent criticism from courts or legal liability.

### **Lack of Regulatory Guidelines**

The Alberta College of Psychologists (2000) outlined several reasons why many governments and organisations have not developed guidelines for psychologists wishing to practice on the Internet. The concerns raised are that (a) the Internet is evolving rapidly, therefore any guidelines developed would be rapidly obsolete; (b) given the borderless nature of the Internet, the very difficult issues of jurisdiction has not yet been resolved; and (c) it is not yet clear whether the Internet provides a sufficient platform for safe and effective practice. Until jurisdictions are able to regulate Internet therapy and appropriate organisation develop and adopt appropriate guidelines it is unlikely that Internet therapy will become accepted as an appropriate form of therapy.

### **Jurisdictional Issues**

Online counselling can be problematic if clients outside the jurisdiction seek to use the service. The difficulty lies in counsellors providing online services across national and international borders where laws and regulations vary. For example, Quebec has a fixed age of consent to treatment and confidentiality, which is 14 years. Below this age, parental or guardian consent is required. In New Brunswick, the age of consent is 16 years and in all other Canadian provinces, the capacity to accept or refuse treatment depends on the adolescent's ability to understand their condition and the options available to them (Canadian Medical Protective Association, 1996).

To manage the issue of jurisdiction and licensing, the American Counseling Association (ACA; 1999) code of ethics for Internet counselling states that "counselors ... do not provide on-line counseling services to clients located in states in which the counselors are not licensed" (ACA, 1999, p.4). This restriction undermines a major advantage of operating online for both clients and practitioners, that is, the ability to increase the accessibility of therapy, particularly for clients who are geographically remote and/or unable to attend face-to-face therapist sessions. Furthermore, this restriction may be difficult to enforce. For example, a survey of U.S. State Attorneys general shows little consistency on whether states claim regulatory authority over practitioners residing outside the state's boundaries (Koocher & Morray, 2000). The situation is magnified in respect to international jurisdictions where qualifications and licensing requirements vary considerably. What recourse does a client in the United States of America where clinicians are licensed have in making a claim of incompetence against an online therapist operating out of a South East Asian or African country?

In contrast to the American Counseling Association regulations, the Alberta College of Psychologists (2000) hold that clients can make complaints in the jurisdiction they reside in if the standards of conduct for that jurisdiction have been violated. The complaint is then forwarded for investigation and resolution to the jurisdiction where the psychologist is licensed. Thus, if an Alberta psychologist is treating a New York client and violates the New York's code of professional conduct of psychologist, the College of Alberta Psychologists must deal with that psychologist on the matter of misconduct. The psychologist could be sanctioned in Alberta for their conduct with the client at the computer in New York as it relates to a violation of the New York code. Similarly, the rapidly growing International Society for Mental Health Online (ISMHO) has published its own set of guidelines for practice, which states that "the counsellor should meet any necessary requirements, for example licensure, to provide mental health services where he or she is located" (ISMHO, 2000, p.3).

This solution still poses several problems as: (a) it requires all psychologists practicing online to be familiar with codes of conduct in all jurisdictions they accept clients from; (b) clients may not disclose, or be untruthful about their location; and (c) both the psychologists' and clients' jurisdiction must have a code of conduct relating to the practice of Internet psychology. The National Board for Certified Counselors (NBCC) code of ethics for Internet therapy follows up on these issues by requiring its members to have links on their Web sites to their own licensing entities and by requiring counsellors

to obtain contact information for at least one on-call counsellor near the client's location (NBCC, 2001). The Canadian Psychological Association deals with the issue of jurisdiction by requiring psychologists practicing online to familiarise themselves with and honour the relevant laws and regulations of all jurisdictions in which they provide therapy. Additionally, if required by the jurisdiction in which their client resides, psychologists must obtain additional certification. Problems of course reside where online therapists are located in unregulated overseas countries.

## **CURRENT ETHICS CODES**

### **National Board for Certified Counselors (NBCC)**

The NBCC was the first organisation to adopt standards for online counselling in September 1997. The board stated that the "goal in creating standards for counseling over the Internet is to curtail unprofessional growth of the technique" (Morrissey, 1997, p.2,) and to "give counselors... the direction needed to minimize risk and danger to WebCounselor and WebClient alike" (Bloom, 1997, p.2, as cited by Shaw & Shaw, 2006). The NBCC defined "WebCounseling" as "the practice of professional counseling and information delivery that occurs when client(s) and counselor are in separate or remote locations and utilize electronic means to communicate over the Internet". Included in the NBCC standards are guidelines for the counselling relationship: (a) providing a local backup counsellor in the client's area (along with local hotline numbers), (b) verifying identity of a consenting adult when parental consent is required, (c) explaining how often e-mails are checked by the counsellor, (d) providing links to licensing and certification boards for verification of credentials, and (e) alerting clients to the possibility of misunderstandings due to a lack of visual cues. The NBCC guidelines also specifically state that the counsellor must disclose the following topics as being inappropriate for Internet therapy: (a) sexual abuse as a primary issue, (b) violent relationships, (c) eating disorders, and (d) psychiatric disorders involving distortions of reality.

The NBCC standards were updated in November 2001 (see Appendix B). Two new guidelines, added at that time, instructed counsellors to determine if the client is a minor and to provide alternative means of communication if computer technology fails.

### **American Counseling Association (ACA)**

Following the NBCC's release of its WebCounseling Standards, Courtland Lee, the then president of ACA, applauded NBCC for establishing ethics guidelines for Internet counselling (Morrissey, 1997, as cited by Shaw & Shaw, 2006). Lee (1998, cited by Shaw & Shaw, 2006) and maintained that "WebCounseling is inevitable because as long as the technology is there, people are going to use it" (p. 2), noting that similar discussions surrounded the introduction of telephone counselling years ago. Lee stated that it was crucial that ACA also develop ethics standards, noting that the "NBCC gave us a good foundation to do that" (Lee, 1998, p. 2, cited by Shaw & Shaw, 2006).

In October of 1999, ACA's Governing Council approved the Ethics Standards for Internet Online Counseling. These guidelines "establish appropriate standards for the use of electronic communications over the Internet to provide online counseling services, and should be used only in conjunction with the *ACA Code of Ethics and Standards of Practice*" (ACA, 1999, p.1). The ACA standards impose stricter standards on online counsellors than any other guidelines (Shaw & Shaw, 2006). The ACA (1999) standards include most of the NBCC standards and add the following: Counsellors must inform clients that counsellors (a) cannot guarantee confidentiality over the Internet, (b) must provide counselling only through secure Web sites or via encrypted e-mail, (c) must provide background information on themselves (education, licensing, certification, and state of practice), (d) must practice within areas of competence, (e) must obtain means of contacting the client in an emergency, (f) must require clients to execute a waiver that includes the limits of ensuring confidentiality over the Internet, (g) must develop an appropriate intake procedure, (h) must provide referrals for clients presenting inappropriate problems for online services, and (i) must provide clients an alternative means of contact for backup purposes.

### **International Society for Mental Health Online (ISMHO)**

The ISMHO was formed in 1997 to "promote the understanding, use and development of online communication, information and technology for the international mental health community" (ISMHO, 2000, p. 1). The ISMHO established "Suggested Principles for the Online Provision of Mental Health Services" (ISMHO, 2000, p. 1). These standards are similar to NBCC and ACA standards; however, they are "suggested" rather than required practices for members. The ISMHO principles echo many of the recommendations first listed by NBCC and ACA, but are not as extensive. The ISMHO provides peer support and insightful discussion as mental health professionals seek responsible ways to use the Internet to provide therapy. The ISMHO provides a public discussion forum, member benefits and sponsors a clinical case study group that provides valuable insights to new clinical issues and intervention formats developing on the Internet.

### **Canadian Psychological Association (CPA)**

Draft guidelines were developed by the CPA Committee on Ethics in June 2006 regarding ethical guidelines for psychologists providing psychological services via electronic media. The guidelines were developed in response to the increasing practice of providing Internet services to clients and are based on the existing ethical principles and values of the CPA, but are particular to the unique nature of Internet therapy. The guidelines include:

- *Respect for Dignity of Persons*
  - Where capacity to consent may be an issue, in-person contracting sessions must be held.
  - Psychologists educate themselves regarding current practices and security devices for electronic communications, and use those systems and practices that are reasonably available, and that best protect their clients' privacy.
- *Responsible Caring*
  - Psychologists keep up to date with the e-service literature, including research literature regarding the efficacy and effectiveness of services using electronic

- media, and take this literature into consideration when deciding what services to provide to which clients, with what methods, and under which circumstances.
- Psychologists ensure that prospective clients for e-services receive an adequate assessment of their needs. If the type of service being offered requires in-person assessment, psychologists provide such assessment or arrange for another health care provider to conduct the assessment prior to beginning e-services.
  - Prior to beginning e-service, the psychologist obtains from the client the name and phone number(s) of someone for the psychologist to contact in an emergency.
  - *Integrity in Relationships & Responsibility to Society*
  - Psychologists inform themselves of jurisdictional requirements regarding licensure or certification, and are licensed or certified in any jurisdiction that requires licensure or certification of psychologists providing e-services to persons who reside in that jurisdiction. This may include being licensed or certified both in a client's home jurisdiction, as well as being licensed or certified in the psychologist's own home jurisdiction.
  - Psychologists familiarize themselves with and honour the relevant laws and regulations of all jurisdictions to which they provide e-services. This includes such matters as age of consent or definitions of capacity to consent, and requirements for mandatory reporting.

The CPA Committee on Ethics are currently revising their guidelines and have stated that the next draft is expected to be completed and ready for consultation by the end of 2008. To the authors' knowledge this has yet to occur.

### **Other Associations**

The American Psychological Association (APA) released a statement in 1997 called "APA Statement on Services by Telephone, Teleconferencing, and Internet." The statement reads, in part, "the Ethics Code is not specific with regard to . . . any electronically provided services as such and has no rules prohibiting such services" (p. 1). The statement then urges any psychologists who are using this technology to follow the existing APA Ethics Code and licensure board rules for any services they provide. The statement does not provide specific guidance for Internet counselling.

In February 2009, the British Association for Counselling and Psychotherapy (BACP) formally accepted online counselling via email, forums and chat. Applications that include online counselling will need to show (a) that the activity was contracted counselling rather than any other activity involving the use of communication skills and, (b) that they have undergone some specialist training in online therapy and are competent to work within this specialised area. Online therapy is not recommended for novice or inexperienced practitioners or those in training without focused ongoing support and guidance from expert specialists in the field. These guidelines will continue to be updated as the field develops.

## COMPARISON BETWEEN INTERNET & FACE-TO-FACE THERAPY

An important consideration regarding Internet therapy is whether the same theories of therapeutic change can be applied to Internet therapy as for face-to-face therapy (Manhal-Baugus, 2001). The two treatment modalities share several commonalities including the provision of structured, evidence-based treatment information and therapist guidance and support to increase client understanding and motivation to complete required homework tasks. However, delivery methods vary on other important elements, largely, the lack of “real-time” verbal dialogue and visual/non-verbal cues inherent in face-to-face therapy.

Although further research is required, several studies have examined Internet therapy in comparison to face-to-face therapy for various clinical and non-clinical issues and found support for a minimal-therapist contact Internet intervention. In a direct comparison study, Internet-based CBT for panic disorder and agoraphobia was compared to face-to-face CBT with 86 patients randomly allocated between the two treatments (Kiroopoulos et al., 2008). Effects of the Internet-based program were found to be comparable to those of face-to-face CBT. Both interventions produced significant reductions in panic disorder and agoraphobia clinician severity ratings, self-reported panic disorder severity and panic attack frequency, measures of depression, anxiety, stress and panic related cognitions, and displayed improvements in quality of life. Participants rated both treatments as equally credible and satisfying. However, participants in the face-to-face CBT group cited higher enjoyment with communicating with their therapist and therapists’ ratings for compliance to treatment and understanding of the CBT material was higher in the face-to-face CBT treatment group. In comparison, the online intervention required significantly less (35%) therapist time than the face-to-face CBT condition. Further research using Internet therapy may need to investigate the impacts of closer monitoring of the provision of treatment to ensure compliance to the treatment protocol and understanding of the online modules. There was no difference in attrition rates for online and face-to-face treatment.

These results are similar to those of Carlbring and colleagues (2005) who found that an Internet-administered self-help plus minimal therapist contact via email therapy program was as efficacious as 10 sessions of manualised individual face-to-face CBT in the treatment of panic disorder. Both programs in Carlbring et al.’s study (2005) reduced bodily sensations associated with the arousal accompanying anxiety, anticipatory and catastrophic thoughts, agoraphobic avoidance, severity of anxiety symptoms, and depression. Similarly, Cohen and Kerr (1998) found no difference in the effectiveness of computer-mediated and face-to-face counselling when treating clients suffering from excessive anxiety. In support of the therapeutic alliance that can be gained during Internet therapy, their randomised outcome study demonstrated no difference in the way client’s rated their counsellors on expertness, attractiveness, or trustworthiness.

### **Communication and Affect**

A central feature of Internet therapy is the modes of communication, which are almost entirely text-based. This is cited as both an advantage (enabling greater care when

choosing words and opportunities for reflection) and a disadvantage (creating potential for miscommunication and lost insights from nonverbal cues). Although further research is required, it is possible that Internet therapy compensates for the loss of direct contact by taking advantage of several other features (Abbot et al., 2008). While face-to-face treatment is verbal and immediate, Internet therapy communications are commonly textual and delayed, producing different treatment learning experiences. The main features of Internet therapy involve clients communicating their experiences, asking and responding to Internet therapist questions in textual form and the associated recursive nature of engaging in this type of a task. Clients are also able to revisit all the treatment communication from their Internet therapist in their own time, which is thought to reinforce treatment information and learning more readily than by exposure to “once off” verbal exchanges with face-to-face therapists. In addition, clients have more frequent and immediate contact with their therapists via email enabling queries to be answered without having to wait until the next face-to-face session. These features provide clients with greater opportunities to learn and reflect over the treatment information, via both the Internet therapy emails and the web-based treatment program. This also stimulated a higher level of cognitive functioning, which enhanced treatment learning (Abbott et al., 2008). Further research may show that the features of Internet therapy may promote effective treatment learning and successful behavioural change.

Some researchers have suggested that when humans are deprived of traditional nonverbal cues through one sensory source, they experience increased sensitivity for other sources of information (Rice & Love, 1987), such as speed of response and words chosen for text-based communication. Bradac, Bowers, and Courtright (1970) identified variables in language intensity, content immediacy, and lexical variation not dependant on face-to-face that make substantial impact on a communicator’s perceived competence, affect and anxiety. The types of words people use and the way they put them together in text can communicate a great deal about how they feel even when they cannot hear or see the person with whom they are directly communicating. In addition to words used, in Internet-based communications colours, caps, emoticons, repeated letters, fonts, sizes, typefaces, spelling, symbols, punctuation, and spacing between words and lines can all be used to help convey the speaker’s feelings. It has been argued that computer-mediated communication may allow levels of affect to exceed those of face-to-face situations (Walther, 1992), which may be assisted by the disinhibiting effect of Internet-based communication (Suler, 2001).

Clients can manipulate cues to mislead if they do not want (or are unable) to communicate honestly. This would likely make it easier to lie to a therapist in Internet counselling as opposed to face-to-face sessions. However, face-to-face therapy also depends on client honesty and if a client is genuinely seeking help and willing to invest the time (and possibly money), there is little to be gained from intentional dishonesty (Alleman, 2002). This is an important factor to consider if counselling is mandatory, for example to comply with court sanctions. In such cases Internet therapy may not be appropriate as individuals are less accountable for their actions or inaction.

### **Attrition**

Further research is needed to investigate attrition rates of Internet therapy; however, high participant drop out rates (30%) have been reported in Internet-based interventions (e.g., Andersson, Stromgren, Strom, & Lyttkens, 2002). Nonetheless, with the accumulation of research in this field, recent research suggests that drop out rates are declining, with controlled trials revealing drop out rates well under 20% (Klein et al., 2006). One group of therapists reported that the use of scheduled follow-up calls at the beginning of treatment greatly reduced drop-out rates, making them comparable with face-to-face therapy (Andersson et al., 2008). However, others have had more problems with this, for example an online intervention for depression and anxiety (*MoodGYM*) reported high attrition rates (90%) (Christensen, Griffiths, Groves, & Korten, 2006; Christensen, Griffiths, Mackinnon et al., 2006). However, these results were analysed based on the number of visitors to the site who successfully continued into the treatment program and reflect both the increased accessibility of the site for potential clients to investigate and “try out” therapy, and the low barriers to enter treatment without high levels of commitment. More research is required to investigate the differences between clients who drop out because they are dissatisfied with the intervention and those who had low levels of commitment and little expectations of being helped.

Preliminary investigations have been conducted to identify factors affecting attrition in Internet-based therapy for Panic Disorder and for reducing psychological risk factors for cardiovascular disease (conducted by the Etherapy Unit; Klein et al., 2006). Findings suggest that amongst clients of Internet therapy certain factors, such as high stress levels, are related to attrition; and drop out rates appear to be lowest when responsive and relatively prompt therapist assistance is provided (Richards et al., 2003). Receptive contact with therapists therefore appears to be particularly significant. Other investigations suggest that one of the most common reasons for not completing all Internet-based treatment modules is that participants lack time or enrol in the program without careful consideration of their stage of readiness and motivation (Andersson et al., 2008; Schneider, Walter, & O’Donnell, 1990). In an attempt to increase completion rates for a Swedish online problem gambling treatment, after the designated eight-week time frame during which clients were expected to complete one work module per week, all modules were opened for clients to access for a period of six months (Carlbring & Smit, 2008). This resulted in treatment completion rates being increased from 50% at the end of eight weeks, to 68% after six months. The effectiveness of this practice may be dependent on the individual client based on the modules that participants do complete and the extent to which they do so. Other options to decrease attrition rates may include increased therapist support (either by email or phone) and inclusion of motivational enhancement exercises in treatment protocol

### **Treatment Credibility, Client Satisfaction**

Other factors involved in participant compliance with Internet-based interventions may include users’ perceptions of the treatment’s credibility and their satisfaction with the treatment. Establishing treatment credibility is an important part of therapy, especially at the initial stages. Treatment credibility of Internet-based treatment has been established (e.g., Klein et al., 2006) although more research is required in this area. One central

hindrance to the lack of acceptance of Internet therapy may be a lack of familiarity with this form of intervention. Rochlen and colleagues (2004) found that respondents (university undergraduate students) expressed more favourable evaluations of face-to-face than online counselling, however, none of the participants had ever engaged in Internet therapy.

In a study designed to investigate the impact of exposure to online therapy on attitudes, participants (undergraduate students) were exposed to audio tapes of face-to-face therapy sessions or transcripts of online sessions (Rochlen, Land, & Wong, 2004). In the online condition the scenarios were viewed on computers and designed to simulate the experience of participating in a real-time Internet text chat session. There was generally a positive impact of participation in the study on attitudes towards online counselling. Results found increases in reported levels of value of online counselling and decreases in online counselling discomfort. These findings are consistent with past studies demonstrating that providing men (who are traditionally less likely to seek therapy) with informative portrayals of psychotherapy can positively influence their opinions, attitudes, and expectations about various help-seeking services (Blazina & Marks, 2001; Gonzales, Tinsley, & Kreuder, 2002; Rochlen, Blazina, & Raghunathan, 2002).

Familiarity and knowledge about the process of Internet therapy appears to increase positive attitudes towards this mode of therapy. A study by Mallen, Day, and Green (2003) found that as online experience increased, participants reported a greater amount of closeness in synchronous-chat conversational dyads. This study found that familiarity with online communication was related to feeling comfortable with technology and understanding the nuances in its rate, presentation, style, and idiosyncrasies. Supporting these findings, responses to an informal survey conducted by *Metanoia*, a nonprofit clearing house for mental health websites, demonstrated that 90% of online clients who participated felt Internet therapy had helped them (Metanoia, 2001b as cited in Alleman, 2002). Many also indicated they would not initially have sought face-to-face counselling although the majority (65%) of these online clients later went on to use face-to-face counselling. Although these results are not rigorously scientific, they are important indicators to support the credibility of Internet counselling and client satisfaction.

### **Therapeutic Alliance**

Several studies have evaluated the session impact and client-therapist alliance of exchanges between clients and therapists engaged in Internet as compared to face-to-face therapy. Mixed results were obtained. Leibert, Archer, Munson and York (2006) found clients established weaker working alliances when working with counsellors online compared to a sample of face-to-face clients. Nonetheless, clients qualitatively reported experiencing greater ease self-disclosing with Internet mental health compared to face-to-face counsellors, particularly in the beginning stages of therapy. Conversely, Cohen and Kerr (1998) examined a single meeting between face-to-face therapy and text chat Internet therapy for anxiety with 24 undergraduate student participants. The only difference found between the two modes of therapy were higher scores for post-session arousal following face-to-face sessions. In a subsequent study, Internet therapy clients

(N=40) indicated a greater working alliance with their therapist than face-to-face therapy clients (Cook & Doyle, 2002).

To evaluate the effectiveness of Panic Online, an Internet-based CBT treatment program, randomised, controlled trials compared the online intervention with both face-to-face therapy (Kiropoulos et al., 2008) and telephone-based therapy (Klein et al., 2006). Results from both studies found that therapist alliance scores were comparable between Internet and face-to-face treatment (Kiropoulos et al., 2008) and Internet and telephone-based therapy (Klein et al., 2006) and that participants reported being equally (and highly) satisfied with their working relationship with their therapists in all different treatment delivery modes. The authors posit that the frequent contact with the therapist (approximately once or twice per week) allowed by Internet therapy may increase the therapeutic alliance due to an increased continuity of care.

In further support of Internet therapy, Reynolds, D'Arcy, Stiles, & Grohol (2006) found that alliance and impact were as strong in online therapies as in face-to-face therapies. Furthermore, online therapists, as compared to face-to-face therapists, tended to rate their online exchanges as somewhat deeper and smoother, and felt more positive and more confident about their therapeutic relationship. The higher session impact ratings by online therapists may stem from the email communication, which allows for greater reflection and editing ensuring that the wording is clear and concise, without any fumbling for words or repeated explanations that may be required in traditional therapy. Internet clients indicated lower levels of openness as compared to prior studies of face-to-face therapy, which may reflect client's ability to present themselves selectively online and avoid material that face-to-face therapists may have detected through nonverbal behaviour (Reynolds et al., 2006).

All the above studies are limited by a small sample size, thus reducing the extent to which results can be generalised; however, they provide some support for the treatment credibility and client satisfaction on online therapy in addition to the ability to establish a good working alliance.

## **INTERNET THERAPIST & CLIENT CHARACTERISTICS**

Several analyses have been conducted to examine the practice of online counselling by investigating the web pages of individuals or organisations offering Internet counselling services (Chester & Glass, 2006; Heinlen, Welfel, Richmond, & Rak, 2003; Laszo et al., 1999; Maheu & Gordon, 2000; Shaw & Shaw, 2006). Heinlen and colleagues (2003) conducted a survey using methods designed to parallel those that consumers might use to locate an Internet therapist. Entering the key words 'online counselling' in several search engines, Heinlen et al. located 136 websites. Results suggested that there were slightly more male than female practitioners and the majority of providers were based in the U.S.. Qualifications varied considerably, with more than one-third having no training in mental health. The most common form of service offered was email (74%) with one-on-one chat services offered on 45% of sites. Fees varied widely from \$25 per email response to a

donation, and from \$12 to \$150 for 50 minutes of live Internet chats. Compliance with the U.S.-based National Board for Certified Counselors (NBCC) standards was poor, for example, less than 25% of sites indicated the use of encryption to protect client confidentiality. Only 3% of sites contained information discussing the possibility of technology failure and how to deal with such situations and eight months after the original survey 37% of the sites were no longer operational with forwarding details not provided.

Direct surveys of online clinicians have also been conducted in an effort to evaluate Internet therapy. Similarly to the findings of Heinlen et al. (2003), surveys reported that online counsellors were typically male and based in the U.S. with a median age in the 40s (Maheu & Gordon, 2000; Powell, 1998). Unlike Heinlen et al. (2003), more than 85% of respondents indicated they were currently licensed, certified, or registered to provide therapy to the public; however most described their services as 'educational' or 'advice' with only 27% describing their services as 'counselling' or therapy' (Maheu & Gordon, 2000). The majority of online counsellors (78%) indicated that they provided services to people in a state other than where they were licensed or registered and only 60% asked in which jurisdiction the client resided (Maheu & Gordon, 2000). Further, 74% had incorrect knowledge about the licensing laws for tele-health.

Online clients were reported to be seeking help for a range of clinical problems (mood, anxiety, sexual or adjustment disorders) and relationship issues (Maheu & Gordon, 2000; Powell, 1998). Clients commonly participated in three to six sessions and were more likely to be female than males. It should be noted that the survey respondents represent a self-selected sample and as such results may be biased. Furthermore, in the rapidly developing field, this research may be outdated, however, it provides context for the background and development of Internet therapy.

Similarly to Heinlen et al. (2003), Shaw and Shaw (2006) conducted a search for online counselling for the period November 29, 2001 to January 25, 2002 in an attempt to assess Internet sites that identified services as online counselling. A total of 139 sites were found from four commonly used directories of online counsellors; however 76 were found to either be no longer available, no longer offering online counselling, contained only advertisements for adjunct services for private offices that did not offer online counselling, or offered only information or advice. This basic search reflected the difficulties a potential consumer may face in locating online counselling sites. Disconcertingly, during the two-month period of the study, 20% of the sites had disappeared, had a statement that they were "for sale" or had changed into a completely different kind of site. This confirms the important issue of client abandonment for which clients had little to no recourse.

Analysis of data provided on the web sites revealed that 27% of online counsellors held a Master's level degree in psychology, counselling or social work and that 11% held a Doctorate in psychology or counselling. An additional 34% listed themselves as Master's- or Doctoral-degree holders but did not indicate an area of study. Thirteen percent had other majors such as divinity or nursing; 14% did not list a degree. Forty

percent of website indicated an affiliation with an association, most commonly ISMHO, National Association of Social Workers or Academy of Certified Social Workers, ACA, NBCC, and American Association of Marriage and Family Therapy. The majority of websites were based in the U.S., although England, Canada, Australia and Hong Kong were also represented and 19% did not identify from where they were operating. In terms of services provided, 38% used email only, 56% offered a combination of email plus other services (chat, telephone, and/or video counselling), and 7% offered only chat, telephone, or video counselling.

Shaw and Shaw (2006) investigated the compliance of online counsellors with ethical standards and expectations. In terms of trustworthiness and accountability, in addition to the identifying information described above, 62% of sites gave an address or telephone number for alternate contact information. In terms of informed consent, 61% of sites stated that online counselling is not the same as face-to-face counselling, 67% stated that not all problems were appropriate for online counselling, and 59% gave referral information or suggestions for clients whose problems were inappropriate for online counselling. Only 32% of the sites required that the client sign a waiver that explained the limits of confidentiality on the Internet. Regarding client information and intake procedures, only 38% of the sites had an intake procedure, 45% of the sites required the client to give their full name and address. For confidentiality, only 27% of the web sites used a secure site or encryption software, and only 33% had a statement indicating that confidentiality could not be ensured over the Internet. For issues relating to minors, only 35% of sites stated that minors could not use their service or required the written consent of a guardian and 46% of sites required clients to state their age or date of birth. Sites on which all the counsellors identified themselves as licensed appeared to have greater compliance with ethical guidelines, especially for counsellors who provided their full name, degree, and site of practice.

Further indicators of ethical compliance included listed associations and provision of alternate contact details. This study revealed both a lack of knowledge of, and compliance with ethics codes by online counsellors, although this appeared to be somewhat mitigated by association with professional organisations. Shaw and Shaw (2006) recommend wider education for both the public and mental health professionals regarding ethical codes for Internet therapy and for training sessions and seminars to be conducted. Furthermore, the authors recommend that governing bodies and related associations formulate specific regulations for provinces to enable Internet counsellors to practice in an ethically responsible manner.

In a more recent analysis that aimed to replicate and extend previous research, Chester and Glass (2006) profiled online counsellors, clients and the online counselling practice. Notifications of the study were sent to 399 individual email addresses gathered from a search of websites providing Internet counselling. The final sample consisted of 67 participants who completed a 47-item questionnaire. Although the results are based on a self-selected sample, which may bias findings, they provide an important insight into the current state of Internet therapy. The results of this study are presented below:

### *Therapist Characteristics*

Participants were aged 28 to 69 years, ( $M=46.9$  years,  $SD=9.3$  years) with equal gender distribution and were all currently offering or had experience offering Internet counselling services. The majority (87%) were licensed or registered to provide counselling as either therapists (28%) or psychologists (22%). Similarly to previous studies, the majority resided in the U.S. (62%), with others in the U.K. (13%) and Australia (7%). An average 19.6% of all professional work was conducted online and nearly all respondents (97%) combined online work with face-to-face counselling with a proportion of clients, and 75% had referred clients to face-to-face counselling. Nearly half the respondents (43%) were employed in independent practice, 81% practiced alone and experience ranged from less than five years to over 20 years.

### *Client Characteristics*

Internet counsellors estimated that the majority of online clients were female (70%) with client age concentration in the 25-44 age group, with relatively few clients over the age of 55. A steady increase in client load was reported over the previous three years with an average of 13 clients reported three years ago (based on the 15 participants practicing at this time) to 47 clients in the past year (based on the 49 participants practicing at this time). The length of online counselling varied from a single session to several months and in general was short term with an average of five sessions per client ( $SD=4$ ). Just over half the online clients (52%) received sessions for less than one month. Clients most commonly presented with relationship issues followed by family issues, mood disorders and anxiety.

### *Internet Counselling Practice*

Respondents had been practicing online for two months to eight years, with a mean length of 2.3 years ( $SD=1.8$ ). The most common theoretical orientation indicated was CBT (40%) followed by eclecticism (32%). Email was the most popular technology used in 71% of online counselling followed by Internet chat (17%). Respondents often offered free initial email (56%) or chat (31%) content and fees averaged US\$1 per minute or approximately US\$50 per hour and a small group (11%) did not charge for email or chat services.

### *Ethical Issues*

The majority of respondents (90%) provided information to clients about the possible limitations of online counselling and considered some problems unsuitable for Internet therapy (89%). Respondents also largely provided services to clients outside the jurisdiction in which they were licensed or registered to practice and 42% did not use any type of encryption or have procedures to deal with technological failures (35%).

In a similar investigation of online client characteristics, but focussed directly on mental health therapy, Leibert and colleagues (2006) surveyed 81 participants who had past or present experience with online mental health counselling. The average age of participants was 29.4 (Range 14-56,  $SD=11.4$ ). The majority of the sample were female (82.7%), white (82.7%), had an undergraduate degree or higher (36%), were not married (76.3%) and earned less than US\$20,000 annually (48.1%). Participants indicated high general

use of the Internet (over 10 hours per week) and the number of hours spent on the Internet per week was significantly more likely to predict use of online counselling. The majority (84%) engaged in online counselling for a maximum of one hour per week and sought help for co-occurring complaints, for example depression, anxiety and relationship problems. The most frequent reasons cited for using Internet therapy were convenience and privacy/anonymity. Email and instant messaging were the most popular types of communication and a majority (79%) had tried either face-to-face individual or group therapy. Feedback on the advantages and disadvantages of online therapy indicated that the privacy and anonymity conferred heightened emotional comfort for the client compared to face-to-face counselling, enabling greater disinhibition. The most common perceived disadvantage was deficits in the counselling relationship caused by either absence of body language or loss of personal contact with the therapist. These responses indicate that the solidarity and anonymity of Internet therapy are its greatest advantage and disadvantage.

## **CLIENT SUITABILITY FOR INTERNET THERAPY**

Pervious discussions have been based on available literature and aimed to examine the strengths and limitations of Internet therapy as a general tool for mental health interventions. The following will use the literature to evaluate the suitability of various client subgroups for Internet therapy as well as considering client suitability specifically for online interventions for gambling problems:

### **Women**

Despite population data that suggest men and women are equally likely to gamble, men are more likely to seek treatment for problem gambling (Crisp et al., 2000). For example, an evaluation of problem gambling treatment in Ontario found that men constituted a greater proportion (66%) of clients seeking help for gambling problems than women (34%) (Rush & Urbanoski, 2004). There are a number of reasons explaining these findings. Females who seek assistance from health or welfare professionals are less likely to be routinely assessed for gambling problems (Downing, 1991; Mark & Lesieur, 1992). The paucity of women in treatment may also imply that existing programs fail to take into account needs and issues that are predominantly of concern to women, such as child care, sexual assault and domestic violence. Women who enter treatment programs designed for men may find that program staff do not have the expertise or resources to deal with problems that are specific to their gender (Reed, 1985). An investigation of the gender specific treatment needs of problem gamblers found that traditional programs originally designed for men should be modified to suit the needs of female problem gamblers, for example by being provided in gender neutral settings with a greater emphasis placed on supportive counselling (Crisp et al., 2000). Data from problem gambling helplines suggests that women are more likely to seek help than men, but are less likely to utilise treatment interventions (Bellringer, Pulford, Abbott, DeSouza, & Clarke, 2008), indicating that women recognise the need for treatment, but these needs are not satisfactorily met by existing.

Although the number of women seeking help for problem gambling is increasing, 12-step support groups have predominantly involved middle-age men (McGowan, 2003a). Conventional 12-step support groups are not perceived as 'woman friendly' and are criticised for failing to acknowledge gendered aspects of addiction and recovery, as well as reinforcing stereotypical ideas and practices concerning women (Doyal, 1995; Harrison, 1997; Kast, 1990 as cited in McGowan, 2003a). The experience of male-dominated dynamics in GA groups has prompted many women not only to seek out, but actively create alternatives such as women-specific support groups both online and offline (McGowan, 2003b). As with face-to-face therapy, Internet support groups and group therapy also appear to be subject to gender-bias based on a review of relevant literature suggesting that online interactions are not gender neutral (McGowan, 2003a). However, online groups do allow individuals to gather from various locations for a specific purpose, for example, creating a women's support group or online therapy group for problem gambling would be entirely possible. Indeed, a study of an online support group/newsletter, Women Helping Women ([www.femalegamblers.info](http://www.femalegamblers.info)), for women problem gamblers revealed that this is a valid and useful approach for participants (McGowan, 2003a).

The advantages of online therapy and support groups for women cited by participants included:

- Being able to identify with the stories of others and related to other members of the group
- Overcoming the shame, guilt, and embarrassment associated with face-to-face meetings
- Lack of guilt over missing meetings due to a lack of alternative child-care arrangements
- Empathy, understanding and group support
- Anonymity, safety and security
- Equality in numbers
- Empowerment through dialogue between women and the choice and actions of making changes (Freestone, 2008)

Pew Internet Project surveys between January and June in 2005 indicate that women slightly outnumber men in the U.S. Internet population (Pew Internet & American life Project, 2005). While various measures suggest that men are slightly more engaged with their Internet use than women, at the same time women are closing the gap. In particular, compared with men, women are more likely to use the Internet to send and receive email, look for health and medical information, and use emails and websites to discuss and get support for health or personal problems. Furthermore, women appear to use the Internet in a richer and more engaging way. Women are more likely than men to use emails for communication and feel satisfied with the role of email in their lives, especially when it comes to nurturing their relationships. The study showed that more women 43%, than men 33%, said that communicating by email has improved relationships with family members (Pew Internet & American life Project, 2005). Additionally, more women than men said email has brought them closer to their family and friends, and that they have learned more about their family and friends by using email. These results indicate that

online text-based communication appears to satisfy deep, emotional needs for women and that this is an appropriate mode of communication for personal thoughts and feelings, perhaps more so than face-to-face interaction.

### **Men**

While men are more likely to engage in treatment for problem gambling than women (Rush & Urbanoski, 2004) numerous authors have described the characteristics associated with interest and successful engagement in traditional psychotherapy, including being emotionally expressive, vulnerable, intimate, as being in contrast with the values of the male culture and norms (Good, Gilbert, & Scher, 1990; Kelly & Hall, 1992; O'Neil, 1981a, 1981b; Robertson & Fitzgerald, 1992; Rochlen, 2001; Wilcox & Forrest, 1992). Overall, men of varied nationalities, ethnicities, racial backgrounds, and ages seek professional help to a lesser extent than women (Addis & Mahalik, 2003). In a study addressing men's perception of different theoretical approaches to counselling, Rochlen and O'Brien (2002) found men preferred a more directive approach over a more contextual, emotional oriented approach. Although research on gender differences in treatment are limited, data from the BreakEven problem gambling intervention based in Victoria, Australia suggest that when gender differences in treatment-seeking are controlled for, men are less likely to complete treatment than women (Crisp et al., 2000).

The atmosphere and conditions of Internet therapy may not encompass the levels of expressiveness and vulnerability involved with face-to-face counselling that men may find off-putting. One study showed that whereas women generally show more interest in traditional counselling than men, attitudes towards Internet counselling show no such gender differences (Rochlen, Beretvas et al., 2004). Further research showed that men with self-described discomfort expressing their emotions demonstrated a preference for online counselling as opposed to face-to-face therapy (Rochlen, Land, & Wong, 2004). Evidence of this relationship supports the cited benefit of Internet therapy as appealing to populations who are uncomfortable with verbal expression and as such, less likely to seek therapy. Further support for the effectiveness of Internet therapy for men comes from a study directly comparing the effectiveness of Internet-based CBT and face-to-face group CBT for sub-threshold depression (Spek, Nyklicek et al., 2007). Significantly fewer men dropped out of the Internet-based treatment (7%) than the group treatment (23%). Although the authors do not indicate a reason for this difference, together with previous results it may suggest that Internet-based CBT may be more suitable for men than group therapy due to the anonymity and reduced discomfort with expressing emotions in public.

### **Youth**

Young people have specific barriers when it comes to accessing mental health services (Owens et al., 2002). These include both structural barriers such as time, costs, and travel, and personal barriers such as the young person being overwhelmed with unfamiliar issues. Because of these and other obstacles, the majority of adolescents who require services do not receive them. There is also evidence that adolescents prefer to seek help from informal sources, such as family and friends, than formal supports, including school counsellors and mental health professionals (King et al., 2006). This appears to be also true for adolescent problem gamblers, who typically do not seek help (Gupta &

Derevensky, 2000). Research indicates that the Internet is rapidly becoming a major source of health information for adolescents (Gray, Klein, Noyce, Sesselberg, & Cantrill, 2005). Preliminary research indicates that adolescents regard the Internet as appealing because it is an accessible and anonymous method of seeking help (Gray et al., 2005; Nicholas, Oliver, Lee & O'Brien, 2004).

In a large-scale study, 17,000 year 10 students from South Australia were surveyed about their use of the Internet to seek counselling and advice for personal problems (Oliver & Nicholas, 2005). The results reveal adolescents seek help from the Internet at the same rate they seek help from mental health professionals such as school counsellors, psychiatrists and psychologists. The authors commented on the benefits of Internet therapy for teenage boys, who use the Internet as much as females, but are much less likely to seek help in person. This hypothesis is supported by research demonstrating that about one in three adolescents are able to self-disclose better online than offline, which holds more for boys than girls (Schouten, Valkenburg, & Peter, 2007).

Another group who are hypothesised to benefit from Internet therapy are socially anxious adolescents. Studies support the hypothesis that adolescents who are socially competent in offline settings also more often use online communications to stay in touch (Valkenburg & Peter, 2007), indicating that these adolescents may feel comfortable self-disclosing to an online therapist. However, in comparison with their socially competent peers, socially anxious adolescents more often prefer online self-disclosure to offline self-disclosure (Valkenburg & Peter, 2009). Because socially anxious adolescents are inhibited in face-to-face social interactions, they may prefer a more protected environment in which they feel less inhibited to reveal their concerns. The Internet provides them with such an environment.

The reduced auditory and visual cues of online communication diminish the constraints that socially anxious adolescents typically experience in offline settings (Schouten et al., 2007). Furthermore, because socially anxious adolescents often prefer settings in which interactions can be prepared ahead of time, they find the control over message construction, which is possible in online communication, more important than less socially anxious adolescents do (Schouten et al., 2007). While there is merit in encouraging socially anxious teenagers to overcome these fears using therapy as a safe place to practice discussing their thoughts and feelings, online therapy may also be beneficial for those who would not otherwise seek help.

A qualitative study was conducted by King and colleagues (2006) at Kids Help Line ([.kidshelp.com.au](http://kidshelp.com.au)), a free and confidential 24-hour telephone and online counselling (provided in real-time, text exchange) service specifically for Australians aged between five and 18 (typically used by adolescents). Online focus groups were conducted with 39 participants revealing that participants reported the online environment to be less confronting compared to traditional forms of counselling and the Internet was more private as they could not be overheard. The participants indicated that they were comfortable with text communication and felt online counsellors were more supportive than telephone counsellors, indicating that the reduced emotional range in Internet

counsellor communication was an advantage. The most commonly reported challenges with text communication were concerns that counsellors might not be able to adequately understand the participants' emotions, that miscommunications could occur, and that it was more difficult to build a therapeutic alliance. Kinds Help Line online services had limited hours of availability (closed at 9pm) and ended sessions after approximately one hour. Participants reported waiting for up to three hours to chat with a counsellor or missing out altogether, which highlights the importance of having an adequate number of counsellors available, extending hours of operation, and the possibility of having repeated sessions.

Internet therapy may be particularly appropriate for youth given their greater familiarity with the technology. Youth typically use the Internet for online purchases and games, to communicate with friends and family (via email, personal profiles [e.g. MySpace], and networking sites [e.g. Facebook]), complete school and university work, make a variety of purchases and online transactions and conduct research on a wide variety of topics ranging from medical advice to movies and music downloads. Research shows that many undergraduate students use email to support each other both academically and personally (McCormick & McCormick, 1992), indicating that a large number of individuals already have some associations of Internet-use with psychological assistance. Results from the Pew Internet and American Life Project found that in 2007-2008, 93% of teenagers between the ages of 12 and 17 used the Internet, an increase from 73% in 2001. Thirty-seven percent of teenagers who used the Internet said that they used email, instant messaging, and/or chat rooms to discuss subject matter that they would not have discussed with someone in person (Pew Internet & American Life Project, 2001).

Among older teenagers (15-17 years old), 21% said they had searched the Internet for information on sensitive subjects about which they found it difficult to talk to others and nearly one third of teenagers who go online at home do so privately in their rooms or other secluded areas.

It is important for both counsellors and adolescent clients to take care in transferring the high levels of comfort that adolescents have with Internet use into a therapeutic relationship. Over-familiarity with the Internet appears to have lead adolescents to view Internet-based communications as not 'real writing', but rather the same as phone calls and casual conversations (Pew Internet & American Life Project, 2008b). However, in focus groups, teenagers said they are motivated to write when they can select topics that are relevant to their lives and interests and survey results show that the majority of youth enjoy writing for personal enjoyment, including writing in a journal, blogging, and writing music or lyrics (Pew Internet & American Life Project, 2008b). These results indicate that teenagers are able to write expressively and appropriately, and enjoy writing about their own lives, thoughts, and emotions. This suggests that Internet-based therapy may be successful amongst this age group. Care should be taken to ensure that emails between a therapist and client are carefully considered and worded, rather than terse and unedited, and counsellors should become familiar with the online language (textese) of adolescents (e.g., lol, bbs, pos).

An important issue to consider in regards to youth using online counselling resources is the appropriate age of consent. Many online counselling sites list a warning on their home page such as “You must be over 18 to use these services or have written consent from a legal guardian”. If sites intend to prevent minors from using Internet therapy services, additional precautions should be taken such as requiring a client to enter their age and date of birth in the intake procedure, or providing some form of age verification. Although it is quite possible for adolescents to lie to obtain access, it is unethical for counsellors not to make a serious attempt to assess whether or not the client is minor (Shaw & Shaw, 2006). Alternately, websites may provide online therapy specifically tailored for adolescents, such as Kids Help Line, or youth oriented CBT for problem gambling.

### **Older Adults**

While Internet use continues to be populated largely by younger generations, larger percentages of older generations use online facilities more than previously, according to the Pew Research Center’s Internet and the American Life Project survey for 2006 to 2008 (Pew Internet & American life Project, 2009). The biggest increase in Internet use since 2005 can be seen in the 70-75 year-old age group. While 26% of adults aged 70-75 were online in 2005, 45% of that age group is currently active online. Email is the most popular activity by older adults, with 74% of Internet users aged 64 and older sending and receiving emails. Compared with teens and Generation Y (ages 18-32), older generations use the Internet less for socialising and entertainment and more as a tool for information searches, emailing, and buying products. In particular, older Internet users are significantly more likely than younger generations to look online for health information. Health questions drive Internet users aged 73 and older to the Internet just as frequently as they drive Generation Y users, outpacing teens by a significant margin. Since 2005, broadband Internet access has increased dramatically in the U.S. across all age groups, but older groups are still largely unconnected to high-speed Internet, with only 16% of adults aged 73 and above having broadband access at home.

## **EMPIRICAL SUPPORT FOR INTERNET THERAPY**

### **Health Psychology**

A Medline and PsychINFO search of the literature reveal that Internet therapy programs have been used successfully in the treatment of several psychiatric and non-clinical conditions including:

- Reducing risk factors for eating disorders (Bruning Brown, Winzelberg, Abascal, & Barr Taylor, 2004; Winzelberg et al., 2000; Zabinski et al., 2001)
- Weight loss (Oenema, Brug, & Lechner, 2001; Tate, Jackvony, & Wing, 2003; Tate, Wing & Winett, 2001)
- Obesity (Harvey-Berio et al., 2002)
- Chronic headaches (Devineni & Blanchard, 2005; Strom, Pettersson, & Andersson, 2000)
- Insomnia (Strom, Pettersson, & Andersson, 2004)
- Breast cancer (Lieberman et al., 2003)

- Encopresis in children (Ritterband et al., 2003)
- Tinnitus (Andersson et al., 2002; Kaldo-Sandstrom, Larsen, & Andersson, 2004), including results demonstrating the effectiveness of Internet therapy for tinnitus distress in comparison to a live treatment group (Kaldo et al., in press cited by Andersson et al., 2008).
- Chronic Pain: In a randomised controlled trial (with a waitlist control) Internet therapy was shown to be effective in assisting chronic pain patients, both with and without the addition of brief telephone calls (Buhrman, Faltenhag, Strom, & Andersson, 2004; Buhrman et al., unpublished data cited by Andersson et al., 2008).
- Stress including the use of applied relaxation that was reportedly as beneficial as face-to-face administration of the technique (Carlbring, Bornstjerna, Norkrans, Waara, & Andersson, 2007; Zetterqvist, Maanmies, Strom, & Andersson, 2003).

### **Medical Counselling**

A prospective study evaluating the effectiveness of a non-profit Internet-based remote counselling service funded by Intermedico Network, through which clients from around the world could make requests for counselling on any medical matter, was conducted by Labris, Coertzen, Katsikas, and Petounis (2002). A total of 15,456 Internet users visited the site over the eight years during which the study was conducted, demonstrating that individuals were interested in this services. The majority of clients were from Europe, North American and Australia and 67% lived in urban areas, with the remainder being residents of remote rural areas with limited local medical coverage.

Internet-based counselling was sought for the following reasons: 56% wanted to evaluate the services and have their medical queries explained; 28% had already contacted local medical services but considered the information received was unsatisfactory; and 14% stated they could not afford local medical services. The majority of the sample (75%) contacted the organisation again to express their satisfaction, while 65% explicitly stated that the information received had helped them to understand the issue of interest. Seventy-four per cent considered the 'empathy' of the service sufficient, although only 61% considered the 'responsiveness' sufficient, mainly due to the delays inherent in email communication. In none of the 1500 cases analysed were there any legal problems or special consideration required for local legislation, ethics and culture. Some technical difficulties were experienced as the portal became inaccessible five times and counselling was not possible on 44 days, however there was no hacking of the website. The results suggest that Internet-based counselling is a useful addition to conventional practice, particularly for those who are unable or unwilling to access alternative services.

### **Anxiety & Depression**

Based in Australia, the Etherapy Unit at Swinburne University has demonstrated considerable success in delivering Internet therapy for panic disorders and agoraphobia (e.g. Klein et al., 2006; Kiropoulos et al., 2008). Similar results have emerged based on programs run in Sweden that have demonstrated, using randomised controlled trials, the effectiveness of Internet therapy in reducing symptoms of panic disorder when directly compared to face-to-face treatment (Carlbring et al., 2001; Carlbring et al., 2005). Results showed that the Internet and face-to-face therapy were largely equivalent in terms of

outcome, with a vast majority in both groups receiving substantial symptom reduction. Similar effects were found when Internet therapy was combined with brief, structured weekly telephone calls that provided support and covered progress in the program (Carlbring, Bohman, et al, 2006). Furthermore, data from an on-going effectiveness trial of Internet-delivered CBT for panic disorder indicates that the treatment works with regular patients in mental health care (as opposed to recruited in media as research participants) indicating the efficacy of this treatment for individuals seeking help in the general population (Andersson, Cuijpers, Carlbring, & Lindefors, 2007).

Treatment for social phobia has also been shown to be amenable to Internet therapy. An Internet-based treatment with telephone support was found to be comparable to Internet treatment that included two live exposure sessions (Carlbring, Gunnarsdottir, et al., 2007). An open trial with less therapist input also result in good outcomes (Carlbring, Furmark, Steczko, Ekselius, & Andersson, 2006). In a meta-analysis of the effects of Internet-delivered CBT for depression and anxiety disorders (compared to a waitlist control) the mean effect size was large ( $d=0.91$ ) indicating that the interventions are having a significant impact in reducing clinical disorders (Andersson et al., 2007).

Spek, Cuijpers and colleagues (2007) conducted a meta-analysis of 12 randomised controlled trials ( $N=2334$ ) to determine the effectiveness of Internet-based CBT programs for symptoms of depression and anxiety. Results showed that interventions for anxiety had a large mean effect size ( $d=0.96$ ) and interventions for depression had a small mean effect size ( $d=0.22$ ). However, the authors posit that this might be explained by differences in the amount of therapist support, as studies that had greater therapist support appeared to have greater effect sizes. While more research is needed, these studies indicate that Internet-based CBT is a very promising line of treatment, with the potential to reach people who would not otherwise receive treatment.

### **Smoking**

Smoking cessation websites have become increasingly utilised in an effort to reach a larger proportion of the population. In addition to traditional sites offering information, tips and referral details, these sites can offer sophisticated, interactive counselling programs at a population level based on participant's responses to questions about their personal characteristics and preferences. The Internet-based program can match this data with relevant pieces of advice and information and send feedback to participants and counselling materials tailored to their personal profile (Etter, 2006). Personalised feedback materials include electronic documents, audio files, email messages or documents sent by postal mail. Tailored variables may include demographics, level of dependence, motivation to quit, perceived barriers to cessation, perceived risk, knowledge about treatment etc. For ex-smokers, questions may include the quit date, intensity of withdrawal symptoms, use of smoking cessation medications, relapse situations, etc. In a randomised controlled trial of a tailored versus untailored Internet-based Quitters program, after 10 weeks continuous abstinence rates were higher among participants in the tailored program (Strecher, Shiffman, & West, 2005). In a non-randomised trial, an Internet-based program using automated email messages doubled quit rates assessed after 30 days, compared with a single-point-in-time web-based

educational intervention (Lenert, Munoz, Perez, & Bansod, 2004). This evidence supports the use of personally tailored computer generated automated emails, with the possibility that programs may be more effective if trained therapists were involved in the communication with participants.

An online 5-week smoking cessation program was designed and evaluated by Schneider and colleagues (1990). Users were provided with behavioural instruction modules and intervention content was tailored according to the individual user's smoking history, responses to computer-generated questions and treatment progress. In addition, an online forum allowed discussion between users and contact with treatment staff. In a randomised control trial (n=1158), participants who received the full program were significantly more likely than the control group to maintain abstinence. Those who received the program, but did not have access to the online discussion group were significantly less likely to report abstinence than those in all other groups. Among those who completed the program but did not report abstinence, there was a significant reduction in mean daily cigarette consumption, suggesting that an online smoking intervention can be useful in assisting individuals to reduce cigarette consumption.

However, as this study was based on self-report data the results may be biased. This study also had a high drop-out rate with just 44% of the total sample providing six-month follow-up data. This may be accounted for by the low barriers to entry, that is, people could sign up immediately with minimal effort, which may have resulted in a greater proportion of poorly motivated participants entering the study. Despite the attrition rate, the study shows that an online smoking intervention can attract a large number of participants and retain the majority (61% accessed the system more than once).

Etter (2006) raises several problems with smoking cessation websites; firstly that they are often owned by either companies that aim to sell smoking cessation products (e.g., nicotine gum or patches, nasal sprays and microtabs) who are in direct competition with each other or; secondly, that smoking cessation websites are owned by tobacco companies, such as Quit Assist, the most popular smoking cessation website in the U.S., which is owned by the tobacco company Philip Morris (Etter, 2006). This represents a conflict of interest and highlights the need for independently run and evaluated smoking cessation websites.

A review of English-language websites concluded that over 80% of smoking cessation websites provided no coverage of one or more of the key components of tobacco treatment recommended in Public Health Service guidelines and only 20% use interactive features to provide practical counselling (Bock et al., 2004). These results demonstrate that while the Internet has the potential to provide access to millions of smokers to counselling programs designed and run by highly qualified smoking cessation experts, this technology is under utilised and smokers seeking quality tobacco dependence treatment on the Internet may have difficulty distinguishing among the numerous websites and finding appropriate Internet-based treatment options. An analysis of usability suggested that for a site to be effective, users must be able to grasp the functioning of the site immediately upon scanning the home page (Bock et al., 2004). If a

website is easy to use and contains useful and interesting features, users are more likely to return for repeat visits, which may increase their likelihood of quitting smoking.

### **Substance Abuse**

The increasing number of online treatment options worldwide shows that treatment facilities are willing to experiment with online healthcare. A review of the current state of the art in substance abuse treatment over the Internet is promising (Copeland & Martin, 2004). Some authors report online substance abuse treatment to be successful in addressing an underserved population (Blankers, Kerssemakers, Schramade, & Shippers, 2007; Postel, de Jong, de Haan, 2005). For example, in comparison to face-to-face clients, clients seeking Internet therapy for problem drinking were more likely to be female, more highly educated, more often employed and older indicating that this therapy is appealing to a different demographic of those in need of treatment. Results of the first randomised clinical trials support the use of the Internet to extend to treatment options for substance-abusers (Hester & Delaney, 1997; Kypri et al., 2004; Riper et al., 2008).

The Substance Abuse Treatment Centres (SATC) in the Netherlands has provided two evidence-based online treatment programs since 2003: CBT and motivational enhancement training. These programs have led to the development of online interventions for alcohol-, cannabis-, cocaine- and tobacco-users and for pathological gamblers. A trial is currently underway that aims to compare two online treatment programs for problem drinkers: (1) an anonymous, online non-counsellor involved, fully automated self-guided treatment program (self-help); and (2) a real-time online, non-anonymous counsellor-guided therapy program for problem drinkers (therapy) (Blankers, Koeter, & Schippers, 2009). The self-help program has been shown to be highly attractive and promising in its effects (Blankers et al., 2007). However, participants reported that they missed the opportunity to interact with a counsellor on a regular basis. The online therapy program uses weekly online exercises and guided interventions augmented by individual, private real-time chats with the therapist. Each chat lasts approximately 40 minutes during which feedback on homework is provided and the client is motivated to enhance their attempt to stop or reduce drinking. A research project is currently underway to evaluate the effectiveness of this program.

There is also evidence to attest to the usefulness of online support groups for individuals with alcohol problems. Moderation Management (MM) is a group for nondependent drinkers who would like to achieve abstinence or moderate drinking that uses internet-based support groups as opposed to face-to-face support groups used by Alcoholics Anonymous (AA) (Humphreys & Klaw, 2001). An evaluation of the Internet-based interventions offered by MM found that those who used the online services were more likely to be female, had higher levels of education and were more likely to be atheists or agnostics (Humphreys & Kraw, 2001). The most commonly given reasons for accessing the online services were accessibility and convenience, privacy, lack of treatment options or groups close by and greater levels of comfort when disclosing personal feelings and experiences. These results suggest that Internet-based interventions may be appealing to those who may not otherwise seek treatment as they feel uncomfortable or are unable to attend groups and therapy sessions. For example, women and non-spiritual individuals

may feel uncomfortable attending AA meetings and find it difficult to share in these settings, but are able to disclose anonymously online.

The Internet has also been used to provide normative feedback for individuals' drinking habits based on others of the same gender and age groups, a brief intervention that has been theorised to increase motivation for change (Agostinelli & Miller, 1994; Miller & Rollnick, 1991) and found to promote behavioural change in alcohol drinkers (Agostinelli, Brown, & Miller, 1995) and smokers (Curry et al., 1991; 1992). An evaluation of a pilot feedback program that provided individuals with information about their drinking in comparison with other similar individuals, found that the site was accessed by a high number of individuals (500 per month) and about half (56%) of respondents stated the feedback was very or extremely useful (Cunningham, Humphreys, & Koski-Jannes, 2000). The feedback appears to be useful in heightening awareness of problem drinking as 34% said that they were surprised by how much more they drank than other people and many more problem drinkers (53%) than non problem drinkers (17%) reported being surprised by this feedback. The feedback was largely viewed as accurate by regular drinkers but not so well for heavy episodic drinkers and those who consumer alcohol infrequently. Although no data was gathered on the efficacy of the program, it provides support for the ability of Internet interventions to reach a large number of people, serve a wide geographical area and be cost effective.

A follow-up study (Cunningham, Humphreys, Koski-Jannes, & Cordingley, 2005) demonstrated that participants who received an additional self-help workbook following the normative feedback reported drinking less and experiencing fewer consequences at the three-month follow-up than those who received only the Internet-based feedback. Participants who received the Internet-based personalised feedback, without the self-help book, demonstrated a trend towards reduced drinking, but had this was not significantly different from their baseline alcohol consumption, indicating that some form of therapeutic input is necessary to assist problem drinkers. These results should be interpreted with caution due to the lack of comparative wait-list control group and small self-selected sample; however they provide some support for the use of Internet interventions to reach an underserved population in need. For example, 58% of participants in the pilot study (Cunningham et al., 2000) were female and a study of Internet-mediated alcohol self-help groups found that over 80% of users had never sought alcohol treatment (Humphreys & Klaw, 2001).

### **Other Interventions**

A Medline and PsychINFO search of the literature reveal that Internet therapy programs have also been used successfully in the treatment of several non-clinical conditions including:

- Public speaking fear (Botella et al., 2000)
- Restructuring on the irrational career beliefs of adolescent girls (Kovalski & Horan, 1999)
- Jet-lag symptoms (Lieberman, 2003)

Generally, the majority of the above programs have relied on CBT methods and results from evaluation trials suggest that the Internet is a very promising medium for delivering effective treatment interventions for a wide range of clinical disorders, health concerns and medically-related difficulties, and non-clinical problems.

## **INTERNET-BASED INTERVENTIONS FOR PROBLEM GAMBLING**

Unfortunately there is little empirical evidence regarding the effectiveness of online therapy for problem gambling, however, all currently available programs will be described below. It is important to consider whether Internet therapy reaches an appropriate population of users given that problem gambling is associated with excessive expenditure, which may mean that individuals needing help with gambling-related problems may not have access to the Internet. In 2008, 84% of Canadians had access to the Internet with the majority of adults having Internet access at home (Cunningham, Selby, Kypri, & Humphreys, 2006; Internet World Stats, 2008). Furthermore, two-thirds of those with Internet access have been to a health website (Ipsos-Reid, 2002, as cited by Cunningham et al., 2006), including individuals who use a wide range of different drugs (Nicholson, White, & Duncan, 1999) and are willing to discuss details of their drug use in Internet forums. A telephone survey of adults in Ontario, found that after controlling for demographic characteristics, heavy smokers were less likely (48%) to have home Internet access than non-smokers (69%), and current drinkers (73%) were more likely to have home access than abstainers (50%) (Cunningham et al., 2006).

These results indicate that Internet access is readily available to alcohol and substance users and, given the high comorbidity rates between problem gambling and substance use/abuse (Kessler et al., 2008), suggest that the Internet may form a useful medium for the provision of treatment services for gambling-problems. Supporting this conclusion are findings from a 2007 study that showed that 73% of adults classified as problem gamblers in Ontario had access to the Internet in their homes (Cunningham, 2009).

### **Suitability for Problem Internet Gambling**

Similarly to other estimates of problem gambling treatment seeking, the majority of Internet problem gamblers do not appear to seek interventions. Responses to a telephone survey of 8,498 Canadians indicated that the rates of problem gambling amongst Internet gamblers (17.1%) were 4 times higher than found in land-based gamblers (4.1%; Wood & Williams, 2009). Similarly, an online survey of 12,521 adults from 105 countries found that 16.4% of Internet gamblers were problem gamblers compared to only 5.7% of land-based gamblers (Wood & Williams, 2009). In these samples, only 9.4% of international and 8.4% of Canadian Internet problem gamblers have sought help for their problems (Wood & Williams, 2009). Contrary to hypotheses that Internet gamblers may be more comfortable seeking help online, while Internet therapy was more appealing to Internet than non-Internet Canadian problem gamblers, the large majority of Internet problem gamblers indicated that they would prefer to seek help from a face-to-face counsellor than from an Internet counselling service (Wood & Williams, 2009). Internet

problem gamblers preference for face-to-face counselling may be in part due to a desire to avoid temptation by accessing help via a computer. It is important not to overgeneralise the results from a single study, but these findings suggest that while online therapy may be a useful adjunct to land-based treatment, it is not likely to be a solution for all Internet gambling problems.

However, there may still be value in providing Internet therapy for problem gamblers. One quarter of Canadian Internet gamblers and 15.9% of Canadian non-Internet gamblers indicated they would be most comfortable seeking help via Internet counselling (Wood & Williams, 2009). A higher proportion of international respondents indicated a preference for Internet counselling with 29.8% of Internet problem gamblers and 34.6% of non-Internet problem gamblers indicated a greater comfort level with this form of treatment. Furthermore, data from Internet-based problem gambling treatment programs in Norway and Sweden indicate that the majority of presenting clients are experiencing significant problems with online gambling (Carlbring & Smit, 2008; Eidem, 2008). This may indicate the lack of alternate treatment options for Internet problem gamblers, or a desire to seek web-based treatments.

### **Internet Tailored Feedback for Problem Gambling**

Individualised feedback programs may be an effective form of brief intervention for problem gamblers. Participants in an international online survey were given interactive feedback based on their responses that informed them how normative their gambling behaviour was, projection of their yearly expenditures, explorations of why certain beliefs they held were gambling fallacies, their risk for becoming a problem gambler, their current score on the Canadian Problem Gambling Index (Wood & Williams, 2009). The majority of participants (65.2%) reported that this feedback was somewhat or very useful, with this percentage being significantly higher for problem gamblers (70.6%). Furthermore, 33.5% of problem gamblers who took this survey reported that they expected their gambling behaviour would decrease subsequent to the survey. These results suggest that brief online interventions probably have some utility in the treatment of problem gambling and may lower the prevalence of gambling-related problems.

Based in Canada, *CheckYourGambling.net* is a free online screen for gambling problems provided by Evolution Health Systems (van Mierlo, 2009). It offers an online screen in English or French that allows individuals to check how their own gambling behaviour compares to that of individuals similar to themselves. The screen includes five pages and takes approximately five to ten minutes to complete. Questions include frequency of betting on different forms of gambling, typical gambling expenditure, irrational thinking or behaviour strategies and the individuals' thoughts and feelings about their gambling behaviour. These questions generate a report immediately that summarises the information provided by the individual and reports where they fall in comparison to others from their country. They are also told their problem gambling index score, which outlines their level of risk for being a problem gambler. The report includes accurate information about irrational beliefs and behaviours and tips on how to gamble in a responsible, low risk manner. The aim of the online screener is to assist individuals in assessing their own behaviour and being aware of whether they may need to alter their

gambling or seek additional help or treatment. A strength of the site is that it offers private, anonymous feedback in an objective and non-judgmental manner but encourages self-awareness and reflection. This intervention has not been empirically tested, so the impact on individuals is unknown, however the reported findings by Wood & Williams (2009) suggest it may be a useful intervention for problem gamblers.

### **Internet-Based Support Groups for Problem Gambling**

A search conducted in February 2009, for gambling support groups online through the popular search engine 'Google.ca' found 13 currently active groups devoted to the topic of problem gambling (see Appendix A). Most of these groups are open only to members, although the majority are anonymous and free to join. Several offer multi-lingual services including email and chat-based counselling to individuals located around the world. One site, GamblingTherapy.org, reports that thousands of clients have used the services, and other forums receive hundreds of posts on forums/bulletin boards each month. This sample search reveals only the easily found gambling support groups and related traffic online. Of concern, many sites did not list adequate contact information or provide information about the facilitators. Two sites had notices indicating that the server was due to close and the sites would be terminated unless appropriate action was taken. This search revealed that appropriate online help for gambling is difficult to find and locating a qualified group facilitator and counsellor online may be difficult for potential clients. This situation could be remedied by credible websites (e.g. [problemgambling.ca](http://problemgambling.ca); [responsiblegambling.com](http://responsiblegambling.com).) including advice for individuals looking for online support groups and therapy for problem gambling and links to credible sites.

It is important to note that Internet-based support groups (including bulletin boards and chat sites) are not intended as treatment interventions, but rather serve as an adjunct support service where peers can seek and provide advice for others impacted by problem gambling. Very few studies have been conducted to study the impact of online support groups for problem gambling making it difficult to evaluate the efficacy of these forums for assisting gamblers and concerned significant others. However, the research that is available indicates that Internet forums may be useful and beneficial, particularly for those who would not otherwise seek help for example due to fear of stigma, discomfort in face-to-face situations (Cooper, 2004; McGowan, 2003a; Wood & Wood, 2009).

### Gender Specific Online Support Groups

McGowan (2003a) examined a women-only online newsgroups-style forum for problem gambling issues designed as an adjunct to face-to-face support groups. The forum aimed to provide relevant information and facilitate mutual support to assist the processes of recovery in the tradition of GA. Posts on the discussion forums follow the GA tradition of sharing personal stories and common themes included: losing control, loss of material goods and experience of legal consequences, and feelings of shame and self-loathing. Posts also indicated the women's appreciation of hearing others' stories and realising that they are not alone resulting in the construction of an online women's only community that shared their experiences of suffering and offered empathic acceptance. A third category of themes concerned social and moral reconciliation in the process of recovery

from problem gambling including the positive consequences of staying with the GA program.

In addition to posts by problem gamblers, the online forum provided space for professional perspectives where therapists and other experts regularly posted articles about problem gambling and the therapeutic processes. Although the group included a space for professional opinion (which was written in a narrative style in contrast to academic discourses), this is a departure from the tradition of GA, and some embedded references to experts indicated an undercurrent of distrust remains, with a preference for mutual support. Additional benefits of the group included the needs met by gender-specific support groups and ability to write and communicate in a highly expressive and emotionally demonstrative style that is reportedly missing in men-dominated GA groups.

The evaluation of this online group for female problem gamblers indicated that members derived significant benefits from the online community and these benefits were directly related to aspects of the Internet including narrative/written communication, dislike of male-dominated face-to-face meetings, accessibility, and convenience and immediacy.

### GAweb

In an exploratory study (Cooper, 2004), a 41-item survey was completed by 50 pathological gamblers recruited from *GAweb*, a peer-support group, which was available from 1986 to 2001. Participants had a mean age of 43 years, were generally well-educated, evenly divided by gender (52% male) and the majority were married or in a common-law relationship, employed and resided in large urban centres in the U.S.. Overall, 80% of participants reported attendance at some form of face-to-face intervention at some stage in their lives (GA and/or treatment). Despite this, 78% reported at some point they had avoided going to a face-to-face self-help group or treatment, for a range of reasons that were related to stigma, concerns about confidentiality, unwillingness to make a commitment, discomfort about personal disclosure and inconvenience.

The majority of respondents stated that their exposure to *GAweb* had:

- increased the likelihood that they would continue returning to that website (86%)
- increased the likelihood that they would seek out additional forms of Internet self-help (76%)
- increase the likelihood that they would attend face-to-face GA meetings (78%)
- increase the likelihood they would seek face-to-face treatment services (50%)

The majority of participants also reported that the opportunity to engage in lurking behaviour (anonymously reading the postings of others without detection) increased the likelihood of their disclosing gambling problems both online and in face-to-face meetings and treatment. The site appeared to be helpful given that 70% of respondents indicated that *GAweb* made a difference to their gambling behaviour. Positive factors included the ease and immediacy of access to *GAweb* regardless of geography or weather and anonymous nature of the site that increased their levels of honesty. Many also reported that they were helped through the online archives of previous postings, which were always

available. For 20% of the sample, *GAweb* was the only means of help used to deal with gambling problems. This may suggest that for some, online forums may be the only support they are able, or willing, to receive, while for others it is a useful adjunct to treatment interventions. However, as this study utilised a self-selecting sample it is difficult to make generalised conclusions about other problem gamblers who seek help online.

#### U.K. Internet Forums for Problem Gambling

A recent study examined two U.K. online forums designed to support people with gambling problems and others affected by problem gambling (e.g. partners, relatives and friends) (Wood & Wood, 2009). The two forums examined were the GamCare forum and the Gambling Therapy Forum, both of which have been operating for several years by organisations that provide numerous other forms of support services for individuals with gambling problems. At the time when the study was conducted, there were approximately eight thousand registered members across both the forums, around half of those were “active”, in that they had logged in at least once in the last six months.

A content analysis of sixty posts identified that the forums served a variety of purposes including:

- Forum members providing advice or information to another member (38% of posts)
- A supportive statement (37% of posts)
- Personal stories (25% of posts)
- Requests for help and answers to specific questions (24% of posts)
- Personal statements (10% of posts)
- Introductions by new members (8% of posts)

Online interviews were conducted with 19 self-selected participants (10 female), 17 of whom had or were experiencing gambling problems and two who were married to someone with a gambling problem. Analysis of discussions revealed several significant perceived benefits of the online forum including:

- Feeling less alone through shared personal experiences
- A sense of community and friendship providing a means of mutual support
- Assistance with self-discovery and insight through reading others posts and the process of writing their own thoughts down
- Increased feelings of accountability to themselves and other forum members through regular posts
- Being reminded of how bad things can get through reading other’s posts, deterring potential relapses and assisting with resisting urges
- Learning about problem gambling and different strategies for dealing with problems
- Convenience and accessibility, particular for those who were either geographically remote or who could not attend other services because of commitments such as child care

These themes were used to construct an online questionnaire completed by 121 participants (53 male; 52 female 16 unknown). Participants were aged between 18 and 61 years ( $M = 41$ ;  $SD = 11$ ). Participants were mostly white in ethnic origin (96%), two-

thirds were from the U.K., with other participants from the U.S. (14%), Australia (11%), Canada (7%), as well as Sweden (1%) and Finland (1%). The majority of participants (62%) found one of the forums by searching for help on the Internet, with others referred via gambling websites (15%), websites for problem gambling (10%), a friend or relative (6%), telephone helpline (3%), from a professional (3%) or from a sign on a gambling machine (1%). Most participants had been a member of one of the forums for several months (40%), or for a year or more (31%). Half of the participants reported that they used one of the forums every day, and 39% reported using a forum a few times a week. There was no significant association between gender and frequency of forum use.

Most participants went to one of the forums because they were personally experiencing some kind of gambling problem (67%), because they were no longer experiencing gambling problems and wanted some support (17%) or because they were seeking help for a partner, relative or friend (16%). Females were more likely to be seeking help regarding other's gambling problems and males were more likely to be seeking support as recovered gamblers. The majority of participants (58%) reported having contacted another support service at some stage in the past. This was most likely to be a face-to-face support group (30%), a telephone helpline (17%), a doctor (9%) or residential treatment (3%). For those who had used other services previously, the online forum was used due to a preference for help online (56%), additional help (48%), convenience and accessibility (17%), dissatisfaction with previous services (15%) and a desire for a second option (9%). Almost half of participants reported it would be either fairly difficult or extremely difficult to get alternative help (49%) indicating that the online forum is reaching a group of individuals who would not otherwise receive help.

Specific reasons for using the Internet-based forums included the ease of access (80%) and constant accessibility (70%), ability to talk to others in the same situation as themselves (73%), anonymity (49%), and a dislike of discussing gambling issues on the phone (27%) or face-to-face (21%). Participants were very positive about the efficacy of the forums in helping them with their problems. The vast majority of participants found the following features either somewhat useful or very useful

- being anonymous (90%)
- writing a continuous personal diary (57%)
- telling their own story (88%)
- asking for help from other members (81%)
- getting professional advice (56%)
- reading other people's stories (98%)
- having 24 hour, seven days per week access to the forum (97%)
- having a specific section to discuss non-gambling issues (40%)
- discussing Gamblers Anonymous matters (42%)
- and writing responses to other forum members (87%).

There were no significant gender differences in relation to the utility of any of the forum features.

As with previous studies, interpretation of these results requires caution due to the small, self-selected sample utilised. However, until more extensive studies are completed they provide useful insight into the use and benefits of Internet-based support groups for problem gambling.

### GamTalk

*GamTalk* was launched in October, 2008 as a nation-wide free online support service for anyone with gambling issues in Canada. Initially sponsored by the Nova Scotia Gaming Corporation, *GamTalk* provides opportunities for people who wish to discuss their own personal gambling issues, concerns about a friend or relative, or swap advice on how to gamble safely and in moderation. Modelled after similar forums that exist in the U.K. the service offers anonymous forums that are all facilitated by a moderator and an online live chat section. The various forums include:

- An introduction section where new members can introduce themselves
- Chatroom feedback
- My Story – where members can tell their story
- Overcoming Problems – members discuss difficulties and strategies for recovery
- Progress Diary – members record their progress and share their thoughts, feelings, and experiences
- GA Talk – for specific GA issues
- Family and friends – for concerned significant others
- Strategies to help avoid developing problems – for those who don't want to quit gambling but need assistance on staying in control
- The lounge – for non-gambling related topics
- Feedback and suggestions
- A French forum

As of March 2009 *GamTalk* had 234 members, with approximately 2-3 new members joining each day, largely as a result of Google advertisements in the form of sponsored links to particular searches (Wood, 2009). Approximately 150 different visitors are logged each day, who may or may not be members, and members reportedly lurk first before making a post. The site also lists other resources including helpline numbers, other support services, and other international online forums for gambling issues. The site also includes contact details in the form of an email address, allowing members to contact the facilitator directly with concerns or issues. No evaluation has been conducted to examine the usefulness of the site for problem gamblers, although such research would provide valuable information regarding what elements of this service assist gamblers in their recovery without seeking formal treatment.

## **Internet-Based Therapy for Problem Gambling**

### Sweden

The only published randomised controlled trial to evaluate the effectiveness of Internet therapy for problem gambling (to the authors' knowledge) was conducted in Sweden based on slutaspela.nu (Stop Playing) (Carlbring, 2005; Carlbring & Smit, 2008). Participants were current pathological gamblers (N=66), not presenting with severe

comorbid depression. The majority of participants reported problems with Internet poker (38%) or electronic gaming machines (34%) and the sample consisted of mostly males (86%) with gambling debts (71%). Participants were randomly allocated to either a wait-list control or an eight-week Internet based cognitive behaviour therapy program with minimal therapist contact via email and weekly telephone calls of less than 15 minutes. The program was time effective as the average time spent on each participant, including phone conversations, email and administration was four hours.

Treatment was based on established CBT methods, as described in self-help books (Hodgins, 2002; Ladouceur & Lachance, 2006). The text was divided into eight modules; the first four modules included motivational interviewing techniques to assist individuals in making a decision about their gambling. Participants were instructed to answer open-ended questions that would evoke talk of change and were encouraged to ask for input from their relatives on different aspects of their gambling. In addition, the first four modules included a time line follow-back and mapping of the reasons for gambling. The last four modules consisted of the actual treatment. The client completed one module each week which included reading and completed exercises, providing answers to essay-style questions via email, and posting comments on an online bulletin board. Feedback on homework assignments was usually given within 24 hours after participants has sent their answers via email. Once weekly, a telephone call was made by the therapists to each participant with the purpose of providing positive feedback and encouragement as well as to answer any questions of the participant about the modules. Each conversation lasted approximately 15 minutes and the therapist decided whether the client was ready to move to the next module.

Half of the participants completed all eight modules within the intended eight -week period. After this time, participants were given open access to the rest of the program; at six-month follow-up, 68% of participants had completed the entire program. One month following the completion of the program gambling-related problems, anxiety and depression were significantly reduced in the experimental group and quality of life had significantly improved. Anxiety and depression remained low in the treatment group at 6, 18, and 36 month follow-ups. Clinical interviews were conducted over the telephone at 18 and 36 months and found that the majority of participants had made moderate (17.6%, 11.8%) or large improvements (50.5%, 61.8%) demonstrating the long-term maintenance of treatment effects.

The effect sizes in this study were lower at post-treatment than were those reported in a meta-analysis of problem gambling treatments by Pallesen and colleagues (2005 as cited by Carlbring & Smit, 2008;  $d = 2.01$  vs. 0.83). However, this may be due to differences in measurements. Nonetheless, Carlbring and Smit (2008) reported higher effect sizes at the 18- and 36-month follow-ups compared with the mean of the 29 studies included in Pallesen et al.'s metal analysis ( $d = 1.96$  and 1.98 vs. 1.59). However, these effect sizes should be interpreted with caution as they include different outcomes measures. The authors acknowledge that the results of this study are limited by the lack of a follow-up control group (waitlist participants had received treatment by this stage) and the possibility of spontaneous recovery or other extraneous factors that may have boosted

results to overestimate the true impacts of treatment. Nonetheless, this study provides support for the use of Internet-based, therapist guided self-help for treating pathological gamblers who are not severely depressed. The treatment is free of charge and open to all Swedish citizens.

### Norway

The geographic landscape of Norway means many citizens live far away from treatment options and perceived stigma prevents many individuals from seeking help for gambling problems. To overcome these barriers to treatment an online treatment program for problem gambling was launched in November 2007. Funded by the Norwegian Ministry of Health and run by Innlandet Hospital Trust, the program aimed to reach out to groups of problem gamblers not accessing treatment, such as Internet gamblers, and offer greater flexibility in treatment including reduced time and monetary commitment.

The gambling treatment program is run from the site [.spillbehandling.](#) (Distance based therapy for problem gamblers in Norway) and offers a free structured therapy program for problem gambling. All communication between clients and therapists is conducted through the Internet and telephone and the treatment lasts for approximately three months. Client assignments provide the structure and content for the telephone meetings, and all assignments are based on CBT principles. There are a total of nine assignments that need to be completed, in addition to the various screenings: SCL 90-R (Symptom Checklist Revised), GBQ (Gamblers Believes Questionnaire) and SOGS-R (South Oaks Gambling Screen). The assignments are sent once a week through an online account that each client get access to when starting. The assignments focus on topics within gambling behaviour and how to deal with the negative consequences/challenges caused by gambling. The clients also access an online discussion forum, so they can communicate with each other.

The nine assignments consist of:

- Motivation / goals
- Readiness to change (the stages)
- Analyzing gambling situations
- High-risk situations / Identifying automatic erroneous thoughts
- Flashcard & notebook (Self-help tools used in treatment)
- Financial situation and challenges
- Relationship, trust/honesty

When the program was initially launched clients were required to have a referral from their GP to start treatment. However, in March 2009 intake procedures were modified to allow clients to contact the therapists and program coordinators directly through the website to commence treatment.

The site received 400-600 hits per month between December 2007 and June 2008. As of April 2009, a total of 59 clients had contacted the program to start treatment. This included 41 clients referred by their doctor and 18 signed up through the website since March 2009. The majority of participants are males (51 men, 8 women) and ages range

from 19-56 years. Online gambling is the most commonly cited presenting problem, with online casinos (slot machines) followed by online poker being the highest represented forms of gambling although football betting and horserace betting are also represented as main problems.

The majority of clients (n=22, 37%) have reportedly completed the treatment program and claim to have reached their goal to stop gambling which has resulted in significant improvements in quality of life. In addition to self-report measures, repeated SCL 90-R and GBQ measures indicate a positive change in all symptoms including depression, anxiety and concentration. The GBQ retest shows fewer erroneous thoughts regarding gambling behaviour. Some clients continue to gamble after completing the program, but describe this to be more controlled and reduced as compared to before treatment. Of the 59 clients who have expressed interest in starting treatment since the program began, nine (15%) never started and eight (14%) dropped out, while 20 (34%) are still in treatment or about to commence treatment. Most of the clients who dropped out quit early, that is, before completing half of the program. Two clients reported that they had reached their goals, describing no more urges to gamble and therefore wished to leave the program. The remained did not explain their reasons for quitting.

Clients have reported positive feedback on the treatment and satisfaction with the combination of written email assignments and telephone calls. The program is intended to offer a complete treatment, although it may also be used in addition to other forms of therapy including group therapy or GA. Follow-up phone calls are made at three and six months after treatment to check in with clients. In a report of the program there appeared to be no technical issues, and the program appeared to be successful in reaching clients who live in areas without outpatient treatment, making it easier to seek help (Eidem, 2008). However, difficulties included problems reaching clients, clients being able to skip appointments or not complete assignments and treating clients who live outside of Norway. Clients have also reported that online therapy is in very close proximity to online gambling sites, which may be a temptation. Further information is expected to be available during 2009.

### Finland

Similar to online gambling treatment programs operating in Norway and Sweden, Finland also offers online therapy for problem gamblers. Initially begun for alcohol, drug and mental health treatment the use of Internet-based protocols is designed to empower clients to use their own resources and take advantage of the strength of the written word. Additionally, the online program aims to overcome shame and stigma associated with face-to-face therapy, and lower the threshold to seek help. *Päihdelinkki* (=AddictionLink in English) offers a full-service addiction site for Finland including peer support and discussion, self-help resources and professional support and counselling. Founded in 1996, the site is accessed by approximately 40,000 individual visitors a month (Peltoniemi & Bothas, 2007). For example, in May 2006, 6,179 individuals took the online gambling test and 7,5975 individuals used the online discussion forums. Approximately 12% of counselling provided by the site is for problem gambling, which included individuals seeking help for their own gambling problems and concerned

significant others seeking help relating to another's gambling. Further research regarding this site is expected to be available in 2009.

#### United Kingdom

*GamAid* ([.gamblingtherapy.](http://www.gamblingtherapy.com)) is an online service that provides clients with available links and information or allows clients to talk to an online advisor (during the hours of service), or request information to be sent via email, mobile phone, or post (e.g. referrals to local services). *GamAid* aims to reduce client gambling behaviour and provide assistance for clients to do so, but is not intended as a traditional treatment service as advisors communicate with clients in order to provide reassurance and give advice rather than act as counsellors.

Launched in November 2004 (forum and support group followed in June 2005) the services offered include online advice and support for individuals, online support groups, a forum, and a database of resources. The first contact is the Helpline, where an individual is connected to an advisor anonymously, and can see the advisor over a webcam connection (one-way) but communicate by typing. Online support groups are run at various times providing live chat with others, facilitated by a therapist. A 24 hour forum is also available and email advice (reply within 24 hours) can be used, with a multilingual service available (spanning 22 countries). Online counselling services are available with British Association of Counsellors and Psychotherapists (BACP) accredited counsellors, however there is normally a charge for this service.

In the first three months of operation in comparison to the existing phone line *GamAid* was able to respond to approximately 20% more 'calls', although the vast majority of these were 'answered' passively as opposed to actively (Farrel-Roberts, 2005). In the first three months of operation 20,889 individuals visited the site (although this may include repeat visitors), 4,422 clients talked to an advisor, 1,072 talked to a counsellor, 744 sent emails and 10% of clients were less than 18 years of age. The majority of clients were from the U.K, although a significant proportion of clients were from the U.S., with Canada also represented as a minority of clients.

In an evaluation study of *GamAid*, 80 clients completed an online evaluation 15-item questionnaire over a period of nine weeks (Wood & Griffiths, 2007). The response rate was 19.4%, with significantly more females responding, and as such the results should be interpreted with caution as it is difficult to ascertain whether this service is more appealing to females, or whether females were more likely to respond to the survey. As the sample was self-selected this may present a biased interpretation of the service. The respondents were aged between 14 and 64 years ( $M=36$ ,  $SD=11$ ) and were mostly Caucasian (86%). Of those seeking help for a gambling problem Internet gambling was the preferred form of gambling for the majority of respondents (28%), followed by bookmakers (18%). Internet gamblers utilised *GamAid* service more than any other comparable U.K. service (in contrast to Wood & Williams, 2009), indicating that this may be an appropriate mode of support for this group, which is important given the higher prevalence of problem gambling amongst Internet gamblers (Focal Research

Consultants, 2008; Volberg, Nysse-Carris, & Gerstein, 2006; Wood, Williams, & Lawton, 2007).

When asked their reason for accessing the site, 65% of the participants reported they were experiencing gambling problems, 26% wanted help for a friend or relative and 9% sought help, guidance and advice on specific issues (e.g., recovering gamblers seeking additional support or reassurance from spouses of problem gamblers in treatment). When asked how useful *GamAid* was, the vast majority agreed or strongly agreed that:

- *GamAid* provided a useful service (86%);
- helped participants consider their options (84%);
- helped the participant be more confident to seek other help (80%);
- helped the participant decide what to do next (71%) and
- made the participant feel more positive about the future (63%).

Additionally, the majority of participants agreed or strongly agreed that the *GamAid* advisor they contacted online understood their needs (85%) and was supportive (88%). The questionnaire also elicited qualitative feedback which indicated that clients appreciated the immediate availability of the service and assistance provided, that it was faster and cheaper than phone calls, and that they did not have to directly talk to a counsellor.

Due to the cross-sectional nature of the study, brief time period and small, non-representative sample, this study (Wood & Griffiths, 2007) did not provide any data on the effectiveness of *GamAid* services in reducing problematic gambling behaviour. The evaluation study did suggest that *GamAid* is successfully assisting individuals to consider options, feel more confident about seeking help, and providing useful information of local help, referrals and additional information. *GamAid* offers an international service that is free-of-charge and most of those who had used another service reported that they preferred *GamAid* because they preferred online help as it was easier to access and they were more comfortable talking online than on the phone or face-to-face. Technical problems were found with the site including difficulties reading the communication screen, and blocks placed by corporate and university systems preventing individuals accessing *GamAid* from some networks. Overall, the brief evaluation found that *GamAid* appears to provide a useful service, particularly for online gamblers and women, catering for individuals around the world.

### Australia

*Improving the Odds* ([://www.improvingtheodds.com.au/](http://www.improvingtheodds.com.au/)) is an internet-based treatment program that was developed to assist problem gamblers to either control or abstain from gambling. The program is based at Griffiths University and available for Australian residents only. Before commencing treatment, all clients must meet DSM-IV criteria for pathological gambling as assessed by an online checklist. Participants in the *Improving the Odds* program complete sessions online and are provided with automated feedback on their progress. The program uses CBT techniques and involves participation in six weekly sessions online. The focus is on learning skills and strategies to assist individuals to be able to control their gambling behaviour and urges. A research study is currently

underway to examine the effectiveness of this program and results are expected to be available in 2009.

### Canada

A pilot project was conducted by the International Centre for Youth Gambling Problems and High-Risk Behaviors at McGill University to provide online help for adolescents and young adults with gambling problems throughout Canada. The Centre developed an online platform operated by psychology graduate students (supervised by psychologists) that offered individual and group chats for approximately 28 hours per week. The online chat software was encrypted to provide ultimate security to individuals.

Topics included focused upon:

- Understanding the motivations for gambling
- Analysis of gambling episodes
- Establishing a baseline of gambling behaviour and encouraging a decrease in gambling
- Addressing cognitive distortions
- Establishing the underlying causes of stress and anxiety
- Evaluating and improving coping abilities
- Rebuilding healthy interpersonal relationships
- Restructuring free time
- Fostering effective money management skills
- Relapse prevention

The creative team for website design including developmental psychologists, gambling and media experts and graphic designers developed all the rooms on the website. The website was field tested on adolescents for its attractiveness and appeal. The separate teen and young adult (aimed at college-aged youth) sites were widely promoted through schools, universities, health care providers, and popular media (including youth magazines and television shows) across Canada. Staff training included the development of a comprehensive and detailed training manual that was revised based on student feedback.

From January through June, 2007 the site had 2,161 different visitors; 4,102 visits; and 1,031,893 hits. In total, from inception (November 2005) through the end of June 2007 the site has received 1,999,778 hits. Although the website received a large number of visitors and hits, and strong endorsement from the clinical and educational community, the number of adolescents engaged in this service was minimal. Upon completion of the pilot project funding was not continued and the websites are no longer operational. The chief reason cited for the project termination was a lack of clients to warrant service continuation.

### **Questions for an organisation to consider before proceeding with the provision of Internet counselling**

- Which type of online counselling services will be delivered and in what order will they be delivered?
- Do they have the technological capacity to support these changes?
- Do they have sufficient human resources to train, develop, implement, manage and supervise online services?
- Will they charge for online services?
- How will they identify clients and secure client confidentiality?
- Will their insurance company cover them for this service?
- Will an evaluation of online services be completed?
- What ethical and professional position will be taken?

### **What needs to be done in order to provide online counselling**

Koocher and Morray (2000) recommend attention to seven specific areas for practitioners who decide to offer Internet therapy 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
  - Open disclosure to third-party payers of services that were delivered electronically
- An appropriate Internet-based intervention must be designed. It has been suggested that existing CBT treatments and self-help guides that have been empirical support should form the basis of Internet Therapy. Certain aspects must be adopted for appropriate Internet use and minimal therapist support. A continual evaluation program should be conducted to assess shifts in focus on which treatment components to emphasise.
  - Potential clients need to be directed towards appropriate online help.
    - There is such a vast degree of content on the Internet, the majority of which is not helpful, and furthermore may be harmful to problem gamblers (e.g. online gambling sites).
    - Individuals seeking help for gambling problems must know where to find it. Widespread media campaigns should be used to advertise the availability of any online gambling counselling services and how these can be accessed.
  - Clinicians and health workers need to be educated about the benefits of online counselling so that appropriate referrals can be made.
  - It needs to be clarified that Internet therapy is not intended to replace face-to-face therapy, but act as an adjunct to encourage those who do not seek traditional forms of help to consider a new form of assistance or act as a 'booster' or those currently or previously engaged in treatment.

- More research is needed to investigate the impacts of online counselling. Many clinicians are slow to adopt Internet counselling due to the paucity of research demonstrating its effectiveness, particularly compared to face-to-face therapy.

### Training of Internet Therapists

Many highly trained and experienced counsellors mistakenly assume skills will be easily transferable online and that they will not need any additional skills to engage in Internet therapy (Helton, 2003). This is a largely incorrect assumption; Internet therapists need to be adequately trained and supervised to acquire the skills involved in engaging, building a therapeutic bond, and effectively treating a client entirely based on text communication. Therapist skills in providing treatment via the Internet include the ability to communicate empathy via text as well as positive reinforcement and encouragement (Abbott et al., 2008; Childress, 2000; Mallen et al., 2005). Online practitioners need to be aware at the difficulty in conveying intonation and the possibility of being misinterpreted.

The Clinical Case Study Group of the International Society for Mental Health Online suggest that Internet therapists need specialised training for aspects of technology, theory, applications and ethics related to the provision of online therapy (Fenichel et al., n.d). Clinicians need to be skilled writers and typists. They require sufficient technological training to be able to inform, warn and guide clients through any technical issues likely to be encountered. Online therapists must know how to find resources and referrals for clients and to verify client identity or locate emergency resources. They must be competent enough to evaluate website design and security. Clinicians also need a working knowledge of the phenomena particular to online communication such as disinhibition and masking of affect. Internet therapists should be aware of and be able to discuss with clients the potential risks involved with online therapy including clients being vulnerable to unscrupulous individuals and untrained/unlicensed counsellors, reduction in primary face-to-face relationships in favour of online relationships and development of inappropriate online relationships and boundaries.

Methods of training include Internet therapists using the technologies in supervision sessions, practicing skills and techniques using “dummy” participants, observing the work of experienced Internet therapists and incorporating Internet therapy curriculum into therapist training and professional development programs (Abbott et al., 2008; Mallen et al., 2005).

## **FURTHER RESEARCH**

Further research should address the following areas:

- The differential effects and effectiveness of various online therapeutic interventions for problem gambling. For example, the benefits of Internet therapy versus online unassisted self-help versus peer-based support groups.
- Which clients are suitable candidates for online therapy? Research is needed to clarify important inclusion and exclusion criteria to establish which clients would

benefit from Internet therapy and which clients should be referred to other forms of help.

- Is Internet therapy providing services for clients who would normally not seek treatment? i.e. is this mode of therapy extending or replacing existing services
- How to educate consumers about Internet therapy to assist potential clients in assessing whether Internet therapy is suitable and how to select a therapist and behave in therapy, i.e. what is expected of them and what they should expect of a therapist.
- Evaluation and random controlled trials of the effectiveness of Internet-based interventions for problem gambling.

## CONCLUSIONS

Despite some evidence of Internet therapy's usefulness, it is important to emphasise that the services are not intended to replace traditional face-to-face meetings with trained professionals. Practitioners and researchers have combined modes of treatment in an attempt to offer new or extended forms of therapeutic services. It is expected that this form of therapy will create new opportunities for new forms of communication to supplement mental health services. As reviewed in this report, there are too few studies evaluating the effectiveness and impact of Internet therapy for problem gambling. Furthermore, these are limited in their samples and methodologies, making it difficult to generalise the findings. Therefore, as with any new intervention, it is important to continue to conduct studies to investigate the impact of this new mode of service delivery.

As a whole, Internet therapy should be viewed as an adjunct to face-to-face therapy at a societal level. The central benefits of Internet therapy are that it allows a potentially effective intervention to be offered to individuals with clinical psychological problems, who would not otherwise seek or receive help. Internet therapy is not suited to all individual clients or clinicians, but offers an important and useful intervention that may be used by a greater proportion of individuals in need of professional therapeutic assistance who would not otherwise seek assistance.

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## APPENDICES

### Appendix A

#### Online gambling support groups – based on Google search “online problem gambling support groups”

- Gamblers Anonymous L.A. chat room (open to all registered GA members)
- Getting Past Gambling (<http://www.gettingpastgambling.com/>) - chat room, no obvious facilitator listed
- Linked By Addiction – reported to close February 2009 possibly due to lack of maintenance
- Recovery & Beyond ([.recoveryandbeyond.](http://recoveryandbeyond.com)) – online support forum combined with exercise from work books (purchase required) run by Shawn Jordan and Drew Hartt (recovered gamblers). Based in Calgary.
- Safe Harbor Compulsive Gambling Hub ([.sfcghub.](http://sfcghub.com)) – Message boards and chat rooms for compulsive gamblers and friends/family. Donations accepted, based in Los Angeles, CA.
- Kazs Coffee Lounge ([://au.groups.yahoo.com/group/kazscoffeelounge/](http://au.groups.yahoo.com/group/kazscoffeelounge/)) – Message boards for problem gamblers, based on, but not affiliated with GA. Founded in November 2001 179 members, 372 messages posted in Jan 2009.
- The Last Bet ([://health.groups.yahoo.com/group/thelastbet/](http://health.groups.yahoo.com/group/thelastbet/)) – Online message board, predominantly, but not limited to women. Established March 2003, 76 members, 343 posts in January 2009.
- Gambling Addiction & Recovery Support Group ([://dailystrength.org/c/Gambling-Addiction/support-](http://dailystrength.org/c/Gambling-Addiction/support-)) – Bulletin board
- Smart Recovery ([.smartrecovery.](http://smartrecovery.com)) – free face-to-face and online help groups based on SMART self-management and recovery training. Includes all addictions including gambling. Based in Mentor, OH. Cited as being recognised by the American Academy of Family Physicians, the Center for Health care Evaluation, the National Institute on Drug Abuse (NIDA), US Department of Health and Human Services, and the American Society of Addiction Medicine.
- Gambling Therapy ([.gamblingtherapy.](http://gamblingtherapy.com)) – available internationally. Offers online support groups, forums and email therapy. Launched by Gordon House Association (now the Gordon Moody Association) in November 2004.
- Problem-gambling.org – Chinese website
- Getting Past Gambling ([://health.groups.yahoo.com/group/GettingPastGambling/](http://health.groups.yahoo.com/group/GettingPastGambling/)) – online forum
- Recovery World Gamblers Anonymous ([://www.recovery-world.com/Gamblers-Anonymous.](http://www.recovery-world.com/Gamblers-Anonymous/)) – facilitates chat rooms, online meetings and email meetings, based on GA to address problem gambling in a multilingual forum.

## **Appendix B**

### **National Board for Certified Counselors – Standards for the Ethical Practice of Internet Counseling**

#### **Internet Counseling Relationship**

1. In situations where it is difficult to verify the identity of the Internet client, steps are taken to address impostor concerns, such as by using code words or numbers.
2. Internet counselors determine if a client is a minor and therefore in need of parental/guardian consent. When parent/guardian consent is required to provide Internet counseling to minors, the identity of the consenting person is verified.
3. As part of the counseling orientation process, the Internet counselor explains to clients the procedures for contacting the Internet counselor when he or she is off-line and, in the case of asynchronous counseling, how often e-mail messages will be checked by the Internet counselor.
4. As part of the counseling orientation process, the Internet counselor explains to clients the possibility of technology failure and discusses alternative modes of communication, if that failure occurs.
5. As part of the counseling orientation process, the Internet counselor explains to clients how to cope with potential misunderstandings when visual cues do not exist.
6. As a part of the counseling orientation process, the Internet counselor collaborates with the Internet client to identify an appropriately trained professional who can provide local assistance, including crisis intervention, if needed. The Internet counselor and Internet client should also collaborate to determine the local crisis hotline telephone number and the local emergency telephone number.
7. The Internet counselor has an obligation, when appropriate, to make clients aware of free public access points to the Internet within the community for accessing Internet counseling or Web-based assessment, information, and instructional resources.
8. Within the limits of readily available technology, Internet counselors have an obligation to make their Web site a barrier-free environment to clients with disabilities.
9. Internet counselors are aware that some clients may communicate in different languages, live in different time zones, and have unique cultural perspectives. Internet counselors are also aware that local conditions and events may impact the client.

#### **Confidentiality in Internet Counseling**

10. The Internet counselor informs Internet clients of encryption methods being used to help insure the security of client/counselor/supervisor communications. Encryption methods should be used whenever possible. If encryption is not made available to clients, clients must be informed of the potential hazards of unsecured communication on the Internet. Hazards may include unauthorized monitoring of transmissions and/or records of Internet counseling sessions.

11. The Internet counselor informs Internet clients if, how, and how long session data are being preserved. Session data may include Internet counselor/Internet client e-mail, test results, audio/video session recordings, session notes, and counselor/supervisor communications. The likelihood of electronic sessions being preserved is greater because of the ease and decreased costs involved in recording. Thus, its potential use in supervision, research, and legal proceedings increases.
12. Internet counselors follow appropriate procedures regarding the release of information for sharing Internet client information with other electronic sources. Because of the relative ease with which e-mail messages can be forwarded to formal and casual referral sources, Internet counselors must work to insure the confidentiality of the Internet counseling relationship.

### **Legal Considerations, Licensure, and Certification**

13. Internet counselors review pertinent legal and ethical codes for guidance on the practice of Internet counseling and supervision. Local, state, provincial, and national statutes as well as codes of professional membership organizations, professional certifying bodies, and state or provincial licensing boards need to be reviewed. Also, 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. Internet counselors also consider carefully local customs regarding age of consent and child abuse reporting, and liability insurance policies need to be reviewed to determine if the practice of Internet counseling is a covered activity.
14. The Internet counselor's Web site provides links to websites of all appropriate certification bodies and licensure boards to facilitate consumer protection.