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Professional Issues

Crossing the Line: Interstate Delivery of Remote Psychological Services

James D. Herbert, ***Drexel University***

Elizabeth M. Goetter, ***Drexel University, University of California, San Diego*****, and** ***VA San Diego Healthcare System***

Evan M. Forman, ***Drexel University***

Erica K. Yuen, ***Drexel University, Medical University of South Carolina, Ralph H. Johnson Veterans Affairs Medical Center***

Breann M. Erford, Joseph J. Milillo, and Stephanie P. Goldstein, ***Drexel University***

The past decade has witnessed a dramatic increase in interest in evidence-based practice in applied psychology and related fields. Given its historical grounding in science, it is not surprising that behavior therapy has emerged at the forefront of this movement. Despite the widespread need for efficacious and cost-effective treatments and the development and scientific validation of interventions for a range of conditions, many of those who could benefit from such services do not receive them (Kohn, Saxena, Levav, & Saraceno, 2004; Wang, Berglund, & Kessler, 2000).

There are a number of reasons for the gap between the development of scientifically sound, evidence-based practices, the availability of such services, and the ability of those in need to access

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them. Among these barriers are problems associated with dissemination, cost, stigma, and, most important, geography. Dissemination efforts have been hampered by insufficient resources, especially considering what is required to train existing providers in new treatment modalities. Even when available, the cost of services is prohibitive for some individuals. In some communities there remains a stigma associated with psychotherapy. Linguistic minorities may not have access to trained providers who speak their language. Individuals with physical or mental disabilities may be unable to travel easily to a provider's office.

Technology and the Problem of Geography

Many of these barriers reflect a fundamental reality of contemporary mental health services: There is a geographic maldistribution of trained providers with respect to many of those in need. In Kansas, to cite just one example, the vast majority of mental health providers live in two urban areas, and 100 of the state's 105 counties are designated as mental health professional shortage areas (Nelson & Velasquez, 2011). Indeed, approximately three-quarters of the counties nationwide have a shortage of mental health professionals (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009), and these geographic barriers are even more acute for ethnic minority populations (McCord et al., 2011). The mismatch in location between providers and patients is even more pronounced when it comes to specialist providers, such as behavior therapists specializing in the treatment of a particular condition. For example, in a review of the ABCT therapist directory, we found that only 167 out of over 2,000 therapists (8%) reported a specialization in the treatment of social anxiety disorder, and among the 8% of therapists who did report such expertise, only 1% practiced in a nonmetropolitan area (Yuen, Herbert, Forman, Goetter, Comer, & Bradley, 2012).

A promising approach to addressing this gap is through technology. Over the past few years, a growing number of health-care providers have begun exploring the use of various communication technologies to deliver services remotely. Various terms have been used to describe this approach, including *telehealth* and *e-health*, and with respect to behavioral health services in particular, *telemental health* or *telepsychology* (Baker & Bufka, 2011). Commonly used technologies include the telephone, cell phones and other mobile devices (e.g., tablets), websites (with or without adjunctive therapist assistance), Internet-based virtual-reality platforms (e.g., Second Life), and videoconferencing programs (e.g., Skype, Google Chat, iChat, FaceTime; Yuen, Goetter, Herbert, & Forman, 2012). Through these technologies, specialist providers can offer services to patients situated at geographically distant locations. In recognition of the role that remote treatments are destined to play in the U.S. health-care system, the landmark federal Patient Protection and Affordable Care Act of 2010 features a number of provisions to promote telehealth.

Many of the advantages of such remote services are obvious. Individuals, regardless of location, can gain access to specialist providers who would otherwise remain out of reach. For example, a housebound Spanish-speaking mother suffering from panic disorder with agoraphobia in rural Iowa can be connected with a Spanish-speaking anxiety disorder expert in Philadelphia via the videoconferencing pro-

gram Skype. Remote treatments are convenient, as patients can access services from their home, while traveling, or on breaks at work. They reduce the burden of commuting, parking, and accrued transportation costs. Remote treatments may help address the issue of stigma for some individuals because of the added confidentiality afforded by not having to sit in a quasi-public waiting room at a therapist's office. They also prevent dual relationships that can occur in rural or small town settings in which providers and patients may know each other. Furthermore, remote treatments promote high-quality services and healthy competition among practitioners by providing consumers access to a range of services beyond one's immediate physical community.

There are also a number of corresponding issues that must be addressed with these new modalities of service delivery, including concerns regarding confidentiality, the therapeutic relationship, crisis management, technological problems, and therapist competence (Van Allen & Roberts, 2011). Confidentiality can be compromised by breaches in electronic security systems (Schwartz & Lonborg, 2011). Of course, it should be remembered that traditional face-to-face communications are not necessarily at lower risk of security breaches (e.g., unauthorized physical access to protected health information), and well-configured Internet-based services can actually provide additional levels of confidentiality in some respects. Another area of concern is whether the critical therapist-patient relationship will be degraded by remote treatment formats. Although anything other than traditional, in-person, face-to-face contact will undoubtedly be less desirable for some individuals, it should not be assumed that remote treatment (e.g., via videoconferencing) negatively affects the therapeutic relationship or results in less effective treatment. Research shows that both strong therapeutic alliances and treatment results can be achieved through remote intervention (Bouchard et al., 2004). In fact, a meta-analysis found no differences in treatment effect sizes for randomized controlled trials comparing in-person and Internet-based treatment modalities (Barak, Hen, Boniel-Nissim, & Shapira, 2008). Moreover, no research evidence to date supports the assumption that traditional face-to-face treatment is superior to comparable remotely delivered treatment (Harris & Younggren, 2011).[1] Nevertheless, such unsubstantiated assumptions persist, as reflected in a policy statement of the Massachusetts Board of Psychologists that raises cautions about remote practice (Massachusetts Office of Consumer Affairs and Business Regulation, 2006).

Being at a geographic distance may pose challenges in dealing with crisis situations such as domestic abuse or suicide attempts. As they would do in their home state of practice, it is important that clinicians familiarize themselves with the appropriate resources in the patient's community, as well as applicable local standards (e.g., which standards with respect to duty-to-warn/protect are operative in a given jurisdiction). Again, however, even in traditional settings, such crisis management already relies on technological tools, particularly the telephone, and telemental health settings do not preclude use of these tools. Finally, telepsychology demands that providers not only practice within their areas of competence, but also that they be competent with respect to whatever technological tools they utilize.

In summary, the use of technological tools to deliver psychological services remotely has enormous potential for bridging the gap between evidence-based services and those in need, but also presents various challenges. These challenges are not insurmountable, and in fact, solutions are quickly emerging with the rapid evolution of this field.

Interjurisdictional Practice

The biggest barrier to the widespread adoption of telepsychology is not technological or therapeutic, but regulatory. That is, it remains unclear what services can be legally offered across state lines within the U.S. When a psychologist consults with her patient who is located in a different state, the question arises as to where the interaction is taking place; is it the state in which the psychologist is located, the state in which the patient is located, the state in which the computer server is located, or perhaps some combination of these?[2] The 10th Amendment to the U.S. Constitution reserves the powers not explicitly delineated to the federal government to the states, and this includes the licensure of health-care professionals. Psychologists, physicians, social workers, counselors, and other health-care professionals are therefore licensed by the individual states. Moreover, each state has different legislative and regulatory standards, and there is no general reciprocity across states.[3]

In an effort to shed light on this issue with respect to the practice of psychology in particular, the American Psychological Association's Practice Organization (APAPO) recently conducted a review of the licensure laws and associated regulatory standards in all 50 states (APAPO, 2010). This review found that only 3 states

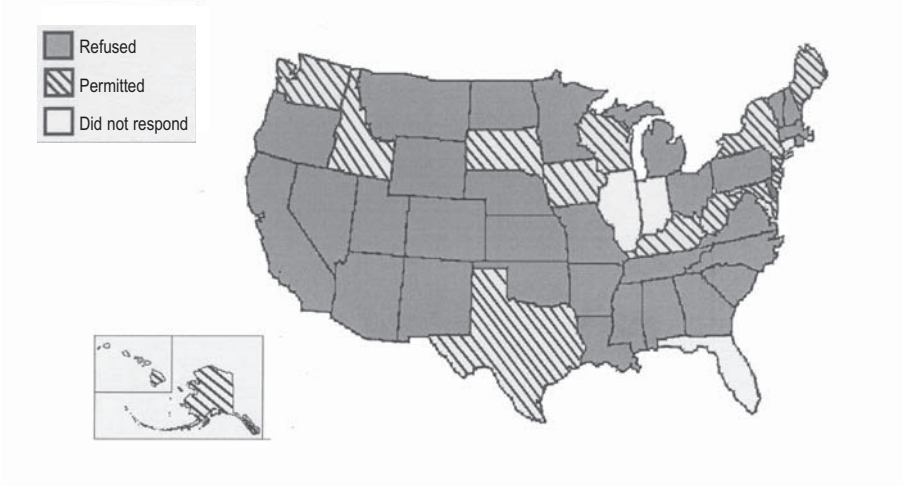

Figure 1. Response by states to request to permit residents to receive remote study treatment

[1]Gros, Yoder, Tuerk, Lozano, and Acierno (2011) found that videoconferencing exposure therapy for veterans with posttraumatic stress disorder, although quite effective in absolute terms, appeared to be somewhat less effective than in-person exposure therapy. However, the patients were not randomly assigned to conditions, precluding conclusions about differential effectiveness.

[2]The present discussion will focus on the licensure of professional psychologists, although the issues are similar for other health-care professionals, who are also licensed by the individual states.

[3]Licensure is likewise handled by the individual provinces in Canada.

(California, Kentucky, and Vermont) have laws specifically governing telehealth that apply to psychologists. The specific provisions of the three laws vary considerably. For example, the California statute explicitly excludes telephone and email communications, whereas Vermont makes no such exclusions. The laws also differ with respect to the specific information that is required to be disclosed to patients undergoing remote psychological services. The boards of 8 additional states (Colorado, Florida, Georgia, Massachusetts, North Carolina, Texas, Virginia, and Wisconsin) have issued opinions on telepsychology, generally specifying the issues that should be covered in obtaining informed consent (e.g., potential confidentiality risks associated with breaches in security). With respect to the delivery of psychological services across state lines, the APAPO report found that several states (e.g., Florida, Georgia, Massachusetts, North Carolina, Texas, and Wisconsin) have issued policy statements. Although the specifics vary, these policies generally require that psychologists be licensed in the state in which the recipient of services is located. Despite such explicit policies prohibiting interstate practice, the boards reported little enforcement activity to date.

Despite the comprehensiveness of the APAPO review, it remains unclear how the state licensing boards interpret the standards, especially given that the majority of states do not have telepsychology laws, and the majority of state boards have not issued explicit policy statements. The psychology licensing boards are charged with interpreting their state licensure laws, and are typically afforded considerable discretion to establish policies and procedures that govern the practice of psychology. This authority becomes especially important given that there are few explicit legislative guidelines with respect to interjurisdictional practice. In addition, many state laws treat trainees and research studies somewhat differently than routine clinical practice, which further complicates the question of when interstate practice may be allowed. Moreover, state boards tend by nature to be conservative, and licensure laws were developed in an era in which psychological services were restricted to situations in which the provider and consumer were located in the same room (Harris & Younggren, 2011).

In 2010, we launched a research project in which we sought to evaluate the effectiveness of a cognitive behavior therapy program for obsessive-compulsive disorder delivered via the teleconferencing program Skype (Goetter, Herbert, & Forman, in preparation). Following Institutional Review Board approval, announcements for the study were posted online, and we began receiving solicitations of interest from around the country. Before proceeding, we determined that it would be prudent to seek explicit permission from each state licensing board to treat individuals within their state. Specifically, we sought clarification from each state licensing board, as a complement to information provided on websites and by the APAPO review, regarding their view of the legality of offering clinical services via telepsychology in the context of a research study.

Method and Results

A letter was sent to the state licensing boards in 49 states, plus the District of Columbia. The letter described the study, and noted that patients from the state in question may be contacting us regarding enrolling. We requested that the board indicate whether such treatment would or would not be permitted under the board's interpretation of state statutes and related policies. As the authors are located in Pennsylvania, we inquired of the Pennsylvania board how it would treat a request from a psychologist licensed in another state to provide telepsychology services to a Pennsylvania resident.

Over the following 3 months, 20 states responded to this initial letter. Of these, five states (Hawaii, Idaho, New Jersey, South Dakota, and Wisconsin) approved the enrollment of residents of their states in the project, and 15 states refused (Alabama, California, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Montana, New Hampshire, North Carolina, Ohio, Oklahoma, South Carolina, Vermont, and Wyoming).

We then undertook a coordinated, additional 7-month effort to contact the licensing boards of the remaining 29 states and the District of Columbia. This consisted of emails, letters, and telephone calls, including several repeated attempts to reach the boards that were initially unresponsive.

Through these efforts, all but 4 states eventually responded to our requests for clarification. In addition to the 5 states that originally permitted practice within their

state, an additional 9 states and the District of Columbia granted permission for their residents to participate in the study. The final breakdown is illustrated in Figure 1. A total of 15 state boards (including the District of Columbia) granted permission to treat individuals within their state in the context of this study, whereas 31 states explicitly prohibited doing so. Despite repeated attempts using various methods, 4 states (Connecticut, Florida, Illinois, and Indiana) never replied to our request. In the case of Pennsylvania, the board referenced a 1999 memorandum that neither approved nor disapproved the practice of telepsychology, and sent an email indicating that the board did not have the authority "to issue advisory opinions or pre-approve specific conduct." In a telephone conversation, the board administrator indicated that it was likely that the board would view a request to provide telepsychology services to someone within Pennsylvania as requiring licensure within the state (Christina Stuckey, personal communication, March 27, 2012).

The responses of the states varied considerably along a number of parameters. In some cases, an administrative staff person replied to our request, whereas in other cases the reply came from a board member or an attorney. A few states (e.g., Idaho) explicitly applauded our efforts to seek clarification on these issues and provide treatment to their residents. Others (e.g., Alaska) expressed a laissez-faire approach, leaving it up to the individual resident to decide whether he/she wanted to pursue treatment from a provider out of the state. Some states (e.g., North Carolina), even when ultimately deciding that they could not permit remote treatment of their residents, reached out to us to explore the possibility of some kind of exception that might permit the project to proceed. In contrast, one state sent a sharply worded letter from an attorney forbidding any involvement of the state's residents in the project.

Of the states that did permit their residents to obtain remote treatment, the reasons likewise varied. Even among these states, most did not permit psychologists from outside their jurisdiction to practice without limits. In some cases, exceptions to a general prohibition against interstate practice were made because the project was a research study rather than for-profit clinical services. In other cases, exceptions were made because the therapists were supervised trainees in a doctoral program, and were explicitly excluded by statute to practice limitations placed on licensed psychologists. Finally, other states permitted the project under a temporary practice exemption, which allows psychologists licensed in another state to practice within the state for a limited number of days per calendar year.

Regarding the temporary practice exemption, it is noteworthy that although several states have such exemptions in their licensing statutes, some contain ambiguities that are open to interpretation. For example, it is sometimes unclear if an exemption of 20 days per year refers to 20 total days or 20 consecutive days, and if any contact whatsoever (e.g., scheduling an appointment) "counts" as one of these days. Although some boards were helpful in interpreting these ambiguities, other boards steadfastly and expressly refused to provide clarification of their own statutes and policies.

Discussion

Internet-mediated and related forms of remote psychological services can greatly increase the availability of evidence-based practice, including various forms of behavior therapy. The practice of remote treatment is growing rapidly, as evidenced not only by the rapid growth of professional and scientific publications in the area, but stories in the popular media as well. The widespread availability of mobile devices, broadband Internet connectivity, and related user-friendly software applications is rapidly changing the way psychotherapy is practiced. For example, in an early paper on telepsychology published only just over a decade ago, Childress (2000) opined that it was unlikely that videoconferencing technology would ever become widely available or accepted. Yet Skype alone now has nearly 700 million users worldwide, with up to 34 million of them using the service at any given time (Rao, 2011; Russell, 2012).

Inconsistent Legal and Regulatory Landscape

Unfortunately, the regulations governing the practice of remote treatment have not kept pace with these developments. State licensure laws are inconsistent with one another, and typically are silent with respect to the subject of interjurisdictional practice. The few practice guidelines that exist for remote psychological services are confusing and sometimes even contradictory with one another.

Given that the interpretation of each state's licensure statute resides with the state's licensing board, we attempted to clarify each state's policies with respect to interstate delivery of remote treatment in the context of a clinical research study by contacting the various state boards. The majority of the boards interpreted their laws such that psychological services provided to residents of their state were considered to be taking place within that state, regardless of the practitioner's physical location. Thus, psychologists not explicitly licensed within the state were prohibited from practicing within it. The states that did permit the study to proceed did so based on a variety of rationales. In some cases a board explained a specific exception to their law that would otherwise require licensure within that state to practice within its boundaries, whereas in other cases a board simply indicated that the study could proceed but without articulating its reasoning.

Our findings illustrate the inconsistency across states with respect to the legality of the interstate practice of psychology. In discussions of remote psychological services across state lines, many authors have emphasized the importance of contacting the state licensing board in which a potential patient resides to seek guidance (APAPO, 2010; Pennsylvania State Board of Psychology, 2010). The present results reinforce the wisdom of that advice. However, it should be noted that only a minority of states promptly replied to our queries seeking clarification, and that even after several months and repeated contacts, four states never did respond. Especially given the ambiguity of the current regulatory landscape, it is incumbent upon licensing boards to respond promptly and clearly to psychologists seeking guidance on remote practice. Nevertheless, given the rate at which remote practice is growing and the anticipated increase in the number of practitioners seeking clarification, responding promptly to individual inquiries is likely to pose increasing challenges to state boards. This highlights the importance of clear and readily accessible policy statements regarding interjurisdictional practice on state board websites. As discussed above, the majority of state boards do not currently have clear policy guidelines on their websites.

Meanwhile, given that the majority of states did not permit the enrollment of their residents in our study, the most prudent course is for psychologists to assume that interstate practice is prohibited, until and unless explicitly shown to be otherwise in a given circumstance. Moreover, we do not recommend that practitioners rely on our findings to make decisions about the legality of interstate practice within any given state for two reasons. First, the present re-

sults must be interpreted in the context of a particular clinical research study. Some boards' interpretations of the legality of standard clinical practice, or even of other types of research, may differ from their interpretations of this particular study. For example, Iowa granted our request to enroll residents in the study because psychology trainees are granted an exemption despite an explicit policy statement on their website against treating Iowa residents without being licensed in the state. Second, this area is fluid and evolving rapidly, and by the time a psychologist reads this paper some states may have modified their relevant statutes, or some state boards may have issued or modified policy statements on interstate practice.

The irony of the prohibition against the interstate practice of psychology is that unlicensed coaches, psychotherapists, and other providers who face no such limitations are proliferating rapidly (Williams & Menendez, 2007). For example, a Google search of "online therapy" reveals over 27 million hits with links to service providers of varying levels of specialization, including artificial intelligence "chatbots," "eCounselors," and licensed providers of varying (and often unverifiable) professional backgrounds. Such unregulated practice is far less likely than evidence-based behavior therapy to be scientifically grounded, and precludes the public from enjoying the protections afforded by regulatory oversight. Thus, the widespread availability of these potentially unqualified providers may result in more individuals receiving lower-quality or ineffective services in lieu of treatments that work.

Potential Solutions

Various professional organizations (e.g., the National Register, the American Board of Professional Psychology) are seeking to address this issue. For example, the Association of State and Provincial Psychology Boards (ASPPB) has developed an Interjurisdictional Practice Certificate, in which participating states permit psychologists holding the certificate to practice temporarily within their states; so far only five states (Georgia, Idaho, Kentucky, Mississippi, and South Carolina) participate in this program. Other programs are designed to facilitate obtaining licensure in another jurisdiction, for example by banking credentials, which is a way to centrally store evidence of professional education and achievements so that they may be easily submitted to any licensing board in the future. These "legal fictions" may indeed facilitate the process of obtaining licensure in another state, but currently do not permit practicing on an ongoing basis within a state in which one is not explicitly licensed. Thus, as they currently stand, they do not resolve the issue.

Unless the federal government acts to supersede individual state licensure laws, the only truly comprehensive solution would be some form of national telepsychology consortium, in which states would agree on practice standards and qualifications, and the license of a practitioner within a member state would permit practice within other participating states (Harris & Younggren, 2011). Complaints could be lodged with the board in which the psychologist is licensed regardless of where the service took place. In some ways this would be analogous to the system currently in place in the Veteran's Administration (VA), in which a psychologist licensed in any state can practice anywhere within the VA system. Despite the obvious appeal of such a registry, the idea faces a number of challenges. First, in many states, participation would require legislative action to change the state licensing law. Second, states with higher licensure standards (e.g., higher required scores on the Examination for Professional Practice in Psychology) may be hesitant to recognize the licenses of states with lower standards. Nevertheless, as discussed by Harris and Younggren (2011), the profession of nursing has been at the forefront of true interstate practice, having developed a consortium program that could serve as a model for other health professions.

Despite the various challenges, it is imperative that policymakers proactively address the issue of interstate practice. The APA recently developed a Task Force on the Development of Telepsychology Guidelines for Psychologists, staffed by members of APA, ASPPB, and the APA Insurance Trust, in an effort to develop guidelines for the practice of telepsychology. Technological developments will continue, and it is inevitable that remote services will be increasingly demanded by the public and will be increasingly offered by behavioral health professionals. Psychologists are poised to assume a leadership role in resolving the issue of interjurisdictional practice, but to do so they must act quickly before the issues are inevitably resolved by the courts in ways that may be far from ideal. In addressing these issues, policymakers should take care to balance possible risks against the enormous benefits afforded by remote services,

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in-press

The Relationship Between Baseline Drinking Status, Peer Motivational Interviewing Microskills, and Drinking Outcomes in a Brief Alcohol Intervention for Matriculating College Students: A Replication

"When students articulate no desire to change their alcohol use and related behaviors, simple reflections may only mirror these sentiments and actually impede the change process. It is important to note that these hypotheses can only be explored by coding student change talk . . ."

Tollison et al.
Behavior Therapy, in press
doi: 10.1016/j.beth.2012.09.002

archive

"One of the distinguishing features of science is that it strives for maximal simplicity, parsimony, and consistency in its basic assumptions, whereas common sense is content with complexity, multiplicity, and inconsistency."

Mowrer, O H. (1947)
"On the Dual Nature of Learning—A Reinterpretation of 'Conditioning' and 'Problem Solving'"

and to ensure that they are guided by the best available science rather than misguided assumptions and clinical lore.

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Correspondence to James D. Herbert, Ph.D., Department of Psychology, 119 Stratton, 1341 Chestnut Street, Philadelphia, PA 19104; james.herbert@drexel.edu