Therapist Boundary Crossings in the Digital Age: Psychologists’ Practice Frequencies and Perceptions of Ethicality

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Psychologists today are challenged as ethical decision makers by the ever-expanding development and use of digital technology in their own lives and in the lives of their clients. In this survey study, 256 doctoral-level U.S. psychologists rated their frequency of engagement in and ethical attitudes regarding four digital boundary crossings: advertising online, providing psychoeducation online, engaging in a digital nonssexual multiple relationship, and patient-targeted Googling. The study also examined six potential predictors of engagement and attitudes: therapist gender, therapist theoretical orientation, therapist years of professional clinical experience, client gender, the interaction of therapist gender and client gender, and digital status (i.e., therapists’ self-identification as digital natives or digital immigrants). Practice frequencies and ethicality ratings varied significantly depending on the boundary crossing considered. Significant predictors were identified only for one digital crossing: patient-targeted Googling. Therapist gender predicted the frequencies of patient-targeted Googling and hours of professional clinical experience predicted ethicality ratings. Professional implications, training recommendations for therapists, and directions for additional research are included.

Public Significance Statement
This study revealed that U.S. psychologists’ practice frequencies and ethicality ratings for four digital boundary crossings (advertising online, providing psychological education online, accepting “follow” or “friend” requests from clients via social media, and patient-targeted Googling) vary widely according to the crossing considered. Significant predictors (therapist gender and hours of professional experience) were identified only for patient-targeted Googling. Participants’ ethicality ratings pointed to the need for more guidance regarding digital crossings. The article presents recommendations for updating the APA Ethics Code, therapist training, and future research.

Keywords: internet, social media, boundary crossings, ethics, psychotherapy

Edward is experiencing some depression and anxiety since he was furloughed from his job 3 months ago. His partner suggests that he consider engaging in therapy. He discovers a local therapist whose psychoeducational Instagram posts he enjoys. In addition to following this therapist’s Instagram page, Edward can use search engines and social media links to discover details of this therapist’s education and training history, as well as political views and social relationships. In turn, should Edward call and make an appointment, the therapist may perform the same online searches of him. How do therapists negotiate appropriate boundaries around the therapeutic relationship when so many may be crossed on the internet?

In the past two decades, we have witnessed a virtual explosion in the development and use of the internet in the U.S. as a resource for information (e.g., from websites; Pew Research Center, 2019a) and connection (i.e., through social media; Pew Research Center, 2019b).

Both therapists and clients in the U.S. participate in this ever-expanding dimension of communication, leading (both accidentally and intentionally) to information about each other. Therapists and therapists-in-training report that they disclose personal and professional information on the internet (Kolmes & Taube, 2014; Lehavot et al., 2010; Tunick et al., 2011). And, Kolmes and Taube (2016) found that nearly 70% of the clients they surveyed acknowledged searching for and finding personal information about their therapists online. Of these clients, only 27.6% informed their therapists of these online discoveries.
In addition, the expansion of technology has opened the potential for extra-therapeutic contact between therapists and clients. For example, research findings have revealed that clients request connections with their therapists’ personal social media profiles. Knox et al. (2019) found that clients not only extended digital “friend” requests to their therapists and therapists’ family members through Facebook but also initiated contact through private Facebook messages. And, Tunick et al. (2011) reported that of the 65% of their participants (U.S. child psychologists and psychologists-in-training) who maintained social networking websites, nearly one quarter received requests from clients to be “friends” or join the client’s digital social network (24%); 3% of the therapists accepted such requests.

Furthermore, therapists intentionally seek information about their clients on the internet, typically by Googling them or searching on social media (both actions termed patient-targeted Googling). In one study, 27% of U.S. psychologists-in-training endorsed patient-targeted Googling (Lehavot et al., 2010). Tunick et al. (2011) reported that 32% of their sample engaged in this behavior for various reasons (e.g., therapeutic concern, curiosity), but only 20% of those informed their clients that they had done so. And, more recently, nearly half (48%) of the U.S. therapists and therapists-in-training surveyed by Kolmes and Taube (2014) endorsed such information searches in the absence of a crisis or informed consent. Patient-targeted Googling, without client knowledge and/or permission, and without a compelling therapeutic reason (e.g., safeguarding the client’s physical safety), heightens the ethical ambiguity of this particular crossing.

Several authors have observed that the pervasiveness of such internet use by therapists and clients has complicated and challenged our traditional concepts of boundaries in psychotherapy (Kolmes & Taube, 2016; Zur & Zur, 2011). These online disclosures, discoveries, and virtual interactions by both parties in the therapeutic relationship may be considered a new dimension of external-interpersonal boundary crossings. For example, a client may discover information about a therapist beyond what is communicated in their sessions by accessing the therapist’s disclosures in an online advertisement or on a webpage or blog. And, a therapist may gain extra-therapeutic information about a client by searching social media sites. Further, a therapist and client who engage in digital interactions (e.g., become Facebook friends) develop another relationship beyond the therapy relationship.

Gutheil and Gabbard (1993) first defined external-interpersonal boundary crossings in the context of in-person psychotherapy as deviations from common clinical practices of setting and maintaining the structural frame around the therapy interaction. The authors argued that the appropriateness of such crossings is often highly behavior and context dependent; a specific crossing may or may not be harmful to a specific client and/or the therapeutic alliance, and may sometimes be useful. As such, boundary crossings are not de facto unethical. In contrast, however, boundary-crossing behaviors that are highly likely to cause harm or exploitation of the client, loss of the therapist’s objectivity and ability to practice competently, and/or damage to the therapeutic relationship across contexts are termed boundary violations. Boundary violations (e.g., therapist sexual intimacy with a current client) are unethical (American Psychological Association [APA], 2017) and often illegal.

Unfortunately, there is no consistent guidance across the professions in the U.S. for how therapists may negotiate the establishment and maintenance of ethical digital external-interpersonal boundaries. Notably, the ethics codes for social workers (National Association of Social Workers [NASW], 2017) and counselors (American Counseling Association [ACA], 2014) specify standards regarding the negotiation of some digital crossings. For instance, social workers are admonished that they should understand that the posting details of their personal lives may negatively impact clients who come across this information. Furthermore, they are admonished not to engage in social media relationships with clients (NASW, 2017). Counselors are advised against patient-targeted Googling without a client’s informed consent (ACA, 2014). However, the Ethical Principles of Psychologists and Code of Conduct (APA, 2017) does not include any such standards. Without specific ethical standards to guide them, U.S. psychologists must consider the foundational ethical principles and other professional standards of clinical care in their deliberations regarding whether or not to engage in a digital boundary crossing.

Clinical and Ethical Implications

Several mental health professionals and researchers have considered the potential clinical impacts of digital boundary crossings, ranging from positive to negative, as well as the ethical implications of such practices. First, several advantages of these crossings uphold Beneficence, defined by the APA as “[striving] to beneficence those with whom they [psychologists] work” (2017, p. 3). For example, therapists’ advertising and/or listing online professional biographies may provide background information that helps clients feel more confident that their therapists have meaningful skills to offer (Kolmes & Taube, 2016). And, patient-targeted Googling may also support the best interests of clients by providing critical historical or current status information for those with dementia or traumatic brain injuries (Clinton et al., 2010) or those who reveal risk for self- or other-harm outside of the therapy session (Kolmes & Taube, 2014; Tunick et al., 2011).

Positive effects of digital crossings also uphold the Principle of Justice, defined by the APA as the recognition “that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists” (APA, 2017, p. 4). For example, providing psychoeducation online may specifically allow marginalized groups to access tools for self-regulation, self-understanding, and communication. It may also function as pro bono service delivery. Furthermore, therapists’ digital self-disclosures may reveal their “understanding of issues and problems specific to vulnerable patient groups” (Kaluzeviciute, 2020, p. 314), which may enhance a sense of safety for those who have had negative experiences with therapy.

On the other hand, the potential clinical disadvantages of digital crossings can undermine Nonmaleficence, psychologists’ ethical mandate to “do no harm” (APA, 2017, p. 3). One issue frequently noted regarding therapists’ digital self-disclosures is that clients may be alienated by what they find and/or infer poor boundary maintenance on therapists’ parts (Kaluzeviciute, 2020; Kolmes & Taube, 2016). Such clients may self-censor during sessions or prematurely terminate treatment. In addition, therapists’ in-person self-disclosures may have reduced efficacy.
given information already disclosed and discovered digitally (Kaluzeviciute, 2020).

In addition, Clinton et al. (2010) noted that diagnostic formulation, treatment planning, and intervention shaped by unverified and potentially inaccurate information from patient-targeted Googling may be misguided and ultimately harmful. And, therapists may find that client information discovered online (again, whether accurate or not) triggers negative countertransference reactions to the client that may also interfere with the therapeutic alliance and/or the effectiveness of therapy. For example, what might a therapist experience if they discover a client’s scathing critiques of previous therapists on Twitter?

One type of digital boundary crossing, a social media relationship established between therapist and client, or between the therapist and someone close to the client (e.g., Facebook friends), involves the formation of a nonsexual multiple relationship (NSMR). The APA Ethics Code defines a multiple relationship as occurring when a psychologist is “in a professional role with a person and (a) at the same time is in another role with the same person, (b) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (c) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person” (APA, 2017, p. 6). A digital NSMR may involve relational transactions between the two parties that cause clients’ confusion regarding therapists’ motivations for professional interventions and/or impairment of therapists’ objectivity, just as with traditional NSMRs (Younggren & Gottlieb, 2004; Zur & Zur, 2011).

Digital boundary crossings may also undermine the Principle of Respect for People’s Rights and Dignity, specifically the clients’ right to privacy and confidentiality (APA, 2017). For example, therapists’ engagements in digital NSMRs with their clients (e.g., through Facebook or other social media group exchanges) may allow other individuals to surmise the existence of a therapeutic relationship, especially if the therapist is open about connecting online with clients and engaging in digital exchanges (Zur & Zur, 2011). And, there is a potential for significant damage to the client’s trust in the therapist and sense of safety in the relationship if they discover that their therapist has impinged on their privacy by Googling them without their knowledge or consent. The client’s discovery may come either through a slip by the therapist or through an intentional follow-up with the client about clinically relevant information discovered (e.g., suicidal ideation; Kolmes & Taube, 2014).

The Study

Although there are a few empirical reports of how often therapists engage in some specific digital boundary crossings, to date, there is only one study that examined more than one type of digital crossing. As reported above, Tunick et al. (2011) studied the frequencies of two digital crossings among U.S. child psychologists and psychology trainees: digital NSMRs (i.e., accepting a “friend” request from a client or a request to join their digital social network) and patient-targeted Googling.

Furthermore, the potential predictors of practice frequencies of digital crossings are sparsely identified and limited to the practice of patient-targeted Googling. Jent et al. (2011) studied medical school and behavioral health faculty and trainees, and found that only trainees endorsed patient-targeted Googling. The authors attributed this difference in behavior to the likely digital generation gap between the faculty and the trainees. Prensky (2001) popularized the terms digital native (i.e., individuals who grew up with the internet and digital devices) and digital immigrant (i.e., those who were exposed later in life and may be less fluent in digital norms and skills) to differentiate these two groups. Furthermore, Kolmes and Taube (2014) found that psychodynamic or integrative therapists were significantly more likely to engage in patient-targeted Googling than therapists with a cognitive-behavioral therapy (CBT) approach. These researchers did not find any other significant predictors among the participant demographic characteristics they examined (e.g., age, education, and profession).

Our first two objectives in this study, therefore, were to examine the practice frequencies of four digital boundary crossings by currently practicing psychologist therapists in the U.S. and to identify predictors of those practices. These crossings were, as phrased on our study survey, as follows: (a) advertising online [e.g., via an online personal biography CV, a practice website, online listings (e.g., on a Health Maintenance Organization’s list of providers), and/or other online advertisements]; (b) using social media platforms such as YouTube, Tumblr, Twitter, Instagram, or Facebook to provide online psychoeducation; (c) accepting social media connections requests (e.g., to be Facebook friends) from a client (i.e., engaging in a digital NSMR); and (d) searching for information about a client online via search engines (e.g., Google) or social media (e.g., Facebook). These four digital boundary crossings have been commonly identified in the literature (e.g., DiLillo & Gale, 2011; Kaluzeviciute, 2020; Knox et al., 2019; Kolmes, 2012). The six predictor variables we examined were as follows: (a) therapist gender, (b) therapist theoretical orientation, (c) therapist years of professional clinical experience, (d) client gender, (e) the interaction between therapist gender and client gender, and (f) digital status (i.e., therapists’ self-identification as digital immigrants or digital natives). These predictor variables also have been noted previously in the literature on traditional and digital boundaries (e.g., Baer & Murdock, 1995; Borsy & Pope, 1989; Kaluzeviciute, 2020).

We also note that the examination of therapists’ ethical attitudes toward the practice of digital boundary crossings has been limited to patient-targeted Googling (DiLillo & Gale, 2011; Lehavot et al., 2010). And, again, research regarding predictors of those ratings is rare. DiLillo and Gale (2011) reported significant positive correlations between clinical psychology, counseling psychology, and school psychology graduate students’ level of training and their ethical perceptions of two forms of patient-targeted Googling (i.e., using search engines or social media to search for clients’ personal details). However, the correlation between year in training and ethicality rating for patient-targeted Googling using social media was very small ($r = .09$). These authors found no significant correlations between participants’ ethical perceptions and one other predictor, participant age.

The next two objectives of this study were to gather data regarding therapists’ perceptions of the ethicality of our four digital boundary crossings and, again, to identify significant predictors of those perceptions among the six we examined.
The Survey

The online survey we constructed gathered demographic data on our U.S.-practicing psychologist respondents (via the Demographic Questionnaire) and either their practice frequencies or ethical ratings of the four digital crossings included in this study [via the Therapeutic Practices Survey (TPS)]. There were four versions of the TPS, such that participants either provided ethicality ratings or practice frequencies for the four crossings, with either a male or female client. This survey structure, based on Baer and Murdock’s (1995) approach, allowed us to assess the effect of client gender, one of our predictors.

We recruited in three ways: emailing professional listservs for psychologists, posting on various Facebook groups for therapists, and asking doctoral-level psychologists to “snowball” the survey via email to professional contacts. Individuals were invited to participate if they were doctoral-level psychologists (i.e., with either a PsyD or PhD), U.S.-licensed, and currently seeing adult patients in therapy. Participants were offered the opportunity to participate in a raffle for four $100 Amazon gift cards, but were not otherwise compensated for participation. Participants chose whether to provide contact information for the raffle; that information was not linked to participants’ survey responses.

Although 447 individuals accessed this online survey, 358 individuals met our completion standard of 85% or more of survey items (80.1% completion rate). An additional 101 participants’ responses were excluded because they were not doctoral-level psychologists (N = 73), did not see adult patients in therapy (N = 13), were not licensed in the U.S. (N = 10), or had either been sanctioned by a licensing board or had their license in a U.S. state(s) revoked or suspended (N = 5). One additional participant appeared to have randomly responded based on their response to an embedded validity question regarding the ethicality of accepting a client’s handshake, which they rated “unquestionably unethical.”

The final group contained 256 participants: 130 respondents who answered questions about practice frequencies of digital boundary crossings (68 answered questions regarding a female client and 62 answered questions regarding a male client) and 126 respondents who answered questions about the ethicality of the digital crossings (61 answered questions about a female client and 65 answered questions about a male client). Preliminary analyses (analyses of variance and chi-square analyses) were conducted to ascertain whether those answering questions regarding a male client versus a female client within the practice frequencies group and within the ethicality ratings group differed on the demographic variables. No significant differences were detected. As such, the client gender subgroups were combined within the Practice Frequencies group and within the Ethicality Ratings group. Table 1 shows the descriptive data regarding our participants in the Practice Frequencies form) was so positively skewed (indicating predominately zero frequency of practice) that ordinal regression analyses to identify predictors could not be performed validly.

And, one of the predictor variables, digital status (native vs. immigrant), was also extremely skewed. Only seven participants self-identified as a digital native (three who responded to the Ethicality Ratings form and four who responded to the Practice Frequencies form). As such, this predictor variable was eliminated from our analyses.1 Given the generational differences between digital natives and digital immigrants originally noted by Prensky (2001) and others, we considered therapist age as a possible proxy for digital status. Based on the literature, we created new digital native and digital immigrant categories using 1980 as the birth year cutoff (Prensky, 2001). However, with this calculation, we captured only six of the seven who originally self-identified as a digital native.

1 In response to one of the reviewers for this article, we considered deleting all seven of the participants who self-identified as digital natives. However, visual comparisons of the mean values and variances for all dependent variables, as well as the ordinal regression analyses, with and without those seven subjects revealed only minor shifts in the data between the two samples, and did not change the significance or direction of our significant results. We decided, therefore, to retain the seven participants in our final data set.
Given that factors other than age likely contribute to individuals’ self-perceived or actual digital competence (e.g., access to technology moderated by various demographic factors; Pew Research Center, 2019a; Zur & Zur, 2011), we concluded that the validity of this alternative operationalization of digital status was not clearly established. We elaborate on the implications of these findings for future research methodologies later in the article.

### Results

#### Practice Frequencies

There were 130 therapist participants who provided information about their frequencies of practice for each of the digital boundary crossings (see Table 2). Therapist participants reported the highest practice frequencies for advertising online; only 26.9% indicated that they had “never” engaged in this crossing. In contrast, the vast majority of participants indicated that they “never” engaged in providing psychoeducation via social media (70.0%) and digital NMSRs (95.4%). Interestingly, a smaller majority (59.2%) indicated that they had “never” Googled a patient.

#### Predictors of Practice Frequencies

Therapist gender was a significant predictor of participants’ practice frequencies of one digital boundary crossing: patient-targeted Googling. Males were less likely to endorse higher...
Table 2
Clinicians’ Responses Regarding Digital Crossings, Male and Female Clients Combined

<table>
<thead>
<tr>
<th>Item</th>
<th>1 N (%)</th>
<th>2 N (%)</th>
<th>3 N (%)</th>
<th>4 N (%)</th>
<th>5 N (%)</th>
<th>1 N (%)</th>
<th>2 N (%)</th>
<th>3 N (%)</th>
<th>4 N (%)</th>
<th>5 N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advertising</td>
<td>35 (26.9)</td>
<td>15 (11.5)</td>
<td>20 (15.4)</td>
<td>25 (19.2)</td>
<td>35 (26.9)</td>
<td>4 (3.2)</td>
<td>2 (1.6)</td>
<td>16 (12.7)</td>
<td>76 (60.3)</td>
<td>28 (22.2)</td>
</tr>
<tr>
<td>Psychoeducation</td>
<td>91 (70.0)</td>
<td>12 (9.2)</td>
<td>17 (13.1)</td>
<td>6 (4.6)</td>
<td>4 (3.1)</td>
<td>4 (3.2)</td>
<td>9 (7.1)</td>
<td>23 (18.3)</td>
<td>72 (57.1)</td>
<td>18 (14.3)</td>
</tr>
<tr>
<td>Digital NSMR</td>
<td>124 (95.4)</td>
<td>6 (4.6)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>98 (78.4)</td>
<td>24 (19.2)</td>
<td>1 (0.8)</td>
<td>0 (0.0)</td>
<td>2 (1.6)</td>
</tr>
<tr>
<td>PTG</td>
<td>77 (59.2)</td>
<td>45 (34.6)</td>
<td>7 (5.4)</td>
<td>1 (1.8)</td>
<td>0 (0.0)</td>
<td>39 (31.0)</td>
<td>61 (48.4)</td>
<td>13 (10.3)</td>
<td>12 (9.5)</td>
<td>1 (1.8)</td>
</tr>
<tr>
<td>Handshake</td>
<td>0 (0.0)</td>
<td>8 (6.2)</td>
<td>34 (26.2)</td>
<td>41 (31.5)</td>
<td>47 (36.2)</td>
<td>0 (0.0)</td>
<td>2 (1.6)</td>
<td>0 (0.0)</td>
<td>68 (54.0)</td>
<td>56 (44.4)</td>
</tr>
</tbody>
</table>

Note. For practice frequencies (PF), N = 130. 1 = never, 2 = rarely, 3 = sometimes, 4 = fairly often, 5 = very often. For ethicality ratings (ER), N = 126. 1 = unquestionably unethical, 2 = ethical under rare circumstances, 3 = don’t know/not sure, 4 = ethical under many circumstances, 5 = unquestionably ethical. For ethicality ratings of patient-targeted Googling, OR = 19, 95% CI [.05, .71], p < .05.2 Therapist professional clinical experience, therapist theoretical orientation, client gender, and the interaction between therapist and client gender did not predict any of the digital boundary crossing frequencies.

Ethicality Ratings

Ethicality ratings of the four digital boundary crossings were provided by 126 therapist participants (see Table 2). As with practice frequencies, respondents’ ratings varied sharply depending on the type of digital boundary crossing considered. The vast majority rated advertising online as either “unquestionably ethical” (22.2%) or “ethical under many circumstances” (60.3%). A notable percentage (12.7%) indicated that they did not know or were unsure of the ethicality of this practice. Similarly, a majority of the participants rated providing psychoeducation via social media as either “unquestionably ethical” (14.3%) or “ethical under many circumstances” (57.1%). Of note is that an even higher percentage of the respondents (18.3%) reported that they did not know or were unsure about this crossing than about advertising online.

In stark contrast, a vast majority of participants 78.4% rated a digital NSMR “unquestionably unethical” (78.4%) or “ethical under rare circumstances” (19.2%). And, only 0.8% expressed uncertainty about ethicality of this crossing. Although somewhat less skewed, therapists’ ethicality ratings of patient-targeted Googling were also quite negative. Nearly one-third (31.0%) rated this crossing “unquestionably unethical” and about one-half (48.4%) deemed this crossing “ethical under rare circumstances.” Interestingly, 10.3% expressed uncertainty (“don’t know/not sure”) about the ethicality of patient-targeted Googling.

Predictors of Ethicality Ratings

Therapist professional clinical experience proved to be a significant predictor for ethicality ratings for one digital crossing: patient-targeted Googling. Ordinal regression analyses indicated that moderately more experienced therapists (i.e., those with 10,000–14,999 hr) were more likely to provide higher ethicality ratings for patient-targeted Googling compared to the least experienced therapists (i.e., those with 4,999 hr or less); OR = 4.22, 95% CI [1.23, 14.44], p < .05. Analyses also revealed that therapist professional clinical experience, therapist gender, and client gender were significant predictors of participants’ ethicality ratings for digital NSMRs. However, the wide confidence intervals for the odds ratios for all three predictors, likely due to limited cell sizes, precluded valid interpretation of the results. There were no significant predictors for the ethicality ratings for the other two crossings.

Discussion

Our data raised several points for discussion. First, our findings demonstrated that therapists do engage in digital boundary crossings, some crossings more than others. Advertising online was the crossing most liberally practiced. Engaging in digital NSMRs reflected the most conservative practice frequencies. Participants in this study provided near-unanimous reports of never engaging in this digital boundary crossing, a result consistent with Tunick et al.’s (2011) earlier finding that only 3% of U.S. child psychologists and psychologists-in-training accepted invitations from client(s) to join their social media network.

Of note, Schwartz-Mette & Shen-Miller (2018) offered a contemporary comparison point for these findings with their data for traditional boundary crossings. For example, our results differ from their findings regarding the traditional crossing of “Advertising in newspapers or similar media,” which was “never” or “rarely” practiced by 86.4% of their sample of U.S. psychologists. It is possible that this practice was never a popular way for clinicians to advertise; 85.6% of U.S. psychologists in Pope and colleagues’ earlier survey also endorsed “never” or “rarely” advertising (Pope et al., 1987). We suggest that the development of the internet has allowed for databases such as Psychology Today that offer clinicians greater value due in part to the fact that their advertising now is accessible to a broader range of consumers, and, in part due to present-day consumers’ expectations that they may learn more about their treatment providers online (Zur & Zur, 2011). Similar to our results, however, Schwartz-Mette and Shen-Miller’s sample provided practice frequencies that were also markedly conservative for traditional NSMRs such as providing therapy to a friend (94.8% endorsed “never” doing so) and inviting a client to a party or social event (94.8% reported “never”).

Note: This dependent variable (practice frequencies for searching for client information online) violated the assumption of odds, so it cannot be assumed that the OR can be applied equally to each practice frequency of k relative to practice frequencies of less than k.
Second, our therapist respondents made distinctions in their ethicality ratings among different digital crossings. A majority of therapist participants provided generally positive ethicality ratings for advertising online and for providing psychoeducation online via social media. Meanwhile, respondents reported more conservative ethicality ratings for patient-targeted Googling and, particularly, engaging in digital NSMRs. We propose three explanations for these results. First, advertising and providing psychoeducation online are unidirectional therapist-to-public communication(s) involving nonspecific others (including potential clients), which is not true of digital NSMRs and patient-targeted Googling that are directly linked to an actual client. And, similarly, the first two crossings do not inherently run the risk of potentially violating a client’s privacy; the other two crossings do. Third, advertising and providing psychoeducation online involve therapist disclosure that may be controlled by the therapist, which is not necessarily true of digital NSMRs. For example, a client who is also a Facebook friend may disclose some information about the therapist in their social media exchange that they acquired in their therapy session (e.g., that the therapist went on vacation) that the therapist has not noted on their profile.

Closely consistent with our findings for online advertising, the majority of participants in Schwartz-Mette and Shen-Miller’s (2018) study rated advertising in newspapers or similar media either “unquestionably ethical” (23.8%) or “ethical under many circumstances” (33.1%). And, again reflecting our findings for digital NSMRs, almost all of their participants found similar traditional NSMRs “unquestionably unethical” or “ethical under rare circumstances”: providing therapy to a friend (93.0%) and inviting a client to a party or social event (93.1%).

Third, examination of the ethicality ratings for each of the digital boundary crossings does not necessarily explain our participants’ reports of practice frequencies. For example, the results of this study revealed a discernable discrepancy between therapist participants’ low practice frequencies of providing psychoeducation online and their relatively positive ethicality ratings for this crossing. One reason for this discrepancy may be therapists’ lack of interest, self-perceived expertise, and/or technology skills. Some therapists may simply be focused on their clinical practice and not interested in teaching. Or, they may feel that they do not possess the requisite competence to educate others. And, some, particularly those less fluent with technology, may be deterred from providing psychoeducation by the significant investment of time and money required to master digital editing programs and/or hire graphic designers and social media consultants.

The opposite discrepancy was revealed for patient-targeted Googling. Although therapists were quite conservative in their ethicality ratings for this digital boundary crossing in our study, a notable percentage (40.8%) endorsed engaging in the crossing at least “rarely.” Our findings of practice frequencies for patient-targeted Googling are similar to those reported in other studies cited above. The discrepancy in our study may be due at least in part to the relative ease and assumed anonymity of engaging in this crossing.

Fourth, we found notable levels of uncertainty among our participants regarding the ethicality of three of our four digital boundary crossings. As noted above, therapists reported the most uncertainty about the ethicality of providing psychoeducation online (18.3%), followed by advertising online (12.7%), and patient-targeted Googling (10.3%). This result may reflect, at least in part, the fact that 2017 APA Code of Ethics (APA, 2017) does not provide direction to psychologists regarding the appropriate negotiation of digital crossings. As such, we suggest that APA follow the lead of other mental health professions and revise the APA Code to include specific standards for psychologists to use in their negotiation of such challenges. This recommendation is also urgent due to the rapidly rising percentage of therapists who identify as digital natives or as digital immigrants who are increasingly comfortable with technology, and may, therefore, be more prone to encountering ethical dilemmas in their online lives (Kaluzeviciute, 2020; Prensky, 2001).

Fifth, the predictors of practice frequencies for our four digital boundary crossings were elusive in our data, a finding consistent with previous research. We did identify one for patient-targeted Googling: therapist gender. Our finding that female therapists were more likely to engage more often in patient-targeted Googling than male therapists was unexpected. Schwartz-Mette and Shen-Miller (2018), for example, found no gender differences in practice frequencies of traditional nonsexual boundary crossings. Our results simply may reflect broader gender differences in internet use, as self-identified females outnumber self-identified males on the social media sites Facebook, Instagram, and Pinterest (Pew Research Center, 2019b). It is possible, too, that female therapists may be more motivated to learn about their clients. For example, as a reflection of wider systemic issues of violence against women, female therapists may be more vigilant regarding their physical safety than male therapists, and thus more inclined to conduct informal checks for client histories of aggressive or violent behavior (i.e., criminal records). These hypotheses are speculative and merit further research.

And, sixth, we found one predictor (therapist clinical experience) for therapists’ ethicality ratings for only one digital crossing, also for patient-targeted Googling. Our data revealed that moderately more experienced therapists, compared to new career psychologists, were more liberal in their ethical evaluations of this digital crossing. The results may reflect more seasoned therapists’ increased confidence in their ability to discern under what circumstances such practices may be exercised to protect a client and/or enhance the client’s care, upholding the general ethical principle of beneficence. Furthermore, as Schwartz-Mette and Shen-Miller (2018) suggested, these moderately more experienced therapists are further removed from supervision than those early in their career, and may be more protective of their own autonomy regarding boundary negotiations with clients. It is important to note, as discussed above, that higher ethicality ratings did not translate into higher practice frequencies for this crossing. Therapists appeared to recognize that a practice could be ethical under rather extraordinary circumstances that did not often occur.

The absence of significant findings regarding the ethicality ratings of the most experienced therapists in our study (i.e., those with 15,000–19,999 or 20,000 hr and above) may indicate that much more experienced therapists, who are likely older and, thus, digital immigrants, view patient-targeted Googling with more caution due to lack of familiarity with the technology platforms (Pew Research Center, 2019a, 2019b) and/or with digital etiquette norms (Prensky, 2001). As such, for the most experienced therapists in our sample, the increased confidence in their clinical judgment afforded by years of experience may be mitigated by their relative lack of confidence in managing the digital world.
Limitations of the Study

One limitation of this study is that, due to our recruitment methods, it was not possible to assess the total number of potential participants who received an invitation to participate. As such, an accurate return rate could not be calculated, raising the potential issue of selection bias in our final participant group. Selection bias in our recruitment method may also have been introduced by the fact that we used Facebook as the sole social media source; demographic groups are unevenly represented on this platform (Pew Research Center, 2019b).

Furthermore, therapist participants commented in their feedback to the investigators on the fact that they were asked for demographic information, including whether there had been any disciplinary actions against their licenses, before they were presented with the study survey. As such, participants may have been primed to respond to the practice frequencies or ethicality ratings questionnaire more conservatively. We do note, however, that several of our findings are consistent with those of previous studies.

One of the aims of this study was to examine the association of therapists’ digital status (i.e., native vs. immigrant) with both their frequencies of engaging in digital boundary crossings and their perceptions of the ethicality of each crossing. Unfortunately, only seven respondents self-identified as digital natives given our definition (i.e., being surrounded by internet- and computer-based tools such as smartphones, email, and social media for most of one’s childhood). As we indicated above, we considered but then rejected an alternative way to operationalize digital status using participant age. We continue to think that therapists’ digital status is likely a moderator of practice frequencies of and/or ethical ratings for digital boundary crossings. However, more sophisticated measurement of the concept that incorporates technology interest, skills, comfort, and actual use appears necessary, particularly as we move beyond the turn of the 21st century, and the presence and complexity of technology continue to expand.

We attempted to increase the accuracy of responses regarding the participants’ level of professional clinical experience by removing the problem of variable hours worked in years of practice (i.e., some working full time and some working part-time). We assessed this variable by asking for their hours of therapy provided since graduate school in an open-ended question. However, as one respondent noted, we may have introduced enough cognitive demand to decrease the validity of some responses. A viable alternative method may be to ask participants two questions: How many therapy hours per week on average had each provided during their career and, separately, how many years of clinical practice each had accumulated?

Although we intended to assess the gender of our respondents by offering a contemporary range of therapist gender identity options (e.g., gender fluid and uncertain) on our Demographics Questionnaire, 98% of the participants self-identified as either “female” or “male.” As such, we could only analyze the predictive effect of therapist gender on practice frequencies and ethicality ratings using the binary categories.

Furthermore, we were likely not specific enough in the clinical practice data we gathered from our participants. Failing to assess the specific population(s) of adult clients seen by our participants may have suppressed some potential explanations for the variance in our results. For example, it is possible that participants primarily treating clients with significant interpersonal issues associated with trauma may have been more vigilant, and thus more conservative, regarding perceived ethicality and practices of digital boundary crossings than those predominantly seeing clients with behavioral health issues (e.g., smoking cessation).

And, similarly, we did not make some details explicit regarding our digital boundary crossings that in hindsight may have introduced additional variance in participants’ ethicality rating and practice frequency responses. For example, we did not specify in what form the participants advertised online (e.g., via Psychology Today or professional listservs), provided online psychoeducation (e.g., in written form on a blog or a YouTube video presentation), or Googled their clients (e.g., with or without consent of the client). It is of note that a significant number of participants responded that they were unsure of the ethicality of those three crossings.

Professional Implications

Given that our respondents registered uncertainty regarding the ethicality of three of our four digital boundary crossings (i.e., advertising online, providing psychoeducation online, and patient-targeted Googling), we recommended above that the American Psychological Association revise the Ethics Code to address therapists’ personal and professional use of social media and the negotiation of digital boundary crossings. We offer several specific suggestions.

First, we recommend that psychologists with expertise in and comfort with mental health technology be specifically recruited to committees shaping future iterations of the Ethics Code to ensure familiarity with current trends in online interaction. Second, we suggest that new standards urge psychologists’ careful consideration of the possible implications and outcomes of digital disclosures and contacts with clients. The ever-increasing use of the internet for personal and professional purposes opens psychologists to the possibility of having an indelible record of their words or behaviors amplified hundreds of thousands of times. Third, we recommend the creation of standards that encourage and guide psychologists’ disclosure of their policies regarding digital communications and connections to clients (e.g., digital NSMRs), as well as the informed consent of clients to engage in certain digital behaviors (e.g., patient-targeted Googling; Jen et al., 2011). Finally, we anticipate that new ethical standards regarding most digital boundary crossings will most likely mirror those for more traditional nonsexual boundary crossings—that those crossings that do not impair the therapist’s objectivity or ability to competently practice, and do not exploit or harm the client and/or the therapeutic relationship are not de facto unethical. As such, we urge a careful delineation of the factors that may contribute to a negative versus positive outcome of the crossing for psychologists to consider in their decision-making process. In the case of digital NSMRs, for instance, such factors may include whether the multiple relationship is necessary, therapist’s motivation for participating in the extra-professional relationship (i.e., whose needs this relationship meets), the extent of the therapist–client power differential, the extent of potential role conflict, and the potentials for harm and benefit to the client and third parties (Sonne, 2006; Younggren & Gottlieb, 2004; Zur & Zur, 2011).
Training Implications

To anticipate and minimize the potential impairment of the therapist and/or harm to the client or therapeutic relationship from digital boundary crossings, we propose the following considerations for training therapists at all levels of experience. First, training should emphasize therapist awareness of their own digital activities and presence. Therapists may be challenged to review their personal digital practices (e.g., social Googling) and carefully consider the clinical and ethical implications of the same practices with clients (e.g., patient-targeted Googling). Our data suggest that this challenge may be particularly relevant for female therapists. Clinicians may also be advised to periodically Google themselves, or even set a regular alert on mentions of their name on the internet. As Kolmes and Taube (2016) noted, therapists may be shocked by what they find about themselves online, and then, what others may find. The literature on the frequencies with which clients Google their therapists, often without informing them, is striking. And, research suggests that what clients find via Googling their therapists may specifically damage the therapeutic relationship (Kolmes & Taube, 2016).

Therapists also should be instructed that digital disclosures and contacts have future implications as well as those in the present. Tunick et al. (2011) cautioned that information that has been disclosed online is likely accessible long after it is posted. For example, therapists who provide online psychoeducational blogs should consider how future research and/or evolving professional standards may render material inaccurate.

Second, therapists should be taught basic precautions regarding their personal digital disclosures because of the potential for harm to clients and/or the therapeutic relationship (Knapp et al., 2017). These include maximizing privacy controls and exercising high selectivity in accepting social media “friends” or “followers.”

Third, in addition to implementing maximum privacy settings on digital disclosures, therapists would benefit from instruction regarding how to craft every disclosure with the assumption that they are discoverable by clients. This caution is especially applicable regarding disclosures on professional listservs or social media groups or “anonymous” admissions (e.g., made under a pseudonym) in comment sections or on social media platforms such as Reddit, where therapists may be most tempted to assume otherwise (Kolmes & Taube, 2016). Furthermore, therapists should evaluate digital requests as they relate to specific implications for individual clients. Clinton et al. (2010) observed that clients’ requests of their therapists to Google them or view their social media pages should be carefully evaluated in terms of their interpersonal patterns and expectations of, for example, exploitation or rejection. Finally, Lehavot et al. (2010) urged therapists to consider whether their online disclosures (anonymous and otherwise) would affect not only therapists’ individual relationships with clients but also the public’s perception of psychologists as a whole.

Fourth, therapists need to learn how to discuss digital boundary crossings with clients. As noted in this and previous studies, both therapists’ and clients’ internet use can lead to information about and extra-therapeutic contact with each other. As with other potential complicating factors, the possibility of these digital interactions should be openly acknowledged by therapists to introduce a platform for discussing them if (and, more likely, when) they arise. For example, Zur and Zur (2011) encouraged therapists to avoid therapeutic rupture around online discoveries by including a clear discussion during the informed consent process of therapists’ policies and practices regarding the sharing of information and connections via the internet. Furthermore, clients may be specifically invited to share in session any reactions to their discoveries of therapists’ digital self-disclosures (Gottlieb, 2018). Such discussions may be especially fruitful for digital natives, for whom digital self-disclosures have always coexisted with their in-person interactions (Prensky, 2001).

Fifth, supervisors and trainees need to discuss digital crossings with each other. Lehavot et al. (2010) noted that supervisees may be reticent to seek supervision regarding these practices because they assume that their supervisors (particularly those who are older) do not have the knowledge of or experience with digital technology to be helpful. Given this warning, supervisors, regardless of digital status, would benefit from learning how to initiate and incorporate the topic of digital crossings into their conversations with trainees, especially as they track trainees’ interactions with clients and assess trainees’ experience with ethical decision making regarding boundaries.

Future Research

There are several directions for future research. More research needs to be done on how therapists’ digital status may be accurately operationalized and then reassessed as a predictor of the practice frequencies and perceptions of ethicality of various digital boundary crossings, especially compared to traditional crossings. Another important direction for future research may be to assess the trends regarding graduate and postgraduate training therapists have received in negotiating digital versus traditional boundaries, and again, whether that variable may predict digital crossing behaviors and ethicality ratings. An interesting extension of this idea is researching how supervisors’ digital status affects their conversations with supervisees about digital crossings. Also, we invite researchers to replicate and extend this study with the methodological improvements suggested above and with additional digital crossings (e.g., texting or emailing clients for clinical purposes, gaining online with clients to build rapport, and attending virtual events such as weddings that mark significant events in clients’ lives).

References
