3-2020

Nonsexual Boundary Crossings in Psychotherapy: Factors in Ethical Decision-Making

Katherine S. H. Wu
kawu@llu.edu

LOMA LINDA UNIVERSITY
School of Behavioral Health
in conjunction with the
Faculty of Graduate Studies

Nonsexual Boundary Crossings in Psychotherapy: Factors in Ethical Decision-Making

by

Katherine S.H. Wu

A Dissertation submitted in partial satisfaction of
the requirements for the degree
Doctor of Philosophy in Clinical Psychology

March 2020

Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

_____, Chairperson

Janet L. Sonne, Adjunct Professor of Psychology

_____

Stephanie Goldsmith, Associate Professor of Psychology

_____

David Vermeersch, Professor of Psychology

_____

Jennifer Weniger, Associate Clinical Professor in Interdisciplinary Studies

ACKNOWLEDGEMENTS

I am grateful to Dr. Sonne for her tremendous investment in this project and for role modeling the pursuit of precision. I would also like to thank Dr. Goldsmith, Dr. Vermeersch, and Dr. Weniger for agreeing to serve on my committee. This project would not be the same without their detailed edits and thoughtful feedback. The same is true for the Sonne lab members, who include Dexter Chia, Debora Handojo, Lacie Parker, Nikki Patel, Pooja Raghani, Jake Vermeersch and Mabel Wong, and Kaylin Miller, another doctoral candidate at Loma Linda University. Dr. Nicholas Rockwood, Dr. Holly Morrell, Neilson Chan, and Griffin Boostrom were instrumental in providing statistical advice. In addition, this project would similarly have not been possible without the generous involvement of the participants who took the time to participate in this survey.

On a personal note, I would like to honor my 外婆 and 阿媽. I am proud to be the granddaughter of such extraordinarily funny, adaptable, and determined women. My achievements and those of generations after mine are possible only because of them.

CONTENT

TABLES

Tables Page

ABSTRACT OF THE DISSERTATION

Nonsexual Boundary Crossings in Psychotherapy: Factors in Ethical Decision-Making
by

Katherine Wu

Doctor of Philosophy, Graduate Program in Clinical Psychology
Loma Linda University, March 2020
Dr. Janet L. Sonne, Chairperson

Seminal ethics studies in psychology have evidenced significant variance among practitioners in their ethical attitudes toward and engagement in various nonsexual boundary crossings; they have also identified therapist and client factors that account for some of that variance (Borys & Pope, 1989; Pope, Tabachnick, & Keith-Spiegel, 1987). Boundary crossings, as defined by Gutheil and Gabbard (1993), are deviations from common clinical practices that are not necessarily unethical. Examples of traditional crossings include nonsexual touch and nonsexual multiple relationships.

This study was designed to update the literature regarding nonsexual boundary crossings in light of contemporary study designs and demographic categories, significant American Psychological Association (APA) demographic shifts, revisions of the APA Ethical Principles and Code of Conduct (APA, 2017), and the advent of the Internet.

Approximately 250 U.S.-practicing doctoral-level clinical psychologists were surveyed for their demographic characteristics and either ethicality ratings and practice frequencies for seven boundary crossings, including both traditional and Internet-based boundary crossings. Ordinal and binary logistic regressions were performed to test hypotheses regarding factors accounting for variance in these ethicality ratings and practice frequencies. Exploratory analyses were conducted to examine differences in data

between traditional and digital crossings, and between the findings of this study and previous studies regarding ethicality ratings and practice frequencies.

Therapist gender, theoretical orientation, clinical experience, and client gender were found to predict significant variance in ratings and frequencies for specific crossings. There was no significant interaction between therapist and client gender in predicting either ratings or frequencies. Therapists found two digital crossings (advertising online and providing psychoeducation online via social media) generally ethical, but found two other digital crossings (searching for client information online and accepting a social media request from a client) generally unethical. Therapists also appeared to more often express uncertainty regarding the ethicality of digital crossings than with regard to traditional crossings; and, they provided practice frequencies for some digital crossings that were inconsistent with corresponding ethicality ratings. These findings may reflect several decades of ethics training regarding traditional crossings, inconsistent ethical training regarding digital crossings, and the continuing need to emphasize self-awareness in formal ethics training.

CHAPTER ONE

INTRODUCTION

"Boundaries are curious things. They protect and constrain. They provide limits, but therein they provide freedom...(A)ttending to boundaries is an important part of a competent professional's work; this portion of therapeutic work requires discipline, foresight, and compassion" (Sommers-Flanagan & Sommers-Flanagan, 1998, p. 42).

Boundaries in Psychotherapy

Smith and Fitzpatrick (1995) described clinical boundaries as a "therapeutic frame" that delineates the social roles played by therapist and client as they engage in psychotherapy (p. 499). This therapeutic frame includes structural factors such as session length and fees and interpersonal/psychosocial factors such as physical contact and gift-giving (Brown, 1991; Sawyer & Prescott, 2011). It also includes the language the therapist uses in session and the clothing the therapist wears (Gabbard & Crisp-Han, 2010).

There is a strong consensus in psychology ethics literature that these interpersonal boundaries are valuable across theoretical orientations and therapeutic contexts. Their construction and maintenance are foundational to treatment process and efficacy (Corey, Corey, & Callanan, 2011). Multiple authors have maintained that boundaries are the bedrock for defined and open communication in the vulnerable emotional context of psychotherapy (Borys, 1994; Gabbard & Crisp-Han, 2010; Pope & Keith-Spiegel, 2008; Smith & Fitzpatrick, 1995). Gutheil and Gabbard (1998) commented that "*external*

boundaries are created so that *psychological* boundaries can be crossed through a variety of mechanisms common to psychotherapy" (p. 411, emphasis in original).

Appropriate boundaries enhance the therapeutic alliance, which in turn is crucial to long-term therapeutic efficacy (Sommers-Flanagan & Sommers-Flanagan, 1998). For instance, boundaries guide therapists in making ethically sound choices that protect each member of the therapeutic alliance (Borys, 1994; Lamb & Catanzaro, 1998). Explicitly discussed ideas about what is appropriate and inappropriate for the therapeutic space also help clients correctly grasp the motives behind therapist behaviors and messages (Langs, 1982).

The mere process of engagement with clear interpersonal boundaries can be healing for patients (Borys, 1994). Sommers-Flanagan and Sommers-Flanagan (1998) cited Rogers (1942) in writing, "the [therapeutic] relationship itself is a central component of the work being provided...the correctly enacted relationship is considered to be not only necessary but sufficient for bringing about therapeutic change" (p. 38). In therapy, patients may experience clear, adaptive boundaries for the first time, in the sense that both people in this mutually positive relationship are allowed to state their needs and limitations (Borys, 1994). In boundaried psychotherapeutic relationships, clients' emotions and values are respected and their vulnerabilities are safeguarded. While these boundaries are sometimes uncomfortable for clients who are accustomed to ambiguity or enmeshment, they can be internally integrated over time such that clients practice appropriate boundaries in other relationships in their lives.

Boundary Crossings in Psychotherapy

Gutheil and Gabbard (1993) defined boundary crossings in psychotherapy as deviations from common clinical practices of boundary setting or maintenance that may or may not be harmful and may sometimes be useful. In their 1998 article, Gutheil and Gabbard observed that boundary crossings are often constructive and important social responses to a patient's grief, need, or pain that help maintain the therapeutic relationship. For instance, a psychotherapist may cross a physical boundary and hug a patient who is grieving a terminal illness diagnosis or help another patient who has fallen on the floor to help him back to a sitting position. Other examples of common constructive boundary crossings may include appropriate therapist self-disclosure, shaking hands with a client, gift-giving by a client, and the therapist and client engaging in nonsexual multiple relationships.

Such boundary crossings can be valuable not only because they humanize the therapeutic relationship, but because instances of therapeutic ruptures due to boundary crossings being repaired can increase therapeutic alliance. Simon (1992) went as far as to propose that the therapeutic process of addressing boundary crossings is a major driver of psychotherapeutic work. Suppose, for example, a therapist self-discloses a personal stressor to a client who was parentified early in childhood and the client responds with overconcern. This boundary crossing results in role reversal and potentially compromises therapeutic rapport. In this case, the therapist has an opportunity to transform an obstacle into a healing experience for his or her client by responding with acceptance and empathy to the client's negative reaction to this boundary crossing (Gutheil & Gabbard, 1998).

This discussion may be an emotionally corrective experience for the client, whose vulnerable emotions were likely neglected in childhood due to his or her parentification.

Traditionally, discussion and research regarding boundaries in psychotherapy have involved various crossings such as therapist self-disclosure, accepting gifts from and giving gifts to patients, extra-office time and place arrangements, bartering for goods and services, physical touch, and multiple relationships. With the advent of technology, however, other possible boundary crossings between therapist and patient have emerged for examination. Therapists are not exempt from the widespread popularity of social media, especially those therapists who are considered "digital natives"—those whose Internet use is inextricably ingrained in being a social self (Prensky, 2001). In contrast to digital natives, "digital immigrants" are individuals born before the Internet went into widespread use and have adopted it (Prensky, 2001).

Prenksy (2001) wrote of a fundamental difference in communication style and use of technology between digital immigrants and digital natives. Although many digital immigrants still use social media, they often have a lesser fluency with online cultural norms than digital natives (Kolmes, 2012). Many of the therapists who are supervising younger therapists and trainees are unlikely to have grown up using social media. However, clinical practice will be increasingly dominated by both therapists and patients who are digital natives, making this arena of boundary crossings highly salient for contemporary and future research on boundary crossings.

Boundary Violations

Boundary violations are boundary crossings that are inappropriate and are associated with negative outcomes for the patient and/or the therapeutic relationship (Gutheil & Gabbard, 1993). They are typically exploitative and/or interfere with the therapist's objectivity; as such, boundary violations are usually unethical, and often illegal (Zur, 2004).

A key aspect of boundary violations is that therapists have gratified themselves at the client's expense (Brown, 1991). Brown (1991) generally categorized boundary violations as (a) invasive violations or (b) failures to protect. Invasive violations occur when clients' boundaries are actively intruded upon. Failures to protect either occur when therapists "spill" their own feelings and needs in counterproductive ways, or therapists' ignorance of treatment techniques interferes with the therapeutic relationship (p. 327).

Brown (1994) outlined two notable characteristics of most boundary violations. The first is that the therapist objectifies the client, such that some aspect of the client becomes more salient than either the client as a whole person or the therapy relationship as a process dedicated to the well-being of that whole person. For instance, Brown (1994) wrote that the therapist who found her client's sense of humor uplifting might have objectified her client by allowing and encouraging the use of this humor even when it is clearly functioning as a maladaptive defense mechanism. Brown (1994) also cited the example of a clinician who reduced his fees for professional athletes if the athlete allowed the therapist to use the athlete's name in subsequent advertising of psychotherapeutic services.

The second characteristic of most boundary violations is that the therapist acts strictly on impulse when deciding to enact the boundary crossing. For instance, a therapist who is facing a visibly distressed client may impulsively initiate self-disclosure in an effort to re-connect with the client, only to realize that this self-disclosure is distressing for the client to experience. Moments of such impulsiveness may bypass the therapist's more typical ethical decision-making process or may be the results of the therapist's under-developed skill at ethical decision-making.

Some therapist boundary crossings are so likely to result in harm to a patient that they have been identified in the APA Ethics Code, and often in state laws and regulations, as de facto boundary violations. A widely acknowledged a priori boundary violation among the mental health professions is sexual boundary crossings (Pope, 1990). Sexual contact between therapists and clients was first explicitly banned in the 1977 APA Ethics Code (APA, 1977). Subsequent versions of the APA Ethics Code have retained this prohibition (APA, 1992; 2002; 2010; 2017). Further, most U.S. states have developed legal statutes (civil and criminal) establishing therapist sexual boundary crossings as grounds for civil suit, misdemeanor or felony charges, and/or mental health licensing sanctions.

To Cross or Not to Cross Nonsexual Boundaries in Therapy

As noted above, there are some boundary crossings, such as sexual boundary crossings that are identified as de facto unethical and/or illegal boundary violations. However, most nonsexual boundary crossings are not so defined a priori. Instead the clinician is required to use clinical judgment and appropriate decision-making to decide

whether or not to engage in a particular nonsexual boundary crossing. Nonsexual boundary crossings in therapy with current clients are the focus of this study. The section below briefly outlines the chronological development of opinion among psychologists in the U.S. regarding whether therapists should ever cross nonsexual boundaries with clients in order to assure that boundary violations will not occur.

The Case for Nonsexual Boundary Crossings

The majority of arguments for nonsexual boundary crossings with psychotherapy clients remind readers of how helpful these crossings can be in establishing, maintaining, or repairing the therapeutic alliance. For example, Alexander and Charles (2009) framed boundary crossings as "[expanding] the resources available to achieve common goals" (p. 18). Empirical support for this argument is provided by results of Ramsdell and Ramsdell's 1993 study. In their study, clients rated four interpersonal behaviors (all of which may be considered boundary crossings) as beneficial: their addressing counselors by the counselors' first names, counselors visiting clients in the hospital, counselor self-disclosure during therapy sessions, and shaking hands with each other. O'Leary, Tsui, and Ruch (2012) conceptualized boundaries in the therapeutic relationship to be around and connecting, rather than between, therapist and client. In doing so, they emphasize transparency, reciprocity, and humanistic interaction in the therapeutic relationship.

In addition, multiple theoretical orientations, including behavioral, humanistic, group, family, existential, feminist, and Gestalt therapies, emphasize boundary crossings as a part of their therapeutic work (Lazarus, 1994; Zur & Lazarus, 2002). Using therapist self-disclosure as an example of boundary crossing, Brown (1991) suggested that

appropriate therapist self-disclosure is a powerful tool for instruction, illustration, role modeling, and normalization. For instance, when Lesbian, Gay, Bisexual, or Transgender (LGBT) therapists self-disclose their sexual orientation to LGBT clients, therapists have an avenue by which to role model positive perspectives on being a LGBT individual (Brown, 1991). This self-disclosure challenges harmful stereotypes that alienate LGBT clients from seeking LGBT community, enhances exploration of clients' identity and preferences, and promotes appropriate requests for help.

Well-delivered self-disclosure from therapists may also "humanize" and "deformalize" therapeutic interaction from clients' perspectives (Audet, 2011, p. 93; Sommers-Flanagan & Sommers-Flanagan, 1998). Sommers-Flanagan and Sommers-Flanagan (1998) remarked that clients who see a therapist's messy desk may be relieved of the perception that the therapist is perfect or, in fact, that there is a perfect human being. Self-disclosure allows therapists to communicate their own fallibility, to normalize an experience their patient has shared, or model their own behaviors in similar situations. After well-delivered, early therapy self-disclosure from their therapists, clients in Audet's 2011 study shifted from perceiving therapists as "formal" and "authoritative" to being more "natural or organic" and "friendly." Clients felt that this self-disclosure moved them from being a "case to be analyzed" and "just an appointment" to feeling that they were worthy of respect, trust, and care in their therapists' eyes (Audet, 2011, pp. 92-93). Therapist self-disclosure also diminished some clients' doubts about younger or inexperienced therapists, as these disclosures revealed that the therapists had experiences beyond textbook learning (Audet, 2011).

Johnson and Johnson (2005) wrote of the advantages of another type of boundary crossing—nonsexual multiple relationships. They argued that the "embedded practice" of military psychologists who work and live with service personnel holds significant therapeutic advantages (p. 73). These military psychologists are so immersed in the unit's experience and culture, for instance, that they become uniquely approachable; they may gain cultural currency by adhering to community norms; and they have an undeniable appreciation of the unique pressures faced by their unit members. Being an embedded member of rural or other isolated communities may also counteract the wariness with which therapists are often viewed (Smith & Fitzpatrick, 1995). By visibly participating in community life, counselors humanize themselves. This humanization may counteract the effect of clients' potential negative stereotypes and fear of the unfamiliar with regard to psychotherapy.

Kiselica (2003) wrote of the importance of nonsexual boundary crossings in working with another therapeutic population: adolescent males. This population is often hesitant to discuss heavier, emotionally vulnerable topics because such disclosures betray a rigid set of masculine ideas (Jansz, 2000; Williams, 1985). Jansz (2000) identified four key aspects of U.S. masculine ideals: stoicism, aggression, autonomy, and achievement. Adolescent males in the U.S. not only suppress their own expressions of emotional or physical pain; they also mock and/or disapprove of expressions of pain, worry, or caring in other adolescent males (Oransky & Maracek, 2009). Therapists who work with these adolescent males may find boundary crossings such as humorous self-disclosure and conducting therapy in non-office environments particularly fruitful (Kiselica, 2003). Kiselica described building rapport by tossing a ball back and forth outside while in

session, using adolescent-friendly slang, and building a shed or model airplane with clients. These gestures of openness and cultural sensitivity allowed adolescent male clients to open up in relationship-building situations that were immediately familiar to them.

In other cultural contexts, clients are likely to expect therapist engagement in social practices that cross traditional Western therapeutic boundaries. For example, first generation Asian immigrants may feel surprised or even alienated if their therapist refuses a gift, especially if this gift is not excessive in monetary value. Flexibility toward giving and receiving gifts allows therapists to communicate respect for such clients' cultural practices (Moleski & Kiselica, 2005).

Multiple authors promote the idea that a therapist's crossing a physical boundary with a client through nonsexual touch is specifically helpful for building rapport. Satir (1972), for instance, wrote about how helpful it is to touch clients in order to engage more deeply with them during treatment. Touch may be especially emotionally corrective for clients who have never experienced safe physical touch (Wilson, 1982). According to Wilson, clients' trust and acceptance of themselves is facilitated by this safe, accepting nonsexual touch. Mintz (1973) supported the use of nonsexual physical touch as a grounding point for clients from a mind-body perspective. Finally, Fromm-Reichmann (1950) suggested that clients are more likely to open up in therapy and do meaningful self-exploration when touched appropriately.

Another line of reasoning for engaging in boundary crossings emphasizes patient safety and welfare. Brown (1991) argued that boundary crossings are unavoidable and warned that therapists participate in less informed and systematic decision-making when

they exaggerate the danger of benign boundary crossings in the attempt to avoid boundary violations (Brown, 1987). Rather than seeking to prevent boundary crossings, feminist therapists focus on fostering forethought and nonjudgmental self-awareness, both of which maximize the efficacy of boundary crossings as therapeutic interventions. Along the same lines, Zur (2007; 2008) asserted that nonsexual multiple relationships specifically make client exploitation much less likely. Isolation and mystery are factors in interpersonal violations such as domestic violence and cult indoctrination (Zur, 2007). These factors are decreased when clients are connected in multiple ways to their therapist. Additionally, others have suggested that engagement in nonsexual multiple relationships with clients may prevent therapists from covering up evidence of exploitation by expanding the visibility of the relationship outside of the privacy of the office (Tomm, 1993).

Another line of argument for the acceptance and then examination of what constitutes appropriate boundary crossings is that they are inevitable, particularly in small or isolated communities (Simon & Williams, 1999). Alexander and Charles (2009) argued that it is imperative that ethical standards do not put therapists in these communities in an impossible middle ground between realistic practice and the threat of transgression. In urban situations, counselors already chance seeing patients at social events or at religious meetings, having mutual acquaintances with patients, or accidentally attending the same support group meeting (Moleski & Kiselica, 2005). Other therapists, however, are additionally socially and professionally intertwined with clients from the same naval carrier, expatriate population, rural community, religious community, academic community, and/or marginalized group. Religious clients may feel

more comfortable with therapists from their faith tradition, LGBT therapists who participate in LGBT organizations are more likely to have multiple relationships with LGBT clients, and deaf therapists are often sought out by deaf clients for their sensitivity to issues uniquely faced by deaf individuals (Hill & Mamalakis, 2001; Kessler & Waehler, 2005; Schank & Skovholt, 1997). These counselors have a higher probability of treating their child's friends or friends' children, treating multiple members of the same family, buying goods or services from clients, or seeing clients at community events (Pugh, 2006; Schank & Skovholt, 1997). Psychologists who work at university counseling centers may teach classes that their clients take, may advise campus groups that their clients participate in, and attend the same college events that their clients attend (Dallesasse, 2010). Therapists' chances of indirect multiple relationships are only multiplied when they supervise counseling trainees (Schank & Skovholt, 1997). Sommers-Flanagan and Sommers-Flanagan (1998) opined that it is unethical (a violation of the ethical principle of Justice) to deny former patients in their small and isolated community the opportunity to train in psychology at the local university merely because these former patients have sought their counseling services.

In the military, therapist and other healthcare professionals' social enmeshment is exceptionally amplified, even in comparison to the previously described groups. Johnson and Johnson (2005) wrote that in the military, "a client might be the person who takes the trash out of one's stateroom, serves food in the officer's cafeteria, cuts one's hair, cleans one's teeth, or exchanges social pleasantries during the myriad chance meetings in the passageways, bathrooms, exercise facilities, and social-gathering areas within the ship" (p. 77). Because healthcare professionals are officers in the military, they are also

simultaneously bound to sometimes-conflicting roles with their clients. For example, the therapist as an officer may be administratively compelled to mark a client as unfit for service—even knowing that this action will cause client distress and/or therapeutic rupture (Johnson & Johnson, 2005).

Approaching the argument from a different perspective, Lazarus and Zur have vehemently argued against what they perceived to be boundary-related overcaution by some professionals. In his 1994 article, Lazarus polemicized the issue of boundaries by describing "anxious conformists" whose impossible devotion to rules explodes any hope of therapeutic efficacy (p. 255). In contrast, Lazarus wrote, "truly great therapists" are "courageous and enterprising helpers, willing to take calculated risks" (p. 260). While he holds the idea of boundaries themselves as valuable, he believes that blanket use of certain boundaries (i.e., "hiding behind" them) is dehumanizing for the client; the therapist becomes an inhuman figure and the alienated client therefore experiences the therapeutic interaction as devoid of natural warmth and intimacy (p. 260). Lazarus (1994) recounted how his own decisions to socialize with clients outside therapy, to play tennis with them, to take long walks together, to accept and give small gifts, and to attend parties with them have resulted in conclusively positive outcomes. He has also treated his own relatives and friends. Lazarus (1994) noted that engaging in such nonsexual multiple relationships also gives him crucial outside data that allows him to work more effectively as a psychotherapist.

Moreover, Zur (2008) asserted that the idea of an inherent therapist-patient power differential has been used to "demonize" nonsexual multiple relationships and other boundary crossings (p. 32). In his opinion, this idea is both an archaic holdover from

early psychoanalytic theory and overblown from legitimately alarming cases of sexual contact between therapists and clients. For Zur, the fault in the latter case lay with moral character of the individual therapists themselves. Zur opined that these clinicians are moral outliers within psychology, individuals who have a "disposition to corruption," and a "propensity to exploit their power for their own selfish gain…and a lack of personal integrity" (2008, p. 40). Furthermore, he asserted that the power differential itself does not truly exist. Therapists and clients, Zur posited, have equal but different forms of power. Zur further posited that other writers' unnecessary focus on this power differential serves only to unrealistically boost therapists' sense of mastery over their clients, which infantilizes the clients and decreases therapeutic efficacy.

Zur (2001) gave anecdotal examples of how therapeutic effectiveness is maximized by engaging in healthy boundary crossing, citing examples such as making home visits to homebound individuals, working with schizophrenic patients who are radically more open in the outdoors, and meeting in public areas with patients recovering from sexual abuse by a therapist. Zur (2001) recounted how, in these cases, boundary crossings allowed therapy to occur in the first place and thereby fulfill principle of Justice—that all individuals should have access to psychotherapy (APA, 2017). Sommers-Flanagan and Sommers-Flanagan (1998), like Zur, shared moving anecdotes about therapeutic turning points that were directly born of benign boundary crossings. In one case, a client who commandeered time-keeping responsibilities for her therapy sessions began processing her pathological need for control only after Dr. Rita Sommers-Flanagan extended her therapy session by a few minutes.

Other authors have taken less zealous approaches to advocating against unnecessary legalism regarding therapist boundary crossings. Gottlieb and Younggren (2009) took a critical second look at Guthiel and Gabbard's slippery slope concern that minor boundary crossings lead to more egregious violations (e.g., therapist-client sexual intimacy), and commented that this situation rarely occurs in actual practice. Furthermore, this charge may have harmed therapists by concentrating their attention on fearing even minute deviations from tradition during or outside of the therapy session (Pope & Vasquez, 2007).

Instead, Gottlieb and Younggren (2009) proposed that psychologists fall into one of three general categories. The first is Zur's morally astray psychologist who ignores ethical codes entirely, exploits clients at will, and should generally not be practicing psychology. Knapp, Handelsman, Gottlieb, and VandeCreek (2013) defined this psychologist as the marginalized therapist, whose low personal ethics disastrously intersects with low professional ethics. The second is a larger mixed group of psychologists who are certainly vulnerable to boundary violations based on a wide range of individual variables. The third represents the vast majority of psychologists. They typically practice safe and effective boundary management. They are therefore unlikely to ever fall into danger of committing boundary violations. Knapp and colleagues (2013) concluded that this dominant majority of psychologists crosses boundaries in a manner that is therapeutically sound and involves very low risk to the client or the therapeutic relationship.

The Case Against Nonsexual Boundary Crossings

Public discussion of topics related to therapist-client boundary crossings was not only minimal before the 1960's; it was actively suppressed (Smith & Fitzpatrick, 1995). However, some did voice opinions. For example, Menninger (1958) argued that the therapist's physical contact with a patient, even nonsexual, creates counterproductive transference and countertransference. Wolberg (1954) similarly remarked that nonsexual physical contact should be entirely prohibited in therapeutic relationships because it leads to either sexual feelings or anger toward the therapist.

In the 1960's, significant social changes in the United States raised public and psychologists' interest in dialogue on exploitation of clients by psychotherapists, particularly by sexualized boundary violations (Smith & Fitzpatrick, 1995). Feminist writing on power differentials, for instance, created a useful framework for understanding a similar differential within the therapeutic relationship (Gottlieb, Younggren, & Murch, 2009).

In its 1977 revision of the Ethics Code, the American Psychological Association (APA) first explicitly banned therapists' sexual intimacies with patients (APA, 1977). This change sparked significant developments in ethical thought. Psychologists began to focus on how nonsexual boundary breaches also could be harmful. Langs (1982) went so far as to define specific seating configurations in the therapy office and to prohibit taking insurance because of automatic boundary crossings in confidentiality. However, practitioners also began to tease apart how some boundary crossings could be benign or even therapeutically constructive (Gottlieb et al., 2009).

The 1980s and 1990s saw a large increase in ethics literature on boundary crossings between therapists and clients (Pope & Keith-Spiegel, 2008). As discussed below, research during these two decades uncovered significant relationships between various therapist factors and either attitudes regarding the ethicality of or frequency of practicing various boundary crossings. This interest and awareness in situational ethics was maintained into the 2000s (Gutheil & Gabbard, 1998).

As discussed in greater detail below, the 1992 *Ethical Principles of Psychologists and Codes of Conduct* (APA, 1992), from now on referred to as the 1992 APA Ethics Code, was crafted with significant modifications regarding boundary crossings in response to this dialogue. This Ethics Code was, nevertheless, criticized for having several glaring flaws. The 1992 Ethics Code has been described as being highly ambiguous (e.g., containing a multitude of qualifying words in the standards for conduct) and as protecting psychologists more than it did clients (Bersoff, 1994; Gottlieb, 1993; Pope & Vetter, 1992; Smith & Fitzpatrick, 1995; Sonne, 1994). For example, Standard 1.17 regarding nonsexual multiple relationships stated: "A psychologist refrains from entering into or promising another personal, scientific, professional, financial, or other relationship with such persons if it appears likely that such a relationship reasonably might impair the psychologist's objectivity or otherwise interfere with the psychologist's effectively performing his or her functions as a psychologist, or might harm or exploit the other party" (APA, 1992, p. 5). The 1992 APA Ethics Code clearly held the therapist responsible for avoiding some nonsexual multiple relationships. Simultaneously, it failed to explicitly guide clinicians as to how to assess for the presence of such factors as increased likelihood of exploitation or loss of clinical objectivity (Sonne, 1994).

As briefly discussed above, in 1993 Gutheil and Gabbard published a highly-cited article that posited the existence of a "slippery slope" for therapists that leads from seemingly benign, even beneficial boundary crossings to more egregious boundary violations such as sex between therapists and their clients. Simon (1995) supported Gutheil and Gabbard's notion of a "slippery slope" and noted that a series of boundary violations often do precede therapist sexual misconduct. Simon and other authors argued that patients are not only harmed once sexual contact is initiated; they are harmed by the many ill-advised boundary breaches that occur beforehand (Gutheil & Gabbard, 1998; Simon, 1991, 1995). Excessive or inappropriate therapist self-disclosure about the therapists' fantasies or financial stressors has been reported to be the most frequent boundary violation before sexual contact (Simon, 1991; Smith & Fitzpatrick, 1995). Unhealthy boundary breaches accelerate once they occur if not recognized and addressed. And, as these breaches expand in seriousness and frequency, the therapeutic dyad appears to consistently slide toward more definitive and serious boundary violations (Lamb, Catanzaro, & Moorman, 2003; Pope & Bajt, 1988; Simon, 1991). Simon (1991) suggested that identifying these boundary violations as early as possible is one of the most important measures for avoiding therapist-patient sexual relationships. Consistent with Simon's work, Borys (1988), as well as Lamb and Catanzaro (1998), found a positive correlation between nonsexual multiple relationships between therapists and clients and subsequent therapist-client sexual contact.

In the midst of cautions offered in the literature regarding crossing boundaries with clients, Sommers-Flanagan and Sommers-Flanagan (1998) outlined two potential negative consequences to be taken into account when considering a boundary crossing.

First, boundary crossings, however evanescent when planned, can permanently alter interpersonal dynamics in either healthy or unhealthy ways. While this change can be positive, it is important to consider because it is long-lasting. Second, boundary crossings evoke a host of new questions about what is possible in the psychotherapy relationship in the future. Will the boundary that was crossed be re-created, and how? What other boundaries can or should be crossed now? These questions are an echo of Gutheil and Gabbard's (1993) slippery slope phenomenon.

Similarly, Keith-Spiegel and Koocher (1985) warned that boundary crossings with current clients pose a potential risk because therapists cannot know what twists and turns may occur along the course of therapeutic treatment itself. Boundary crossings done with the best of intentions and current knowledge may create unforeseen issues as time passes that tangle the process of therapy, potentially causing harm to clients. For instance, a therapist might know in advance that boundary crossings may be ill-advised with patients who struggle with a specific set of presenting concerns. However, this therapist and her patient may also not realize that the patient meets the criteria for these conditions until later in the therapy process (Gottlieb et al., 2009).

Much of the discussion regarding the risks of boundary crossings has focused on one particular type: nonsexual multiple relationships. Borys (1994) argued that in nonsexual multiple relationships with current clients, therapists cannot control what they learn about clients in the secondary relationship, and vice versa. Borys also opined that therapists cannot guarantee objectivity when their secondary or tertiary relationships naturally involve self-interest and self-gratification, such as in business partnerships.

Nonsexual multiple relationships may interfere with the therapeutic relationship in other ways by leading to misinterpretation. Keith-Spiegel and Koocher (1985) remarked that patients who have bartered services for therapy may mistake constructive confrontation in session as their therapist's dissatisfaction with their work. Conversely, therapists may find themselves unwilling to raise legitimate issues with a patient's bartered services because it may endanger the therapeutic relationship. Sonne (1994) noted how the very definition of the therapeutic relationship can be skewed in the context of nonsexual multiple relationships. Can clients bring up personal issues in the context of the secondary relationship? If so, how should the therapist proceed? What public places are and are not appropriate for continuing therapeutic work when relevant issues emerge in conversation outside of the therapy office?

Furthermore, patients themselves may view extra-therapeutic social relationships with their therapists as inappropriate and unwanted. For instance, they may feel burdened in therapy by additional self-disclosure in the context of more social relationships with their therapists (Audet, 2011). One therapy client interviewed in Audet's study found his therapeutic relationship "social and superficial" because his therapist shared in detail about going through a similar experience to him (p. 93). One other client reacted poorly to self-disclosure because she disapproved of the life choice her therapist revealed.

Patient self-censoring is another concern raised in the literature concerning multiple relationships. Hill and Mamalakis (2001) wrote about family therapists in the same religious communities as their clients; they added that clients in these kinds of nonsexual multiple relationships are inherently more vulnerable to therapist influence and control. As such, they may behave in self-protective ways that distort the therapeutic

process, limiting their own self-disclosure in session because of the risk of exposure and embarrassment in other social contexts. Even the promise of a future, post-termination multiple relationship may create compromises in honesty in the therapeutic relationship in order to facilitate this future social relationship (Canter, Bennett, Jones, & Nagy, 1994). These compromises have the potential to decrease therapeutic efficacy.

A major historical argument against engaging in boundary crossings is based on the idea of an inherent interpersonal power differential between psychotherapists and their clients (Gabbard, 1994; Schoener, 1995; Sommers-Flanagan & Sommers-Flanagan, 1998). Interpersonal power is often dyadically defined in terms of the possessor's ability to influence others' behavior (Dunbar, 2015). It determines "the topics we discuss, the opinions we share, whether we conform to the expectations of others, and the communication behaviors we choose to enact" (Dunbar, 2015, p. 1). Dunbar (2015) further defined different levels of visibility of power (i.e., manifest, latent, and invisible):

> Manifest power concerns the visible outcomes of power, such as open conflicts or particular verbal and nonverbal strategies used to achieve certain ends. Latent power is identified when the needs of the powerful person are identified or conflicts are avoided due to fear of retaliation by the powerful partner. Invisible power is the result of social or psychological mechanisms that do not necessarily surface in overt behavior or even latent grievances, but may be manifest in systematic differences between men and women due to gender norms, racial inequalities, or other culturally relevant expectancies. Often, the powerful person may not be aware of his or her power, since power is based in the relationship between two people but is influenced by cultural norms in the society at large. (p. 2)

French, Raven, and Cartwright (1959) proposed five bases of interpersonal power. These bases are reward power (the ability or right to reward desired behavior), coercive power (the ability or right to punish undesirable behavior or the absence of desired behavior), legitimate power (power from holding a high-status position that is sanctioned

by society), referent power (in which others admire and emulate the powerful person), and expert power (having expertise in a needed field). Raven and Kruglanski (1970) added another power base—that of informational power. They observe that an individual will internalize the ideas of the informationally powerful person and perform desired actions without need for the influencer to personally push things along (Raven, 1993). In contrast, the use of previously defined five bases requires the influencer to be more active as an initiator (Raven, 1993). Raven (2008) noted that influencers typically do a cost-benefit analysis of power strategies. These analyses consider cost, time, effort, potential hostility of reactions, violation of personal value system or accepted social norms, and need for respect.

Psychologists potentially draw from all power bases (legitimate, expert, referent, informational, reward, and coercive). Therapists have recognized legitimacy and expertise as licensed individuals whose training qualifies them to be a safe person from whom to receive help. Smith and Fitzpatrick (1995) wrote regarding this legitimate and expert power in therapists that "there is the power traditionally ascribed to healers in our society. Like the shaman in less developed societies, the modern healer is perceived as having a special power to alleviate suffering and to prolong life" (p. 501). Some therapists also may be highly admired, either because of their achievements or because of their personal characteristics, and therefore wield referent power. Furthermore, practitioners employ informational power as a function of their advanced education and training; they impart skills, insights, and psychoeducation to clients that are internalized and utilized in the process of change.

Therapists' legitimate, expert, and informational power are linked to clients' inherent vulnerability when seeking help. Clients' vulnerability to the therapist occurs at the onset of therapy, when clients' pain or need causes them to enter therapy (Hill & Mamalakis, 2001; Kagle & Giebelhausen, 1994). At this point they may be in crisis and therefore more open to influence or injury (Canter, Bennett, Jones, & Nagy, 1994; Caudill & Pope, 1995; Corey, Corey, & Callahan, 2011; Koocher & Keith-Spiegel, 1998; Smith & Fitzpatrick, 1995; Zur, 2000). Furthermore, therapists' informational power likely increases as clients begin to self-disclose in therapy. Patients make themselves more vulnerable by expressing feelings, behaviors, and thoughts that they may rarely acknowledge in real life (O'Leary et al., 2012). These may include shameful experiences, unresolved trauma, distressing family histories, and uncomfortable truths about partners, workplace realities, and children. Patients may come out as gay or transsexual to therapists before they do so to partners and their religious communities. They may also explore their uncertainties about seeing reality accurately. While clients expose these secrets and deeply held aspirations in psychotherapy, therapists typically do not do the same (Gabbard, 1994; Smith & Fitzpatrick, 1995). This unequal self-disclosure is a source of inherent therapist power, as the more powerful person in any dyad is typically the one who has reveals the least information about themselves (Hill & Mamalakis, 2001).

Therapists may employ reward power by being directly responsible for making recommendations to social, legal, or other organizations that benefit patients (e.g., on patients' applications for social security benefits or fitness for duty). And, in some cases, the therapist may also hold coercive power. First, some psychotherapy occurs only

because it is court-ordered or mandated by a governing body (e.g., a licensing board; Sawyer & Prescott, 2011). It is therefore involuntary. Second, therapists are mandated reporters who are under ethical and legal obligation to report elder abuse or neglect, child abuse or neglect, and dangerousness to self or others. They have the authority to commit clients who present with potentially dangerous intentions to an involuntary psychiatric hospitalization. Third, the process by which clients file formal complaints against their psychotherapists put clients at more risk in certain ways than it does therapists. Clients', but not therapists', personal lives are subject to public scrutiny via discussion of topics covered in psychotherapy during proceedings concerning possible therapist misconduct (Gabbard, 1994). Because therapy so often involves the most painful, humiliating, and hidden parts of clients' inner and past experiences, this open exposure poses a potential threat of embarrassment and shame to potential client whistleblowers.

This role-based power differential may be further enhanced by the fact that therapists in the U.S. are likely to be from dominant cultural groups. Sources of power in American society include certain demographic factors like being White and male (Fiske & Berdahl, 2007). Although there are more female than male psychologists practicing in the U.S., over 80 percent of active psychologists identified as White in 2013 (APA, 2015). This ethnic homogeneity is especially striking in light of the fact that the percentage of Asian-Americans, African-Americans, and Hispanic Americans in psychology increased significantly from 2005 to 2013 (APA, 2015). Heterosexual and cis-gender individuals are also privileged and considered normative in the U.S. (Herek & Garnets, 2007). It is unclear at this time whether therapists in the U.S. are also dominantly heterosexual or cis-gender. Finally, advanced education is a significant

source of privilege that is often complicit in reproducing racial inequality in the U.S.; becoming a licensed therapist requires this advanced education (Carnevale & Strohl, 2013).

When therapists from privileged cultural groups are oblivious to their group-based privilege, they may fail to address the power imbalances that create potential distance and misunderstanding in the therapeutic alliance (Hays, Dean, & Chang, 2007; Thompson & Neville, 1999). Conversely, exploring issues of personal privilege can decrease therapists' likelihood of using racial stereotypes or alienating ethnocentric values in therapy (Neville, Worthington, & Spanierman, 2001). Issues that culturally privileged therapists should become aware of include mainstream pathologizing of minority values, omitting and minimizing of minority contributions, silencing of or selective attention to minority perspectives, ignorance of minority groups' diversity, denial of minorities' humanity, limiting of minority practices, and exoticizing minority presence in society (Thompson & Neville, 1999). Unawareness or denial in culturally privileged therapists may be especially harmful because less privileged clients may have internalized the discriminatory beliefs that prevent them from understanding their systematic oppression or exploitation (Thompson & Neville, 1999). On the other hand, therapists from minority or marginalized cultural groups may be prone to underestimating the existence or extent of their power differential with clients from the other power bases described above because these therapists may focus mainly on their own oppression (Brown, 1989).

The literature indicates that social power differentials are particularly significant with regard to nonsexual touch in therapy (Alyn, 1988; Durana, 1998). Gender and social status are, for instance, important factors in when, where, and how more powerful

individuals are socially allowed to touch less powerful individuals (Durana, 1998). Nonsexual touch may reinforce unequal power relationships in a way that normalizes what would otherwise be a boundary violation (Alyn, 1988). This concept is likely applicable across all social power differentials.

Finally, a particularly fruitful vein of boundary-related literature specifically exists in the dialogue among authors who advocate for boundary crossings and against overly legalistic practice and those who respond. As stated previously, Lazarus and Zur have presented strong arguments for boundary crossings (Lazarus, 1994; Zur, 2000; 2001; 2004; 2007). For example, Lazarus (1994) argued that contemporary psychologists have unethically forsaken beneficent psychotherapeutic opportunities inherent in boundary crossings in the name of avoiding litigation. In response to Lazarus (1994), Borys (1994) emphatically outlined a vision of therapy in which boundaries are a foundational necessity because they allow for therapist warmth toward patients and for safe, genuine connection. In contrast to Lazarus' depiction of a robotic boundary-emphasizing therapist, Borys' therapist is present and effective precisely because these boundaries are in place.

In response to Lazarus' (1994) anecdotal evidence of boundary crossings and their positive therapeutic results, Borys also cited Pope and Vasquez's 1991 list of "commonly employed justifications for unethical behavior," stating that "the reader will recall that Lazarus actually offered some of these rationales to legitimize some of the boundary alterations he reported engaging in. Clearly, when we are faced with a difficult ethical decision, such justifications may further impair our judgment" (p. 272). These justifications included: "It's not unethical as long as none of your clients has ever

complained about it," "It's not unethical as long as your client wanted you to do it," and "It's not unethical as long as your client's condition made them so difficult to treat and so troublesome and risky to be around that they elicited whatever it was you did" (Pope & Vasquez, 1991, pp. 14-15).

To Cross or Not to Cross: That Remains the Question

Clearly, the professional discourse regarding the potential advantages and risks of nonsexual boundary crossings between therapist and current client suggests that there is merit to both sides of the argument. Gabbard (1994) captured this conclusion by pragmatically challenging mental health professionals to think about the considerable middle ground between "ill-advised self-disclosure and automaton-like coldness" (p. 285). Gabbard's (1994) challenge called for therapists' use of their clinical judgment to decide where that ethical middle ground of maximal benefit and minimal risk regarding boundary crossings for the client and the therapeutic relationship lies. In the process of that decision-making, professional ethical standards such as the APA Ethics Codes and principles can serve as a foundational resource (APA, 1953; 1977; 1992; 2002; 2010; 2017).

Nonsexual Boundary Crossings Examined in the Current Study: Guidance from the 2017 APA Ethics Code

This study focused on seven specific nonsexual boundary crossings in therapy with current clients, some identified in the professional discourse over the decades and some newly identified in the contemporary literature with the advent of the Internet and

widespread, daily use of computer-based technologies. None of the boundary crossings examined in this study have been identified as de facto unethical or illegal (i.e., boundary violations). Instead these crossings are those which require clinicians' careful judgment and decision-making in order to avoid potential harm to clients. This study included two types of deliberate therapist self-disclosure (in-person and digital), searching for client information online, two types of traditionally identified nonsexual multiple relationships (professional and social), and two digitally based nonsexual multiple relationships (accepting a social media request from a client and providing psychoeducation online via social media platforms).

Each of these nonsexual boundary crossings is described below, along with the current relevant APA Ethics Code principles and standards (APA, 2017) designed to offer the decision-maker guidance. Most of the nonsexual boundary crossings have not been specifically addressed in a Code standard to date. Instead the therapist is admonished to adhere to more foundational, and aspirational, ethical principles and more general standards.

Therapist In-Person and Digital Self-Disclosure

Zur, Williams, Lehavot, and Knapp (2009) defined therapist self-disclosure as the transmission of personal information about therapists to psychotherapy clients. They outlined three categories: deliberate, unavoidable, and accidental. Deliberate verbal self-disclosure includes statements in which a therapist might conversationally offer information about his or her personal or life status, preferences, or opinions (e.g., his or her marital status, vacation destination, spiritual background, or political views).

Deliberate nonverbal self-disclosure occurs when therapists communicate personal information without verbal communication, such as when they wear religious symbols and gay pride pins or decorate their office with objects or furniture that reflect their interests and taste. And, deliberate online self-disclosure involves the transmission of information about the therapist online (e.g., the therapist having a website for his or her practice, or listing his or her CV or biography on a health maintenance organization's website or on a university's faculty page). Unavoidable self-disclosure includes therapists' gender presentations, age, and visible disabilities. In small communities, unavoidable self-disclosure often widens to include a much wider range of personal information, ranging from religious affiliation to sexual orientation (Zur, 2008). Finally, Zur and colleagues (2009) defined accidental self-disclosure as those occasions that involve an unplanned witnessing of the therapist by the client such as when the therapist is seen by a client in a public place or when the therapist exhibits unplanned emotional responses to a client's decisions (e.g., grimacing involuntarily when a client reveals a decision to stay with an abusive spouse). This study included an exploration of deliberate self-disclosures by the therapist both in the therapy session and online.

The 2017 Ethical Principles of Psychologists and Code of Conduct (APA, 2017), from now on referred to as the 2017 APA Ethics Code, does not directly address therapist self-disclosure. However, the 2017 APA Ethics Code does contain General Principles that can be relevantly applied to individual instances of potential self-disclosure. The General Principle of Beneficence and Nonmaleficence urges therapists to "strive to benefit those with whom they work and take care to do no harm…to safeguard the welfare and rights of those with whom they interact professionally and other affected

persons" (p. 3). In other words, this General Principle instructs therapists to maximize the benefit and minimize the harm caused by self-disclosure. Another important aspect of beneficence and nonmaleficence is therapists maintaining strong awareness of their own physical and mental states and "personal, financial, social, organizational, or political factors" because of how any of these variables may negatively impact ethical decision-making (p. 3).

Further, the General Principles advocate Justice in practice and admonish psychologists to "exercise reasonable judgment and take precautions to ensure that potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices" (APA, 2017, p. 4). And, the General Principle of Fidelity and Responsibility calls upon clinicians to "uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm" (APA, 2017, p. 3).

Related standards in the Code prohibit therapists from any actions that might increase the likelihood of harm to clients (Standard 3.04a) and from engaging in exploitative relationships (Standard 3.08). Therapeutic self-disclosure must occur within the context of these patient welfare concerns in order to maximize the benefit and minimize the risk of harm of psychotherapy for each client.

Searching for Client Information Online

Therapists have begun to use online search engines such as Google and social media websites such as Facebook to search for information about patients (Kolmes,

2012). The 2017 APA Ethics Code does not, however, explicitly address this boundary crossing. The General Principle of Respect for People's Rights and Dignity, states that "psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination" (APA, 2017, p. 4). Clients not only have the right to privacy; they also grant therapists a profound trust that the 2017 APA Ethics Code explicitly describes in introducing the General Principle of Fidelity and Responsibility. It is crucial to consider how respecting this privacy and upholding clients' trust intersects with the clinical need for an online client information search.

Integrity is another relevant General Principle when therapists decide to engage in this boundary crossing. This principle states that therapists must not "engage in subterfuge [or] intentional misrepresentation of fact" (p. 4). Integrity also requires "accuracy, honesty, and truthfulness" of all practitioners (p. 3). How, then, should therapists respond when clients first disclose information that the therapist has discovered online? Based on the General Principles, clients' potential adverse reactions to being informed of information searches should be considered before the information search, not once in this particular situation.

A related 2017 APA Ethics Code standard includes not discriminating unfairly against clients for reasons such as culture, religion, and sexual orientation (Standard 3.01)—all of which may be discovered via an online search. Other relevant standards include avoiding any action that increases likelihood of harm to a client (Standard 3.04a) and diligently documenting patient-related Internet searches as they pertain to therapeutic work (Standard 6.01). Psychologists may also weigh how and whether searching for

client information online may be appropriately included in the informed consent, which is required for provision of any counseling services (Standard 3.10).

Nonsexual Multiple Relationships

A multiple relationship is defined in the current APA Ethics Code as those relationships "when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) 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 (3) 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). For instance, a psychologist may also be a client's professor, research mentor, employer, friend, social acquaintance, family member, or business partner. As suggested in the Code, nonsexual multiple relationships can be categorized as involving a social, business, or secondary professional (e.g., professor, research mentor) role in addition to the primary therapist/client relationship. Additional extra-therapeutic relationships can occur by intention or by chance (e.g., for instance, when a therapist unexpectedly discovers that his or her client is a member of the same synagogue or gym).

Of the nonsexual boundary crossings discussed in this study, nonsexual multiple relationships have received the most explicit attention in the APA Ethics Codes as they have evolved through revision over the years. Reflecting the evolution of the professional discourse on this topic, the original 1953 APA Ethics Code prohibited multiple relationships under most circumstances, stating that "a psychologist normally should not enter into clinical relationships with members of his own family, with intimate friends, or

with persons so close that their welfare might be jeopardized by the dual relationship" (APA, 1953, p. 4). In Section 3, part d, moreover, the first Code prohibited APA members from seeing students as paying clients "since it may confuse the relationship between the student and the instructor in other activities" (pp. 11-12). Interestingly, the standard did contain an exception; it stated that a "qualified" psychologist could fill both roles if this psychologist were the only clinician available to this trainee.

In contrast, the 2017 APA Ethics Code states that multiple relationships are not necessarily unethical but that psychologists should refrain from entering into a nonsexual multiple relationship "if the relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists" (p. 6). It is the therapist's responsibility, then, to reason through potential risks and decide via review of ethical standards and professional consultation whether or not to engage in the multiple relationship.

This study examined two types of traditional nonsexual multiple relationships (one providing psychotherapy to individuals in one's social circles and providing psychotherapy to a current student or supervisee). In addition, the study also examined two technology-based nonsexual multiple relationships (accepting a social media request from a client and being a providing psychoeducation online via social media platforms). A description of each type of nonsexual multiple relationship is presented below.

Social Nonsexual Multiple Relationships

Social nonsexual multiple relationships entail providing psychotherapy to an individual who is also a participant in the therapist's social circles. Therapists may choose to provide psychotherapy to these individuals themselves. Also, as noted above, Schank and Skovholt (1997) suggested that social nonsexual multiple relationships can occur via informal channels such as when the therapist's partner, children, friends, or colleagues refer someone close to them to the therapist. Therapists' participation in group activities such as religious community, volunteer work, or neighborhood sports teams further increases psychologists' likelihood of encountering individuals they know socially in their practice. For example, a therapist's friend may ask to meet in therapy with the clinician to address issue with a problematic relationship. Similarly, a current client may attend the same church social group as the therapist. As this is a traditional nonsexual multiple relationship, the 2017 APA Ethics Code General Principles and standards described above pertain to all social nonsexual multiple relationships.

Professional Nonsexual Multiple Relationships

Professional nonsexual multiple relationships include the occurrence of supervisory, evaluative, and collegial relationships alongside the primary therapist/client relationship (Moleski & Kiselica, 2005). For example, therapists serving in the military also serve as officers (Johnson & Johnson, 2005). They therefore have an automatic professional nonsexual multiple relationship with every client they see. Other examples include those situations in which the therapist may also serve in the role of clinical supervisor or of course instructor for a client. Like social nonsexual multiple

relationships, this crossing is a type of traditional nonsexual multiple relationship. As such, the 2017 APA Ethics Code General Principles and standards described above also pertain to professional nonsexual multiple relationships.

Accepting a Social Media Request from a Client

Social media platforms are nearly ubiquitous means of online interaction in the U.S. and abroad (Kolmes, 2012; Stutzman, Gross, & Acquisti, 2013; Vitak, 2012). Common social networking sites include Facebook, Twitter, and Instagram (Kwak, Lee, Park, & Moon, 2010; McGough & Salomon, 2013; Pempek, Yermolayeva, & Calvert, 2009; Skeels & Grudin, 2009). Transparency of the therapist increases significantly with social media use (Kolmes, 2012; Zur, 2008). In fact, this transparency mirrors that of therapists in small or isolated communities, in which multiple relationships with clients are inevitable (Zur, 2008).

Zur (2008) observes that therapists should all assume that any social media post they post online can be accessed by every one of their patients and peers. Indeed, privacy and security issues have both been widely noted in the literature on social media (Barnes, 2006; Fire, Goldschmidt, & Elovici, 2014; Hoadley, Xu & Rosson, 2010; O'Keefe & Clarke-Pearson, 2011). In one fascinating study, 86.6% of psychotherapy patients surveyed by Kolmes and Taube (2016) had searched for information about their clinicians online, most often for family information. Only 27.6% of this subgroup informed their clinicians that they had done so. Moreover, only 0.5% of these patients endorsed having hacked into a clinician's online account. Kolmes and Taube (2016) reported that the majority of possible predictors they explored (number of years on the

Internet, therapist degree, treatment setting, and treatment type) did not predict this behavior. However, psychotherapy patients who had undergone group psychotherapy were significantly more likely than those who had not to search for therapist information online. Patients in Kolmes and Taube's 2016 study endorsed curiosity, checking whether the psychotherapist was someone they would like to see at all or continue seeing, and wanting to feel more connected to their therapists as their reasons for conducting these online searches.

Because social media exposes a multiplicity of acquaintances to the same public posts from one's social media account, users do not interact with their online friends with the nuanced personalization that they would in face-to-face conversations (Marwick & boyd, 2011). Vitak (2012) referred to this dynamic as "context collapse," writing that "because of context collapse, users can quickly diffuse information across their entire network and facilitate interaction across diverse groups of individuals who would otherwise be unlikely to communicate" (p. 451). On social media websites, users perform unique personas by disclosing a specific public self-narrative (van Dijck, 2013). It is likely that clients would, at one point, melt into this imaginary audience. This context collapse may then threaten the careful building and maintenance of the therapeutic relationship, or at the very least, create confusion regarding the identities of the therapist and client.

The 2017 APA Ethics Code does not contain specific standards regarding the crossing accepting connection requests from current clients on social media or of maintaining such connections (APA, 2017; Taylor, McMinn, Bufford, and Chang 2010; Tunick, Mednick, & Conroy, 2011). However, multiple sections from its General

Principles and several standards of conduct are pertinent to the topic of having this online multiple relationship, of inevitable public transparency of clinicians, of the potential threats to the therapeutic relationship of context collapse, and of how therapists should make ethical decisions in light of these factors.

First, the General Principle of Beneficence and Nonmaleficence favors the choice of social media connection to occur only if the clinician deems the connection both beneficial and not harmful to the client. This principle includes the idea that clinicians are responsible for monitoring their own physical and mental health because impairments may influence their clinical judgment and efficacy. Echoed here is the General Principle of Integrity, which notes that psychologists "avoid unwise or unclear commitments" (p. 4). In the context of social media connection, in which individuals are frequently exposed to disclosures about each other's major life events, everyday annoyances, and opinions, this ethical self-monitoring lends itself to even the disclosure of one's physical and mental health online. This concept is tied to the General Principle of Fidelity and Responsibility, which compels clinicians to adhere closely to professional conduct and explicitly clarify the obligations tied to being in the therapist role. Further, the General Principle of Respect for the Rights and Dignity of clients specifically includes respect for "cultural, individual, and role differences" (APA, 2017, p. 4) between therapists and patients. These differences may prominently emerge in online interactions due to Vitak's (2012) concept of context collapse, productively or destructively influencing therapist-patient alliance.

A pressing concern in any social media connection—which is public to others on most social media platforms—is confidentiality, which is addressed in Standards 4.01,

4.02, and 4.05. Therapists considering this boundary crossing will ideally discuss in advance how social media connection may alter the limits of confidentiality and also prepare clients for the possibility of information from social media interfering with or enriching in-session content. A therapist adhering to the 2017 APA Code of Ethics will also take care to advise clients that they cannot solicit testimonials and that glowing reviews need not be a part of their social media relationship (Standard 5.05).

Also, clinicians are compelled by Ethics Code standards to avoid harming anyone with whom they work (Standard 3.04a), to avoid participation in activities connected to one's professional role if their personal problems may interfere with professionalism (Standard 2.06a), to avoid making false or deceptive public statements (Standard 5.01), to post only those statements that are validated by "appropriate psychological literature" and their "professional knowledge, training, or experience" (Standard 5.04, p. 9), and to refrain from engaging in a nonsexual multiple relationship that may impair their objectivity, competence, effectiveness, or ability to avoid harming or exploiting their patient (Standard 3.05).

Of note again, and likely a reflection of the evolving nature of ethical issues over time, is that the original Code, the 1953 APA Ethics Code, contained a section that emphasized the need to ensure that clinical work occurred in an appropriate setting—rather than, for instance, in a heated Facebook message concerning a controversial Facebook post (APA, 1953). Further, ongoing social media connection is a form of a nonsexual multiple relationship, and Section 2, part b of the 1953 Code prohibited multiple relationships in most cases (APA, 1953).

Providing Psychoeducation Online via Social Media Platforms

Therapists have begun to branch their services into online culture via platforms such as YouTube, blogs, and social media apps (Kolmes, 2012). Their professional presence online is often part marketing and part psychoeducation. A therapist with a "public" account on social media might list his or her real name and contact information while posting inspirational quotes, interesting research findings, or personal opinions related to psychotherapy for followers to consume. And, current clients may certainly access these public posts, comment on their therapist's online contributions, and "subscribe" or "follow" their therapist's stream of content as it is uploaded to the Internet.

For example, Ali Mattu, Ph.D., is a clinical psychologist at Columbia University whose YouTube channel, The Psych Show, includes psychoeducational videos about topics such as breaking bad habits and using exposure therapy techniques (Mattu, 2019). His channel has over 57,000 "subscribers," which means that over 57,000 individual YouTube accounts automatically receive notifications when new The Psych Show videos are uploaded. Therapists like Mattu potentially increase their public influence and connections to potential patients via these platforms.

The 2017 APA Ethics Code does not directly address the ethicality of providing psychoeducation online via social media platforms. Again, however, therapists are guided by the General Principles and by more general standards for conduct once the decision has been made to engage in this boundary crossing. The General Principle of Beneficence and Nonmaleficence compels therapists to, in this case, "strive" as social media influencers to "benefit those with whom they work and take care to do no harm"

and “safeguard the welfare and rights of those with whom they interact professionally and other affected persons” (p. 3). Another particularly applicable phrase in this Principle is that of being “alert to and [guarding] against personal, financial, social, organizational, or political factors that might lead to misuse of their influence” (p.3). By their very work, social media influencers have expanded influence. They must be even more attentive to ways in which they may be biased by these factors.

According to the General Principle of Integrity, therapists who are social media influencers must also “promote accuracy, honesty, and truthfulness” in their public Internet contributions and “avoid unwise or unclear commitments”—which, for instance, applies to the companies and services that these influencers agree to promote in videos or posts. Moreover, therapists who are mindful of the General Principle of Fidelity and Responsibility must honor the trust placed in them by their Internet followers by being extremely clear on the limits of any advice they dispense, taking responsibility for any mistakes they make, and avoiding exploitation or harm.

This General Principle is also relevant in a unique manner to therapists who are social media influencers in that it prompts psychologists to “contribute a portion of their professional time for little or no compensation or personal advantage.” Social media influencers certainly may reap financial benefits for their online presence; however, their online work also potentially functions as *pro bono* work in the domain of psychoeducation.

This form of connection functions as a nonsexual multiple relationship, which is specifically addressed in the current APA Ethics Code. As noted above, according to Standard 3.05, nonsexual multiple relationships should not be entered into or maintained

when they pose risk of harm to the psychologist's professional competence or to the patient directly (APA, 2017). In addition, the current Code calls for psychologists to protect clients' confidentiality (Standards 4.01, 4.05, 4.06, 4.07), to avoid making fraudulent or false public statements (Standard 5.01a), to clearly identify paid advertisements relating to their professional work (Standard 5.02c), and to ensure as much as possible that their statements on the Internet do not represent having a professional therapeutic relationship with recipients of mass media publications, and are based on professional knowledge (Standard 5.04). Standard 5.04 carries an interesting paradox. Although therapists are admonished in the standard not to operate as if a professional relationship has been established with the recipients of media presentations, it is highly likely that current clients will access the presentations. As such, there is then a professional relationship with some recipients.

A Call for Clinical Judgment and Ethical Decision-making

All therapists face ethical dilemmas regarding crossing nonsexual boundaries with current clients. And, in an article regarding professional boundaries the authors considered entitling "No One is Bullet Proof," Gottlieb and colleagues (2009) wrote: "It is neither safe nor prudent to ignore the possibility that practitioners can harm their patients" (p. 170). Clearly, however, rather than offering proscriptive or prescriptive standards for the therapist's ethical nonsexual boundary negotiations, the current APA Ethics Code (APA, 2017) leaves the clinician ultimately to rely on his or her clinical judgment and ethical decision-making.

Aim of the Current Research

As stated previously, the aim of this research project was to explore therapists' ethical decision-making regarding seven specific nonsexual boundary crossings: two types of deliberate therapist self-disclosure (in-person and digital), searching for client information online, two types of traditional nonsexual multiple relationships (social and professional), and two digitally-based nonsexual multiple relationships (accepting a client's social media request and providing psychoeducation online via social media platforms).

In this study, therapists' ethical decision-making regarding these boundary crossings was conceptualized as Pope and colleagues did in their 1987 study on the beliefs and behaviors of psychologists: (1) therapists' perceptions of the ethicality of the boundary crossing (from now on referred to as "ethicality ratings") and (2) therapists' actual frequency of engagement in the boundary crossing (from now on referred to as "practice frequencies"). In addition, the study examined five factors (four identified in previous research and one new factor) as potentially influencing those judgments: therapist gender, therapist theoretical orientation, therapist clinical experience, whether the therapist is a digital native or digital immigrant, and patient gender.

In this portion of the Introduction, previous research findings (if in existence) regarding the ethicality ratings and/or practice frequencies of each boundary crossing are reviewed. Empirical evidence (again, if in existence) of the degree to which each of the four therapist factors and the one patient factor affect ethicality ratings and practice frequencies is also reviewed.

Empirical Evidence regarding Therapists' Ethicality Ratings and Practice Frequencies in Seven Types of Nonsexual Boundary Crossings

Therapist In-Person Self-Disclosure

There is very little information on therapists' ethicality ratings regarding therapist self-disclosure and the predictors of those perceptions. However, Gibson (2012) opined that therapists' divergence on the utility and ethicality of self-disclosure varies based on their theoretical orientation. She wrote that therapists trained in humanistic, cognitive, and feminist therapies may all be more likely than those trained in other orientations to perceive self-disclosure as ethical and useful. Moreover, Borys and Pope's 1989 survey of APA members included one item concerning therapists' disclosure of their current personal stressors to clients. Although the investigators did not conduct analyses on this single item, inspection of data suggests that ethicality ratings for this boundary crossing differed based on therapist gender and theoretical orientation. Specifically, their results suggest that male therapists rate social involvements, which included deliberate self-disclosure, as more ethical than female therapists and that psychodynamic therapists rate these involvements as less ethical than behavioral, "other," existential, cognitive, gestalt, and existential therapists.

With regards to practice frequencies, in-person, deliberate therapist self-disclosure is among the most prevalent and well-researched of the seven boundary crossings examined in this study. Pope, Tabachnick, & Keith-Spiegel (1987) wrote that 93.3% of APA members they surveyed had used self-disclosure as a therapeutic technique, 89.7% had told a client they were angry with him or her, 56.5% had cried in the presence of a

client, and 51.9% had told a client they were disappointed with the client. Approximately 60 to 70% of clients report having experienced self-disclosure from their therapists (Simone, McCarthy, & Skye, 1998; Ramsdell & Ramsdell, 1993). High frequency of self-disclosure appears to apply across mental health fields, with 80% of psychiatrists, psychologists, and licensed social workers endorsing the use of self-disclosure in session (Mathews, 1989).

When therapists self-disclose, they largely endorse doing so in order to benefit their clients (Mathews, 1989). Over half of psychologists surveyed by Edwards and Murdock (1994) did so in order to increase perceived similarities between themselves and their client, 52% did so in order to model the act of self-disclosure, and 33% did so because the client desired them to do so. Other reasons cited by psychologists in this study were to increase their expert standing (16%) and attractiveness (4%) in clients' eyes. Simone and colleagues (1998) found that therapists self-disclose to universalize clients' experiences, to give clients encouragement and hope, to model coping strategies, and to increase therapeutic alliance.

Previous literature has ruled out and ruled in a wide variety predictors of therapist self-disclosure, sometimes in contradictory fashion. For example, male therapists are specifically more likely than female therapists to tell a client, "I'm sexually attracted to you" (Pope et al., 1987). However, Edwards and Murdock (1994) reported no significant influence of therapist gender on self-disclosure frequency. The therapist's theoretical orientation is an important predictor of therapist self-disclosure (Capobianco & Farber, 2005; Edwards & Murdock, 1994; Ziv-Beiman, 2013). Capobianco and Farber (2005), who examined self-disclosure in child therapists, found that

psychoanalytic/psychodynamic clinicians self-disclose less than cognitive/cognitive-behavioral and "eclectic" therapists even when controlling for therapist gender. Edward and Murdock (1994) reported that psychoanalytic clinicians self-disclose less frequently than humanistic clinicians. Similarly, Ziv-Beiman (2013) identified several studies that found that psychodynamic clinicians are least likely to self-disclose and that humanistic clinicians are most likely to self-disclose.

Therapist Digital Self-Disclosure (Advertising Online)

Literature regarding therapists' ethical attitudes toward digital self-disclosure is scant. It is likely that clinicians' perceptions are influenced by the pragmatic need to adapt to modern referral practices. As with the frequency of digital self-disclosure, ethical attitudes have probably shifted since the 1990s, when just under half of U.S. psychologists found advertising psychology services on the Internet "never or rarely" ethical (McMinn, Buchanan, Ellens, & Ryan, 1999). Factors predicting either practice frequencies or ethicality ratings for therapists' digital self-disclosure appear to not have been researched.

There is also very little literature on therapists' practice frequencies regarding digital self-disclosure. Practice frequencies have likely increased significantly from the 1990s, however, when 98% of psychologists endorsed never having advertised on the Internet (McMinn et al., 1999). Today, approximately 40% of psychotherapy clients find their psychotherapists through an Internet search and not through a friend or medical provider's referral (Kolmes & Taube, 2016). Just over 18% of clients report that Internet searches about potential therapists contribute to their decision to meet or not meet with

the psychotherapist and a quarter find information from these searches helpful for deciding whether or not to continue seeing a psychotherapist (Kolmes & Taube, 2016). Zur and colleagues (2009) noted that contemporary clients "feel entitled to a wide range of information about their caregivers—including mental health providers—so they can make informed decisions regarding their own care" (p. 23).

Searching for Client Information Online

At the time of this study, there was no data on clinicians' ethicality ratings of this boundary crossing. Not surprisingly, factors predicting either ethicality ratings or practice frequencies of online client searches also have not been explored in empirical studies.

What is currently known is that this practice is likely prevalent in younger, digital native psychology trainees (Jent et al., 2011). The literature indicates that 25 to 30% of U.S. graduate students studying psychology have conducted Internet searches for their clients' information or searched for clients' social media profiles (Asay & Lal, 2014; Harris & Kurpius, 2014; Lehavot, Barnett, & Powers, 2010). Further, Hess (2017) reported that 19.3% of psychologists and practicum trainees have done so without client knowledge or consent and that 12.5% have done so with client knowledge and consent. Of note is that there may be overlap in these items, as participants in Hess' 2017 study could endorse having done both.

However, U.S. mental health practitioners as a whole appear to commonly search for client information online without significant attention to client consent or post-search consultation. In contrast to Asay and Lal (2014), Harris and Kurpius (2014), and Lehavot (2010), Kolmes and Taube (2014) surveyed social workers, marriage and family

therapists, and psychiatrists in addition to psychologists. They report that just under half of these mental health practitioners have intentionally used the Internet to search for client information in non-crisis situations and without client consent. While 19% of searchers were looking specifically for misplaced contact information, 81% had done so to verify information shared by clients in session or to obtain treatment-relevant information. Of this half of the mental health professionals surveyed, just under half again disclosed to clients what they had discovered in session; over 70% chose not to seek consultation—presumably from colleagues or supervisors—about their online findings.

Social and Professional Nonsexual Multiple Relationships

Previous research has focused on therapists' ethicality ratings and practice frequencies for social and professional nonsexual multiple relationships, and the factors that affect each. Pope and colleagues (1987) reported that 87.7% of the U.S. psychologists they surveyed rated seeing friends as psychotherapy clients as unquestionably unethical or ethical only under rare circumstances. Just under 80% of respondents endorsed either of these two ethicality ratings (unquestionably unethical or ethical only under rare circumstances) for seeing students or supervisees as psychotherapy clients.

Therapist and patient factors appear to influence therapists' ethicality ratings regarding nonsexual multiple relationships. Borys and Pope (1989) included in their examples of nonsexual multiple relationships items concerning seeing a relative, a friend, a client's lover, or a current student or supervisee, as a client. They reported that therapist

gender, theoretical orientation, and years of clinical experience were significant predictors of respondents' ethicality ratings. Specifically, they found that male therapists rated nonsexual multiple relationships as more ethical than did female therapists. Interestingly, in an effort to more fully explicate the effect of therapist gender, the investigators found that male therapists with primarily female clients rated both social and professional nonsexual multiple relationships as more ethical than did respondents in any other therapist-client gender pairing. Further, the researchers found that psychodynamic therapists rated nonsexual multiple relationships as less ethical than did all other therapists in their study. And, they reported that therapists with 30 or more years of clinical experience rated nonsexual multiple relationships as more ethical than did therapists with less than 10 years of experience.

Baer and Murdock (1995) similarly studied the effect of therapist gender and theoretical orientation, and patient gender on therapists' ethicality ratings. The investigators found that therapist—but not patient—gender significantly predicted ethicality ratings toward only one of their three categories of boundary crossings: nonsexual multiple relationships. Male therapists rated this category of boundary crossings as significantly more ethical than female therapists did. Nonsexual multiple relationship items on their survey included providing therapy to a current client's lover, friend, or relative, and allowing a current client to enroll in their class for a grade. In this study, the interaction between patient gender and therapist gender was not significant for predicting ethicality ratings. The investigators also reported a significant relationship between therapist theoretical orientation and ethicality ratings toward social involvements with clients and nonsexual multiple relationships. Specifically, behavioral and cognitive

therapists rated multiple relationships as significantly more ethical than both humanistic and psychodynamic and analytic therapists did.

With regards to practice frequencies of this boundary crossing, Pope and colleagues (1987) reported that 28.3% of U.S. psychologists they surveyed endorsed seeing friends as psychotherapy clients and 31% endorsed seeing students or supervisees as psychotherapy clients. Male therapists are more likely than female therapists to engage in these types of nonsexual multiple relationships with clients, which is consistent with therapist gender differences in ethical attitudes toward nonsexual multiple relationships (Borys & Pope, 1989).

Accepting a Social Media Request from a Client

The literature does not include information on what factors predict therapists' ethicality ratings regarding accepting these social media invitations from clients. And, evidence on how often clients attempt to contact psychologists via social media is mixed. Between 6% and 40% of U.S. psychologists and psychologists-in-training endorsed having been contacted by clients via social media (Asay & Lal, 2014; Hess, 2017; Tunick et al., 2011). Asay and Lal (2014) reported that 24.1% of U.S. psychology graduate students feel that this contact would constitute an invasion of privacy but that 5.8% would view this contact as a sign of a strong therapeutic alliance. Regardless of their reaction, over 90% of U.S. psychology graduate students indicated that they would discuss the online contact request with the client in question.

The literature on social media and psychology indicates that psychologists and psychologists-in-training rarely decide to accept online invitations from clients to connect

via social media. In a sample of U.S. psychologists that was overwhelmingly composed of graduate students studying psychology, the most frequently endorsed behavior was rejecting client attempts to connect via social media (Taylor et al., 2010). This behavior was more frequently endorsed than posting photos or videos of themselves, family, and/or friends on social media. Moreover, of the child psychologists and psychologists-in-training who were active on social media, over 90% used the highest privacy restrictions possible on every social media accounts (Tunick et al., 2011). Six percent went so far as to use a false name on social media. And, just under 90% of child psychologists and psychologists-in-training would reject invitations by clients to connect via social media. Asay and Lal (2014) noted that nearly three quarters of those participants active on social media also altered their social media posts after starting graduate school.

Providing Psychoeducation Online via Social Media Platforms

Before widespread use of the Internet, approximately 10% of U.S. psychologists gave advice via media "very frequently" (Pope et al., 1987). There is no literature, however, regarding ethicality ratings or practice frequencies for contemporary psychologists regarding this nonsexual boundary crossing. The literature also does not include information on what factors predict therapists' ethicality ratings or practice frequencies regarding this crossing.

As indicated above, however, the majority of U.S. psychologists and graduate students studying psychology appear to use social media (Asay & Lal, 2014; Taylor et al., 2010; Tunick et al., 2011). The studies did not differentiate between those who used

personal social media accounts only, or used social media expressly for public psychoeducation, professional networking, and/or advertising, or both.

Rationale for Proposed Research

Given the long history of professional discourse (and disagreement) regarding therapists' crossing nonsexual boundaries with clients, as well as the (not surprising) lack of specific guidance in the current APA 2017 Ethics Code, therapists are left to make decisions regarding the ethical management of those boundaries by relying on their clinical judgment. Additionally, with the advent and rapid growth of digital technology, the boundary dilemmas that require ethical decision-making have grown.

Previous research suggests that ethicality ratings of various boundary crossings and actual engagement in the behaviors varies among mental health practitioners (Borys & Pope, 1989; Capobianco & Farber, 2005; Edwards and Murdock, 1994; Pope et al., 1987; Ramsdell & Ramsdell, 1993; Simone et al., 1998; Taylor et al., 2010; Tunick et al., 2011). The literature further indicates that some of the variance in therapists' ethicality ratings and practice frequencies regarding nonsexual boundary crossings can be attributed to distinct therapist and patient factors (Baer and Murdock, 1995; Borys & Pope, 1989; Edwards and Murdock, 1994; Pope et al., 1987). However, there appear to be no studies at this time that examined therapists' ethicality ratings and practice frequencies for both traditional and more contemporary boundary crossings. Additionally, there appears to be no research examining traditional and more contemporary predictive therapist and patient factors.

In addition, there appears to be another gap in the research literature; most studies defined predictive therapist and patient factors according to convention several decades ago. While this study re-examined three traditional therapist factors (gender, theoretical orientation, and clinical experience), all three were operationalized specifically in order to be consistent with contemporary understanding. First, over the past decade, the definition of gender identification has changed from binary (e.g., male and female) to nonbinary (e.g., including options such as "Male to Female" and "Female to Male"; Hyde, Bigler, Joel, Tate, & von Anders, 2018; Yeadon-Lee, 2017). Second, previous researchers have asked respondents to designate their theoretical orientation by indicating one from a list (e.g., Psychodynamic, Cognitive Behavioral, and so on). Although therapists may favor one theoretical orientation for their conceptualization of their clients, it is likely that in current practice many – if not most – therapists practice using interventions from a variety of orientations. Third, past investigators have typically defined clinical experience as simply the number of years a therapist has practiced. However, some therapists may have worked a number of years but in a limited-time practice, and thus may not actually be as experienced as a therapist who has worked fewer years in a full-time practice.

This investigation used a binary (e.g., male and female) definition of gender with regard to patient gender. However, this study measured patient gender differently than Pope and his co-investigators (1987) did, in hopes of obtaining more specific results. Pope and colleagues' seminal study assessed patient gender rather indirectly—by asking participants to state whether they saw predominantly male or female clients in their practices. In contrast, this study incorporated Baer and Murdoch's (1995) approach to

studying the effects of patient gender, especially in interaction with therapist gender. Participants in this study each took one Therapeutic Practices Survey regarding either a male or female client.

As discussed above, Prensky (2001) postulated that a novel factor—whether individuals were "digital immigrants" or "digital natives"— created differences in individuals' use of technology. Specifically, he makes the distinction between digital natives and digital immigrants by writing that "[digital natives] have spent their entire lives surrounded by and using computers, videogames, digital music players, video cams, cell phones … Computer games, email, the Internet, cell phones, and instant messaging are integral parts of their lives" (2001, p. 1). This study included this distinction as a therapist factor to enhance understanding of any variance among therapists regarding ethicality ratings and practice frequencies especially for the digital nonsexual boundary crossings (i.e., digital therapist self-disclosure, searching for client information online, accepting a social media request from a client, and providing psychoeducation online via social media platforms).

In summary, this study was designed to potentially advance the conclusions of earlier seminal studies in the context of very different 2019 demographic trends in APA membership, significant changes to the APA Ethics code, widespread contemporary use of the Internet, and therapist and patient factors that were unexplored or defined by outdated concepts.

Hypotheses

1. It was predicted that therapists' gender would predict therapists' ethicality ratings for and practice frequencies of all seven types of nonsexual boundary crossings.

   1.a. It was predicted that therapist gender and patient gender would interact to influence therapists' ethicality ratings for and practice frequencies of all seven nonsexual boundary crossings, except for the crossings of digital self-disclosure (advertising online) and providing psychoeducation online via social media platforms.

2. It was predicted that therapists' theoretical orientation would predict therapists' ethicality ratings and practice frequencies of all seven types of nonsexual boundary crossings.

3. It was predicted that therapists' clinical experience would predict their ethicality ratings for and practice frequencies of each of seven types of nonsexual boundary crossings.

4. It was predicted that whether therapists self-identified as digital immigrants or digital natives would predict therapists' ethicality ratings for and practice frequencies of digital-related boundary crossings. Digital-related nonsexual boundary crossings include digital self-disclosure (advertising online), searching for client information online, accepting a client's social media connection request, and providing psychoeducation online via social media platforms.

CHAPTER TWO

METHODS

Participants

A total of 447 participants for this study were recruited through three methods. The first recruitment method employed social media. A brief description of this study, including a link to the online informed consent form and Qualtrics survey, was posted on Facebook groups whose members included doctoral-level psychologists (i.e., with a Psy.D. or Ph.D. degree; see Appendix F for the full list of Facebook groups contacted). Second, an e-mail containing an identical description of this study was sent to professional mental health association e-mail listservs (see Appendix G for the full list of listservs e-mailed). Third, this same e-mail was forwarded by three doctoral-level psychologists (Dr. Robin Cooper, Dr. Stephanie Goldsmith, and Dr. Janet Sonne) to their professional contacts in a snowball recruitment effort.

It is not possible to accurately calculate the number of unique individuals who reviewed the recruitment post for the study or, consequently, the return rate for this study due to the overlapping nature of these three recruitment methods. First, psychologists are free to join multiple professional listservs. For example, a psychologist in Texas might simultaneously join the Texas Psychological Association (TPA) and the National Latinx Psychologist's Association (NLPA). Moreover, this same psychologist might belong to one or more of the Facebook groups contacted for the purposes of recruitment. Finally, this same psychologist might also have been contacted as a part of snowball recruitment. In addition, the same anonymous survey link was included in all recruitment posts and e-

mails. As such, it is not possible determine the method of recruitment by which the participants accessed the survey.

One hundred and ninety-one participants were eliminated from the initial study sample based first on inclusion criteria and then based on exclusion criteria. Seventy-three participants stated that they were not doctoral-level psychologists (i.e., with either a Ph.D. or Psy.D.), 13 indicated that they did not see adult patients in therapy, and 10 stated that they were not licensed in the U.S. Additionally, one participant responded "unquestionably unethical" to the imbedded validity question regarding the ethicality of accepting a male client's handshake. Eighty-nine participants failed to fill out 85% or less of the items on the survey overall (excluding the consent question). Finally, five participants who had met inclusion criteria endorsed having been sanctioned by a licensing board or having had their license in any U.S. state revoked or suspended.

The final sample contained 256 participants: 61 participants who answered questions about the ethicality of various therapist behaviors with a female client and 65 who answered questions about the ethicality of the same behaviors with a male client, and 68 participants who answered questions about practice frequencies of various therapist behaviors with a female client and 62 who answered questions about practice frequencies with a male client. Demographic data for each group are presented in Table 1.

Table 1. Demographic Characteristics of Participants Responding to Ethicality Ratings and Practice Frequencies Surveys.

	Ethicality Ratings		Practice Frequencies	
	Male Client (*N* = 68)	Female Client (*N* = 61)	Male Client (*N* = 62)	Female Client (*N* = 68)
Demographic Characteristic	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*
Age (in years)	50.0 (12.9)	47.4 (12.8)	49.7 (13.3)	49.4 (14.4)
	N (%)	*N* (%)	*N* (%)	*N* (%)
Ethnicity				
American Indian or Alaska Native	0 (0.0%)	1 (1.6%)	1 (1.5%)	0 (0.0%)
Asian/Indian Subcontinent	1 (1.5%)	0 (0.0%)	1 (1.5%)	0 (0.0%)
Asian/Southeast Asian or Far East	1 (1.5%)	4 (6.6%)	6 (9.7%)	4 (5.9%)
Black or African American	0 (0.0%)	0 (0.0%)	2 (3.2%)	0 (0.0%)
Hispanic or Latino	6 (9.2%)	1 (1.6%)	3 (4.8%)	3 (4.4%)
Middle Eastern	3 (4.6%)	0 (0.0%)	0 (0.0%)	2 (2.9%)
Mixed	2 (3.1%)	3 (4.9%)	5 (8.1%)	2 (2.9%)
White or Caucasian	50 (76.9%)	52 (85.2%)	44 (71.0%)	56 (82.4%)
Other	2 (3.1%)	0 (0.0%)	0 (0.0%)	1 (1.5%)
Gender Identity				
Female	56 (86.2%)	45 (73.8%)	46 (74.2%)	43 (63.2%)
Genderfluid	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (2.9%)
Male	9 (13.8%)	16 (26.2%)	14 (22.6%)	22 (32.4%)

Nonbinary	0 (0.0%)	0 (0.0%)	1 (1.6%)	0 (0.0%)
Transgender Female to Male	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (1.5%)
Other	0 (0.0%)	0 (0.0%)	1 (1.6%)	0 (0.0%)
Digital Identity				
Immigrant	65 (100.0%)	58 (95.1%)	59 (95.2%)	67 (98.5%)
Native	0 (0.0%)	3 (4.9%)	3 (4.8%)	1 (1.5%)
Current Religious Affiliation				
Agnosticism	15 (23.1%)	12 (19.7%)	7 (11.3%)	11 (16.2%)
Atheism	7 (10.8%)	6 (9.8%)	12 (19.4%)	10 (14.7%)
Buddhism	3 (4.6%)	1 (1.6%)	3 (4.8%)	1 (1.5%)
Catholicism	5 (7.7%)	8 (13.1%)	4 (6.5%)	9 (13.2%)
Christianity	12 (18.5%)	19 (31.1%)	14 (22.6%)	10 (14.7%)
Hinduism	0 (0.0%)	0 (0.0%)	1 (1.6%)	0 (0.0%)
Humanism	1 (1.5%)	0 (0.0%)	2 (3.2%)	0 (0.0%)
Islam	1 (1.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Judaism	16 (24.6%)	10 (16.4%)	8 (12.9%)	11 (16.2%)
Other	5 (7.7%)	5 (8.2%)	11 (17.7%)	16 (23.5%)
Theoretical Orientation				
Cognitive-Behavioral (CBT, DBT)	25 (38.5%)	26 (42.6%)	19 (30.6%)	18 (26.5%)
Emotion-Focused	2 (3.1%)	0 (0.0%)	2 (3.2%)	2 (2.9%)

Gestalt	0 (0.0%)	0 (0.0%)	3 (4.8%)	2 (2.9%)
Humanistic	7 (10.8%)	5 (8.2%)	6 (9.7%)	12 (17.6%)
Jungian	0 (0.0%)	0 (0.0%)	2 (3.2%)	1 (1.5%)
Psychoanalytic	1 (1.5%)	3 (4.9%)	2 (3.2%)	2 (2.9%)
Psychodynamic	21 (32.3%)	17 (27.9%)	20 (32.3%)	20 (29.4%)
Other	9 (13.8%)	10 (16.4%)	8 (12.9%)	11 (16.2%)
Psychology Degree				
PhD	37 (56.9%)	39 (63.9%)	36 (58.1%)	42 (61.8%)
PsyD	27 (41.5%)	21 (34.4%)	23 (37.1%)	24 (35.3%)
Doctorate	1 (1.5%)	1 (1.6%)	3 (4.8%)	2 (2.9%)
Therapist Experience Hours				
1 to 5,000	11 (16.9%)	10 (16.4%)	22 (35.5%)	18 (26.5%)
5,000 to 9,999	6 (9.2%)	9 (14.8%)	8 (12.9%)	15 (22.1%)
10,000 to 14,999	12 (18.5%)	8 (13.1%)	8 (12.9%)	5 (7.4%)
15,000 to 19,999	6 (9.2%)	8 (13.1%)	6 (9.7%)	4 (5.9%)
20,000 and above	20 (30.8%)	13 (21.3%)	12 (19.4%)	19 (27.9%)
Did not answer/Invalid answer	10 (15.4%)	13 (21.3%)	6 (9.7%)	7 (10.3%)
Practice Context				
Military Base	0 (0.0%)	1 (1.6%)	0 (0.0%)	0 (0.0%)
Rural	1 (1.5%)	9 (14.8%)	3 (4.8%)	9 (13.2%)

Suburban	30 (46.2%)	21 (34.4%)	25 (40.3%)	19 (27.9%)
Urban	32 (49.2%)	29 (47.5%)	1 (1.6%)	37 (54.4%)
Other	2 (3.1%)	1 (1.6%)	1 (1.6%)	3 (4.4%)
State of Licensure				
Multiple States	3 (4.6%)	2 (3.3%)	0 (0.0%)	0 (0.0%)
AL	0 (0.0%)	0 (0.0%)	1 (1.6%)	0 (0.0%)
AZ	1 (1.5%)	2 (3.3%)	0 (0.0%)	1 (1.5%)
CA	15 (23.1%)	8 (13.1%)	15 (24.2%)	14 (20.6%)
CO	1 (1.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
CT	1 (1.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
DC	0 (0.0%)	1 (1.6%)	1 (1.6%)	1 (1.5%)
FL	0 (0.0%)	0 (0.0%)	1 (1.6%)	0 (0.0%)
GA	1 (1.5%)	1 (1.6%)	0 (0.0%)	2 (2.9%)
HI	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (1.5%)
IL	3 (4.6%)	1 (1.6%)	1 (1.6%)	0 (0.0%)
LA	0 (0.0%)	0 (0.0%)	1 (1.6%)	1 (1.5%)
MA	4 (6.2%)	2 (3.3%)	2 (3.2%)	0 (0.0%)
MD	2 (3.1%)	2 (3.3%)	0 (0.0%)	1 (1.5%)
ME	1 (1.5%)	0 (0.0%)	2 (3.2%)	4 (5.9%)
MI	0 (0.0%)	4 (6.6%)	1 (1.6%)	0 (0.0%)
MN	6 (9.2%)	10 (16.4%)	7 (11.3%)	9 (13.2%)
MO	0 (0.0%)	1 (1.6%)	0 (0.0%)	0 (0.0%)

MS	1 (1.5%)	0 (0.0%)	0 (0.0%)	1 (1.5%)
MT	1 (1.5%)	1 (1.6%)	0 (0.0%)	0 (0.0%)
NH	0 (0.0%)	2 (3.3%)	0 (0.0%)	0 (0.0%)
ND	1 (1.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
NM	0 (0.0%)	1 (1.6%)	0 (0.0%)	0 (0.0%)
NJ	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (1.5%)
NV	0 (0.0%)	2 (3.3%)	0 (0.0%)	0 (0.0%)
NY	4 (6.2%)	6 (9.8%)	9 (14.5%)	6 (8.8%)
OK	1 (1.5%)	0 (0.0%)	3 (4.8%)	0 (0.0%)
OR	1 (1.5%)	0 (0.0%)	1 (1.6%)	1 (1.5%)
PA	9 (13.8%)	3 (4.9%)	4 (6.5%)	8 (11.8%)
SC	0 (0.0%)	0 (0.0%)	1 (1.6%)	0 (0.0%)
TN	2 (3.1%)	2 (3.3%)	1 (1.6%)	0 (0.0%)
TX	7 (10.8%)	7 (11.5%)	6 (9.7%)	11 (16.2%)
UT	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (1.5%)
VA	0 (0.0%)	0 (0.0%)	1 (1.6%)	1 (1.5%)
WA	0 (0.0%)	1 (1.6%)	1 (1.6%)	0 (0.0%)
WI	0 (0.0%)	0 (0.0%)	1 (1.6%)	1 (1.5%)
WY	0 (0.0%)	2 (3.3%)	1 (1.6%)	1 (1.5%)

Measures

Demographic Questionnaire

All participants completed the same demographic questionnaire. The questionnaire contained questions about participant therapists' age, ethnicity, gender identity, whether participants identify themselves as digital natives or digital immigrants (digital identity), current religious affiliation, theoretical orientation used to conceptualize adult patients (regardless of the actual interventions participants used), psychology degree, the approximate number of face-to-face hours total accumulated with adult patients in psychotherapy in all contexts in which participants had worked since graduate school (therapist experience hours), context of practice, and state of licensure (see Appendix B).

Therapeutic Practices Survey

After completing the demographic questionnaire, participants then filled out one of four versions of the Therapeutic Practices Survey (see Appendix C and Appendix D): the Ethicality Ratings/Female Patient form, the Ethicality Ratings/Male Patient form, the Practice Frequencies/Female Patient form or the Practice Frequencies/Male Patient form. Both Ethicality Ratings forms measured participants' rating of the ethicality of each of seven nonsexual boundary crossings on a 5-point Likert scale (5 = *unquestionably ethical*, 4 = *ethical under many circumstances*, 3 = *don't know/not sure*, 2 = *ethical under rare circumstances*, and 1 = *unquestionably not ethical*). Both Practice Frequencies forms measured the frequency of participants' actual engagement in each boundary crossing on

a 5-point Likert scale (5 = *very often*, 4 = *often*, 3 = *sometimes*, 2 = *rarely*, and 1 = *never*). One additional item from Borys and Pope (1989) was included on the Ethicality Ratings ("Accepting a handshake offered by a male/female client") and Practice Frequencies forms ("I have accepted a handshake offered by a male/female client") as a validity measure. The expectation, based on previous research, is that participants would never respond to this item with a 1, meaning either "unquestionably not ethical" with regards to ethicality rating or "never" with regards to practice frequency.

Procedures

Participants were recruited via Facebook groups for therapists (including doctoral-level psychologists), e-mail listservs for doctoral-level U.S. psychologists, and snowball recruitment. The recruitment post and e-mails informed readers of the nature of the study, the approximate time required to take the survey, the link to the online survey, and the offer of an opportunity to participate in a raffle to win one of four $100 Amazon gift cards whether or not they completed the survey. Participants interested in participating in the drawing were asked to e-mail the investigator.

Once participants accessed the link, they read an informed consent form (see Appendix E). Participants who did not consent were automatically redirected to a thank-you message and did not view or respond to measures included in this survey. Those who did consent to participation, in contrast, proceeded to the Demographic Questionnaire (see Appendix B).

Following this questionnaire, participants then completed one of four versions of the Therapeutic Practices Survey (see Appendix C and D), delivered sequentially to

participants, that either used a male or female patient gender in descriptions of seven nonsexual boundary crossings and that either asked for an ethicality rating or actual frequency of each crossing. Participants were not required to respond to all Demographic Questionnaire or Therapeutic Practices Survey items in order to proceed through the measures or exit the study. Upon completion of the survey, participants were directed to a message thanking them for their participation. This message contained a link the informed consent form, should they desire to obtain a copy for their records.

Operationalized Hypotheses and Proposed Analyses

Please see Tables 2 and 3 for a visual summary of these operationalized hypotheses.

1. Male participant therapists will rate each of the seven nonsexual boundary crossings as more ethical and will engage in each of the seven boundary crossings more frequently than any other participant therapist gender (MANOVA).

    1.a. Male participant therapists responding to questions about nonsexual boundary crossings with female patients will rate each of the seven boundary crossings except digital self-disclosure (advertising online) and providing psychoeducation online via social media platforms as more ethical. Male participant therapists will engage in each of the seven boundary crossings except digital self-disclosure (advertising online) and providing psychoeducation online via social media platforms more frequently than any other participant therapist-patient gender dyads (MANOVA).

2. Participant therapists who endorse using psychodynamic theory to conceptualize their patients will rate all seven nonsexual boundary crossings as less ethical and will engage less frequently in all seven boundary crossings than participant therapists who endorse any of the other orientations (MANOVA).
3. Participant therapists with greater experience will rate all seven boundary crossings as more ethical and engage in all seven boundary crossings more frequently than therapists with less experience (MANOVA).
4. Participant therapists who self-identify as digital natives will rate all of the digital boundary crossings (i.e., searching for a client's information online, digital self-disclosure, accepting a social media request from a client, and providing psychoeducation online via social media platforms) as more ethical and will engage in those specific boundary crossings more frequently than those therapists who self-identify as digital immigrants (MANOVA)

Table 2. Operationalized Hypotheses Using Therapist/Client Factors to Predict Ethicality Ratings for Boundary Crossings.

Dependent Variables	Therapist/Patient Factors (Independent Variables)				
	Therapist Gender	Client Gender	Theoretical Orientation	Therapist Experience	Digital Immigrant/ Native
Ethicality Ratings					
In-person SD	X	X	X	X	
Digital SD	X	X	X	X	X
PTG	X	X	X	X	X
SM – C	X	X	X	X	X
SM – P	X	X	X	X	X
NSMR – S	X	X	X	X	
NSMR – P	X	X	X	X	

Note: "X" = hypothesized predictive relationship; "In-person SD" = Deliberate in-person self-disclosure; "Digital SD" = Deliberate digital self-disclosure; "PTG" = Patient-Targeted Googling; "SM – C" = Social Media Connection; "SM – P" = Providing online psychoeducation via social media platforms; "NSMR – S" = Social Nonsexual Multiple Relationship; "NSMR – P" = Professional Nonsexual Multiple Relationship.

Table 3. Operationalized Hypotheses Using Therapist/Client Factors to Predict Practice Frequencies for Boundary Crossings.

Dependent Variables	Therapist/Patient Factors (Independent Variables)				
	Therapist Gender	Patient Gender	Theoretical Orientation	Therapist Experience	Digital Immigrant/ Native
Practice Ratings					
In-person SD	X	X	X	X	
Digital SD	X	X	X	X	X
PTG	X	X	X	X	X
SM – C	X	X	X	X	X
SM – P	X	X	X	X	X
NSMR – S	X	X	X	X	
NSMR – P	X	X	X	X	

Note: "X" = hypothesized predictive relationship; "In-person SD" = Deliberate in-person self-disclosure; "Digital SD" = Deliberate digital self-disclosure; "PTG" = Patient-Targeted Googling; "SM – C" = Social Media Connection; "SM – P" = Providing online psychoeducation via social media platforms; "NSMR – S" = Social Nonsexual Multiple Relationship; "NSMR – P" = Professional Nonsexual Multiple Relationship.

CHAPTER THREE

RESULTS

Initial Analyses of Demographic Variables for Separate Participant Groups

The total sample originally included four groups of respondents. Respondents received a survey of their ethicality ratings or practice frequencies regarding various nonsexual boundary crossings with either a male or female client. Data from these four participant groups were assessed for missing data and the levels in several demographic variables were regrouped for subsequent analysis as described below. Next, the demographic variables were analyzed for significant between-group differences between the male and female client groups for the ethicality ratings and practice frequencies samples.

Missing Data Analysis

There were no participants who failed to complete the Therapeutic Practices Survey version they were presented by Qualtrics. There were seven participants who did not disclose their age and 36 participants who did not respond or whose responses regarding their clinical hours could not be translated into a certain number of hours. For example, their response may have been “thousands,” “many years,” or “DK [don’t know].” These nonnumerical responses regarding clinical hours were coded as missing data.

Demographic Variable Transformations

Levels in several demographic variables were combined in order to run statistical analyses regarding between-group differences for participants who answered questions about boundary crossings with each client gender. First, therapist experience was assessed by asking respondents the approximate number of face-to-face hours total accumulated with adult patients in psychotherapy in all contexts in which participants had worked since graduate school. Participants' responses included actual numbers of hours but also ranges. As such, therapist experience responses were recoded into categorical ranges, such that "1" represented 1 to 4,999 hours accumulated; "2" represented 5,000 to 9,999 hours accumulated; "3" represented 10,000 to 14,999 hours accumulated; "4" represented 15,000 to 19,999 hours accumulated; and "5" represented 20,000 hours or more accumulated.

Levels of several categorical variables were redefined as well. For several variables, levels originally included on the Demographic Questionnaire that contained few or no responses were combined into an "Other" category. These variables included participant therapists' ethnicity, gender identity, current religious affiliation, theoretical orientation used to conceptualize adult patients (regardless of the actual interventions participants used), and practice context.

Therapist ethnicity was assessed by asking participants to select one option for their ethnic background. The "Other" category for this variable was redefined such that it included endorsements of "Middle Eastern," "Asian/Indian Subcontinent," "Other," "Mixed," "Black or African American," and "American Indian or Alaska Native." The remaining categories of this variable – including "White or Caucasian,"

"Hispanic/Latino," and "Asian/Southeast Asia or Far East" – were included unchanged in the final Ethnicity variable.

Therapist gender identity was assessed via a question about how participants identified in terms of gender. Because such a small minority of clients identified as "nonbinary," "transgender female to male," "genderfluid," and "other," these categories were combined into a Transgender and Nonconforming category (TGNC). However, ultimately, very few participants (five total; none in the Ethicality Ratings sample and five in Practice Frequencies sample) identified as having TNGC gender identity. This category was eliminated from further analyses.

Participants' responses to a question regarding their current religious affiliation again resulted in very low frequencies in some of the response choices. The final current religious affiliation variable included the following levels: "Agnosticism," "Atheism," "Catholicism," "Christianity," "Judiasm," and "Other." This "Other" level included original endorsements of Buddhist, Humanist, Hindu, Muslim, and "Other" affiliation.

Participants' theoretical orientation was redefined such that five categories ("Psychoanalytic," "Jungian," "Gestalt," and "Emotion-Focused" and "Other") were combined into an "Other" category. "Cognitive-Behavioral," "Humanistic," and "Psychodynamic" remained unchanged.

And, practice context was redefined to include four levels. These included "Urban," "Suburban," "Rural," and "Other," which included data from participants endorsing either the original "Other" or the "Military Base" practice contexts.
Data regarding participants' most advanced psychology degree and state of licensure was also recategorized for the purposes of subsequent analyses. Therapist degree was assessed

via a question regarding participants' most advanced degree in psychology. Participants provided a variety of responses, including "PhD," "PsyD," "PsyD and PhD," and variations on "Doctorate." As such, this variable was reorganized into three categories – "PhD," "PsyD and PsyD/PhD," and "Doctorate." Again, very few participants identified as having a Doctorate degree (seven total; two in the Ethicality Ratings sample and five in the Practice Frequencies sample). As such, this level of professional degree was eliminated from further study.

Finally, participant therapists' self-reported states of licensure in the U.S. were combined into four U.S. Census Bureau regions (West, South, Northeast, and Midwest) and a category for therapists who had endorsed multiple states of licensure ("Multiple States").

Between-Client Gender Group Differences.

Several analyses were conducted for the demographic variables as now defined to determine whether there were significant differences between individuals responding to the items depicting a male versus a female client on the Ethical Ratings form and on the Practice Frequencies form. These analyses were conducted in order to determine whether responses regarding male and female clients for each category (Ethicality Ratings and Practice Frequencies) could be combined in order to increase the power of the analyses used to test the study hypotheses.

First, two one-way analyses of variance (ANOVAs) were conducted to test whether there was a significant difference in participant age based on whether the survey filled out by the participants addressed boundary crossings with a male or female client.

One ANOVA was performed for participants who filled out an ethicality ratings survey (depicting a male versus a female client) and one for those who filled out a practice frequencies survey (depicting a male versus a female client). There were no significant effects (see Table 7).

Chi-square analyses were performed on the categorical demographic variables in order to determine whether there were significant group differences for those demographics, depending again on client gender. The results are depicted in Table 7. Participants who gave ethicality ratings regarding a male client did not differ significantly regarding their experience, ethnicity, gender identity, current religious affiliation, theoretical orientation used to conceptualize adult patients (regardless of the actual interventions participants used), and practice context from those who gave ethicality ratings regarding a female client. Similarly, there were no differences in any of the demographic variables for therapist participants who endorsed practice frequencies of boundary crossings regarding male versus female clients.

Final Participant Sample Groups

The analyses described above provided statistical support for combining the groups of participants who completed the male- and female-client gender forms of ethicality rating and practice frequency surveys. The demographic data for the two combined samples, with the levels of each variable transformed as described above, are presented in Table 4, below. Tables 5 and 6 contain frequencies and percentages of participants' ethicality ratings and practice frequencies in the two final participant

samples. All further statistical analyses conducted to address the study hypotheses were performed on these two combined samples, as described in the section below.

Table 4. Demographic Characteristics of Participants Responding to Ethicality Ratings and Practice Frequencies Surveys.

	Ethicality Ratings (N = 126)			Practice Frequencies (N = 130)		
	M (SD)	Range	*N*	*M* (SD)	Range	*N*
Continuous Variable						
Age in Years	48.8 (12.9)	29-83		39.5 (13.8)	27-88	
Categorical Variables						
Ethnicity						
White or Caucasian			102			100
Hispanic or Latino			7			6
Asian/Southeast Asian or Far East			5			10
Other			12			14
Gender Identity						
Female			101			89
Male			25			36
Digital Identity						
Immigrant			123			126
Native			3			4
Current Religious Affiliation						
Agnosticism			27			18
Atheism			13			22
Catholicism			13			13
Christianity			31			24

Judaism	26	19
Other	16	34
Theoretical Orientation		
Cognitive-Behavioral (CBT, DBT)	51	37
Humanistic	12	18
Psychodynamic	38	40
Other	25	35
Psychology Degree		
PhD	76	78
PsyD and PsyD/PhD	48	47
Number of Clinical Hours		
1 to 5,000	21	40
5,000 to 9,999	15	23
10,000 to 14,999	20	13
15,000 to 19,999	14	10
20,000 and above	33	31
Did not answer/Invalid answer	23	13
Practice Context		
Urban	61	70
Suburban	51	44
Rural	10	12
Other	4	4
State of Licensure		
West State	30	37
Midwest State	8	4
Northeast State	48	46
South State	26	29
Multiple States	14	14

Data Analyses

The planned analyses designed to test the hypotheses for this study originally consisted of multivariate analyses of variance (MANOVAs). However, the ethicality ratings and practice frequencies data collected for each nonsexual boundary crossing (the 14 dependent variables) were consistently skewed (i.e., had non-normal distributions), violating the assumptions necessary for the MANOVAs (see Tables 5 and 6). Additionally, the dependent variables were measured in Likert scales and were most accurately considered ordinal variables. Ordinal logistic regressions were performed for the majority of data analyses instead.

However, three of the dependent variables were sufficiently skewed that analyses could not be performed. These variables included one item on the Ethicality Ratings form ("Providing therapy to a current supervisee") and two items on the Practice Frequencies form ("Providing therapy to a current supervisee" and "Accepting a social media request from a client"). As Tables 5 and 6 show, the majority of participants endorsed responses of "1" ("unquestionably unethical" for ethicality ratings or "never" for practice frequencies) for all three dependent variables.

The following sections include a discussion of the statistical assumptions required for ordinal logistic regressions, a notation of violations of the assumptions, the overall results of the regression analyses, and a presentation of the results in the order of proposed hypotheses.

Statistical Assumptions for Ordinal Logistic Regression Analyses for Ethicality Ratings and Practice Frequencies Samples

Independence of Observations

Ordinal logistic regression analyses require that each participant contributes only one observation each to the data. Participants could theoretically have elected to take this study's online survey more than once without detection. However, the study was not designed to specifically elicit multiple observations per participant.

Multicollinearity

An assumption of ordinal logistic regression analyses is that independent variables are not perfectly correlated, such that the main effect of one independent variable is indistinguishable from that of another independent variable. Bivariate correlations for therapist gender, therapist theoretical orientation, therapist experience, and client gender revealed no perfect correlations for these independent variables in this study.

Proportional Odds

It is assumed in ordinal logistic regression analyses that each odds ratio, denoted as Exp(B) in Tables 8 to 21, are the same across response levels for the dependent variable being analyzed. In other words, the odds ratio is assumed to describe the relationship between levels "1" and "2" as accurately as it describes the relationship between levels "2" and "3," the relationship between levels "3" and "4," and the relationship between levels "4" and "5." This assumption was violated in ordinal regressions performed on following three dependent variables: ethicality rating of

advertising online; practice frequency for searching online for client information, and practice frequency of providing psychoeducation online via social media platforms.

Overall Results of the Ordinal Logistic Regression Analyses for Ethicality Ratings and Practice Frequencies

Ordinal regression analyses were conducted in order to test the hypotheses regarding whether five independent variables (i.e., therapist gender, client gender, the interaction between therapist and client gender, therapist theoretical orientation, and therapist experience) predicted the ethicality ratings and the practice frequencies for nonsexual boundary crossings. The results of the ordinal logistic regression analyses for each of the ethicality rating and practice frequency items that could be performed are presented in Tables 8 to 18. Overall, two of the regression models tested with the predictors provided a better fit to the data than models without the predictors included. This was true with regard to ethicality ratings for accepting a social media request, $-2LL(10) = 79.30$, $p < .05$, and with regard to practice frequencies for seeing a client who was also in one's social circle(s), $-2LL(10) = 77.18$, $p < .01$.

Implications of the Results of the Regression Analyses for the Study Hypotheses

The results of the ordinal logistic regression analyses partially supported the hypotheses proposed for this study.

Hypothesis 1

It was hypothesized that male therapists would endorse higher ethicality ratings and higher practice frequencies than therapists of any other gender for all nonsexual boundary crossings. The regression analyses for one of the Ethicality Ratings boundary crossing items revealed that indeed male therapists did rate one boundary crossing as significantly more ethical than female therapists. Male therapist participants were 9.49 times as likely as female therapist participants to endorse an ethicality rating of *k* relative to an ethicality rating of less than *k* (where *k* is any of the five response categories in our five-point Likert scale) regarding accepting a social media request from a client (see Table 11). In other words, for this item, male therapists were 9.49 times more likely than female therapists to provide an ethicality rating of 5 ("unquestionably ethical" relative to an ethicality rating of less than 5, to provide an ethicality rating of 4 ("ethical under many circumstances") relative to an ethicality rating of less than 4, to provide an ethicality rating of 3 ("don't know/not sure") relative to an ethicality rating of less than 3, and to provide an ethicality rating of 2 ("ethical under rare circumstances") relative to an ethicality rating of less than 2. As such, male therapists were significantly more likely than female therapists to rate accepting a social media request from a client as more highly ethical.

Further, male therapists appeared less likely than female clinicians to endorse a higher practice frequency of searching for client information online (see Table 15). However, as noted in the discussion of statistical assumptions above, this dependent variable (i.e., practice frequencies for searching for client information online) violated the assumption of proportional odds. As such, it cannot be assumed that the odds ratio for

this dependent variable (OR = .19) can be applied equally to each practice frequency of *k* relative to practice frequencies of less than *k.*

Hypothesis 1a

It was further hypothesized that male therapists would endorse higher ethicality ratings and higher practice frequencies for all nonsexual boundary crossings with female clients except advertising online and providing psychoeducation online than any other therapist-patient gender dyads. The regression analyses did not support this hypothesis of a significant interaction between therapist participant gender and client gender for ethicality ratings or practice frequencies for any of the seven boundary crossings.

Hypothesis 2

It was hypothesized that therapists who endorsed using psychodynamic theory to conceptualize their patients would endorse lower ethicality ratings and lower practice frequencies than therapists endorsing other theoretical orientations for all seven boundary crossings. The regression analyses for ethicality ratings revealed that psychodynamic therapists rated only one of the boundary crossings as significantly less ethical than the reference group of cognitive-behavioral therapists. For the crossing of providing therapy to a client in their social circle(s), psychodynamic therapist participants were .34 times as likely as cognitive-behavioral therapists to endorse an ethicality rating of *k* relative to an ethicality rating of less than *k* (where *k* is any of the five response categories in our five-point Likert scale) (see Table 18). As such, psychodynamic therapist participants were significantly more likely than cognitive-behavioral therapists to endorse a lower ethicality

rating for (i.e., indicate that it was less ethical) engaging in therapy with an individual with whom they were involved socially.

An interesting contrast was revealed in the regression analyses of practice frequencies for this same crossing (i.e., engaging in a social nonsexual multiple relationship). Psychodynamic therapist participants were 15.64 times as likely as cognitive-behavioral therapists to endorse a practice frequency of *k* relative to a practice frequency of less than *k* (where *k* is any of the five response categories in our five-point Likert scale) (see Table 12). Thus, psychodynamic therapist participants were significantly more likely than cognitive-behavioral therapists to endorse a higher frequency of actually engaging in the social nonsexual multiple relationship.

The regression analyses also revealed that "Other"-orientation therapist participants (i.e., "Psychoanalytic," "Jungian," "Gestalt," and "Emotion-Focused" and "Other") engaged more frequently in one of the crossings than the reference group of cognitive-behavioral therapists. Regarding disclosing personal information to a client (i.e., deliberate in-person therapist self-disclosure), "Other"-orientation therapists were 4.18 times as likely as cognitive-behavioral therapists to endorse a practice frequency of *k* relative to a practice frequency of less than *k* (where *k* is any of the five response categories in our five-point Likert scale) (see Table 8). In other words, "Other"-orientation participants were significantly more likely than cognitive-behavioral therapists to endorse engaging more frequently in deliberate in-person self-disclosure.

Hypothesis 3

It was hypothesized that therapists with greater clinical experience would endorse higher ethicality ratings and practice frequencies for all seven boundary crossings. The regression analyses revealed that indeed therapists with greater clinical experience did rate two of the boundary crossings as significantly more ethical and engaged more frequently in three of the crossings than therapists with the least experience.

First, analyses revealed that more experienced therapists were more likely than the least experienced therapists to rate accepting a social media request from a client as more ethical. Specifically, those endorsing between 15,000 and 19,999 clinical hours were 11.25 times as likely as therapists endorsing 4,999 clinical hours or less to endorse an ethicality rating of *k* relative to an ethicality rating of less than *k* (where *k* is any of the five response categories in our five-point Likert scale) (see Table 16).

Second, analyses revealed that more experienced therapists were more likely than the least experienced therapists to rate the crossing of searching online for client information as more ethical (see Table 15). Specifically, those endorsing between 10,000 and 14,999 clinical hours were 4.22 times as likely as therapists endorsing 4,999 clinical hours or less to endorse an ethicality rating of *k* relative to an ethicality rating of less than *k* (where *k* is any of the five response categories in our five-point Likert scale).

Third, analyses revealed that more experienced therapists were consistently more likely than the least experienced therapists to endorse higher frequencies of seeing an individual in therapy who is also among their social circles (i.e., engaging in social nonsexual multiple relationships) (see Table 12). Specifically, those endorsing 20,000 clinical hours or more were 8.58 times as likely, therapists endorsing between 15,000 and 19,999 clinical hours were 9.58 times as likely, and therapist endorsing between 10,000

and 14, 999 clinical hours were 12.18 times as likely to endorse a practice frequency of *k* relative to a practice frequency of less than *k* (where *k* is any of the five response categories in our five-point Likert scale) for this item.

Hypothesis 4

It was hypothesized that therapists who self-identified as digital natives would endorse higher ethicality ratings and practice frequencies for the technology-related boundary crossings (i.e., searching for a client's information online, advertising online, accepting a client's social media connection request, and providing psychoeducation online via social media platforms) than therapists who self-identified as digital immigrants. It was not possible to test this hypothesis because so few participants identified themselves as digital natives (see Table 4).

Table 5. Clinicians' (N = 126) Ethicality Ratings Regarding Male and Female Clients Combined.

Item	Rating 1 N (%)	2 N (%)	3 N (%)	4 N (%)	5 N (%)
Disclosing personal information to a client	2 (1.6%)	50 (39.7%)	5 (4.0%)	66 (52.4%)	3 (2.4%)
Advertising online	4 (3.2%)	2 (1.6%)	16 (12.7%)	76 (60.3%)	28 (22.2%)
Searching for information about a client online	39 (31.0%)	61 (48.4%)	13 (10.3%)	12 (9.5%)	1 (.8%)
Accepting social media connection requests from a client.	98 (78.4%)	24 (19.2%)	1 (.8%)	0 (0.0%)	2 (1.6%)
Using social media platforms to provide online psychoeducation.	4 (3.2%)	9 (7.1%)	23 (18.3%)	72 (57.1%)	18 (14.3%)
Providing therapy to a client in one of my social circles.	37 (29.4%)	72 (57.1%)	1 (.8%)	16 (12.7%)	0 (0.0%)
Providing therapy to a current supervisee.	115 (91.3%)	7 (5.6%)	0 (0.0%)	3 (2.4%)	1 (.8%)
Accepting a handshake offered by a client.	0 (0.0%)	2 (1.6%)	0 (0.0%)	68 (54.0%)	56 (44.4%)

Note: 1 = *unquestionably unethical*, 2 = *ethical under rare circumstances*, 3 = *don't know/not sure*, 4 = *ethical under many circumstances*, 5 = *unquestionably ethical.*

Table 6. Clinicians' (N = 130) Practice Frequencies Regarding Male and Female Clients Combined.

Item	Rating 1 N (%)	2 N (%)	3 N (%)	4 N (%)	5 N (%)
Disclosed personal information to a client.	2 (1.5%)	49 (37.7%)	68 (52.3%)	11 (8.5%)	0 (0.0%)
Advertised online	35 (26.9%)	15 (11.5%)	20 (15.4%)	25 (19.2%)	35 (26.9%)
Searched for information about a client online.	77 (59.2%)	45 (34.6%)	7 (5.4%)	1 (.8%)	0 (0.0%)
Accepted social media connection requests from a client.	124 (95.4%)	6 (4.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Used social media platforms to provide online psychoeducation.	91 (70.0%)	12 (9.2%)	17 (13.1%)	6 (4.6%)	4 (3.1%)
Provided therapy to a client in one of my social circles.	103 (79.2%)	19 (14.6%)	8 (6.2%)	0 (0.0%)	0 (0.0%)
Provided therapy to a current supervisee.	128 (98.5%)	2 (1.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Accepted a handshake offered by a client.	0 (0.0%)	8 (6.2%)	34 (26.2%)	41 (31.5%)	47 (36.2%)

Note: 1 = *never*, 2 = *rarely*, 3 = *sometimes*, 4 = *fairly often*, 5 = *very often.*

Table 7. ANOVA and Chi-Square Analyses of Participants Responding to Ethical Attitudes and Ethical Practices Surveys by Client Gender.

	Client Gender (Ethicality Ratings)				Client Gender (Practice Frequencies)			
	F	χ^2	*df*	*p*	F	χ^2	*df*	*p*
Continuous Variables								
Age in Years	1.25		1	.27	.02		1	.90
Categorical Variables								
Ethnicity		4.97	3	.17		2.68	3	.44
Gender Identity		3.03	1	.082		1.68	1	.20
Current Religious Affiliation		4.95	5	.42		3.87	5	.57
Theoretical Orientation		.69	3	.88		1.78	3	.62
Psychology Degree		.67	1	.41		.03	1	.86
Therapist Experience		2.76	4	.60		5.00	4	.29
Practice Context		8.02	3	.05		4.78	3	.19
State of Licensure		.88	4	.93		2.21	4	.70

Exploratory Analyses

Five sets of exploratory analyses of the data gathered in this study were conducted. First, as noted above, regression analyses provided no evidence for statistically significant interactions between client gender and therapist gender with regard to participants' ethicality ratings and practice frequencies. Additional exploratory regression analyses were used to examine whether client gender alone may predict therapists' ethicality ratings and practice frequencies. Second, because many of the seminal studies explored nonsexual boundary crossings similar to those examined in this study, exploratory analyses were also conducted in order to compare the distributions of both the ethicality ratings and the practice frequencies for the traditional nonsexual boundary crossings reported by in this study with those revealed in earlier studies. Third, exploratory comparisons of participants' ethicality ratings and practice frequencies reported in this study were conducted for each of the three traditional nonsexual boundary crossings. Fourth, an exploratory comparison of findings regarding in-person versus digital self-disclosure was conducted. And, fifth, the data regarding participants' ethicality ratings and practice frequencies for the digital boundary crossings examined in this study were examined for trends, including the distributions and the comparisons of ethicality ratings versus practice frequencies.

Client Gender as a Predictor of Ethicality Ratings and Practice Frequencies

The regression analyses indicated that therapists answering questions regarding male clients were more likely to rate one boundary crossing as more ethical than those answering questions regarding female clients. Specifically, therapists were 5.87 times as

likely to endorse an ethicality rating of *k* relative to an ethicality rating of less than *k* (where *k* is any of the five response categories in our five-point Likert scale) with regard to accepting a social media request from a male client versus from a female client (see Table 16).

Comparisons of Distributions of Ethicality Ratings and Practice Frequencies for Traditional Nonsexual Boundary Crossings between This Study and Seminal Studies

Examinations of the distributions of ethicality ratings and practice frequencies of the three traditional nonsexual boundary crossings in this study (i.e., providing therapy to a current supervisee, providing therapy to an individual in one's social circle, and disclosing personal information to a client) compared to those in previous studies revealed some discrepancies. For example, ethicality rating data in this study appeared more extremely negatively skewed for the item "providing therapy to a current supervisee" (i.e., a professional nonsexual multiple relationship) than did the ethicality data in Borys and Pope (1989) with respect to a similar professional nonsexual multiple relationship. In the current study, 91.3% of therapist participants rated the item "providing therapy to a current supervisee" as "unquestionably unethical" (see Table 5). Borys and Pope (1989) participants were less uniform in their responses. Approximately 44% of participants in this 1989 study rated the similar professional nonsexual multiple relationship of "providing therapy to a current student or supervisee" as "never ethical." However, another 31.0% rated this crossing as "ethical under rare conditions" and 16.0% rated this crossing as "ethical under some conditions." And, 45.8% of respondents in Pope and colleagues' 1987 study rated the crossing of "providing therapy to [a] student or

supervisee" as "unquestionably not" ethical; another 33.6% rated this crossing as ethical "under rare circumstances."

Practice frequencies for the similar crossings of providing therapy to a current supervisee in this study and providing therapy to a current student or supervisee in Borys and Pope (1989) were nearly identical (see Table 6). The vast majority of participants in the current study (98.5%) reported that they never crossed this boundary in practice. The remaining 1.5% provided a practice frequency of "2" ("rarely"). Approximately 90% of therapist participants in Borys and Pope (1989) similarly reported that they never engaged in the crossing with a client or had no opportunity. In contrast, however, 63.8% of Pope and colleagues' 1987 participant sample endorsed "never" providing therapy to their students or supervisees; 31% of this sample endorsed seeing students or supervisees as psychotherapy clients at least "rarely."

There are no comparisons to be made between the current and previous studies with regard to ethicality ratings regarding a social nonsexual multiple relationship between therapists and their clients. However, it can be noted that participants in the current study appeared slightly more conservative in their practices regarding providing therapy to a client in one's social circle(s) than those in one previous study (see Table 6). Approximately 80% of therapists endorsed "never" engaging in this crossing and 14.6% of therapists endorsed "rarely" doing so. Similarly, Pope and colleagues (1987) reported that 70.4% of U.S. psychologists endorsed "never" providing therapy to one of their friends. And, a combined 28.3% endorsed at least "rarely" crossing this boundary.

There was a noted difference between ethicality ratings for disclosing personal information to a client reported in this study compared to ethicality ratings for "disclosing

details of current personal stresses to a client" in Borys and Pope (1989). In this study, 52.4% of participants rated the deliberate in-person therapist self-disclosure as "ethical under many circumstances" and 39.7% rated this crossing as "ethical under rare circumstances" (see Table 5). Only 1.6% of participants in this study deemed this crossing as "unquestionably unethical." Participants in Borys and Pope (1989) appeared more conservative with regard to deliberate self-disclosure. While a similar percentage of Borys and Pope's therapist participants (39.9%) rated this crossing as "ethical under rare conditions" and 29.5 % of their participants rated it as "ethical under some conditions," more of them (26.0%) endorsed an ethicality rating of "1" ("never ethical").

In the current study, practice frequencies of disclosing personal information to a client resembled those reported in two previous studies but strongly contrasted to those in one additional study. Approximately half of this study's therapist participants endorsed a practice frequency of "3" ("sometimes") for this crossing. An additional 37.7% endorsed a practice frequency of "2" ("rarely") (see Table 6). Similarly, approximately 93% of APA members surveyed by Pope, Tabachnick, & Keith-Spiegel (1987) endorsed ever using self-disclosure as a therapeutic technique. And, Mathews (1989) reported that 80% of psychiatrists, psychologists, and licensed social workers surveyed endorsed having specifically used self-disclosure in session. U.S.-practicing doctoral-level psychologists in Borys and Pope (1989) appeared significantly more conservative with reference to the crossing of disclosing details of current personal stresses to a client, however. The majority (60.1%) endorsed a practice rating of "1," signifying that they engaged in this behavior with no clients at all or had no opportunity to do so; approximately 30% endorsed a practice rating of "2," signifying having crossed this boundary with "few

clients,"; and only 7.4% endorsed a practice rating of "3," signifying having crossed this boundary with "some clients."

Comparisons of Ethicality Ratings and Practice Frequencies for Traditional Nonsexual Boundary Crossings

Exploratory comparisons of participants' ethicality ratings and practice frequencies were conducted for each of the three traditional nonsexual boundary crossings (i.e., disclosing personal information to a client, providing therapy to an individual in one's social circle, and providing therapy to a current supervisee). Although the participants in this study did not provide both ethicality and practice frequency responses, the comparisons provided some insights.

Therapist participants in the current study provided approximately equivalently liberal ethicality ratings and practice frequencies for the crossing of disclosing personal information to a client. Only 1.6% endorsed the practice as "unquestionably unethical" and 1.5% reported that they "never" engaged in the behavior (see Tables 5 and 6).

Ethicality ratings and practice frequencies for providing therapy to a client in one's social circle(s) were more conservative overall. Ethicality ratings for this crossing, however, were far less conservative than practice frequencies (29.4% endorsed "unquestionably unethical" versus 79.2% endorsed "never" engaged).

Finally, therapist participants' ethicality ratings were approximately equally, and markedly, as conservative as their reports of practice frequencies for providing therapy to a current supervisee (91.3% endorsed "unquestionably unethical" versus 98.5% endorsed "never" engaged).

Comparison of Ethicality Ratings and Practice Frequencies for Digital and In-Person Self-Disclosure

A good portion of therapists in this study provided more conservative ethicality ratings for the in-person crossing of disclosing personal information to a client (i.e., in-person self-disclosure) than for the digital disclosures of advertising online and of providing online psychoeducation via social media (see Table 5). Approximately 40% of psychologists endorsed finding in-person self-disclosure either "unquestionably unethical" or "ethical under rare circumstances." In contrast, only 4.8% of psychologists provided these two ethicality ratings for advertising online. A slightly higher percentage (10.3%) provided these two ethicality ratings for using social media platforms to provide online psychoeducation.

However, practice frequencies yielded a less defined distinction between in-person and digital self-disclosures (see Table 6). Nearly all therapists in this study (98.5%) endorsed engaging in in-person self-disclosure at least "rarely." And, similarly, the majority of therapists (73.1%) endorsed advertising online at least "rarely." However, a similar majority (70.0%) endorsed "never" using social media platforms to provide online psychoeducation despite providing favorable ethicality ratings for this crossing.

Trends in the Digital Nonsexual Boundary Crossings Data

Inspection of the data revealed some interesting trends regarding participants' ethicality ratings and practice frequencies regarding the four digital boundary crossings examined in this study. Therapists rated the two crossings of advertising online and providing psychoeducation online via social media platforms as more ethical than they

did the two crossings of searching for a client's information online and accepting a social media request from a client. The majority of therapists found advertising online ethical under many circumstances (60.3%) or "unquestionably ethical" (22.2%; see Table 5). In addition, 71.4% of therapists rated providing psychoeducation online via social media as either "ethical under many circumstances" or "unquestionably ethical." In contrast, 79.7% therapist participants rated searching for a client's information online and 97.6% of therapist participants rated accepting a social media request from a client as either "unquestionably unethical" or "ethical under rare circumstances."

Ethicality data also indicated that participants were more undecided with regard to the ethicality of digital boundary crossings versus traditional boundary crossings with one exception. Twenty-three (18.3%) therapist participants endorsed an ethicality rating of "3" ("don't know/not sure") with respect to providing psychoeducation online via social media. In addition, 16 therapist participants (12.7%) endorsed a rating of "3" with respect to advertising online and 13 (10.3%) with respect to searching for a client's information online. In contrast, five (4.0%) participants provided a rating of "3" for disclosing personal information to a client, only one (3%) participant did so for providing therapy to a client in one's social circle(s), and no participants did so for the traditional crossing of providing therapy to a current supervisee. The exception to this trend was the digital crossing of accepting a social media request from a client. As noted above, all participants but one rated this crossing as either "unquestionably unethical" or "ethical under rare circumstances."

Finally, the distributions of practice frequencies for digital crossings differed conspicuously from the distribution of ethicality ratings for these digital crossings – and,

sometimes, from findings in previous literature. First, an equal percentage (26.9%) of therapist participants endorsed a practice frequency of "1" ("never") and "5" ("very often") for the crossing of advertising online. In contrast, only 3.2% of therapists endorsed an ethicality rating of "1" ("unquestionably unethical"), 60.3% endorsed an ethicality rating of "4" (ethical under many circumstances," and 22.2% endorsed an ethicality rating of "5" ("unquestionably ethical") for this crossing. In short, ethicality ratings for this crossing were differently distributed than were practice frequencies. Although in general psychologists rated this digital crossing as ethical, a distinct and rather sizeable group never engaged in the practice.

In comparison, participants' practice frequencies appeared more liberal than their ethicality ratings for searching for information about a client online. While 31.0% of therapists rated this crossing "unquestionably unethical," 40.8% of therapists practiced this crossing at least "rarely." Of note, the participant frequencies for this crossing in the present study are slightly more conservative than those reported in Kolmes and Taube (2014). Approximately half of the sample population of social workers, marriage and family therapists, psychiatrists, and doctoral-level psychologists in their study (48%) endorsed searching for client information online, specifically in non-crisis situations and without client consent. The findings in the current study also differ from previous findings with respect to U.S. graduate students in doctoral psychology programs. Three studies done within the decade before the current study provide evidence that 25 to 30% of graduate students endorse searching for client information online (Asay & Lal, 2014; Harris & Kurpius, 2014; Lehavot et al., 2010).

Therapists also appeared to be more conservative in practice than they were in their perceptions of the ethicality of accepting a social media connection request from a client. A substantial percentage (78.4%) of therapists rated this crossing as "unquestionably unethical." However, an even higher percentage (95.4%) of therapist participants stated that they had "never" engaged in this crossing. Practice frequencies in this study also appeared slightly more conservative than those of child psychologists and psychologists-in-training in Tunick and colleagues' 2011 study. Just under 90% of participants in this earlier study agreed that they would not accept a social media request from a client.

Finally, therapists were also more conservative in practice than they were when assigning ethicality ratings to the crossing of providing psychoeducation online using social media platforms. While 71.4% of therapists rated this crossing either "ethical under many circumstances" or "unquestionably ethical," a nearly equal majority of therapist participants (70.0%) endorsed a practice frequency of "never" engaging in the crossing. Only 3.1% of the therapists in the current study endorsed providing psychoeducation online using social media platforms "very often."

Table 8. Results of Ordinal Logistic Regression for Practice Frequencies of Disclosing Personal Information to a Client.

Independent Variable	*-2 Log Likelihood*	*df*	*B*	*SE*	*p*	95% CI for *Exp(B)*	*Exp(B)*
Model	138.23	10			.20		
Therapist Theoretical Orientation							
Other			1.43	.55	.01†	[1.43, 12.18]	4.18
Humanistic			.82	.66	.21	[.62, 8.33]	2.27
Psychodynamic			.75	.52	.15	[.77, 5.81]	2.12
CBT			*	*	*	*	*
Therapist Experience							
20,000 or more hours			.52	.51	.31	[.62, 4.53]	1.68
15,000 to 19,999 hours			-.36	.74	.63	[.16, 3.00]	.70
10,000 to 14,999 hours			-.68	.67	.31	[.14, 1.90]	.51
5,000 to 9,999 hours			.55	.56	.33	[.57, 5.21]	1.73
1 to 4,999 hours			*	*	*	*	*
Therapist Gender							
Male			-.34	.57	.55	[.23, 2.18]	.71
Female			*	*	*	*	*

Client Gender					
Male	.17	.47	.72	[.47, 2.97]	1.19
Female	*	*	*	*	*
Therapist Gender x Client Gender					
Male x Male	1.05	.86	.23	[.53, 15.49]	2.86
Male x Female	*	*	*	*	*
Female x Male	*	*	*	*	*
Female x Female	*	*	*	*	*

Note: * = Reference category and † = $p < .05$.

Table 9. Results of Ordinal Logistic Regression for Practice Frequencies of Advertising Online.

Independent Variable	*-2 Log Likelihood*	*df*	*B*	*SE*	*p*	95% CI for *Exp(B)*	*Exp(B)*
Model	248.44	10			.57		
Therapist Theoretical Orientation							
Other			.93	.48	.05	[.99, 6.55]	2.53
Humanistic			-.07	.59	.91	[.30, 2.97]	.93
Psychodynamic			.10	.46	.82	[.45, 2.72]	1.11
CBT			*	*	*	*	*
Therapist Experience							
20,000 or more hours			-.65	.46	.15	[.21, 1.27]	.52
15,000 to 19,999 hours			-1.17	.68	.09	[.08, 1.19]	.31
10,000 to 14,999 hours			-.60	.59	.31	[.17, 1.75]	.55
5,000 to 9,999 hours			-.58	.51	.25	[.21, 1.51]	.56
1 to 4,999 hours			*	*	*	*	*
Therapist Gender							
Male			-.39	.51	.45	[.25, 1.84]	.68
Female			*	*	*	*	*

Client Gender					
Male	.03	.42	.95	[.45, 2.36]	1.03
Female	*	*	*	*	*
Therapist Gender x Client Gender					
Male x Male	.07	.76	.92	[.24, 4.81]	1.07
Male x Female	*	*	*	*	*
Female x Male	*	*	*	*	*
Female x Female	*	*	*	*	*

Note: * = Reference category.

Table 10. Results of Ordinal Logistic Regression for Practice Frequencies of Searching Online for Client Information.

Independent Variable	*-2 Log Likelihood*	*df*	*B*	*SE*	*p*	95% CI	*Exp(B)*
Model	127.02	10			.21		
Therapist Theoretical Orientation							
Other			1.16	.59	.05	[1.01, 10.07]	3.19
Humanistic			.98	.70	.16	[.67, 10.59]	2.66
Psychodynamic			.51	.55	.35	[.57, 4.90]	1.67
CBT			*	*	*	*	*
Therapist Experience							
20,000 or more hours			.06	.51	.90	[.39, 2.92]	1.06
15,000 to 19,999 hours			-1.10	.84	.20	[.07, 1.77]	.33
10,000 to 14,999 hours			-1.10	.75	.15	[.08, 1.48]	.33
5,000 to 9,999 hours			-.30	.58	.60	[.24, 2.32]	.74
1 to 4,999 hours			*	*	*	*	*
Therapist Gender							
Male			-1.68	.68	.01†	[.05, .71]	.19
Female			*	*	*	*	*

Client Gender					
Male	-.28	.47	.55	[.30, 1.90]	.76
Female	*	*	*	*	*
Therapist Gender x Client Gender					
Male x Male	1.67	.94	.07	[.85, 33.45]	5.31
Male x Female	*	*	*	*	*
Female x Male	*	*	*	*	*
Female x Female	*	*	*	*	*

Note: * = Reference category and † = $p < .05$.

Table 11. Results of Ordinal Logistic Regression for Practice Frequencies of Providing Psychoeducation Online.

Independent Variable	*-2 Log Likelihood*	*df*	*B*	*SE*	*p*	95% CI for *Exp(B)*	*Exp(B)*
Model	137.81	10			.37		
Therapist Theoretical Orientation							
Other			-.29	.60	.63	[.23, 2.41]	.75
Humanistic			.66	.67	.32	[.52, 7.10]	1.93
Psychodynamic			-.70	.58	.23	[.16, 1.54]	.50
CBT			*	*	*	*	*
Therapist Experience							
20,000 or more hours			-.20	.53	.71	[.29, 2.29]	.82
15,000 to 19,999 hours			-1.59	1.09	.15	[.02, 1.73]	.20
10,000 to 14,999 hours			-1.36	.87	.12	[.05, 1.40]	.26
5,000 to 9,999 hours			-.86	.65	.19	[.12, 1.51]	.42
1 to 4,999 hours			*	*	*	*	*
Therapist Gender							
Male			-.75	.67	.27	[.13, 1.77]	.47
Female			*	*	*	*	*
Client Gender							

Male	-.17	.52	.74	[.30, 2.32]	.84
Female	*	*	*	*	*
Therapist Gender x Client Gender					
Male x Male	.48	1.01	.64	[.22, 11.70]	1.62
Male x Female	*	*	*	*	*
Female x Male	*	*	*	*	*
Female x Female	*	*	*	*	*

Note: * = Reference category.

Table 12. Results of Ordinal Logistic Regression for Practice Frequencies of Providing Therapy to a Client in One's Social Circle(s).

Independent Variable	*-2 Log Likelihood*	*df*	*B*	*SE*	*p*	95% CI for *Exp(B)*	*Exp(B)*
Model	77.18	10			.001†		
Therapist Theoretical Orientation							
Other			1.59	1.17	.18	[.49, 48.42]	4.90
Humanistic			2.08	1.29	.11	[.64, 100.48]	8.00
Psychodynamic			2.75	1.16	.02†	[1.60, 152.93]	15.64
CBT			*	*	*	*	*
Therapist Experience							
20,000 or more hours			2.15	.85	.01†	[1.62, 48.60]	8.58
15,000 to 19,999 hours			2.26	1.08	.04†	[1.16, 79.84]	9.58
10,000 to 14,999 hours			2.50	1.01	.01†	[1.67, 88.23]	12.18
5,000 to 9,999 hours			-.22	1.26	.86	[.07, 9.39]	.80
1 to 4,999 hours			*	*	*	*	*
Therapist Gender							
Male			-.10	.82	.90	[.18, 4.48]	.90
Female			*	*	*	*	*

Client Gender					
Male	-.56	.67	.41	[.15, 2.14]	.57
Female	*	*	*	*	*
Therapist Gender x Client Gender					
Male x Male	.83	1.27	.51	[.19, 27.66]	2.29
Male x Female	*	*	*	*	*
Female x Male	*	*	*	*	*
Female x Female	*	*	*	*	*

Note: * = Reference category and † = $p < .05$.

Table 13. Results of Ordinal Logistic Regression for Ethicality Ratings for Disclosing Personal Information to a Client.

Independent Variable	*-2 Log Likelihood*	*df*	*B*	*SE*	*p*	95% CI for *Exp(B)*	*Exp(B)*
Model	135.76	10			.59		
Therapist Theoretical Orientation							
Other			.19	.54	.73	[.41, 3.49]	1.21
Humanistic			.65	.70	.35	[.49, 7.54]	1.92
Psychodynamic			-.02	.49	.97	[.38, 2.56]	.98
CBT			*	*	*	*	*
Therapist Experience							
20,000 or more hours			-.13	.58	.82	[.28, 2.72]	.88
15,000 to 19,999 hours			.13	.69	.85	[.29, 4.44]	1.14
10,000 to 14,999 hours			.24	.63	.71	[.37, 4.35]	1.27
5,000 to 9,999 hours			.06	.67	.93	[.29, 3.94]	1.06
1 to 4,999 hours			*	*	*	*	*
Therapist Gender							
Male			.35	.70	.61	[.36, 5.58]	1.42
Female			*	*	*	*	*
Client Gender							

Male	-.03	.44	.95	[.41, 2.32]	.97
Female	*	*	*	*	*
Therapist Gender x Client Gender					
Male x Male	1.76	1.11	.11	[.66, 51.42]	5.81
Male x Female	*	*	*	*	*
Female x Male	*	*	*	*	*
Female x Female	*	*	*	*	*

Note: * = Reference category.

Table 14. Results of Ordinal Logistic Regression for Ethicality Ratings for Advertising Online.

Independent Variable	*-2 Log Likelihood*	*df*	*B*	*SE*	*p*	95% CI for *Exp(B)*	*Exp(B)*
Model	162.59	10			.78		
Therapist Theoretical Orientation							
Other			-.27	.55	.62	[.26, 2.25]	.76
Humanistic			.12	.70	.86	[.29, 4.39]	1.13
Psychodynamic			.26	.49	.61	[.49, 3.39]	1.30
CBT			*	*	*	*	*
Therapist Experience							
20,000 or more hours			.42	.59	.48	[.48, 4.81]	1.52
15,000 to 19,999 hours			.60	.71	.40	[.45, 7.24]	1.82
10,000 to 14,999 hours			-.06	.64	.93	[.27, 3.32]	.94
5,000 to 9,999 hours			-.42	.68	.53	[.17, 2.51]	.66
1 to 4,999 hours			*	*	*	*	*
Therapist Gender							
Male			-1.00	.71	.16	[.09, 1.49]	.37
Female			*	*	*	*	*

Client Gender					
Male	-.49	.45	.28	[.25, 1.49]	.61
Female	*	*	*	*	*
Therapist Gender x Client Gender					
Male x Male	.67	1.02	.51	[.26, 14.59]	1.95
Male x Female	*	*	*	*	*
Female x Male	*	*	*	*	*
Female x Female	*	*	*	*	*

Note: * = Reference category.

Table 15. Results of Ordinal Logistic Regression for Ethicality Ratings for Searching Online for Client Information.

Independent Variable	*-2 Log Likelihood*	*df*	*B*	*SE*	*p*	95% CI for *Exp(B)*	*Exp(B)*
Model	164.67	10			.31		
Therapist Theoretical Orientation							
Other			-.84	.54	.12	[.15, 1.25]	.43
Humanistic			-.64	.67	.34	[.14, 1.97]	.53
Psychodynamic			-.44	.47	.36	[.25, 1.63]	.64
CBT			*	*	*	*	*
Therapist Experience							
20,000 or more hours			.89	.57	.12	[.79, 7.39]	2.44
15,000 to 19,999 hours			.24	.68	.72	[.33, 4.85]	1.27
10,000 to 14,999 hours			1.44	.63	.02†	[1.23, 14.44]	4.22
5,000 to 9,999 hours			.46	.66	.48	[.44, 5.81]	1.58
1 to 4,999 hours			*	*	*	*	*
Therapist Gender							
Male			.05	.68	.94	[.28, 3.97]	1.05
Female			*	*	*	*	*

Client Gender					
Male	-.29	.43	.51	[.32, 1.75]	.75
Female	*	*	*	*	*
Therapist Gender x Client Gender					
Male x Male	.88	.98	.37	[.36, 16.28]	2.41
Male x Female	*	*	*	*	*
Female x Male	*	*	*	*	*
Female x Female	*	*	*	*	*

Note: * = Reference category and † = $p < .05$.

Table 16. Results of Ordinal Logistic Regression for Ethicality Ratings for Accepting Social Media Connection Requests from a Client.

Independent Variable	*-2 Log Likelihood*	*df*	*B*	*SE*	*p*	95% CI for *Exp(B)*	*Exp(B)*
Model	79.30	10			.02†		
Therapist Theoretical Orientation							
Other			-1.33	.81	.10	[.05, 1.30]	.26
Humanistic			-.05	.91	.96	[.16, 5.70]	.95
Psychodynamic			-.45	.62	.47	[.19, 2.14]	.64
CBT			*	*	*	*	*
Therapist Experience							
20,000 or more hours			1.36	.89	.13	[.68, 22.42]	3.90
15,000 to 19,999 hours			2.42	1.02	.02†	[1.51, 83.10]	11.25
10,000 to 14,999 hours			.98	.94	.30	[.42, 16.78]	2.66
5,000 to 9,999 hours			.42	1.11	.71	[.17, 13.46]	1.52
1 to 4,999 hours			*	*	*	*	*
Therapist Gender							
Male			2.25	.95	.02†	[1.48, 61.56]	9.49
Female			*	*	*	*	*

Client Gender					
Male	1.77	.76	.02†	[1.32, 26.31]	5.87
Female	*	*	*	*	*
Therapist Gender x Client Gender					
Male x Male	-1.81	1.25	.15	[.01, 1.90]	.16
Male x Female	*	*	*	*	*
Female x Male	*	*	*	*	*
Female x Female	*	*	*	*	*

Note: * = Reference category and † = $p < .05$.

Table 17. Results of Ordinal Logistic Regression for Ethicality Ratings for Providing Psychoeducation Online.

Independent Variable	*-2 Log Likelihood*	*df*	*B*	*SE*	*p*	95% CI for *Exp(B)*	*Exp(B)*
Model	196.39	10			.95		
Therapist Theoretical Orientation							
Other			-.69	.53	.20	[.18, 1.43]	.50
Humanistic			-.75	.67	.26	[.13, 1.73]	.47
Psychodynamic			-.57	.48	.24	[.22, 1.45]	.57
CBT			*	*	*	*	*
Therapist Experience							
20,000 or more hours			-.17	.56	.77	[.28, 2.53]	.84
15,000 to 19,999 hours			.20	.68	.77	[.32, 4.62]	1.22
10,000 to 14,999 hours			-.31	.61	.62	[.22, 2.44]	.73
5,000 to 9,999 hours			.31	.66	.63	[.38, 5.00]	1.36
1 to 4,999 hours			*	*	*	*	*
Therapist Gender							
Male			.06	.68	.93	[.28, 4.06]	1.06
Female			*	*	*	*	*

Client Gender					
Male	.01	.43	.97	[.44, 2.36]	1.01
Female	*	*	*	*	*
Therapist Gender x Client Gender					
Male x Male	-.19	.98	.84	[.12, 5.64]	.83
Male x Female	*	*	*	*	*
Female x Male	*	*	*	*	*
Female x Female	*	*	*	*	*

Note: * = Reference category.

Table 18. Results of Ordinal Logistic Regression for Ethicality Ratings for Providing Therapy to a Client in One's Social Circle(s).

Independent Variable	*-2 Log Likelihood*	*df*	*B*	*SE*	*p*	95% CI for *Exp(B)*	*Exp(B)*
Model	130.11	10			.55		
Therapist Theoretical Orientation							
Other			-1.03	.57	.07	[.12, 1.08]	.36
Humanistic			-.02	.71	.98	[.25, 3.94]	.98
Psychodynamic			-1.07	.51	.04†	[.13, .93]	.34
CBT			*	*	*	*	*
Therapist Experience							
20,000 or more hours			.14	.59	.81	[.36, 3.63]	1.15
15,000 to 19,999 hours			.55	.71	.44	[.43, 7.03]	1.73
10,000 to 14,999 hours			-.45	.64	.48	[.18, 2.25]	.64
5,000 to 9,999 hours			.02	.69	.98	[.26, 3.90]	1.02
1 to 4,999 hours			*	*	*	*	*
Therapist Gender							
Male			.20	.72	.78	[.30, 4.95]	1.22
Female			*	*	*	*	*

Client Gender					
Male	-.25	.45	.58	[.32, 1.90]	.78
Female	*	*	*	*	*
Therapist Gender x Client Gender					
Male x Male	.03	1.03	.98	[.14, 7.69]	1.03
Male x Female	*	*	*	*	*
Female x Male	*	*	*	*	*
Female x Female	*	*	*	*	*

Note: * = Reference category and † = $p < .05$.

CHAPTER FOUR

DISCUSSION

This study was designed to update and enhance the literature regarding nonsexual boundary crossings in the clinical practice of psychologists. As discussed in the Introduction of this study, psychologists have long been engaged in extensive discourse regarding the ethicality of and engagement in nonsexual boundary crossings. Seminal studies were performed to foster better understanding of psychologists' ethical attitudes toward and frequency of engagement in nonsexual boundary crossings (Baer and Murdock, 1995; Borys & Pope, 1989; Edwards and Murdock, 1994; Pope et al., 1987). These studies provided evidence that specific therapist and patient factors account for significant variance in these ethical attitudes and frequencies of engagement.

These seminal studies were performed several decades ago, however. As such, they often tapped participants who represented significantly different demographics than those who represent the profession now. For example, the earlier membership was heavily dominated by White-identified, male psychologists (APA, 2015). As of 2013, 68.3% of psychologists in the U.S. identified as female, meaning that there were 2.1 female psychologists for each male psychologist in the field (APA, 2015). In the same year, 83.6% of psychologists identified as White (APA, 2015). Further, current practitioners are guided by an APA Ethics Code that has changed over the course of time with regards to standards regarding the ethicality of nonsexual boundary crossings (APA, 1953; 1977; 1992; 2002; 2017).

In addition, given the status of technology at the time, the early studies could not capture data regarding potential Internet-based boundary crossings, such as searching

online for information on a client or providing psychoeducation online via social media platforms. This study therefore included four digital nonsexual boundary crossings (i.e., digital therapist self-disclosure, searching for client's information online, accepting a client's social media request, and providing psychoeducation online via social media platforms).

This study also built on the seminal studies listed above by re-examining three traditional therapist predictors (gender, theoretical orientation, and clinical experience) using more contemporary definitions or research methods. First, options for therapist gender were expanded from binary options (i.e., "male" and "female") to include nonbinary options (i.e., "nonbinary," "transgender male to female," "transgender female to male," "genderfluid," "uncertain," and "Other"). Second, this study also attempted to increase the accuracy of participants' identification of their theoretical orientation for practice.

In additional, previous studies simply asked therapist participants to select a theoretical orientation. However, it is possible that many therapists currently practice using interventions from a variety of orientations. As such, this study asked participants specifically what theoretical orientation they used as a foundation for conceptualizing their patients regardless of the actual interventions they used.

And third, therapists' clinical experience was also assessed in a different way from earlier studies which defined clinical experience as therapist participants' number of years in clinical practice. As noted in the Introduction above, therapists may work a number of years but in a limited-time practice. As such, they may not actually be as experienced as a therapist who has worked fewer years in a full-time practice. Therapists'

clinical experience was therefore assessed by eliciting therapist participants' approximation of how many face-to-face hours total they had accumulated with adult patients in psychotherapy in all contexts in which they had worked since graduate school.

In addition, this study examined a novel therapist predictor: whether participants were "digital immigrants" or "digital natives," based on Prensky's 2001 delineation of the two categories. More specifically, this study was designed to reveal how identifying as either a digital immigrant or native might explain variance in therapists' ethicality ratings and practice frequencies for the four digital nonsexual boundary crossings included in this study.

Finally, Pope and colleagues (1987) assessed client gender as a predictor of therapist participants' ethical attitudes toward and/or engagement in nonsexual boundary crossings by asking therapist participants whether they see a more predominantly male or female clientele. The current study measured the impact of patient gender more directly by using Baer and Murdoch's (1995) approach instead. Therapist participants in this study each took one Therapeutic Practices Survey regarding either a male or female client.

In short, this study re-examined trends revealed by seminal research performed in the 1980s and 1990s in light of significantly different APA demographic composition, APA Ethics Code revisions since seminal studies were performed, and the advent of widespread Internet use by both therapists and potential clients. In addition, this study incorporated contemporary methods of assessing therapist gender, therapist theoretical orientation, therapist experience, and client gender as predictors. It added a new potential predictor related to therapists' level of experience with technology.

The first goal of this study was to provide updated or novel findings regarding the frequency of ethicality ratings and practice frequencies of the nonsexual boundary crossings that were included in the survey. The second goal of this study was to provide insight into therapist and patient factors accounting for variance in participants' ethicality ratings and practice frequencies.

The results of this study provided partial support for proposed hypotheses; discussion of these findings is presented first. The results of the exploratory analyses are discussed next. The Discussion concludes with the potential implications of this study for clinical training and for future research.

Discussion of the Results for the Hypotheses

In general, the findings of this study suggest overall that the variance in psychologists' ethicality ratings and practice frequencies with respect to some traditional boundary crossings has shifted over the course of the last few decades. As discussed in more detail below, therapist participants in the current study provided more matching ethicality ratings and practice frequencies for professional nonsexual multiple relationships. They also provided ethicality ratings and practice frequencies with greater variance compared to the ratings and frequencies provided by participants in seminal studies. Finally, therapist participants in the current study provided more conservative practice frequencies regarding social nonsexual multiple relationships compared to those in earlier studies. These shifts in variance with regards to traditional boundary crossings may help explain why the hypotheses for this study were only partially supported. And, variance is limited for some newer digital boundary crossings.

First, it was hypothesized that male therapists would endorse higher ethicality ratings and practice frequencies than therapists of any other gender for all seven nonsexual boundary crossings included in this study. Indeed, male therapists endorsed higher ethicality ratings than female therapists regarding one crossing: accepting a social media request from a client. Male therapists were also more conservative than female therapists in their practice of searching online for client information. There were no significant differences between male and female therapists in the ethicality ratings or practice frequencies for any of the other nonsexual boundary crossings.

A therapist's choosing to form a social media connection with a client would constitute entering into a digital nonsexual multiple relationship, as discussed more extensively in the Introduction for this study. As such, male therapists' higher ethicality ratings for accepting a social media request from a client in this study were consistent with findings from two prior studies. In their 1989 publication about APA members' ethical decision-making, Borys and Pope reported that male therapists provided significantly higher ethicality ratings than did female therapists for social involvements with clients. Likewise, Baer and Murdock's 1995 study revealed that male therapists provided significantly higher ethicality ratings than female therapists did for nonsexual multiple relationships.

The finding in the current study of no therapist gender differences in the ethicality ratings or practice frequencies for more traditional nonsexual boundary crossings may reflect the effects of increased training regarding ethical decision-making processes and the potential difficulties that may result from these traditional boundary crossings. In other words, this training may have heightened awareness among all psychologists. It

may have particularly heightened awareness among male psychologists, who in earlier studies have appeared more likely to perceive crossings as more ethical and to also engage more often in crossings overall, especially when a female client has been involved (Baer & Murdock, 1995; Borys & Pope, 1989).

Further, because these gender differences appeared for only digital nonsexual boundary crossings in this study, it is possible that they are a manifestation of broader gender differences in Internet use. Early research indicated that females are more likely, for example, to use the Internet for interpersonal communication (Weiser, 2000). More recent literature provided similar findings, in that females are more likely to use smartphones for social purposes (Van Deursen, Bolle, Hegner, and Kommers, 2015) and to outnumber males on the social media sites Facebook, Instagram, and Pinterest (Duggan, Ellison, Lampe, Lenhart, and Madden, 2015).

It was further hypothesized that male therapists would endorse higher practice frequencies and ethicality ratings than therapists of any gender when answering questions about female patients for all boundary crossings except Digital Self-Disclosure and Social Media Influence. Results of data analyses in this study did not reveal any significant interaction effects for therapist gender and client gender. This finding does not conform to those reported by Borys and Pope (1989), who found that male therapists with primarily female clients provided significantly higher ethicality ratings than any other therapist-client gender pairing for two types of nonsexual multiple relationships. It is possible that this contrast can be partially attributed to the difference in how the current study and Borys and Pope (1989) assessed client gender. The current study assessed the effect of client gender by providing male and female client versions of the Ethicality

Ratings and Practice Frequencies form based on Baer and Murdock's study design (1995). In contrast, Borys and Pope (1989) assessed the effect of client gender by asking whether therapists saw more female or male clients in their practice. However, male therapists in Baer and Murdock (1995) also provided higher ethicality ratings than female therapists did regarding nonsexual multiple relationships. As such, it is more likely that the contrast between the current study's findings and those of two previous studies are due to increased training regarding ethical decision-making processes and the potential difficulties of these traditional boundary crossings, as discussed above.

Second, it was hypothesized that therapists who endorsed using psychodynamic theory to conceptualize their patients would endorse lower ethicality ratings and practice frequencies than therapists endorsing any other theoretical orientation. Indeed, analyses revealed that psychodynamic therapists endorsed lower ethicality ratings than cognitive-behavioral therapists for providing psychotherapy to a client in one's social circle(s) (i.e., engaging in a social nonsexual multiple relationship). This current finding is consistent with that of Borys and Pope (1989), who found that psychodynamic therapist participants rated nonsexual multiple relationships as significantly less ethical than did all other therapists in their study. However, psychodynamic therapists in the current study provided significantly higher practice frequencies than cognitive-behavioral therapists for the crossing of providing therapy to a client in their social circle(s). This current finding is diametrically opposite to that of Borys and Pope (1989). Psychodynamic therapist participants in their study reported significantly lower practice frequencies of nonsexual multiple relationships than cognitive-behavioral, humanistic, and eclectic/"other" therapists.

Analyses revealed that therapists endorsing "Other" theoretical orientations (i.e., "Emotion-Focused," "Gestalt," "Jungian," "Psychoanalytic," and "Other") endorsed higher practice frequencies than Cognitive-Behavioral therapists for disclosing personal information to a client. Unfortunately, with such different theoretical orientations combined into the "Other" category for this study (e.g., "Psychoanalytic" vs. "Gestalt"), it is difficult to speculate whether specific elements of any theoretical orientation fuel these findings.

Third, it was hypothesized that therapists with greater clinical experience would endorse higher ethicality ratings and higher practice frequencies for all seven boundary crossings. Analyses revealed that therapists with greater experience endorsed higher ethicality ratings for two digital crossings: searching online for client information and accepting a social media request from a client. These current findings are consistent with the finding by Borys and Pope (1989) that therapists with 30 or more years of clinical experience provided higher ethicality ratings for nonsexual multiple relationships than did therapists with less than 10 years of experience. It is possible that this pattern remained consistent for U.S.-practicing doctoral-level psychologists between 1989 and 2019 because increased clinical experience is associated with increased discernment and confidence and, therefore, flexibility.

Analyses also revealed that therapists with greater experience endorsed higher practice frequencies for providing psychotherapy to a client who was also in their social circle(s) (i.e., engaging in a social nonsexual multiple relationship). In contrast, Borys and Pope (1989) did not report therapists' years of experience as a significant predictor of therapists' engagement in nonsexual multiple relationships.

Fourth, it was hypothesized that therapists who self-identified as digital natives would endorse higher ethicality ratings and practice frequencies for the technology-related boundary crossings (i.e., searching for a client's information online, advertising online, accepting a client's social media connection request(s), and providing psychoeducation online via social media platforms) than therapists who self-identified as digital immigrants. This hypothesis could not be tested due to lack of variance in whether participants self-identified as digital natives or immigrants (see Table 1).

In future studies, this information might be elicited in a different manner. Prensky wrote of digital natives that they have "spent their entire lives surrounded by and using computers, videogames, digital music players" (2001; p.1). Thus, this concept could be explored by assessing participants' experience and comfort with digital technology. For example, participants might be asked to indicate the age at which they first used an Internet-based smartphone or computer application. Alternatively, participants could be asked to indicate on a Likert scale how comfortable they are with common Internet applications such as e-mail and social media sites.

Discussion of the Results of the Exploratory Analyses

As reported above, several exploratory analyses were conducted in this study. First, additional exploratory regression analyses were used to examine whether client gender alone predicted therapists' ethicality ratings and practice frequencies. Second, exploratory analyses were conducted in order to compare the distributions of both the ethicality ratings and the practice frequencies reported by participants in this study with those revealed in earlier studies. Third, exploratory comparisons of participants' ethicality ratings and practice frequencies for each of the traditional nonsexual boundary

crossings were conducted. Fourth, an exploratory comparison of findings regarding in-person versus digital self-disclosure was conducted. And, fifth, the data regarding participants' ethicality ratings and practice frequencies for the digital boundary crossings were examined for trends.

Client Gender as a Predictor of Ethicality Ratings and Practice Frequencies

Exploratory analyses of the main effect of client gender alone revealed that all therapists were more likely to endorse higher ethicality ratings for accepting a social media request from a male client compared to a female client. This result is incongruous with Baer and Murdock's 1995 finding that client gender did not significantly predict therapists' ethicality ratings for more traditional boundary crossings that included nonsexual multiple relationships with clients. Baer and Murdock (1995) did not include digital nonsexual multiple relationships in their study, however. The discrepancy between the current study and Baer and Murdock's 1995 findings may occur only with newer digital boundary crossings.

Comparisons of Distributions of Ethicality Ratings and Practice Frequencies for Traditional Nonsexual Boundary Crossings between This Study and Seminal Studies

Exploratory examination of the data revealed that therapists' ethicality ratings were approximately equal in conservativism with practice frequencies for providing therapy to a current supervisee (i.e., with 91.3% endorsing "unquestionably unethical" and 98.5% endorsing "never" crossing this boundary). In contrast, therapists answering questions about providing therapy to a current student or supervisee in Borys and Pope

(1989) appeared significantly less conservative in ethicality rating than in practice (44.4% endorsed “never ethical” and 88.9% endorsed engaging in this crossing with “no clients or no opportunity”). Although Borys and Pope (1989) also included seeing a current student as a psychotherapy client for this item, it is unlikely that the greater discrepancy between ethicality ratings and practice frequencies is completely due to wording differences. Indeed, this discrepant pattern (less conservative ethicality ratings than practice frequencies) was true for every boundary crossing item included in Borys and Pope (1989).

In addition, participants in the current study provided similarly moderate ethicality ratings and practice frequencies for the crossing of disclosing personal information to a client, in that the majority of responses were split between “2” (“ethical under rare circumstances”) and “4” (“ethical under many circumstances”) for ethicality ratings, and “2” (“rarely”) and “3” (“some”) for practice frequencies. In contrast, participants answering questions about disclosing details of current personal stresses to a client in Borys and Pope (1989) appeared much less conservative in their ethical attitudes than in their practices (26.0% endorsed “never ethical” and 60.1% endorsed engaging in this crossing with “no clients or no opportunity”). It is possible that the difference in findings regarding therapist self-disclosure between this study and Borys and Pope (1989) may have to do with different wording. Borys and Pope (1989) specifically assessed therapist participants’ views on disclosing details of current personal stresses to a client, which may be perceived as more problematic than engaging in a client-centered technique involving self-disclosure or disclosing general information. Future researchers hoping to compare their findings to those of seminal studies would likely benefit from

retaining the exact wording of items. However, it is also possible that this difference occurs because a greater number of therapists in 2019 are trained in theoretical orientations that emphasize therapist self-disclosure. Correspondingly, fewer therapists in 2019 may believe that their professional role is to function as a "blank wall," as traditional psychoanalysts would.

The participants in the current study also were fairly conservative in their ethical views on providing therapy to a client in one's social circles (i.e., a social nonsexual multiple relationship); a combined 86.5% rated this boundary crossing either "unquestionably unethical" or "ethical under rare circumstances." However, practice frequencies for this crossing were slightly less conservative; a combined 20.8% indicated that they engaged in providing therapy to a client in one's social circles either "rarely" or "sometimes." These results are partially consistent with earlier literature. Approximately 90% of psychologist participants surveyed in Pope and colleagues' 1987 study rated the crossing of seeing a friend as a psychotherapy client either "unquestionably unethical" or "ethical only under rare circumstances." This is a remarkable similarity, given the elapsed time between studies as well as the potentially different meanings of the boundary items in each study (i.e., the implied distance in "a client in one's social circle(s)," relative to the closeness potentially implied by "one of your friends"). However, a higher percentage (44.5%) of psychologists endorsed actually engaging in "providing therapy to one of your friends" either "under rare circumstances" or "under many circumstances."

Comparisons of Ethicality Ratings and Practice Frequencies for Traditional Nonsexual Boundary Crossings

As noted above, therapist participants' ethicality ratings appeared as conservative as their practice frequencies for providing therapy to a current supervisee (91.3% endorsing "unquestionably unethical" versus 98.5% endorsing "never"). This consistency between attitude and practice is potentially due to enhanced ethical training on potential issues with nonsexual multiple relationships and power dynamics. There may also be a greater diversity of mental health services available to distressed supervisees that decreases social justice-oriented motivations for engaging in this multiple relationship. Indeed, potential clients even in areas with few mental health providers could potentially access psychotherapy via telepsychology and text-based therapy at the time of this study (Hanley & Reynolds, 2009).

With regard to the crossing of disclosing personal information to a client, therapists in the current study again provided ethicality ratings and practice frequencies that appeared consistent with each other. Only 1.6% of therapist participants rated this crossing "unquestionably unethical" and only 1.5% reported "never" crossing this boundary. As is true of the consistency evident in participants' ratings of engaging in a professional nonsexual multiple relationship, it is possible that attitude-practice consistency here is rooted in more rigorous ethics training addressing this traditional crossing.

Finally, the current study included an inconsistent set of ethicality ratings and practice frequencies for the crossing of providing therapy to a client in one's social circle(s). Whereas 29.4% of therapist participants rated this crossing "unquestionably unethical," a much higher 79.3% reported "never" crossing this boundary. One potential reason for this finding is the high percentage of therapist participants in the current study

who endorsed practicing in an urban (51.2%) or suburban context (37.1%). Only 8.6% and 3.1% of therapist participants endorsed, respectively, practicing in a rural or "Other" (including military) context. As discussed more extensively in the Introduction, nonsexual multiple relationships are more likely in rural and military contexts (Smith & Fitzpatrick, 1995). It is possible that the current findings would reflect much greater endorsement of crossing this boundary were participants more evenly distributed among practice contexts. However, it is also possible that this discrepancy reveals a reticence about this crossing that is unrelated to perceived unethicality. Therapist participants generally may desire distinct separation between their professional and personal lives. Indeed, clients may desire the same separation and engage in the telepsychology and text-based therapy options rather than seeking mental health services from psychotherapists in their social or professional circles.

Comparison of Ethicality Ratings and Practice Frequencies for Digital and In-Person Self-Disclosure

As noted in the Results section, therapists appeared to find in-person self-disclosure unethical more often than they did digital disclosures (i.e., advertising online and of using social media platforms to provide online psychoeducation). As such, it is possible that therapists consider the medium of self-disclosure as they evaluate the ethicality of disclosures made by themselves and fellow clinicians.

Differences in therapist self-disclosure in previous literature may speak to how different motives that may explain or validate various types of disclosure. Hill and Knox (2002) cite Mahalik, VanOrmer, & Simi (2000) in noting that feminist therapists may disclose personal information in order to decrease any perceived power difference between themselves and their clients, help normalize clients' shame-tinged experiences, and increase clients' sense of freedom or liberation. Knox and Hill (2003) add that disclosure may add greater authenticity to clients' perception of therapists' humanity, full-ranged emotional engagement with clients' problems, and positive regard toward clients. Disclosures that function as therapeutic interventions may be more common in in-person than in digital contexts.

Hill and Knox (2002) also note that feminist therapists and therapists working with clients who are members of different cultural groups may self-disclose specifically in order to earn clients' trust or to help clients make informed decisions as clients choose their psychotherapists. This rationale may be equally pertinent to in-person and digital self-disclosure.

The potential differences between in-person and digital self-disclosures, as well as the factors related to those differences, deserve more research. This recommendation becomes increasing relevant as digital self-disclosure becomes more likely among U.S. psychologists entering the profession as digital natives.

Trends in Digital Nonsexual Boundary Crossings Data

Three trends broadly apply to ethicality ratings and practice frequencies for four digital nonsexual boundary crossings included in this study (i.e., advertising online, searching for a client's information online, accepting a social media request from a client, and providing psychoeducation online via social media platforms). First, therapists appeared to assign different ethicality ratings and practice frequencies for different digital boundary crossings. This variability suggests that their ethical decision-making processes regarding these more novel boundaries crossings were influenced by more factors than simply that their simply being digital crossings. Second, participants appeared more undecided with regard to the ethicality of three digital boundary crossings than they did with regard to the three traditional crossings included in this study (i.e., providing therapy to a current supervisee, providing therapy to a client in one's social circle or circles, and disclosing personal information to a client). Third, data distributions for ethicality ratings did not match those of practice frequencies for three out of four digital crossings in the current study.

As noted in the Results section, therapists appeared to find two digital crossings significantly more ethical than two other digital crossings. A majority of therapist participants (70 to 90%) provided liberal ethicality ratings (i.e., "ethical under many

circumstances" or "unquestionably ethical") for advertising online and for providing psychoeducation online via social media. Meanwhile, approximately 80 percent of therapists rated searching for information about a client online as either "unquestionably unethical" or "ethical under rare circumstances"; nearly 98% of therapist participants endorsed these views when asked about accepting a social media request from a client.

It is possible that advertising and providing psychoeducation online via social media platforms were more acceptable to the therapists who participated in this study for three reasons. First, these first two crossings involved controlled therapist disclosure, which is not necessarily true of accepting a social media request of a client. Moreover, they were unidirectional therapist-to-public communication(s), which was not true of accepting a client's social media request or of searching for a client's information online. Furthermore, they did not potentially violate a client's privacy, which would generally be true of searching for a client's information online.

Another trend discussed in the Results section above was the uncertainty with which therapists appeared to rate three of the digital crossings compared to traditional crossings. Ten to twenty percent of participants endorsed the option "don't know/not sure" when rating the ethicality of advertising online, searching for information about a client online, and using social media platforms to provide online psychoeducation. This percentage dropped to the single digits for all three traditional crossings, for which the highest percentage endorsing uncertainty was five percent and the lowest was zero.

It is possible that this apparent uncertainty reflects the fact that 2017 APA Code of Ethics (APA, 2017) does not provide direction regarding how to negotiate digital crossings. There may be lack of consensus regarding these crossings in contemporary

U.S. doctoral-level graduate programs' ethics classes. At the time of the current study, there was no literature available to confirm or disconfirm this possibility. However, it is also very likely that the majority of doctoral psychologists took their ethics classes before the advent of digital boundary crossings. They possibly have not had specific opportunities since graduation to explore their ethical decision-making process on this front. It is possible that the next generation of psychologists will receive much more training on digital crossings and have the benefit of accessing more research findings regarding these crossings than the generation of psychologists represented in the current study. Based on this study's comparison of variance in ethicality ratings and practice frequencies for traditional boundary crossings between the current study and previous findings, it is likely that there will be corresponding shifts in variance in ethicality ratings and practice frequencies for digital boundary crossings.

Finally, the distribution of practice frequencies for digital crossings differed conspicuously from the distribution of ethicality ratings – and, sometimes, from findings in previous literature. Just over a quarter of therapists in this study endorsed "very often" advertising online; an additional 19.2% endorsed doing so "fairly often." In contrast, McMinn and co-investigators reported in 1999 that 98% of psychologists endorsed never advertising on the Internet. However, it is possible that the psychologists assessed in their study simply did not have the training necessary to develop that advertising and/or access to online advertising services.

In comparison, participants' practice frequencies appeared more liberal than their ethicality ratings for searching for information about a client online. This discrepancy may be due to a combination of the ready accessibility of this crossing, the assured

anonymity in doing so (i.e., a client cannot directly discover if her therapist searched for information regarding her online), and how relatively common this act is in other circumstances (e.g., when seeking job applicants and after meeting new professional contacts or social acquaintances).

Therapists appeared to be more conservative in practice than they were in their perceptions of the ethicality of accepting a social media connection request from a client. Indeed, psychologists in this study endorsed engaging in this crossing less frequently than child psychologists and psychologists-in-training participants in Tunick and colleagues' 2011 study. It may be that the therapist participants in the current study appeared conservative in their practice, but actually responded that they "never" engaged in the practice because they never had the opportunity. It is also possible that this discrepancy occurred both because Tunick and co-investigators' 2011 study included responses from psychologists-in-training and because the current study specifically focused on psychologists who see adult clients for psychotherapy. Psychologists-in-training, as stated in the Introduction above, are more likely to be digital natives. In addition, psychologists who see child clients for psychotherapy are seeing clients whose use of social media is potentially inextricable from basic social connection; these clinicians may employ social media connection as part of their therapeutic work, such as in monitoring child clients seeking accountability for screen time or therapists' role-modeling healthy disclosure online.

Finally, therapists were also more conservative in practice than they were when assigning ethicality ratings to the crossing of providing psychoeducation online using social media platforms. Again, while the very low practice frequency of this crossing for

the participants in this study may be due to lack of training and/or opportunity, it is of note that Pope and colleagues (1987) reported over three decades ago that approximately 10% of U.S. doctoral-level psychologists endorsed the crossing of giving advice via media "very frequently."

Implications for Clinical Training

Based on the findings of this study, it continues to be true that while variance in psychologists' ethicality ratings and practice frequencies with respect to some traditional boundary crossings has shifted over the course of the last few decades, some remaining variance can be predicted by therapist and client factors. The results also support the possibility that variance in psychologists' ethicality ratings and practice frequencies regarding some digital boundary crossings is predicted by therapist and client factors.

The immediate implication of this finding is that doctoral-level psychology programs will continue to benefit from emphasizing therapist self-awareness within formal instruction in professional ethics in psychology. Sonne & Weniger (2018) note that the ability to initiate the ethical decision-making process requires that clinicians possess self-awareness and sensitivity to what Welfel (2002) describes as the "commonness, complexity, and subtleties of ethical dilemmas" (p. 26). Self-awareness in the form of increased mindfulness has been shown to not only increase individuals' confidence that they will approach ethical dilemmas in a structured manner and act more ethically; it is also associated with lower frequency of unethical behavior (Ruedy & Schweitzer, 2010). A part of this consciousness-raising for doctoral-level students may include students learning the specific results of studies such as this one. Doing so may

help them appreciate how their ethical decision-making process may shift with experience, based on their own cultural experiences, and based on their reactions to different clients.

With regarding to digital boundary crossings, data in this study revealed that therapists potentially found these crossings more ethically ambiguous or more difficult to evaluate. This possibility is supported by the increased frequency with which therapist participants endorsed the ethicality option "don't know/not sure" as compared to their ethicality ratings for traditional crossings. Simultaneously, it is likely that a high percentage of individuals who will from now on enter doctoral-level psychology program will regularly use the Internet and be faced more often with boundary dilemmas regarding potential digital interactions with clients. The findings of this study support the integration of dialogue regarding digital crossings in doctoral-level graduate program's ethics curricula. Similarly, more ethics training needs to be available for practicing psychologists in order to provide updated ethical decision-making models and examples regarding digital crossings.

Another result of this study was that therapists' practice frequencies appeared more liberal than therapists' ethicality ratings for two crossings in this study. While psychodynamic therapists appeared much more likely to provide lower ethicality ratings than cognitive-behavioral therapists for providing therapy to a client in one's social circle(s), they provided much higher practice frequencies for this crossing than cognitive-behavioral therapists. Finally, 40.8% of therapist participants endorsed searching for information about a client online at least "rarely," while 31.0% rated this crossing "unquestionably unethical."

There is a significant body of research that indicates that individuals may fail to act upon their espoused ethical beliefs, engage in heavy revision when describing past unethical behavior, and poorly predict their own behavior when faced with potential ethical dilemmas (Barkan, Ayal, Gino, & Ariely, 2012; Dana, Loewenstein, & Weber, 2012; Tenbrunsel, Diekmann, Wade-Benzoni, & Bazerman, 2010; Tenbrunsel & Messick, 2004). More specifically, earlier literature indicates that ethicality ratings are poor predictions of behavior, which is often more liberal. As such, this study's findings may contribute further to self-awareness training in the ethics curricula in doctoral-level psychology programs' ethics curricula and continuing education programs by normalizing the possibility of inconsistency between ethical conviction and practice. Training institutions would benefit future therapists by openly acknowledging the mechanisms by which ethical values may not be translated into practice. For example, Tenbrunsel and Messick (2004) described four enabling factors of "ethical fading," in which recognition of an ethical dilemma is decreased (p. 224). These are euphemistic language (i.e., the accounting practice is "aggressive" rather than "illegal"; p. 226); the slippery slope, which is extensively discussed in this study's Introduction; inaccurate understanding of causative factors (e.g., incorrectly placing blame on others and therefore failing to correct one's own actions); and poor understanding of one's own consequences on others.

Training institutions would also do well to foster an environment in which the naivete, isolation, or impulsivity that contribute to potential ethical missteps are also openly and nonjudgmentally discussed, so as to produce clinicians who thoughtfully and mindfully engage with ethical gray areas. While Borys and Pope (1989) emphasize the

importance of explicitly discussing the consequences of unethical professional conduct, they also write that "programs need to provide an authentically safe and supportive environment in which students and educators alike can acknowledge and examine the seemingly unacceptable impulses that might tempt them to enter into unethical dual relationships" (p. 298). This principle is applicable to all boundary crossings, especially those digital crossings in which digital native psychologists may encounter with greater frequency and less ethical preparation.

Limitations of the Study and Implications for Future Research

Significant information about this study's apparent limitations arrived in the form of feedback from this study's participants. Participants were, by this study's design, doctoral-level psychologists who were trained in research methods and evaluating research as either practitioner-scholars or scientist-practitioners. A discussion of their insights, feedback from an American Psychological Association Division administrator, and the cost of limited demographic variance in this study's participant pool are discussed below.

Limitations Related to the Demographic Questionnaire

There were six overarching issues with the Demographic Questionnaire used in this study. The first of these was the possibility that placing the Demographic Questionnaire before the Therapeutic Practices Survey triggered stereotype threat and biased participants' responses. Stereotype type is a well-defined phenomenon in which activation of internalized stereotypes inspires fear of confirming negative stereotypes and thereby primes individuals for altered performance and behavior (Schmader, Johns, & Forbes, 2008). Research provides evidence of this phenomenon via lower performance outcomes on math tests for females and for ethnic minorities after negative stereotypes are invoked (Lamont, Swift, & Abrams, 2015; Nguyen & Ryan, 2008; Spencer, Stelle, & Quinn, 1999; Steele & Aronson, 1995). Future researchers may avoid this issue by ordering their demographic questionnaires so that it came after any experimental tasks.

Similarly, participants noted that the Demographic Questionnaire items regarding license-related issues were "activating" to imagine and may have made their answers more conservative. These items asked, in order, whether the participant had ever been sanctioned by a state licensing or certification board, whether the participant's license or certification had ever been suspended (put on probation) by a state licensing or certification board, and whether the participant's license or certification had ever been revoked by a state licensing or certification board. It is possible that the extreme skewedness of responses for three dependent variables (i.e., the ethicality rating for providing therapy to a current supervisee, the practice frequency for providing therapy to a current supervisee, and the practice frequency for accepting a social media request from a client) in this study can be attributed to this issue. As was true of the previous

limitation, future researchers may avoid this issue by placing potentially activating questions after any experimental tasks.

While this study's demographic questionnaire was designed based on a contemporary non-binary definition of gender, data was potentially lost because the survey did not allow participants to select multiple gender identities. One participant noted that they see clients who identify as both trans men and genderfluid; it was additionally noted that trans people who have transitioned may identify both as trans and as male or female. Additionally, one participant noted that having an "Other" gender option without having a fill-in category might potentially have generated feelings of alienation. Of note, there appears to be no research to support or not support this participant feedback, which indicates that this possibility is a significant area of interest for researchers interested in accurately assessing participant gender.

In addition, participants noted that the wording of Demographic Questionnaire in surveying participants' ethnicity and current religious affiliation should be revised in future studies. First, the word "Caucasian" was used as a part of an option (i.e., "White or Caucasian") for participants' ethnic identity. The term "Caucasian" is derived from a racist taxonomy created to justify the enslavement of African peoples and superiority of White/European individuals (Mukhopadhyay, 2016). Literature indicates that this term is, further, functionally redundant in an age in which most who identify as "Caucasian" would likely identify as "White" or "Anglo" as well (Lin & Kelsey, 2000). And, substituting "White" for this outdated term has precedent in social research; the term "White" is used alone as an ethnic identity option on the U.S. Census (Colby & Ortman, 2017). Participants also noted that Catholicism should not have been listed separately

from Christianity. This differentiation has historically occurred in the context of anti-Catholic sentiment among Protestant Christians, sometimes to the effect of institutional discrimination and interpersonal violence (Berg, 2001; Brown & Feener, 2017).

Fifth, the open-ended manner in which therapists' clinical experience (i.e., the approximate number of face-to-face hours total they had accumulated with adult patients in psychotherapy in all contexts in which they had worked) was assessed in the Demographic Questionnaire led to significant loss of data. As noted in the Results section, multiple participants provided non-numerical responses such as "years," wrote that they had accrued "too many to count," or simply skipped the question. One participant wrote in an e-mail that most clinicians "are rarely asked for this total so [answering the question] took some math" and that "it felt confusing for me to try to add up these hours over 10 years of practice." This participant noted that it may have been more productive to decrease the cognitive load involved in this question by asking participants two questions: how many hours per week of face-to-face hours they had provided during their career and, separately, how many years of clinical practice participants had.

Sixth, as noted in the Results section, it was not possible to test the fourth hypothesis in this study because less than 3.0% of the therapist participants in this study identified as digital natives (see Table 1). It is possible to speculate several causes and solutions to this unanticipated issue. First, participants were not directly asked to self-identify as "digital natives" or "digital immigrants." They were asked instead to answer "yes" or "no" to the following prompt: "For most of my childhood, I was surrounded by Internet- and computer-based tools such as smartphones, e-mail, and social media." This

approach poorly captured the digital native concept for U.S.-licensed, doctoral-level psychologists by requiring the widespread use of smartphones and social media applications in one's childhood. This criteria would be best met among digital natives who are currently in high school and college instead. This assessment method is currently flawed but might accomplished its intended purpose in two or three decades.

Millennials are more likely than Generation X and Y doctoral-level psychologists to identify as digital natives (Vogels, 2019). Researchers hoping to capture information regarding this population would potentially benefit from recruiting via the social media platforms that Millennials are most likely to dominate - ones such as Twitter, Reddit, Snapchat, and Instagram (Smith & Anderson, 2019). And, as noted in the Results section, it may have been more useful to participants' comfort with several Internet-based technologies (i.e., using a Likert scale) as an independent variable. A similar alternative to defining participants as digital natives or immigrants would have been asking participants to recall the age at which they first used these Internet-based technologies.

Limitations Related to Recruitment

In an e-mailed reply to the investigators, an APA Division administrator raised one important methodological limitation to any research that employs APA listservs for recruiting doctoral-level psychologists. This administrator noted that nearly half of APA members do not receive e-mails from any Division. This administrator simultaneously noted that many non-doctoral-level therapists also belong to these listservs. As such, use of APA listservs for recruitment excludes this substantial portion of potential participants and potentially invites bias.

An additional recruitment limitation to this study was its low variance in therapist ethnicity. Approximately 80 percent of participants identified as "White or Caucasian." This limitation was consistent with the literature, which states that over 80 percent of psychologists belonging to the APA identified White in 2013 (APA, 2015). Nevertheless, this aspect of the study's findings mean that statistically significant findings cannot be generalized to ethnic minority psychologists.

Limitations Related to Study Design

This study was designed such that participants filled out only one version of the Therapeutic Practices Survey, endorsing either ethicality ratings or practice frequencies for the eight boundary crossings (including one validity item) in this study. This study design allowed for the collection of data on both ethicality ratings and practice frequencies while minimizing the time and effort required for participants to complete the full survey.

An appealing alternative study design would have been to provide each participant both an ethicality ratings and practice frequencies form. This design would have allowed for additional analyses, especially those examining the correlations between participants' ethicality ratings and practice frequencies for each crossing. However, this additional data would have been collected at the cost of adding a significant source of response bias. In that participants would have filled out one Therapeutic Practices Survey form before the next, it is likely that they would have been primed to "autocorrelate" their responses. In other words, whichever form was filled out second would have artificially

resembled the first in terms of participants' responses in order to reduce potential dissonance.

Clinical experience was shown in this study to explain significant variance in psychologists' ethicality ratings and practice frequencies. However, it is possible that what was actually assessed in this study were differences in training / practicing cohorts, as increased age may generally correlate with increased clinical experience. In order to determine the effect of clinical experience alone, these cohort differences would ideally be eliminated via a longitudinal cohort study that tracked variance in ethicality ratings, practice frequencies, and explanatory therapist and client factors as different cohorts gained in clinical experience and, eventually, retired from clinical practice. At the time of this study, there appears to be no such study in publication. Such a study would be ideal in better defining the progression of therapists' ethical decision-making at various stages in their development as clinicians, which in turn would hold substantial value in preparing psychologists for self-aware ethical decision-making throughout their lifetimes.

REFERENCES

Alexander, C., & Charles, G. (2009). Caring, Mutuality and Reciprocity in Social Worker-Client Relationships: Rethinking Principles of Practice. *Journal of Social Work,* 9(1), 5-22.

Alyn, J. H. (1988). The politics of touch in therapy: A response to Willison and Masson. *Journal of Counseling & Development*, *66*(9), 432-433.

American Psychological Association. (1953). Ethical standards of psychologists: A summary of ethical principles. Washington, DC: Author.

American Psychological Association. (1977, March). Ethical standards of psychologists. *APA Monitor*, pp. 22–23.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist*, 47, 1597–1611.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060–1073.

American Psychological Association. (2010). Amendments to the 2002 "Ethical Principles of Psychologists and Code of Conduct" in 2010 and 2016. Retrieved from apa.org/ethics/code

American Psychological Association. (2015, July). Demographics of the U.S. Psychology Workforce Findings from the American Community Survey. Retrieved June 12, 2018, from http://www.apa.org/workforce/publications/13-demographics/report.pdf

American Psychological Association. (2017). Ethical principles of psychologists and code of conduct. Retrieved from https://www.apa.org/ethics/code/ethics-code-2017.pdf

Asay, P. A., & Lal, A. (2014). Who's Googled whom? Trainees' Internet and online social networking experiences, behaviors, and attitudes with clients and supervisors. *Training and Education in Professional Psychology*, *8*(2), 105.

Audet, C. T. (2011). Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers?. *Counselling Psychology Quarterly*, 24(2), 85-100.

Baer, B. E., & Murdock, N. L. (1995). Nonerotic dual relationships between therapists and clients: The effects of sex, theoretical orientation, and interpersonal boundaries. *Ethics & Behavior*, 5(2), 131-145

Barkan, R., Ayal, S., Gino, F., & Ariely, D. (2012). The pot calling the kettle black: distancing response to ethical dissonance. *Journal of Experimental Psychology: General*, *141*(4), 757.

Barker, V. (2009). Older adolescents' motivations for social network site use: The influence of gender, group identity, and collective self-esteem. *Cyberpsychology & Behavior*, *12*(2), 209-213.

Barnes, S. B. (2006). A privacy paradox: Social networking in the United States. *First Monday*, *11*(9).

Bateson, M., Nettle, D., & Roberts, G. (2006). Cues of being watched enhance cooperation in a real-world setting. *Biology letters*, *2*(3), 412-414.

Berg, T. C. (2001). Anti-Catholicism and Modern Church-State Relations. *Loy. U. Chi. LJ*, *33*, 121.

Bersoff, D. N. (1994). Explicit ambiguity: The 1992 ethics code as an oxymoron. *Professional Psychology: Research and Practice*, 25(4), 382.

Beyer, S. (1990). Gender differences in the accuracy of self-evaluations of performance. *Journal of Personality and Social Psychology*, *59*(5), 960.

Borys, D. S. (1994). Maintaining therapeutic boundaries: The motive is therapeutic effectiveness, not defensive practice. *Ethics & Behavior*, 4(3), 267-273.

Borys, D. S., & Pope, K. S. (1989). Dual relationships between therapist and client: A national study of psychologists, psychiatrists, and social workers. *Professional Psychology: Research and Practice*, 20(5), 283.

Brown, B., & Feener, R. M. (2017). Configuring Catholicism in the anthropology of Christianity. *The Australian Journal of Anthropology*, *28*(2), 139-151.

Brown, L. S. (1987, August). Beyond thou shalt not: Developing conceptual frameworks for ethical decision-making. In L. Garnets (Chair), *Ethical and Boundary Issues for Lesbian and Gay psychotherapists*. Symposium presented at the convention of the American Psychological Association, New York.

Brown, L. S. (1989). From perplexity to complexity: Thinking about ethics in the lesbian therapy community. *Women and Therapy*, 8, 13-26.

Brown, L. S. (1991). Ethical issues in feminist therapy. *Psychology of Women Quarterly*, 15(2), 323-336.

Brown, L. S. (1994). Boundaries in feminist therapy: A conceptual formulation. *Women & Therapy*, *15*(1), 29-38.

Canter, M. B., Bennett, B. E., Jones, S. E., & Nagy, T. F. (1994). *Ethics for psychologists: A Commentary on the APA Ethics Code*. American Psychological Association.

Capobianco, J., & Farber, B. A. (2005). Therapist self-disclosure to child patients. *American Journal of Psychotherapy*, *59*(3), 199.

Carnevale, A. P., & Strohl, J. (2013). Separate & Unequal How Higher Education Reinforces the Intergenerational Reproduction of White Racial Privilege.

Caudill Jr, O. B., & Pope, K. S. (1995). *Law & mental health professionals: California*. American Psychological Association.

Colby, S. L., & Ortman, J. M. (2017). Projections of the size and composition of the US population: 2014 to 2060: Population estimates and projections.

Corey, G., Corey, M., & Callanan, P. (2011). *Issues and ethics in the helping professions* (8th ed.). Belmont, CA: Brooks/Cole.

Dallesasse, S. L. (2010). Managing nonsexual multiple relationships in university counseling centers: Recommendations for graduate assistants and practicum students. *Ethics & Behavior,* 20(6), 419-428.

Dana, J., Loewenstein, G., & Weber, R. A. (2012). Ethical immunity: How people violate their own moral standards without feeling they are doing so. *Behavioral Business Ethics: Shaping an Emerging Field*, 201-219.

DeWitt, K. H. (2016). Exploration of appropriate and inappropriate e-disclosure: A qualitative investigation of the decision-making process of counselors in training.

Duggan, M., Ellison, N. B., Lampe, C., Lenhart, A., & Madden, M. (2015). Frequency of social media use. *The Pew Research Center*.

Dunbar, N. E. (2015). A review of theoretical approaches to interpersonal power. *Review of Communication,* 15(1), 1-18.

Durana, C. (1998). The use of touch in psychotherapy: Ethical and clinical guidelines. *Psychotherapy: Theory, Research, Practice, Training*, 24(2), 269.

Edwards, C. E., & Murdock, N. L. (1994). Characteristics of Therapist Self-Disclosure in the Counseling Process. *Journal of Counseling & Development*, *72*(4), 384-389.

Fiske, S. T., & Berdahl, J. (2007). Social power. *Social psychology: Handbook of Basic Principles*, *2*, 678-692.

Fire, M., Goldschmidt, R., & Elovici, Y. (2014). Online social networks: threats and solutions. *IEEE Communications Surveys & Tutorials*, *16*(4), 2019-2036.

French, J. R., Raven, B., & Cartwright, D. (1959). The bases of social power. *Classics of Organization Theory*, *7*, 311-320.

Fromm-Reichmann, F. (1950). Principles of intensive psychotherapy. Chicago: University of Chicago Press, 1950.

Gabbard, G. O. (1994). Teetering on the precipice: A commentary on Lazarus's" how certain boundaries and ethics diminish therapeutic effectiveness". *Ethics & Behavior*, 4(3), 283-386.

Gabbard, G. O., & Crisp-Han, H. (2010). Teaching professional boundaries to psychiatric residents. *Academic Psychiatry*, 34(5), 369-372.

Gibson, M. F. (2012). Opening up: Therapist self-disclosure in theory, research, and practice. *Clinical Social Work Journal*, *40*(3), 287-296.

Gottlieb, M. C. (1993). Avoiding exploitive dual relationships: A decision-making model. *Psychotherapy: Theory, Research, Practice, Training*, *30*(1), 41.

Gottlieb, M. C., & Younggren, J. N. (2009). Is there a slippery slope? Considerations regarding multiple relationships and risk management. *Professional Psychology: Research and Practice*, 40(6), 564.

Gottlieb, M. C., Younggren, J. N., & Murch, K. B. (2009). Boundary management for cognitive behavioral therapies. *Cognitive and Behavioral Practice*, 16(2), 164-171.

Gutheil, T. G., & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. *The American Journal of Psychiatry*.

Gutheil, T. G., & Gabbard, G. O. (1998). Misuses and misunderstandings of boundary theory in clinical and regulatory settings. *American Journal of Psychiatry*, 155(3), 409-414.

Hanley, T., & Reynolds, D. J. (2009). Counselling psychology and the internet: A review of the quantitative research into online outcomes and alliances within text-based therapy. *Counselling Psychology Review*, *24*(2), 4-13.

Harris, S. E., & Robinson Kurpius, S. E. (2014). Social networking and professional ethics: Client searches, informed consent, and disclosure. *Professional Psychology: Research and Practice*, *45*(1), 11.

Hays, D. G., Dean, J. K., & Chang, C. Y. (2007). Addressing privilege and oppression in counselor training and practice: A qualitative analysis. *Journal of Counseling & Development*, *85*(3), 317-324.

Herek, G. M., & Garnets, L. D. (2007). Sexual orientation and mental health. *Annu. Rev. Clin. Psychol.*, *3*, 353-375.

Hess, K. (2017). Therapist Knowledge, Attitudes Toward, and Experiences with Social Media Use in Treating Adolescent Females.

Hill, C. E., & Knox, S. (2001). Self-disclosure. *Psychotherapy: Theory, Research, Practice, Training*, *38*(4), 413.

Hill, M. R., & Mamalakis, P. M. (2001). Family therapists and religious communities: Negotiating dual relationships. *Family Relations*, 50(3), 199-208.

Hoadley, C. M., Xu, H., Lee, J. J., & Rosson, M. B. (2010). Privacy as information access and illusory control: The case of the Facebook News Feed privacy outcry. *Electronic Commerce Research and Applications*, *9*(1), 50-60.

Hyde, J. S., Bigler, R. S., Joel, D., Tate, C. C., & van Anders, S. M. (2018). The future of sex and gender in psychology: Five challenges to the gender binary. *American Psychologist.* Advance online publication.

Jansz, J. (2000). Masculine identity and restrictive emotionality. *Gender and Emotion: Social Psychological Perspectives*, 166-186.

Jent, J. F., Eaton, C. K., Merrick, M. T., Englebert, N. E., Dandes, S. K., Chapman, A. V., & Hershorin, E. R. (2011). The decision to access patient information from a social media site: what would you do?. *Journal of Adolescent Health*, 49(4), 414-420

Johnson, W. B., Ralph, J., & Johnson, S. J. (2005). Managing Multiple Roles in Embedded Environments: The Case of Aircraft Carrier Psychology. Professional psychology: Research and practice, 36(1), 73.

Kagle, J. D., & Giebelhausen, P. N. (1994). Dual relationships and professional boundaries. *Social Work*, 39(2), 213-220.

Kelly, A. E., & Rodriguez, R. R. (2007). Do therapists self-disclose more to clients with greater symptomatology?. *Psychotherapy: Theory, Research, Practice, Training*, *44*(4), 470.

Keith-Spiegel, P., & Koocher, G. P.(1985). *Ethics in psychology: Professional Standards and Cases*.

Kessler, L. E., & Waehler, C. A. (2005). Addressing Multiple Relationships Between Clients and Therapists in Lesbian, Gay, Bisexual, and Transgender Communities. *Professional Psychology: Research and Practice*, 36(1), 66.

Kiselica, M. S. (2003). Transforming psychotherapy in order to succeed with adolescent boys: Male-friendly practices. *Journal of Clinical Psychology*, *59*(11), 1225-1236.

Knapp, S., Handelsman, M. M., Gottlieb, M. C., & VandeCreek, L. D. (2013). The dark side of professional ethics. *Professional Psychology: Research and Practice*, 44(6), 371.

Knox, S., & Hill, C. E. (2003). Therapist self-disclosure: Research-based suggestions for practitioners. *Journal of clinical psychology*, *59*(5), 529-539.

Kolmes, K. (2012). Social media in the future of professional psychology. *Professional Psychology: Research and Practice*, *43*(6), 606.

Kolmes, K., & Taube, D. O. (2014). Seeking and finding our clients on the Internet: Boundary considerations in cyberspace. *Professional Psychology: Research and Practice*, 45(1), 3.

Kolmes, K., & Taube, D. O. (2016). Client discovery of psychotherapist personal information online. *Professional Psychology: Research and Practice*, 47(2), 147.

Koocher, G., & Keith-Spiegel, P. (1998). *Ethics in psychology*. Oxford University Press: NY.

Kwak, H., Lee, C., Park, H., & Moon, S. (2010, April). What is Twitter, a social network or a news media?. In *Proceedings of the 19th International Conference on World Wide Web* (pp. 591-600). ACM.

Johnson, W. B., Ralph, J., & Johnson, S. J. (2005). Managing Multiple Roles in Embedded Environments: The Case of Aircraft Carrier Psychology. *Professional psychology: Research and practice*, 36(1), 73.

Lamb, D. H., & Catanzaro, S. J. (1998). Sexual and nonsexual boundary violations involving psychologists, clients, supervisees, and students: Implications for professional practice. *Professional Psychology: Research and Practice*, 29(5), 498.

Lamb, D. H., Catanzaro, S. J., & Moorman, A. S. (2003). Psychologists reflect on their sexual relationships with clients, supervisees, and students: Occurrence, impact, rationales and collegial intervention. *Professional Psychology: Research and Practice*, 34(1), 102.

Lamont, R. A., Swift, H. J., & Abrams, D. (2015). A review and meta-analysis of age-based stereotype threat: Negative stereotypes, not facts, do the damage. *Psychology and aging*, *30*(1), 180.

Langs, R. (1982). Psychotherapy: A Basic Text New York: Jason Aronson.

Lazarus, A. A. (1994). How certain boundaries and ethics diminish therapeutic effectiveness. *Ethics & behavior*, 4(3), 255-261.

Lehavot, K., Barnett, J. E., & Powers, D. (2010). Psychotherapy, professional relationships, and ethical considerations in the myspace generation. *Professional Psychology: Research and Practice*, *41*(2), 160.

Levitt, D. H., Farry, T. J., & Mazzarella, J. R. (2015). Counselor ethical reasoning: Decision- making practice versus theory. *Counseling and Values*, *60*(1), 84-99.

Levitt, H. M., Minami, T., Greenspan, S. B., Puckett, J. A., Henretty, J. R., Reich, C. M., & Berman, J. S. (2016). How therapist self-disclosure relates to alliance and outcomes: A naturalistic study. *Counselling Psychology Quarterly*, *29*(1), 7-28.

Lin, S. S., & Kelsey, J. L. (2000). Use of race and ethnicity in epidemiologic research: concepts, methodological issues, and suggestions for research. *Epidemiologic reviews*, *22*(2), 187-202.

Litt, E. (2012). Knock, knock. Who's there? The imagined audience. *Journal of Broadcasting & Electronic Media*, *56*(3), 330-345.

Mahalik, J. R., Van Ormer, E. A., & Simi, N. L. (2000). Ethical issues in using self-disclosure in feminist therapy. *Practicing Feminist Ethics in Psychology*, 189-201.

Marwick, A. E., & boyd, d. (2011). I tweet honestly, I tweet passionately: Twitter users, context collapse, and the imagined audience. *New media & society*, *13*(1), 114-133.

Mathews, B. (1989). The use of therapist self-disclosure and its potential impact on the therapeutic process. *Journal of Human Behavior & Learning*.

Mattu, A. (2019). the Psych Show. Retrieved December 9, 2019 from https://www.youtube.com/user/thepsychshowdotcom.

McGough, B. L., & Salomon, D. (2013). Engaging students through social media. In Proceed*ings of the Charleston Library Conference* (pp. 283-286).

McMinn, M. R., Buchanan, T., Ellens, B. M., & Ryan, M. K. (1999). Technology, professional practice, and ethics: Survey findings and implications. Professional Psychology: Research and Practice, 30(2), 165.

Mearns, J., & Allen, G. J. (1991). Graduate students' experiences in dealing with impaired peer, compared with faculty predictions: An exploratory study. *Ethics & Behavior*, *1*(3), 191-202.

Menninger, K. (1958). Theory of psychoanalytic technique.

Mintz, E. (1973). On the rationale of touch in psychotherapy. In E. Hendrik and M. Ruitenbeck (Eds.), *The analytic situation. How patient and therapist communicate*. Chicago: Aldine Publishing Company.

Moleski, S. M., & Kiselica, M. S. (2005). Dual relationships: A continuum ranging from the destructive to the therapeutic. *Journal of Counseling & Development*, 83(1), 3-11.

Mukhopadhyay, C. C. (2016). Getting rid of the word" Caucasian. *Privilege: A Reader*, 21.

Neville, H. A., Worthington, R. L., & Spanierman, L. B. (2001). Race, power, and multicultural counseling psychology: Understanding white privilege and color-blind racial attitudes. *Handbook of Multicultural Counseling*, 257-288.

Nguyen, H. H. D., & Ryan, A. M. (2008). Does stereotype threat affect test performance of minorities and women? A meta-analysis of experimental evidence. *Journal of Applied Psychology*, *93*(6), 1314.

O'Keeffe, G. S., & Clarke-Pearson, K. (2011). The impact of social media on children, adolescents, and families. *Pediatrics*, *127*(4), 800-804.

O'Leary, P., Tsui, M. S., & Ruch, G. (2012). The boundaries of the social work relationship revisited: Towards a connected, inclusive and dynamic conceptualisation. *British Journal of Social Work*, 43(1), 135-153.

Oransky, M., & Marecek, J. (2009). "I'm not going to be a girl" masculinity and emotions in boys' friendships and peer groups. *Journal of Adolescent Research*, *24*(2), 218-241.

Pattison, J. E. (1973). Effects of touch on self-exploration and the therapeutic relationship. *Journal of Consulting and Clinical Psychology*, *40*(2), 170.

Pedersen, D. M. (1973). Self-disclosure, body-accessibility, and personal space. *Psychological Reports*, *33*(3), 975-980.

Pempek, T. A., Yermolayeva, Y. A., & Calvert, S. L. (2009). College students' social networking experiences on Facebook. *Journal of applied developmental psychology*, *30*(3), 227-238.

Petrides, K. V., & Furnham, A. (2000). Gender differences in measured and self-estimated trait emotional intelligence. *Sex roles*, *42*(5-6), 449-461.

Pope, K. S. (1990). Therapist-patient sex as sex abuse: Six scientific, professional, and practical dilemmas in addressing victimization and rehabilitation. *Professional Psychology: Research and Practice*, *21*(4), 227.

Pope, K. S., & Bajt, T. R. (1988). When laws and values conflict: A dilemma for psychologists. *American Psychologist*, *43*(10), 828.

Pope, K. S., & Keith-Spiegel, P. (2008). A practical approach to boundaries in psychotherapy: Making decisions, bypassing blunders, and mending fences. *Journal of Clinical Psychology*, 64(5), 638-652.

Pope, K. S., Tabachnick, B. G., & Keith-Spiegel, P. (1987). Ethics of practice: The beliefs and behaviors of psychologists as therapists. *American Psychologist*, 42(11), 993.

Pope, K. S., & Vasquez, M. J. (1991). *Ethics in Psychotherapy and Counselling.* San Francisco: Josey-Bass.

Pope, K. S., & Vasquez, J. M. T. (2007). *Ethics in Psychotherapy and Counseling: A Practical Guide for Psychologists.* (3rd ed.). San Francisco: Josey-Bass.

Pope, K. S., & Vetter, V. A. (1992). Ethical dilemmas encountered by members of the American Psychological Association: A national survey. *American Psychologist*, *47*(3), 397.

Prensky, M. (2001). Digital natives, digital immigrants part 1. *On the horizon*, *9*(5), 1-6.

Pugh, R. (2006). Dual relationships: Personal and professional boundaries in rural social work. *British Journal of Social Work*, 37(8), 1405-1423.

Qualtrics, I. (2013). Qualtrics. com. *Provo, UT, USA.*

Ramsdell, P. S., & Ramsdell, E. R. (1993). Dual relationships: Client perceptions of the effect of client-counselor relationship on the therapeutic process. *Clinical Social Work Journal*, 21(2), 195-212.

Raven, B. H. (1993). The bases of power: Origins and recent developments. *Journal of social issues*, 49(4), 227-251.

Raven, B. H. (2008). The bases of power and the power/interaction model of interpersonal influence. *Analyses of Social Issues and Public Policy*, 8(1), 1-22.

Raven, B. H., & Kruglanski, A. W. (1970). Conflict and power. *The structure of conflict*, 69-109.

Rogers, C. (1942). *Counseling and Psychotherapy*. Boston: Houghton Mifflin.

Ruedy, N. E., & Schweitzer, M. E. (2010). In the moment: The effect of mindfulness on ethical decision making. *Journal of Business Ethics*, *95*(1), 73-87.

Satir, V. (1972). *Peoplemaking*. Science and Behavior Books.

Sawyer, S., & Prescott, D. (2011). Boundaries and dual relationships. *Sexual Abuse*, 23(3), 365-380.

Schank, J. A., & Skovholt, T. M. (1997). Dual-relationship dilemmas of rural and small-community psychologists. *Professional Psychology: Research and Practice*, 28(1), 44.

Schmader, T., Johns, M., & Forbes, C. (2008). An integrated process model of stereotype threat effects on performance. *Psychological review*, *115*(2), 336.

Schoener, G. R. (1995). Assessment of professionals who have engaged in boundary violations. *Psychiatric Annals*, 25, 95-99.

Simon, R. I. (1991). Psychological injury caused by boundary violation precursors to therapist patient sex. *Psychiatric Annals*, 21(10), 614-619.

Simon, R. I. (1992). Treatment boundary violations: Clinical, ethical, and legal considerations. *Journal of the American Academy of Psychiatry and the Law Online*, 20(3), 269-288.

Simon, R. I. (1995). The natural history of therapist sexual misconduct: identification and prevention. *Psychiatric Annals*, 25(2), 90-94.

Simon, R. I., & Williams, I. C. (1999). Maintaining treatment boundaries in small communities and rural areas. *Psychiatric Services*, 50(11), 1440-1446.

Simone, D. H., McCarthy, P., & Skay, C. L. (1998). An Investigation of Client and Counselor Variables That Influence Likelihood of Counselor Self-Disclosure. Journal of Counseling & Development, 76(2), 174-182.

Skeels, M. M., & Grudin, J. (2009, May). When social networks cross boundaries: a case study of workplace use of facebook and linkedin. In *Proceedings of the ACM 2009 International Conference on Supporting Group Work* (pp. 95-104). ACM.

Smith, A., & Anderson, M. (2019, April 17). Social Media Use 2018: Demographics and Statistics. Retrieved from https://www.pewinternet.org/2018/03/01/social-media-use-in-2018/.

Smith, D., & Fitzpatrick, M. (1995). Patient-therapist boundary issues: An integrative review of theory and research. *Professional psychology: Research and Practice*, 26(5), 499

Sommers-Flanagan, R., Elliott, D., & Sommers-Flanagan, J. (1998). Exploring the edges: Boundaries and breaks. *Ethics & behavior*, 8(1), 37-48.

Sonne, J. L. (1994). Multiple relationships: Does the new ethics code answer the right questions?. *Professional Psychology: Research and Practice*, 25(4), 336

Sonne, J.L. & Weniger, J.L. (2018). Ethical clinical practice: Negotiating a whole lot of gray in a wise way. In Butcher, J.N., Hooley, J.M., & Kendall, P.C. (Eds.) *AP Handbook of Psychopathology* (pp. 729-749). Washington, DC: American Psychological Association.

Spencer, S. J., Steele, C. M., & Quinn, D. M. (1999). Stereotype threat and women's math performance. *Journal of Experimental Social Psychology*, *35*(1), 4-28.

Steele, C. M., & Aronson, J. (1995). Stereotype threat and the intellectual test performance of African Americans. *Journal of personality and social psychology*, *69*(5), 797.

Stutzman, F., Gross, R., & Acquisti, A. (2013). Silent listeners: The evolution of privacy and disclosure on facebook. *Journal of privacy and confidentiality*, *4*(2), 2.

Taylor, L., McMinn, M. R., Bufford, R. K., & Chang, K. B. (2010). Psychologists' attitudes and ethical concerns regarding the use of social networking web sites. *Professional Psycholo*

Tenbrunsel, A. E., Diekmann, K. A., Wade-Benzoni, K. A., & Bazerman, M. H. (2010). The ethical mirage: A temporal explanation as to why we are not as ethical as we think we are. *Research in Organizational Behavior*, *30*, 153-173.

Tenbrunsel, A. E., & Messick, D. M. (2004). Ethical fading: The role of self-deception in unethical behavior. *Social justice research*, *17*(2), 223-236.

Thompson, C. E., & Neville, H. A. (1999). Racism, mental health, and mental health practice. *The Counseling Psychologist*, *27*(2), 155-223.

Tomm, K. (1993). The ethics of dual relationships. *The California Therapists*, Jan./Feb., 7-19.

Van Dijck, J. (2013). 'You have one identity': performing the self on Facebook and LinkedIn. *Media, Culture & Society*, *35*(2), 199-215.

Tunick, R. A., Mednick, L., & Conroy, C. (2011). A snapshot of child psychologists' social media activity: Professional and ethical practice implications and recommendations. *Professional Psychology: Research and Practice*, *42*(6), 440.

Van Deursen, A. J., Bolle, C. L., Hegner, S. M., & Kommers, P. A. (2015). Modeling habitual and addictive smartphone behavior: The role of smartphone usage types, emotional intelligence, social stress, self-regulation, age, and gender. *Computers in Human Behavior*, *45*, 411-420.

Vitak, J. (2012). The impact of context collapse and privacy on social network site disclosures. *Journal of Broadcasting & Electronic Media*, *56*(4), 451-470.

Vogels, E.A. (2019, September 9). Millenials stand out for their technology use, but older generations also embrace digital life. Retrieved from https://www.pewresearch.org/fact-tank/2019/09/09/us-generations-technology-use/.

Weiser, E. B. (2000). Gender differences in Internet use patterns and Internet application preferences: A two-sample comparison. *Cyberpsychology and behavior*, *3*(2), 167-178.

Welfel, E.R. (2002). *Ethics in counseling and psychotherapy: Standards, research, and emerging issues* (2nd Ed.) Pacific Grove, CA: Brooks/Cole.

Williams, D. G. (1985). Gender, masculinity-femininity, and emotional intimacy in same-sex friendship. *Sex Roles*, *12*(5-6), 587-600.

Wilson, J. M. (1982). The value of touch in psychotherapy. *American Journal of Orthopsychiatry*, *52*(1), 65-72.

Wolberg, L. R. (1954). The technique of psychotherapy. New York, New York: Jason Aronson, Inc.

Yeadon-Lee, T. (2017). Non-binary gender identities: challenges and opportunities for re-making gender. In: *The Annual Brighton Trans and Non-Binary Conference* 207, 20.07.2017, University of Brighton, Brighton, UK. (Unpublished).

Ziv-Beiman, S. (2013). Therapist self-disclosure as an integrative intervention. *Journal of Psychotherapy Integration*, *23*(1), 59.

Zur, O. (2000). Going too far in the right direction: Reflections on the mythic ban of dual relationships. *The California Psychologist*, *33*(4), 14-16.

Zur, O. (2001). Out-of-office experience: When crossing office boundaries and engaging in dual relationships are clinically beneficial and ethically sound. *Independent Practitioner*, 21(1), 96-100.

Zur, O. (2004). To cross or not to cross: Do boundaries in therapy protect or harm. *Psychotherapy Bulletin*, *39*(3), 27-32.

Zur, O. (2007). Touch in therapy and the standard of care in psychotherapy and counseling: Bringing clarity to illusive relationships. *US Association of Body Psychotherapy Journal*, 6, 61, 93.

Zur, O. (2008). Re-Thinking the "Power Differential" in Psychotherapy: Exploring the Myth of Therapists' Omnipotence and Patients' Fragility. *Voice: The Art and Science of Psychotherapy*, 44 (3), 32-40.

Zur, O., & Lazarus, A. A. (2002). Six arguments against dual relationships and their rebuttals. Dual relationships and psychotherapy. Adapted from: *Dual Relationships and Psychotherapy*. New York, New York: Springer.

Zur, O., Williams, M. H., Lehavot, K., & Knapp, S. (2009). Psychotherapist self-disclosure and transparency in the Internet age. *Professional Psychology: Research and Practice*, *40*(1), 22.

Appendix A

Recruitment Post

Hello everyone!

I am a Ph.D. clinical psychology graduate student in the Department of Psychology at Loma Linda University. I am recruiting doctoral-level clinical psychologists (Ph.D./Psy.D.), who are U.S.-licensed therapists and see adult therapy patients to participate in my dissertation survey study, chaired by Dr. Janet Sonne. Survey questions will address your decision-making regarding relational boundaries with clients. Participation is expected to take only about 10 minutes of your time and will involve your online completion of an informed consent form, a demographics questionnaire, and an 8-item survey. This study has been approved by Loma Linda University's IRB. Below is the link to the study:

https://llu.co1.qualtrics.com/jfe/form/SV_7QwKeGVBo82vrj7

Regardless of whether you choose to participate in my dissertation study by accessing the link above or not, and with the gracious support of Loma Linda University's Department of Psychology, I can offer you the opportunity to win one of four $100 Amazon gift cards. To enter, please e-mail me before July 1, 2019 at kawu@llu.edu with "ETHICAL DECISIONMAKING" in the subject line and state that you would like to enter this drawing. The four winners of the drawing will be e-mailed by me the code for their Amazon gift card.

Please note that your e-mail to me and e-mail address will not be used for any purpose other than for notifying you if you have won a gift card. And, if you do decide to participate in my study, your e-mail to me and e-mail address will be securely stored separately from and not linked to your questionnaire or survey responses. And, finally, your e-mail to me and your e-mail address will be deleted from my computer files at the end of the drawing.

Thank you very much for your time,

Katherine Wu, M.A.
Loma Linda University
Loma Linda, California

Appendix B

Demographic Questionnaire

1. How do you identify in terms of gender?
    a. Female
    b. Male
    c. Nonbinary
    d. Transgender Male to Female
    e. Transgender Female to Male
    f. Genderfluid
    g. Uncertain
    h. Other

2. Your age (in years):
   [Fill in the blank]

3. Is this statement True or False for you?

   For most of my childhood, I was surrounded by Internet- and computer-based tools such as smartphones, e-mail, and social media.

    a. True
    b. False

4. What is your ethnic background?
    a. American Indian or Alaska Native
    b. Asian/Southeast Asia or Far East
    c. Asian/Indian Subcontinent
    d. Middle Eastern
    e. Black or African American
    f. Hispanic or Latino
    g. Native Hawaiian or Other Pacific Islander
    h. White or Caucasian
    i. Mixed
    j. Other

5. What is your current religious affiliation?
    a. Agnosticism
    b. Atheism
    c. Buddhism
    d. Catholicism

e. Christianity
f. Humanism
g. Hinduism
h. Islam
i. Jainism
j. Judaism
k. Sikhism
l. Other

6. What is your most advanced degree in clinical psychology?
   [Fill in the blank]

7. Are you currently licensed or certified to practice clinical psychology?
   a. Yes
   b. No

8. If you are licensed or certified to practice clinical psychology, in what state/states are you licensed or certified? (Write "NA if you are not currently licensed or certified).
   [Fill in the blank]

9. Have you ever been sanctioned by a state licensing or certification board?
   a. Yes
   b. No

10. Has your license or certification ever been suspended (put on probation) by a state certification board?
    a. Yes
    b. No

11. Has your license or certification ever been revoked by a state licensing or certification board?
    a. Yes
    b. No

12. Are you currently engaged in a clinical practice in which you see adult patients in psychotherapy?
    a. Yes
    b. No

13. In what state is your clinical practice located?
    [Fill in the blank]

14. What is the geographical context of your practice?
    a. Urban
    b. Suburban
    c. Rural
    d. Military Base
    e. Other

15. Recognizing that you may have varied the time involved in clinical practice per week over the course of your career to date since graduate school, approximately how many face-to-face hours total have you accumulated with adult patients in psychotherapy in all contexts in which you have worked?
    [Fill in the blank]

16. What theoretical orientation do you use as a foundation for conceptualizing your therapy patients regardless of the actual interventions you use?
    a. Cognitive-Behavioral (including CBT and DBT)
    b. Emotion-Focused
    c. Gestalt
    d. Humanistic
    e. Jungian
    f. Psychodynamic
    g. Psychoanalytic
    h. Religious-Based
    i. Other

Appendix C

Therapeutic Practices Survey: Practice Frequencies Form

Please rate each of these behaviors in terms of how often you have engaged in this behavior in your practice.

	1 *Never*	2 *Rarely*	3 *Sometimes*	4 *Fairly Often*	5 *Very Often*
1. I have disclosed personal information about myself to a female/male client. (*Deliberate in-person self-disclosure*)					
2. I have advertised online via an online personal biography/CV (e.g., on a faculty practice's web page), my practice's website, online listings (e.g., on a HMO's list of providers), and/or advertisements (e.g., on Facebook or other websites). (*Deliberate digital self-disclosure*)					
3. I have searched for information about a female/male client online via search engines (e.g., Google) or social media (e.g., Facebook). (*Searching for client information online*)					
4. I have accepted a social media connection request (e.g., to be Facebook friends) from a female/male client. (*Social Media Connection*)					
5. I have used social media platforms such as YouTube, Tumblr, Twitter, Instagram, or Facebook to provide online psychoeducation. (*Social Media Psychoeducation*)					

6. I have provided therapy to a female/male client who is in one of my social circles (e.g., same religious organization, parent-teacher organization, advocacy group). (Social *NSMR*)					
7. I have provided therapy to a current female/male supervisee. (Professional *NSMR*)					
8. I have accepted a handshake offered by a female/male client. (*Validity Question*)					

Appendix D

Therapeutic Practices Survey: Ethicality Ratings Form

Please rate each of these 8 behaviors in terms of the extent to which you consider the practice ethical.

	1 *Unquestionably Unethical*	2 *Ethical Under Rare Circumstances*	3 *Don't know/ Not sure*	4 *Ethical Under Many Circumstances*	5 *Unquestionably Ethical*
1. Disclosing personal information about myself to a female/male client. (*Deliberate in-person self-disclosure*)					
2. Advertising online via an online personal biography/CV (e.g., on a faculty practice's web page), my practice's website, online listings (e.g., on a HMO's list of providers), and/or advertisements (e.g., on Facebook or other websites). (*Deliberate digital self-disclosure*)					
3. Searching for information about a female/male client online via search engines (e.g., Google) or social media (e.g., Facebook). (*Searching for client information online*)					

4. Accepting social media connection requests (e.g., to be Facebook friends) from a female/male client. (*Social Media Connection*)					
5. Using social media platforms such as YouTube, Tumblr, Twitter, Instagram, or Facebook to provide online psychoeducation. (*Social Media Psychoeducation*)					
6. Providing therapy to a female/male client who is also in one of my social circles (e.g., same religious organization, parent-teacher organization, advocacy group). (Social *NSMR*)					
7. Providing therapy to a current female/male supervisee. (Professional *NSMR*)					
8. Accepting a handshake offered by a female/male client. (*Validity Question*)					

Appendix E

Informed Consent

Loma Linda University
School of Behavioral Health
11130 Anderson Street
Department of Psychology
Loma Linda, California

Title:	Therapist and Patient Factors in Ethical Decision-Making
SPONSOR:	LLU Department of Psychology
PRINCIPAL INVESTIGATOR:	Janet Sonne, Ph.D.

WHY IS THIS STUDY BEING DONE?

The purpose of the study is to examine factors that affect therapists' decisions regarding relational boundaries with adult therapy clients. You are invited to participate in this study if you hold a doctoral degree (Ph.D. or Psy.D.) in clinical psychology, currently hold a license in good standing to practice psychology in at least one U.S. state, and currently see adult clients in therapy. We hope to recruit at least 260 participants.

HOW WILL I BE INVOLVED?

Participation in this study involves your completion and submission of an online demographic questionnaire and a brief survey form asking about your decision-making regarding relational boundaries with adult psychotherapy clients. The total time expected for completion of these documents is about 10 to 15 minutes. You may also elect to voluntarily enter a drawing for one of four $100 Amazon gift cards whether or not you decide to participate in or complete the study, as described in our study recruitment post.

WHAT ARE THE REASONABLY FORESEEABLE RISKS OR DISCOMFORTS I MIGHT HAVE?

This study poses no greater risk to you than what you would routinely encounter in day-to-day life. We will be asking some potentially sensitive questions regarding your negotiation of various relational boundaries with your adult psychotherapy clients that may cause some discomfort or distress as you consider and submit your responses. None of the potential boundary crossings presented, however, are de facto unethical or illegal.

We have taken the following precautions to mitigate the possibility of your discomfort or distress as you respond to the survey. First, you have the right to refuse to answer any question you choose not to answer. And, you may withdraw from the study at any time.

Second, we have engaged a number of safeguards to protect the confidentiality of your responses. Your online survey responses are not linked to any information regarding your individual identity, and you are not asked to provide any specific identifying information on the documents you will complete beyond general demographic information (e.g., gender, etc.). The survey platform (Qualtrics) is configured so as to automatically delete location data and IP addresses; this is accomplished via activating an "Anonymize Responses" option for this survey.

If you decide to enter the drawing and submit your e-mail address to the student investigator as described in the recruitment post, neither your e-mail nor your e-mail address will be linked in any way to your survey responses should you participate in the study, nor used for any other purpose other than to notify you that you have won a gift card. Your survey responses and your e-mail and your e-mail address will be securely and separately stored in electronic password-protected files stored on a Loma Linda University-based drive. No hard copies of survey results or e-mails or e-mail address entries will be made or distributed. All e-mails and e-mail addresses will be deleted from the student investigator's computer files immediately following notification of the winners of the results of the drawing. All survey data will be kept for 3 years after the completion of the study.

Further, any survey answers you provide will be analyzed only in combination with other participants' answers. As such, any publications or presentations that are based on this research project will refer only to analyses of group results.

WILL THERE BE ANY BENEFIT TO ME OR OTHERS?

You have the option of entering a drawing for one of four $100 Amazon gift cards regardless of whether you participate in or fully complete this study. Entry in the drawing is completely voluntary. Your e-mail to the student investigator expressing your desire to be entered into the drawing and your e-mail address will not be used for any purpose other than notifying you that you have won a gift card. Your e-mail and e-mail address will be securely stored and not linked in any way to your responses on the demographic questionnaire or the survey. Further, your e-mail to the student investigator and your e-mail address will be deleted from the student investigator's files at the end of the drawing.

Other than the potential for winning one of the Amazon gift cards, you are not likely to benefit directly from participation in this study. However, the findings of this study may benefit the profession of clinical psychology, therapists, and clients by informing ethical decision-making among licensed clinical psychologists rendering clinical services to adult patients, and, consequently enhancing the standard of care.

WHAT ARE MY RIGHTS AS A STUDY PARTICIPANT?

Your participation in this study and your entry into the drawing are separate, and each entirely voluntary. You may refuse to participate at the outset of this study. You may

refuse to answer any questions in the study that you do not wish to answer. And, you may withdraw from the study at any time once the study has started. Regardless of whether or not you participate in the study, you may choose to enter the drawing or you may choose not to. You may also print a copy of this Informed Consent Form.

WHAT COSTS ARE INVOLVED?

There is no cost to you for participating in this study.

WILL I BE PAID TO PARTICIPATE IN THIS STUDY?

You will not be paid to participate in this research study.

WHO DO I CALL IF I HAVE QUESTIONS?

If you have questions about this research study, please do not hesitate to contact the graduate student investigator, Katherine Wu, at (949) 861-0907 or at kawu@llu.edu, or the Research Committee Chair, Dr. Janet Sonne, at (909) 558-9138 or at jsonne@llu.edu.

If you would like to contact an impartial third party who is not associated with this study regarding concerns you have about this study, please contact the Office of Patient Relations, Loma Linda University Medical Center, Loma Linda CA 92354 by emailing patientrelations@llu.edu or calling (909) 558-4647.

PARTICIPANT'S STATEMENT OF INFORMED CONSENT

I have read the contents of this consent form and have been given an opportunity to ask questions regarding this study. I have been provided an option to print a copy of this informed consent form.

I hereby indicate below my voluntary consent or non-consent to participate in this study. This does not waive my rights, nor does it release the investigators or institution from their responsibilities. I may call or email Dr. Janet Sonne (909-558-9138; jsonne@llu.edu) if I have additional questions or concerns.

Thank you for your time and consideration.

Appendix F

List of Professional Facebook Groups Contacted for Recruitment Purposes

1. Acceptance and Commitment Therapy
2. Addiction Professional Referral Group
3. Addiction Therapists Group
4. Asian American Christian Therapists
5. Asian Therapists
6. Attachment-Based Therapists
7. Austin Mental Health Professionals
8. AZ Mental Health Professionals
9. BLACK THERAPISTS ROCK!
10. Chattanooga Mental Health Professionals
11. Clinicians of Color in Private Practice
12. DC Therapist Connect
13. EMDR Therapy Practitioners
14. Emotionally Focused Therapy Group
15. Filipino American Mental Health Practitioners
16. Florida Mental Health Professionals
17. Inland Empire Shrinks
18. Kalamazoo Mental Health Professionals Network
19. Knoxville Mental Health Professionals
20. LA Therapists
21. Latinx Psychotherapists
22. LGBQIA and Trans Affirming Therapists
23. Maternal Mental Health Professionals
24. Melanin & Mental Health Professional Groups
25. Mental Health Professionals
26. Mental Health Professionals and Social Workers of SE Michigan
27. Mental Health Professionals of California
28. Mental Health Professionals of Fairfield County, CT
29. Midsouth Therapist Network Page
30. Mississippi Mental and Behavioral Health Professionals
31. MN LGBTQ+ Therapists Network
32. Montana Mental Health Professionals
33. Muslim Mental Health Professionals and Students
34. My Private Practice Tribe
35. NOLA Counselors
36. North Texas Mental Health Professionals
37. NQTTCN
38. Online Therapists Group
39. Orange County Shrinks
40. Perinatal Mental Health Professionals
41. Portland Oregon Mental Health Professionals
42. Private Practice Therapists of Rochester, NY

43. Professional Mental Health Counselors, Social Workers, and Psychologists
44. Radical Social Work Group
45. San Francisco Bay Area Psychotherapists
46. SD Mental Health Professionals
47. Self-Care for Therapists
48. South Florida Psychotherapists
49. Southern Wisconsin Mental Health Professionals Resource Networking
50. Therapist Community
51. Therapists in Corvallis & Albany
52. Therapists of Las Vegas
53. TIPP
54. Vegan Therapists and Mental Health Workers

Appendix G

List of Professional E-mail Listservs Contacted for Recruitment Purposes

1. American Psychological Association, Division 12
2. American Psychological Association, Division 35
3. American Psychological Association, Division 42
4. American Psychological Association, Division 43
5. Asian-American Psychological Association
6. National Latinx Psychological Association
7. Alabama Psychological Association
8. Arkansas Psychological Association
9. California Psychological Association
10. Iowa Psychological Association
11. Kansas Psychological Association
12. Kentucky Psychological Association
13. Maine Psychological Association
14. Minnesota Psychological Association
15. New Hampshire Psychological Association
16. New York State Psychological Association
17. Pennsylvania Psychological Association
18. Texas Psychological Association
19. Wyoming Psychological Association