

Social Media in the Future of Professional Psychology

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Abstract

In the past several years, the practice and profession of psychology have been greatly influenced by digital culture and social media. The prevalence of psychologists using websites and technology to engage, socialize, market, and interact has created new opportunities and challenges for the practitioner, particularly in regard to potential therapeutic and extra-therapeutic interactions with clients on the web. Given the speed with which these media are permeating our world, we can expect to see a proliferation of new issues, challenges, and opportunities for clinical practice and the delivery of services. This article provides an overview of the relevant issues, ongoing trends, and what the future holds for psychology, psychologists, and the populations we serve. How current technological and policy shifts may influence clinical practice, clinical training, and our responsibilities as providers of clinical care will be addressed.

Keywords: Internet, social media, technology, digital culture, ethics, practice

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Introduction

Social networking sites are becoming a standard means of living and interacting. Two thirds (66%) of American adults use social media sites such as Facebook, Twitter, LinkedIn, and MySpace (Smith, 2011). Many of these sites are being accessed by mental health professionals who are using them to connect socially with peers, network with other professionals, and provide education to consumers of psychological services. This article provides an overview of the pertinent issues, continuing trends, and the future outlook for psychology, psychologists, and the people we serve. It will address how shifts in current and future technology and policy may affect clinical care, clinical training, and our responsibilities as clinicians. Applicable ethical issues as well as potential dilemmas for practitioners will be defined.

The primary activities that occur on social networking sites include the exchange of messages, news items, events, photos, videos, and the quick sharing of additional information through “liking,” “sharing,” “retweeting,” and “+1,” actions. However, the development of new technologies is increasing at a pace that makes it difficult for clinicians to fully understand the ethical implications of their activities on these sites. As a consequence, this creates challenges for clinical training programs to provide adequate supervision and training on how to manage the development of trainees’ professional identities with their online presence. This can prove even more onerous when one’s online presence began primarily as a social one, early in life, as is the case for many “digital natives,” (Prensky, 2001) who were born during or after the introduction of digital technology and are entering psychology programs today. At the same time, digital natives are being taught and supervised by “digital immigrants,” (individuals born before the existence of digital technology who have adopted it later in life) who do not always fully

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perceive the nuances of digital culture. This wave of plugged in consumers and clinicians who are fluent in online culture and social networks will influence our cultural understandings of digital interactions and the delivery of services in ways that we are only beginning to comprehend and in some other ways that are difficult to predict.

At the same time, technological advances are creating exciting new ways for psychologists to offer help to their clients. Some clinicians are using text (via blogging or e-mail), audio recordings, and videochat (such as YouTube, Skype or other videoconferencing systems) to provide a range of services from psychoeducation to psychotherapy. Others are using applications and other technological tools to augment treatment, measure progress, and make therapeutic interventions.

The most commonly used social networking sites by Americans include Facebook, Twitter, and LinkedIn. Facebook currently reports having more than 800 million active users (Facebook, 2011). As of November 3, 2011, LinkedIn claimed to operate the world's largest professional network on the Internet with more than 135 million members in more than 200 countries and territories (LinkedIn, 2011). Twitter reported more than 300 million users as of 2011, generating more than 300 million tweets and handling more than 1.6 billion search queries per day (Wikipedia, 2011).

Digital Transparency

Recent research indicates that clinicians and clients are experiencing a different type of transparency when it comes to sharing online spaces. In some ways, this type of visibility and accessibility mirrors the offline interactions that have been occurring between clinicians and clients in rural communities and discrete communities within cities, where it is harder to prevent

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client-psychotherapist overlaps in other aspects of the shared community (Zur, 2006). One of the more common forms of both intentional and accidental discovery of client information on the Internet is the unearthing of shared or overlapping friend networks on social media sites (Kolmes & Taube, 2010). This experience of access and visibility may be magnified for clients and clinicians who identify as members of shared cultural groups either through ethnicity, sexual orientation, disability, religion, substance recovery programs, or even professional networking groups.

Some have encouraged clinicians to regularly search for online information about themselves in order to ascertain what clients may discover about them on the Internet (Zur & Donner, 2009). Several years ago, clinicians seemed primarily focused on concerns that clients might discover information about them on the Internet. Nevertheless, such discoveries may never be brought to the attention of clinicians. Research on 332 psychotherapy clients found that although 70% of clients reported finding personal information about their psychotherapist on the Internet, only 28% discussed these findings with their psychotherapist (Kolmes & Taube, 2011). Most of these discoveries occurred on Google, Facebook, and LinkedIn. Many of these clients admitted to feelings of shame, discomfort, and embarrassment for seeking out information about their psychotherapist and they worried that disclosing these searches to their psychotherapist would result in judgment or rejection.

More recently, there has been a sharper focus on the ethics and clinical effects of psychotherapists using Internet search engines and social networking sites to seek and obtain information about those whom they are treating. Lehavot, Barnett, and Powers (2010) found that 27% of student psychotherapists had sought information about clients on the Internet. Their

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respondents reported both positive and negative influences of such search behavior on the clinical relationship. Lal and Asay (Martin, 2010) reported that 22% of 193 clinical psychology graduate students had Googled their psychotherapy clients. In a survey of 227 multidisciplinary psychotherapists, Kolmes and Taube (2010) found that 28% accidentally found information about current psychotherapy clients online whereas 48% intentionally sought this information. Facebook and Google were most commonly reported as the sites of discovery. A more recent study by DeLillo and Gale (2011), surveyed 854 doctoral students in psychology and found that despite their beliefs that it was usually unacceptable to use search engines or social networking sites to find client information, 97.8% had still reported doing so at least once in the past year.

When it comes to working with younger populations, Tunick, Mednick, and Conroy (2011), surveyed 246 psychologists and trainees about their behavior around their adolescent clients' online presence. Many reported being concerned about items they found on clients' social media profiles. Jent, et al. (2011) found that trainees are conducting social media searches on their clients that faculty would not endorse—suggesting that there is a divide between the beliefs and practices of trainees and faculty, which again, may reflect the distinction made between digital natives who are growing up in a point and click culture and digital immigrants who did not come of age at a time when this was de rigueur.

Consumers Using Social Media To Find Health Information

The Pew Foundation (Fox, 2011) has found that 80% of Americans have looked online for health information, whereas 34% of Internet users and 25% of adults have read someone else's commentary or experience about health or medical issues online. Another 16% have sought out online reviews of doctors. People are seeking out support groups, looking for health

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care providers, and checking online reviews of providers. The issue of psychotherapy clients leaving online reviews of their psychotherapists is meanwhile causing additional anxiety for mental health professionals who feel gagged by confidentiality requirements and unable to defend themselves against negative reviews or unable to ask current clients for positive reviews as this violates Standard 5.05 of our Ethics Code (American Psychological Association [APA], 2010).

Psychologists Using Social Media

Marketing

Many psychologists are establishing a professional presence on their own websites and social media sites as a means of directly marketing their practices (Johnson, 2011). They are blogging, and using Twitter, Facebook, LinkedIn, and other sites to get their message out about the services they provide and network with other clinicians. They participate in public or semi-private forums such as LinkedIn groups or professional listservs in which they get to demonstrate their expertise and increase their visibility and credibility. Oftentimes, they use these postings to encourage potential clients to make contact with them or to encourage other clinicians to consider referring to them. Many of them provide information about the services they provide and areas of special interest.

Engaging Off-Duty

Others avoid establishing a formal social networking presence, but they participate in publicly accessible web interactions such as commenting on news stories, blogs, or listservs sometimes without full awareness that these interactions are creating public and discoverable

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records of their interactions, or —what a more web-savvy marketer would refer to as — “brand impressions.”

When a clinician posts a message or comment on a blog from the privacy of her office, she may not consider that her students, clients, or friends and family members of her clients may search for her and later find this information. This can be of considerable concern when clinicians use nonprofessional listservs in their personal lives, sharing details they would not want clients to see, or even just when clinicians debrief on their personal Twitter or Facebook profiles after a long day of work, not comprehending that they are sending distinct messages to their social communities about how they perceive and experience their professional work.

Other psychologists may reconsider their presence on social media sites and they may be surprised to discover that some sites, such as Facebook, make it difficult to delete your account and may still retain your data, including photos and Wall postings, even after you have terminated your account (Cheng, 2012). Another new issue for psychologists to contend with is Google’s image search feature which provides a person the ability to upload a photo of an individual from any website, and then to drop it into the search field to find every other website on which that photo has appeared. A client could feasibly do this using a psychologist’s website photo, and if this photo was also used on a dating site, or any other social media site, all of the sites on which the photo has appeared would show up.

Other clinicians who are not intentionally creating profiles on the Internet, are sometimes discovering their professional practices listed on consumer review sites such as Yelp or Healthgrades which automatically use search engines to auto-feed business data and create listings for health care providers on these directories. Many of these clinicians are surprised to

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find their practices listed on such sites and have reported difficulties having them removed (Nelander, 2011). On a site like Yelp, client reviews are also connected to their friend networks, and if someone has Facebook Instant Personalization enabled, their review will also be announced to their Facebook contacts. When clients leave a review of a clinician on one of these sites, it will also affect the Google search rankings for the practitioner, and clinicians may remain unaware that their practice is getting attention on the Internet, whether it is positive or negative.

Some medical providers have become so anxious about the negative impact of online consumer reviews that they have resorted to seeking out companies such as Reputation Defender which charges a significant amount of money to help post positive information with the goal of increasing positive search results on Google. Others have turned to Medical Justice, which has sold gag order contracts to doctors, designed to restrict the freedom of speech of their clients (Masnick, 2011). These contracts assigned the client's copyright over to the medical provider when online reviews have been left, allowing the doctor to request their removal from the site on which they are posted. Some sites have not complied with these requests, as recently discovered (Lee, 2011), and due to a recent lawsuit, Medical Justice has retired these contracts. Other similar contracts have specified that a provider may terminate care if the client leaves a review on an online site. Such contracts are likely illegal and unethical and this author would not endorse the use of such questionable infringements on clients' civil liberties when they are in the vulnerable position of seeking clinical care.

Engaging On-Duty

Other psychologists are intentionally using professional listservs, group postings, blog comments, and such for professional purposes. Many of these clinicians are seeking referrals or

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consultation or are providing commentary on postings left by other colleagues. In some cases, they may be compromising ethics codes (APA, 2010) by providing excessive clinical details beyond the extent necessary for the consultation, or by seeking consultation from people whose competence and expertise they cannot ascertain. They are also engaging in public consultation that will remain archived and available to hundreds or more individuals, some of whom may have a personal relationship with the individual being seen in therapy. Considering that many individuals may refer friends or family members to colleagues they “know” from professional listservs, there is an increased risk of boundary violations when clinicians seek consultation and provide details that make these clients recognizable to other professionals who may also be on the listserv and who may know or may have referred these clients.

Both Donner (2007) and Behnke (2007) have addressed the dangers inherent when psychologists fail to use discretion when seeking consultation or referrals via professional listservs. Clinicians may wish to follow Donner’s recommendation to describe the expertise of the clinician when seeking consultation and referrals, as opposed to offering up identifying details such as a client’s exact age, ethnicity, or other distinguishing details that may increase the likelihood that such a client might be recognized by readers of the posting. Such an example would be to ask for a clinician with expertise in working with substance abuse in LGBT adults in New York City, rather than posting, “Need referral for a 30 year old bisexual male living in Greenwich Village, New York, who has substance abuse issues with cocaine and alcohol and is engaging in unsafe sexual practices.”

Adjunct to Clinical Practice

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Some clinicians may not be using the Internet to provide clinical care, but they may be looking at the social networking profiles of their clients, with them, reviewing exchanges that occur on these sites to help a client gain greater insight into their relationships and behavior. Others may willingly view photos or videos that are sent to them by clients either during or out of session. For example, a client who is working on anxiety around public speaking may wish to show a clinician a YouTube video of a successful presentation he gave; or a client who is working on de-cluttering her home may wish to share photos with her psychotherapist on the progress she makes toward releasing objects and clearing her space.

Other clinicians may be incorporating apps and other technological tools to collaborate with clients and help them track symptoms, behaviors, and implement interventions. Some examples of such apps include MoodKit, PTSD Coach, Jawbone Up, and FitBit. Some of these are less “social” in that the data is not shared with other users, but can be charted and shared with the clinician. Other sites utilize social media to create supportive online communities with the goal of helping to reinforce people in changing their health habits. Health Month, an online social game, is one such example in which people set monthly goals and work in teams to earn points toward reaching their goals.

Provision of Care

Many psychologists are turning to telemental health treatment via text or video. There are compelling reasons for practitioners to consider such technologies (e.g., enhancing services for rural populations, increasing access to care, and treating special populations who may not be able to find clinicians with expertise to help with their issues in their own communities, such as transgender clients who cannot find a clinician in their community with the expertise to provide

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competent care). Although the provision of telemental health services has been written about widely and is beyond the scope of this particular article, it is worth noting that despite research indicating the efficacy of such treatment, some clinicians (Thompson & Vivino, 2011) express concerns about attunement and attachment challenges posed by telemental health treatment, including the lack of eye contact and the inability to perceive small physiological shifts in clients, including changes in breathing, flushing, tears, or body movements. However, it is possible that such criticisms are culturally biased. We do not yet know whether children growing up on social media and who have regular video contact with traveling parents or relatives in other locations will experience the same attachment lapses that digital immigrants experience with video technology.

In addition, technology is currently being developed (Machtig & Danto, 2011) that will allow for eye contact during video chat. Other assistive technological developments may soon allow for greater input than is provided by face-to-face therapy, including accurate measurements of breathing, heart rate, skin flushing, and other indicators of physiological arousal. Some may find the disinhibition effects of using computer technology allows clinicians greater comfort in requesting that clients utilize supportive technology during online sessions. When attachment research is further explored for those who are digital natives, and further technological advances are made, we may need to revise our concepts of the attachment and attunement possibilities between clients and clinicians using online treatments.

Infants and Children on Social Media

Many parents are now creating social networking profiles for their infants. Some parents have created Twitter or Facebook profiles for children yet to be born. One study of 2,200 parents

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from 10 countries found that the average age for “digital birth” is 6 months old and that 92% of toddlers have an online presence by the age of 2 years (Stamoulis, 2011). Some parents are using YouTube to share embarrassing moments from their child’s lives such as a well-known video called “David After Dentist,” in which a seven-year-old child under the influence of anesthesia was filmed by his father after dental surgery (DeVore, 2008). This video has been viewed 103,756,845 times.

Another recent example of Mommy Blogging gone viral is the example of Nerdy Apple Bottom, a blogger whose 5-year-old son wanted to dress as a female cartoon character on Halloween. Other parents raised eyebrows and she responded with a blog entry entitled “My Son is Gay,” which went national, winding up with news stories and television appearances (Howard, 2010) turning her five-year-old son into a minor celebrity. Although Nerdy Apple Bottom later deleted the post and closed her blog to comments, the original postings are archived on other sites and a Google search for the item turns up over 100,000 separate entries. Other parents are blogging and posting status updates about child behavioral problems or their parental frustrations. Because these postings have the potential to influence the social and professional lives of these children as they get older, and because children are in no position to provide consent to the posting and sharing of this information, this is creating interesting predicaments for which we have yet to see outcome data or solutions.

Other concerns are that photos and details shared about children with wide audiences on social media sites can create safety risks for children who could potentially be preyed on by adults who can then collect detailed information about these children. Similar concerns have prompted the Federal Trade Commission to draft the Children’s Online Privacy Protection Act

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(Bureau of Consumer Protection, 2000), which is intended to give parents control over what information websites can collect about their children. The challenge is that many parents themselves are still sharing a wide variety of information that may put their own children at risk and there is the question as to whether future policies or governmental interventions will be implemented for the protection of children or whether parents will always have the final say in what they get to post about their own child online.

Implications of Social Media for Psychologists Providing Clinical Care

Clinical Training

It is clear that as digital culture continues to blossom, there will be significant influences on clinical services and the need for these issues to be addressed in doctoral training programs. These clinical psychology training programs would do well to first develop their own policies about whether they obtain information about applicants on the Internet and whether trainee Internet behavior will be subject to review by peers and instructors. Some schools or supervisors may wish to incorporate the review of the social media profiles of students as part of professional development, and discuss what kind of information would be appropriate or inappropriate to share in status updates on such sites. There will be an increased need for supervisors to include questions about online extratherapeutic encounters that may occur as a part of trainees' clinical relationships and to update their own knowledge so that they can provide culturally competent supervision.

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Professors and supervisors will also need to be able to supervise students about how to manage clinical exchanges that address the online transparency of both psychotherapist and client, including revelations about social proximity, and the discovery of other personal information. Clinicians may need increased coursework in crafting an online professional identity and managing the clinical challenges that may arise. However, problems may arise when professors and supervisors are less facile than their students in understanding the use and implications of newer technology, whereas students may be less perceptive about the nuances of managing one's professional identity.

The Ethics Code for psychologists may need to be updated to reflect how psychologists represent themselves on the Internet and the potential blurring between personal and professional information that is occurring. In effect, the Internet is turning many clinicians unwittingly into media psychologists without proper training. It is turning other clinicians into detectives, who use online searches to verify information provided by clients in psychotherapy or simply to seek information about clients out of curiosity. Some of these activities would already be addressed by our current Ethics Code which says that we enter into relationships of trust and fidelity with our clients and inform them of our policies and procedures early in treatment. A number of authors are beginning to acknowledge how clinicians need to address the ethical issues related to the Internet and our clinical relationships, many beginning with the informed consent process (Barnett, 2009; Clinton, et al., 2010; Kaslow, Patterson, & Gottlieb, 2011; Kolmes, 2010; Lehavot, Barnett, and Powers, 2010).

Search, Transparency, and the Crafting an Online Identity

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The research has clearly indicated that both clients and psychotherapists are finding information about one another via search engines and social networking sites. Even photo albums of family vacations and social outings can be exposed simply by failing to stay up-to-date on changes in privacy settings on Facebook. Social sharing on social media sites is opening up our behaviors and activities to wide audiences when we read articles, watch videos, comment on the Walls of our friends, or purchase items. These data trails are creating opportunities for both clients and psychologists to obtain personal information about one another. Other public records sites such as Intelius, Spokeo, Pipl, and DexKnows enable people to search for addresses, family members, home values, and other information such as criminal records and divorce or marriage histories. Psychologists have been reporting using information obtained about clients to inform clinical decision-making and assessment. What some clinicians may fail to understand is that some individuals who are fluent in social media may be crafting online personae for particular audiences. Taking all information found at face value can fail to take in the complexities of crafting a digital identity (Marwick & Boyd, 2011).

Social Media Policies

Meanwhile, clinicians and training sites should also be implementing social media policies (Barnett, 2009; Kolmes, 2010) that specifically address intern conduct and clinician conduct and explain how interactions between clinicians and clients will be handled. Such policies would be included as part of the informed consent process early in treatment. They would include information such as the clinician's posting of status updates, management of friend or contact requests from clients, whether a clinician responds differently to these requests

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if they come from current versus terminated clients, clarification that a clinician's presence on a consumer review site is not a request for a testimonial, and whether the clinician uses search engines to obtain information about clients in her care. Such policies can also serve as a way of normalizing clients' curiosity about their psychotherapist, which may lead some clients to engage in Internet searches. Having these discussions as part of informed consent may decrease the shame and stigma experienced by clients when they imagine bringing Internet search behavior back into treatment and the clinician will have an opportunity to manage these issues with greater sensitivity and compassion.

Developing Clinical Competence

Clinicians will need to gain a deeper understanding of how clients use and experience social networking sites. Just two decades ago, having an active Internet presence was considered a potential sign of antisocial or addictive behavior, but it is now a widely accepted form of personal and business networking. The cultural divide between digital natives and digital immigrants may make it more difficult for some clinicians to understand individuals who are dealing with challenges related to the merging of social, professional, and support networks in online spaces. Socially networked clients may struggle with painful emotions related to viewing or monitoring the online activities, photos, or interactions of ex-relationship partners. Asking a client to simply stay off of the Internet may not be practical when an individual's work and social life is enmeshed with their online life. The ability for a clinician to be knowledgeable enough to work with a client on developing strategies for blocking individuals and screening and filtering information may be extremely useful for some clients.

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Individuals working with adolescents may need to be aware of the self-harm behaviors that are occurring on sites such as Facebook and Formspring. Digital bullying and self-harm (Boyd, Ryan, & Leavitt, 2011; Shrock & Boyd, 2011) are new issues for today's youth and it will be essential for clinicians to explore whether adolescents are participating in attacks on their own reputations. There is also the danger of taking information found on social media profiles at face value. Young people on social media are usually crafting identities for particular digital audiences, which may include crushes, friend groups, teachers, parents, and ex-boyfriends or girlfriends. If clinicians intend to incorporate the social media profiles of their teen clients into treatment, they should ask questions to help them understand what kind of a digital identity this client is looking to construct, and for whom, rather than assuming that information on the profile should all be taken at face value (Marwick & Boyd, 2011). Good questions can include, "Who would you like to see this?" "What would you like them to believe about you?" and "What are you choosing to conceal?" Understanding an individual's thinking in regard to the construction of an online identity can be illuminating.

Other clients will experience cyberstalking, cyberharassment, or cyber-bullying. Research has indicated that online harassment is more psychologically harmful than offline harassment because of its ongoing nature, difficulties evading the abuse (it may reach the victim via mobile devices and in the home), and the ability for the abuser to remain anonymous (Lakhani, 2011). Clinicians need to better understand the use of location-based services (LBS) and how they work, particularly when working with clients who are victims of stalking or online harassment. These clients may have their location data shared by others, which may pose safety

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risks, or they may be accidentally sharing such data with others by having passive LBS enabled on their devices.

Those providing couples counseling will need to have an understanding of the multiple meanings of sexual and emotional connection with others on the Internet for their clients. Some partners have differing understandings of what constitutes “real” intimacy or even evidence of infidelity. Others are interested in negotiating emotional or sexual relationships outside of their primary relationship with one another. The meanings of these exchanges are personal and vary between individuals. Some clients will be coming to therapy for help negotiating sexual contact with others on the Internet, whether this involves “sexting,” (exchanging sexually explicit messages or photos via mobile devices) or other erotic exchanges (Blue, 2008). Clinicians have an opportunity to help such clients create better agreements and understand their respective values and meanings around online sexuality. If a clinician rushes to the assumption that these behaviors automatically indicate compulsive or addictive behavior, they may be failing to be helpful to some clients.

Other challenges may include the management of online data belonging to the deceased (National Public Radio, 2011). There are sites that may serve as useful resources both for terminally ill clients and their surviving family members. When someone with an active Internet life passes away, there are those who are left to manage social media profiles that often serve as a form of online memorial, but these individuals may get locked out because of privacy restrictions.

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Lastly, by being visible on social networking sites and the Internet, clinicians will need to establish clear communication with clients about when the patient-provider relationship actually begins. Clients may believe that sending e-mail or notes on social networking sites establishes a clinical relationship. Clinicians who enable Wall postings or blog comments on their sites may need to create clear disclaimers to help guide those who participate in these forums who may be seeking care (Recupero, 2006).

Policy Changes

A number of significant questions become apparent when one considers the upsurge in digital culture and social media. Sites such as Yelp have paved the way for social sharing of consumer information, even when that information is health care related. If cultural notions about privacy are shifting, does it stand to reason that this may eventually have the power to change laws, ethics, and standards related to privacy or confidentiality in clinical care? Will the transparency of digital payment data being shared on social networks change people's views about the stigma related to seeking psychological care? Such changes might carry enough weight to change some of the more ingrained assumptions we hold about patient privacy and confidentiality. If there is a strong trend of clients behaving in ways that are inconsistent with an expectation of confidentiality, this might potentially influence the behavior and expectations of those providing treatment. One example of this could be that in the next decade, clinicians may no longer be prohibited from requesting client testimonials on review sites or asking for other kinds of endorsement from clients.

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Given that so many parents are creating online accounts for their infants and children and sharing so much personal and private information without the child's control or consent, there may also be the potential for the scope of mandated child abuse reporting laws to expand based on discovery that parents are sharing information about their children that has the potential to harm them. Further research on the effects of parental sharing about children on social media sites will likely influence future policy and procedures about this.

Lastly, there may be changes and new pressures placed upon clinicians who observe unethical online behavior by other practitioners on listservs and other social media sites. The American Medical Association (2011) issued a report on Professionalism in the Use of Social Media which requires physicians to address this with the individual or report it to authorities. Similar policies for psychologists may place a burden on some clinicians given how frequently such ethical misconduct can occur.

Cultural Shifts Influencing Provision of Services

There is great potential for technology enhancements to improve to the extent that providing telemental health services will be more appealing to more clinicians. Will face-to-face services, rather than becoming outdated, be a higher value service than online treatment? Will the technological enhancements and ability to transcend time and space make online treatment more appealing? Will there be psychological differences in who prefers which type of service?

When treatment moves into the digital realm, there is also the likelihood that this will shift our concepts of time and frame in reference to the therapy hour. Clients may book segments of time that do not even happen during a specific time slot, but which, are adaptable and

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accessed at different points in the day. How this may change the treatment relationship and theoretical frameworks remains to be seen.

Conclusion

We, as a profession, need to brace ourselves for new understandings and flexibility as to how social media and online culture are influencing our field. New services and technologies may contradict our current understandings of privacy, confidentiality, and the need to conceal ourselves outside of the clinical relationship. It is possible that privacy and confidentiality in the future of professional psychology may take a new shape.

However, psychologists are also going to have to become much more savvy about privacy settings and be much more aware of how they wish to shape their professional (and personal) identities in a world in which we can be easily accessed and recognized without our awareness. There will need to be more research on the effects of whether finding this information is harmful or beneficial to treatment, and under which conditions and for which populations.

With the new openness that the Internet is bringing to us, we can expect to see more open source collaboration and sharing in terms of psychoeducation and resources for clients who may also become more autonomous in seeking support, sharing resources, and engaging in self-care via technology and peer groups. Consumers will likely experience greater empowerment regarding the demystification of the range of services they may access and the choices they have in shaping their treatment, as well as the ability to attach and connect to

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providers of choice who previously may have remained a mystery to them until they showed up for an initial session.

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