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Psychotherapist Awareness and Competence Managing Social Media Concerns

Jing Wen Ong

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PSYCHOTHERAPIST AWARENESS OF AND COMPETENCE MANAGING SOCIAL MEDIA CONCERNS

by

JING WEN ONG

(Under the Direction of Dorthie Cross)

ABSTRACT

Social media use increased substantially in recent years, spurring the growth of research focused on its association with mental health. Previous research examined the relationship between positive and negative aspects of mental health and social media use. Other studies explored the relevance of social media to professional practice of psychologists including the use of social media to reach populations with limited access to mental health services and ethical dilemmas arising from social media use; however, there is limited understanding of the pertinence of social media to concerns that clients discuss in therapy and therapist competence in handling these discussions. The purpose of the current study was to explore therapists’ ethical decisions and clinical judgments, as well as to examine factors like therapist age and personal experience using social media. 122 mental health professionals and trainees completed a survey with four vignettes of social media-related ethical and clinical situations (searching client social media, sharing personal views on social media, responding to client being cyberbullied, responding to client getting unhealthy dieting advice on social media), as well as questionnaires examining their self-reported experiences, beliefs, knowledge, and skills about social media and experience talking with clients about social media. Results revealed that social media use was common in the sample, and there was a negative correlation between participant age and level of social media use and knowledge about social media. In addition, findings showed divergence of participants’ ethical decision-making from professional guidelines, with participants’ choosing responses that were more cautious than guidelines. Also, vignette responses about whether to search a client’s social media were more cautious than participants’ own self-reported actual behavior, and findings revealed differences in participants’ searching behaviors based on their level of social media use. Several items assessing participants’ social media experiences, beliefs, knowledge and skills were related to vignette responses about sharing advocacy content and incorporating social media in therapy activities. Results with clinical vignettes overall showed willingness to discuss social media with clients. These findings contribute to an underdeveloped research area and inform ethical and clinical education and training regarding social media.

INDEX WORDS: Social media, Ethics, Psychotherapy, Rurality
PSYCHOTHERAPIST AWARENESS OF AND COMPETENCE MANAGING SOCIAL MEDIA CONCERNS

by

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DOCTOR OF PSYCHOLOGY
PSYCHOTHERAPIST AWARENESS OF AND COMPETENCE MANAGING SOCIAL MEDIA CONCERNS

by

JING WEN ONG

Major Professor: Dorthie Cross
Committee: Ryan Couillou
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Electronic Version Approved:
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DEDICATION

I would like to share my joy and accomplishment with my family. This dissertation work is dedicated to all of you. To my father, Chin Chuan Ong, who taught me the value of education and inspired my relentless passion and pursuit of knowledge. To my siblings, Jing Wei, Ting Sheng, and Ting En, you showed up in my life and never left me alone, but I know I never walk this world alone. To my partner, Chih-Hao, who has been my greatest support and source of happiness in life.
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CHAPTER 1
INTRODUCTION

Rationale

Social Media and Mental Health

Social media use increased exponentially over the past two decades. In 2021, 72% of U.S. adults surveyed by Pew Research Center reported using at least one social media platform, compared to only 7% in 2005, and by 2015, 89% of surveyed U.S. adolescents already reported using at least one social media platform (2015; 2018a; 2021). Mental health problems have also increased during the same period (Ballou et al., 2019; Brignone et al., 2020), leading to assumptions that social media use is to blame; however, the actual relationship between social media use and mental health is more complicated (Ferguson, 2021).

Social media use has been linked with both positive and negative aspects of mental health and well-being, including social support, life satisfaction, loneliness, depressive symptoms, and body dissatisfaction (Boer et al., 2020; Bue et al., 2020; Shensa et al., Wright et al., 2020). Past studies that found a positive correlation between social media use and well-being focused on its relationship with social capital (Deters & Mehl, 2012; Nabi et al., 2013; Steinfield et al., 2008; Valenzuela et al., 2009), and this may be particularly important for individuals who live in rural and geographically isolated areas and have limited access to offline social support (Brunette et al., 2019; Escobar-Viera et al., 2020; Fischl et al., 2020; Paceley et al., 2022). Moreover, previous research supports mental health professionals’ use of social media to reach rural populations and others with limited access to mental health services (Brunette et al., 2019; Dickson et al., 2017; Shepherd et al., 2015; Stermensky & Ogbeide, 2017; Taylor et al., 2012).

The other side of wider access offered by social media, however, can mean more opportunities for social comparison, cyberbullying, harassment, and other experiences correlated with lower general well-being (Escobar-Viera et al., 2020; Katzer et al., 2009). Both positive and negative social media
experiences deserve the attention of psychologists; clients bring up these experiences in therapy, and how therapists respond is important (Hess, 2017; Ong & Cross, 2022; Pagnotta et al., 2018).

Given previous studies showing the relevance of social media to both positive and negative aspects of mental health and the possibility of using social media to reach populations with limited access to mental health services, therapists should consider giving social media greater focus in their work. If clients want to explore issues related to social media use, therapists should be ready to have those conversations. In addition, social media may offer therapists a wider range of tools to aid the therapeutic process (e.g., communication, resources).

**Psychotherapist Social Media Competence**

However, there has been a lack of understanding of the pertinence of social media to concerns that clients discuss in therapy and the therapists’ competence in handling these discussions. In clinical practice, social media raises multiple challenges for therapists, including ethical dilemmas and limited awareness of or even biases about social media use which could limit their competence when working with clients (Lis et al., 2015; Osis & Pelling, 2015; Taylor et al., 2010). In the first study to explore therapist social media competency and therapist-client relationship, Pagnotta et al. (2018) found that adolescent clients reported stronger therapeutic alliances the more they perceived their therapists as competent in handling discussions of social media. Therefore, the current study attempts to extend previous research in exploring therapists’ awareness and competency in managing social media-related ethical and clinical decisions.

**Purpose**

The purpose of the current study is to explore therapists’ ethical and clinical decisions on subjects relevant to social media. Additionally, the study will examine therapists’ self-reported knowledge, experiences, and attitudes about social media, as well as their experience and comfort in having conversations with their clients about social media and whether social media is integrated into therapy interventions or activities.
Significance

Exploring therapists’ social media competency could help guide future clinical interactions with clients who need to talk about social media use. Past research highlights the need for understanding and responding to social media issues and, at the same time, raises questions about the degree to which some therapists are ready for it, especially given limited training and professional guidance on these issues and variability in therapists’ own familiarity with social media (Lis et al., 2015; Osis & Pelling, 2015; Pagnotta et al., 2018; Taylor et al., 2010).

First, many existing studies examine therapists’ attitudes and behaviors related to ethics, such as searching client social media information (Jent et al., 2011; Wardi-Zonna et al., 2020), and the proposed study will examine some of these questions again with the goal of getting the most up-to-date data in this fast-changing environment. Second, only two studies have examined how therapists actually handle social media discussions in session, both from a client perspective (Ong & Cross, 2022; Pagnotta et al., 2018). Therefore, the proposed study will fill a gap in the literature by exploring therapists’ clinical decisions relevant to addressing social media issues in session. Third, social media may be an important tool for improving access to mental health services in rural areas (Brunette et al., 2019; Dickson et al., 2017; Taylor et al., 2012), and the proposed study will be the first to compare therapists practicing in rural areas and those practicing in non-rural areas on these social media issues. Fourth, and finally, the proposed study will explore therapists’ personal and professional familiarity with social media and their previous training, if any, on social media-related matters.

The results of the study could showcase the level of competency and familiarity of current therapists and trainees in ethical and clinical issues related to social media and could add to current understanding and policy considerations regarding how best to approach these issues. Exploration of these practices could help policymakers establish new or update existing professional guidelines about social media. The results could also inform therapist training and education, including continuing education workshops, to improve awareness and competence around social media issues.
Literature Review

Social Media

Social networks or social networking sites are web-based services that provide platforms for users to create individual profiles, identify their social connection to others using the same platforms, and engage with these and other users (Boyd & Ellison, 2008). The terms social networking sites and social media are often used interchangeably, even in academic literature, but there are differences. The biggest difference is that social media sites allow users to broadcast information to broad audiences whereas social networking sites allow users to communicate with individuals with whom they share a connection and interest (Edosomwan et al., 2011); however, with the constant changes and growth of technology, the distinction between the terms blurred. Businesses and professionals now commonly use social networking sites as a medium of marketing, advertising, and communication with customers, and both social media and social networking now share overlapping features that allow users to share profiles with individuals within their social networks and others who use the sites.

Common features of social networking and social media sites include information and communication tools that allow individuals to identify other users with whom they have a connection (e.g., “friends”, “followers,” “subscribers”), communicate with other users publicly (e.g., “comment”) or privately (e.g., “direct message”), post content (e.g., status updates, blogs, images, videos), and share content from other users (Boyd & Ellison, 2008). For the purposes of the current study, social networking sites and social media are used interchangeably to refer to online platforms with features similar to the ones described above.

Broad Adoption and Frequent Use

Over the past two decades, social media use has increased dramatically. In 2005, only 7% of U.S. adults surveyed by Pew Research Center reported using at least one social media platform, compared to only 72% in 2021. By 2015, 89% of adolescents already reported using at least one social media platform (2015; 2018a; 2021). In addition, people are spending more time on social media and logging on more frequently. In 2015, only 24% of teens reported going online almost constantly, but an updated report in
2018 showed a nearly doubled increase in teens (Pew Research Center, 2018b). Though the statistics vary according to different social media sites, most individuals reported daily use of social networking sites. For example, 71% of Facebook users and 59% of Snapchat or Instagram users reported accessing these social platforms at least once a day (Pew Research Center, 2021). Among the wide variety of social networking sites, YouTube and Facebook remain the most popular sites with 81% and 69% of participants reporting using these sites (Pew Research Center, 2021).

**User Demographics**

Though social media use is widespread, there are differences in user demographics in terms of both frequency of use and types of platforms used. Among U.S. adults, Black and Hispanic individuals and women are somewhat more likely to use social media in general and some platforms in particular. For example, Hispanic and Black Americans are more likely to use Instagram and Hispanic Americans are more likely to use WhatsApp compared to White individuals. For Pinterest, more women than men reported using the site (Pew Research Center, 2021). Other demographics to consider are age, rurality, and profession.

**Age.** Overall, social media use is associated with younger age with individuals ages 18 to 29 years and 30 to 49 as the largest consumer groups of these platforms with 84% and 81% reported using at least one social media, respectively (Pew Research Center, 2021). Adolescents ages 13 to 17 years also demonstrate heavy internet and social media use with 92% of teenagers reporting daily internet use and 71% reporting using at least one social networking site (Pew Research Center, 2015). Social media use among middle age and older adults has increased over the years. In 2021, 73% of adults between 50 and 64 and 43% of adults aged 65 and above reported they use at least one social media site (Pew Research Center, 2021). Notably, there are also age differences in the types of platforms used, with Instagram, Snapchat, and TikTok dominating the social media industry among individuals ages 18 to 24 (Pew Research Center, 2021).

**Rurality.** There are some differences in social media use in rural areas compared to non-rural areas. In 2021, 66% of people in rural areas reported using at least one social media site, compared to
76% of people in urban areas (Pew Research Center, 2021). This difference, however, may be due partly to the older age of rural residents compared to non-rural residents (Symens Smith & Trevelyn, 2019), and social media engagement is generally comparable in rural and non-rural teens (Pew Research Center, 2015). There are also small differences in platforms used by rural and non-rural residents in that people in rural areas are less likely to use LinkedIn, possibly because people in rural areas are also less likely to be employed (Hargittai, 2020), but the most popular platforms among individuals who live in urban, suburban, and rural areas are similar. Take the example of Facebook: 70% of individuals who reported living in urban and suburban areas as compared to 67% of people who reported living in rural areas reported ever using the social networking site (Pew Research Center, 2021). People in rural areas are somewhat less likely to use social media, but when they do, they generally use similar platforms. A previous study did find different rural and urban patterns of engagement (e.g., rural users having fewer and more local social media friends), but it was conducted 15 years ago and focused on an outdated platform (Gilbert et al., 2010), so whether the findings still apply is unclear.

**Profession.** Health professionals are similar to the general population in terms of their overall adoption of social media. Jent and colleagues (2011) surveyed the social media use of 109 medical and mental health practitioners (80% women; 46% White, 13% Black or African American, 31% Hispanic or Latinx, 6% Asian or Pacific Islander, and 5% Other). The results showed that 88% of experienced practitioners stated they maintained at least one personal social media profile. Similarly, in a sample of 138 psychologists, social workers, and counselors (88% women; 89% European American, 6% African American, 2% Latino American, 2% multiracial), Wardi-Zonna and colleagues (2020) found that 91% had at least one social media account, and 46% used social media for personal reasons, 40% for both personal and professional reasons, and 8% for professional reasons only. Comparing these findings to Pew Research Center’s (2021) data, it appears that mental health professionals are at least as likely, if not more likely, to use social media as the general public.
Clinical Relevance of Social Media

Though many therapists are social media users themselves, therapists’ understanding and skills to navigate the online world might not be compatible with the needs and demands of their clients, particularly in terms of understanding the relationship between social media use and mental health, knowing how to incorporate social media discussions into therapy, and navigating complicated ethical boundaries.

Social Media Use and Mental Health

The rise in both mental health problems and the popularity of social networking sites, especially among adolescents, has attracted many researchers to explore the relationship between social use and the mental health of users. Research in this area is mixed, however, with findings showing correlations between both positive and negative aspects of mental health and social networking use (Boer et al., 2020; Bue et al., 2020; Shensa et al., 2018). Moreover, much of the causal claims, particularly about the negative impacts of social media use on mental health, have found little to no evidence, even within studies of adolescents (Vuorre et al., 2021; Ferguson et al., 2022).

Teenagers themselves have varied perspectives about the impact of social media use on their generation. In a survey by the Pew Research Center with 743 adolescents (2018a), a large portion of teens (45%) reported thinking social media has neither positive nor negative influence on people of their age. Among those who expressed a strong subjective view, 31% expressed that they believed social media has had a mostly positive effect, and 24% claimed that the effect was mostly a negative one. Those who believe that social media has a mostly positive impact emphasized its importance in social connectivity with both ease of communication with friends and family and opportunities to meet new people (Pew Research Center, 2018a).

Positive Associations with Mental Health and Well-Being. Some previous studies have found correlations between social media use, life satisfaction, and general well-being (Nabi et al., 2013; Steinfield et al., 2008; Valenzuela et al., 2009). These findings may reflect the opportunities provided by social networking sites to facilitate and maintain social capital.
Ellison and colleagues (2007) found that the intensity of participants’ engagement on Facebook predicted of the formation bridging social capital (relationships connecting different social clusters), which can help facilitate new relationships, and maintenance social capital (maintenance of previous social relationships) with 286 college students (mean age = 20 years). In a longitudinal study of 92 college freshman, Steinfield and colleagues (2008) found that Facebook use was associated with the development and maintenance of bridging social capital. The research showed that the intensity of Facebook use of college freshmen predicted their bridging social capital one year later, even after controlling for their internet activity in general. Additionally, the researchers found a stronger positive relationship between intense Facebook use and bridging social capital for students who reported lower self-esteem versus those with higher self-esteem, suggesting that students with lower self-esteem benefitted more from using social media to develop a broad social network.

Notably, the idea that social media can facilitate well-being through the building of social capital has experimental support. Deters and Mehl (2012) found an effect of increasing Facebook status updates on reducing loneliness. Among the 86 college students aged between 18 to 22 years (61% = women) who participated in the research, 37 participants received daily reminders to post more status updates for seven days. The results showed that the participants in the experimental conditions expressed a reduction in loneliness and daily feeling of social connectedness is a significant moderator of the effect of increased status updates on loneliness.

It is important to note, however, that users can experience both positive and negative aspects of social media at the same time. For example, in an online qualitative study of 2408 American adults ages 18 to 30 years (1598 individuals identified as exclusively heterosexual, 417 individuals identified as lesbian, gay, and bisexual), Escobar-Viera and colleagues (2020) explored the perceived positive and negative influences of social media on lesbian, gay, and bisexual individuals and heterosexual individuals. On the one hand, in line with the findings described above, lesbian, gay, and bisexual participants were more likely than heterosexual participants to report that social media benefited them by increasing social capital and connection with affirming communities. On the other hand, the results also showed that 40%
of the code frequency count was for content about to negative impacts of social media (e.g., negative interactions, bullying, social comparison, body dissatisfaction, social isolation, negative emotional contagion), including negative emotional contagion, social comparison, real-life consequences, and profile management.

**Negative Associations with Mental Health and Well-Being.** Findings are much more mixed for correlations between social media use and negative mental health outcomes, such as loneliness and depression, though social media use has been linked to different psychological problems (e.g., cyberbullying, upward social comparison, body dissatisfaction) that contribute to mental health problems.

**Cyberbullying.** The advancement of internet technology and social media has also created new avenues for misbehaviors including cyberbullying, which can occur in the form of flaming (i.e., posting angry and insulting content to or about someone), harassment, exclusion, and online stalking. Though social media users of all ages can experience cyberbullying, adolescents and young adults more likely than other age groups to experience it (Vranjes et al., 2018; Wang et al., 2019). In different studies that involve cyberbullying among adolescents, 20 to 67% of cyberbullying occurred in services provided on social media platforms such as chat rooms (Katzer et al., 2009), message boards (Juvonen & Gross, 2008), and instant messaging (Kowalski & Limber, 2007).

Cyberbullying is associated with serious distress and worse mental health (Chudal et al., 2022; Maurya et al., 2022). Maurya and colleagues (2022) tracked the psychological outcomes of adolescents who experienced cyberbullying after three years in a sample of 4428 adolescent boys (mean age = 18) and 11864 adolescent girls (mean age = 19). The results showed that adolescents who experienced cyberbullying are more likely to report depressive symptoms and suicide ideation three years later.

In a sample of 21,688 adolescents ages 13 to 15 years from 13 Asian and European countries, Chudal and colleagues (2022) found that cyberbullying occurred both alone and in combination with bullying behaviors offline. The results showed a range of the prevalence rate of any bullying behaviors across countries, with Japan being the lowest at 16% and Indonesia being the highest at 44%. Across different countries, the mean prevalence rate of any bullying behaviors is 28%, including cyberbullying.
only (5%), a combination of online and offline bullying (6%), and offline bullying only (18%), meaning that more than half of adolescent who experience online cyberbullying also experience offline bullying. Though bullying across different contexts (online or offline) is associated with internalizing and externalizing symptoms, reports of internalizing symptoms are the highest among adolescents who experienced bullying across both online and offline contexts.

Using a qualitative methodology, Pyzalski and colleagues (2022) provided in-depth exploration of cyberbullying with a sample of 55 adolescents ages 13 to 16 years (30 boys, 25 girls). Bullying behaviors that happened in real life could not only be transferred to the online scene, but also become worse due to the sense of anonymity offered by various digital communication platforms that has been shown to increase the frequency and severity of aggressive online behaviors. In addition, cyberbullying may take the form of one-to-one private communication or involve public communication, such as posting violent content publicly on social media which allows the participation of a broader party (Pyzalski, 2022). Though adolescents in the study by Pyzalski and colleagues (2022) considered these issues to be serious, they also viewed current cyberbullying prevention and intervention efforts as ineffective and passive.

**Upward Social Comparison.** Upward social comparison refers to comparisons that people make between themselves and others who they perceive to be better than them in some way (Festinger, 1954). Social media provides users with more frequent upward comparisons to other users who also tend to post selectively self-enhancing content (Fan et al., 2019; Fox & Vendemia, 2016; Sabatini & Sarracino, 2015), and these upward comparisons are associated with worse mental health and body image (McComb et al., 2023). Wilksch and colleagues (2020) studied the correlation between social media use and disordered eating in an Australian sample of 996 students in grades seven and eight (mean age = 13.08; 54% girls, 46% boys). Specifically, the results showed that girls who did not use any social media reported significantly lower disordered eating thinking patterns (e.g., concerns related to weight and eating) compared to girls who used two or more social media accounts. Similarly, boys who used more than two social media accounts were more likely to endorse disordered eating thinking patterns than boys who used
fewer than two social networking sites (Wilksch et al., 2020). The results showed a similar pattern with reported disordered eating behaviors (e.g., meal skipping, strict diet, strict exercise). Girls who did not own any social media accounts were less likely to report any disordered eating behaviors than girls who used two or more social networking sites. Likewise, boys who owned more than two social media accounts were more likely to report disordered eating behaviors (Wilksch et al., 2020). Rodgers (2019) explored how social media use relates to body image and eating patterns in a sample of 681 adolescents in Australia (mean age = 13; 48% women). The results revealed the role of internalization of social media ideal (e.g., idealized body images of social media models) as the mediator of the relationship between social media use on appearance upward comparison, body dissatisfaction, and restricted diet. Bue (2020) tracked the attention of 157 U.S. women ages between 18 to 35 years old paid to their individual photos. The results showed that women who experienced body dissatisfaction spent more time looking at body areas that they felt nervous about compared to women who did not report body dissatisfaction. Moreover, the frequency of Instagram use but not Facebook use was a significant predictor of increased attention to the body areas that they felt nervous about. Bue’s (2020) findings demonstrate that upward social comparison on social media is not confined to adolescent users.

Upward social comparison on social media is also not exclusive to body image and physical appearance. A German study by Brandenberg and colleagues (2019) examined both professional (e.g., XING) and private use of social networking sites (e.g., Facebook) among 145 adults (e.g., 52% women, 48% men, ages between 20 to 58 years). The results showed that higher activity in either professional or private use of social platforms was correlated with social comparison (Brandenberg et al., 2019). The researchers hypothesized that greater social media activity is correlated negatively with self-esteem and positively with depressive symptoms potentially due to negative feedback from upward social comparison.

Findings on the association between social media use and mental health are mixed because it simultaneously has the potential to broaden social interactions and increase social capital while also affording greater opportunity for cyberbullying and harassment and for upward social comparison,
especially but not exclusively with regard to body image. There are also other factors to consider, such as types of platforms used and culturally normative levels of use, when trying to understand the mixed findings.

**Types of Platforms Used.** A possible reason for the mixed findings about the relationship between social media use and mental health outcomes (e.g., loneliness, life satisfaction) may be because the results are complicated by the type of social networking sites used (Pittman & Reich, 2016; Wright et al., 2020). For example, in a sample of 253 college students (mean age = 23; 64% men, 36% women), Pittman and Reich (2016) found that using image-based social media platforms (e.g., Instagram, Snapchat), but not text-based social networking sites (e.g., Twitter), were associated with higher life satisfaction and lower loneliness.

Wright and colleagues (2020) analyzed the correlation between daily time spent on different social media platforms (e.g., Instagram, Facebook, LinkedIn, Marco Polo) and a number of well-being variables (e.g., loneliness, depression, anxiety) in a sample of 630 college students ages 18 to 24 years (mean age = 22, 63% women, 83% White). They found a significant positive correlation between the number of social networking sites used and social integration and perceived peer support; however, the researchers also found that a greater amount of time spent on social media every day was correlated with negative mental health outcomes including loneliness, depression, and anxiety. Among these individuals, users of Snapchat reported higher levels of loneliness, more depressive symptoms, and greater anxiety. At the same time, they also reported lower levels of life satisfaction.

On the other hand, Wright et al. (2020) also found that LinkedIn users reported experiencing more positive affect and subjective social status. At the same time, there were negative correlations between more time spent on LinkedIn and negative mental health outcomes such as loneliness, depressive symptoms, and anxiety. It is important to note that LinkedIn is considered a professionally used social media platform and LinkedIn users in the study were significantly older. Therefore, the number, types, and time spent on social media platforms (e.g., professional, image-based) and age of users could potentially play a part in the relationship between social media use and mental health variables.
Culturally Normative Levels of Use. Another factor that may contribute to mixed findings for the relationship between social media use and mental health is cultural differences in typical levels of use. Studies point to the importance of differentiating between intense (e.g., more time spent on social media) and problematic social media use (e.g., preoccupied thoughts about social media, failure to reduce time spent on social media, frequently neglect of daily activities due to social media use) when discussing the relationship between social media use and mental health (Boer et al., 2020). Using data from a cross-national survey with 154,981 youths aged 11, 13, and 15 years old, Boer and colleagues (2020) found that adolescents who reported problematic social media use scored lower in life satisfaction, school satisfaction, and perceived support from friends and family across nations. They also expressed higher levels of pressure at school and more self-reported psychosomatic symptoms (Boer et al., 2020). On the other hand, there was more variability in the relationship between intense social media use and mental health outcomes across countries, considering differences in the prevalence of social media use. Specifically, in countries with a higher-than-average prevalence of social media use, teens who reported intense social media use also reported higher life satisfaction, but the opposite was true for countries with lower-than-average prevalence (Boer et al., 2020).

Social Media as a Distinct Culture

The invention of social media creates and shapes new cultural norms and practices as individuals navigate relationships, socialization, and communication in the online world. Youths who grew up in the digital age are referred to as a unique cultural group given that social media defines and shapes their culture and experiences (Hoffman, 2013, Pagnotta et al., 2018). Social media has become the venue for adolescents to explore important developmental tasks (e.g., peer relations, self-expression, sexuality) that were confined within in-person interactions for previous generations (Pagnotta et al., 2018). Previous studies suggest social media is the major scene for peer relationships among adolescents and young adults as they form and maintain social capital (Ellison et al., 2007; Steinfield et al., 2008), exchange intimate self-disclosure, and create and reinforce shared cultural norms and references with one another (Davis, 2012). LGBTQ individuals describe opportunities to build relationships in a way that helps increase the
sense of belongingness to the LGBTQ community (Escobar-Viera et al., 2020; Lucero, 2017). Moreover, in a study of 218 college freshmen (64% women, mean age = 18.07), Yang and Brown (2016) discussed the self-expression of young adults through social media. The findings suggested young adults expressed their identities selectively to increase social desirability and their self-presentation shifted over time as they experienced important developmental transitions to college. Given that social media serves as the sociocultural context in which individuals represent themselves and navigate important developmental tasks and their connections with their psychological outcomes, it is important for mental health practitioners to take a culturally informed approach when working with individuals who are active users of social media (Hoffman, 2013).

Multicultural competency involves three major concepts including knowledge, skills, and awareness (Sue & Sue, 2003). The model highlights the importance of increasing understanding of individuals’ cultural norms and backgrounds, using culturally informed practices and interventions, and increasing awareness of their own biases (Sue & Sue, 2003). Applying the multicultural model, therapists working with active users of social media should increase their knowledge of normative use of social media as compared to potentially harmful consequences resulting from intensive or problematic social media use as suggested by the existing literature (Hoffman, 2013, Pagnotta et. al., 2018). In addition, therapists may remain informed of the popular social networking sites used by their clients to support clients in using social media in a healthy manner. Lastly, therapists should increase awareness of the prevalence of social media in their clients’ lives and recognize potential biases and stereotypes that could interfere with their work with clients to encourage open discussions of social media when it is relevant to therapy goals (Hoffman, 2013, Pagnotta et. al., 2018).

Pagnotta and colleagues (2018) attempted to understand and examine therapists’ social media competency with a sample of 77 teenagers aged between 14 to 17 years (62% girls, 38% boys; 83% White; 4% Black or African American, 5% Hispanic or Latinx, 8% Biracial or Mutiracial). Perceived social media competency was measured using a survey, Social Media Counseling Inventory, adapted from the Cross-Cultural Counseling Inventory–Revised (CCCI-R; LaFromboise et al., 1991) based on the
multicultural competency model. The results showed that the perceived multicultural and social media competency of therapists were significant predictors of the therapeutic alliance among all adolescents who are social media users, regardless of the intensity of adolescents’ social media use. As such, the results suggest the importance of awareness and respect, knowledge, and skills relevant to social media use when working with clients who use social networking sites (Pagnotta et. al., 2018).

**Accessibility**

Moreover, studies have suggested the possibility of incorporating social media and other online tools to reach populations with limited access to mental health services in rural areas (Brunette et al., 2019; Dickson et al., 2017; Fischl et al., 2020). For example, in a study of adults with serious mental illness in the rural Northeast region of the United States in 2017, Brunette et al. (2019) found that 68% reported using social media, which was comparable to the general population (69%) and higher than overall rural rates (59-60%) reported during the same period (Pew Research Center, 2021). In addition, 76% of participants in Brunette et al.’s study reported a willingness to use a digital device to access mental health services. In another example, in a 2012-15 longitudinal study of substance misuse among rural Appalachian women, Dickson et al. (2017) used Facebook to maintain contact with participants over time. In that study, 64% of participants used Facebook, which was higher than the general population (54-62%) during the same period (Pew Research Center, 2021). Dickson et al. discovered that participants with Facebook accounts were five times more likely to attend a three-month follow-up interview than participants without Facebook accounts. Social media could be used to increase accessibility and reduce attrition not only research studies, but also in mental health services.

Previous research on social media use and aspects of mental health point to the need for therapists to be aware of the prevalence of social media use, understand the complex relationship between social media use and mental health, and recognize the relevance of social media to people’s lives, as well as its potential usefulness to clinical practice. At the same time, therapists should be aware of the ethical issues posed by their own and their clients’ social media use.
Ethical Challenges of Social Media

Social media raises multiple challenges to ethical practice. For example, therapists may receive friend requests from clients or discover that they share online acquaintances with clients. There is also disagreement on the ethics of therapists searching for clients’ social media, communicating with clients on social media, or sharing personal views on social media (Otis & Pelling, 2015; Taylor et al., 2010). Mental health practitioners who use social networking sites for personal or professional purposes report concerns with boundary crossing, clients’ misconceptions of the professional’s accessibility and availability, increased disclosure of both clients and therapists on social media, and ethical dilemmas when clients reach out to them or search for their information via social media (Kolmes & Taube, 2014). Though there are many potential ethical concerns, social media represents a distinctive threat to both clients’ and therapists’ expectations of privacy because therapists have the capacity to search for information about their clients and vice versa.

Searching Clients’ Social Media

Many therapists have searched for clients on social media, though proportions vary across studies. In a sample of psychologists, social workers, and counselors, Wardi-Zonna and colleagues (2020) found that 9% of participants stated they either came across clients’ social media accidentally or intentionally (Wardi-Zonna et al., 2020). In study of 227 mental health professionals, ages 23 to 80 years (mean age = 41; 74% women; 59% psychologists, 16% professional counselors, 12% clinical social workers, 10% marriage and family psychotherapists, 2% psychiatrists), Kolmes and Taube (2014) examined therapists’ self-reported history of encountering clients’ information on social media. Their results revealed substantially higher rates than in Wardi-Zonna et al. (2020) in that 52% of participants reported seeing a client’s social media, whether intentionally or not. Furthermore, Kolmes and Taube (2014) found that most searches were intentional and not related to a crisis: 48% of the participants conducted intentional searches of client information in non-crisis situations, 8% reported conducting searches in crisis situations, and 28% of participants came upon client information accidentally. The most common venues for intentional searches in non-crisis situations were Google (76%) and Facebook (40%).
On the other hand, those who unintentionally stumbled across client information mostly found it on Facebook (62%), Google (30%), LinkedIn (17%), and shared email lists (8%).

In a study of faculty and trainees, Jent and colleagues (2011) found that 13% of participants stated they searched for information about a client or client’s family member online, 10% that they searched for a patient’s social media profile online, and 6% that they had communication with a previous or current patient through social networking sites (Jent et al., 2011). Comparing faculty and trainees, Jent et al. found that trainees were more likely than faculty to report behaviors of searching for patient information and communicating with patients online. This finding may be due to trainees having less experience or being younger and more likely to engage in social media in the first place.

Though many therapists have searched for a client on social media, fewer therapists are aware of the impacts of non-disclosed information found online on therapeutic relationships. Among the 52% of participants in Kolmes and Taube (2014) who encountered online information about current clients, only 4% reported a negative impact on treatment itself, but 13% reported a negative impact on clinician objectivity, 16% reported a significant reduction in their comfort with clients, and 8% thought it harmed their relationship with their client (Kolmes & Taube, 2014). These findings highlight the importance of education and training, as well as policies and guidelines, relevant to searching clients’ social media profiles.

**Sharing Personal Information on Social Media**

Therapists sometimes search clients’ social media, and clients sometimes search therapists’ social media. In fact, in their study of mental health professionals, Wardi-Zonna et al. (2020) found that 52% of participants reported they had received a friend request by a client, and 11% received a request from a client’s family member. These friend requests are by their nature observable to the therapists receiving them and can be addressed in subsequent sessions. What is not as immediately observable to a therapist, however, is when a client just searches for information about them online.

Practitioners’ sharing information on social media might result in personal information being shared and accessed by anyone, including clients, colleagues, and strangers, which could affect aspects of
the therapeutic relationship that are essential to building therapeutic alliance and trust with clients (Baier, 2019). Many mental health practitioners reported having awareness of the importance of maintaining their privacy on social media and adding restrictions to the accessibility of content (Lehavot, 2010). For instance, among 302 graduate students in the psychology programs (81% of whom reported they had clinical training experiences), approximately 80% indicated they restrict the accessibility of their profiles on social media so that their information can only be accessed by their identified list of friends.

Nonetheless, research has found that many mental health professionals do not have effective strategies for protecting their privacy on social media despite their awareness and attempts to restrict access by changing privacy settings (Osis and Pelling, 2015). Osis and Pelling (2015) examined the Facebook use of 36 Australian psychologists (mean age = 51) and 40 counselors (mean age = 51 years) using a mixed-method study. In an examination of the Facebook profiles of the 12 participants who granted them access, the researchers discovered mismatches between self-reported restrictions versus their observations (Osis and Pelling, 2015). In other words, the researchers were able to access information that the participants assumed was protected and unavailable to others due to the privacy settings they adopted. For instance, the researchers found information on a participant’s Facebook profile that conveyed religious and political beliefs (Osis and Pelling, 2015). This is not a unique case; other research has shown that clients reported finding therapists’ personal information (e.g., family, home address, photos, relationships, friends) online (Kolmes & Taube, 2016). Notably, disclosure of personal information, including political opinions, on social media may be viewed less negatively by trainees or earlier career health professionals compared to previous generations of professionals (Charles et al., 2015; Jain et al., 2014; Levinsohn et al., 2017).

Therapist self-disclosure is often considered a valuable clinical tool that is used with caution and discretion, as therapists weigh the potential benefits (e.g., rapport building) and the risks (e.g., boundary-crossing) when making a decision on whether to self-disclose (Taylor et al., 2010). Nonetheless, therapist self-disclosure may be inevitable in this digital age because therapists’ information is readily available and accessible to clients through therapists’ social media profiles. Kolmes and Taube (2016) explored
client search behaviors of therapist information online with a sample of 332 participants ages 18 to 62 years (93% women, 91% White, 67% heterosexual) who have had psychotherapy experiences and encountered therapists’ information online, either intentionally or unintentionally. Among the 70% of participants who found their therapists’ personal information online, a majority (87%) did it deliberately (Kolmes & Taube, 2016). Besides a general search engine, social media is the next most popular venue for access to therapists’ personal information, with 55% of participants using social media to seek information about their therapists.

Though the most frequently reported impacts of discovery of therapists’ information online were neutral (e.g., sensitivity to the client, sensitivity in online disclosure of clinically relevant information) or positive (e.g., expertise, clinical skills, and training, client identification with therapists), some participants reported negative effects that could impact the therapeutic relationship and treatment efficacy (Kolmes & Taube, 2016). For instance, 15% of participants reported a decrease in the sense of clinician availability to clients, and 14% stated their discovery of therapists’ information negatively impacts clinician boundaries. Furthermore, 25% of participants expressed a reduction in their comfort level and an increase in distress level. Other more commonly reported negative impacts include perceived therapeutic alliance (17%), level of disclosure to therapists (16%), and trust (16%). Despite these negative impacts, few participants (28%) disclosed their discovery of therapists’ information, and those who did not disclose their findings cited feelings of shame and fear of therapists’ negative responses as their rationale (Kolmes & Taube, 2016). Again, these findings highlight the need for education and training, as well as policies and guidelines, regarding therapists’ personal and professional use of social media platforms.

**Education, Training, and Guidelines**

Though mental health professionals have reported the emergence of ethical challenges related to social media, the field of psychology has been slow to respond with education, training, and ethical guidelines relevant to social media. Wardi-Zonna and colleagues (2020) found that 28% of participants expressed that they had not received any education or training related to ethics related to social media use. In 2021, the American Psychological Association (APA, 2021) published the *APA Guidelines for the*
Optimal Use of Social Media in Professional Psychological Practice in response to the demand for a professional practice guideline on social media-related issues for psychologists. The APA guidelines addressed several ethical dilemmas reported in previous studies (e.g., Jent et al., 2011; Kolmes & Taube, 2014), including psychologists searching for clients’ information and maintaining contact with clients on social media. Specifically, Guideline 2.3 addresses important ethical considerations related to psychologists searching for clients’ information on social media and the Internet. In searching for clients’ information online without their consent, clients’ rights to privacy and confidentiality, as well as self-determination in choosing disclosure of personal information were violated. In addition, psychologists face additional dilemmas on whether to use such information they obtained without clients’ consent because their use of such information could negatively impact therapeutic bond and trust. Therefore, APA (2021) advises psychologists to avoid searching for clients’ information online or on social media without client consent; however, psychologists searching for clients’ information online or on social media could be justified in urgent cases where internet searches could help prevent harm to clients or others.

Moreover, the APA guidelines highlight the importance of increasing awareness of potential ethical risks and implications relevant to psychologists’ social media use and knowledge regarding social media and its relations with mental health (APA, 2021). In addition, psychologists are urged to establish social media policy in practice and consider including training and education in their practice.

Though the guidelines help to address whether to search for client information online and stresses the importance of therapists being thoughtful about their own information online, whether and how therapists should share information related to their personal or professional values remains less clear. Social media adds to the complexity of existing ethical dilemmas concerning personal and professional boundaries (Haeny, 2014). In particular, Haeny (2014) discusses conflicting ethical principles and codes relevant to psychologists sharing personal views on conventionally sensitive or controversial topics such as political activities or social causes. Specifically, in the Ethical Principles of Psychologists and Code of Conduct (APA, 2017a), Principle E: Respect for People's Rights and Dignity highlights psychologists’ responsibilities to respect individual differences and refrain from involvement of prejudice, biases, and
discrimination based on identities and ability status. Moreover, Guideline 5 of the Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality (APA; 2017b) encourages psychologists to work toward promoting social justice through advocacy efforts. On the other hand, Standard 3.04: Avoiding Harm details psychologists’ responsibilities to avoid or minimize harm to clients and others (APA, 2017a). According to this ethical standard, psychologists must consider how their disclosure of opinions would affect their relationships with clients (Haeny, 2014).

Though psychologists do not have to abide by the APA Ethics Code for their personal activities, how psychologists completely separate professional and personal boundaries and prevent the consequences and damages to their professional relationships resulting from their actions during their personal time remain a difficult question (Haeny, 2014). In addition, the accessibility of personal and private information on social media further clouds the boundaries between psychologists’ personal and professional activities. Therefore, psychologists are advised to participate in social media with the understanding that any information they disclose on social media might be readily available and accessible to others, including their clients (APA, 2021). Psychologists are advised to refrain from posting any information that may damage the reputation of psychology, to separate personal and professional social media profiles, and to carefully weigh the risks and benefits of online interactions with clients on professional social media depending on the purpose and nature of social media sites they use (APA, 2021). As psychologists discover and utilize social media for advocacy efforts, psychologists also face ethical challenges in navigating sharing of personal views and opinions on personal and professional social media on conventionally sensitive or controversial topics.

On the one hand, the existing literature provides strong support for the relevance of social media to therapy given its prevalence in everyday activities and relationship to general well-being and various mental health variables. Clients are likely to use social media and may desire to talk about social media, and therapists should be ready to have those conversations. On the other hand, social media presents many ethical challenges, and current research suggests that mental health professionals may have limited awareness of some ethical issues associated with social media (e.g., the potential accessibility and
unintentional self-disclosure of their information on social media). Therefore, the current research aims to build on and extend the underdeveloped area of study by exploring the competency and experiences of therapists in clinical and ethical decision-making on subjects relevant to social media.

Current Study

Study Goals

The current study was conducted with three primary goals in mind. My first goal was to explore therapists’ self-reported social media use, and well as their beliefs, knowledge, and skills related to social media, including their experience having conversations with clients about social media and integrating social media into therapy conversations, interventions, or activities. My second goal was to explore therapists’ ethical decisions and clinical judgments about specific scenarios relevant to social media. Finally, my third goal was to explore differences between therapists practicing in rural and non-rural areas. Though I had a few specific hypotheses, the study was primarily exploratory because this area is still relatively understudied.

Study Questions and Hypotheses

- I explored participants’ social media use (number and types of platforms used, level of daily use) and their social media experiences, beliefs, knowledge, and skills. I hypothesized that most participants would use some form of social media and that age would be negatively correlated with level of social media use (number of platforms, daily use) and with pro-social media experiences, beliefs, knowledge, and skills.

- In addition to exploring overall responses to the vignettes (e.g., most common options selected, confidence in decisions), I also had specific hypotheses about therapist age and social media use:
  - **Vignette 1**: I hypothesized that participants who reported that they would search a client’s social media would be younger and report higher social media use.
- **Vignette 2**: I hypothesized that participants who selected the options to recommend that a colleague delete their social media accounts and avoid sharing political or advocacy content would be older and report lower social media use.

- **Vignette 3**: I hypothesized that participants who selected the option to recommend that a client delete social media accounts would be older and report lower social media use. I also hypothesized that participants who selected the option to take time in session to review privacy settings and harassment reporting tools would be younger and report higher social media use.

- **Vignette 4**: I hypothesized that participants who selected the options to recommend that a client delete social media accounts or avoid social media health communities entirely would be older and report lower social media use. I also hypothesized that participants who selected the option to take time in session to review material together, encourage body positive accounts, and spend time outside of session reviewing material would be younger and report higher social media use.

- There is not enough research to support specific hypotheses about differences in rural and non-rural therapists’ social media use and attitudes, so I explored this area by comparing participants practicing in rural and non-rural areas on their level of social media use (number of platforms, daily use, use of professional accounts), as well as on their social media experiences, beliefs, knowledge, and skills. I also compared participants practicing in rural and non-rural areas on specific social media experiences of searching clients and being searched by clients.
CHAPTER 2

METHOD

Participants

Recruitment

157 mental health professionals and trainees were recruited to participate in the study. The recruitment process started with locating listservs of professional networks of mental health professionals (e.g., APA), graduate programs, and internship sites listed on the APPIC website. Then, recruitment emails were sent out to listservs for mental health practitioners and training faculty, as well as to program directors who then distributed the recruitment email to trainees. To enroll in the study, participants had to be at least 18 years of age, identify as a mental health professional, training faculty, or trainee (graduate student, predoctoral intern, postdoctoral resident) in a mental health-related field (clinical psychology, mental health counseling, marriage and family therapy, social work, or any area that requires psychotherapy training or practice), and have had at least one year of experience in providing mental health treatment.

Demographics

Of the 157 who enrolled in the study, 35 were excluded based on missing an attention check (n = 1), providing incomplete data (n = 33), or not meeting the inclusion criteria (i.e., not having at least one year of clinical experience; n = 1). Of the 122 participants included in the final sample, 117 of them who reported their age were between the ages of 23 to 62 years (M = 33.76 years, SD = 8.99). Of those 122 participants, 96 identified as cisgender women, 21 as cisgender men, two as transgender men, and one as a non-binary individual. Two individuals elected to self-describe their gender (one described as a “woman” and another as a “transgender, two-spirit, agender” individual).

Regarding race and ethnicity, 96 of the participants identified as White; 13 as Asian; two as Hispanic, Latino, or Latin origin; and one as Black or African American, and eight participants selected multiple options. Five selected Hispanic, Latino, or Latin origin in combination with Asian (n = 2), Black or African American (n = 1), American Indian or Alaska Native (n = 1), or White (n = 1). One participant
selected Black or African American and Asian, another Black or African American and White, and one
Asian and White. One participant indicated that they preferred not to report their race or ethnicity, and
one participant skipped the question.

Regarding rurality, 50 participants reported they currently practiced in urban areas, 50 that they
practiced in suburban areas, and 22 that they practiced in rural areas. In terms of current professional role,
half ($n = 61$) the participants reported that they were mental health professionals; three that they were in
academics, teaching, or research roles; 46 that they were graduate students or predoctoral interns; and 12
that they were postdoctoral fellows or residents.

**Materials**

**Vignettes**

To explore participants’ ethical and clinical decisions regarding common social media related
concerns, I created four vignettes based on vignettes from previous studies and clinical cases from
personal anecdotes to explore the decision-making process of therapists. Two vignettes described an
ethical scenario: (1) whether to search a client’s social media (Jent et al., 2011) and (2) how to respond to
a colleague asking advice about sharing political and advocacy issues on social media. Two vignettes
described a clinical scenario: (3) responding to an adolescent client who is being cyberbullied (Cyber
Bullying Awareness, Action & Prevention, n.d.) and (4) responding to an adult client with body image
concerns getting unhealthy dieting advice on social media (John, 2021). Each participant saw the same
version of each vignette.

I created questions to explore participants’ chosen actions after being presented with each
vignette. After reading each vignette, participants were asked to indicate how they would respond to the
scenario described. Participants were presented with a list of possible actions they could take in response
to the social media-related situation, and they could select as many options as they wanted. In addition,
participants rated how confident they felt about the action(s) they selected on a scale of 1 to 7 ($1 = not at
all confident, 7 = completely confident)$.
Prior to the study, a draft of the vignettes and the post-vignette evaluation questions were distributed to doctoral student colleagues and revised based on their feedback and input. See Appendix A for the vignettes and associated questions.

**Questionnaires**

In addition to reviewing and evaluating the four vignettes, participants completed self-report questionnaires about their level of social media use; their social media ethics training; their therapy experiences, beliefs, knowledge, and skills about social media; and their demographics. See Appendix B for the questionnaires.

**Pew Research Social Media Checklist**

To assess the number and type of social media platforms used by participants, I adopted items from the *Pew Research Social Media Checklist* (Pew Research Center, 2021). The first item assessed the types of social networking sites used by participants by listing popular social media platforms and asking participants a dichotomous question (*yes/no*) about whether they use them, and participants’ scores for number of platforms used was based on the sum of their responses. For the current study, I also added questions about whether they used the platforms using a personal account, professional account, or without an account.

Regarding the other items adopted from the *Pew Research Social Media Checklist*, the second item assessed the frequency of use using a 4-point Likert scale, and the third item assessed the difficulty to stop using social media using a 5-point Likert scale, but I did not analyze these two items for the current study.

**Media and Technology Usage and Attitudes Scale**

To assess participants’ frequency of social media use, 10 items related to social media activities (e.g., “check your social media accounts”) from the *Media and Technology Usage and Attitudes Scale* (MTUAS; Rosen et al., 2013) were included in the survey. The MTUAS is a 60-item self-report measure used to assess the frequency of technologies and social media use and attitudes towards technology. Items are rated on a 10-point Likert scale (1 = *never*, 10 = *all the time*). Participants’ scores for frequency of
social media use were based on the mean of their responses across the 10 items. The internal consistency of items in the current study was excellent (alpha = .91).

**Therapist Social Media Experiences, Beliefs, Knowledge, and Skills**

This questionnaire was created for the current study. It included two parts. The first part included nine items about participants’ experiences and opinions about searching client information on social media and being searched by a client on social media and about their training regarding social media ethics. Five items from the first part were adapted from the survey items from the study of Jent and colleagues (2011). The second part included nine multiple items. Five items were about how often clients or supervisees brought up social media and four items were about beliefs, knowledge, and skill with social media relevant to therapy.

**Professional Training, Credentials, and Experiences**

This questionnaire was created for the current study to explore participants’ professional training and clinical experiences such as their current professional role, licensure status, and theoretical orientation. The survey includes 11 items.

**Demographics Form**

A demographics form was also administered. It included questions about age, gender, race/ethnicity, sexual orientation, and rurality. I collected data on participant’s rural status (rural, suburban, urban) in terms of where they grew up, where they currently lived, and where they practiced. For the purpose of the current study, I only focused on rurality in terms of where they currently practiced, and I collapsed suburban and urban into one category, creating a dichotomous rural practice variable (rural vs. non-rural).

**Procedure**

Participants were recruited through listservs and social media of professional networks of mental health professionals, and graduate programs. In addition, recruitment emails were sent to program directors of graduate programs and internships sites listed on the APPIC website. If interested, participants were redirected to Qualtrics where they were presented with an informed consent document
and asked to read it and indicate their willingness to consent. If they declined, the survey would end. If they chose to participate, they were asked to complete a CAPTCHA and then asked if they had ever had experience as a therapist. If they could not pass the CAPTCHA or reported no previous therapist experience, the survey ended. Otherwise, they were asked to read four vignettes of different social media-related ethical and clinical situations to respond to each vignette accordingly. The order of the vignettes was randomized. Following the vignettes, participants completed questionnaires about social media beliefs, knowledge, and experience and about their professional training and experiences related to social media. These questionnaires were presented in random order. Finally, participants completed the Demographic Form. One attention check item was also embedded within the study. Participants who were willing to provide their email address were compensated with an Amazon gift card worth US$5.00 and entered into three drawings for another Amazon gift card worth US$50.00. See Appendix C for study flow.

All study materials and procedures were approved by the Institutional Review Board at Georgia Southern University.

**Data Quality Check**

Participants had to pass an attention check item (“It is important that you pay attention to this study. Please leave this item blank”) embedded in a study questionnaire. One participant did not leave it blank and, therefore, data from the participant was not included in the analyses.

**Data Analysis**

All variables were preliminarily examined, and several variables were found to be slightly but significantly skewed. Age and years of therapy experience were significantly negatively skewed. In addition, how often participants incorporated social media in their case conceptualizations, assessment, and therapy activities; how often trainees brought up social media in supervision; and how skilled they felt about handing social media discussions with clients were negatively skewed. Number of platforms used, daily social media use, how often clients brought up social media, how important participants considered talking about social media boundaries with clients, how knowledgeable they felt about social
media, and how much they considered social media the real world were positively skewed. Because of these significantly non-normal distributions, I used non-parametric tests to examine correlations (Spearman correlations) and compare groups (Mann-Whitney U tests).
CHAPTER 3

RESULTS

Social Media Use, Experience, Beliefs, Knowledge, and Skills

All 122 participants reported using at least one of the platforms listed in Table 1, though two participants reported only using YouTube. The mean number of platforms used was 6.39 (SD = 2.62), mostly using personal accounts (M = 4.89, SD = 2.25). Four participants reported having no personal social media account, and three participants had neither a personal nor a professional account. The most popular platforms used were Facebook, Instagram, and YouTube for personal accounts and LinkedIn for professional accounts. On the MTUAS, participants obtained a mean score of 4.34 (SD = 1.55), meaning they tended to use social media between once a week and several times a week.

Table 1

<table>
<thead>
<tr>
<th>Social Media Platform</th>
<th>Personal Account</th>
<th>Professional Account</th>
<th>View Content Without Account</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Facebook</td>
<td>100</td>
<td>81.97%</td>
<td>6</td>
</tr>
<tr>
<td>Instagram</td>
<td>94</td>
<td>77.05%</td>
<td>9</td>
</tr>
<tr>
<td>YouTube</td>
<td>72</td>
<td>59.02%</td>
<td>9</td>
</tr>
<tr>
<td>Pinterest</td>
<td>63</td>
<td>51.64%</td>
<td>2</td>
</tr>
<tr>
<td>SnapChat</td>
<td>59</td>
<td>48.36%</td>
<td>0</td>
</tr>
<tr>
<td>WhatsApp</td>
<td>49</td>
<td>40.16%</td>
<td>0</td>
</tr>
<tr>
<td>Twitter</td>
<td>47</td>
<td>38.52%</td>
<td>10</td>
</tr>
<tr>
<td>TikTok</td>
<td>39</td>
<td>31.97%</td>
<td>1</td>
</tr>
<tr>
<td>Reddit</td>
<td>32</td>
<td>26.23%</td>
<td>1</td>
</tr>
<tr>
<td>NextDoor</td>
<td>26</td>
<td>21.31%</td>
<td>0</td>
</tr>
<tr>
<td>LinkedIn</td>
<td>15</td>
<td>12.3%</td>
<td>74</td>
</tr>
</tbody>
</table>

NOTE: Four participants also indicated that they used social media platforms not listed, and their text response were BeReal (two cases), Clubhouse (one case), and GroupMe (one case).

With regard to specific hypotheses, my hypothesis that most participants would report using at least one social media platform was supported. In fact, all participants used at least one platform, and 119 (97.54%) reported having at least one personal or professional social media account. The other specific hypothesis was that age would be negatively correlated with level of social media use based on number of
platforms used and frequency of social media use, as well as with pro-social media experiences, beliefs, knowledge, and skills, and I conducted Spearman correlations to test the hypothesis. I found that there was a negative correlation between participant age and the number of social media platforms used, $r (117) = - .39, p = < .001$, and daily social media use, $r (117) = - .29, p = .002$, which supported the first part of my hypothesis that age would be negatively correlated with social media use.

Participants were asked to rate how often they incorporated social media in case conceptualization, therapy discussions and activities, and assessment. In addition, participants were asked about their self-reported skillfulness in incorporating social media in therapy activities, beliefs regarding the relevance of social media to the “real world” and the importance of discussing social media boundaries with clients (see Table 2). Regarding therapists’ social media beliefs, knowledge, and skills, participants on average believed it was important to discuss social media boundaries with clients ($M = 5.11, SD = 1.34$) and rated highly on the relevance between social media experiences to the real world ($M = 5.13, SD = 1.42$). Moreover, they also perceived themselves as knowledgeable ($M = 4.83, SD = 1.38$) and somewhat skillful in social media-related discussions ($M = 3.99, SD = 1.43$). (These items were rated on a 1 to 7 scale with higher scores indicating more agreement.) However, participants did not often incorporate social media in therapy [e.g., case conceptualization ($M = 1.00, SD = 1.07$), therapy discussions and activities ($M = 1.57, SD = 1.23$), assessment ($M = 1.10, SD = 1.22$). They also did not seem to encounter social media-related discussions in supervision ($M = 1.33, SD = 1.13$), but they did experience clients who brought up social media in therapy ($M = 2.42, SD = 1.21$). (These items were rated on a 0 to 4 scale with higher scores indicating higher frequency.)

Support for my specific hypotheses about age and social media use in relation to pro-social media experiences, beliefs, knowledge, and skill, was mixed. The correlations showed mixed support for my hypothesis that age would be correlated with pro-social media beliefs, knowledge, and skills. Specifically, there was a negative correlation between participant age and self-reported knowledge regarding social media sites and culture, but there were no significant relationships found between participant age and
social media use and any other items measuring pro-social media experiences, beliefs, knowledge, and skills (see Table 2).

**Table 2**  
*Age and Social Media Use Correlations with Social Media Experiences, Beliefs, Knowledge, and Skills*

<table>
<thead>
<tr>
<th>Item</th>
<th>Spearman Correlations</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age ( (N = 117) )</td>
<td>No. of Platforms ( (N = 122) )</td>
<td>Frequency of Use ( (N = 122) )</td>
<td></td>
</tr>
<tr>
<td>1. How often do you incorporate social media in your case conceptualization of your clients or your supervisee’s clients?</td>
<td>.04</td>
<td>.13</td>
<td>.13</td>
<td></td>
</tr>
<tr>
<td>2. How often do you incorporate social media use into therapy discussions and activities?</td>
<td>.06</td>
<td>.11</td>
<td>.11</td>
<td></td>
</tr>
<tr>
<td>3. How often do you ask about client social media use as part of your assessment?</td>
<td>-.004</td>
<td>.07</td>
<td>.02</td>
<td></td>
</tr>
<tr>
<td>4. How often have your clients brought up social media in therapy?</td>
<td>.10</td>
<td>-.06</td>
<td>.04</td>
<td></td>
</tr>
<tr>
<td>5. How often has a trainee (student or supervisee) discussed social media issues brought up by their clients?</td>
<td>.18 ( (N = 82) )</td>
<td>-.08 ( (N = 86) )</td>
<td>-.10 ( (N = 86) )</td>
<td></td>
</tr>
<tr>
<td>6. In your opinion, how important it is to discuss social media boundaries with clients?</td>
<td>.05</td>
<td>.14</td>
<td>.07</td>
<td></td>
</tr>
<tr>
<td>7. How knowledgeable are you about social media sites and social media culture?</td>
<td>-.30** ( **p &lt; .01 )</td>
<td>.43*** ( ***p &lt; .001 )</td>
<td>.39*** ( ***p &lt; .001 )</td>
<td></td>
</tr>
<tr>
<td>8. How skilled are you at including clients’ social media experiences into therapy discussions and activities?</td>
<td>.10</td>
<td>.02</td>
<td>.11</td>
<td></td>
</tr>
<tr>
<td>9. In your opinion, how relevant are social media experiences to the “real world”?</td>
<td>.08</td>
<td>.15</td>
<td>.14</td>
<td></td>
</tr>
</tbody>
</table>

**Therapists’ Ethical Decisions about Social Media Scenarios**

**Searching Client Social Media**

Specific to the first vignette, I hypothesized that participants who reported that they would search for the client’s social media would be younger than participants who reported that they would not; however, only four participants out of 122 reported that they would search in response to the first vignette, so planned analyses were not conducted. In their text responses, many participants emphasized they would not search for client’s social media, citing ethical boundaries and protecting client’s privacy (e.g., “Searching for a client's social media is within itself an invasion of privacy and poor ethical
boundaries”), as well as fears about what they might encounter (e.g., “I would never check a client’s social media out of fear of this very kind of predicament/ethical dilemma.”). On the Therapist Social Media Experiences, Beliefs, Knowledge, and Skills questionnaire, 96 out of 121 participants reported that they believed it is an invasion of privacy to search client information on the Internet or social media. Also, 112 of 122 participants believed social media profiles without any privacy settings were public information, though this question was about social media accounts broadly and was not specific to client social media profiles. Among the four who reported that they would have searched, two emphasized the relevance of the privacy settings of clients’ social media profiles, stating they believed searching for public social media profiles would not be an ethical issue (i.e., “I think viewing a patients public social media page is appropriate - as it is public knowledge,” “If the person is open online, then I do not necessarily see a problem looking”).

Interestingly, despite overwhelming consensus on the vignette not to search the client’s social media, I found that 32% of participants reported that they had personally searched for clients on social media. Basing the analysis on self-reported actual behavior, I conducted Mann-Whitney U tests to examine if there were any significant differences between participants who reported they have searched for client information online or on social media compared to those who had not searched for client information. I compared groups on age and social media use, as well as years of clinical experience. The results showed participants who reported they had searched for a client or a client’s family on the Internet or social media reported higher frequency of social media use ($M = 4.78, SD = 1.52, mean rank = 73.64$) than those who had not conducted any client searches on the Internet or social media ($M = 4.13, SD = 1.53, mean rank = 55.80$), $z = -2.60, p = .01$. There was no difference for age, $z = -0.11, p = .91$, number of platforms used, $z = -1.55, p = .12$, or years of clinical experience, $z = -.86, p = .39$.

Additional chi-square tests were computed to examine if there were any significant differences between participants with or without history of internet searches of client information in terms of self-reported ethics training and awareness of ethical guidelines related to social media. Most participants reported receiving education or training regarding social media ethics, including in a graduate program ($n$
= 85), practicum or internship (n = 49), postdoctoral training (n = 22), and continuing education (n = 37). Only 16 participants indicated they had not received education or training regarding social media ethics, and they were no more likely than the others to have searched for client information online, $\chi^2 (1) = 1.48$, $p = .18$. Moreover, 72% of participants reported there was social media related policy established at their practice, but it was not related to history of searching for client information online, $\chi^2 (1) = 3.04$, $p = .08$. Finally, 62% had reviewed professional guidelines about social media, 20% were aware of guidelines but had not reviewed them, and 18% were not aware of guidelines in their field. It was not related to history of searching client information online, $\chi^2 (2) = 2.69$, $p = .26$

For the second part of the first vignette, participants were asked to choose their responses with the assumption that they searched for the client’s social media and found information that suggest suicidal risk. No participants chose to proceed as if they never saw the client’s social media as they recognized the legal, ethical, and clinical considerations they would need to contemplate regarding the decisions (e.g., “It's important to maintain confidentiality and boundaries; however, it's important to also weight patient safety”). Given the complication of the situation and potential ethical violations with actively searching for client information on social media, many participants noted they would choose to consult with a trusted colleague and take actions to ensure the client’s safety (e.g., “If I stepped beyond my ethical principles and engaged in a behavior that led me to reading that it puts me in a tricky position. But now I'm obligated to check on their safety…consulting with my supervisor and/or trusted colleague would be my initial response so that … keeping my ethics in check”). See Table 3 for frequencies of participants responses to part two of the first vignette.
Table 3
Number of Participants Who Selected Each of the Options for Vignette 1

<table>
<thead>
<tr>
<th>Options</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would consult with a trusted colleague.</td>
<td>85</td>
</tr>
<tr>
<td>I would call my supervisor immediately [if applicable].</td>
<td>80</td>
</tr>
<tr>
<td>I would call the client immediately.</td>
<td>79</td>
</tr>
<tr>
<td>I would call a mental health crisis team or law enforcement to request a wellness check.</td>
<td>73</td>
</tr>
<tr>
<td>I would call the client's emergency contact.</td>
<td>37</td>
</tr>
<tr>
<td>I would wait to for the next therapy session to discuss the issue with the client.</td>
<td>1</td>
</tr>
<tr>
<td>I would wait for the next supervision meeting to discuss the issue with my supervisor [if applicable].</td>
<td>1</td>
</tr>
<tr>
<td>I would proceed as usual as if I never saw the client's social media.</td>
<td>0</td>
</tr>
</tbody>
</table>

Sharing Personal Views on Social Media

For the second vignette, the most common responses were to recommend that a colleague increase privacy on their personal and professional accounts and to not share political or advocacy content on their professional account (see Table 4). I hypothesized that older participants and participants with less social media use would be more likely than younger participants and participants with more social media use would report that they would recommend a colleague delete personal or professional social media accounts and refrain from posting political or advocacy content. Regarding the first part of my hypothesis, only one participant reported that they would suggest a colleague delete personal social media account and two participants reported they would suggest a colleague delete professional social media account. Therefore, no further analysis was computed. Rather than recommend deleting accounts, participants were much more in favor of recommending increasing account privacy restrictions. 106 participants elected they would suggest increasing privacy restrictions on a colleague’s personal social media accounts, and 34 participants chose the option to suggest increasing privacy restrictions on professional social media accounts. Some notable written responses show that many participants believed it is important that a therapist’s “personal page is inaccessible to clients” to ensure “safety as a therapist” and “prevent clients from accessing personal information.” One participant wrote “Boundaries are more blurred with public, personal pages social media accounts as this allows clients to not only view content,
but connect with (like, follow, etc.) the page.” These comments suggest participants were aware of ethical dilemmas that can arise if making connections with clients on one’s personal social media accounts and were also aware of different expectations for professionalism when it comes to personal and professional social media accounts.

Table 4
Number of Participants Who Selected Each of the Options for Vignette 2

<table>
<thead>
<tr>
<th>Options</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would suggest increasing privacy restrictions on their personal</td>
<td>106</td>
</tr>
<tr>
<td>social media account(s).</td>
<td></td>
</tr>
<tr>
<td>I would suggest not posting or sharing potentially political content</td>
<td>77</td>
</tr>
<tr>
<td>on their professional social media account(s).</td>
<td></td>
</tr>
<tr>
<td>I would suggest increasing privacy restrictions on their professional</td>
<td>34</td>
</tr>
<tr>
<td>social media account(s).</td>
<td></td>
</tr>
<tr>
<td>I would suggest not posting or sharing advocacy activities on their</td>
<td>31</td>
</tr>
<tr>
<td>professional social media account(s).</td>
<td></td>
</tr>
<tr>
<td>I would suggest not posting or sharing potentially political content</td>
<td>11</td>
</tr>
<tr>
<td>on their personal social media account(s).</td>
<td></td>
</tr>
<tr>
<td>I would suggest they proceed as usual, maintaining their current</td>
<td>9</td>
</tr>
<tr>
<td>social media practices.</td>
<td></td>
</tr>
<tr>
<td>I would suggest not posting or sharing advocacy activities on their</td>
<td>5</td>
</tr>
<tr>
<td>personal social media account(s).</td>
<td></td>
</tr>
<tr>
<td>I would suggest deleting their professional social media account(s).</td>
<td>2</td>
</tr>
<tr>
<td>I would suggest deleting their personal social media account(s).</td>
<td>1</td>
</tr>
</tbody>
</table>

Regarding the second part of my hypothesis, in terms of providing recommendations regarding posting political content or advocacy activities, only 11 participants elected to recommend a colleague not post political content on their personal social media, and Mann-Whitney U tests showed no group differences in age, \( z = -1.17, p = .24 \), number of platforms used, \( z = -1.17, p = .24 \), or frequency of use, \( z = -0.86, p = .39 \). Participants who recommended not sharing political content on personal accounts had somewhat more years of experience than those who did not make that recommendation, but it was not significant, \( z = -1.75, p = .08 \). Only five participants chose that they would recommend a colleague not to share advocacy activities on personal social media.

On the other hand, participants were more cautious in terms of professional accounts. 77 participants elected they would suggest a colleague not to share political content on their professional social media accounts, and 31 chose that they would suggest not to post advocacy activities on
professional social media accounts. I conducted Mann-Whitney U tests and found no differences in age, $z = -.40, p = .69$, number of platforms used, $z = -.88, p = .38$, frequency of use, $z = -.45, p = .66$, or years of clinical experience, $z = -1.14, p = .25$, for participants who recommended not posting political content on professional accounts versus those who did not choose that response. With regard to posting advocacy activities on professional social media accounts, participants who suggested not posting reported to have somewhat more years of clinical experience ($M = 11.89, SD = 9.68, \text{mean rank} = 70.97$) than those who did not choose to make such recommendation ($M = 7.43, SD = 5.67, \text{mean rank} = 57.57$), but it was not significant, $z = -1.84, p = .07$. Likewise, participants who reported they would recommend a colleague not to post advocacy activities on professional social media account reported to use somewhat fewer social media platforms ($M = 5.65, SD = 2.37, \text{mean rank} = 51.19$) than those who did not choose to make such recommendation ($M = 6.64, SD = 2.18, \text{mean rank} = 65.01$), but it was not significant, $z = -1.90, p = .06$. There was also not a difference in age, $z = -1.29, p = .20$, or frequency of social media use, $z = -1.22, p = .22$.

Reviewing participants’ written responses regarding their recommendations for this vignette, participants cited different ethical and clinical considerations. For instance, a participant wrote “I believe that as professionals, clients need to be able to have us be whomever they need us to be (transference wise) and if we have things readily accessible online, we cannot be that for them.” Other participants believed that “I think we [mental health professionals] ought to be authentic in our work” and “We [mental health professionals] can't pretend to be blank slates.” Moreover, professionals had different opinions regarding sharing advocacy versus political content on social media, depending on the content (advocacy vs. politics) and whether information was shared on personal or professional social media accounts. For instance, a participant wrote “Advocacy is important and needs to be seen. Political posts are not appropriate.” A participant cited their reasoning for recommending not to post political-related content as to “avoid alienating clients” but believed that “social justice advocacy is part of ethical practice”. The same participant also recognized that “Advocacy posts are more complex and can overlap with ‘politics’ for some people.” Similarly, another participant wrote “I’m torn about disclosing advocacy
because, while it might reflect one’s politics, I believe it has be out in the open to be effective or what’s the point.” On the other side of the spectrum, some participants noted “As a psychologist, I have been trained that community outreach and human rights activism is a part of our calling in supporting all people's mental health. Mental health is not free from politics.” and “Health care is political. Social media public health and mental health advocacy is an important avenue for reaching communities that may otherwise not have valuable information about their health.”

Additional findings related to therapists’ beliefs and behaviors in interaction with clients or client information on social media were found. I explored participants’ experiences being searched online and having interaction with clients online. On the Therapist Social Media Experiences, Beliefs, Knowledge, and Skills questionnaire, 52% of participants indicated they were aware of client searching of therapists’ or therapists’ family information on the Internet or social media. Moreover, 24% of participants reported a current or former client had interacted with them on either their personal social media account (n = 24), professional social media account (n = 4), or both (n = 1). Only two participants indicated they had interacted with a current or former client’s social media account using their personal social media profiles.

**Therapists’ Clinical Decisions about Social Media Scenarios**

**Cyberbullying**

For the third vignette, I first explored common responses among participants. The most common responses were to focus on school-based bullying and to encourage clients to report harassment and increase privacy restrictions on their social media accounts (see Table 5).
Table 5
Number of Participants Who Selected Each of the Options for Vignette 3

<table>
<thead>
<tr>
<th>Options</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would add new therapy activities on school-based bullying.</td>
<td>84</td>
</tr>
<tr>
<td>I would encourage the client and their parents to discuss solutions to bullying with the school.</td>
<td>75</td>
</tr>
<tr>
<td>I would encourage the client to report online harassment or bullying on their social media account(s).</td>
<td>73</td>
</tr>
<tr>
<td>I would encourage the client to review social media privacy settings on their account(s).</td>
<td>61</td>
</tr>
<tr>
<td>I would encourage the client to limit their daily use of social media.</td>
<td>55</td>
</tr>
<tr>
<td>I would spend time in session showing the client how to report harassment or bullying on their social media account(s).</td>
<td>51</td>
</tr>
<tr>
<td>I would encourage the client to view social media as not reflecting real life and to increase their time spent in offline social interactions.</td>
<td>49</td>
</tr>
<tr>
<td>I would spend time in session showing the client how to change privacy settings on their account(s).</td>
<td>33</td>
</tr>
<tr>
<td>I would encourage the client to temporarily deactivate their social media account(s).</td>
<td>15</td>
</tr>
<tr>
<td>I would proceed as usual, focusing only on the client's depression and anxiety.</td>
<td>14</td>
</tr>
<tr>
<td>I would encourage the client to permanently delete their social media account(s).</td>
<td>0</td>
</tr>
</tbody>
</table>

Regarding my specific hypotheses, I hypothesized that age would be younger and level of social media use and pro-social media experiences, beliefs, knowledge, and skills would be higher for participants who reported that they would include social media cyberbullying concerns in therapy. There were no differences in age or frequency of social media use, but participants who reported that they would encourage the client to review privacy settings reported to use more social media platforms. Interestingly, they also rated their skill level in including social media experiences into therapy lower than participants who did not elect the option (see Table 6). Participants who elected to take action in session to show client how to change privacy settings reported using more social media platforms, incorporating social media in conceptualization and interventions more frequently, and rated higher on an item asking how relevant are to the “real world.” Additionally, they reported more frequent encounters of clients actively bringing up social media in therapy (see Table 7).
Table 6
Group Comparisons for Recommendation that Client Review Account Privacy Settings

<table>
<thead>
<tr>
<th></th>
<th>Recommended</th>
<th></th>
<th></th>
<th>Did Not Recommend</th>
<th></th>
<th></th>
<th>z</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>Mean rank</td>
<td>M</td>
<td>SD</td>
<td>Mean rank</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>32.92</td>
<td>8.43</td>
<td>54.90</td>
<td>34.68</td>
<td>9.56</td>
<td>63.46</td>
<td>-1.37</td>
</tr>
<tr>
<td>Number of Platforms</td>
<td>6.80</td>
<td>2.03</td>
<td>67.96</td>
<td>5.97</td>
<td>2.42</td>
<td>55.04</td>
<td>-2.04*</td>
</tr>
<tr>
<td>Frequency of Use</td>
<td>4.43</td>
<td>1.45</td>
<td>64.91</td>
<td>4.24</td>
<td>1.65</td>
<td>58.09</td>
<td>-1.07</td>
</tr>
<tr>
<td>Consideration of social media in case conceptualization</td>
<td>.98</td>
<td>1.09</td>
<td>60.66</td>
<td>1.02</td>
<td>1.06</td>
<td>62.34</td>
<td>-.28</td>
</tr>
<tr>
<td>Inclusion of social media in discussions and activities</td>
<td>1.41</td>
<td>1.19</td>
<td>57.07</td>
<td>1.74</td>
<td>1.26</td>
<td>65.93</td>
<td>-1.43</td>
</tr>
<tr>
<td>Inclusion of social media in assessment</td>
<td>.93</td>
<td>1.06</td>
<td>58.24</td>
<td>1.26</td>
<td>1.35</td>
<td>64.76</td>
<td>-1.08</td>
</tr>
<tr>
<td>Frequency of client-initiated social media discussion</td>
<td>2.33</td>
<td>1.27</td>
<td>59.78</td>
<td>2.51</td>
<td>1.14</td>
<td>63.22</td>
<td>-.56</td>
</tr>
<tr>
<td>Knowledge of social media sites and culture</td>
<td>4.84</td>
<td>1.39</td>
<td>62.37</td>
<td>4.82</td>
<td>1.38</td>
<td>60.63</td>
<td>-.28</td>
</tr>
<tr>
<td>Skill including clients' social media experiences in therapy</td>
<td>3.66</td>
<td>1.44</td>
<td>54.22</td>
<td>4.33</td>
<td>1.35</td>
<td>68.78</td>
<td>-2.33*</td>
</tr>
<tr>
<td>Belief in relevance of social media to &quot;real world&quot;</td>
<td>5.08</td>
<td>1.48</td>
<td>60.48</td>
<td>5.18</td>
<td>1.37</td>
<td>62.52</td>
<td>-.33</td>
</tr>
</tbody>
</table>

*p < .05
### Table 7

*Group Comparisons for Recommendation to Review Client Account Privacy Settings in Session*

<table>
<thead>
<tr>
<th></th>
<th>Recommended</th>
<th></th>
<th>Mean rank</th>
<th>Did Not Recommend</th>
<th></th>
<th>Mean rank</th>
<th>z</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td></td>
<td>M</td>
<td>SD</td>
<td>Mean rank</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>32.28</td>
<td>7.32</td>
<td>54.56</td>
<td>34.32</td>
<td>9.52</td>
<td>60.67</td>
<td>-.87</td>
</tr>
<tr>
<td>Number of Platforms</td>
<td>7.48</td>
<td>1.75</td>
<td>78.50</td>
<td>5.98</td>
<td>2.30</td>
<td>55.20</td>
<td>-3.27**</td>
</tr>
<tr>
<td>Frequency of Use</td>
<td>4.63</td>
<td>1.44</td>
<td>71.27</td>
<td>4.23</td>
<td>1.59</td>
<td>57.88</td>
<td>-1.86</td>
</tr>
<tr>
<td>Consideration of social media</td>
<td>1.42</td>
<td>1.12</td>
<td>75.08</td>
<td>.84</td>
<td>1.01</td>
<td>56.47</td>
<td>-2.73**</td>
</tr>
<tr>
<td>in case conceptualization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inclusion of social media</td>
<td>1.94</td>
<td>1.17</td>
<td>72.00</td>
<td>1.44</td>
<td>1.23</td>
<td>57.61</td>
<td>-2.07*</td>
</tr>
<tr>
<td>discussions and activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inclusion of social media</td>
<td>1.33</td>
<td>1.14</td>
<td>70.48</td>
<td>1.01</td>
<td>1.25</td>
<td>58.17</td>
<td>-1.81</td>
</tr>
<tr>
<td>in assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency of client-initiated</td>
<td>2.79</td>
<td>1.05</td>
<td>72.70</td>
<td>2.28</td>
<td>1.23</td>
<td>57.35</td>
<td>-2.21*</td>
</tr>
<tr>
<td>social media discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge of social media sites</td>
<td>5.15</td>
<td>1.23</td>
<td>68.08</td>
<td>4.71</td>
<td>1.42</td>
<td>59.06</td>
<td>-1.29</td>
</tr>
<tr>
<td>and culture</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skill including clients' social</td>
<td>4.18</td>
<td>1.19</td>
<td>66.24</td>
<td>3.92</td>
<td>1.51</td>
<td>59.74</td>
<td>-.91</td>
</tr>
<tr>
<td>media experiences in therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Belief in relevance of social</td>
<td>4.91</td>
<td>1.45</td>
<td>75.92</td>
<td>5.73</td>
<td>1.15</td>
<td>56.15</td>
<td>-2.81**</td>
</tr>
<tr>
<td>media to &quot;real world&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05, ** p < .01

Participants who reported that they would encourage the client to report cyberbullying on their social media accounts reported to use more social media platforms, use social media more frequently, and be more knowledgeable about social media sites and culture than participants who did not elect the option (see Table 8). Participants who elected to take action in session to show client how to report online harassment and bullying reported incorporating social media in interventions more frequently and rated higher on an item asking how relevant are to the “real world.” They also reported more frequent encounters of clients actively bringing up social media in therapy (see Table 9).
<table>
<thead>
<tr>
<th>Metric</th>
<th>Recommended</th>
<th>Did Not Recommend</th>
<th>z</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>Mean rank</td>
</tr>
<tr>
<td>Age</td>
<td>33.84</td>
<td>9.32</td>
<td>57.86</td>
</tr>
<tr>
<td>Number of Platforms</td>
<td>6.75</td>
<td>2.09</td>
<td>66.98</td>
</tr>
<tr>
<td>Frequency of Use</td>
<td>4.56</td>
<td>1.46</td>
<td>68.62</td>
</tr>
<tr>
<td>Consideration of social media in case conceptualization</td>
<td>1.04</td>
<td>1.09</td>
<td>62.73</td>
</tr>
<tr>
<td>Inclusion of social media in discussions and activities</td>
<td>1.66</td>
<td>1.28</td>
<td>63.62</td>
</tr>
<tr>
<td>Inclusion of social media in assessment</td>
<td>1.01</td>
<td>1.20</td>
<td>59.29</td>
</tr>
<tr>
<td>Frequency of client-initiated social media discussion</td>
<td>2.41</td>
<td>1.25</td>
<td>61.53</td>
</tr>
<tr>
<td>Knowledge of social media sites and culture</td>
<td>5.11</td>
<td>1.31</td>
<td>68.31</td>
</tr>
<tr>
<td>Skill including clients' social media experiences in therapy</td>
<td>4.00</td>
<td>1.40</td>
<td>61.93</td>
</tr>
<tr>
<td>Belief in relevance of social media to &quot;real world&quot;</td>
<td>5.11</td>
<td>1.34</td>
<td>60.08</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01
I also explored recommendations to eliminate or reduce social media use. No participant recommended that the client permanently delete their account, but 15 recommended temporary deactivations. Additionally, 49 recommended clients view social media as not real life and spend more time offline, and 55 recommended limiting daily use (see Table 5). Participants who recommended temporary deactivation were older ($M = 40.73$, $SD = 11.87$, mean rank = 80.77) than those who did not ($M = 32.74$, $SD = 8.07$, mean rank = 55.80), $z = -2.67$, $p = .008$, and reported more years of clinical experience, $M = 12.93$, $SD = 8.15$, mean rank = 83.34 vs. $M = 8.00$, $SD = 6.85$, mean rank = 58.07, $z = -2.55$, $p = .01$. However, participants who reported they would recommend the client to limit their daily use of social media also reported to be more knowledgeable about social media sites and cultures ($M = 5.24$, $SD = 1.39$, mean rank = 72.24) than those who did not choose to make the recommendation ($M = 4.49$, $SD = 1.30$, mean rank = 52.69), $z = -3.12$, $p = .002$, but did not differ by age, $z = -3.46$, $p = .64$. 

### Table 9
Group Comparisons for Recommendation to Review Cyberbullying Reporting Options in Session

<table>
<thead>
<tr>
<th></th>
<th>Recommended</th>
<th></th>
<th></th>
<th>Did Not Recommend</th>
<th></th>
<th></th>
<th>z</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M$</td>
<td>$SD$</td>
<td>Mean rank</td>
<td>$M$</td>
<td>$SD$</td>
<td>Mean rank</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>33.73</td>
<td>8.38</td>
<td>60.23</td>
<td>33.78</td>
<td>9.47</td>
<td>58.11</td>
<td>-.34</td>
</tr>
<tr>
<td>Number of Platforms</td>
<td>6.69</td>
<td>2.40</td>
<td>66.32</td>
<td>6.17</td>
<td>2.15</td>
<td>58.04</td>
<td>-1.29</td>
</tr>
<tr>
<td>Frequency of Use</td>
<td>4.28</td>
<td>1.60</td>
<td>63.28</td>
<td>4.37</td>
<td>1.53</td>
<td>60.22</td>
<td>-.47</td>
</tr>
<tr>
<td>Consideration of social media in case conceptualization</td>
<td>1.10</td>
<td>1.04</td>
<td>65.36</td>
<td>.93</td>
<td>1.09</td>
<td>58.73</td>
<td>-1.08</td>
</tr>
<tr>
<td>Inclusion of social media in discussions and activities</td>
<td>1.90</td>
<td>1.25</td>
<td>70.50</td>
<td>1.34</td>
<td>1.17</td>
<td>55.04</td>
<td><strong>-2.46</strong>*</td>
</tr>
<tr>
<td>Inclusion of social media in assessment</td>
<td>1.31</td>
<td>1.27</td>
<td>68.08</td>
<td>.94</td>
<td>1.17</td>
<td>56.77</td>
<td>-1.84</td>
</tr>
<tr>
<td>Frequency of client-initiated social media discussion</td>
<td>2.69</td>
<td>1.16</td>
<td>69.60</td>
<td>2.23</td>
<td>1.21</td>
<td>55.68</td>
<td><strong>-2.22</strong>*</td>
</tr>
<tr>
<td>Knowledge of social media sites and culture</td>
<td>4.88</td>
<td>1.31</td>
<td>61.58</td>
<td>4.79</td>
<td>1.44</td>
<td>61.44</td>
<td>-.02</td>
</tr>
<tr>
<td>Skill including clients' social media experiences in therapy</td>
<td>4.18</td>
<td>1.29</td>
<td>66.06</td>
<td>3.86</td>
<td>1.52</td>
<td>58.23</td>
<td>-1.24</td>
</tr>
<tr>
<td>Belief in relevance of social media to &quot;real world&quot;</td>
<td>5.49</td>
<td>1.30</td>
<td>70.19</td>
<td>4.87</td>
<td>1.45</td>
<td>55.26</td>
<td><strong>-2.35</strong>*</td>
</tr>
</tbody>
</table>

* $p < .05$
Similarly, participants who reported they would encourage the client to view social media as not reflecting real life and to increase their time spent in offline social interactions reported using more social media platforms ($M = 6.84$, $SD = 2.43$, mean rank = 69.79) than those who did not elect this option as their responses ($M = 6.08$, $SD = 2.11$, mean rank = 55.94), $z = -2.14$, $p = .032$, but not differed by age, $z = -1.57$, $p = .18$.

Reviewing participants’ written responses regarding factors they considered in choosing their responses to the third vignette, participants commented on the importance of social media to the social life of teenagers. Specifically, a participant wrote: “While social media may not feel like ‘that big of a deal’ to adults, in a teen’s life it is very meaningful and important and I wouldn’t want to minimize that importance to the teen.” Moreover, another participant suggested “Deleting social media accounts doesn’t stop harassment and limits ability to socially engage.” Regarding whether to take actions regarding social media in session, there were differences in opinions. One participant stated “I don’t believe doing the phone privacy stuff in session is appropriate” and another mentioned they would consider “ethical boundaries around how to teach social media literacy to client and family without violating confidentiality; implications of bia(s) between generations and different values/perspectives around social media use.” On the other hand, another participant indicated “I would discuss and spend time showing the client how to make changes to their accounts/report harassment just so that they would have the option and be able to use it if need be.”

**Body Image and Unhealthy Dieting Advice**

Lastly, for the fourth vignette, I first explored common responses among participants. The most common options selected by participants were to talk to the client about health misinformation, focus more on social comparison and body positivity in session, and to recommend limiting daily social media use (see Table 10).
Table 10
Number of Participants Who Selected Each of the Options for Vignette 4

<table>
<thead>
<tr>
<th>Options</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would talk with the client about health misinformation on social media.</td>
<td>103</td>
</tr>
<tr>
<td>I would add new therapy activities related to social comparison.</td>
<td>84</td>
</tr>
<tr>
<td>I would add new therapy activities related to body positivity.</td>
<td>68</td>
</tr>
<tr>
<td>I would encourage the client to limit their daily use of social media.</td>
<td>61</td>
</tr>
<tr>
<td>I would encourage the client to avoid unhealthy social media content and engage only with social media accounts embracing body positivity.</td>
<td>54</td>
</tr>
<tr>
<td>I would encourage the client to increase their time spent in offline social interactions.</td>
<td>52</td>
</tr>
<tr>
<td>I would offer to spend time in session reviewing social media accounts together with the client.</td>
<td>45</td>
</tr>
<tr>
<td>I would proceed as usual, focusing only on body image, excessive exercise, and food restriction.</td>
<td>17</td>
</tr>
<tr>
<td>I would encourage the client to temporarily deactivate their social media account(s).</td>
<td>7</td>
</tr>
<tr>
<td>I would encourage the client to permanently delete their social media account(s).</td>
<td>0</td>
</tr>
</tbody>
</table>

I specifically hypothesized that age would be younger and level of social media use and prosocial media experiences, beliefs, knowledge, and skill would be higher for participants who reported that they would include social media body image concerns into therapy, particularly whether participants would review social media sites together in session. There were no significant differences between participants who reported that they would talk to the client about health misinformation on social media compared to participants who did not elect the option (see Table 11). Participants who reported that they would review social media accounts in session with clients rated somewhat higher on an item asking how relevant are to the “real world” ($M = 5.47, SD = 1.36$, mean rank = 69.84) than those who did not choose to take such action ($M = 4.94, SD = 1.43$, mean rank = 56.62), $z = -2.04$, $p = .04$. There were no other differences in terms of age, social media use, or other items related to social media experiences, beliefs, knowledge, and skill (see Table 12).
Table 11

*Group Comparisons for Recommendation to Talk to Client about Health Misinformation on Social Media*

<table>
<thead>
<tr>
<th></th>
<th>Recommended</th>
<th>Did Not Recommend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Age</td>
<td>33.56</td>
<td>8.63</td>
</tr>
<tr>
<td>Number of Platforms</td>
<td>6.40</td>
<td>2.26</td>
</tr>
<tr>
<td>Frequency of Use</td>
<td>4.27</td>
<td>1.52</td>
</tr>
<tr>
<td>Consideration of social media in case conceptualization</td>
<td>1.01</td>
<td>1.09</td>
</tr>
<tr>
<td>Inclusion of social media in discussions and activities</td>
<td>1.60</td>
<td>1.27</td>
</tr>
<tr>
<td>Inclusion of social media in assessment</td>
<td>1.08</td>
<td>1.20</td>
</tr>
<tr>
<td>Frequency of client-initiated social media discussion</td>
<td>2.45</td>
<td>1.25</td>
</tr>
<tr>
<td>Knowledge of social media sites and culture</td>
<td>4.89</td>
<td>1.37</td>
</tr>
<tr>
<td>Skill including clients' social media experiences in therapy</td>
<td>3.96</td>
<td>1.37</td>
</tr>
<tr>
<td>Belief in relevance of social media to &quot;real world&quot;</td>
<td>5.15</td>
<td>1.42</td>
</tr>
</tbody>
</table>
Table 12
*Group Comparisons for Recommendation to Spend Time in Session Reviewing Social Media Sites with Client*

<table>
<thead>
<tr>
<th></th>
<th>Recommended</th>
<th>Did Not Recommend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Age</td>
<td>32.92</td>
<td>8.38</td>
</tr>
<tr>
<td>Number of Platforms</td>
<td>6.69</td>
<td>2.40</td>
</tr>
<tr>
<td>Frequency of Use</td>
<td>4.28</td>
<td>1.60</td>
</tr>
<tr>
<td>Consideration of social media in case conceptualization</td>
<td>1.10</td>
<td>1.04</td>
</tr>
<tr>
<td>Inclusion of social media in discussions and activities</td>
<td>1.90</td>
<td>1.25</td>
</tr>
<tr>
<td>Inclusion of social media in assessment</td>
<td>1.31</td>
<td>1.27</td>
</tr>
<tr>
<td>Frequency of client-initiated social media discussion</td>
<td>2.69</td>
<td>1.16</td>
</tr>
<tr>
<td>Knowledge of social media sites and culture</td>
<td>4.88</td>
<td>1.31</td>
</tr>
<tr>
<td>Skill including clients' social media experiences in therapy</td>
<td>4.18</td>
<td>1.29</td>
</tr>
<tr>
<td>Belief in relevance of social media to &quot;real world&quot;</td>
<td>5.49</td>
<td>1.30</td>
</tr>
</tbody>
</table>

* p < .05

Furthermore, participants who recommended temporarily deactivating social media accounts reported being more knowledgeable about social media sites and culture (M = 5.56, SD = 1.22, mean rank = 86.50) compared to participants who did not make that recommendation (M = 4.77, SD = 1.37, mean rank = 59.98), z = -1.98, p = .048. In addition, participants who reported they would recommend the client to limit their daily use of social media were older (M = 35.52, SD = 9.78, mean rank = 65.58 vs. M = 32.03, SD = 7.85, mean rank = 52.53), z = -2.09, p = .04, and rated higher when asked about the importance of discussing the importance of social media boundaries with clients (M = 5.33, SD = 1.25, mean rank = 69.54 vs. M = 4.94, SD = 1.39, mean rank = 53.46), z = -2.58, p = .01, than those who did not elect to encourage the client to limit social media use. Moreover, participants who reported they would encourage the client to spend more time on offline social interactions also reported a lower level of
daily social media use ($M = 4.00, SD = 1.57$, mean rank = 54.27) than those who did not elect to take such actions ($M = 4.58, SD = 1.50$, mean rank = 66.97), but it was not significant, $z = -1.95, p = .05$.

In terms of important factors in considerations, one participant discussed protecting client privacy, stating that “I would not review social media with a client due to concerns about confidentiality.” On the other hand, other participants believed in the importance of incorporating social media use in interventions. For example, a participant wrote, “The approach of correcting misinformation and being part of the client’s social media use would be a better approach to help the client than dismissing the client’s positive experiences on social media altogether by telling them to limit social media use.”

**Additional Findings**

I also explored confidence ratings for all four vignettes. Participants were the most confident in their responses to the first vignette about whether to searching client social media, followed by the second vignette about sharing political or advocacy content on social media, the fourth vignette about responding to client getting unhealthy dieting advice on social media. Participants were least confident about their responses to the third vignette about an adolescent client being cyberbullied. Paired samples t-tests showed the confidence ratings for Vignette 1 were significantly higher than the ratings for each of the other three, ratings for Vignette 2 were significantly higher than for Vignettes 3 and 4, and ratings for Vignette 4 were significantly higher than ratings for Vignette 3.

**Table 13**

*Confidence Ratings for Each Vignette*

<table>
<thead>
<tr>
<th>Vignette</th>
<th>$M$</th>
<th>$SD$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vignette 1 – Ethics: Searching client social media</td>
<td>6.26</td>
<td>1.21</td>
</tr>
<tr>
<td>Vignette 2 – Ethics: Sharing political or advocacy content on social media</td>
<td>5.45</td>
<td>1.10</td>
</tr>
<tr>
<td>Vignette 3 – Clinical: Responding to client being cyberbullied</td>
<td>4.85</td>
<td>1.16</td>
</tr>
<tr>
<td>Vignette 2 – Clinical: Responding to client getting unhealthy diet advice on social media</td>
<td>5.18</td>
<td>1.00</td>
</tr>
</tbody>
</table>

 NOTE: Confidence ratings were on a 1 to 7 scale, with higher scores indicating greater confidence.

**Rurality**

I conducted independent t-tests to explore differences in level of social media use (e.g., number of platforms, frequency of use, use of professional accounts), as well as social media beliefs, knowledge, and
skills, and professional social media experiences (e.g., searching clients, being searched by clients, other interactions). The results showed that there were no significant differences between participants who reported practicing in a rural versus non-rural areas, except for their self-reported frequency in incorporating social media in case conceptualization of their clients for their supervisee’s clients. Specifically, participants who reported they are currently practicing in non-rural areas (e.g., urban/suburban) reported they incorporate social media in case conceptualization more frequently ($M = 1.10$, $SD = 1.10$, mean rank = 64.69) than those who reported practicing in rural ($M = .55$, $SD = .80$, mean rank = 47.00), $z = -2.25$, $p = .025$. 
CHAPTER 4
DISCUSSION

Review of Findings

Prevalence of Social Media Use and User Age

Consistent with my hypotheses, I found that social media use was common in the sample with all 122 participants reporting using at least one social media platform and all but two reporting having at least one social media account. Therapists in this study were just as likely, maybe even more likely, to use social media as the general public (Pew Research Center, 2021). In addition, I found that age was negatively correlated with level of social media use, based on number of platforms used and frequency of social media use. The results supported the hypothesis as participants who are younger reported using more social media sites and spending more time on social media every day. This finding is consistent with previous studies (Pew Research Center, 2015; Taylor et al., 2010).

Pro-Social Media Experiences, Beliefs, Knowledge, and Skills

I hypothesized that age would be negatively correlated with pro-social media experiences, beliefs, knowledge, and skills. Though there were not significant findings with many items measuring frequency and self-reported skill level in incorporating social media in therapeutic activities, as well as beliefs regarding social media, there was a significant negative correlation between participant age and self-reported knowledge level of social media sites and culture. The findings suggest participants who are younger reported being more knowledgeable about social media sites and culture which is consistent with previous research (Osis & Pelling, 2015).

Ethical Challenges of Social Media

Searching Client Information on Social Media

I hypothesized that participants who reported that they would search for the client’s social media would be younger than participants who reported that they would not. Additional analyses were not conducted because only four participants reported that they would search. However, 32% of participants reported they had searched for clients on social media or the Internet in the past, which is consistent with
previous studies that found therapists’ searching behaviors of client information on social media (Jent et al., 2011; Kolmes & Taube, 2014). Interestingly, the vignette created for the current study asked if participants would search for client information in a potential crisis situation, and a previous study showed that fewer professionals reported searching for client information in a crisis (8%) versus non-crisis situations (48%; Kolmes & Taube, 2014). The current findings, along with previous study suggest therapists are not likely to search for client information in crisis situations and that there are reasons and circumstances, other than crisis, that may lead to therapists searching for a client or a client’s family on the Internet or social media. The study of Kolmes and Taube (2014) found that a majority of participants searched for client information online to confirm information disclosed in therapy, to verify if the client is a part of their social network, or to search for client contact information that were lost. More than a third (38%) of participants reported searching for information unrelated to treatment such as arrest records, social media updates, and relationships.

Non-parametric group comparisons and chi-square tests were conducted to examine if there are differences between participants with and without the history of searching client information. There were no significant findings related to age and pro-social media experiences, beliefs, knowledge, and skills, but the results did show that participants who reported they had searched for a client or a client’s family on the Internet or social media reported more frequent social media use as compared to those who did not report past searching behaviors. Related to therapists searching behaviors, 79% participants believed that it is an invasion of privacy to search client information on the Internet or social media, but 92% participants responded they believe social media profiles without any privacy settings as public information. These findings are not surprising because a previous study found that the majority of health professionals in their sample held similar beliefs (Jent et al., 2011).

Importantly, however, the results showed complication in ethical issues related to searching for client information online. Therapists believed that searching for clients’ information without their consent would be an invasion of privacy, but the boundaries between public versus private information on social media could be confusing because most participants believed that social media profiles without any
privacy settings were public information. Indeed, several participants commented “this would be different if the client had a private social media page versus a public one” and “I think viewing a patients public social media page is appropriate - as it is public knowledge.” Findings also suggest therapists are aware of ethical responsibilities after they are made aware of potential suicide risks of clients. A participant commented, “Now that I have seen it, I have a duty to protect the safety of the individual and need to follow appropriate steps to ensure they are receiving adequate care.” With regards to the appropriate steps, many participants would choose to consult with a supervisor or a trusted colleague, call the client immediately, and/or call for a wellness check on the client.

**Sharing Political or Advocacy Content on Social Media**

I hypothesized that older participants and participants with less social media use would be more likely than younger participants and participants with more social media use to report that they would recommend a colleague delete personal or professional social media accounts and refrain from posting political or advocacy content, but only one participant reported that they would suggest a colleague delete personal social media account and two indicated that they would suggest a colleague delete professional social media account. In terms of providing recommendations about whether to post political content or advocacy content, fewer participants elected to make recommendations about a colleague’s decisions regarding personal than professional social media accounts. This is not surprising given the APA Ethics Code does not apply to psychologists’ personal and private lives (Nadal, 2017). Several participants commended individuals’ rights to their personal social life but indicated it is important to maintain privacy of personal social media (e.g., “I think they have a right to post what they want to personally, but that that should be difficult to find”). However, several participants commented on the blurring of boundaries in the realm of social media. A participant wrote “even if their account is person [personal] it's [posting on social media’s] still a public action.”

Regarding professional social media accounts, more participants \((n = 77)\) chose to suggest a colleague not to share political content and 31 participants elected they would suggest avoiding advocacy content on social media. Previous discussions on sociopolitical involvement of psychologists shed light
into the differences related to therapists’ responses towards posting advocacy and political content (Andrade & Campo-Redondo, 2020; Nadal 2017). APA’s Code of Ethics cautions psychologists against misusing their influence and engaging in activities that negatively impact their objectivity or exposing clients to harm (Nadal 2017). Therefore, psychologists may take a more cautious stand against taking public stances on social and political issues that are perceived as controversial to avoid causing harm to clients and negative impacts on their role as psychologist. In addition, the historical view for psychology to be apolitical and for psychologists to remain neutral continues to be influential (Nadal 2017). Indeed, several participants discussed neutrality (e.g., “neutrality should be maintained in professional social media spaces”) and concerns about the impacts of political content on therapeutic relationships (e.g., “could potentially damage the relationship/their care”) as their reasons for avoiding political content or advocacy content that could “potentially be political.”

Participants appeared to experience more confusion and conflict related to posting advocacy activities on social media. One participant reported feeling “torn about advocacy content,” and this sentiment was shared by several participants. Another participant wrote about conflicting ethical responsibilities: “We have an ethical duty to care for our clients. However, we are also called by our ethical commitments to engage in efforts to promote diversity, equity, inclusion, and justice.” Still others highlighted the importance of following APA’s ethical guidelines with regards to advocacy (e.g., “I would be okay with advocacy posts, especially if it’s in-line with APA principles and advocacy targets”). These findings could be relevant to the change in contemporary psychology with the rise of multiculturalism and social justice efforts. Activists and psychologists operating on critical, feminist, and multicultural psychology have challenged the transitional view of maintaining neutrality and lack of social justice efforts in psychology in recent years (Flynn et al., 2021; Nadal 2017). Notable but non-significant results suggest individuals who chose to suggest a colleague not to post advocacy related content on professional social media accounts reported somewhat more years of therapy experiences and used somewhat fewer social media platforms. Graduate students or early career professionals who have
fewer years of clinical experience are more likely to be educated and trained in these newer perspectives that focus on social justice.

**Clinical Relevance of Social Media**

**Cyberbullying**

I hypothesized that age would be younger, and level of social media use and pro-social media experiences, beliefs, knowledge, and skill higher, for participants who reported that they would include cyberbullying concerns into therapy. The findings supported the hypothesis that level of social media use and pro-social media experiences, beliefs, knowledge, and skill higher, for participants who reported that they would include cyberbullying concerns into therapy. Specifically, participants who reported they would include social media bullying concerns into therapy (e.g., encourage the client to review privacy settings, show client how to change privacy settings, encourage the client to report online harassment and bullying) also reported they use more social media platforms than those who did not choose these options. Furthermore, individuals who elected to encourage the client to report online harassment and bullying also rated their daily social media use and knowledge level regarding social media sites and culture higher.

In addition, participants who chose to incorporate social media in therapy activities (show the client how to change privacy settings and how to report online harassment and bullying) also reported incorporating social media in interventions more regularly, viewing social media as more relevant to the “real world”, and more frequent encounters of clients bringing up social media in sessions. These findings are not surprising given that participants with prior experiences in social media discussions in therapy may feel more comfortable about showing clients how to change privacy settings and report online harassment and bullying on social media. On the other hand, participants who chose to encourage the client to review privacy settings reported a lower self-reported skill level related to social media use. Even though this finding seems to be out of order, participants’ responses regarding their considerations may shed some light into the finding. Given the vignette portrayed a situation faced by a 15-year-old teenager, participants may have assumed that teenagers have better skills than they do when it comes to social
media use. For instance, a participant wrote, “I might need some training myself in how to respond to bullying or manage social media privacy” and another mentioned “I would present the option of reporting it as bullying via social media and make sure they know how (which I’m sure they would know much better than me).”

Regarding recommendations therapists made related to social media use of clients, participants who chose to encourage the client to deactivate their social media temporarily were older and reported more years of clinical experience than those who did not make such recommendations. However, participants who chose to encourage the client to limit social media use reported to have more knowledge about social media sites and culture than those who did not choose to do so.

**Body Image Concerns and Unhealthy Dieting Advice on Social Media**

Lastly, for the fourth vignette, I hypothesized that age would be younger, and level of social media use and pro-social media experiences, beliefs, knowledge, and skill higher, for participants who reported that they would spend time in session reviewing social media sites with the client. There were no significant differences between participants who reported that they would include social media body image concerns into therapy in terms of age and level of social media use. In terms of pro-social media beliefs, knowledge, and skills, there are some similar patterns found related to the third vignette. Specifically, participants who reported that they would review social media accounts in session with clients also rated higher on an item asking how relevant are to the “real world” than those who did not choose to take such action. The results show that participants who reported they would recommend the client to limit their daily use of social media are older than those who did not elected to encourage the client to limit social media use. Moreover, participants who reported they would encourage the client to limit daily use of social media also rated the importance of discussing social media boundaries higher.

**Common Themes in Clinical decisions**

A review of findings in both clinical vignettes shows that there are similar patterns. In particular, participants who chose to take active actions to involve social media in therapy activities in both vignettes (e.g., show how to change privacy settings show how to report online harassment and bullying, and
review social media accounts in session) also rated higher relevance of social media to the “real world.” Therefore, the results suggest individuals who are aware of the connections between the digital space and individuals’ life offline influence their decisions to take more active actions in incorporating or addressing social media in clinical work. Furthermore, older participants were more likely to recommend temporary deactivation (third vignette) and recommend the client to limit their daily use of social media (fourth vignette). These findings are not surprising given that research has shown social media use is associated with younger age (Pew Research Center, 2015; Taylor et al., 2010). Those who grow up using social media may have a better understanding of the importance of social media use and its connections with individuals’ life offline. Consistent with the findings, many participants commented on the potential drawbacks of suggesting the client delete or deactivate social media in the third vignette (e.g., “I could see deleting social media account being perceived as a 15 y.o. as further ostracizing”) and limit social media use in the fourth vignette (e.g., “The approach of correcting misinformation and being part of the client's social media use would be a better approach to help the client than dismissing the client's positive experiences on social media altogether by telling them to limit social media use.”).

On the other hand, participants who reported they would suggest the client to limit social media use also reported they are more knowledgeable about social media sites and culture and rated the importance of discussing social media boundaries higher. Similarly, participants who reported they would recommend the client to view social media as not real life and increase offline interaction reported using more social media platforms. Even though this finding seems to be out of order, participants’ responses regarding factors they considered may shed some light into the reasoning of their responses. In both scenarios, participants discussed their hesitancy to make specific suggestions following APA’s Principle E: Respect for People's Rights and Dignity that outlines the importance of respecting clients’ self-determination in making decisions. For instance, in Vignette 3, a participant wrote, “Balance autonomy of decision making with safety/risk given impact social media can have on adolescent self-esteem.” In Vignette 4, a participant commented, “Would want to balance client’s autonomy with ensuring they have factual information about dieting/disordered eating concerns.”. Moreover, other participants believed
making recommendations about social media are ethical violations and can negatively impact therapy (e.g., “I would mostly stay away from the ‘encouraging’ the client to participate in any specific behaviors. For example, I don't think it’s ethical to tell the client what to do in regard to their use of social media”, “I would want to address the effects on online bullying but I also think it would be ineffective/potentially boundary-crossing to try to dictate what a client does with their social media.”, and “Making recommendations about social media extend beyond the therapy process and could have other unintended consequences”). Given that, participants who believed in the importance of discussing social media in therapy and their knowledge level of social media sites and culture may be more likely to consider making a recommendation related to limiting or decreasing social media use of clients.

Even though there is greater consensus related to deleting social media accounts because only a few participants chose to make such suggestions, the findings suggest therapists have mixed feelings and opinions towards the less extreme approaches such as limiting social media use. Indeed, participants’ written responses suggest many participants chose to explore the client’s assessment of the benefits and risks of social media use such as “be more mindful of the potential impact of social media and to weigh the benefits vs. harms in regards to their mental well being”, “As the social media bullying is directly related to their depression, it is appropriate to address and to provide guidance on how to make adjustments to improve mental health”, “I would not want to invalidate the client's felt connection to others through these social media platforms, however, I would want them to consider the pros and cons of the content they are consuming. I don't know that it would be helpful to ask the client to fully stop engaging in social media, especially because the messaging described exists well beyond internet platforms. Therefore, I think it would be more effective to learn how to more appropriately navigate it.”).

**Rurality**

Comparing results in terms of rural and non-rural areas, participants who reported they were currently practicing in non-rural areas reported they incorporate social media in case conceptualization more frequently than those who reported practicing in rural areas. Other than that, there were no significant differences between participants who reported practicing in a rural versus non-rural areas in
other aspects of social media experiences, beliefs, knowledge, and skills or in their level of personal or professional social media use or self-reported behaviors in interaction with clients or client information on social media. Even though there are small differences in social media use of individuals who lives in rural versus urban areas (Pew Research Center, 2021, April), other studies have found comparable rates of social media use in rural areas (Brunette et al., 2019). Moreover, social media has been viewed as a favorable method to reach rural populations with limited access to mental health services (Brunette et al., 2019; Dickson et al., 2017; Fischl et al., 2020). Therefore, rurality might not limit therapists’ access to social media and tendency to use social media.

**Theoretical Implications**

The literature on the encounters of social media-related issues in therapy is new and developing. The current research aimed to explore therapists’ ethical and clinical decisions on social media-related issues. Previous studies revealed differences in therapists searching behaviors in crisis versus non-crisis situations and the results of current research supported previous findings. Furthermore, numerous papers have attempted to address therapists’ self-disclosure on social media (Baier, 2018) or therapists’ dilemma with promoting social justice and political involvement in their professional roles (Andrade & Campo-Redondo, 2020; Nadal 2017). The current findings provided support to the dilemma experienced by therapists with varying opinions on whether therapists should disclose their views related to social causes or political content on social media. The findings suggest the importance of addressing the conflicting perspectives and ethical guidelines regarding the role of mental health professionals in promoting social justice (e.g., social justice advocates, conventional views of maintaining neutrality).

Furthermore, the findings show that pro-social media beliefs impacted participants’ decisions to involve social media in therapy activities in session. Previous studies in social media competency of therapists focus on client perspectives (Pagnotta et. al., 2018). Therefore, the findings contribute to a largely underexplored area in literature. Moreover, the current findings help to better understand how clinicians come to their clinical decisions relevant to social media and variables that are in play in their decision-making process.
Clinical Implications

The current study sought to answer questions pertinent to clinical practice with the exploration of therapists’ ethical and clinical decisions on subjects relevant to social media. The findings suggest the importance of discussing social media-related ethical and clinical issues in therapist training and education.

Despite the establishment of social media policy at workplace and previous training, participants were challenged by social media-related ethical decisions. The results show that 32% of clients reported they had conducted social media or internet searches of a client or a client’s family. Similarly, the findings related to therapist self-disclosure on social media suggest there should be more guidance and discussions around therapist disclosure of advocacy and political content. With the movement towards social justice efforts in psychology (Andrade & Campo-Redondo, 2020; Nadal 2017), participants continued to experience uncertainty related to the appropriateness of their active engagement and involvement in social justice efforts in their professional roles given the conflicting ethical and clinical considerations. The findings suggest the importance of addressing potential conflicts experienced by clinicians in order to support them to effectively navigate and promote social justice efforts in professional roles. These findings suggest nuanced yet important issues that would require more focus in current ethical guidelines, training/education, and policy around social media-related issues. Specifically, the complexity of the bounds of privacy and confidentiality on social media is an important focus.

Furthermore, the findings suggest the importance of increasing self-awareness and self-regulation of therapists’ social media use. For instance, participants who reported greater social media use daily are more likely to search for client information online. Therefore, mental health professionals who use social media should monitor their behaviors to safeguard professional boundaries and ethical integrity.

Participants’ responses offer some recommendations to ethical dilemma related to social media use. Specifically, many participants agree that they would want to get in contact with a client (e.g., call the client immediately, wellness check) if they believe there is any potential suicide risks. Regarding posting advocacy or political content on social media, participants propose prevention efforts such as discussing
social media use and boundaries in the intake process. Typically, trainees and early career professionals rely on supervision for guidance. Many participants also discussed seeking peer consultation and/or supervision in their decision-making process across several vignettes, but the findings show social media-related issues bring new challenges that require a reassessment of typical problem-solving methods given that consultations and supervision may not yield satisfying results if the supervisor and/or more experienced colleagues may not be attuned to technology and social media advancements.

Additionally, the results suggest participants who used more social media platforms and had more pro-social media experiences, beliefs, knowledge, and skills would feel more comfortable incorporating social media in therapy activities in relevant situations (e.g., social media bullying, disordered eating with the involvement of social media). These findings demonstrate the relevance of social media to therapy and therefore, therapists may need to keep up with the popular social media and its use (e.g., ways to change privacy settings and report online harassment) to better advocate and support clients. Moreover, it is also important to include discussions of social media use and clinical cases in therapist education and training as increased experience in incorporating social media in therapy and understanding of its relevance to clients’ lives would help therapists to better support clients in difficult situations related to social media use.

**Rural Implications**

The results suggest there were no significant differences between participants who reported practicing in a rural versus non-rural areas, other than frequency of incorporating social media in case conceptualization. Given that previous studies suggest variability in differences in social media use in terms of rurality (Pew Research Center, 2021, April; Brunette et al., 2019). The current findings suggest rurality may not limit therapists’ access to social media, as well as their attitudes, knowledge, and skills related to social media use.

**Limitations**

There are several limitations in the current study. Firstly, the main findings rely on participants’ responses to four hypothetical scenarios using vignettes. Though the use of vignettes allows the
exploration of participants' beliefs, attitudes, and responses in ways that minimize social desirability (Evans et al., 2015), vignettes are not real-life scenarios. Specifically, written vignettes may not fully capture reality as well as other methods of presenting or simulating real-life scenarios (e.g., videos; Erfanian et al., 2019). Though attempts were made to use vignettes from previous studies and modify actual clinical cases from case studies and personal anecdotes to provide details that resemble actual cases, the vignettes may fail to fully capture in-depth details that clinicians would have for their clients. Moreover, using vignettes may fail to accurately reflect participants' actual beliefs and behaviors in real life (Erfanian et al., 2019). The relationships between participants' stipulated behaviors in response to a hypothetical scenario and their actual behaviors are not fully understood. Furthermore, participants who read the same vignette may come to different understandings and conclusions about the vignettes depending on their individual interpretation and judgments (Erfanian et al., 2019). For instance, the vignettes adopted gender-neutral language, but some participants used other pronouns in their responses. These variability and assumptions are not uncommon in studies utilizing vignettes (Erfanian et al., 2019). However, the impacts of individual assumptions and interpretations on the results were not fully understood and explored. Therefore, future studies may want to address the limitations of using vignettes to assess participants' clinical and ethical decision making related to social media use.

Secondly, the current study employed self-reported measures and questions. Therefore, response bias could exist and influence the findings (Rosenman et al., 2014). Despite the attempt to minimize social desirability bias through the adoption of vignettes, it is impossible to eliminate social desirability bias or other types of response bias in participants’ response. Therefore, future studies may consider using measurements and methodology that could prevent response bias. For example, adding question at the end about how truthfully they responded, and collecting data in a more anonymous way by separating the participant email entry from the rest of the survey.

Thirdly, the vignettes and post-vignette questions are created for the purpose of current study. These questions are mostly single-item questions that do not allow comprehensiveness in assessing participants' attitudes and beliefs. Moreover, conducting many individual correlations and t-tests may
result in an increased risk of Type I errors. As such, it would be beneficial for future studies to use more comprehensive measures that allow a more thorough assessment and analysis of participants experiences, knowledge, skills, and beliefs related to social media.

**Future Directions**

Given current findings suggest complexity in therapist’s ethical and clinical decision making, especially with conflicting ethical principles and professional values. Future research should extend on current studies and focus on collecting in-depth data regarding therapists’ considerations when making decisions regarding social media-related issues. Collecting enriched data would allow increased understanding of the specific steps and factors that therapists use to evaluate social media-related issues and make decisions.

In addition, therapists’ understanding of professional roles and responsibilities, as well as clinical and ethical decision-making, are informed by theoretical orientations adopted by therapists. Past research has shown differences in client searching behaviors based on theoretical orientations. Specifically, individuals who adopted mainly cognitive behavior therapy reported less client searching behaviors than individuals who used psychodynamic or integrative approaches (Kolmes and Taube, 2014). Given that the sample of current study was not diversified in terms of theoretical orientations, no conclusions can be drawn in this area. Therefore, future studies should consider recruiting a sample with representations of all theoretical orientations to clarify whether there are differences in theoretical orientations on therapists ethical and clinical decision-making.

Moreover, the current study explored therapists’ responses towards ethical and clinical issues involving social media use, but the findings were not able to determine the effectiveness of therapists’ responses. The findings suggest a general agreement amongst participants in specific areas. For instance, only few participants elected to search for client information in the first vignette, chose to suggest a colleague to delete personal and professional social media accounts in the second vignette, and selected the option to suggest clients to delete social media accounts in the third and fourth vignettes. Though participants’ responses show consensus in specific areas, the variability of elected options makes it
difficult to know which responses were considered as more effective and align with common clinical, professional, and ethical practice. Therefore, future research should further explore therapists’ and clients’ perceptions on effective and competent approaches in respond to difficult ethical and clinical decisions related to social media.
CHAPTER 5

CONCLUSION

The purpose of the research is to explore therapists’ ethical and clinical decision making on social media-related clinical situations. Even though not all hypotheses were supported by the findings, the findings contribute to the underdeveloped research area by showing therapists’ responses in challenging ethical and clinical scenarios related to social media. Firstly, results show that only a few participants reported they would search for client information in a hypothetical crisis scenario, but a considerable percentage of participants reported they have searched for client information online and those who reported such behaviors reported higher daily social media use. Similarly, more participants suggested not posting political content on personal social media. Of those who elected not to post advocacy content, individuals are more likely to report somewhat more clinical experience and use somewhat fewer social media accounts. These findings hold strong clinical implications in informing education and training related to social media ethics. Moreover, the results suggest social media experiences, beliefs, knowledge, and skills influence therapists’ choices to incorporate social media in therapy activities. These findings suggest the importance of therapists’ increased awareness of how social media contribute to clients’ mental health wellness and willingness to increase understanding of social media to be an advocate and support for clients.
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APPENDIX A: VIGNETTES

INSTRUCTIONS: You will be presented four short descriptions of psychotherapy scenarios. After reading each scenario, you will be asked questions about how you would respond.

[Vignette 1.1] You've been seeing a 30-year-old client regularly on an outpatient basis for three months, and the focus of therapy has been the client's depression and anxiety. In therapy, the client frequently discusses their social media activity and sometimes even logs onto their social media accounts to show you their own and other people's posts, pictures, and comments related to session topics. During the last appointment, the client appeared more stressed than usual and declined to discuss the source of that stress. Today, they didn't show up for their appointment at all. Given their frequent use of social media, you may be able to do a quick search to learn more about their current situation.

In this scenario, would you search your client's social media?

☐ Yes
☐ No

How confident do you feel about whether to search your client's social media?

☐ 1 – Not at all Confident
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7 – Completely Confident

[Vignette 1.2] Regardless of how you answered, assume that you do search your client's social media. The first website you visit is your client's public social media profile where you see their most recent post, "This life has finally pushed me past the breaking point. Goodbye," which they posted a couple hours ago.

In this scenario, how would you respond? Check all that apply.

☐ I would proceed as usual as if I never saw the client's social media.
☐ I would call the client immediately.
☐ I would wait to for the next therapy session to discuss the issue with the client.
☐ I would call my supervisor immediately [if applicable].
☐ I would wait for the next supervision meeting to discuss the issue with my supervisor [if applicable].
☐ I would consult with a trusted colleague.
☐ I would call the client's emergency contact.
☐ I would call a mental health crisis team or law enforcement to request a wellness check.
☐ Something else not listed: ________________
How confident do you feel about the response(s) you selected?

- 1 – Not at all Confident
- 2
- 3
- 4
- 5
- 6
- 7 – Completely Confident

Briefly explain why you would respond to the situation in this way. Are there particular ethical, legal, clinical, personal, or other factors you considered? ________________

Would you acknowledge to the client that you searched their social media?

- Yes
- No

Would you acknowledge to your supervisor that you searched the client’s social media?

- Yes
- No
- Not applicable
[Vignette 2] A colleague of yours asks to consult about an issue that arose recently. When not seeing clients, your colleague is involved in advocacy efforts related to mental health and related social issues, and they often share their advocacy activities (e.g., fundraisers, speaking events) and political views on both their personal and professional social media accounts. Your colleague tells you that they had been seeing a 30-year-old client on a regular outpatient basis for the last three months, and during the most recent appointment, the client disclosed that they searched your colleague's social media and saw posts about your colleague support of causes and views the client strongly opposes. The client told your colleague that they no longer feel comfortable discussing some aspects of their personal life in therapy and plan to find a new therapist. Your colleague asks you for advice on their social media activity going forward.

In this scenario, what advice would you offer your colleague? Check all that apply.

- I would suggest they proceed as usual, maintaining their current social media practices.
- I would suggest increasing privacy restrictions on their personal social media account(s).
- I would suggest increasing privacy restrictions on their professional social media account(s).
- I would suggest not posting or sharing potentially political content on their personal social media account(s).
- I would suggest not posting or sharing potentially political content on their professional social media account(s).
- I would suggest not posting or sharing advocacy activities on their personal social media account(s).
- I would suggest not posting or sharing advocacy activities on their professional social media account(s).
- I would suggest deleting their personal social media account(s).
- I would suggest deleting their professional social media account(s).
- Something else not listed: ________________

How confident do you feel in the suggestion(s) you selected?

- 1 – Not at all Confident
- 2
- 3
- 4
- 5
- 6
- 7 – Completely Confident

Briefly explain why you would advise your colleague in this way. Are there particular ethical, legal, clinical, personal, or other factors you considered? ________________
You have been seeing a 15-year-old client regularly on an outpatient basis for three months. The focus of therapy has been the client's depression and anxiety. Before the most recent session with the client, the client's parents tell you they are concerned about a recent change in the client's behavior. The parents explain that a few weeks ago the client abruptly became more socially withdrawn from friends, reluctant to go to school, and, according to teachers, unwilling to participate in class activities. The parents are unaware of what caused this change. In your one-on-one session with the client, the client tells you that a few weeks ago they spent the night with a few friends, and while they were asleep, their friends applied make up on their face with toothpaste and lipstick to make them look funny. Though their friends were just trying to be silly and meant no harm, the client explains, one friend posted a picture on social media, which led to the client becoming the subject of public ridicule and humiliation. One nasty comment about their physical appearance attracted many more unpleasant comments from peers at school and people they did not know at all, breaking their self-confidence with each new comment.

In this scenario, how would you respond? Check all that apply.

☐ I would proceed as usual, focusing only on the client's depression and anxiety.
☐ I would add new therapy activities on school-based bullying.
☐ I would encourage the client and their parents to discuss solutions to bullying with the school.
☐ I would encourage the client to view social media as not reflecting real life and to increase their time spent in offline social interactions.
☐ I would encourage the client to review social media privacy settings on their account(s).
☐ I would spend time in session showing the client how to change privacy settings on their account(s).
☐ I would encourage the client to limit their daily use of social media.
☐ I would encourage the client to temporarily deactivate their social media account(s).
☐ I would encourage the client to permanently delete their social media account(s).
☐ I would encourage the client to report online harassment or bullying on their social media account(s).
☐ I would spend time in session showing the client how to report harassment or bullying on their social media account(s).
☐ Something else not listed: ____________________

How confident do you feel in the suggestion(s) you selected?

☐ 1 – Not at all Confident
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7 – Completely Confident

Briefly explain why you would respond in this way. Are there particular ethical, legal, clinical, personal, or other factors you considered? ____________________
[Vignette 4] You've been seeing a 30-year-old client regularly on an outpatient basis for three months. The focus of therapy has been the client's use of excessive exercise and food restriction to lose weight. The client has made great improvements, but they still weigh themselves multiple times a day and frequently ignore their hunger. Though they participate actively in therapy, the client feels uncomfortable telling their friends and family about their body image issues or about being in therapy. During the most recent session, the client tells you they started following social media accounts about dieting and weight loss. The client also tells you they search dieting and weight loss hashtags to find collages of carefully portioned meals and relatable posts and floods of supportive comments about body image and eating struggles, though they sometimes also encounter images of very thin bodies. The client expresses feeling connected to people in these social media communities in a way they can't be to others in real life. The client adds that they can helpful dieting advice shared by people in these communities and by other fitness influences. One account the client follows offered a simple piece of advice: "To lose weight, never eat when you're not hungry." The client tells you they found the advice helpful for maintaining their weight goals.

In this scenario, how would you respond? Check all that apply.

☐ I would proceed as usual, focusing only on body image, excessive exercise, and food restriction.
☐ I would add new therapy activities related to body positivity.
☐ I would add new therapy activities related to social comparison.
☐ I would encourage the client to increase their time spent in offline social interactions.
☐ I would encourage the client to limit their daily use of social media.
☐ I would encourage the client to temporarily deactivate their social media account(s).
☐ I would encourage the client to permanently delete their social media account(s).
☐ I would talk with the client about health misinformation on social media.
☐ I would encourage the client to avoid unhealthy social media content and engage only with social media accounts embracing body positivity.
☐ I would offer to spend time in session reviewing social media accounts together with the client.
☐ Something else not listed: ________________

How confident do you feel about the response(s) you selected?

☐ 1 – Not at all Confident
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7 – Completely Confident

Briefly explain why you would respond in this way. Are there particular ethical, legal, clinical, personal, or other factors you considered? ________________
APPENDIX B: QUESTIONNAIRES

Social Media Use Questions – adapted from survey items from Pew Research Center (2018, 2021)

1. Please tell me if you ever use any of the following. Do you ever use...
   A. Twitter  o Yes  o No  o Don't Know
   B. Instagram o Yes  o No  o Don't Know
   C. Facebook  o Yes  o No  o Don't Know
   D. Snapchat  o Yes  o No  o Don't Know
   E. YouTube   o Yes  o No  o Don't Know
   F. WhatsApp  o Yes  o No  o Don't Know
   G. Pinterest  o Yes  o No  o Don't Know
   H. LinkedIn  o Yes  o No  o Don't Know
   I. Reddit     o Yes  o No  o Don't Know
   J. TikTok     o Yes  o No  o Don't Know
   K. Nextdoor  o Yes  o No  o Don't Know
   L. Something else not listed: ____________

   Based on Pew Research Center’s (2021) methods, A-E were presented at the top of the list but in random order, followed by F-K in random order. L was not in Pew's version but was added for the current study and was presented last.

2. What kind of [PLATFORM] account, if any, do you have?
   ○ Personal account only
   ○ Professional account only
   ○ Both a personal account and a professional account
   ○ Neither. I look at content on the site, but I don't have an account.

   This item appeared as a follow-up item appeared for each site (A-K) endorsed in item 1. This item not in Pew's version and was added for the current study.

3. Thinking about the social media sites you use, about how often do you visit or use social media sites?
   ○ Several times a day
   ○ About once a day
   ○ A few times a week
   ○ Every few weeks
   ○ Less often
   ○ Don't Know

   This item was modified. Pew Research Center’s (2021) version repeats this item for each social media site used. I modified it to apply more generally to overall use of social media across different sites.

4. How difficult would it be, if at all, to give up the social media sites you use in your life?
   ○ Very hard
   ○ Somewhat hard
   ○ Not too hard
   ○ Not hard at all

   A version of this item was included in Pew Research Center’s (2018) social media survey. The original item was “How difficult would it be, if at all, to give up the following things in your life? If you do not use or have the item, just tell me. How hard would it be for you to give up social media?”
Media and Technology Usage and Attitudes Scale, modified subscale (MTUAS; Rosen et al., 2013)

How often do you do each of the following activities on social media sites?

1. Check your social media accounts.
2. Check your social media accounts from your smartphone.
3. Check social media accounts at work or school.
4. Post status updates.
5. Post photos.
7. Read postings.
8. Comment on postings, status updates, photos, etc.
9. Click "Like" to a posting, photo, etc.
X. Skip this item. Leave it blank and go on to the next one. [ATTENTION CHECK]
10. Share other people's postings, status updates, etc.

Response options for all 10 items:

- Never
- Once a month
- Several times a month
- Once a week
- Several times a week
- Once a day
- Several times a day
- Once an hour
- Several times an hour
- All the time

The MTUAS includes 60 items and has a 9-item subscale about social media use. Item 1 in that subscale was originally “Check your Facebook page or other social networks,” item 2 was originally “Check your Facebook page from your smartphone,” and item 3 was originally “Check Facebook at work or school.” I modified the wording for items 1-3 and added an item about sharing other people’s posts to be more broadly applicable to the wider range of site used since the MTUAS was developed.
Therapist Social Media Experiences, Beliefs, Knowledge (created for study)

PART 1: ETHICS QUESTIONS

1. Have you ever searched for information about a client or a client's family on the Internet or social media?
   - Yes
   - No

2. To your knowledge, has a client ever searched for information about you or your family on the Internet or your social media?
   - Yes
   - No

3. Has a current or former client ever interacted with your social media account (messaged you; posted to your account; commented on, liked, or shared your posts; followed you)
   - Yes, my personal social media
   - Yes, my professional social media account
   - Yes, both personal and professional social media accounts
   - No

4. Have you ever interacted with a current or former client's social media account (messaged them; posted to their account; commented on, liked, or shared their posts; followed them)?
   - Yes, my personal social media
   - Yes, my professional social media account
   - Yes, both personal and professional social media accounts
   - No

5. In your opinion, is it an invasion of privacy to conduct an Internet or social media search of clients?
   - Yes
   - No

6. In your opinion, are social media profiles with no privacy settings public or private information?
   - Public
   - Private

Items 1, 3, 4, 5 and 6 in Part 1: Ethics Questions were adapted from survey items from the study of Jent and colleagues (2011).

7. Where did you receive education/training regarding ethics relevant to social media?
   - None
   - Graduate program
   - Practicum/internship
   - Postdoctoral training
   - Continuing education

8. Is there social media related policy established where you practice (where you see clients or teach or supervise trainees, or in your graduate program)?
   - Yes
   - No
   - Don't know

9. Are you aware of any ethical standards or professional guidelines related to social media in your respective field?
   - Yes, I've reviewed these standards or guidelines
PART 2: THERAPY QUESTIONS

1. How often do you incorporate social media in your case conceptualization of your clients or your supervisees’ clients?
   - Never
   - At least once
   - More than once
   - Several times
   - More times than I can count

2. How often do you incorporate social media use into therapy discussion or activities?
   - Never
   - At least once
   - More than once
   - Several times
   - More times than I can count

3. How often do you ask about client social media use as part of your assessment?
   - Never
   - At least once
   - More than once
   - Several times
   - More times than I can count

4. How often have your clients brought up social media in therapy?
   - Never
   - At least once
   - More than once
   - Several times
   - More times than I can count

5. How often has a trainee (student or supervisee) discussed social media issues brought up by their clients?
   - Never
   - At least once
   - More than once
   - Several times
   - More times than I can count
   - Not applicable

6. In your opinion, how important it is to discuss social media boundaries with clients?
   - 1 – Not at all important
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7 – Very important

7. How knowledgeable are you about social media sites and social media culture?
   - 1 – Not at all knowledgeable
8. How skilled are you at including clients' social media experiences into therapy discussions and activities?
   - 1 – Not at all skilled
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7 – Very skilled

9. In your opinion, how relevant are social media experiences to the "real world"?
   - 1 – Not at all relevant
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7 – Very relevant
Professional Training, Credentials, and Experiences (created for study)

1. Which of the following best describes your current professional role?
   - Graduate student
   - Postdoctoral fellow/resident
   - Academic, teacher, or researcher
   - Clinician, practitioner, or mental health professional
   - Something else not listed: __________

2. How many hours per week, on average, do you see clients? __________

3. For how many years have you/did you see clients, including graduate school? __________

4. Which of the following best describe the majority of clients you are currently seeing or had seen?
   - Children (up to ages of 12)
   - Adolescents (13 – 17 years old)
   - Young adults (18 – 21 years old)
   - Early adulthood (21 – 34 years old)
   - Middle adulthood (35 to 64 years old)
   - Old age (age 65 and above)

5. Do you hold a current masters- or doctoral-level license?
   - Yes, I'm currently licensed.
   - No, but I'm license-eligible and actively pursuing licensure.
   - No, but I was licensed in the past.
   - No, I have never been licensed.

6. Are you currently supervising graduate students and/or postdoctoral fellows/residents who are seeing clients?
   - Yes, currently
   - No, currently
   - No, but I have in the past
   - No, never

7. Are you currently teaching courses for graduate students and/or postdoctoral fellows/residents who are seeing clients?
   - Yes, currently
   - No, currently
   - No, but I have in the past
   - No, never

8. [GRAD STUDENTS ONLY] Have you completed an ethics course yet?
   - Yes
   - No, but I will soon
   - Not applicable. My program doesn't offer an ethics course.

9. Which of the following degrees have you obtained? Check all that apply.
   - [ ] Applied behavior analysis (□ doctorate □ masters)
   - [ ] Clinical psychology (□ doctorate □ masters)
   - [ ] Counseling psychology (□ doctorate □ masters)
   - [ ] Marriage and family therapy (□ doctorate □ masters)
   - [ ] Mental health counseling (□ doctorate □ masters)
   - [ ] Pastoral counseling (□ doctorate □ masters)
   - [ ] School psychology (□ doctorate □ masters)
   - [ ] Social work (□ doctorate □ masters)
   - [ ] Another doctoral degree not listed: __________
☐ Another masters degree not listed: _________
☐ Another graduate degree not listed: _________
☐ None of the above. The highest degree I've obtained is a bachelors.

10. What is the primary theoretical orientation from which you operate?
   ○ Behavior Therapy
   ○ Cognitive-Behavior Therapy
   ○ Existential Therapy
   ○ Feminist Therapy
   ○ Humanistic Therapy (Emotion-Focused, Gestalt, Person-Centered)
   ○ Interpersonal Therapy
   ○ Integrative
   ○ Narrative Therapy
   ○ Positive Psychology
   ○ Psychoanalytic/Psychodynamic Therapy
   ○ Third Wave Cognitive-Behavior Therapy (Acceptance and Commitment Therapy, Dialectical Behavior Therapy, Mindfulness-Based Cognitive Therapy)
   ○ Something else not listed: ___________

11. [IF INTEGRATIVE SELECTED] What are the two most important theoretical orientations you draw from? Choose two.
   ○ Behavior Therapy
   ○ Cognitive-Behavior Therapy
   ○ Existential Therapy
   ○ Feminist Therapy
   ○ Humanistic Therapy (Emotion-Focused, Gestalt, Person-Centered)
   ○ Interpersonal Therapy
   ○ Narrative Therapy
   ○ Positive Psychology
   ○ Psychoanalytic/Psychodynamic Therapy
   ○ Third Wave Cognitive-Behavior Therapy (Acceptance and Commitment Therapy, Dialectical Behavior Therapy, Mindfulness-Based Cognitive Therapy)
   ○ Something else not listed: ___________
**Demographics Form**

1. How old are you (in years)? ___________

2. How would you describe your sexual orientation?
   - Asexual
   - Bisexual
   - Gay or lesbian
   - Pansexual
   - Heterosexual
   - Prefer to self-describe: ___________
   - Prefer not to say

3. How would you describe your gender or gender identity? Check all that apply.
   - Cisgender man
   - Cisgender woman
   - Non-binary
   - Transgender man
   - Transgender woman
   - Prefer to self-describe: ___________
   - Prefer not to say

4. How would you describe your racial/ethnic background? Check all that apply.
   - American Indian or Alaskan Native
   - Asian
   - Black or African American
   - Hispanic, Latino, or Latin Origin
   - Middle Eastern or North African
   - Multiracial/Multiethnic
   - Native Hawaiian or Pacific Islander
   - White
   - Prefer to self-describe: _______________
   - Prefer not to say

5. What is your marital status?
   - Divorced
   - Married
   - Never married
   - Separated
   - Widowed

6. What is your relationship status?
   - In a relationship
   - Not in a relationship
   - It's complicated

7. Which of the following best describes the area where you were raised?
   - Urban
   - Suburban
   - Rural

8. Which of the following best describes the area where you currently live?
   - Urban
9. Which of the following best describes the area where you currently see clients or supervise trainees?
   - Urban
   - Suburban
   - Rural
APPENDIX C: STUDY FLOW

Block 1: Informed Consent

- Yes, I read the terms above and consent to participate in this research.
- No, I do not consent to participate in this research. [END OF SURVEY]

Block 2: CAPTCHA

[ MUST HAVE CLICKED TO PROCEED ]

Block 3: Are you currently seeing clients?

- Yes, currently
- No, but I have in the past
- No, never [END OF SURVEY]

Blocks 3-6: Vignettes (presented in random order)

- Vignette 1 (ethical, searching a client’s social media)
- Vignette 2 (ethical, therapist social media activity)
- Vignette 3 (clinical, cyberbullying)
- Vignette 4 (clinical, unhealthy dieting)

Block 7-10: Questionnaires (presented in random order)

- Social Media Use Questions (Pew Research Center, 2021)
- Media and Technology Usage and Attitudes Scale, modified subscale (Rosen et al., 2013)
  - Embedded attention check item [ MUST HAVE LEFT BLANK FOR DATA TO BE INCLUDED IN ANALYSES BUT COULD HAVE COMPLETED STUDY REGARDLESS ]
- Therapist Social Media Experiences, Beliefs, Knowledge, and Skills (created for study)
- Professional Training, Credentials, and Experiences (created for study)

Block 11: Demographics Form

Block 12: Debriefing and Instructions for Compensation