The Ethical Considerations of Mental Health Clinicians Using Public Media

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Since I started my podcast in 2008, I have paid close attention to the potential effects on clients, trainees, and society. As the podcast has grown in popularity, my concerns have increased. To combat my worries, I set out to clarify and make public my ethical decision-making process. In this paper, I will discuss the ethical considerations regarding my public media activity since it has the potential to negatively affect clients, students, supervisees, and the public. This paper represents my experience and judgment, along with supporting viewpoints of ethics experts.

Media Platforms

I am involved in several types of public media that require consideration. I host two podcasts—*The Psychology In Seattle Podcast* and *The Couple and Family Therapy Podcast*—that are available on podcast apps, YouTube, Spotify, and other platforms. I am interviewed as an expert on the radio, television, podcasts, and news outlets. On social media platforms (i.e., Facebook, Instagram, Twitter), I post podcast episodes, research findings, and pictures, such as a picture of a colleague and me at a training. I have written articles for print publications, such as the *Family Therapy Magazine*. I also provide public trainings and lectures that are recorded and made available on the internet. It should be noted that aside from a few exceptions discussed below, my personal social media activity (i.e., personal Facebook and Instagram activity) will be excluded from this paper since I employ privacy settings designed to prevent clients from gaining access, which conforms to the consensus recommendation for mental health clinicians (Kaslow et al., 2011).

Why Use Media?

Since I decided to become a therapist at the age of 24, the foundational purpose of every professional decision I've made has been to attempt to make a positive difference. For the first thirteen years of being a therapist, supervisor, and educator, I felt satisfied in my mission. I was helping clients reduce their symptoms and improve their relationships. I was helping students and supervisees develop as clinicians. It was wonderful to witness clients and trainees transform, improve their self-esteem, and give back to their communities. Each session, class activity, and supervision meeting held something special to me.

Then, in the mid-2000s, I started listening to podcasts. I loved the long-form, in-depth discussions about science, movies, astronomy, and of course, psychology and psychotherapy. Back then, the podcasting landscape was like the Wild West. If you had a little tech knowledge and something to say, you could be one of the most popular podcasts in the world. I wondered if I could extend my mission of positive change through a podcast of my own. I also felt my work was becoming less challenging and somewhat routine.

In 2008, I started a podcast called *Psychology In Seattle*. For the first seven years, there were relatively few listeners, although they were loyal and encouraging. Then, in 2015, at the suggestion of a listener, I created a page on Patreon.com, which allows listeners to become "patrons" for $5 a month in support of the podcast. I honestly did not think anyone would give me their hard-earned money, but some did. A causal loop occurred. As more people become patrons, I was able to take fewer clients and supervisees, which meant I could spend more time on the podcast, which made the podcast better, which attracted more listeners, who donated more money, and so on. Fast forward to 2019, and now I spend more time and make more income from the podcast than I do from all my other work activities combined: therapist, professor, supervisor, and author.

The personal meaning of the podcast has increased as well. To prepare for each episode, the podcast gives me an excuse to fully research topics that I've always wanted to have deeper knowledge of, such as attachment theory, Bowenian theory, and psychodynamic theory. For example, to prepare for an in-depth episode on attachment theory, I spent several months reading, contemplating, and talking with experts. That series of episodes ended up being 17 hours long, which indicates how much knowledge I acquired during those months of study.

The podcast has connected me with several important people in my life, including one of my heroes: the renowned psychotherapist Irvin Yalom. My co-host and friend, Humberto Castañeda, and I have had the opportunity to have deep and meaningful conversations on the podcast—conversations that we will not likely ever forget. Also, my media involvement has increased client, supervisee, and consultee referrals. Additionally, I'm fairly certain that the vast majority of my book sales are from podcast publicity. Furthermore, Washington State law allows me to use my podcast prep to meet some of my continuing education requirements for licensure.

Most importantly, I get a tremendous amount of personal meaning from my attempt to make the world a better place through public media. Since the beginning of my career in psychotherapy, this has been my prime directive. When I retire, I want to look back on a life in which I at least attempted to make a positive difference in the lives of others. My public media involvement has been a significant part of that effort, since it grants the opportunity for me to reach a wider audience. Every day, I receive messages from listeners who have benefited from the podcast, such as: "You're awesome and educational, and you've brought me to a point of insight that I never would be at without you." It's messages like these that keep me going. (It should be noted that all quotes from listeners are published with their consent.)

Benefits of Clinicians Using Media

As with many (if not all) actions taken by psychotherapists, the benefits and risks must be carefully examined and contemplated (AAMFT, 2015; ACA, 2015; APA, 2017). There are several known risks when therapists participate in media, which will be the main focus on this paper. However, there are also a number of benefits, which I will discuss first.

In our field, few would question the value of publishing in a peer-reviewed journal. However, I experience mixed reactions from colleagues when it comes to publishing a podcast or YouTube video. While attending an ethics training on clinicians using social media, the crowd consensus was clear: it is unethical for mental health professionals to use social media, end of discussion. One therapist even proclaimed that it was unethical and unwise for clinicians to have a personal Facebook page, regardless of the privacy settings. I've heard similar sentiments from colleagues at my university. I find this attitude to be outmoded, ignorant of the research, and neglecting of the possible benefits to society. Several studies have found that for both clients and practitioners, the best way to disseminate reliable psychological information is through popular forms of communication, like the internet (Beutler, Williams, & Wakefield, 1993; Dirks et al., 2018). If the purpose of clinical publishing includes disseminating information to both clinicians and the public, we must go beyond the status quo of our typical methods of communication.

Klaus and Hartshorne (2015) assert that the biggest advantage to social media is the ability to spread knowledge to audiences around the globe, most of whom have limited access to mental health care and psychoeducational services. This benefit cannot be overstated. Worldwide, around 1.1 billion people currently suffer from a mental disorder (Ritchie & Roser, 2018), and most do not have access to mental health care (Kohn et al., 2004). Internet media is clearly not a substitute for individualized care, but every little bit helps, especially for the millions without access to affordable care. If we as a profession are truly dedicated to helping others, the call to action is clear. We must do what we can to reach as many people as possible.

As a testament to my efforts on the podcast, a listener from the UK wrote me:

> Thanks for your contribution to the world… Your efforts increase possibilities for empathy and compassion between people and move us a little closer in reducing unnecessary suffering. I think you're providing a point of access to information that is, sadly, often locked behind the doors of the university lecture theatre or the therapist office. I don't think it's an exaggeration to say that the future of humanity is dependent on the democratisation of this knowledge… you are making a difference.

Other listeners have communicated similar feelings. According to a recent podcast listener survey (Honda, 2018), one respondent wrote, "I love this podcast, it's helped me with my own issues a lot, and also helped me and my husband." Another respondent wrote, "The podcast has helped me through the worst of times." I do not provide these quotes to boast, but to point out that when clinicians use media, we break out of our isolated offices to spread empathy, compassion, destigmatization, and the democratization of evidence-based, helpful knowledge.

The internet is full of laypersons offering their opinion about psychological topics. For example, there are articles written by journalists diagnosing (from afar) Former President Barak Obama with several disorders, such as narcissistic personality disorder and psychopathy (Mikkelson, 2019). Since the inception of the internet, all controversial public figures have been "diagnosed" extensively by online

commentators. If we don't participate in the online conversation, the public can be easily led astray. You only have to look at Twitter or your Facebook feed to see evidence of this phenomenon. Without us organizing a strong presence in the media, many dubious, unchecked notions become established facts in the public sphere, while evidence-based, professional viewpoints go unheard. We can complain about this all we want, but until we actually do something about it, we are perhaps part of the problem.

My podcast educates about hopefully-relevant psychological topics, such as personality disorders, parenting, and psychotherapy ethics. On the podcast listener survey (Honda, 2018), many respondents indicated they appreciated the podcast for its education value on these topics. For example, one respondent wrote, "I learn so much from the deep dives and it enhances my therapy practice. My clients find this very useful as well." Another wrote, "I've learned more from this podcast than from my Master's in professional psychology."

I have often imagined an ideal world in which many more clinicians publish their work in a way that reaches a larger audience. In private conversations with fellow professors at my university, I have often thought or said aloud: "If only this brilliant educator was heard by the entire world!" We can only achieve this by getting over our fears, which is facilitated by a strong understanding of the ethical considerations discussed in this paper.

Internet media can also be used for training purposes to improve clinician competency. Disseminating quality guidance to clinicians is particularly important given that research has found that clinical supervision is often substandard. For example, Ellis and colleagues (2013) surveyed 363 supervisees in the U.S. and found that 93% of the participants were currently receiving inadequate supervision and 35% were categorized as experiencing harmful supervision, which can involve supervisory practices that are cruel, exploitative, shaming, discriminatory, or traumatizing. The topics for my podcast episodes are mainly driven by requests from the listeners, half of whom are mental health clinicians according to a recent listener survey (Honda, 2018). Over the past 10+ years, I have published well-researched episodes on important clinical topics, such as countertransference management, ethical dilemmas, and harmful therapies. On the listener survey (Honda, 2018), a number of respondents indicated the podcast helped their career as a clinician. For example, one respondent wrote, "This podcast has been a critical part of my development as a therapist! I have not always had access to quality supervision, and this podcast has been super to supplement with. Thanks so much for all your hard work!" Another respondent wrote, "As a new clinician, the podcast helps normalize some of my irrational thinking in my world of non-existent supervision, all the while delivered with humor." (It should be noted that I make it clear to listeners via disclaimers that the podcast is not a replacement for clinical supervision.)

Klaus and Hartshorne (2015) assert that media can also be a way for a clinician to stay in touch with their clients in-between sessions. Some clients listen regularly to my podcast, and report that some discussions are a helpful adjunct to their in-person treatment. Although I generally discourage clients from listening to my podcast (which will be discussed in detail below), if a client does listen, we discuss how the podcast can hurt (e.g., activate trauma) or benefit (e.g., increase self-awareness). For example, as an attachment-based therapist, clients often ask me for further clarification regarding attachment

theory and the development of a sense of self. Instead of using important session time, I can point them to one of my podcast episodes. Plus, they can (and sometimes do) listen repeatedly to some episodes as a way to help solidify their insight and ongoing personal transformation. Furthermore, I ask clients to tell me what they episode they listened to and what they learned, so I can address any misunderstandings.

We can also use media to advocate for marginalized groups. According to the American Association of Marriage and Family Therapy (AAMFT) Code of Ethics (2015), therapists are defined by a commitment to service, advocacy, and public participation, which is considered equal in importance to our clinical work. Psychologists are held to a similar standard in that the American Psychological Association (APA) Code of Ethics (2017) states that psychologists need to be aware of their professional and scientific responsibility to society. The American Counselor Association (ACA, 2014) and the National Association of Social Workers (NASW, 2017) also hold a core professional value of promoting social justice. It is clear that among all the various professions in the field of mental health, ethical practice involves thinking beyond clients to society at large.

Anyone paying attention can see our social ills. For example, a large volume of empirical research has found that persons with mental illness or disabilities are stigmatized and discriminated against (Corrigan, 2002), and thus they avoid seeking treatment (Vogel, Wade, & Hackler, 2007). Additionally, according to recent polls, a majority of Americans say racism is a major problem in our society (Arenge, Perry, & Clark, 2018), and 42% of women say they have faced sexism on the job (Parker & Funk, 2017). In response to these and other findings, I do my part by discussing progressive topics in a way that laypersons can understand. I try to translate empirical data and the prevailing research in an engaging manner. For example, there is a sizable and vocal group of men on the internet who deny the research on sexism and believe men are in fact the oppressed gender. I engage with these men every week in an attempt to change their hearts and minds. Many times, I have thrown up my hands and given up, but then I remember that without some contact with people like me, they will be lost in a sea of propaganda. On the internet, there are charismatic, destructive voices persuading entire sections of our society, and without a strong opposition from clinicians, researchers, and others, I worry about our fate as a culture.

The internet craves our voice on these matters. On the podcast listener survey (Honda, 2018), a number of respondents indicated their favorite part of the podcast was the focus on social justice topics, such as sexism, homophobia, racism, ableism, homelessness, and mental health stigma. Contrary to the seemingly popular notion that clinicians should not use social media, it could actually be considered unethical that we don't collectively do more to advocate on all media platforms. If we are to truly help others, we cannot sit quietly in our offices and depend on others to provide the clinical voice. We must reach out to where people live, which is more and more predominantly on the internet. But first, we must consider the risks.

Risk: Confidentiality Violations

Across all mental health professions (e.g., AAMFT, 2015; ACA, 2014, APA, 2017; NASW, 2017), and across several professional arenas (i.e., clinical, education, supervision), the overarching ethical obligations are to uphold the principles of beneficence, do no harm, justice, and client autonomy (Corey, Corey, & Callanan, 2011; Heckner, 2010; 2011; Welfel, 2013). Before mental health clinicians publish to media such as Twitter or YouTube, these basic principles need to be carefully considered, particularly the risk to confidentiality.

There is a longstanding consensus in our field that effective treatment and training depend on privacy (Kaslow et al., 2011). For clients, students, and supervisees to feel safe to discuss sensitive material, they need to know that we will not disclose their confidential information to others unless compelled by law or ethical code. With my own therapists and supervisors, I have revealed extremely personal information that would mortify me if made public. Since the beginning of my foray into media over ten years ago, I have seriously considered the confidentiality of my clients, students, and supervisees. This rudimentary ethical code can be easily followed by simply not talking about them. It's just that simple. However, given the newness of some media platforms, there are deceptive temptations to break confidence.

There are accounts of clinicians posting detailed complaints about clients on social media (Chamberlin, 2007). For example, I saw the following Facebook post by a colleague: "Ugh. Long day. Tough clients." Posting complaints on social media is considered gossip in that it is in service of the clinician's own needs (Campbell et al., 2010; Gabbard et al., 2001), which in this case, is likely a need for venting or validation. Clinicians have also been known to post pejorative comments about particular types of clients (e.g., "I hate borderlines"). If one of their clients—past, present, or future—saw a post like this, harm to the relationship and treatment could occur. If I saw a post by my therapist that read "Ugh… my clients today," my trust in her would be injured, perhaps irreparably. Although clinicians' privacy settings might prevent access to their clients, it's nearly impossible to confirm that clients are not Facebook "friends" with someone who does have access. Furthermore, even if clients never gain access, posts like this reflect negatively upon our profession, which is also considered unethical (Myers et al., 2012) and causes distrust of therapists in general.

Confidentiality breaches can occur when clinicians provide case examples. In the service of training and professional advocacy, it is considered acceptable to disclose client or trainee information as long as the clinician takes reasonable steps to disguise identity and to limit the discussion to only germane details (APA, 2010; Caldwell, 2015; Campbell et al., 2010; Fisher, 2009; Gabbard, 2000). Professionals tend to adequately apply these precautions in traditional contexts, such as clinical publication, consultation, and training lectures. However, there is little written on how to apply the ethical codes to podcasting and YouTube, since the audience is potentially billions of individuals who have a greater chance of knowing or mistaking the identity of the case example.

Whenever I detect the educational need to provide a case example on the podcast or in interviews, I safeguard confidentiality by using the methods used in traditional settings: 1) provide a fictional composite of several individuals; 2) ask for written permission, while carefully considering the power differential between me and the client or trainee; or 3) speak in such general terms that the individual would not be identifiable, so much so that the individual would not suspect I was talking about them. For longer descriptions, I tend to use fictional, composite cases, since detailed descriptions of actual clients or trainees could lead to easier detection. For instance, when providing a detailed case of preoccupied attachment style, I provided a detailed history, from birth to adulthood, since I wanted the listeners to get a comprehensive picture of how that attachment style develops and manifests. This necessitated a composite, since the high level of detail could not adequately mask the individual's identity to all those who might hear it. I also provided the caveat that the case was a fictional composite to avoid the possibility of mistaken identity.

For shorter case examples, I tend to use actual clients or trainees and provide limited information. I avoid current cases, since the current pool of clients and trainees is relatively small. For instance, if I were talking about borderline personality disorder, I might provide the following case example: "Years ago, a client of mine often worried about my perception of them and whether or not I was going to abandon them." Since I have treated hundreds of individuals with borderline personality over my 20+ years as a clinician, it would be unlikely that the referenced individual would suspect I was talking about them, given the description's brevity and lack of detail. Even if they did suspect it was them, it's not likely they would be harmed or upset by the statement since it is not denigrating, particularly since I adamantly emphasize normalization and non-shaming of such conditions throughout my podcast.

A key word in the standard of confidentiality is "reasonable." If a client or trainee's identity was discovered after taking reasonable precautions, then the breach is generally not considered an ethical violation (Fisher, 2009). For example, let's say I said on a podcast, "Years ago, I had a supervisee who struggled with understanding her ethical responsibilities." Let's also say that the supervisee's friend listened to the podcast and accurately identified that case example since the friend knew about my past involvement with the supervisee and about the supervisee's struggle with ethics. This is not likely to be deemed unethical since I took reasonable measures to mask identity (i.e., extremely limited details, not a current supervisee) and there is no way for the friend to positively confirm that the case example is in fact the supervisee in question. In summary, confidentiality can be upheld by simply not talking about clients or trainees, and if a case example is needed for education purposes, then reasonable precautions should be taken, such as getting permission, using a fictional composite, or providing limited details.

Risk: Boundary Violations

Ethical dilemmas often involve boundaries. When one of my clients asks a personal question, should I answer it? If a friend refers their neighbor to my practice, should I take the client? If a client gives me a gift, should I refuse it? According to Gutheil and Gabbard's (1993) terms, are these non-harmful boundary crossings or are these harmful boundary violations? Although many clinicians might have clear-cut answers, the solutions to these ethical dilemmas have varied by time and place.

For the first several decades of our profession, no formal ethical standards existed (Abeles & Koocher, 2011). As a consequence, several prominent figures in early psychotherapy—Sándor Ferenczi, Frieda Fromm-Reichmann, Otto Rank, Karen Horney, and others—had sexual relationships with clients, and some even married them (Baur, 1997; Pope & Bouhoutsos, 1986). Based on the example set by these early pioneers, these sorts of boundary crossings persisted throughout the 20th century. In the 1990s, research found that 3% of male counselors reported having sex with a client (Sehl, 1998) and sexual impropriety was the second-most common malpractice claim (Reamer, 1995).

Increased clinical awareness and public shame eventually led to a cultural shift in the field of psychotherapy, toward an emphasis on boundaries, which were seen as a preemptive barrier to the "slippery slope" toward a sexual relationship (Barnett, 2007). Today, not only is this boundary crossing frowned upon, but it is one of the only crossings that is specifically identified as an ethical violation and crime in many areas (AAMFT, 2015; ACA, 2015; APA, 2017). As time progressed, new therapists entering the field were trained to be wary of these "slippery slope" boundary crossings, such as seeing clients in coffee shops and excessive self-disclosure, mostly in the effort of preventing a sexual relationship.

Based on my graduate school experience, trainees are not given the broader context of these precautions and consequently develop a rigid, dogmatic approach to ethical decision-making—one that involves following rules for the rule's sake rather than for the client's sake. Often in consultations with other clinicians, the knee-jerk reaction is to emphasize the importance of establishing "firm" boundaries. Whenever there is a scenario in the grey zone, clinicians tend to react out of fear. For example, I am a member of a Facebook consultation group for supervisors, and a member asked if it was okay to refer her client's daughter to her supervisee. The immediate responses were short and to-the-point: "No, never, absolutely not!"

Arnold Lazarus (2007), a distinguished and leading figure in the field of psychotherapy, responded to these knee-jerk reactions by writing: "I have met far too many psychotherapists who practice defensively, allowing their fear of attorneys and licensing boards to dictate how they treat their clients" (p. 405). He goes on to write that although books on ethics have become long and complicated, there are just a few imperatives that must be respected: "do not exploit, disparage, abuse, undermine, or harass a client, and steer clear of any sexual contact. We must also appreciate the significance of confidentiality, integrity, respect, and informed consent" (p. 405). Aside from those fairly simple and obvious ethical directives, Lazarus explains that all the rest of the ethical codes are negotiable—not insignificant or irrelevant, but flexible to the multifactorial situation at hand. Other ethical experts agree with this nuanced position (e.g., Vasquez, 2007). This flexibility is central when considering using media as a mental health clinician.

Before discussing the flexible end of the spectrum, let us illuminate the rigid side. In the professional literature, it's generally accepted that boundary violations should be avoided when possible (Barnett, 2007). Common examples include socializing with a client at a dinner party, inappropriate or unwanted touching, and frequent out-of-session communication (e.g., texting as if a friend or romantic interest).

There are several purposes to these boundaries, including avoiding the "slippery slope" toward sexual relations and subtly communicating that the client is responsible for the therapist's emotional needs.

I was hired as an ethical consultant by a woman whose clinician allowed himself to slide down that slippery slope toward a sexual relationship. At first, the client was very much attached to her older male therapist. He made her feel special and valued. As therapy progressed, and as the relationship became more intense, he would occasionally hold her hand while she was crying. This was the beginning of the "slippery slope." Holding a client's hand is generally considered acceptable, but without proper precautions, it can lead to more concerning boundary crossings. In another session, he hugged her while she cried. In following sessions, he held her longer. That eventually progressed to him holding her throughout the session while he caressed her body and told her how attracted he was to her. According to her, she appreciated their deep connection, but she also knew she was playing with fire. She was certain that their next session would involve overt sexual activity, so she terminated. Later, she began to feel she had been exploited by him, and that he had used her for his own sexual needs. She became justifiably upset and angry, so she complained to the licensing board. After a long investigation, his license was revoked. Years later, she would tell me that she was still processing the trauma of that relationship. This demonstrates why boundaries are critical to client well-being and to our profession's reputation (Jordan et al., 2014; Lehavot, Barnett, & Powers, 2010).

Boundary crossings don't have to lead to sex for harm to occur. A podcast listener provided the following example. She wrote that she liked her therapist, but she had to terminate because she was moving out of the area. While at a store in her new town, something triggered her trauma and she became distressed. She contacted her therapist. The therapist called her immediately and talked her through the distress. This boundary crossing was not harmful, but opened the door to future harm. Later, the client was triggered again, and she once more reached out her former therapist. This time the therapist did not respond. This happened a few more times. She was hurt and wondered why her therapist was ignoring her calls for help.

The therapist should have established a boundary from the start by setting expectations that she won't be providing services after termination and by emphasizing the importance of the client hiring a clinician in the new town. I speculate that the therapist cared about the former client and did not want to leave the client out on a limb, which is understandable. I have felt that pang of guilt many times after termination. To avoid confusion, hurt feelings, and possible litigation, clinicians need to manage their unhelpful reactivity and proactively establish boundaries in light of potential client harm. Along these lines, other common examples of potential harmful boundary crossings include letting sessions go long, responding immediately to frequent texts or email when that is not the therapist's general approach, and disclosing unprocessed erotic or romantic countertransference to a client.

Having established that boundaries are often helpful and necessary, excessive boundaries can hinder treatment unnecessarily and prevent us from helping the public at large through public media. Barnett (2007) points out that it is generally accepted among ethics experts that many boundaries can be crossed without harm to the client (Barnett & Yutrzenka, 1995; Lazarus, 1998; Smith & Fitzpatrick, 1995;

Williams, 1997; Zur, 2001). For example, in the beginning of my career, a family client left a message informing me that their teenage daughter had died from an accidental overdose and they wanted to meet with me as soon as possible. If I was to uphold rigid professional boundaries, I would have replied that I do not provide crisis services and that they were free to discuss this in my office during our next appointment which was two weeks out. However, in this rare and terrible circumstance, I contemplated the bigger picture. I decided to cross that boundary by scheduling an in-home session for that evening, since I figured they might need to stay home for various reasons. In their living room, we met for over three hours. We talked, cried, and sometimes sat in silence. It was one of most important sessions of my career. Based on my experience with them, I was fairly sure the family would not interpret this crossing as a new feature of our relationship, and I resolved to not letting this be the first step down a slippery slope toward harmful boundary violations. Months later, they thanked me for being there through the most difficult moment of their lives. If I had followed rigid, reactionary rules, I would have missed the opportunity to be the therapist they needed. All of this in line with Barnett's (2007) assertion that avoiding boundary crossings may prevent *potential* client harm, but doing so can result in a sterile, distant relationship that lacks the core components of an effective therapeutic relationship.

When inflexible boundaries are applied to particular cultural groups, the clinician may inadvertently contribute to the client's experience of ongoing marginalization (Moorehead-Slaughter, 2007; Vasquez, 2005, 2007). For a portion of my early career, I provided in-home therapy for families experiencing poverty, some of whom were undocumented Latinx families. When I arrived at their homes, the families were immensely grateful for my help. I was perhaps the only member of the system of power who treated them with respect and spent the time to get to know each member of the family. As a token of their gratitude, they often offered me food, like tamales or cornbread. At first, I would refuse. I was following the rules that were given to me in grad school and supervision. However, over time, I learned that the gift of food was a central tradition for these families. To refuse was sending a message that I did not think they were worthy enough to give me anything of value and that I was not actually interested in their well-being, just like their experience with many other so-called helpers. My service was free of charge to them, and they wanted to "pay" in the way they could: with food. Accepting the gifts tangibly showed that I cared about them and their homeland, which strengthened our therapeutic relationship and their self-esteem. Upon realizing this cultural truth, I shed my inflexible boundary and enjoyed lunches of tamales and cornbread for many months.

In summary, our profession began with little consideration for boundaries, which led to flagrant client harm. As our profession became more buttoned-up, we swung the pendulum too far resulting in most clinicians being terrified of "breaking the rules" rather than considering why the rules exist in the first place. This fear instills untherapeutic distance and prevents us from listening to our clinical judgment. Boundaries are important, but it's all in the consideration, not in the dogma. Keep all of this nuance in mind as I discuss multiple relationships and self-disclosure in public media.

Risk: Harmful Multiple Relationships

Similar to the code of confidentiality, all professions in mental health dedicate a significant portion of their ethical codes to the discussion of multiple relationships with clients, students, and supervisees (AAMFT, 2015; ACA, 2014, APA, 2017; Giota & Kleftaras, 2014; NASW, 2017). A multiple relationship occurs when a clinician, educator, or supervisor initiates one or more other roles beyond the primary professional role, such as a supervisor becoming best friends with a trainee. Multiple relationships can impair clinician objectivity, competence, and effectiveness, and can negatively affect the relationship. Since there is a power differential between clinicians and clients/trainees, having more than one relationship can result in the client feeling trapped, confused, or exploited. For example, if a therapist hires a client as a babysitter, there are a number of potential pitfalls. The client might feel obligated to take the job for fear of being rejected as a client. Also, if the therapist depends on the client's babysitting service, the therapist might avoid confronting the client in session, for fear of the client refusing to babysit.

Other classic examples of multiple relationships are the following: 1) a clinician becomes friends with a client or trainee, 2) a therapist accepts a client who is related to the therapist's friend, 3) a therapist invests in a client's business venture, 4) a therapist has sex with a client, 5) a clinician/educator accepts a student as a client, 6) a supervisor hires a supervisee to treat their children, 7) a therapist loans money to a client, and 8) a client finds the therapist on a dating website. Before engaging in a multiple relationship, clinicians need to thoroughly contemplate the potential consequences of the boundary crossing to ensure it does not interfere with treatment or training, and that it is welcomed by the client or trainee (Barnett, 2007; Lazarus, 2007). Also, clinicians should carefully consider their bias in decision-making and seek consultation since some multiple relationships are self-serving.

As with other types of boundary crossings, multiple relationships are not inherently harmful or unethical (Corey, Corey, & Callanan, 2011; Fisher, 2009). When a clinician works in a small town, it is often unrealistic to avoid such relationships since the town may only have one therapist, one dentist, one grocer, etc. If the dentist needs a therapist, and the therapist needs a dentist, and there's no other viable option, then both professionals will need to engage in a multiple relationship. If such communities are to benefit from mental health services, these multiple relationships must be permitted. This does not mean that the therapist is off-the-hook. It just means that the therapist needs to consider the ethics carefully and take actions to protect the client from harm.

With my media involvement, the main multiple relationship of concern is when clients, students, and supervisees listen to my podcast. With these individuals, I am both their therapist or trainer and their podcaster. Without carefully considering these two relationships, harm could occur. It should be pointed out that currently all mental health professions lack specific ethical guidelines regarding clinicians using public media, such as podcasts (Myers et al., 2012). However, a number of authors (e.g., Fisher, 2009) have provided general questions to help guide the evaluation of any sort of multiple relationship.

First, are the two relationships incompatible? If a client or trainee were to listen to the podcast, much of the podcast content would be highly compatible with their treatment or training. There is a great deal of synergy between all of my roles: therapist, educator, supervisor, and podcaster. With clients, I might talk about how their particular attachment injuries affected their development. With trainees, I might lecture on how to assess attachment injuries and current relationship complexes. On my podcast, I might talk generally about attachment theory, knowing that both clinicians and laypersons are listening. All three of these roles are different but compatible, since no role contradicts another and the overarching effort is the same: to help people understand attachment.

Second, does the secondary relationship privilege my needs over theirs? A client or trainee could feel obligated to listen and subscribe to my podcast for fear of insulting me and receiving substandard treatment or training. I mitigate this risk by not talking about my podcast and other media activity with clients, students, or supervisees, aside from the necessary disclosures while obtaining informed consent, which are discussed below. Also, I always downplay my media involvement with clients and trainees because I don't want to give the impression that I want accolades for it. This way, I give the message that I'm not concerned about their listenership, and if they do listen to the podcast, they are not obligated to discuss it with me when we meet. Having said that, some clients and trainees occasionally volunteer that they listened to a podcast episode. For example, a client told me he listened to an episode about avoidant attachment and how much it helped him understand himself and have self-compassion.

Third, is the new role an increase in harmful intimacy? A common multiple relationship that increases harmful intimacy is when a therapist socializes with a client. In my situation, if a client or trainee were to listen to the podcast, they might feel more "connected" to me. However, I would not interpret this as harmful intimacy, since no rational listener would interpret the one-way communication as a private relationship. Fourth, does the secondary role increase vulnerability to harm? Harm is extremely unlikely to occur as long as I continue to follow my policies of only publishing accurate information, not violating confidentiality, remaining professional, and self-disclosing only harmless or helpful information (self-disclosure is discussed in more detail in a later section).

The discussion of harm requires clarification between unethical harm—due to clinician incompetence, neglect, unfairness, or discrimination—and incidental outcomes that may be painful or difficult for the client or trainee (Campbell et al., 2010). For example, let's say I have a client who experienced significant relational trauma as a child. In the course of treatment, his trauma condition produces an anxiety about me abandoning him as a client. Before treatment began, I informed him that I had a podcast about psychology and that he was better off not listening to it since it could interfere with our therapeutic relationship. Against my advice and with informed knowledge that it could hurt him, he listens to one of my podcasts. To be clear, this is a boundary crossing committed by me in the form of a multiple relationship, since the podcast is available to the public and it's reasonable for a client to be curious. In the podcast episode, I say that therapists have the right to terminate with clients who become violent with the therapist. This exacerbates his fears of abandonment, even though he has never been violent with me. Over time, his fear intensifies, and he terminates. According to my take on the ethical codes

and consensus opinion in the literature (e.g., Campbell et al., 2010), the pain created by my boundary crossing is not an ethical violation since it was not the result of therapist neglect, incompetence, unfairness, or discrimination. This is the sort of pain that is expected when clients with relational trauma engage in a meaningful, long-term relationship with a therapist. This sort of difficulty is distinct from the harm that could occur if a client or trainee listened to a podcast in which I openly complained about clients, insulted their political party, or disclosed a sexual fantasy about a trainee. It would be reasonable to conclude that the pain produced from these sorts of boundary crossings is unethical harm, since it is the result of neglect, incompetence, unfairness, or discrimination.

To reduce the risk of harm, I have developed a number of policies regarding multiple relationships. If a client asks me to read their question on the podcast, I would politely inform them of my policy (given to them during informed consent) that I do not read clients' questions on the podcast to avoid an unnecessary multiple relationship and possible confidentiality breaches. If a supervisee publishes research and I ask the supervisee if they want to present their findings on the podcast, I will be mindful of the power differential and emphasize that there will be no consequences to them refusing. If a client or trainee wants access to the premium content of the podcast (which requires a paid monthly subscription), I will grant them access free of charge; this will eliminate the risk of them feeling as though they have to continue paying for a subscription for fear of me finding out that they have canceled their payment. If a client or trainee expresses interest in attending a live podcast event, I will encourage them to not attend for fear of harm; if they plan on attending anyway, I discuss the expectations and risks with them beforehand. If a podcast listener asks to hire me as their supervisor or therapist, I will encourage them to seek services from a different professional; this policy is easy to follow since my practice has been full for over a year. With these and other policies on multiple relationships, I am confident that the risk of harm can be kept minimal, as evidence by the fact that no client or trainee has ever complained, formally or informally, about my media involvement.

Risk: Harmful Self-Disclosure

A major ethical consideration when podcasting and using social media is the issue of self-disclosure, which is defined as revealing personal information to a client or trainee (Hill & Knox, 2002; Zur et al., 2009). Since the dawn of our profession, clinicians have grappled with the question of whether, when, and how to self-disclose (Wolitzky, 2011). In the literature, authors have tried to aid in our ethical deliberations by identifying different dimensions of self-disclosure: intentional vs. unintentional, avoidable vs. unavoidable, and helpful vs. unhelpful. At the basic level, a clinician's attire and office décor are forms of unavoidable self-disclosure. On the informed consent form, clinicians intentionally self-disclose their educational background and theory of change. If a therapist is visibly pregnant, that is also an unavoidable self-disclosure, as is running into clients at the movies. Also, the internet has exponentially increased the possibility of clinicians revealing at least some information to the public, and as Gabbard et al. (2011) and Taylor et al. (2010) point out, we must learn to adapt to our new online reality. These sorts of self-disclosures are considered innocuous and/or unavoidable.

Usually when clinicians, educators, and supervisors consider self-disclosure, more significant revelations are being pondered, such as whether or not to tell a client about the therapist's own struggles with mental illness. Throughout my career, I have heard many opinions about these sorts of self-disclosures. Some consider it central to their style of therapy, and others consider it entirely unethical. Research has found that 90% of therapists report they disclose personal information to clients (Henretty & Levitt, 2010), and an average of 4% of all therapist interventions involve self-disclosures (Hill & Knox, 2002). These clinicians are wise to use self-disclosure since two large meta-studies conducted by Hill and Knox (2002) and Henretty and Levitt (2010) showed that therapist self-disclosure has positive effects on clients including improving the therapeutic alliance, increasing client self-disclosure, and reducing client drop out.

From a feminist and multicultural viewpoint, not self-disclosing can contribute to our male-centered, patriarchal society (Vasquez, 2007). Johnson (2014) asserts that patriarchal societies prefer masculine traits, such as toughness, logic, and autonomy, whereas feminine qualities such as vulnerability and emotional expressiveness are devalued. When therapists self-disclose, they model positive associations with human vulnerability, and they eschew the restrictive and limiting patriarchal value of stoicism. Mahalik, VanOrmer, and Simi (as cited in Hill & Knox, 2002) point out that feminists support therapist self-disclosure in that it equalizes the power in the relationship, which is not only just but can also help the client feel less shame and more self-worth.

On the other hand, there is a dark side to self-disclosure in that some revelations are made to benefit the clinician rather than the client. For example, I have heard accounts of therapists talking at length about their own personal struggles, which results in the client resenting the therapist for wasting precious session time and for pushing the client into the helping role. These modes of disclosure are considered unethical since treatment is harmed (Gutheil & Gabbard, 1993; Knox et al., 1997).

With my public media activity, I have always been mindful of self-disclosure. For most clients and trainees, casual self-disclosure on my podcast is not risky, such as talking about my favorite movie. However, as Lazarus (2007) points out, self-disclosure and boundary crossings are particularly risky for clients and trainees who are susceptible to considerable transferential reactions, such as those who qualify for the labels of borderline, paranoid, psychopathy, and so on. Whenever I publish anything, I play it safe by assuming that all clients and trainees—past, present, and future—will see or hear the publication, even though a majority of them won't. For example, I don't talk about most of my political beliefs since strong political opinions can easily alienate others. When I accidentally let those opinions slip out, I go back and edit out the disclosure prior to publication. This policy applies to podcast guests as well. For example, if a guest reveals that they think Republicans are universally malevolent, I edit that part out. Other avoided topics include my preferences for particular types of clients, my frustrations with clients or trainees, and my unprocessed emotions. Although there are times when I wish to discuss these topics, I ask myself: would I reveal this to a client or trainee? If there is even a remote possibility of a client or trainee being harmed by a self-disclosure, I refrain from voicing it.

After an extensive and systematic review of the research literature, Hill and Knox (2002) recommended that clinicians should disclose infrequently and it should be in the service of normalization, modeling, strengthening the alliance, or offering alternative ways to think or act. In following these guidelines, I have self-disclosed a number of select personal details. For example, during an episode on anxiety, I revealed to the podcast audience that I have suffered from panic attacks. I did this intentionally, with forethought, and in the effort of normalizing and modeling how to not be ashamed and seek help. Listeners responded positively to this disclosure. If I had withheld my struggles, I suspect the episode would not have been as impactful.

When it comes to self-disclosure in public media, I have been inspired by my professional heroes. Irvin Yalom has been effectively self-disclosing for decades. His book, *Love's Executioner* (1989), is often assigned reading in training programs. Throughout the book, he honestly and bluntly reveals his inner life as a working psychotherapist along with his feelings about his family. In other books, he writes in detail about his childhood, his family, and his marriage. These publications have been available to the public, including his clients and trainees, throughout his career.

Another renowned figure in psychotherapy, Donald Winnicott, also self-disclosed in his publications. In his 1949 paper, *Hate in the Counter-Transference*, he described his countertransferential feelings of rage toward a difficult client. It was a controversial paper since it was shameful for a psychoanalyst to have a strong emotional reaction to a client. His self-disclosure in this publication permanently improved our understanding and management of countertransference (Gelso & Hayes, 2007). Without Winnicott's self-disclosure, we might still be stuck in the view that good therapists never have feelings in session.

Virginia Satir, a major figure in family therapy, often self-disclosed her inner world. In her seminal work, *Conjoint Family Therapy* (1964), she wrote about her micro-emotional reactions during particular sessions. This became a hallmark in her style of training other therapists. She would demonstrate her second-by-second internal process while joining a family emotional system and how to use those emotional reactions to help the family grow and function better.

Murray Bowen, another pioneer in family therapy, presented his paper *Toward a Differentiation of a Self in One's Own Family* (1972) at a national meeting of family therapists in 1967. In this paper, he wrote about his 12-year effort to become less emotionally reactive with his family-of-origin. This paper is considered to be a major milestone in family therapy (Kerr, 1981), and 50 years later, it is still being assigned as required reading for family therapy trainees. To fully explain his new theory of individual and family functioning, he chose to self-disclose his own process, and it became one of the most important works in our field.

These heroes of psychotherapy wisely self-disclosed in public media to help us realize our humanity. They apparently were not caught up in unjustified paranoia about boundaries and self-disclosure. Without forerunners like them, where would we be? On my podcast, I have been trying to follow in their footsteps.

Risk: Harmful Unprofessionalism

When engaging in media, clinicians must consider how their behavior will reflect on the profession. For example, on my podcast, it could be deemed unprofessional for me, as a therapist, to tell a distasteful joke, post pictures of me being inebriated, or denigrating a competing podcast. If our profession is going to survive and thrive, we need the respect of the public. Whether we like it or not, people often look up to us. With that privilege comes the responsibility of leading by example.

Professionalism is not easily defined. Authors in our field put forth a number of disparate definitions that range from polite behavior to the aspiration to altruism, accountability, duty, integrity, and respect for others (Caldwell, 2015; Gabbard et al., 2011). For the purposes of this discussion on public media, I will define professionalism as representing the profession well and providing a good example to follow. Authors also differ regarding whether or not these principles apply to off-duty clinicians. I believe that professionals should be able to be themselves after work, such as having a drink or two and telling distasteful jokes among friends. Without that chance to recharge, we run the risk of burnout. So, although I think we should act freely while not working, we should balance that by considering how we might be representing our field.

When recording episodes of the podcast, I refrain from behavior that could be seen as unprofessional, such as ranting about a coworker. However, the distinction between “unprofessional” and “acceptable” behavior is often in the eye of the beholder. For example, over the years, I have received a few emails from listeners who express that they believe it is unprofessional for me to comment on current events (e.g., the Michael Jackson molestation controversy), even though I am careful about my words and claims, and I do so only in the service of providing educational commentary and advocacy for marginalized groups. There are currently over 100,000 listeners to the podcast; if 99.9% consider a particular action of mine as professional, that leaves one hundred listeners who will deem the behavior as unprofessional. Therefore, attempting to please everyone would necessitate avoiding public media altogether, which would deny the potential benefits outlined at the beginning of this paper. However, this does not negate, in any way, my responsibility to strive for professionalism while in the public eye.

When I entered the field, I realized I needed to develop two distinct modes: a professional mode and a personal mode. At home, I was myself. At work, I maintained my professional mode, which is less spontaneous and more conscientious. When I started the podcast, I already had 13 years of practicing my professional mode at work, so it wasn’t difficult for me to remain professional while recording episodes. Over the past 10+ years of podcasting, I have occasionally felt the urge to slip into my personal mode. I might feel compelled to tell a crass joke or speak candidly about my negative feelings about a specific coworker. I either refrain from that urge or I edit it out later. For example, I recently ranted about the internet trolls who attack me online, but I later excised it from the podcast episode because I deemed it unprofessional. Remaining professional might limit the appeal of my podcast, since shock value often increases popularity. However, if we, as a profession, are going to help the world, we must have the world’s respect, and in order to earn and retain that respect, we must remain professional.

Risk: Inaccurate Publications

According to the various professional ethical codes, clinicians take reasonable precautions to ensure that publications and public statements are accurate and factual (AAMFT, 2015; ACA, 2015; APA, 2017). Normally this standard is considered when a clinician publishes research, makes claims about their effectiveness, or advertises qualifications, services, or fees. I consider my podcast and other media activity to be a professional publication since I introduce myself as a "licensed therapist and professor." When I report research findings, I make sure I provide accurate information by taking careful notes and providing references. When discussing topics in which I have no formal competence (e.g., law, medicine), I always provide a thorough caveat that I am a layperson and that all of the presented information is from what I could find in a short internet search. When providing diagnostic commentary on public figures, such as Ted Bundy, I always begin with a caveat that ethical clinicians do not diagnose from afar and that all presented commentary is entirely speculative and based on information in the media. When guests make uneducated claims about sensitive topics like medicine, I either edit the statement out or I quickly provide a caveat that the guest is speculating since they are not qualified to make such a statement. When advertisers hire me to endorse a product, I make sure I am not being asked to say anything that is not based on sound, published evidence.

As with professionalism, these caveats and clarifications probably reduce the potential popularity and revenue of the podcast. One does not have to look far to see examples of the potential riches one could make by making dubious declarations. A 2014 report revealed that even though 60% of the advice given by Dr. Oz on his TV show lacked scientific basis, he has amassed a worth of $30 million (Schein, 2018). I did not enter this field for fame and money, so I've never been tempted to publish sensational and inaccurate information as a means to gain popularity. As with other ethical standards, not giving into this temptation helps me sleep better at night.

Ethical Decision-Making

Ethics authors (e.g., Barnett, 2007) wisely observe that many ethical predicaments have no right answer and thus necessitate a decision-making process rather than a set of rules. A number of authors (e.g., Fisher, 2009; Klaus & Hartshorne, 2015; Nagy, 2005; Younggren & Gottlieb, 2004) have provided ethical decision-making models that can help guide my behavior in public media. The following is a compilation of those models. Since most of the grey-area dilemmas with public media activity involve boundary crossings (i.e., self-disclosure and multiple relationships), I will focus on the ethical decision-making regarding those areas.

When considering a boundary crossing, mental health clinicians should make sure that 1) the risk of harm is low, 2) the benefits outweigh the risks, 3) the necessity of the crossing has been considered, 4) the client or trainee will not likely misinterpret the crossing or consider it unwelcome, 5) the intention is to help the client or trainee and not to meet one's own needs, 6) the clinician is not hindered by their own bias, 7) the client or trainee's sensitivities are considered, 8) the power differential has been considered, 9) the clinician has achieved competency in evaluation and execution of that crossing, 10)

when possible, the client or trainee has provided informed consent, and 11) when possible, the clinician has consulted with a respected colleague. If you have ever contemplated grey-area ethical dilemmas, you know that these criteria are not always easy to evaluate. For example, how do we measure the "weight" of the benefits versus the "weight" of the risks? Where is the threshold between "low" and "moderate" risk? Ethics experts (e.g., Barnett, 2007; Kaslow et al., 2011; Klaus & Hartshorne, 2015) acknowledge the reality of these ambiguities and recommend that clinicians apply these decision-making models in a thoughtful, respectful, and flexible manner, while avoiding rigid adherence to strict rules that can overlook the nuances and client's best interest.

As a demonstration of the ethical decision-making process, let us consider the boundary crossing of me publishing a podcast episode about a movie review that is potentially heard by clients and trainees. One, hearing my opinion about a movie is not likely to cause harm, as long as I avoid making statements like "only idiots like this movie." Two, there is a benefit to taking this ethical risk since I promote helpful values on the podcast, such as empathy for others and self-compassion. Three, although the crossing is not strictly necessary, the overall benefit to listeners justifies the publication.

Four, clients and trainees are not likely to misinterpret the content, such as interpreting the episode as an invitation for a social relationship. They are not likely to consider it invasive or unwelcome, since they do not have to listen and I do not encourage them to listen. Five, although the episode does not specifically address goals of therapy or training, it could be argued that lighthearted content provides listeners with an entertaining respite from the stress of life. Six, although I am potentially biased to publish this episode out of some narcissistic need, it is not harmful to clients or trainees.

Seven, I cannot imagine a client having a sensitivity or issue that would be agitated by the content, particularly since I don't treat severe mental illness. Eight, since clients and trainees know they are free to listen or not listen without any consequence, the power differential is not at play. Nine, as to my competence level in this ethical area, over the past two decades I have attained competence by reading hundreds of sources, attending trainings specifically on the topic of using media as a clinician, consulting directly with experts, and eliciting feedback from listeners, clients, and trainees.

Ten, I inform clients and trainees about the risks of initiating a professional relationship with a podcaster/clinician. Eleven, I have consulted with experts regarding my public media involvement and they all agree that publishing such an episode is not an ethical violation. Only after all of this is considered will I publish something online. It might seem like a laborious process, but it protects clients, students, and supervisees, and reduces my anxiety about ethical complaints.

Informed Consent

All of this leads to the topic of informed consent. One of the through lines of various ethical codes is the principle of autonomy: the acknowledgement that clients and trainees are free to make their own decisions (Gabbard et al., 2011). In order to make those decisions, clinicians, supervisors, and instructors have an affirmative obligation to adequately inform of the relevant risks, preferably in written form

(Kaslow et al., 2011). Media involvement presents a number of risks to clients and trainees, all of which need to be effectively communicated and comprehended before consent is obtained to begin treatment or supervision. As a culmination of my knowledge and experience with public media, I provide the following disclosures in my initial paperwork and verbally review it with clients and supervisees.

Before engaging in a professional relationship with me, you should know that I am involved in public media: podcasts, interviews, published articles and books, and posting to professional websites and social media. Since entering the field of psychotherapy in 1995, my primary mission has been to make a positive difference. In 2008, after thirteen years of being a therapist, educator, and supervisor, I decided to extend that mission to public media. In doing so, I incurred the ethical responsibility of carefully considering whether or not the benefits justify the risk (AAMFT, 2015; ACA, 2015; APA, 2017).

The benefits include: 1) reaching individuals who don't have access to care, 2) the democratization of knowledge, 3) increasing compassion (and self-compassion) for those who are suffering, 4) combating misinformation, 5) providing an adjunct to care, and 6) advocating for marginalized groups.

The risks include: 1) confidentiality violations, 2) harmful boundaries, and 3) not representing the profession well. As an example of a boundary concern, if you listen to my podcast, you might learn details about my life that could complicate our working relationship—such as a political belief or my take on a public figure. Also, if you comment on one of my social media posts, someone might guess that we have a professional relationship, which would compromise your privacy and confidentiality.

To reduce these risks, I adhere to the following guidelines. I recommend you avoid my public media involvement since you could learn things about me that might interfere with our working relationship. If you choose to listen to my media publications, please alert me beforehand so we can discuss measures to guard against harm to our professional relationship.

I will not discuss anything about you in public media. Whenever I discuss cases, I protect clients' and supervisees' identities by composing a fictional person, speaking in general terms that don't reveal the individual, or obtaining prior consent. This protects your rights to privacy and confidentiality.

I will not respond to "friend" requests, and I will not "follow" you. This protects you from being exposed to unhelpful details about my life and from being discovered as one of my clients or trainees. It also protects my right to privacy. This extends even after termination of our professional relationship.

I discourage you from commenting on my professional social media accounts. If you do comment, I will not respond to your comments. This protects you from being exposed as one of my clients or supervisees and from you confusing social media with proper care.

If you email a question to my podcast, I will not read your question on air, and I will only respond in person. This protects your confidentiality and from you confusing podcast questions with your care. If

you wish to contact me, use my email address or phone number only. Other methods of communication are not reliable and may violate your right to confidentiality.

I discourage you from attending a podcast live event, but if you do attend, please alert me beforehand so we can discuss measures to protect your confidentiality and care.

I will not Google you without your consent unless there is a serious risk of harm that justifies the action. This protects your privacy and safeguards against me losing objectivity. It also protects against you feeling invaded and betrayed by me.

You should not become a paying "patron" of my podcast on Patreon, since becoming a patron involves a fee. You might feel obligated to continue paying for a subscription beyond your preferred time span. If you want access to patron content, let me know and I will give you access at no charge.

Similar to in-person meetings with you, I might be required by law to contact the authorities if you reveal on social media that you or someone else is in serious harm or if you reveal a child or dependent adult is being abused. If you have any questions or concerns about this, please let me know. It's my job to answer your questions and address your concerns.

Recommendations Summary

Before embarking into public media, clinicians should take some time to review the ethical literature, consult, and develop a plan to protect their clients, trainees, and themselves. Clinicians should develop a mission statement to guide them in their decision-making. For example, I knew from the start that I wanted to make the world a better place. This mission has guided me during confusing moments while engaging with the broader world of the internet. Clinicians should develop a well-versed ethical decision-making system. Clinicians should obtain professional competency through trainings, reading, and consulting. Boundary crossings, such as multiple relationships, should be avoided or accounted for. Before engaging in public media, clinicians should take an inventory of which self-disclosures are ethical and comfortable and which are not. Clinicians should never post anything that could be harmful or hurtful to clients or trainees, even to their private Facebook account since clients or trainees might be friends of friends who have access to that post. When faced with an ethical dilemma, clinicians should consult with a respected colleague. Self-disclosure in the media should be avoided unless it is deemed unlikely to harm. Clinicians should document relevant information, such as a client commenting on the clinician's social media. Feedback should be sought along the way (from consumers, clinicians, clients, and trainees) to guide content and ethical decision-making. Before posting to public media, clinicians should contemplate how they are representing the profession. Of course, clinicians should avoid publishing inaccurate information and breaking the confidentiality of their clients and trainees. Furthermore, clients and supervisees should be adequately informed regarding the risks before consenting to the professional relationship.

There are some other minor recommendations worth noting. Clinicians should regularly review the privacy settings on their private social media accounts. Although, clinicians need to be aware that clients and trainees might know how to gain access to information that the clinician believes to be private. For example, a podcast listener told me that her therapist said he was competent in treating her condition. Later, he asked her a question on Reddit (without knowing it was her, since she used an online alias) regarding how to treat that condition. She said she felt betrayed by his deception and afraid of his lack of competence.

Clinicians should regularly Google themselves to see what information is available to clients, students, and supervisees. When I Googled myself a number of years ago, I found that someone was using my full name (which is fairly unique) as a pseudonym on a pornography website. I contacted the user and asked them to use a different name and they obliged.

When being interviewed in the media, the clinician should inform the interviewer about what is off-limits. For example, when I am being interviewed on the radio, I inform the producers that I will not answer questions about particular clients or my private life. This circumvents awkward and uncomfortable moments in which I have to quickly evaluate and respond.

Lastly, and most importantly, clinicians should engage with public media without undue fears. The world craves our voice. If we are bogged down by unnecessary fears, no one will ever benefit from our viewpoints. We all know how helpful we can be in our offices. It's time to spread that helpfulness to the rest of the world.

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