2020

The Lived Experiences of Online Therapists Maintaining Ethical Boundaries

Talia Singer
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Talia Singer

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Rachel Piferi, Committee Chairperson, Psychology Faculty
Dr. Valerie Worthington, Committee Member, Psychology Faculty
Dr. John Astin, University Reviewer, Psychology Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2020

Abstract

The Lived Experiences of Online Therapists Maintaining Ethical Boundaries

Talia Singer

Dissertation Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

March 2020

Abstract

The provision of counselling and psychotherapy using technology, also referred to as telecounselling or e-therapy, is a burgeoning area of mental health care that has garnered much enthusiasm. Many professional health organizations have developed ethical guidelines to specifically address this unique style of treatment. Skepticism remains in the area of applying standards into practice. Ethical guidelines are meant to be broad principles that can be applied to a range of unique practice experiences. The problems is that these principles have been developed over a century of practice-based experiences and designed to address situations that the clinician faces when their client is being treated in the same room. There is a gap in knowledge that has yet to describe what unique practice-based ethical challenges arise when the client is being treated remotely or even asynchronously through an electronic 'office space.' This qualitative hermeneutic phenomenological study explored the lived experiences of practitioners with online practice and the ethical usage of electronic treatment platforms. The sample consisted of 10 practitioners licensed in Ontario who have been using online forums for at least 1 year. The study unveiled themes of shifting power dynamics and new ideas in boundary crossing electronically. Online therapeutic interventions present new challenges in how mental health professionals present themselves as ethical clinicians; therefore, the theory of professional identity was a fitting theoretical framework to guide this inquiry. The social change implications of this research are directly related to the implementation of ethical guidelines and empowering practitioners to have a voice in their evolution.

The Lived Experiences of Online Therapists Maintaining Ethical Boundaries

Talia Singer

Dissertation Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

March 2020

Dedication and Acknowledgement

I would like to acknowledge my research chair Dr. R.L. Piferi for her guidance and support. I would also like to acknowledge my family, including my parents, Danny and Barbara Benoliel who without their encouragement and love I would not have reached this life milestone. This research is dedicated to my husband Seth and my children, Noa and Amity. We share an endless wonder about the world and a love of learning. Thank you for supporting my quest.

Table of Contents

Chapter 1

Introduction

The provision of counselling and psychotherapy using technology, also referred to as telecounselling or e-therapy, is a relatively new medium for providing psychotherapy that has garnered much enthusiasm in the counselling and therapy community (Johnson, 2014; Madej, Sendler & Makara-Studzińska, 2016). Different variations of online therapy (e.g. phone, text, video, and email) are being studied in a rapidly growing body of scholarly publications (Johnson, 2014). Remote modalities of providing electronic mental health services (e-mental health) have been described as a practical alternative to traditional in-person therapy (Madej et al., 2016). The technological options for mental health counsellors, psychotherapists, and psychologists include videoconferencing, where the patient is engaged in a synchronous audio-visual session, and asynchronous interventions using text or email. With so many options available, it was incumbent upon professional licensing and governing organizations for mental health professionals to provide guidelines for ethical practice (Samson-Daly, Wakefield, McGill, Wilson & Patterson, 2016).

In a comparison of ethical guidelines and practice recommendations for the provision of online mental health services from 19 separate regulatory organizations spanning 7 countries, it was concluded that despite the enthusiasm for this new therapeutic modality there is a gap in understanding how these guidelines are applied in practice (Sansom-Daly, Wakefield, McGill, Wilson & Patterson, 2016). Furthermore, it is unclear what unique ethical challenges may ensue from this mode of practice. A recent

survey of therapists using technology in their practice found that ethical challenges are the most often cited barrier between their enthusiasm for these online modalities and implementing them into regular practice (Glueckauf et al., 2018).

Despite these barriers, enthusiasm for online therapy services continues to flourish due to the growing need for accessible mental health services both in urban and rural locations. Online therapy provides much-needed service to individuals who may be service-shy to access face-to-face counselling (Harris & Birnbaum, 2015). There is a benefit to exploring therapists' lived experiences to learn more about the ethical challenges found in online counselling modalities.

This chapter includes a review of the key points that I explored in the study, including: (a) background on the current topic, (b) the problem statement, (c) the purpose of this study, (d) the research question, (e) the theoretical framework to support the concepts, (f) the nature of the study, (g) constructs defined, (h) assumptions, (i) the scope and delimitations, (j) limitations, (k) the significance of the study, and (l) a summary of the above.

Background

Online Counselling in Canada and the United States

While Internet and video-based therapeutic interventions are relatively new in the field of health and medicine, phone-based interventions for mental health have been in place for a better part of 50 years (Prentice& Dobson, 2014). The first telephone suicide prevention services were implemented in Canada and the United States in the 1960s and 70s and continue to this day (Leenaars, 2009; Office of the Surgeon General, 2012).

Some examples of phone, text, and online chat crisis intervention include: The Kids Help Phone **(**kidshelpphone.ca**),** a registered charity created in 1989 and Crisis Services Canada **(**crisisservicescanada.ca), a federal non-profit created in 2002 and funded by the Public Health Agency of Canada. A review of Kids Help Phone services in 2016 concluded that clients with serious to severe mental health concerns (i.e. suicidal ideations and symptoms of psychosis) tend to utilize the most detached virtual medium, *Live Chat*, which allows a client to type anonymously with a therapist on their computer without sharing any identifying or traceable information; not even their voice (Haner & Pepler, 2016). The service providers (i.e. online therapists) not only face the ethical dilemmas concerned with helping someone in this state, but they also face the added barrier of such clients misconstruing their typed messages due to a higher risk of cognitive distortions in their present psychological state (Haner & Pepler, 2016). This issue is one of many issues identified as an ethical concern unique to online therapy.

Ethical Standards of Practice in Online Therapy

Numerous international licensing and professional organizations have created ethical guidelines, such as the Canadian Psychological Association (CPA, 2017), which approved ethical guidelines for electronic psychological services in 2006. These guidelines offer legal and regulatory provisions regarding issues such as consent, crisis intervention, and privacy online (CPA, 2017). These and other guidelines often include information regarding the issues of professional boundaries in a generalized and vague way that does not involve real-life practice-based scenarios (Kendall et al., 2011). Similarly, an international review of ethical guidelines for online mental health services

found recommendations in preventing the crossing of professional boundaries, though no concrete practice recommendations are made by the regulatory colleges explored in the review (Samson-Daly et al., 2016). Despite the existence of professional codes of ethics, professional misconduct through the crossing of boundaries continues to occur (Kendall et al., 2011; Fronek & Kendall, 2016). This may be because ethical dilemmas related to setting boundaries a complex facet of the therapeutic relationship that is continually negotiated throughout the therapeutic time (Kendall et al., 2011). Johnson (2014) contends that therapists using technology have an even higher duty to adhere to ethical standards of practice than face-to-face therapists due to the elevated competency required to operate in a professionally responsible manner.

Boundaries as a Therapeutic Tool

Boundary setting in therapy is guided by the standards of practice set by individual professional organizations (Drum & Littleton, 2014). These rules for appropriate interactions are part of what determine what behaviors constitute ethical practice. They are instilled to differentiate the therapeutic relationship from a social or business one (Drum and Littleton, 2014). Such rules also exist to mitigate potential power imbalances between therapist and client (Kendall et al., 2011, p.510). Drum and Littleton (2014) distinguished between two types of boundary lapses: boundary crossing, and boundary violations. Boundary crossing, the focus of this study, is often considered a minor transgression that could result in minor harm to the therapeutic relationship. Such situations can range from the therapist disclosing some personal detail about themselves or a client request for a hug at the end of treatment (Drum & Littleton, 2014). Boundary

violations, however, are clear and grave abuses of the therapeutic relationship that often describe sexual, physical, emotional, or psychological assaults and harms. The more minor boundary crossing is not always viewed as a negative behavior, and under some circumstances may even lead to strengthening the therapeutic bond (Kozlowski, Pruitt, DeWalt, & Knox, 2014). The problem with operationalizing boundary crossing lies in the ambiguous and situational nature of the action and outcome (Drum & Littleton, 2014). Additionally, the terms 'boundary' or 'boundaries' in relation to counselling or psychotherapy have only been explored by few scholars (Kendall, Fronek, Ungerer, Malt, Eugarde & Geraghty, 2011). Boundaries related to ethics in health are still a largely misunderstood phenomenon. Kendall et al. (2011) authored the first validated Boundaries In Practice (BIP) Scale that both describes the construct of ethical boundaries across 4 domains (knowledge, comfort, ethical decision making and experience), and measures clinician's level of skills across these fields.

The online environment poses novel dilemmas in boundary crossing that have not yet been identified to the full extent. Drum and Littleton (2014) noted that clients and therapists possibly do not possess the proper "schema" of what to expect in a online therapy setting, which puts both at risk for unanticipated tests of boundaries (p.2).

Problem Statement

Internet-based therapies are not only popular, they are expected by a technology-savvy generation of health consumers (Simpson, Richardson & Pelling, 2015). Researchers looking at health care practitioners' lived experiences with online counselling consistently determined that, despite the obvious benefits such as increased

accessibility and anonymity, practitioners do not feel wholly prepared to embrace this form of service deliver (Berry, Bucci & Lobban, 2017; Glueckauf et al., 2018). There is a gap in the literature on the implications of boundary crossing in an online environment, as well as limited understanding of how practitioners practicing online understand and respond to ethical dilemmas in their everyday work (Drum & Littleton, 2014; Harris & Robinson Kurpius, 2014; Kendall et al., 2011). The existing problem with online counselling is that this relatively new format for providing mental health services has little regard for how to implement the ethical nuances of professional practice standards (Samson-Daly et al., 2016).

Purpose of the Study

The purpose of this study was to explore the lived experiences with ethical boundaries among practitioners that offer mental health services online. Through reflecting on the construct of ethical boundaries in practice, I explored what the experience is like for those practitioners using this new modality to deliver care. Additionally, exploring this phenomenon has led to understanding how online therapists set boundaries in practice in comparison to face to face practitioners and the unique ethical dilemmas they face.

Research Questions

The research questions that guided this study were:

1. What are the lived experiences of registered mental health professionals licensed in Ontario in practicing online?

2. What are the lived experiences of these professionals in maintaining ethical boundaries with their patients?

Theoretical Framework

Professional Identity: An Intertwining of Identity Theory and Social Identity Theory

Online therapeutic interventions present new challenges in how mental health professionals present themselves as ethical clinicians (Shepler, Ho, Zoma, Bober & Dluzynski, 2016). The boundaries that these clinicians set in practice are related to their individual and social identities and these boundaries need to be better understood (Kendall et al., 2011). Historically, the professional identity of counsellors and therapists is somewhat conflated, both to the public they serve as well to the members of the individual professions despite being regulated separately (Alvez & Gazzola, 2013). The concept of professional identity is believed to be a dynamic process between one's individual identity and social identity that permanently alters both in the process (Crigger & Godfrey, 2014).

Identity theory (IT) is one that crosses epistemologies in psychology, sociology, anthropology, philosophy, among others (McLean & Syed, 2014). In the field of psychology IT has been shaped by Mead (1934) Stryker and Serpe (1968, 1982) to encompass the notion of the role we play in society. Our roles (i.e. identities) are plentiful and placed in a hierarchical order depending on their salience to the situation and/or behavior (Stryker & Serpe, 1982). A teacher, for example, may also have the role of a child, but this role is only salient in the presence of her parent.

Social Identity Theory (SIT), according to Tajfel (1969), is used to understand identity as being tied and affirmed through group membership. People can belong to several groups at once (i.e. family, professional, community, and social class), and these memberships are a source of pride (Tajfel, 1969). SIT differs from ID in that in SIT our *belonging* is what makes us who we are. Farnham and Churchill (2011) contend that our identities range in how integrated or faceted they are. Therapists, like most people, are multifaceted and some facets may be off limits to the client, while others may be integrated into their professional identity. For example, a therapist presumably acts differently with her client than she does her children; however, he or she may share a facet of their identity with their client such as cultural heritage. According to Farnham and Churchill (2011), our identities are titrated by the impression people desire to make on others. Research on boundary setting makes poignant how difficult it is to identify the moment a boundary is crossed; is it sharing a personal detail? Is it allowing a patient to send a text rather than an email? (Drum & Littleton, 2014). It may be that the identities we try to keep faceted become intertwined in these moments. Professional identity is a purposeful integration of one's inner self and social self; perhaps offering a professional service through remote means blurs one's role identities in unexpected ways.

Nature of the Study

In this hermeneutical phenomenological study, my goal was to develop a comprehensive understanding of what ethical boundaries mean and what it is like to maintain them online. Laverty (2003) described the difference between traditional phenomenology as described by Husserl (1970) and hermeneutical phenomenology as

discussed by Gadamer (1983). In traditional phenomenology, the researcher suspends their heuristic attitudes and biases about their subject of interest for the purpose of removing preconceived ideas from understanding the phenomenon (Laverty, 2003). Hermeneutical phenomenology describes the evolution of understanding of a phenomenon as a partnership between researcher and their participant to appreciate the issue from a historical perspective, integrating the researcher's background into the new understanding gained through data collection. Hermeneutical phenomenology is well suited to studying experiences of psychotherapists and psychologists, particularly since I am a psychotherapist and cannot separate my understanding of the phenomenon of online counselling from my own experiences and professional socialization in this field.

The participants included 8–10 registered mental health professionals in Ontario (i.e. registered mental health nurse, registered social worker, registered psychotherapist, or registered psychologist) who have used online counselling or psychotherapy methods in the past year. According to Moustakas's (1994) method, I asked the participants in this study two broad questions: a) What is your experience with this phenomenon (i.e. setting ethical boundaries in online practice? and b) What situations have shaped your understanding of this phenomenon (i.e. what setting ethical boundaries online should be)? I added other open-ended questions as each interview built upon on the knowledge of the previous one. I used the The Boundaries in Practice scale (BIP) scale as a guide or reference for categorizing typical ethical dilemmas in practice during the analysis (Kendall et al., 2011). The research questions I chose were designed to examine how each therapist manages professional boundaries online in comparison with face-to-face

counselling, as well, exploring what unique ethical challenges they have experienced in this modality. I asked the therapists to identify the online treatment setting they use most often (i.e. text, email, or videoconferencing) to compare boundary settings across virtual domains.

I used a phenomenological design to explore in greater detail the concept of boundary setting with this population (online therapists) and their unique perspectives on the dilemmas that are unique to their work. This research design was useful for addressing the gap identified by Drum and Littleton (2014) who called for increased understanding of applied behaviors therapists employ when faced with a boundary issue in practice. The authors (2014) further recommended identifying how these issues were unique to an online setting rather than face-to-face.

Definitions

Counselling vs Psychotherapy: While these two terms are often used interchangeably, only psychotherapy is considered a controlled act in Ontario. According to the College of Registered Psychotherapists of Ontario (CRPO), psychotherapy is one of 14 controlled acts restricted to licensed health professionals. Counselling in this study is a broad term used to describe a mental health practitioner, the sample population was drawn from registered professions practicing psychotherapy in Ontario.

Ethical Boundaries: Boundaries in a professional counselling or psychotherapy capacity are understood to be the guidelines the health professional abides by to promote a therapeutic relationship between themselves and their client (Drum & Littleton, 2014).

These set of rules are integral to ethical practice, yet, often are undefined. Ethical dilemmas related to boundaries are often influenced by the unequal distribution of power that is inherent in the therapeutic relationship (Kendall et al., 2011). Kendall et al. (2011) operationalized boundary violations across four domains identified in the literature: knowledge, comfort, ethical decision making, and experience.

Online Counselling: Online counselling is defined as a mental health professional engaging in counselling or psychotherapy with a client that is located remotely using technology (Cipolletta & Damiano, 2017). There has been a myriad of substitute terms for online counselling in the literature including, cyber counselling (Mishna, Bogo & Sawyer, 2015), tele-mental health (Abrams et al., 2017), tele-psychology (Drum & Littleton, 2014), etc. for the purposes of this study the inclusive term of online counselling was used (Cipolletta & Damiano, 2017).

Assumptions

Assumptions in phenomenological research include presumptions that the participants contribute a thorough and honest account of their experiences (Harris, 2017). As this was a hermeneutic process, another assumption was that I, as the researcher, had sufficient insight and interpretive understanding of my own biases and preconceptions. *Sufficient* insight is extremely subjective in a hermeneutic study and is subject to critiques of validity. Achieving validity in the hermeneutic approach is a desire that our own insights will allow the researcher to be immersed in the world of the phenomenon, "…let us stand, albeit slightly off balance, in the same world, while having extricated ourselves" (Rashotte and Jensen, 2007, p.96). A valid and reliable hermeneutic study in part relies

on where the researcher stands; so close, yet slightly removed from their data. Finally, as there is little generalizability in phenomenological research, there is the assumption that this type of study will offer necessary insight into the phenomenon of study with this sample population (Harris, 2017).

Scope and Delimitations

This study was limited to only those practitioners who are licensed to provide the regulated act of psychology and/or psychotherapy in Ontario; including mental health nurses, psychiatrists, registered psychotherapists, social workers, and psychologists were considered as participants. Furthermore, only those licensed professionals who have had 1 year of experience in online counselling/psychotherapy were eligible. To facilitate recruitment, a link to the study was featured on LinkedIn as well as the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists (OACCPP) organizational website and e-blast and invited participants who engage in online therapy. Additionally, I planned to reach out to several training certificates and workshops in online counselling through the University of Toronto that could be used to recruit graduates through flyer or email. One such course was titled, Foundations of Cybercounselling, and is taught by Therapy Online (http://therapyonline.ca), a privately certified educational organization operating in Toronto, Ontario. I preferred to recruit participants through an academic certificate programs in order to ensure consistency in the training and professional interests of study participants. However, this did not seem to be necessary in the end, as recruitment strategies wound up being a snowball sampling where one participant recommended another.

Limitations

Asking registered professionals to reflect and reveal ethical ambiguities and challenges in their practice requires a lot of trust between researcher and participant. Wilson (2015) noted that attempting to persuade the reluctant participant often does not yield good data. Finally, one of the most challenging limits of phenomenological research is knowing when to stop. In-depth, open-ended interviews can be mined for an enormous amount of data. Knowing when the saturation point has been reached is a skill that may be limited by the researcher's experience with this type of study (Wilson, 2015).

Phenomenological research results in a sampling of shared experiences. Therefore, a major limitation of this type of research is the absence of generalizability (Wilson, 2015).

Significance

This research fills a gap in understanding what ethical boundaries mean in practice rather than as a set of professional standards (Kendall et al., 2011). The conclusions add to scholarly knowledge of how online therapists implement boundaries and whether there are ethical dilemmas that that emerged from this evolving form of treatment. This research problem was unique because it addressed three under-represented concepts in the literature: (a) applied boundary setting, rather than broad practice standards; (b) boundary setting in an online environment vs a traditional setting, and (c) the voices of the practitioners themselves and the unique experiences they have had that may be generalized. The results of this study will add to the growing body of literature on online therapy, while also increasing understanding of the applied behaviors

therapists employ to instill and maintain professional boundaries and how these differ from face to face treatment as found by Drum and Littleton (2014).

The knowledge gained from this study will help to strengthen the therapeutic relationship between therapist and client by providing therapists with the practical knowledge they require to set professional boundaries. This knowledge can be used in training and academic institutions to better prepare mental health professionals for the concerns they may face as suggested by Fronek and Kendall (2016). Additionally, online forms of mental health support are here to stay; therefore, providing therapists with the knowledge they need to do their job well is incumbent on scholars seeking to improve evidence-based measures (Perle, Langsam & Nierenberg, 2011).

Summary

The problem that I addressed in this study is the lack of first-hand knowledge of the experiences of implementing ethical boundaries that meet professional guidelines in an online environment. Moreover, I explored if there is a consensus in an understanding of what constitutes ethics in practice in the first place. I asked participants, ‘what do ethical boundaries mean to you?’ to gain insight into the lived experiences of practicing ethically in a profession that relies on boundaries to maintain a good therapeutic relationship. A hermeneutic phenomenological approach allowed me to bring my own experiences and reflections as a therapist to the investigation. A phenomenological approach revealed that therapists rely on their individual sense of ethics more heavily than their professional and social ethical responsibilities when faced with moral dilemmas in online counselling and therapy.

Chapter 2: Literature Review

Introduction

Ethical boundaries are ubiquitous to all competency standards in the helping professions (Williams and Izaak, 2018). Each discipline in healthcare has the autonomy to regulate what they define as ethical practice, including what constitutes a boundary violation (Canadian Psychological Association, 2017). The term *boundary* appears to be used differently by different professional organizations. For instance, the American Psychological Association (APA, 2017) uses the term boundary in their ethical principles to describe psychologists' *boundaries of competence*; This term is used to describe knowing the limits of one's knowledge and education when providing treatment (p.5). For the purposes of this research, I used the term boundary as described by the Canadian Psychological Association (CPA, 2017) when they describe appropriate relationship boundaries between client and practitioner. The CPA (2017) uses this term to delineate instances where the therapeutic relationship could be compromised in regard to safety, integrity, or dignity of the client or the therapist (p.26). The growing popularity of online mediums to provide therapy is an opportunity to explore the next evolution in understanding professional boundaries and include the experiences of practitioners in applying them to practice (Lustgarten & Colbow, 2017).

In this chapter, I will explore the theoretical foundation of professional identity and how it informs the application of boundaries in online therapy. The history of technology and therapy is discussed in terms of the challenges it creates within the counselling profession as well as the opportunities to be gleaned. Finally, a brief

introduction of hermeneutical phenomenology is discussed as the ideal method to capture the voices of those practitioners at the forefront of this evolution in online therapy.

Literature Search Strategy

I applied literature search strategies such as using Boolean operators to search related words such as, *ethics* and *online therapy*; *Identity* and *Counsellors*; *Challenges* and *e-therapy* into various search engines. I also applied strategies such using an asterisk after words such as e-therapy to expand on a single term as well as alternative terms for the same idea (ex. Therapy/counselling/mental health counselling). I used several databases such as Sage, EBSCO Host, CINAHL Plus, PsycArticles, Eric, and The Cochrane Library. I selected three keywords, a) *psychotherapist*, b) *identity*, and c) *online therapy* for an initial literature search and then expanded through the use of alternate words. The term *psychotherapist* was also substituted for *mental health counsellor* and *counsellor*. The term, *identity* was also substituted for *professional identity, identity development, social identity,* and *identity* theory. Finally, the term, *online therapy* had the most variations and was substituted for: *tele-counselling*, *tele-health*, *tele-mental health*, *tele-psychiatry, Skype, video counselling, virtual counselling, videoconferencing, internet interventions,* and *online therapy*. I refined my searches by using articles within the past 5 years. All searches were refined by a date range or no earlier than 5 years, journal articles and peer reviewed status.

This literature review begins with an exploration of how the theory of professional identity grounds us in our ethical orientation in practice. It could be argued that our professional choices such as whether to offer services online are ingrained in us

at the training level. Woo, Lu, Harris and Cauley (2017) hold an opposing view is that our comfort level with any one modality of providing services is a component of our individual disposition. The theory of professional identity is applicable to exploring the ethical challenges of online therapy because it includes a combination of personal and social identity theories.

Theoretical Foundation: Professional Identity

Ethical practice in therapy is part of a professional identity and the product of a reflexive practitioner (Levitt, Lu, Pomerville & Surace, 2015). Reflexivity is a social theory that describes the reciprocal process of an individual's perception of interacting with their environment (Levitt et al., 2015). The ethical practitioner's perceptions of online therapy affect the online therapeutic environment, which in turn acts to change the therapist's perceptions. Ethical practice for mental health professionals is tied to concepts in professional identity, socialization, and presentation of self (Woo, et al., 2017). Understanding how online therapists maintain professional boundaries is an exploration of their professional identity, which develops from the continuous reflexive interaction through their career (Moss et al., 2014). Crigger and Godfrey (2014) maintain that professional socialization if done properly can contribute to improved professional achievements, increase confidence in a society of the profession, and promote positive outcomes in academic programs specializing in one's profession. While other disciplines in healthcare such as nursing, medicine, social work, etc. have ample research on their professional identity development, counsellors and therapists are relatively new to the

field of healthcare, and bare considered by some scholars to have an underdeveloped sense of professional identity (Alves & Gazzola, 2011; 2013; Woo et al., 2017).

Professional Identity of Counsellors and Therapists

Part of the reason that professional identity of counsellors and therapists is somewhat unclear is that of the large variation in regulatory standards across Canada and the United States (Alvez & Gazzzola, 2013; Burns & Cruikshanks, 2017). Additionally, efforts to regulate tools of the counselling and therapy profession, a significant measure of professional identity, are largely inconsistent geographically. For example, the College of Registered Psychotherapists of Ontario, established in 2015 has only recently defined the controlled act of psychotherapy, the characteristic therapeutic tool of psychotherapists that distinguishes them from other health professionals (CRPO, 2018). Without such professional regulations and guidelines, professional identity is difficult to formulate. Additionally, counsellors, counselling psychologists, and psychotherapists are distinct mental health professions who are referred to interchangeably in the literature and even within professional accreditation boards (Burns & Cruikshanks, 2018). While there is significant overlapping in their roles, the regulatory bodies governing their work are separate.

Professional identity can be thought of as an interdependent relationship between individual professional identity and collective professional identity. Effective professional socialization into a field should result in significant changes to a clinician's individual identity, which in turn will have an impact on the collective identity of the

profession (Crigger & Godfrey, 2014). The following discussion explores how both individual and social identity influences professional identity.

Identity Theory (ID)

Our identity helps us to anchor our existence in the vast macrocosm of our lives. It is a constant heuristic and unconscious evaluation of our similarities or differences compared to others (McLean & Syed, 2014). McLean and Syed (2014) differentiate between the terms, *self* and *identity*, where *self* describes the interior consciousness of our mind, while *identity* describes our exterior presentation in society (p.12). In psychology in the 1930s, identity theorist George Herbert Mead was the first to describe identity as an interaction between self and society (McLean & Syed, 2014). This notion of the self being influenced by your position in society has been expanded upon in areas of sociology, history, anthropology and the like (McLean & Syed, 2014). For example, famed sociologist, Erving Goffman, in his seminal book *The Presentation of Self in Everyday Life* (1959) likened our sense of identity to a performance, acting on stage (Bullingham & Vasconcelos, 2012). Identity, for Goffman (1959) involved a front of stage presentation where we dramatize ourselves to fit social norms and back of stage presentation where we act more unguarded. According to Goffman (1959), a front of stage blunder could cause personal shame or to "losing face", but if a mask is well work it can inhabit many successful identities (Bullingham & Vasconcelos, 2012, p. 1). In this way, according to Goffman, identities are managed depending on the social situation we find ourselves in. This phenomenon has been termed *impression management* (McLean

& Syed, 2014, p. 14). This term later evolved to include *role-identity* and *identity salience* by Stryker (1968) and Stryker and Serpe (1982).

Role identity, according to Stryker (1968) is a form of self-concept that only takes meaning from complementary roles in society. For instance, the role of a parent takes meaning from that of a child, or the role as a health care provider takes meaning from having a patient and so on. Stryker's notion of role identity is more nuanced than Mead's symbolic interactionism of self in society because these labels are not only reflexive according to social norms, they are interchangeable, nuanced, and dynamic (Hogg, Terry & White, 1995).

Identity salience, according to Stryker and Serpe (1982) is the probability that a facet (or role) of identity is prominent in each situation. Stryker and Serpe (1982) proposed that our role identities are placed in a hierarchy depending on our behaviors. For instance, a parent who is at work is still a parent, but during the workday, their behavior indicates that their role as an employee is most salient.

In summary, identity theory are roles individuals play in society chosen from a myriad of self-concepts depending on the situation at hand. To deviate from role expectations may cause distress or low self-worth (Hogg et al., 1995). If identities are reflexive to social norms, deviating from these norms could cause cognitive dissonance. For instance, Smith and True (2014) examined the "warring identities" of veterans turned civilians (p.147). Operating in the role of a veteran when the social expectation is to play the role of civilian may cause psychological distress associated with post-traumatic stress disorder. *Presenting* ourselves as ethical practitioners is part of a nuanced identity that

might differ from face-to-face counselling to online counselling creating a possibility for warring identities (Bullingham & Vasconcelos, 2013). Erving Goffman's seminal theory of identity as being a mask worn when we *present* ourselves to others is often a metaphor used to describe the online persona as an avatar of self. In the online environment, both practitioner and client can adopt a virtual identity. The practitioner adopts one of an ethical professional, that may be a blending of their individual and social identity (Billingham & Vasconcelos, 2013).

Social Identity Theory (SIT)

While identity theory is concerned with the role a person plays within a social group, social identity theory explores the person within the group itself (McLean & Syed, 2014). How individuals categorize themselves as belonging to one group over another is a process of in-group identity vs out-group identity. Theorists Tajfel and Turner (1979) stated that the way in which people categorize themselves has an impact on our motivation to maintain a positive social identity. No one wants to belong to a subordinate group, whether it be nationality, ethnicity, gender, occupation etc.; therefore, sometimes the process of categorization can lead to stigma, stereotyping, and prejudice (Tajfel & Turner, 1979). The idea of self-enhancement relates to social identity in that people wish to think of themselves in a positive light and therefore their belonging is reinforcing of this (Hogg, Abrams & Brewer, 2017). For instance, a person belonging to a certain political party must perceive their party as having superior ideals or agenda to an opposing party. While it may not be necessary to malign the opposing political party, it certainly helps generate in-group affiliation to the political party of one's choice.

Research Literature Review

Socializing Ethical Counsellors

Creating in-group affiliation in a professional organization begins with an established robust professional identity (Woo, Lu, Harris & Cauley, 2017). A strong professional identity not only serves to create affiliation among existing members but also serves as an aspirational focal point for potential members and member trainees. According to Woo et al. (2017), professional identity development is a process of titration that begins in one's master's level academic work and becomes fully saturated by the time a practitioner is in a teaching position within their profession. For counsellors, a durable professional identity is imperative for optimal ethical practice which ultimately leads to increased social status among society and other established helping professions (Woo et al., 2017).

Ethics as a component of professional identity in counselling has been shaped by classical cognitive development theories such as Kohlberg's (1971) seminal moral development theory and scholars who challenged and built on Kohlberg's work (i.e. Gilium, 1982; Krebs & Denton, 2005). Modeling after Piaget's developmental stages, Kohlberg's (1971) theory of morality is constructed in six concrete stages starting in childhood. Each stage builds in complexity in terms of moral judgement, ultimately leading to a compass of social justice (1971). Notable critics of Kohlberg such as Gilliam (1982) maintain that Kohlberg's theory is male-centric, ego-centric, and lacks attention to the interpersonal aspect of moral reasoning, including empathy and caring. This feminist interpretation, while notable, is like Kohlberg's assumption that moral reasoning operates

linearly, whereas, Krebs and Denton (2005) challenged the 'staged' model for a more practical and situational approach to moral reasoning. Krebs and Denton (2005) proposed in their pragmatic model of morality that people are much more complex in their moral judgement and have a myriad of decision-making tools at their disposal that is used through evaluating the complexity of the dilemma at hand. Krebs and Denton (2005) maintained that only very young children follow Kohlberg's pre-conventional stages of moral development due to their limited cognitive functions, however, once matured, people's options in decision making infinitely increase. Finally, the authors (2005) noted that augmented ethical decision-making tools lead to a progression of entropy in ethical decision making when they noted, "It also follows that the more morally mature people become, the more structurally flexible—and inconsistent—their moral judgments will be" (p. 634).

Individuation, variety, and critical appraisal when facing an ethical dilemma are exactly what Lloyd-Hazlett and Foster (2016) argued good professional socialization should foster. According to the authors (2016), practitioners do not practice ethics didactically; rather, there is an element of personal discretion in choosing how to behave in accordance with any given situation. Moffett, Becker, and Patton (2014) also noted that simply the existence of ethical standards is not sufficient to ensure ethical behavior because individuals must be personally motivated and committed to continually act on discrepancies in ethics. To recognize and act in accordance with practice standards Moffett et al. (2014), maintain that there must be a prerequired "sensitivity" to ethical concerns because, without this prerequisite, no action can commence (p.229). Ethical

sensitivity is described as a personal disposition or virtue that according to the authors (2014) encompasses "integrity, honesty, responsibility, compassion, and courage" (p.230). The idea of imposing personal moral values in professional decisions involving ethics is reiterated by Heller-Levitt, Farry, and Mozzarella (2014) who examined ethical reasoning among counsellors. Heller-Levitt et al. (2014) found through interviewing counsellors that personal morals and values were the first of four tools in making ethical decisions in practice. The other three tools included the client's well-being, open communication in the decision-making process, and factors associated with the counsellor's education and training.

If personal values play such a large role in professional ethics and decisions, perhaps it is a symbiotic mechanism of like attracting like; meaning that ethically sensitive individuals are attracted to professions that are identified by their ethical commitments. This concept, known in business ethics has been coined 'moral identification' (May, Chang & Shao, 2015). Moral identification is a theory posed by May et al. (2015) where the individual feels that they belong to a social group due to the group's ethical mandate. This theory not only explains why some individuals may be attracted to helping professions but why the stronger the affinity between personal and group morals, the lower the instances of unethical acts by employees.

Virtues, Values, Morals, and Ethics

"…virtue is not merely a state in conformity with the right principle, but one that implies the right principle; and the right principle in moral conduct is prudence."

- Aristotle, *The Nicomachean Ethics*, book 6, p. 165-166

Long before conventional theories of moral development were conceived, the classical philosophers knew that acting ethically was not simply a matter of following the rules. Aristotle's writing conveys that the ability to infer what the right thing to do originates in personal characteristics of virtue. Virtue is often a synonym for morals which is also confused with values and ethics due to their use interchangeably in the literature. Though related, these terms are, in fact, distinct ideas in moral philosophy (Chowdhury, 2016; Hitlin, 2011).

Aristotle took aim at the notion of virtue in his book, *Nichomachean Ethics*, in which he described happiness as a product of engaging in virtuous activities (May, 2010; Waterman, 2011). Ideally, our identity formation according to Aristotle is realized through reaching our potential as human beings, living life in accordance with our 'true self', and honing virtues of the soul (Waterman, 2011). Virtues, in classical terms, are exceptional character traits which lead one to do what is 'good' and is continually challenged by vices presented in daily life. The idea between choosing what one 'ought' to choose vs. what they must 'ought not' to choose is the core of classical philosophy focusing on the Diamon, or the true self (Waterman, 2011, p. 360). The true self is a benevolent self that fulfills not only one's potential, but the potential of mankind; becomes what a 'good' man can truly be (Waterman, 2011).

If virtues are aspirational characteristics, values might be a more descriptive evolution of this construct in that these aspirational characteristics are within reach when they are developed reflexively with the environment. As we grow we gain a sense of what is 'right' and what is 'wrong' that inform our judgement and behaviors (Hitlin,

2011). Values, according to Hitlin (2011) form the "core of the self" which when taken collectively create a "moral framework" by which our actions are informed (p. 516). Values, therefore, are concrete characteristics (i.e. Joe is an honest man) that are shaped and formed both intuitively in response to an environment that promotes certain values over others (i.e. honesty is the best policy). Values in turn evolve in the lexicon into morals, which describes a group of values that are collectively esteemed (Hitlin, 2011).

Moral ideologies are still highly individual as they are informed by our personal values and characteristics. For instance, Waterton (2011) notes that suicide bombers act from a moral sense of duty which, while unconventional, is a certain interpretation of morality based on a set of personal and collective values. As mentioned previously, a critique of moral identity theory, as described by scholars such as Kohlberg (1971), is that it isolates morality from the society in which it is formed. Therefore, contemporary scholars of moral theory contend that morality is affirmed through the ethical context surrounding it (Schwartz, 2016). Chowdhury (2016) delineates between morals and ethics by explaining that morals are inherently internal structures made of individual values that are formed through heuristic mechanisms of identity formation. Ethics, on the other hand, are social reflections of human behavior that are organized into systems that inform social order and justice. Chowdhury (2016) maintains that although values and morals are more internally forged, and ethics are externally imposed, all three are informed by culture. Keirl (2015) discusses morals and ethics across cultures noting that in Western culture adhering to ethics is considered a singular action, whether moral or immoral, the "choice-maker" is one individual considering themselves in the outcome (p.4). In

contrast, Buddhist and Eastern cultures aspire to rise above the self to a state of 'no self' as a moral aspiration; meaning, external relationships guide ethical behavior.

Jaffe, Kushnirovich, and Tsimerman (2018) noted that while morals may have some similarities across cultures, how they inform social rules and laws (i.e. ethics) tend to contrast greatly (i.e. abortion laws, immigration and deportation laws, or laws relating to crime and punishment). National culture and politics are crucial in the development of morality because they inform and are informed by institutional ethics. Jaffe et al. (2018) stated that the purpose of developing a moral sense of self is to feel a sense of purpose and dedication within our daily lives in association with our chosen social groups. Sharing meaning with others gives us a social sense of purpose. As we grow we feel the need to share our moral foundation with others, a term Jaffe et al. (2018) call "moral agency" (p.822). Finally, shared morals become social institutions (i.e. social ethics), which are then translated in different professions who then, in turn, enrich our individual sense of values (Jaffe et al., 2018).

Ethical standards in professional practice cement the idea that we have shared morals and therefore we share responsibility in upholding them (Francis & Dugger, 2014). Ethical standards in the field of mental health are not in place because therapists are not moral enough left to their own devices, but because ethical dilemmas and conflicts are simply too easily found. The work of therapy tackles complex issues of emotions, vulnerability, conflict, and fragility of the human experience. Therefore, standards of ethics are not there to corral bad behavior, but rather, reflect good intentions of the practitioner. Through professional membership, the therapist pledges their

commitment to their client's wellbeing even in the face of conflict with their personal values and morals (Francis & Dugger, 2014).

Beyond Ethics

Francis and Dugger (2014) theorize beyond the initial purpose of ethical standards as a leveler in the moral playing field to note that ethical standards are a *symbol* of professionalism. Clients engaging in therapy can be sure that not only will their needs be met ethically, but their welfare and safety is safeguarded by the rules of practice (Francis & Dugger, 2014). The ethical code for any health professional is a declaration of non-maleficence; no harm or the least amount of harm possible (APA, 2017). This kind of professional judgement requires not just a literal translation of ethical standards, but the ability to apply them to a myriad of unpredictable situations. The American Psychological Association (APA) has one of the most cited ethical standards in health and medicine (Sikora, 2017). The preamble to the APA (2017) code of ethics maintains that ethical standards are not exhaustive, and therefore, whether a certain scenario is covered by the standards or not, members are required to use their best judgement in holding themselves to the highest ideals of client care (Sikora, 2017). This echo of Aristotle's statement on the virtuous person is one who can imply the right principle when faced with a moral dilemma. Aristotle knew that conformity is not as useful to morality as foresight, prudence, and critical thinking (May, 2010).

Navigating Countertransference: An Ethical Task of Counsellors

Morals, as we now know, are not absolute but are context driven. The context of an online environment in therapy presents a new challenge in applying one's best

judgement in compliance with ethical standards of practice (Tappin & Capraro, 2018). In all professions, we accept that there are symbols and tools of practice that serve to confirm the role one is a part of, both for themselves and others. The uniform is the best example of a symbol of professionalism that garners social attributions; for instance, judges wear robes and have gavels, policemen have uniforms and guns (Joseph and Alex, 1972). Therapists, as professionals do not have a recognizable uniform, however, the Freudian couch is the quintessential symbol of psychotherapy and psychoanalysis (Yablon, 1995). In Schachter and Kächele's (2010) discussion of the symbolic meaning behind the couch in psychoanalysis, they note that this iconic representation of therapy was more than furniture, its purpose according to Freud was to manage transference and countertransference.

Sigmund Freud coined the terms transference and countertransference to describe the phenomenon of unconscious emotional exchange in therapy (Searles, 2017). Transference is simply the 'transfer' of one's past emotional states into the present therapeutic space. More specifically, the key work of therapy takes place when the patient unconsciously relives their past experiences and transfers their feelings onto the therapist (Searles, 2017). The therapeutic technique involved in transference takes place through re-living stressful situations in a safe space that provides an opportunity for reflection and insight with a skilled listener (i.e. the therapist). Transference can be thought of a type of 'rehearsal; through which one may learn new skills in overcoming their past feelings of powerlessness or fear (Searles, 2017, p. 197). Countertransference is the emotional state the therapist finds themselves in while knee deep in the patient's

transference (Searles, 2017). A less convoluted explanation is that we are all human beings and hearing people recall difficult events in their life also impacts the therapist. Countertransference is the feelings that are stirred in the therapist in session and are a useful therapeutic tool (Searles, 2017).

Freud's iconic analysis couch was a tool to mitigate countertransference and focus on the patient's transference in session (Schachter & Kächele, 2010). According to classical psychoanalysis, this was accomplished by the patient lying supine on the couch while the analyst sat in a chair facing away from the patient. This positioning facilitated a dynamic where the patient could free associate without the interference from the therapist's facial expressions (i.e. emotional reactions) (Schachter & Kächele, 2010). Online therapy not only removes the iconic symbols of professionalism from the therapeutic environment but also serves to change the dynamic in session where a therapist is looking directly into the screen increasing the opportunity for countertransference. As noted earlier, changing these aspects of therapy does not imply that therapist will behave in unethical ways, however, the context of applying ethical decision-making changes. If we were to substitute a different profession and strip them of their identity, such as a police officer without their uniform, similar ethical questions would arise. While countertransference is an important therapeutic tool, it can also be a hindrance in influencing the therapist in such a way that they interfere and even damage the therapeutic process at the expense of the patient (Hayes, Nelson & Fauth, 2015). Without the pomp and circumstance of the therapist's office, it may be that previously unfamiliar and improbable circumstances for transference and countertransference are

more likely to occur (Kadish, Schön, Green, Hanson & Kuhn, 2018). A therapist practicing online will have to seek and find where the professional boundaries lie in a virtual world.

Navigating Professional Boundaries

A boundary, according to Gabbard (2016), is typically used to define geographic borders, however, it has also been adopted to delineate the limit beyond which one should not cross professionally. Typically, literature exploring professional boundaries only describes instances of boundary transgressions that end in adverse consequences, rather than providing examples of what constitutes operating within (Smythe, Hennessy, Abbott & Hughes, 2018). Gabbard (2016) explains that while the initial intention behind the term "professional boundaries" was to describe emotional boundaries within the therapeutic relationship, the term has been somewhat distorted to describe abuse of power in therapy (p. 1). Gabbard (2016) noted that abuses of power include "abstinence, neutrality, optimal gratification, countertransference…, self-disclosure by the analyst, as well as the notion of transference itself" (p.1). It seems as though the term 'boundary' has shed an unholy light on the work of therapy, mainly transference and countertransference, possibly doing a disservice in misrepresenting their essential functions in therapy. Professional boundaries, it seems, only come to light when they have been crossed and dragged in the media in an effort to frighten professionals and clients alike of the possibility of corruption in therapy (Gabbard, 2016; Smythe et al., 2018).

A more holistic definition of professional boundaries according to Gabbard (2016) can be described in psychoanalytic terms of the "analytic frame" (p.2). The frame

in therapy and counselling is not a hard set of limits, but rather a dynamic container in which the realities and fantasies of therapy live and breathe (p.2). The frame is a safe container to co-examine thoughts and experiences where the therapist establishes an equilibrium between safety and freedom of expression (Gabbard, 2016). Measures of safety might include a list of prescribed rules that are both spoken and unspoken. For example, the therapist cannot have any physical contact with the client (mostly unspoken), however, the therapist must verbalize their intention to maintain confidentiality and limits of confidentiality (spoken). Measures of free expression can include allowing space for the client to verbalize their thoughts without fear of judgement, managing the flow of communication, and creating a safe atmosphere for therapeutic work to be done (Gabbard, 2016). Other theorists postulated that the 'frame' is that which distinguishes therapy from other experiences. Grant and Mandell (2016) content that health care providers often err on the side of framing boundaries that are too narrow for fear of crossing them. Inflexible and impermeable professional boundaries create distance in the therapeutic relationship, causing unnecessary challenges to creating good working alliance. Good boundaries, according to Grant and Mandell (2016) are the kind that leave room for flexibility and authenticity in the relationship.

Regarding boundaries in face-to-face therapy sessions the topic of boundaries is extremely vague (Samson-Daly et al., 2016). Professional organizations such as the Canadian Counselling and Psychotherapy Association (CCPA) and the Canadian Psychological Association (CPA) define boundaries in two ways: 1) relationship boundaries and 2) professional boundaries. Relationship boundaries include identifying

situations that might pose a conflict of interest, such as a dual relationship. A dual relationship is one in which the therapist knows the client in another way other than professionally (i.e. neighbor, friend, family member) (CPA, 2017). Professional boundaries are the sanctions that limit the practitioner to operating within their field of knowledge and expertise; meaning they refer to another clinician when necessary (CCPA, 2015). All other manner of boundary keeping in face-to-face practice is implied to be understood by the practicing professional who's only guidance is in the form of a warning when the CCPA (2015, p. 30) states:

> "Boundary violations are acts that breach the core intent of the professional-client association. They happen when professionals exploit the relationship to meet personal needs rather than client needs."

The introduction of technology in therapy has posed new challenges to navigating boundaries for several reasons, one of which may be the false sense of security that comes with the physical distance between client and practitioner (Drum & Littleton, 2014). Other caveats to boundaries in online care may be the simple matter of the unexpected. While therapy in close proximity can foresee some looming boundary issues such as a sexual relationship or touching of some kind, online therapy cannot predict where the exact line is drawn between appropriate and inappropriate (Drum & Littleton, 2014). Kendall et al. (2011) operationalized clinical boundaries across four domains: knowledge, comfort, ethical decision making and experience, however, these domains have not been applied in a virtual setting. The online environment can be an

asynchronous form of communication which may lead to delay in responding to a boundary violation that much more harmful.

A Brief History of Technology and Therapy

The notion of providing mental health care through remote communication was pioneered by the father of psychoanalysis, Sigmund Freud, who often corresponded with his patients and conferred with colleagues about cases via mail (Recupero, 2005; Library of Congress; Witt, Oliver & McNichols, 2016). The next phase in distance counselling was the use of the telephone which allowed clinicians to bridge the distance gap and connect with clients in real time. The first suicide hotlines were established in the late 1950s in Lost Angeles and served as a model for national and international suicide hotline centers providing telephone counselling on a 24-hours-a-day basis (Office of the Surgeon General, 2012; Witt et al., 2016). In the United States in 2001, the Substance Abuse and Mental Health Services Administration (SAMHSA) took the LA model nationally to create the National Suicide Prevention Lifeline (NSPL) (800–273–TALK/8255) staffed with volunteer counsellors and connecting callers to their local chapter for support. As of 2017, over ten million calls have been answered through what they term “the nation’s mental health public safety net” (NSPL, 2017).

When the Internet became more mainstream in the early 90s new modes of communication added yet more options for connecting remotely. Data from Statistics Canada’s 2012 Canadian Internet Use Survey revealed that roughly 83% of Canadians, approximately 32 million Canadians, have Internet access and access it daily (Statistics Canada, 2014). This number is assumed to be greater today. Moreover, the Mental Health

Commission of Canada (2015) reported results of the Canadian Internet Registration Authority (CIRA) that Canadians spend roughly 45.6 hours online per month, in comparison to 40.3 hours in the United States, and 24.4 hours globally, making Canadians the most accessible population online (Campbell, Cohen, Grande & Hopkins, 2015).

Internet-enabled technologies including video, text, email, and SMS were introduced to counselling and therapy as the technologies emerged over the past 30 years. While it may seem like a recent technology, the use of video conferencing has been around for over 50 years (APA, 2018). According to the American Psychological Association (APA) (2018), the term telepsychiatry is used to describe technological mediums to provide mental health care. The APA states that the first recorded use of video was in the 1950s at the Nebraska Psychiatric Institute who utilized videoconferencing in group therapy and long-term therapy. The first practice guidelines for integrating technology into counselling were formed by the American Telemedicine Association, founded in 1993 (APA, 2018). Today, there are over 19 different practice guidelines globally that vary considerably in the expectations of therapy provided online (Sansom-Daly et al., 2016).

Practice Guidelines: A Review

The adoption of practice guidelines specific to online therapy has been a fragmented endeavor that slowly spread from one regulated profession to another (Ostrowski & Collins, 2016). For example, in the United States, the National Board for Certified Counselors (NBCC) released their version of standards for online health

delivery in 1997, while the Clinical Social Work Federation (CSWF) only made recommendations to their members in 2001 (Ostrowski & Collins, 2016). North of the border in Canada, the Canadian Psychological Association (CPA) released a Draft Ethical Guidelines from providing psychological services through electronic means in 2006. The CPA based their draft recommendations on their statement document in 1999 warning practitioners of risks to ethical violations (CPA, 1999). The Association of Canadian Psychology Regulatory Organizations did not introduce their Standards for Telepsychology until the much later in 2011 (ACPRO, 2011, June 4).

Samson-Daly et al. (2016) reviewed 19 practice guidelines from around the world to measure their level of consensus and found that these guidelines shared a remarkable similarity in nearly all their recommendations other than the area of professional boundaries. The authors (2016) concluded that while the provision of online therapies drastically reduces accessibility barriers to mental health supports, the disparities in ethical boundary guidelines leave a chasm of risk for both practitioner and client. Williams and Izaak (2018) state that there is a contradiction in the fact that ethical standards are meant to be a living document reflecting the changing world of healthcare at any given time, while at the same time, practitioners in the field have little to no "voice" in the evolution of the standards that bind them (p.6). Often, ethical standards become a legal blanket of imparting blame on those members who violate ethical boundaries rather than strengthening ethical deduction and inviting ethical dialogue among established ethical practitioners (Williams & Izaak, 2018). Despite these risks and

lack of representation of real-world practice issues involving technology in therapy, online therapies seem only to be gaining in popularity.

Advantages to Online Therapy

Samson-Daly et al. (2016) noted that the benefits of online therapy are nearly identical to face-to-face modalities. In fact, online therapy has gained so much support that in 2014 the Mental Health Commission of Canada (MHCC), a non-profit government task force, released a briefing document lauding the benefits of online mental health care and identified six areas where technology can be beneficial: 1) promotion and prevention, 2) chronic illness management, 3) improved accessibility, 4) mitigate disparities in access to care and increase cultural competency, 5) address health disparities in First Nation, Inuit and Métis populations, and 6) provide opportunities for mental health leadership and collaboration with government and communities (MHCC, 2014).

Many scholars concur with the findings of the MHCC (2014), particularly with the benefits of improved accessibility (Kauer, Mangan & Sanci 2014; Lal & Adair 2014; Mishna, Bogo & Sawyer, 2015; Langarizadeh et al., 2017). Mishna et al. (2015) found that online mental health services surpassed face-to-face counselling in the practicality of accessing counselling as well as in the ease of disclosure. One participant noted, "'it [cyber counseling] did help because there were some things that I knew I wasn't able to look at someone in the face and try to talk to them about.'' (Mishna, 2015, p.173). A systematic review by Kauer et al. (2014) found while there was no change in help-seeking behavior in young people, as typically thought, online therapy improves health

literacy, which in turn contributes to readiness to engage in therapy. A review by Lal and Adair (2014) address the fact that online therapy reduces the cost of services leading to improved accessibility for low-income populations generating interest among government organizations who are interested in online therapy as a population health strategy (McCord, Saenz, Armstrong & Elliot, 2015).

Finally, Langarizadeh et al. (2017) concluded that asynchronous psychotherapy has the potential for great benefits in coordinating care and increasing accessibility to mental health support. Asynchronous, according to the authors, refers to the time lag in online modalities such as email or phone that may or may not be used by clinical and patient simultaneously. Langarizadeh et al. (2017) clarified that the potential benefits for this type of therapeutic intervention are great, provided that "detailed clinical guidelines" precede this intervention (p.242).

Barriers in Online Therapy

Samson-Daly et al.'s (2016) review of international guidelines identified various ethical challenges to Internet-based therapies, the most prominent of which, is privacy online. A secured and confidential distance-based counselling session is still limited by the security of the Internet (Samson-Daly et al., 2016). Lustgarten and Colbow (2017) took this further in their discussion of telemedicine and government surveillance.

Privacy in times of government surveillance. Lustgarten and Colbow (2017) contend that the government leaks instrumented by the infamous Edward Snowden in 2013 alerted the public to the fact that the National Security Agency in the United States had access to what the public considered to be protected online data. This data includes

but is not limited to: emails, chats, texts, videos, photos, both stored and live video feed (Lustgarten & Colbow, 2017). The reason why this is of concern is due to the fact that nearly ten years ago the APA found that roughly 87% of mental health practitioners utilize telecommunications in their practice (i.e. phone and/or email). With the rapid advancement of communication technology, it is a modest estimation that this number has increased both in size as well as variation in modalities (Lustgarten & Colbow, 2017). Lustgarten and Colbow (2017) maintain that while a variety of practice guidelines for online therapies exist, none have considered the breadth of privacy concerns that were brought to public knowledge as a part of the Snowden leaks. Furthermore, while the data breaches mostly concerned residents of the United States and Britain, it can be inferred this breach has international implications.

While issues of privacy remain tantamount to trust and ethical practice in therapy, therapists are not without options in this age of online snooping. Lustgarten and Colwbow (2017) make several suggestions for reflexive practitioners who wish to keep their code of ethics updated with the times:

1. Informed Consent: Practitioners should remain knowledgeable about changes in the field of telecommunications and modify their informed consent process to reflect this. Additionally, the authors (2017) invite practitioners to collaborate with their clients on the parameters of informed consent in order to include new knowledge on privacy.

2. Use Appropriate Software: Practitioners are advised to use software that has end-to-end encryption capabilities to offer their clients the highest available privacy measures for their online data.
3. Increase Knowledge: Practitioners must incorporate technology into their continuing education if they are using telecommunication services in their practice. This might involve dedicating a computer solely for this purpose and either learning which software and hardware are best suited to this or employing someone who has this knowledge.
4. Two- Factor Authentication Measures: This measure has been vaguely suggested by the APA's (2007) record keeping guidelines when they state, "Psychologists protect electronic records from unauthorized access through security procedures (e.g., passwords, firewalls, data encryption and authentication)" (p.998). Lustgarten (2016) advises a two-factor authentication measure to increase protection.
5. Advocate for a Privacy Officer: This should be a measure that is mandatory for all regulatory colleges.
6. Increase Training Opportunities: Coursework at the training and professional level is necessary to keep up with the rapid changes in communication technology. The lack of training is discussed by other authors are a barrier to maintaining privacy and adhering to ethical standards.

Lack of training options. McCord et al. (2015) raised the concern that not only are educational opportunities lacking in online therapy, but practicum experiences at the

training level are inadequate, as well as supervisor expertise in this area. Additionally, the APA has no standards for education related to online therapies. The absence of educational requirements and criteria have far-reaching implications. McCord et al. (2015) offer the perspective that knowledge in this area can impact the diagnosis and course of treatment. For example, personal biases towards technology may lead one practitioner to believe that a client using online therapy modalities has an overreliance on technology, while another may view it as an appropriate use of time and skills. Finally, McCord et al. (2015) warn that a lack of continuing education in technology and therapy may push practitioners to operate within the "fringes of competency" (p.332).

Inconsistent terminology. To provide standards of education for online therapies, Ostrowski and Collins (2016) recognize that there must be some agreement on the terminology utilized in this burgeoningly popular field of mental health care. In their investigation of the licensing boards in the United States alone, the authors (2016) identified 19 different terms utilized for describing mental health care delivered through an electronic medium. Ostrowski and Collins (2016) note that such a large variation in terminology not only impacts how practitioners search for their licensing board standards of practice but has much larger implications in the field of research in amalgamating similar, yet, separated field of knowledge.

Special populations. While online therapies have been adopted unilaterally across various mental health professions, there is little regard for how this modality may impact special populations (Samson-Daly et al., 2016). Populations that may be more vulnerable using this medium include individuals with cognitive impairments, clients in

crisis, and clients experiencing symptoms of psychosis. Any future guidelines in the delivery of online therapy must indicate recommendations for these populations.

These and all the barriers mentioned has not stopped the rapid pace of adopting online therapy modalities. Witt et al. (2017) added a practical piece into consideration when they identified the necessity by both parties to be camera ready, quick typists, and expressive writers.

The Future of Online Counseling

Despite the enthusiasm from the mental health community to keep up with the changing times, it appears that clients may not be as eager as anticipated to be removed from the therapist's couch as believed (Apolinário-Hagen, Kemper & Stürmer, 2017). Apolinário-Hagen et al. (2017) conducted a systematic review assessing study participants on two indicators of acceptability of online therapies: 1) Perceived helpfulness of online therapy and 2) Intention to use online therapy modalities. In both cases, most participants preferred face-to-face interventions to online interventions. Apolinário-Hagen et al. (2017) noted that there are several reasons why this could be apart from the noted effectiveness of online therapeutic interventions. The first reason lies with familiarity. It may be that the public sees face-to-face treatment as a hallmark of good therapy. This coupled with low awareness about the effectiveness of online therapy interventions could contribute to low rating in perceived helpfulness leading to lower intention to use online opportunities to seek mental health support. The future of online counselling may involve a hybrid version where clients can be introduced over time to alternative communication mediums.

Counseling via avatar. Reservations from the public aside, online modalities in mental health seem to be marching ahead unencumbered. Witt et al. 2016 discussed the phenomenon of avatar-mediated counselling, also known as, a multi-user virtual environment (MUVE). In a MUVE either the counsellor or the client, or both create a simulated reality where the appearance of participants can be manipulated beyond human (i.e. animal or mythological creature). Some research in this area points to the effectiveness of MUVE in lessening anxiety. Barriers to this type of technology mostly center on the computer skills of the users.

Another caveat of counselling via avatar is centered in the uncharted territories of transference and countertransference online (Kadish et al., 2018). The use of a computer screen changes the visual field of traditional therapy to one where the therapists and client's gaze are visible simultaneously. Whether or not this has a negative impact on therapy is not yet known, and more research needs to be done in this area (Kadish et al., 2018). The introduction of an avatar may create temptation to cross boundary lines, such as virtual 'touch', not previously crossed before. Drum and Littleton (2014) mentioned the difference between 'crossing' a boundary and 'violating' a boundary. It seems that touch in the face-to-face environment is easily regarded as a behavior that would traverse all boundaries, however, with the use of avatars there may be therapists who make a case for crossing that boundary since physical touch is not violated. There are many yet to be explored scenarios in understanding how professional boundaries are maintained and hearing from those practitioners engaging in this modality is needed.

Hermeneutical Phenomenology: Sharing Understanding

Qualitative research methodology is a method to explore a research question from a dynamic world view (Sloan and Bowe, 2014). The qualitative researcher does not seek static data, rather, is a gatherer of experiences and reflexive observations of the human condition and the ever-changing world she lives in. Phenomenology is both a philosophy as well as methodology developed by German philosopher Edmund Husserl at the turn of the 19th Century. Husserl was interested in understanding objects (i.e. phenomena) through how people experience or interpret them (Sloan & Bowe, 2014). Phenomenology as a research methodology is concerned with how a phenomenon is perceived; this is an exploratory method that goes into greater detail of the minutiae of experiences.

Traditional phenomenological research methods are a pillar of qualitative data collection that are more concerned with asking the right question rather than finding the *right* answer (Heinonen, 2015). Phenomenological research methods are tasked primarily with uncovering the *lived experiences* of phenomena where the researcher approaches their topic of study with open curiosity rather than preconceived conclusions. The researcher's curiosity is preserved through two methods: epoché and reduction (Heinonen, 2015). Through the use of epoché, the researcher must 'bracket' their biases and expectations of the phenomena in question, and reduction is a tool to find the concentration of meaning in the haystack of experiential data (Heinonen, 2015, p. 35).

Two chief methods of phenomenology research are 1) descriptive and 2) interpretive. Descriptive phenomenology preceded interpretive and is also known as transcendental phenomenology. This type of phenomenology was described by Husserl

as an “objectivisation” of phenomena where the researcher “transcends”’ the small details involved and understands it from a “global” perspective (Sloan & Bowe, 2014, p. 1294). While it may be impossible to completely remove oneself from the object of observation, the research nonetheless, for descriptive purposes must acknowledge they are interfering with their data and continue to examine the phenomena as if removed. Opposingly, interpretive phenomenology, also known as hermeneutics, asks the researcher to engage with the phenomena and use their own experiences as part of the interpretive process (Sloan & Bowe, 2014). Hermeneutics was refined by followers of Hursserl, such as Gadamer and Max van Manen to explore how language in qualitative interviews drives the researcher in a “hermeneutic circle” to uncover truths of the phenomena (p.1296). The hermeneutic circle is not depicted as an unbroken path of going around in circles, but rather a spiral process of moving between the text of the interview and the interpretive work of the researcher (Erlingsson & Brysiewicz, 2017). Greek philosopher Heraclitus famously said, “No man ever steps in the same river twice, for it's not the same river and he's not the same man”, such is the spiral or hermeneutic reduction of data and analysis (Graham, 2015).

Hermeneutical phenomenology recognizes that the researcher has power over data and is therefore entrusted with being forthcoming with any biases, experiences, or pre-emptive thoughts about the research subject prior to collecting data (Crowther et al., 2017). These biases are not ‘bracketed’ as they are in traditional phenomenology, rather they are used as a tool to share in the experience of the phenomenon (Heinonen, 2015). The researcher’s existing knowledge and prejudices are made transparent and thus act as

a catalyst to asking the research question that then initiates data. Just as I, the researcher and a psychotherapist have a stake in the outcome of the findings of this research, hermeneutics is a fitting data collection method to a research question involving ethics in online therapy. The interpretation of data in hermeneutics involves deep listening to uncover shared meaning "between and beyond the words" in a dialectical movement between the transcript and the story that unfolds (Crowther et al., 2017, p.13). The hermeneutical researcher approaches the transcript as a story editor entrusted with finding the essence of meaning in the participant's experiences and trimming the excess. The researcher moves between the transcript and the emerging story repeatedly to methodically shape the participant's words in a way that is true, succinct, and compelling (Crowther et al., 2017). The hermeneutic process is not unlike psychoanalytic therapy when the therapist is charged with active listening and deep understanding. There is no agenda in hermeneutics of revealing any universal truths, empirical proof, or hard data; The task is to capture the experience of another from different points of view of a shared phenomenon (Crowther et al., 2017). It is primarily because I am a therapist that I am the ideal editor to the story of ethical challenges into an emerging practice in online therapy methods. The next chapter will describe the methodology involved in hermeneutical phenomenology in greater detail.

Summary

The ethical practitioner, according to many professional practice standards, is one who both adheres to the ethical principles dictated by their profession, as well as applies the uppermost interpretation of the standards when faced with an ethical quandary (APA,

2017; CPA, 2017, CRPO, 2016). From this review of online therapy, it is salient that an ethical practitioner wishing to use technology in their practice must be fully informed of both the risks and the benefits associated with it and pass this information on to their client (Lustgarten & Colbow, 2017). Furthermore, being informed includes expecting and reflecting on the potential boundary violations that may occur (Gabbard, 2016). Informed consent, for example is one such standard that may be challenged as a boundary in an online setting. The notion of consent is ubiquitous among health care practitioners and a key to their identity as an ethical practitioner, however, consenting to online therapy may prove to have more complications not yet delineated in standards of practice (Sommers-Flanagan, 2015).

The theory of professional identity coincides with the discussion of online therapy ethics because changes to practice directly and indirectly impact professional identity and socialization (Moss, Gibson & Dollarhide, 2014). As far as professional identity is concerned, there is a lack of opportunity for professionals in practice to have a voice in the ethical codes that guide their practice (Williams & Izaak, 2018). Individual input into professional practice standards not only contribute practical issues into the definition of ethical conduct, but also incorporates influences such as culture, geography, and politics (Williams & Izaak, 2018).

Finally, discovering what ethical dilemmas arise in online therapy on the individual practitioner level is important because the objectivity of ethical standards do not encompass the subjective morality of those implementing them (Williams & Izaak, 2018). The implied expectation is that the practitioner's moral orientation imparts

integrity onto the profession when their morals align with professional ethics (Williams & Izaak, 2018). What is yet to be known in online therapy are the moral pitfalls that rub against exiting ethical standards, and the only way to discover them is to ask. The next section will review why hermeneutical phenomenology was the ideal method for practitioners to be heard.

Chapter 3: Research Methodology

Introduction

The purpose of this qualitative hermeneutic phenomenological study was to explore the phenomenon of ethical boundaries in the online therapy setting. As discussed in the previous chapter, a hermeneutic approach that incorporates my experience as the researcher is the ideal approach to uncovering the gap in knowledge on ethical practice in online therapy. While both traditional descriptive phenomenology and interpretive hermeneutic phenomenology involve epoché-reduction, a hermeneutic approach consists of the researcher taking the stance of "radical openness" to the data (Errasti-Ibarrondo et al., 2018). My philosophical stance from a researcher point of view acknowledges that my social identity as a therapist is intertwined with the data I seek to collect and therefore my reflective writing must acknowledge this. My study served to identify the unique practice-based challenges mental health professionals are faced with when their clients are located remotely, outside the clinical office. Increased knowledge in this area will aid in improving ethical standards of practice as they continue to evolve in an increasingly digital world. Using a hermeneutic approach allowed me, as a mental health professional, to be part of the exploration. This research contributes to knowledge of applied ethics and the practical aspects of working within theoretical ethical standards of practice. As participants revealed their practical ethical challenges in the online therapy setting, it is my hope that their voices can be added into considerations as professional guidelines evolve in this area.

In this chapter I discuss the purpose of the research and how it contributes to closing a gap in knowledge on this topic, as well as the methodology it will entail. This chapter will also include information on the role of the researcher in this hermeneutical approach as well as participant recruitment strategies and any conflicts of interest. Finally, I will outline the data analysis procedure and how reliability and validity will be addressed.

Research Design

This hermeneutical phenomenology study involved individual face-to-face interviews with 8—10 therapists who have at least 1 year of experience using online therapy methods. I analyzed the data using a recommended combination of manual text analysis as well as qualitative research software (Dedoose Version 8.0.35, 2018) to assist with the organization of data (Salmona, Lieber, & Kaczynski, 2019). Using both researcher-driven analysis as well as computerized analysis contributed to the validity and rigor of the findings. I used van Manen's (1990, 2016) method for conducting hermeneutic phenomenology research consisting of 4 phases. First, I uncovered the present understanding of the phenomena. This phase begins by acknowledging my own understanding and identify gaps in my knowledge. These gaps are described through the my own lens of experiences and biases about the phenomena. These biases are outlined in a pre-understanding narrative as described in my positionality statement above. Van Manen (2016) describes this stage as uncovering the "datum" or the "thing given or granted" (p.53).

Second, I conducted an iterative investigation. van Mannen (2016) describes this phase as a reflexive and continuous view of the data to extrapolate themes. This is done through combing through the data and uncovering etymological sources, idiomatic phrases, and experiential accounts drawn from the participants, the literature, and my own pre-understanding. It is important to note that in hermeneutics, data consists not only of the description of an experience but also how it made the participants and the researcher feel psychologically, emotionally, socially, and physically (van Manen, 2016). For this study, the interview involved designated open-ended questions regarding ethical challenges that included follow up questions directly related to ethical boundaries as identified by the Boundaries in Practice Scale developed by Kendall et al. (2011).

The third step involves reflexively reflect on the data by assigning codes to the identified themes. The themes are continually reflected upon using the transcription, the data software analysis, and the researcher's own reflections. The final step is phenomenological writing. This is the last step in uncovering the true essence phenomena, for which the researcher must be prepared for the possibility of revealing nothing new (van Manen, 2016). Since phenomenology is an investigation into the lifeworld of others, the researcher must be prepared for the possibility that this knowledge has already been captured when reviewing the literature. When documenting the findings, van Manen (2016) emphasizes the use of anecdotes in the writing process to add an authentic voice of the experience into the writing. However, these anecdotes are not used in the same sense as perhaps an ethnographic study. Anecdotes are selected to exemplify the 'theme' uncovered by the researcher (van Manen, 2016). Each snippet of a

story is an encapsulation of the deeper meaning the experience brings to the broader understanding of the phenomena. The process of writing, for van Manen (2016), brings forth “textual reflection” as the researcher writes and rewrites their findings (p.129).

Research Rationale

Phenomenology is a philosophy and a methodology of research, of which the foundation is reflection on the narrative data collected (Errasti-Ibarrondo, Jordán, Díez-Del-Corral & Arantzamendi, 2018). Van Manen (2014), a notable scholar in hermeneutics, is well-known for stating that the method of hermeneutics is, “no method” (Van Manen, 2016, p. 30); nonetheless, he pioneered the technique of epoché ,which serves to isolate themes from the narrative data (Errasti-Ibarrondo et al., 2018). As both traditional phenomenology and transcendental phenomenology (which include hermeneutics) involve the bracketing of experiences, or epoché-reduction, the *technique* of hermeneutics begins with the researcher’s self-reflection. The researcher, as a primary tool of data collection must first identify all those presuppositions and biases about the topic of interest and laying them bare. Identifying any subconscious position on the phenomenon of interest is imperative to the second step in hermeneutics; openness (Errasti-Ibarrondo et al., 2018). The researcher is tasked with consciously opening their mind and let themselves be led by the stories of lived experience they are privileged to hear through the interview process. The third step in hermeneutics is combing through the text to identify repetitive emerging themes. In the final step, the researcher reflexively moves backwards and forwards from their own experience and knowledge on the subject to the experience of the participants to gain new insight and understanding (Errasti-

Ibarrondo et al., 2018). In essence, the researcher is sewing a tapestry of experiences in order to see the themes of the whole, all the while being aware of their own biases and assumptions that may enrich or interfere with the data.

Rational

Hermeneutic phenomenology was the best research methodology to understand the phenomenon of ethics in online counselling for several reasons. The primary reason I chose this method was because I am a psychotherapist engaging my own clients both face-to-face and online. I must therefore approach this topic with the 'openness' that is central to hermeneutics. This involves being aware of my own experience and open to the experiences of others (Errasti-Ibarrondo et al., 2018, p.1729). Ethics is typically a provocative subject in clinical practice, after all, no one wishes to be unethical. Discussing a sensitive topic such as ethics in lived experiences, therefore, mandates change resulting from the knowledge gained on this subject. As Walden University (n.d.) promotes Scholars for Change, a research topic that can provoke transformation in how ethical standards are understood and applied in a digital age is appropriate. Furthermore, hermeneutics is an exercise in self-awareness typical of counselling and therapy in which the professional must always be reflecting on transference and countertransference in session (Heinonen, 2015). A therapist in session with their client is taking the emotional temperature of the session through examining their own thoughts and feelings while simultaneously absorbing the presence and narrative of their client. One of the critiques of hermeneutics is that, since it is not an overwhelmingly popular choice of research methodology, it may be difficult for an inexperienced researcher to be skilled in

reflexivity (Errasti-Ibarrondo et al., 2018). With my experience as a therapist, reflexivity is ingrained into my existing practice and is a well-used skill to employ.

Finally, hermeneutics was the ideal phenomenological method because of the lifeworld assumptions central to this method. The lifeworld philosophy, which is harmonious with theories in other caring professionals such as nursing, assumes that lived experiences must be viewed from the perspective of being part of the world holistically; body, mind, and soul (Palesjö, Nordgren & Asp, 2015). Being in the world imparts meaning on our experiences. Heinonen (2015) explained that the lifeworld consists of five dimensions (p.37): a) the lived space, b) the lived body, c) the lived time, d) the lived relations to others, and e) the lived association with technology. These five existential dimensions of the lifeworld are all relevant to practicing online therapy because accessing help online inherently changes our association to time, place, relationships, and comfort with new online mediums.

Validity of the Hermeneutic Design

Strategic sequencing of these four stages by van Manen's (2016) helped to achieve validity of the findings. I used a thick description of participant experiences in the form of direct quotations from the interviews in the analysis and discussion of the findings (Ravitch & Carl, 2015). Since the researcher must stay as immersive to the data as possible to extract a true understanding of the phenomena a dialogic engagement, or peer debrief may also add to validity of the analysis. Finally, regarding validity, I also employed data triangulation, gathering data from different participants from differing

professions at different locations in order to bring together a variety of perspectives (Ravitch & Carl, 2015).

Research Questions

1. What are the lived experiences of registered mental health professionals licensed in Ontario in practicing online?
2. What are the lived experiences of these professionals in maintaining ethical boundaries with their online patients?

Role of the Researcher

The researcher in qualitative research is the primary research instrument who is responsible for recruitment, designing the research question, interviewing participants, coding, and analysis (Creswell, 2014). As noted earlier, the first step in hermeneutics is for the researcher to disclose their position on the subject and identify any biases or assumptions about the topic of study that will interact with the reflection on the data.

Positionality. I am a mental health clinician and have been professionally trained in three interrelated health disciplines: nursing, art therapy, and psychotherapy. As such, I have an integrated professional identity as a mental health therapist. My ethical orientation in practice has been informed by three distinct, yet similar, ethical standards belonging to a) The College of Psychotherapist of Ontario, b) The Canadian Art Therapy Association, and c) the College of Nurses of Ontario. Regarding the use of technology, only the College of Psychotherapists of Ontario (CRPO) has a designated position on the use of technology as a part of the professional practice standards (CRPO, 2016, p. 35—36). The CRPO's professional standard on electronic practice mandates that members

apply the same rules concerning confidentiality and consent to care that apply to face-to-face practice. The only additional information the CRPO provides in this regard is that members check their liability insurance to ensure they are covered for this type of therapeutic medium (p.36). As a member of the CRPO, I find this professional standard to be incongruent with the literature on some of the concerns of online therapy. For example, the CRPO does not mandate any special training for therapists in this specialized mode of interaction as advised by McCord et al. (2015), nor does it highlight any risks to safety or boundary violations or how to mitigate them as identified by Kadish et al. (2018). Finally, meeting a client online is similar to a blind date in that the client may find it easier to mask their identity online. While the CRPO (2016) does stipulate in their standard on electronic practice that clients may not be anonymous, it may be that their identity is harder to validate which then may create a safety concern for special populations at higher risk for mental illness and harm (Samson-Daly et al., 2016).

Personal stakeholder concerns. In my private practice as a therapist I receive referrals from Sunnybrook Hospital in Toronto. The majority of my clients referred from Sunnybrook have been discharged to community mental health services after a period of in-patient care for mental illness such as major depression with suicidal ideations or attempts, schizophrenia, and mood disorders. I have not yet integrated distance therapy modes with these clients and so far, have only used telecounselling services with clients who have milder symptoms and who are well known to me in counselling using face-to-face therapy for some time. I am aware through my interaction with colleagues that online therapy is pronounced in the work of other therapists, but I am unaware of which

modalities are popular and what ethical considerations other therapists take into account when practicing online. I am also interested in learning if there are any unique challenges that other therapists have come to know through their practice that is unexpected or perhaps not covered through the traditional standards of practice and may contribute to enhancing practice standards.

Personal commitment to client care. My interest in the topic of ethical practice in online therapy stems from my personal identity as a moral person as well as my social identity as a registered nurse, art therapist, and psychotherapist. The desire to do no harm is ingrained in my professional identity through the concept of non-malfeasance or the desire to do no harm adopted from a medical model of ethics (Canadian Nurses Association, 2017). As nursing was my first professional affiliation, the Canadian Nurses Association's (CNA) Code of Ethics (2017) mandates that part of my ethical responsibility as a practitioner is to "...question, intervene, report and address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent and ethical care" (CNA, 2017, p. 8). I add my voice to the scholars calling for practice informed ethical standards for online therapy.

Competency maintenance and development. Reflective practice is part of the CNA's (2017) expectation of ethical conduct of nurses. Each year nurses certified in Canada are expected to engage in ethical reflection in order to empirically review their own practice and judgments in care. My reflections in this study as I gather data will add

to my continued commitment to competency maintenance and professional development as a mental health professional.

Engaging in change. Technology's increasing presence in our daily lives including our work lives cannot be denied or ignored. Rather than waiting for professional organizations to update existing ethical standards with practice based scenarios, it is my ethical responsibility to venture out and seek them (Bolton, 2017). This is reflected in the College of Psychotherapists (2011) ethical standard, Responsible Citizenship, as well as the CNA's (2011) stipulation that "nurses have an obligation to participate in the effective evolution of self-regulation" (p.11). Anticipating and planning for changes occuring in practice is part and parcel of my professional identity.

My role as the primary research instrument in this study is to achieve epoché and authenticity in order to first, incorporate and then, transcend my own assumptions and biases (Mantua & Van, 2015). Hermeneutics is an interpretive, rather than descriptive phenomenology research method, therefore, my presuppositions listed above are not bracketed away from the data but are understood to be integrated into the data (Manua & Van, 2015). My work as a therapist living in an increasingly digital world makes it possible to empathize with the participants and be open to hearing their experiences. Reflexivity in hermeneutical research is iterative and was therefore used throughout the process after each interview and at each stage of focus coding (Ravitch & Carl, 2016).

Participants of the Study

Sampling consisted of a purposeful sampling strategy of an emergent subgroup of licensed mental health practitioners in Ontario practicing online. All my research took

place in Toronto, Ontario, and participants were interviewed via a PHIPA compliant software, Zoom . The participants involved 8-10 registered mental health professionals in Ontario (i.e. Registered Social Worker, Registered Psychotherapist, or Registered Psychologist) who have used online counselling or psychotherapy methods in the past year and have had at least 1-year experience with online therapy. This time range was chosen so that study participants could draw on some lived experience that can contribute effectively to the research question. Participants were invited through a paid ad in the OACCPP e-blast and print material, as well as an ad placed on LinkedIn. A letter of organizational recruitment hat was used with the OACCPP is provided in Appendix A. This letter will be sent by email. Any eligible participants as well as the participating organizations received a copy of the informed consent (Appendix D) as well as the interview protocol found in Appendix E.

Interview Protocol

For the study, Bevan's (2014) method of phenomenological interviewing was applied to formulate a semistructured interview protocol (Appendix E). Essentially, phenomenological interviewing, a postmodern analysis, must take the position of the person who is experiencing the phenomenon, rather than an academic or theoretical stance. The interview process is guided by the knowledge that phenomenon is experienced by a complex person living in a complex world (Bevan, 2014). Integral to the phenomenological process is uncovering the "modes" of appearance that the phenomenon takes through capturing the experience from not only different points of view but different ways of experiencing (thoughts, feelings, memories, etc.) (p.137). As

this is a hermeneutic study, I must first uncover my own modes of experiencing through exploring my positionality while simultaneously maintaining "deliberate naiveté" in the interview protocol (Bevan, 2014, p. 138).

Bevan's (2014) interview process consists of three stages: 1) contextualization (uncovering the world in which the phenomenon lives), 2) apprehending the phenomenon (describing how the phenomenon is experienced), and 3) clarifying the phenomenon through what Bevan (2014) calls "imaginative variation" (p.138). Imaginative variation is the researcher's opportunity to use the knowledge they have gained through direct description of the phenomenon by their research participant and expand on it by imagining the phenomenon in different scenarios. For this study I utilized the Boundaries In Practice (BIP) scale to add context and imaginative variation to the phenomenological interview (Kendall et al., 2011). Appendix F outlines a structure for the interview process applied in this study but is by no means prescriptive or restrictive. This method is appropriate in maintaining consistency in my interviews and contributes to reliability of the data collection process (Bevan, 2014).

Ethical Protection

As a requirement for all Doctoral research studies at Walden University, this research proposal was submitted to Walden's Institutional Review Board to review the ethical implications of the proposed research topic and methodology. There were several factors regarding ethical protection to consider.

Consent. Informed consent and full disclosure of the possible risks and benefits of participation was outlined in a recruitment letter (see Appendix D) to potential

participants and then introduced again prior to commencing each interview (Ravitch & Carl, 2015). Participants were aware they could withdraw from the study at any time, as well, they had the opportunity to review their interview transcript and redact any statements they wished. It was anticipated that the risk involved, while minimal, may include disclosure of unethical practice online. It was important for the informed consent process that participants are aware that confidentiality will be maintained barring any statements that fall under the Mandatory Reporting Obligations mandated by any of the regulated professional colleges included in the participant recruitment. Participants were informed of the issues that fall under the Mandatory Reporting Obligations prior to commencing the interview.

Transparency. I have a duty to ensure internal-facing transparency where I clearly outline the goals of the research, the timelines associated with the study, and data security to my participants (Ravitch & Carl, 2015). I also have a duty to external-facing transparency where I mitigate threats to the validity of the data by declaring any biases and limitations of this research findings and clearly outline the goals of the study to potential stakeholders (Appendix A, B, & C).

Confidentiality. My duty to maintain confidentiality of my participants is outlined in my letter of consent. Confidentiality in this study was ensured through the use of pseudonyms in the collection of the data as well as the written report of the data (Ravitch & Carl, 2015). As mentioned earlier when discussing consent, there could have been a small risk of Duty to Report, therefore, a separate secured document with the participant's legal name was kept if necessary for legal purposes, but not needed in the

end. The participants had an opportunity to review the transcripts and redact or clarify any statements. During this process should they had felt that they could be identified through deductive disclosure of particular experiences, I would have provided the opportunity for the participant to change any identifying characteristics in the final report (Ravitch & Carl, 2015).

Security of Data. Data is stored in a double password protected file on the researcher's cloud account to mitigate lost data (Ravitch & Carl, 2015). The coding sheets utilize the pseudonyms of the participants so that any identifying information cannot be gleaned from them. No one other than the researcher has access to this data, however, in the case of a data breach I will report the breach to the participant as soon as I become aware of it.

Chapter 4: Results

Introduction

The purpose of this hermeneutic phenomenological study was to explore the lived experiences of mental health professionals working in Ontario with online modalities of delivering therapy, and their experiences with maintaining ethical boundaries with their patients. In this chapter, I discuss the demographic representation of 10 research participants and an analysis of the semi-structured interviews they took part in. The interviews were between half an hour to an hour in duration, depending on the participant's preference. I conducted the interviews mainly by video-conferencing software Zoom, with one participant interview taking place by phone. Interviews were recorded with the participant's permission and transcribed by the researcher.

This study provided a point of curiosity for me on the phenomenon of working as a therapist online which provided participants with the opportunity to retrospectively reflect on their lived experience with the phenomena. This retrospective look into our own experience can never be true to the actual experience because individuals do not usually take the time in the course of a lived experience to note, 'I'm having a lived experience.' Therefore, any kind of questioning of a moment means that the moment has already passed (Van Manen, 2017). As Van Manen (2017) notes, "The problem of phenomenology is not how to get from text to meaning but how to get from meaning to text" (p. 813). In this study I explored how therapists experienced the online therapeutic space and what kind of ethical challenges they came across in their work. Participants expressed enjoyment in being able to reflect on their practice, teach me as the researcher

what they love about their work, and share their learnings from trial and error utilizing a fairly new therapeutic modality.

I transcribed each interview and sent them to participants for review to strengthen methodological rigor. Participants were invited to correct any errors or omissions, provide clarification, add information or redact elements of the interview as they wished in order to maintain the value of it being their narrative and taking ownership of the information they provided. Only one participant wished to redact approximately 2.5 minutes from the transcript and provide a clarified explanation to a particular question.

Setting

I conducted ten interviews between June and August of 2019. Two participants were recruited through an ad posted both digitally and in print in the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists (OACCPP) newsletter, May 25th, 2019. I recruited the remaining eight participants through a post published on June 21, 2019 on LinkedIn and word of mouth by participants who recommended other therapists. All interviews, except one, took place by video conferencing software Zoom, which is compliant with The Personal Health Information Protection Act (PHIPA) in Ontario. The only exception was an interview that took place by phone while the participant was commuting in their car. Nine of the ten participants attended the online interview from their home, eight of whom were in their home office and one from their bedroom.

Prior to each interview, I sent participants a list of free and sliding scale counselling in their community as well as a detailed consent form which they signed. At

the start of each interview I reviewed the basic tenets of consent and reminded them of their right to withdraw from the study at any time or skip questions they felt uncomfortable answering. I also asked participants for permission to record the interview for transcription purposes. An interview protocol was used to guide questions related to the participant's experiences working online and ethical challenges they may have encountered, but overall, the interviews flowed and built on one another by sharing some of the phenomenological examples provided by the previous interviewee. This collection of examples was shared in a form of "wonder" (i.e. 'I wonder if you share this experience') by myself to maintain the hermeneutic form of questioning by Heidegger (van Mannen, 2017, p. 816).

Demographics

All participants had some experience with at least one year of providing services online, with the majority of participants providing therapy, and one participant providing supervision to other therapists. While the inclusion criteria for participants specified online therapy, I decided to include the participant who was providing clinical supervision because the limits to confidentiality were the same, and thus, the same standard of ethics applied. All participants were registered professionals as psychotherapists or social workers. Two of the participants had additional skills in the fields of expressive arts therapy. Participants were represented by eight female therapists and two male therapists, with four participants having extensive experience in online therapy, three participants having moderate experience, and three limited experience in online modality.

The descriptive statistics of the participants is provided in Table 1.

Table 1

Participant Demographics

	Years Experience	Credential	Place of Work	Modality	Software
Participant 1	5+	RP	Private & Organization	Text only	n/a
Participant 2	5+	RP	Private & Organization	Email only	secure
Participant 3	2-5	RP	Private practice	Text, email, video	Skype Facetime Zoom
Participant 4	2-5	RP	Private practice	Video only	Zoom/Theralink/Tranquil
Participant 5	5+	RP/Art Therapist	Private practice supervision	Text, email, video-	Skype/Facetime
Participant 6	1	RP/Music Therapist	Hospital Telehealth	Telehealth video conferencing	OTN
Participant 7	1	MSW	Private practice	Video	Zoom
Participant 8	1	RP	Private practice	Text, email, video	Skype/Facetime
Participant 9	2-5	RP	Private practice	Text/Email/Video	Skype/Facetime
Participant 10	5+	MSW	Private practice/contract	Video Only	OncallHealth/Inkblot

Nine of the 10 participants used online modalities in a private practice setting (either home or office based), while one participant working in a hospital setting utilized the Ontario Telemedicine Network; a province-wide, two-way videoconferencing network to connect hospitals and professionals across Ontario. Six of the 10 participants exclusively used platforms that are PHIPA compliant, while one participant used a mixture of secure and unsecure platforms, and three participants used exclusively unsecure platforms.

Data Collection

Using a hermeneutic approach, I did not identify any themes prior to the interview process as a method of Dasein, or 'being present' with each experience (Regan, 2012). To use a Dasein approach in research is to allow the interviewee's experiences to wash over the interviewer in a way that the interviewer fuses their own experiences with that of

the interviewee, to find shared meaning. In this way, the themes that emerge from the interviews are a collection of subjective truths that enliven the phenomenon for the interviewer in a profound way (Regan, 2012). As each interview was completed, the subsequent interview would incorporate ideas discussed in the prior interviews. Upon initial read through of the interviews, 10 themes emerged. As I read each interview individually, 17 codes were used to organize the data. I subsequently narrowed down these codes to two main themes and nine sub-themes.

Methodology

Using the Walden University approved methodology strategy, I began my recruitment in June 2019 with an ad placed in the OACCPP e-blast and newsletter. I was contacted by a participant through this ad who partook in the interview and then referred a colleague. After further approval from the Walden Ethics Review Board, I placed an ad on LinkedIn on my professional profile and connected with several more participants, one of whom referred two other participants. I sent participants the consent form and a list of free and sliding scale counselling services prior to their scheduled interview. Each interview began with my asking for approval to record the session as well as a review of the consent form they signed. Participants were also reminded that they can skip any questions as well as end the interview at any time.

The duration of the interview process ranged from approximately 28 minutes to the longest interview being 53 minutes. At the end, I asked each participant if they wished to add anything to the conversation on the topic of practicing online or ethics online. I also assured participants a secondary opportunity to expand on their ideas when

reviewing the transcript of their interview. I used a semi-structured format to solicit participant experiences online using Bevan's (2014) method of phenomenological interviewing. Van Manen (2017) describes the inevitable process of "fading of meaningfulness" when exploring a phenomenon (p. 812). This is due to the fact that the interviewee is reflecting on memories of experiences long since passed. Bevan (2014) posited an interview structure which is geared towards immersion in the phenomena. He divided the interview into three parts: contextualization (how does the phenomenon appear in their world of the interviewee), apprehending the phenomenon (what does a typical experience with the phenomenon look like), and clarifying the phenomenon (describe how the phenomenon appears or acts in different situations). The last section, clarifying the phenomenon, is also known as "imaginative variation" where the interviewee is invited to think more abstractly about the phenomenological experience (Bevan, 214, p. 138).

At the end of the interview process, 10 general codes emerged from the conversations. Upon reviewing each transcript individually using colour codes, I identified a final 16 for a total of 26. The transcripts were coded once by hand and a secondary time using research software Dedoose, version 8.2.14 for further analysis. I used the Dedoose software to view code co-occurrence which then led to a narrowing of codes down to 17 in total.

Situated Experiences

Four participants became familiar with online modalities of counselling through their employer, three of whom worked for private therapy services and one participant

was employed by a hospital that utilized the OTN. The remaining six participants began utilizing online modalities through the organic process of client-mediated supply and demand to expand services in private practice.

Analysis of Experience

Van Manen (2017) urged researchers using phenomenology to not mistake the process of hermeneutic epoché or reduction as an alternate version of quantitative 'counting' of themes or categories (p.813). Rather, the researcher must be reflectively listening to the *meaning* the phenomenon has for the interviewee, and thus be reawakened to a new way of seeing the phenomenon. The research does this all while being aware of the preconceptions and biases that arise along the way. Using a hermeneutic lens, I read the transcripts for the first time and made notes about any ideas, preconceptions, or simply free flowing words that came to mind, much like Gadamer's process of a dialogue with the self (Gill, 2015).

The second time I read the transcripts, I carefully re-experienced the dialogue in each interview between myself and the interviewee by taking each line of text and assigning it a category in the Dedoose software. In this process I also identified 'interesting quotes' which stood out from the transcript as a unique voice, the Dasein, of the person describing their experience with the phenomena. A third read of the transcripts allowed me to explore the unfolding of the phenomenon of online counselling from a "temporal distance" in which I attempted to review the ten unique voices I heard and notice my own fears (including my own relationship with being ethical) and surprises with the data (Regan, 2012, p. 294). A final read through made clear some join

realizations in understanding the phenomenon in a new way that is both a joining of meaning making, while at the same time maintaining the uniqueness of each experience with the phenomena (van Manen, 2017).

Evidence of Trustworthiness

Credibility

Prolonged engagement. True prolonged engagement, according to Padgett (2012), involves multiple interactions with participants over long periods of time. This prolonged immersion in the culture of inquiry theoretically acts as a means of determining veracity of data. I could argue that as a qualified member of the psychotherapy field I am already entrenched in the community I am researching. However, having never used online therapy modalities myself, I was an 'outsider' in this respect. Facilitating 10 online interviews allowed me to immerse myself in the world of online communication in which I had to consider many aspects related to ethical practice as therapists working online tend to do. I ensured that I used a secure and privacy compliant software platform, Zoom, in order to put my interviewees at ease that I was taking the security of our conversations seriously. I also began each interview with a review of the consent form which described the limits to confidentiality, the same limits imposed in a counselling session. Prolonged engagement is also meant to acclimatize the researcher to the culture of study; therefore, I could express that having already established common ground with participants negates some aspects of reactivity and responder bias (Padgett, 2012).

Thick description. Tracy and Hinrichs (2017) described thick description as part of the main strategies for achieving credibility in qualitative research. Thick description depends on the real-life examples conveying the intricacies of the phenomenon, rather than theoretical musings on the topic. The lived experiences of each research participant in which they were asked to provide context for their narrative provided a landscape of thick description. Thus, for each theme identified in this research, I will illustrate in great detail in the next chapter how their shared experiences give life to the phenomenon of working online.

Member checks. This strategy for strengthening credibility involves the crucial step of presenting the raw data to the participants for review for authenticity (Anny 2014). In this case, I sent each participant a transcript of their interview and asked to review it for errors, omissions, and veracity. Only one participant wished to amend their transcript and omitted roughly 2.5 minutes from the transcript. He later wished to explain his point differently and sent the interviewer a detailed email with a revised response. I emailed all participants a summary of the findings to comment, review, and provide feedback.

Transferability

Nominated and volunteer samples. Morse (1991) argued that this method of sampling where a positive experience of one participant who then nominates others can be beneficial, there is risks of referrals that do not fit the research criteria. Luckily, in this case, a few points of contact where research participants contacted the researcher in response to an ad generated trustworthy and appropriate referrals of other participants.

These participants were not only engaged in the area of research but were eager to share their experiences making for a rich dialogue.

Multivocality. Closely tied to sampling, multivocality is the inclusion of different perspectives on the phenomenon of interest (Tracy & Hinrichs, 2017). This study included a variety of health care practitioners who practiced in a myriad of settings and used a large selection of online tools. This diversity of voices to the topic of online therapy provided a multifaceted dialogue on the phenomenon.

Dependability

Code-recode procedure. As suggested by Anny (2014) two-week intervals were used in the process of generating codes. The first set of codes were generated from the first read through of the transcripts. Each code was highlighted in the transcript under a different colour, through which ten codes were identified. Two weeks later, a second read through of the transcripts organized the codes into a word document, generating a list of codes for each interview, making some additions to the list of codes. Two weeks later, the transcripts were uploaded into the software Dedoose, version (). Each transcript was carefully reviewed for a third time, in which a final count of 20 codes were identified.

Confirmability

Audit trail. The advantage of using software to organize data is the transparency and ease from which anyone can follow the process from coding to the generation of themes. The software not only stores the transcripts in a secure way, but also keeps track of each line of coded text and cross references code co-occurrence. In this way, an audit of the research process leaves a reliable and confirmable trail (Anny 2014).

Overview of Codes

Sixteen codes were identified through a review of the transcripts with an addition of the Boundaries in Practice scale (Kendall et al., 2011) for a total of seventeen codes in all. An additional eight sub-codes were identified in the process of breaking down these concepts. Four of the sub-codes belonged to topics that were more general such as ethics, risk, therapeutic environment, and training. The Boundaries in Practice scale (Kendall et al., 2011) had four sub-codes that delineated the four components of the scale. The codes and sub-codes are defined below:

Accessibility. Accessibility in this case is anything related to the convenience or ability of the client to reach the therapist when needed or vice versa. Accessibility may also be used to describe the social determinant of health of facilitating access to health services for groups that may have social, economic, physical, mental or geographic barriers (Government of Canada, 2019).

Benefits. This code describes accounts where participants discussed the advantages particular to online therapy.

Challenges. This code describes accounts where participants discussed the disadvantages specific to online therapy.

Communication. This code describes details related to engaging online either by writing such as in text or email or speaking such as in phone or video. This code includes the sensory experiences of communicating through these mediums. An example of this can be the ‘zone of reflection’ a therapist enters into in order to communicate with a

client online, or the background interference of a client's dog disrupting a train of thought online.

Disinhibition. This code describes the lack of restraint, instances of impulsive behavior, or lax judgement that participants described either on the part of the client or the therapist because they were located remotely.

Therapeutic environment. This code describes the psychological safe space where the work of therapy is done. Traditionally in face-to-face therapy the therapeutic environment was the therapist's office. In the online environment, the therapeutic space can vary significantly from an exchange on a phone by text, a client attending session from the interior or their parked car, or a therapist communicating through video chat from their basement. A sub-code that was identified through the interviews as the term 'container'. Participants tended to describe the experience of working online as a space they had to 'contain'. Sometimes this described a potential risk, such as they were concerned that online sessions were not 'contained'. Sometimes, the container described the literal frame of the video screen that blocked out other visuals in the room.

Therapeutic relationship. Pertaining to the bond between client and therapist. Sometimes this was described as 'therapeutic alliance', 'attunement', or 'attachment', but it all related to how strongly client and therapist sensed connection with one another. Power is a sub-code to emerge from the therapeutic relationship.

Ethics. This code encapsulates anything pertaining to professional principles that regulated professionals must abide by to maintain integrity in their practice. In this code, the sub-code 'boundaries' was identified as an element of maintaining ethical practice

that participants were keenly aware of. Boundaries in professional practice is a broad term describing the power dynamic between client and therapist where there is risk of exploitation or harm. Boundaries in online practice seemed to shift varying ways; sometimes minor and imperceptible, such as receiving a message by email or text off-hours, to more serious and challenging, such as the experience of two participants who became aware their client was engaging in a sexual act while on the phone with them.

Insurance. This code arose from participants reflecting on whether they were legally covered to provide services online. Approximately half of the interviewees had not checked that their insurance coverage protected online services, they assumed it was part-and-parcel of their general coverage. While this may seem to be a sub-code of ethics, I ultimately chose to separate it because while it is a requirement to be a member of a regulatory college, it is not a component of standards of ethics.

Modality. This code pertains to the ways in which clients and therapists may communicate in the online environment, such as text, email, phone, or video conferencing.

Risk. Risk was identified as any kind of exposure to or possibility of threat or danger arising from the therapist and client located remote from one another. Examples included testing emergency contacts prior to starting session or getting more detailed information on where the client was located. The sub-code ‘added-vigilance’ was identified as an element of risk in the ways in which therapists tended to mitigate foreseeable hazards working online. An example of this would be asking a client if there

is anyone else located in the room with them, or additional follow up to an email that was difficult to decipher the client's state of mind through text alone.

Stigma. While this code yielded only three excerpts, they were from three different participants and were deemed important to include in the findings of this study. This code was applied to the ideas where online therapeutic services served to destigmatize both therapy in general as well as how therapy is delivered.

Session structure. This code was applied to descriptions of how therapists planned and executed their online sessions. For some, online sessions began and ended a certain way, while others allowed the session to unfold naturally.

Technology. This code was created to capture any description of equipment or support services that could either facilitate or hinder a session.

Training. This code encapsulated ideas of either obtaining additional training in online practice, areas in which participants felt they needed training, or how they trained themselves to practice online (such as trial and error). A sub-code that emerged from these discussions was 'professional competency'. The idea of training was often linked to identifying oneself as competent or incompetent to offer certain services or be offering services within one's scope of practice.

Transference/countertransference. This code encompasses key concepts in therapy that involve the unconscious projection of emotions from either the client onto the therapist (transference) or vice versa (countertransference). For instance, a client may transfer their unconscious sexual desires onto their therapist who they only speak to in

text. A therapist may inadvertently be curious about a client's boyfriend from seeing a photo of him hanging in the background of the video chat frame.

Boundaries in Practice Scale. The Boundaries in Practice scale (BIP) developed by Kendall et al. (2011) was incorporated into the interviews as part of clarifying the phenomenon of boundaries. The BIP's (2011) subsets were treated as four sub-codes: a) knowledge, b) comfort, c) ethical decision making, and d) experience.

Results

Two main themes emerged from the hermeneutic cycle of engaging with the narrative, the codes that emerged from those narratives, and reflexive reflection on the research questions. Each research question and the theme that follows are described below.

Research Question #1: What are the lived experiences of registered mental health professionals licensed in Ontario in practicing online? Engaging with this research question through the lens of the data and the subsequent codes that arose from the hermeneutic process revealed an overall theme of power. The idea of a power imbalance between therapist and client in traditional face-to-face settings, is born from a multitude of professional standards of practice of health care providers (Zur, 2009). The Canadian Counselling and Psychotherapy Association (2015), for example, states in their Standards, "They [counsellors] should address or take action against unequal power relationships…" (p.8). The theme of Power and how it alternates between clinician and client was a key concept that encompassed the lived experience of practicing online. Power is present in nearly every code derived from the narratives; from the way in which

therapist and client communicated, their access to therapy, the technology and training involved, and the risks and challenges that arose in practice. The word, *Redistribution*, was chosen to reflect the rearrangement in the once common place power differential between therapist and client that is uniquely changed due to online practice. Therefore, the theme of Power Redistribution was chosen to reflect the overall lived experiences of therapists with the power dynamic in their practice and the restructuring of their traditional understanding of how to safeguard their clients from harm. Power Redistribution can be organized into four subthemes: a) power over the environment, b) power over space, c) power over time, d) power of self-representation. Flors' (2018) matrix of relative power was used as a guide to determine power allotment.

Power Redistribution

Power over environment. The online environment can be entered through a myriad of sensory means; audio, visual, or combination of the two. Whether therapists are operating by text, email, phone, or video conferencing, their choice of therapeutic environment facilitated the mutual technological preference of both therapist and client meaning that therapists who enjoy texting attract clients who enjoy texting, and so forth. At times, power of choice over the environment according to the participants, felt more balanced towards the clients seeking therapy. Some participants felt a reluctance to delve into the online world but felt obliged to 'get with the times' rather than offer online services because it was their preferred medium. Participant 7 noted, "I'm not doing a lot of it [online therapy]. And if somebody does approach me and asks for it, specifically for

online therapy. I will say, you know, that's not my preferred or primary mode of therapy. I feel like I don't…It's not my area."

Power in the online environment can also be translated into literal technological power supply in bars depicting the strength of Internet service. Often, the strength of Internet connection equalized the power differential between therapist and client in that the strength of connectivity either facilitated or hindered the session taking place. Participant 6, a registered psychotherapist working at a large hospital in mid-town Toronto engaged with his client online using the Ontario Telehealth Network, a hospital based, high speed Internet video communication technology. The client came for treatment at his local hospital to access music therapy, not offered at his local institution. In this case, online therapy provided access and equity to a treatment otherwise inaccessible from a remote location.

> …This is a system that hospitals regularly use for teleconferencing between professionals at hospitals and telemedicine between patients and practitioners in permanent, remote communities. So, each of those rooms had high quality microphones embedded into the ceiling, and a large, very large drop-down fabric screen with a projector, or a large TV screen in his case. Um, so we are looking at images of each other that are larger than life.
>
> And any sound that we're making at each other is being captured with relatively high…possibly high-quality microphones and being listened to on relatively high-quality speakers. But it's important to note that this is not happening on a laptop…over a bad Internet connection…. with tiny little laptop speakers. We had

> a proper set up …it's a dedicated fiberoptic network so we're not going to be interfered or slowed down by the neighbors downloading large files like that, that you get with [name of Internet provider].

This example in describing the therapeutic environment provided a clear analysis of how high-quality technology can facilitate a good experience for both the client and the therapist. In this case, power over the environment favors both client and therapist equally. In using the OTN, both therapist and client have equitable sound quality, visuals, and Internet speed.

The experience described above, however, is rarer in the lived experiences of nearly every other participant interviewed. On the side of equalizing the denial of privilege or power over the environment, many participants spoke of the challenges of their home or office Internet connection. Technology disruptions could either interrupt a session temporarily or make a session impossible to proceed with. Participant 10 noted,

> I had a client where we were constantly having connectivity issues. It was definitely on his end. And it would just it would cause the flow the flow of the sessions to be very disjointed. Like there wasn't a good flow and then I feel guilty even though which I knew was on his end, but I wanted him to have a good experience. So, I would call on my phone and then we would try it again on the video and then there's like. In a way that the boundary issue cuz I would go over time in a way that I wouldn't normally cuz I was trying to make up for the technical issues. Even though I would say like, you really need to talk to a tech person and do a practice and figure it out what you needed to do, and he never

> did. But I still wanted the sessions to go well, it was frustrating for me also… you know, and I didn't feel like I was a good experience. We'd go back and forth, and I will go over time.

In this case, despite the technological malfunction being on the client's end, power over the therapeutic environment was denied equally to both therapist and client; no access and no delivery. At times, power over the environment was at the mercy of the Internet provider, the weather, or software malfunction that disrupted a therapy session. Other times, power over the environment meant power over protecting health information, which fell into the realm of power and responsibility of the therapist. Participant 7 noted,

> …because there's so many different platforms. And so many of them saying we have this level of security we have this level of security and so much information about you know, is Skype secure? Is Zoom secure? Lots of question marks and I think because I don't feel…you know, I did some research. I found Zoom and Zoom, you know, encrypts and they do two-way encryption back and forth.

In the online environment, the client is not in control of their personal health information but is subject to the protection of whichever platform the therapist chooses. While the power is in the hands of the therapist, so is the professional liability in choosing an online platform that meets privacy requirements. When participants were not as versed in the rigor and variety of online software, they were limited to using only familiar and often less reliable online mediums that generated a feeling of powerlessness, as participant 3 described, "I started using Skype, nasty little platform just so unstable".

Sometimes, the choice of a less reliable software was a fear that the client was not up to speed on technology, as Participant 9 stated, " I find, people know more about Skype and use Skype and so I feel and this might be my own stuff, but I feel there would be resistance if I would say, hey, I'm going to send you the link for this new program. I need you to download it. I need you to get acquainted with it."

Power over space. According to the participants, the therapeutic environment online has no pre-determined appearance. Both the therapist's space as it appears on-screen and the client's space is curated on an individual basis. It follows that the benefits and challenges to the space in the online world, depending on the circumstances, is an equalizer of privilege and power. The subjective experience of consciously curating the 'scene' or allowing it to be seen in the first place can enhance privilege or deny privilege. For instance, participant 7 stated that her client enjoyed showing her his home, "Almost like he wanted me to come into his space to see for the state of his…kind of equating his well-being to his place. So, in a way, it was an opening to his worlds." The environment as a reflection of the state of one's mental health is a window into the life of the clients not otherwise available in face-to-face counselling. Many therapists described how they organized the wall behind them in video conferencing so that the client would only see what they therapist wished them to see. Participant 7 noted,

> I am very conscious about what the client sees, you know, if it's not in my office, right? I'm very aware that then they are seeing my home environment. So, you know, I would be doing that from like I said my home office where the background is, maybe my books that have you know Psychotherapy kind of

> content as opposed to my family or my kitchen or…more personal because it is a self-disclosure .

Some therapists, however, such as Participant 3 video conferenced using Skype or FaceTime from wherever she happened to be. This gave the therapist a great sense of freedom in power over what a therapeutic space could be, but also required adaptability on the part of the clients. She noted, “I'm also in different locations. In the beginning, I mentioned that some clients adapt very quickly to that and some clients have looked like they need a moment”. In this case the therapist is cognizant of the power over her choice of space and the impact it may have on the client.

Participant 5 noted that her messy office space was also a choice that served to humanize the therapist and equalized the power differential:

> So I usually addressed it [messy space] because some people find it chaotic and some people…actually I’ve had a lot of people say, oh my God, that's so wonderful because I thought you had everything under control…Okay, you know what, like I'm not in control of everything but this is my sanctuary.

The option of providing and attending therapy online opens endless choices in venue. This too be a power equalizer between therapist and client, however, at times the therapeutic space can be hijacked and tilt privilege and power in favor of one party over the other. For example, Participant 7 described the benefits of ‘walking alongside’ a client with agoraphobia out their front door using either telephone or video. A privilege that face-to-face clients would not have. ‘Walking alongside’ a client, however, can have unexpected outcomes when Participant #4 found her client was video conferencing her

from inside her closet. The client had disclosed domestic abuse and was challenged in finding a safe space inside her home.

> I think with her she was always in a very dark spaces like she was hiding, you know she was speaking softly, and she was kind of very aware of what was going on around her…you know, I really, I felt like I was in hiding with her some of that time and that was that was uncomfortable.

The participants shared that the power over space typically required additional consideration that was often garnered through trial and error, particularly if the therapist was just starting out in online practice. Inattention to space can have the effect of catching a therapist off guard, for example, Participant 9:

> Another thing I can add is when I'm working from home, like right now, the client can see some aspect of my house behind me. So that's another thing that I find different and some of them will say like, oh, that's cool your books in the back. What are those books? You know, they'll ask me is that your kitchen behind there? And I'll say yes it is, you know, but where that would never happen in my office. They would they would see aspects of me from how I chose to decorate that space, but it feels very different. I've been very thoughtful about how I decorate that space. So, this is like all my crap is in the back I have a duvet that needs to be washed, you know, this is my home office.

Therapeutic space can also be internal, as Participant 4 noted, clients can practice cognitive or coping skills learned in therapy out in the 'real world' rather than in the safety of the therapist's office,

> I've also thought of it as an advantage right, practicing coping in may be in a situation where you're surrounded by things that remind you of anxious thoughts. I think that's something I've done a lot with clients, um, kind of like exposures or practicing and then when they're out of session, you know, they're already in their home and they've already tried that skill and maybe it's a little bit more accessible.

The therapeutic space being outside the curated walls of the office provide the client seeking therapy with the type of exposure and skill building that breaks barriers between self and society.

Power over time. As with space, the power to cross time zones and communicate during *off hours* is both a privilege and a deficit of online service delivery. As accessibility increases so does boundary testing on both sides. For instance, Participant #9 discussed a client who moved away to a different Time Zone, and the client attends her therapy session first thing in the morning when she wakes up from the comfort of her bedroom, since the therapist is three hours ahead. At the same time, when the client is done with her workday and available to attend a therapy session, it is already past working hours where the therapist is located. It is tempting, as Participant 3 stated, for clients to reach out when it is convenient for them because of the flexibility of the online environment. Participant 3 has a client who works night shift and sends her texts off hours due to her unique working schedule. The same participant described how time can bend online in that therapy can extend beyond the typical time bounds of the session:

> I've actually had one client who has just released a book on her experience of recovery from childhood sexual abuse who would email me. What we would

> touch on in our sessions that she just couldn't stay out loud. So, she would then go to email and finish saying it and then we would use that as a steppingstone to the next part of the discussion.

This extension of the therapeutic time was often challenged by the client and it was up to therapist's preference whether they indulged the client or not. Participant 8 described offering videoconferencing as the main medium of service delivery but found that clients would also text her:

> Yes, I do text therapy with my existing clients just like when they're in sticky situations, I've done some text therapy, but I sort have kept it short and very deliberate. Same as email. I try not to use it on going but because my cell number is also my text number, my clients avail themselves to that and then, sometimes I just can't talk on the phone, I provide feedback or some brief therapy in text too.

For Participant 8, the power over time could be viewed as a slippery slope, as in, one text begetting another, until it is 24 hours a day:

> I've had clients text me in the middle of the night, I don't always respond to them in the middle of the night unless it's like a clear emergency…but I have clients, New Year's Eve…text me. So, no. Everywhere I am, I text. It's sort of my mobile office. My 1:1 client time is in my office and everything else really isn't in my office.

Many participants only had one phone that operated both as a personal and professional line, so that 'time at work' extended beyond office hours whether they chose it or not. Participant 7 discussed the complexity of having one phone,

> So interesting though, because sometimes I'm out and I will get a phone call from a number I don't recognize, maybe I'm in a store and I'll get, you know, the phone, and I'll answer not knowing who it is. It could be the bank. It could be could be a person phoning for therapy or a client because I don't have my client list on my phone…And I've answered it and then it's a client somebody wanting therapy and all the sudden they're like wanting to get into you know their issues.

Power over time in this way oscillates between client and therapist in a kind of tug of war dynamic where the client tugs and time and the therapist are put in the awkward position of deciding whether or not to engage in therapy outside the session. The interesting phenomenon in the power over time, is that this dynamic could be easily remedied by the therapist acquiring a second phone for work purposes only.

Power over self-representation. Individual and professional identity in the online environment seems to be more pliable than in-person. This is not a new concept in the literature, and has been coined the *Online Disinhibition Effect*, by Suller (2004). Online Disinhibition Effect or ODE describes the observation that people tend to behave online in ways they would never behave in a face-to-face environment. They may act in a way that is unrestrained, more expressive, and less considerate of social consequence (Suller, 2004). As it pertains to the counselling relationship, there is great potential to foster a more intimate attachment between client and therapist online, one that is facilitated by being less restrained, more informal and using real life-visual stimuli of the personal world of the other. For example, Participant 10 describes the client's ease of engaging from their home, "I usually see people seem quite comfortably on their couch.

Like I have seen University students and a lot of times they're sitting on their bed". Participant 3 experienced interpersonal closeness with her client online through the shedding of social stigma in attending therapy. She describes the invitation into the client's personal life as a revelation of power over self-representation, "It's completely different. Completely… I've had one client sitting in her dorm room, we're having a session [and] her roommate will walks in and she's like.. 'Oh hey! Say hi to [name of therapist]'!...". In this case, the participant described that client was so unguarded in her relationship with her therapist she turned her laptop around so that her roommate could wave to her.

Self-representation on the part of the therapist can also be less guarded online. Participant 10 described a client's glimpse into her personal life, "…once I was having Internet connectivity issue so I moved to the main floor [from the basement]...And it happened to be when my infant son had woken up and was crying, so, there has been that one instance where, you know, my clients can hear my kids screaming". This very personal insight into the therapist's family falls into the category of *benign disinhibition* online (Suller, 2004). The opportunity to share such personal information between therapist and client is not considered harmful to the therapeutic relationship, but it would likely never happen in-person because the therapist would have more power over self-representation.

Toxic disinhibition has a more hostile or sexualized connotation to letting one's guard down (Suller, 2004). Both participants #8 and #9 describe clients contacting them

by phone for an intake assessment, only to realize that the client is engaging in sexual activity on the other end.

Overall, these personal insights gained through a power redistribution in the online environment were mostly described in a positive manner with the opportunity to bring therapist and client closer in a more authentic way. online availability of therapeutic services seems to facilitate a fluidity in power dynamic akin to Therapeutic Communities (TCs) practiced in the treatment of addictions in the 1950s where therapists and clients had an egalitarian system of decision making (Witeley, 2004).

Research Question #2: *What are the lived experiences of these professionals in maintaining ethical boundaries with their patients?* An ethical boundary can be as firm as stone (i.e. thou shall not have a sexual relationship with your client) or can be an invisible line in the sand; you're expected to know it's there and heaven forbid you should cross it. As described in Chapter 2, boundaries in counselling and therapy are often vague and arbitrary (Samson-Daly et al., 2016). While the explicit 'rules' therapists must abide by are pretty much understood, the unspoken rules, the areas of grey where most ethical dilemmas live are subjective to individual, social, and environmental influences (Chowdhury, 2016). Boundaries can be described with a psychoanalytic lens as the "frame" or container where the therapist and client meet (Gabbard, 2016, p. 2). The frame is permeable, dynamic, and mostly in the hands of the therapist to keep the frame safe from harm. From the interviews, it was made clear that the boundary or 'frame' was not so much permeable as it was at times indistinguishable. There appears to be a kind of anti-gravity experience in the online environment that expanded the ethical frame beyond

borders. Chairs and tables, the hum of a familiar air conditioning unit, pictures on the wall, and even a surly receptionist in the waiting room act like a gravitational force that enable the ethical frame in the face-to-face space.

The second research question exploring how these professionals maintain ethical boundaries with their patients gave rise to the theme of being 'unbounded' in the online environment. Unboundedness in this case is the experience of crossing a boundary that would be clearer or even unthinkable in a face-to-face therapeutic interaction. Some examples from the interviews include unexpected intrusions into the therapeutic space on either the part of the therapist or the client (Participant #3), casual or inappropriate attire on either party (Participant #4), or unlikely therapeutic interactions that take place online, such as texting on New Year's Eve (Participant #8). The theme of Unboundedness has two subthemes: a) the client unbound and, b) the therapist unbound. They are discussed in further detail in the section ahead.

Unboundedness

The notion of being 'unbounded' was introduced by Participant 2 which emerged as a general theme when engaging with the interviews overall. While the participant's intention was to describe the phenomenon of working outside one's scope of practice, the more I engaged with the experiences of the participants the more it became clear that an 'unboundedness' was a theme that was part of the phenomenon of practicing online, and that it was tied to ethical practice. As with the concept of power and power imbalances in therapy, boundaries are a concept known to regulated health care professionals that is cemented in codes of ethics. For the College of Registered Psychotherapists of Ontario,

boundaries are a part of the very first principle in the Ethical Code (2011), Autonomy and Dignity of All Persons. This principle states, “To respect the privacy, rights and diversity of all persons; to reject all forms of harassment and abuse; and to maintain appropriate therapeutic boundaries at all times” (para 1). As stated earlier, the term ‘boundaries’ can be ambiguous; most practitioners have a strong sense of ethical boundaries in theory rather than practice (Levitt, Farry & Mazzarella, 2015). The challenge in applying boundaries in the online world only seems to increase due to its’ heightened sense of unpredictability.

The unbounded therapist. Becoming unbounded on both the part of the therapist is an ethical myopia where the risk of crossing ethical boundaries is barely perceptible due to the benefits of increased accessibility rather than risk protection. As the interviews with participants progressed there seemed to emerge a confirmation bias, where the participant came to believe in a superpower to detect and mitigate risk without formal training in or knowledge of common boundary issues online. This is the irony of being unbounded; most participants rated their ethical decision making as fairy high while simultaneously describing breaches in boundary keeping. In several instances’ participants would state their commitment to keeping certain boundaries and then immediately discuss times in which they unexpectedly crossed them. For example, both Participant #8 and Participant 9 clearly articulated the ethical standard of privacy and confidentiality and addressed the ways in which they mitigated other people being present in the room at the time of therapy, while at the same time they were using software for their therapy session that is not privacy protected or PHIPA compliant (ex.

Skype). Another example was evident in Participant #9 where they described taking extra steps to do an intake screen of a client for risk, while simultaneously being unaware of their own professional insurance coverage. They stated, “Yeah. I think I just sort of take the insurance for granted and don't really read the fine print”. Four of the ten participants had not checked their liability insurance to ensure coverage for online services.

Participant 3 was asked to rate their ethical decision-making skills through the Boundaries in Practice Scale from least comfortable to most comfortable, to which they responded, “Totally comfortable. Oh, yeah, my decision-making, ethically, is moral decision-making. Okay… And does that kind of push a little bit of a boundary in that way? Yep, but you know what? That's okay for me.” When asked about her liability insurance, she noted, “That's an interesting question. That's a very interesting question. I have not even… That's a very interesting question.” The question of liability insurance preceded the rating of ethical decision-making skills.

The unbounded therapist has carefully considered their course of action in case of emergency on the side of the client but has not effectively planned for emergencies on their end, particularly if they run a home-office. For example, Participant 5 described an unexpected moment in the middle of a session,

> I had a session an online session. I had just gotten online…when my middle son burst into my office which they know not to do but holding his hand, he had broken his finger at multiple places. And you could see on the screen what was happening, and she could see what was happening and I said, you know my goodness. I'm really sorry, but I think I'm going to have to go. I will let you know

> when I can reschedule, and she said, ‘no problem’, and I shut it down and we went to the hospital.

The therapist’s life making unexpected appearances in the online session is not uncommon, but also not anticipated on the part of the participants. In all instances they were described as anomalies, however, when the collective narrative was reviewed, it seemed to be a common occurrence.

The unbounded client. The unbounded client, on the other hand, is a biproduct of testing the therapeutic relationship. Several studies site the disinhibiting effect of an online presence known as Online Disinhibition Effect (Lapidot-Lefler & Barak, 2015; Suller, 2004; Wu, Lin & Shih, 2017). Engaging in online therapy seems to be no different in creating opportunity for disinhibition on the part of the client, however, the client’s level of unboundedness in therapy relies on the level of unboundedness on the part of the practitioner, much like face-to-face counselling. Participant 1 described a common boundary issue among clients participating in text-based counselling. They described what they coined the ‘pen pal effect’ which effectively mimics transference love by the means of texting. Participant 1 explained that in this situation, the client is unable to differentiate their therapist from a friend because they are communicating with them through an informal medium.

The pen pal effect on text, while boundary testing is a glimpse into the slippery slope of unboundedness; the unexpected disinhibiting effect of being online. Participant 1 continued in describing the challenges of containing the client’s natural disinhibited self,

> But um...Yeah but clients, still a lot of clients will be trying to get closer to the therapist and you know, understandably, there's more leeway for that online therapist. It's more open to that. It would be like...you know the analogies in-person always help, so you know it would be like a client dropping by the therapist's office to say hello. So that would be very unusual and preventable if you had a receptionist and a waiting room, but it's easier… it's harder to protect yourself online from that. Without someone popping in with a quick memo.

Text-based counselling seemed to be particularly prone to both therapist and client being unbounded due to the feeling of anonymity of being unseen. Participant #1 described the power of transference and countertransference than can take place from simply imagining what the other looks like.

> And then there's the text space where you don't see the client, there's a lot of room for countertransference. And women are always bringing in their romantic and sexual issues. You know, really free... And then was always in this situation where I was being Dr. Love in advising them, and then to a certain extent they would project their ideal male figure onto me... It's no small challenge representing that and keeping it within bounds.

The expectation on the part of the therapist of the client being more disinhibited, more unbounded than in-person is one way to keep the frame in-tact. It's not always possible to be so reflexive, however, when working online. Participant #4 describes a first interaction with a client in which the client opened their video conference screen and to the surprise of the therapist the client did not have a shirt on and was smoking marijuana:

> I know I mentioned in the past I did see one client that saw me in his underwear smoking a joint during the session and that is something I…It was a first session so I was hesitant to approach but I did ask him especially for future sessions around the substance use to keep that outside of the session.

At this point, the client's level of unboundedness is a product of Online Disinhibition Effect, as it is unlikely, they would have walked all the way to a traditional therapist's office without a shirt. Since the therapist addressed it immediately and requested the client get dressed and abstain from smoking until the end of the session, the therapist created the boundary. Participant #7 stated it well when they said, "There's always clients that…will push the boundaries and try it and either negotiate in the moment or…You know in session and around you how they would find it useful to use other forms of communication outside of the session, but I really do try to keep it all in the session. I can't say I'm 100% successful with that."

The resulting effects of a virtual space where therapist and client meet are summarized in Chapter 5 where it will be tied to the theoretical model of professional identity. The next chapter will also describe the limitations present in this study as well as recommendations for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

A decade and a half ago Knapp and Slatter (2004) described risk to professional boundaries in what they termed *non-traditional settings*, to describe in-home psychotherapy treatment. They noted that typically, clients who seek therapy have a "general schema" for what therapy might look like in-person in an office setting (p.555). In non-traditional settings both therapist and client are likely unprepared, at least in the beginning, for what the online session might look like, which can be understood both figuratively and literally.

In the figurative sense, clients may not be aware of their propensity to be disinhibited: unexpectedly informal from the comfort of their own home. The therapist may try to formalize or contain a session within bounds but lacks experience doing so in a virtual space. The therapist may also be unprepared for what they are like in the online world. One participant noted that she was unexpectedly surprised by seeing her own image in the video conferencing software. Having what she describes as poor image of self, she was then met with the literal image of herself online; whereas, in a face-to-face setting, it would be unlikely one would conduct a whole session with your own image staring back you.

In the literal sense, the schema in non-traditional settings of what the office looks like for both client and therapist may not mesh with what is expected; whether the client is attending a session from the inside of their closet (as described by Participant 4), or the therapist is sitting conducting the session from their kitchen (as described by participant

3). Popular culture has yet to catch up to the image of being *in treatment* online as it has the Freudian couch. Another literal iteration of the unknown schema is who might be in the room. Knapp and Slattery (2004) described that in in-home therapy clinicians are likely to be invited to dinner, because the home is a place where clients may entertain guests. The home is a place where it is natural to "take great liberties in setting the tone and the agenda for the activities" (p. 556). Therefore, inviting your therapist into your home via your computer screen is much like inviting a close acquaintance who happens to know your inner thoughts and has little-to-no judgement of your lifestyle. It could naturally be assumed that your therapist would be perfectly comfortable leading a session while their client is attired in their pyjamas in bed. In this final chapter I will discuss the findings from this study and show how unnavigated schemas related to Knapp and Slattery's (2004) non-traditional therapeutic environments call for more vigilant boundary setting.

Interpretation of the Findings

The purpose of this study was to explore the lived experiences of mental health professionals with online therapy, with a focus on the issue of ethical practice. Two main themes emerged from the hermeneutic exploration of the data. First, offering professional therapy services online involves a shift in traditional power dynamics between client and therapist. This theme was named *Power Redistribution*. Power redistribution spanned several areas of client-therapist relationship, including power over the environment, power over space, power over time, and power of self-representation.

The second theme, *Unboundedness*, describes the almost invisible ways that ethical boundaries slip through the cracks unawares in online platforms.

Theme 1: Power Redistribution

Power Redistribution as a theme revealed a shift in the balance of power between the traditional roles of client and clinician in the online space. The first key finding in the current study is that power redistribution online occurs as a result of the mailability in self-representation on virtual platforms. This opportunity to change how one is viewed, interacted with, and available to others in a digital space is an opportunity equally provided to client and practitioner. This finding is consistent with a study by Lamas et al. (2017) which described how patient empowerment is enhanced online, redistributing power once held solely in the hands of the practitioner. According to Lamas et al. (2017), while the practitioner still retains some of the treatment expertise (which patients may now have available through Googling their symptoms), the patient has the power to affect how the practitioner is represented online through a rating or review of their services. Power redistribution in this study was organized into four subthemes: a) power over the environment, b) power over space, c) power over time, d) power of self-representation. These four subthemes converge in their implications on professional practice standards.

Power over the environment. As noted in Chapter 4, one of the main themes of this phenomenological exploration was a re-distribution of power between client and clinician. Part of this balancing of power comes directly from both parties being in their own environment. This advantage seems to benefit client and practitioner equally and is reminiscent of a treatment model in addictions known as therapeutic community (TC).

TCs became popular in modern times in the 1940s and 50s as a democratic treatment environment (Haigh, 2017). Clients and clinicians were often on first name basis and TCs had a peer-to-peer, self-help philosophy. These “flattened hierarchies” between clinicians and clients were meant to enhance social networking and connectedness (Clarke, 2017, p. 207). The idea behind TCs is that a deficit of social power is associated with psychological distress and that through a more balanced structure of authority, psychological health can be regained, and social networking enhanced (Boyling, 2011). This idea that the environment in which therapy takes place influences power hierarchies is reflected in the findings from this study. Shifts in power dynamics, as related to environment, were differentiated by the modality such as synchronous text-based therapy, video conferencing, or asynchronous email.

Disciples of TC’s share a moral ideology of challenging the “dilemma of paternalism” inherent in medicine (Boyling, 2011, p. 155). Waterman’s (2011) description of the word ‘virtue’ encompassed not only fulfilling one’s own prospects but fulfilling a need that served mankind. Through this study I have uncovered that online therapy serve society not only by challenging traditional hierarchies, but also by expanding access and equity to mental health services. Online modes of therapy clearly provide resources to people who live in remote areas that are limited in face-to-face resources, as well as those who suffer with mental illness that are a barrier to leaving their home.

The online therapeutic environment inherently redistributes power once held by the therapist in face-to-face interactions. In my speaking with the participants of this

phenomenological study, this is not so in the online experience. The online environment can therefore be considered a digital iteration of the therapeutic community where both client and clinician have agency over their respective environments; over space; over time. There is a cost however, to this power shift in the therapeutic dynamic.

Power over space. A key sub-theme of power redistribution is the power over space. In chapter 4 I discussed the idea of space as the 'scene' in which therapy takes place online. This subtheme is consistent with the literature I presented in Chapter 2 which reviewed the symbolic meaning behind certain objects in the therapeutic space, such as the traditional Freudian couch. In online therapy, both the seen and unseen shape the way the therapeutic relationship molds itself. The reason why this is important is because of the ways in which transference and countertransference are transformed online. There is a seamlessness, immediacy, and automatic nature of self-disclosure online, particularly in video conferencing: This is me; this is me in my living room, my basement, my kitchen, or home office. This is my dog, my cat, my roommate, my kids; this is my life. By meeting online, therapist and client open an invisible door that illuminates details of the other's existence in a more detailed and personal way than ever imagined in a traditional therapy session. This direct observation of the personal life or 'space' of the other cannot help but shake the conventional power dynamic to its core.

If identities online are a 'face' we wish to present, as in Goffman's (1959) theory of identity, therapy online using video is akin to the breaking the fourth wall in a performance; performer and audience suddenly aware of the bold-face reality of the other. Regarding video conferencing, Participant 9 noted that this experience is facilitated

by an invitation to entre, “it’s almost as if they’re inviting you into their space as opposed to the opposite.” This sudden insight into the reality of the other’s existence is unexpectedly disarming and is channeled through the sensory experience of seeing into the camera. The camera is a wormhole by which the therapist can travel through time and space to the living environment of their client. Looking into the camera not only provides the gazer with visual data of the intimate life of the other, but also facilitates staring into the eyes of the other due to the nature of computer cameras. In this sense, all that is seen is what is conscious because reality is too distracting to sense the unconscious.

Power over time. The power struggle over therapeutic time reflects the argument by Lloyd-Hazlettt and Foster (2016), that ethical practice has an element of subjectivity and personal discretion. Because of the immediacy, unpredictability, and attention-grabbing nature of a text-message, engaging with a client in a virtual space such as a smart phone shifts into a space of personal choice rather than a prescribed ethical decision. If professional socialization is the key to fostering good ethical decision making among practitioners, as Lloyd-Hazlettt and Foster (2016) stated, then it may be that online therapy is simply too new to have been part of the socialization processes. Until such time, it may be that the power dynamics remain a point of contention.

Power over self-representation. ***Individual identity*****.** The theme of power redistribution in relation to self-representation was found to be congruent with Goffman’s (1959) theory of identity as a mask and Stryker’s (1968) concept of identity salience. Goffman famously likened our identities to a mask that we wear in front of others as we play a certain role (1959). Stryker furthered this theory in writing that the masks are

interchangeable depending on the most appropriate identity in any given situation. For, example, Participant 10's session was unexpectedly interrupted with the sound of her crying newborn. Participant 5 experienced a similar scenario when her session was interrupted by her teenage son amid a medical emergency. In both cases, the identity of therapist and mother made their appearances during the course of a therapy session. In both situations, identity of the clinician was interchanged with the identity of mother; whichever identity was most urgent (i.e. emergency medical situation) was most prominent in that moment. Where power comes into focus in regard to identity is with the exchange. In the role of therapist, the clinician theoretically holds more power than the client. However, change the role to a more vulnerable one, such as a new mother hearing her baby cry, the power dynamic shifts in the client's favor. The client then must be the one to allow the session to be interrupted and show empathy towards the therapist, not the other way around.

The online world presents new challenges for power over self-representation. Valkenburg and Peter (2011) hypothesized two contrary outcomes to constructing individual identities online. The first hypothesis is known as *self-concept fragmentation* or *fragmentation hypothesis* (p.123). In this possible scenario, an individual's identity becomes shattered into a multitude of faces that are incohesive and inherently fragile. Valkenburg and Peter (2011) referred specifically to adolescence in this hypothesis, maintaining that such an outcome is a reactive type of identity that at its core is unoccupied (Pilarska, 2017). When identities are split in contrasting and diffused presentation it could lead to interpersonal distress. An example of a fragmented identity

online can be a client's identity on social media portrayed as positive, productive, and emotionally stable, in contrast to the client's presentation online with their therapist. The client in therapy online may be a complete contradiction to their social media profile: struggling, depressed, or otherwise unwell. Another example using the therapist can be a privately held social media identity that voices biases or even prejudiced beliefs while at the same time maintaining professional social media accounts exhibiting tolerance and inclusivity.

Valkenburg and Peter (2011) hypothesized a second possible outcome of creating multiple online identities, the self-concept unity hypothesis. In this hypothesis, identity is honed and clarified through opportunities for self-representation online. What once may have been more recessive aspects of personality in competition with dominant traits, with the endless opportunities afforded online, secondary personality traits can be explored more fully when they find a virtual community. In the case of the self-concept unity hypothesis, both client and therapist have increased opportunities to *save face* due to the many points of possible validation from such a diverse virtual world.

In this study, participants' individual identity was at times at risk of being fragmented due to the risk of being seen by the client in multiple roles. In the example of Participant 10's unexpected interruption with the sound of her crying newborn, her identity was fragmented into both mother and therapist. However, there is equal opportunity for self-concept unity, especially for the therapist who can market their services through various social media platforms.

Online social identity: Chapter 2 I reviewed Tajfel and Turner's (1979) social identity theory of intergroup behavior which establishes that people strive to be recognized as members belonging to a collective, rather than on the outside looking in. So vital is the concept of belonging that Jetten et al. (2017) stated that "the health of every person is intimately tied to the conditions of group life" throughout the course of their entire life (p.789). When belonging is beneficial for body and mind, the social community can be curative, however, when belonging is unwanted, beyond one's control, or is defined by stigma, belonging can be a curse (Jetten et al., 2017). Being diagnosed with a mental illness, for example, can unwillingly cage an individual into a grouping they do not wish to affiliate with. The anonymity that comes with online interactions, however, can change how people participate in social interactions. According to Millham and Atkin (2018), the introduction of online communities means that people no longer need to congregate in person in order to get the sensation of belonging. This is a kind of social power.

The power over self-representation as a member of a group is consistent with the literature that discusses the social capital of online self-disclosure as a form of belonging. Belonging in online communities is often fostered on online platforms where self-disclosure is moderated, but also an expected part of the membership *fee* (Millhan & Atkin, 2018). Social media platforms such as Instagram and Facebook, for instance, require a higher personal *fee* for active membership. Such platforms run on postings of intimate life details as a personal tax of belonging to the platform; It follows that the

more you belong online, the higher the rate of personal exposure (Millhan & Atkin, 2018).

As therapist and client converge on an online platform, be it text, video, or phone, their social identities converge where belonging may differ for each by their group affiliation online. The power to capitalize on the sense of belonging online is a hidden influence on the power dynamics in session. For instance, a bad review online by a client, depending on the power of the platform, can impact the therapist's career.

Theme #2: Unboundedness

A second key finding in the current study is that online therapeutic interactions blur boundaries that are otherwise clear in face-to-face settings. This is consistent with the literature on a phenomenon known as Online Disinhibition Effect which describes the deterioration of personal restraints in social interactions online that are typically present in face-to-face interactions (Lapidot-Lefler & Barak, 2015; Suller, 2004; Wu, Lin & Shih, 2017). The current study found that one of the risks of online interactions is that degree to which a client is disinhibited may be moderated by the degree to which their therapist is disinhibited. The burgeoning world of online practice is a largely experimental field where therapists try their hand at using technology and set boundaries mostly based on trial and error. The unknown ethical issues that might arise foster 'unbounded' territory that may or may not be identified by the boundary setter, the therapist. This uncharted territory is a transference wilderness where the client's disinhibitions can run amok with little navigation. The client may be inclined to text their therapist at midnight based on an experience where the therapist texted back after hours one time (i.e. Participant #8). The

client may be inclined to dress inappropriately based on a continuum of casual wear that becomes more casual over time (i.e. Participant #4). The client may be inclined to answer their video chat from their bedroom, closet, or backyard, feel more and more emboldened with the casualness of conversation (i.e. Participant #3). Boundaries and the lack thereof are a balance between client and clinician that requires closer attention.

The unbounded professional. The recently regulated Controlled Act of Psychotherapy in Ontario is a forging of a new relationship between psychotherapists and the public (Ministry of Health and Long-Term Care, 2017). Prior to the proclamation of this act, psychotherapy was a therapeutic intervention that could be done by any number of lay health care providers who did not have the requisite education, practice, or oversight as it does now. Setting such a boundary in creating a controlled act makes psychotherapy exclusive to six regulatory Colleges in Ontario, including the College of Psychotherapy, the Ontario College of Social Workers and Social Service Workers, and the College of Psychologists of Ontario. This exclusivity not only protects the public by setting a standard of practice, but also offers a boost in professional identity to the six regulated bodies able to provide it.

Håland (2012) contends that boundaries are vital to professional identity in establishing who is on the inside and who is on the outside looking in. Boundaries in professions, as Håland (2012) put it, must have some flexibility in order to withstand social change and maintain public trust. Therefore, boundary setting as well as descriptions of boundary crossing must evolve over time. With the introduction of online services, professional boundaries must bend and shape themselves to a renegotiated

identity in order to maintain public trust as well as reflect contemporary values (Håland, 2012). Defining what is and is not therapeutic is ultimately in the power of the professional associations who set those boundaries. Any changes to the 'work' of therapy can have significant consequences on the legitimacy of a profession. In this sense, when professional identity is challenged one's individual identity as a 'professional' is also at risk (Håland, 2012). Håland (2012) argues that the introduction of technology in medicine offers benefits in efficiencies and potential cost-savings, however, it also poses a risk of possible discord with professional values in health care such as putting the needs of the client first. This study's participants often expressed the challenge of balancing the benefits, such as increased access, against the challenges of keeping sessions 'contained' as they called it.

Unboundedness: Seeing and being seen. Gaze in the form of eye contact can be both a measure of psychological wellness and withdrawal as well as a measure of secure attachment (Folly & Gentile, 2010; Schore, 2001). In therapy, however, the concept of *gaze* is a much-debated idea in the literal as well as philosophical interpretation. While this did not emerge from the interviews directly, the hermeneutic process of engaging with the narratives uncovered a form of unboundedness as related to gaze. Being *seen* in therapy evokes aspects of boundary setting and power in who is being seen and who is doing the looking. When the therapist gazes at their client, the client allows or inhibits their true self to be seen; the client has power in deciding how much to reveal. Three scholars, in particular, made the gaze in therapy a topic of philosophy, Jean-Paul Sartre's (1943) *Being and Nothingness*; Jaques Lacan's (1965-66) *L'Objet de la Psychanalyse: Of*

the Gaze As Objet Petit a, and Michal Foucault's (1963) *Birth of the Clinic*. All three provide unique insight in how seeing and being seen in the therapeutic sense influences power and defines limits between client and therapist.

Sartre (1943). Sartre's (1943) ontological exploration of gaze as a possibility of being *seen* in the world by the other, rather than simply the physicality of using one's eyes to look was a revelation of insight into our existential need to be witnessed in the world (Ma, 2015). According to Ma (2015), Sartre's view of *being seen* is the moment in which we are aware of our own conscious existence. In therapy, the act of being seen by the other, to be gazed upon as a client by a therapist is to validate one's existence. In the case of video conferencing, it is impossible to escape being looked at, but not necessarily *seen*. Alternately, in the case of email or text therapy, one can only be *seen*, but not necessarily observed with the eyes. There is power at play in how much one reveals about themselves online while at the same time knowing that the boundaries have a much further limit. Opening a computer screen showing one's home already set the boundary further than in a face-to-fac encounter. The unbounded nature of video is akin to a voyeuristic experience.

Lacan (1965-66). According to Ma (2015) Lacan's view of gaze in therapy is described as constantly seeing ourselves from our own interpersonal point of view as well as a societal point of view. Because we live among others, we tend to see ourselves and be seen from a socio-cultural perspective. In therapy, the client paints a picture of themselves for the therapist to gaze upon. It may not be a literal presentation of facts, but rather a presentation of self that invites the therapist to know the client from a certain

perspective (Ma, 2015). Online therapy can either extend boundaries by providing the painter (mainly the client) a certain palate to work with. Both client and therapist, if working from a personal space such as a home environment, have some choices in how they curate the backdrop of their online session. In text therapy, however, the painter extends boundaries by limiting the visual, thus allowing for a broader scope of the imagination. In text-based therapies, transference and countertransference, the tools of psychotherapy, are magnified in the online arena in a way that Participant #1 describes text-delivered therapy as being "really inside each other's heads and hearts". There is a power dynamic in revealing only the basic of what is necessary and no more.

Foucault (1963). Foucault extends the notion of sociocultural way of being seen and focuses on the field of medicine as a power differential in doctor looking upon their patient to find a diagnosis (Besley, 2009). Foucault, according to Besley (2009) views therapeutic gaze as a political intervention, engaging in a power dynamic where authority and boundaries have been traditionally set by the therapist or physician. This one directional social control of who sees and who is looked at are challenged in the dynamics of power and boundaries in online therapy. To see a therapist working in their home office challenges traditional power dynamics, as does the casualness of texting.

Power Redistribution, Boundaries, and Practice Standards.

The history of psychotherapy and the standards regulating it is steeped in dialogues of power and privilege. Power and privilege are enmeshed in our mental health system, as therapy is not often covered by public or private health insurance, as other therapeutic interventions are. Privilege and power in the therapeutic dynamic are part of

professional practice standards for regulated health care professionals. For instance, Practice Standard 1.8 from the College of Registered Psychotherapists of Ontario (2016) discusses the Standard of Undue Influence and Abuse (p.20):

> Clients and/or their representatives may be emotionally and otherwise vulnerable. At the same time, clients may be particularly influenced by the views or suggestions of their psychotherapist. It is important therefore to ensure that clients feel safe with their therapist, and that they are not subjected to inappropriate influence or abuse.

Regulated health care professionals are trained to lookout in a protective sense and uncover where there may be an abuse of power. This phenomenological study uncovered several subthemes under the umbrella of power redistribution, because it appears to be inherent in the modality of the virtual office space in which the power dynamics shift almost imperceptibly. Regulatory colleges should treat the online office space as a new and yet to be defined therapeutic space with its own unique ethical challenges.

Professional Standards, Education, and Training

Several authors called on professional colleges to act on two separate issues: 1) Create separate competency standards for online therapy, and 2) Provide training and education in this specialty area (Johnson, 2014; Harris & Birnbaum, 2015; Sansom-Daly et al., 2016). Scholars agree that a much more nuanced look at the practical implications of online work is needed to critically evaluate how current standards are practiced electronically. As Drum and Littleton (2014) noted, ethical guidelines can be

simultaneously rigid as well as overly broad in capturing ethical challenges in practice. Standards of practice or guidelines such as the current electronic guidelines provided by the CRPO, in their current, state do not encapsulate the multi shades of grey found in boundary setting online. What is clear from the experiences of mental health professionals in this study is that boundary issues were more often unexpected rather than anticipated. The most prominent ethical challenge found in this study was the unforeseen reallocation of power between therapist and client. Only two of the ten participants had participated in or contributed to formal training in online therapy, leaving a large gap in need among practitioners.

Implications

Practice Implications

Håland (2012) take on the necessity of flexibility in any successful evolution of professional identity is key to the practice implications of this study. It cannot be disregarded that online practice is the next evolution of the practice of therapy and mental health services. Professional colleges must delve into this practice area on more than a superficial level. For instance, the current draft Electronic Practice Guidelines (2018) put forth for public input by the College of Registered Psychotherapists (CRPO) notes that therapists should "recognize the potential impacts of the use of the technology with regard to the client-therapist relationship and the therapeutic process" (p.2). This sweeping statement gives no indication of what such impacts could be. In order to maintain a newly established public trust in the CRPO, professional colleges such as this

would do well to reflect deeply on the potential impacts of providing therapy online (Håland, 2012).

Regarding changes to traditional therapeutic gaze, participants in this study were able to describe the ways in which they see with their eyes in ways they have never seen their clients before.

Training Implications

A recent study by Glueckauf et al. (2018) sampling 164 participants, representing professional psychologists on the topic of telecommunication in therapy found that 96% of respondents indicated the need for training on the matter. Moreover, respondents noted the need for instruction and education on the "clinical, legal, and/or ethical issues related to telehealth" (p.210). 90% of those respondents also encouraged training on matters of technology and software platforms delivering such services. A percentage of these respondents also brought up the issue of lack of awareness of such trainings that may be available to them. Only two of the ten respondents in this survey had formal training in online therapy practices.

According to McCord, Saenz, Armstrong and Elliott (2015) training should begin at the academic level and integrated into current Master's programs teaching counselling and psychotherapy. Of the 6000 plus current psychotherapists registered with the CRPO there should be a way to upgrade one's skills in this unique area of practice. Currently, one of the most popular trainings in Toronto is a one-day workshop by the Ontario Association of Mental Health Professionals (OAMHP formerly the OACCPP). According

to the CRPO's draft Electronic Practice Guidelines (2018) "members should consider receiving training" (p. 2); a suggestion, not a mandate.

Social Change Implications

This study poses some significant social change implications. Nearly 30 years ago MacKinnon (1993) described the therapist as a "powerbroker" in the context of therapy. The role of the powerbroker in this setting is to be knowledgeable and continually informed of the contemporary critical theory in which therapy is taking place. The therapist's role is to "resist" preconceived notions of who the client is as well as who they think they are within the context of therapy and be open to interpretation of self and the *other* (p.122). MacKinnon (1993) notes, "the activities of therapists are inevitably and inescapably embedded in relations of power" (p.122). In today's context online mediums of therapy have reshaped and reimagined the relations of power. Thirty years later, it is still our "ethical imperative" to be aware of the power dynamics, including the propensity of disinhibition online.

Bridging the gap in new power dynamics in online setting through the use of specific guidelines to steer and inform online practice ensure responsibility and accountability from regulating bodies, thus protecting the interests of therapists and clients. This can potentially lead to enhanced professional identity in society. It is clear from this study that therapists are willing and eager participants in this process interested in gaining skills and enhancing knowledge in this area. Studies like these can serve to inform future trainings of counsellors in identifying the gaps in knowledge.

Recommendations for Future Scholarship

Future scholarship can extend the ideas presented in this study by further exploring the redistribution of power online as well as the change in boundary setting. The phenomenological findings are only a presentation of ideas expressed among ten participants, leaving ample room for further scholarship on these themes. On the convergence of the themes of power and boundary setting through the lens of therapeutic gaze it may be interesting to explore how and when eye contact is made online on the part of the therapist and the client. Additionally, the focus of the February 2018 issue of the Journal of Clinical Psychology was devoted to the topic of aesthetic and the therapist's office. Seven articles within this issue discuss the various ways in which aesthetics impact therapy (Geller, 2018). One of the contributors, Jackson (2018), asks "what does it mean to transform an empty room into a therapeutic space?" (p.234). He notes, "There is no doubt that our surroundings affect our moods, thoughts, and behaviors." In turn, how does online environment affect mood, thought, and behavior? This is a focus of future scholarship.

Limitations

Limitations are a natural part of the research process. This study was limited by three main constraints. The first was generalizability. While all participants were licensed to practice the Controlled Act of Psychotherapy (2017) in Ontario, participants were limited to the Province of Ontario. Participants represented membership with the College of Registered Psychotherapists and College of Social Work, however this study was not

able to capture the lived experience of other providers able to practice psychotherapy such as psychiatrists and psychologists.

The second possible limitation was the use of hermeneutics. The very fact that I, as the researcher used my own experience as a licensed psychotherapist in Ontario to recruit participants created an opportunity for bias in the form of transference and countertransference between researcher and participant. In part, the hermeneutic process is meant to sweep me into the lived experiences of the phenomena (Erlingsson & Brysiewicz, 2017). Hermeneutics is not a research method meant to report on a phenomenon but rather see past it and uncover new meaning through the deductive process of the hermeneutic circle (Erlingsson & Brysiewicz, 2017). One of the ways in which I mitigated potential biases is through the use of member checking. The transcripts were sent to each participant to check for accuracy, and two participants chose to clarify their meaning, one of whom wished to omit a portion of the conversation.

Finally, in dealing with the concept of professional ethics, it is natural that participants as well as myself would like to be seen as 'good therapists' giving rise to social desirability bias. Social desirability bias is often more challenging in qualitative interviews because of the lack of clinical distance offered by a quantitative survey. Latkin et al. (2016) discuss two methods of mitigating such bias; rapport building, and assertion of privacy of information. All participants expressed at the end of the interview their enjoyment of the discussion and their appreciation at the opportunity to contribute their experiences to what they view as an important emerging topic in therapy. Regarding privacy, participants were informed of the use of pseudonyms which were used on the

transcriptions provided to them for checking, as well, the use of Zoom, a PHIPA compliant software provided an extra layer of privacy protection.

Conclusion

As enthusiasm in the form of new business opportunities and accessibility features of online modes of therapy grow, so do the practice implications in the form of professional ethics among service providers (Madej et al., 2016). This is a critical time for professional identity among counsellors to seize the opportunity to redefine and reshape the therapeutic relationship online. We can no longer ignore the inherent changes that electronic delivery of services has on the therapeutic relationship in the forms of power dynamics as well as boundary setting. If therapists are vulnerable to lack of information and guidelines in this area, clients in turn become susceptible to risk. Current standards of practice and guidelines are current legislation and codes of conduct offer minimal support and must be expanded to touch upon the most critical issues presenting online. New educational standards may be warranted to ensure all clinicians gain such skills and supervision implications may also be necessary to support them.

References

Abrams, J., Sossong, S., Schwamm, L. H., Barsanti, L., Carter, M., Kling, N., ... & Sullivan, M. (2017). Practical issues in delivery of clinician-to-patient telemental health in an academic medical center. *Harvard Review of Psychiatry, 25*(3), 135—145. DOI: 10.1097/HRP.0000000000000142

American Psychological Association. (2007). Record keeping guidelines. *The American* Psychologist, 62(9), 993. DOI: 10.1037/0003-066X.62.9.993

American Psychological Association. (2017). Ethical principles of psychologists and code of conduct (2002, Amended June 1, 2010 and January 1, 2017). Retrieved from: https://www.apa.org/ethics/code/ethics-code-2017.pdf

American Psychological Association. (2018). *History of telepsychiatry*. Retrieved from: https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/history-of-telepsychiatry

Apolinário-Hagen, J., Kemper, J., & Stürmer, C. (2017). Public Acceptability of E-Mental Health Treatment Services for Psychological Problems: A Scoping Review. *Journal of Medical Internet Research, Mental Health, 4*(2), DOI: e10. http://doi.org/10.2196/mental.6186

Anney, V. N. (2014). Ensuring the quality of the findings of qualitative research: Looking at trustworthiness criteria. *Journal of Emerging Trends in Educational Research and Policy Studies (JETERAPS), 5*(2), 272—281. Retrieved from http://jeteraps.scholarlinkresearch.com/articles/Ensuring%20The%20Quality%20Of%20The%20Findings%20new.pdf

Aristotle. (2003). *The nicomanchean ethics, book 6.* Tredennick (Ed.), (J.A.K. Thomson, Trans.). London, England. (Original work published 1953).

Association of Canadian Psychology Regulatory Organizations. (2011, June 4). Model standards for telepsychology service delivery. Retrieved from: http://www.cpmb.ca/documents/Telepsychology.Standards.4June2011.pdf

Bevan, M. T. (2014). A method of phenomenological interviewing. *Qualitative Health Research*, 24(1), 136—144. DOI: 10.1177/1049732313519710.

Berry, N., Bucci, S., & Lobban, F. (2017). Use of the Internet and Mobile Phones for Self-Management of Severe Mental Health Problems: Qualitative Study of Staff Views. *Journal of Medical Internet Research Mental Health, 4*(4). DOI: 10.2196/mental.8311

Besley, T. (2009). Foucauldian influences in narrative therapy: An approach for schools. *The Journal of Educational Enquiry, 2*(2). Retreived from: file:///Users/taliasinger/Downloads/559-Article%20Text-2307-1-10-20090625.pdf

Bevan, M. T. (2014). A method of phenomenological interviewing. *Qualitative health research, 24*(1), 136—144. Retrieved from: https://doi.org/10.1177/1049732313519710

Bolton, J. (2017). The Ethical Issues which must be addressed in online counselling. *Australian Counselling Research Journal, 11*(1), 1—15. Retrieved from: https://pdfs.semanticscholar.org/7672/e027112ac09a772542430a31890496136e6d.pdf

Boyling E. (2011). Being Able to Learn: Researching the History of a Therapeutic Community. *Social History of Medicine*, *24*(1), 151—158. DOI:10.1093/shm/hkq096

Brenner, P. S., Serpe, R. T., & Stryker, S. (2014). The causal ordering of prominence and salience in identity theory: An empirical examination. *Social Psychology Quarterly, 77*(3), 231—252.

Bullingham, L., & Vasconcelos, A. C. (2013). 'The presentation of self in the online world': Goffman and the study of online identities. *Journal of Information Science, 39*(1), 101-112. Retrieved from: https://doi.org/10.1177/0190272513518337

Burns, S., & Cruikshanks, D. R. (2017). Evaluating Independently Licensed Counselors' Articulation of Professional Identity Using Structural Coding. *Professional Counselor*, *7*(2), 185—207. DOI: 10.15241/sb.7.2.185

Burns, S. T., & Cruikshanks, D. R. (2018). Independently Licensed Counselors' Connection to CACREP and State Professional Identity Requirements. *Professional Counselor*, *8*(1). DOI: 10.15241/stb.8.1.29

Campbell, R., Cohen, K., Grande, E. D., & Hopkins, C. (2015). E-mental health in canada: transforming the mental health system using technology. *Mental Health of Canada* 2014. Retrieved from: https://www.mentalhealthcommission.ca/sites/default/files/MHCC_E-Mental_Health-Briefing_Document_ENG_0.pdf

Canadian Counselling and Psychotherapy Association. (2015, April). Standards of Practice, 5th Edition. Retrieved from: https://www.ccpa-accp.ca/wp-content/uploads/2015/07/StandardsOfPractice_en_June2015.pdf

Canadian Nurses Association. (2011). Practice standards: Ethics. Retrieved from: https://www.cno.org/globalassets/docs/prac/41034_ethics.pdf

Canadian Psychological Association, Committee on Ethics. (1999). Cautions and guidelines for psychologists providing services by telephone or online. (Draft). Ottawa, ON: Author. /aboutcpa/committees/ethics/psychserviceselectronically/

Canadian Psychological Association. (2006). Draft ethical guidelines for psychologists providing psychological services via electronic media. Retrieved from: https://www.cpa.ca/docs/File/Ethics/Draft_Guidelines_EServices_31Oct2013.pdf

Canadian Psychological Association. (2017). Canadian Code of Ethics for Psychologists, Fourth Edition. Retrieved from: https://www.cpa.ca/docs/File/Ethics/CPA_Code_2017_4thEd.pdf

Carpendale, J. I. (2000). Kohlberg and Piaget on stages and moral reasoning. *Developmental Review*, *20*(2), 181—205. DOI: https://doi.org/10.1006/drev.1999.0500

Chowdhury, M. (2016). Emphasizing Morals, Values, Ethics, and Character Education in Science Education and Science Teaching. *Malaysian Online Journal of Educational Sciences*, *4*(2), 1—16. Retrieved from: file:///Users/taliasinger/Downloads/12645-1561-24823-1-10-20180725.pdf

Clarke, J. M. (2017). The case for “fluid” hierarchies in therapeutic communities. *Therapeutic Communities: The International Journal of Therapeutic Communities*, *38*(4), 207—216. DOI: 10.1108/TC-05-2017-0016

College of Registered Psychotherapists. (2018). Controlled Act Task Group Consultation Documents. Retrieved from: https://www.crpo.ca/wp-content/uploads/2018/08/Controlled-Act-of-Psychotherapy-Final-Documents.pdf

Creswell, J.W. (2014). *Research designs: Qualitative, quantitative, and mixed methods approaches* (4th Edition). Thousand Oaks, CA: Sage Publications.

Crigger, N., & Godfrey, N. (2014). From the inside out: A new approach to teaching professional identity formation and professional ethics. *Journal of Professional Nursing*, *30*(5), 376—382. DOI: https://doi.org/10.1016/j.profnurs.2014.03.004

Crowther, S., Ironside, P., Spence, D., & Smythe, L. (2017). Crafting stories in hermeneutic phenomenology research: A methodological device. *Qualitative health research*, *27*(6), 826—835. DOI: https://doi.org/10.1177/1049732316656161

Donahue, E.M., Robins, R.W., Roberts, B.W., & John, O.P. (1993). The divided self: Concurrent and longitudinal effects of psychological adjustment and social roles on self-concept differentiation. *Journal of Personality and Social Psychology*, 64, 834—846

Dowling, M. J., & Rickwood, D. J. (2014). Experiences of counsellors providing online chat counselling to young people. *Journal of Psychologists and Counsellors in Schools*, 24(2), 183-196. DOI: https://doi.org/10.1037/0022-3514.64.5.834

Drum, K. B., & Littleton, H. L. (2014). Therapeutic boundaries in telepsychology: Unique issues and best practice recommendations. *Professional Psychology: Research and Practice*, *45*(5), 309—315. https://doi.org/10.1037/a0036127

Erlingsson, C., & Brysiewicz, P. (2017). A hands-on guide to doing content analysis. *African Journal of Emergency Medicine*, *7*(3), 93—99. https://doi.org/10.1016/j.afjem.2017.08.001

Errasti-Ibarrondo, B., Jordán, J. A., Díez-Del-Corral, M. P., & Arantzamendi, M. (2018). Conducting phenomenological research: Rationalizing the methods and rigour of the phenomenology of practice. *Journal of Advanced Nursing*, 74, p. 1723—1734. DOI: https://doi.org/10.1111/jan.13569

Farnham, S. D., & Churchill, E. F. (2011, March). Faceted identity, faceted lives: social and technical issues with being yourself online. In *Proceedings of the ACM 2011 Conference* on Computer Supported Cooperative Work (pp. 359—368). ACM. DOI: https://doi.org/10.1145/1958824.1958880

Foley, G. N., & Gentile, J. P. (2010). Nonverbal communication in psychotherapy. *Psychiatry (Edgmont (Pa. : Township))*, *7*(6), 38—44. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2898840/pdf/PE_7_6_38.pdf

Foucault, Michel. (1963). *Birth of the Clinic.* London*:* Allen Lane.

Francis, P. C., & Dugger, S. M. (2014). Professionalism, Ethics, and Value-Based Conflicts in Counseling: An Introduction to the Special Section. *Journal of*

Counseling & Development, 92(2), 131–134. https://doi-org.ezp.waldenulibrary.org/10.1002/j.1556-6676.2014.00138.x

Fronek, P., & Kendall, M. B. (2016). The impact of Professional Boundaries for Health Professionals (PBHP) training on knowledge, comfort, experience, and ethical decision-making: a longitudinal randomized controlled trial. *Disability and Rehabilitation*, 1—8. https://doi.org/10.1080/09638288.2016.1236152

Gabbard, G. O. (2016). *Boundaries and boundary violations in psychoanalysis* [2nd Ed.]. Arlington, VA; American Psychiatric Publishing.

Gadamer, H. (1983). Hermeneutics as practical philosophy. In F. G. Lawrence (Trans.), *Reason in the age of science*. (pp. 88—138). Cambridge: The MIT Press. DOI: https://doi.org/10.1017/S0012217300019338

Gazzola, N., Smith, J. D., King-Andrews, H. L., & Kearney, M. K. (2010). Professional characteristics of Canadian counsellors: results of a national survey. *Canadian Journal of Counselling, 44*(2), 83—99. Retrieved from: https://www.questia.com/library/journal/1P3-2179146001/professional-characteristics-of-canadian-counsellors

Gill, S. (2015). Holding oneself open in a conversation: Gadamer's philosophical hermeneutics and the ethics of dialogue. *Journal of Dialogue Studies*, *3*(1), 9—28. Retrieved from: http://ghfp.org.uk/Portals/ghfp/documents/Scherto_Gill2015_JDS_Dialogue%20Ethics.pdf

Glueckauf, R. L., Maheu, M. M., Drude, K. P., Wells, B. A., Wang, Y., Gustafson, D. J., & Nelson, E. L. (2018). Survey of psychologists' telebehavioral health practices: Technology use, ethical issues, and training needs. *Professional Psychology: Research and Practice, 49*(3), 205. Retrieved from: https://telehealth.org/blog/wp-content/uploads/2018/09/Glueckauf-et-al-2018-PP-RP.pdf

Gilligan, Carol (1982). In a Different Voice: Women's Conceptions of Self and Morality, *Harvard Educational Review*. *47*(4), 481—517. DOI: https://doi.org/10.17763/haer.47.4.g6167429416hg5l0

Given, L. M. (2008). *The SAGE encyclopedia of qualitative research methods* (Vols. 1-0). Thousand Oaks, CA: SAGE Publications, Inc. DOI: 10.4135/9781412963909

Goffman, E. (1959). The presentation of self in everyday life. *New York*.

Government of Canada. (2019, June 28). Social determinants of health and health inequalities. [website]. Retrieved from: https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html

Graham, D.W. (2015). Heraclitus, *The Stanford Encyclopedia of Philosophy* (Fall Edition), E. N. Zalta (ed.), Retrieved from: https://plato.stanford.edu/archives/fall2015/entries/heraclitus/.

Grant, J. G., & Mandell, D. (2016). Boundaries and relationships between service users and service providers in community mental health services. *Social Work in Mental Health*, *14*(6), 696—713. DOI: https://doi.org/10.1080/15332985.2015.1137258

Geller, J. D. (2018). Introduction: The transformative powers of aesthetic experiences in psychotherapy. *Journal of Clinical Psychology*, *74*(2), 200—207. DOI: https://doi.org/10.1002/jclp.22582

Gutheil, T. G., & Gabbard, G. O. (1998). Misuses and misunderstandings of boundary theory in clinical and regulatory settings. *American Journal of Psychiatry*, *155*(3), 409—414. DOI: https://doi.org/10.1176/ajp.155.3.409

Haigh, R. (2017). Therapeutic communities enter the world of evidence-based practice. British Journal of Psychiatry, 210(5), 313—314. DOI:10.1192/bjp.bp.116.193326

Håland, E. (2012). Introducing the electronic patient record (EPR) in a hospital setting: boundary work and shifting constructions of professional identities. *Sociology of Health & Illness*, *34*(5), 761—775. DOI: https://doi.org/10.1111/j.1467-9566.2011.01413.x

Haner, D., & Pepler, D. (2016). "Live Chat" Clients at Kids Help Phone: Individual Characteristics and Problem Topics. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *25*(3), 138. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5130086/pdf/ccap25_p0138.pdf

Hardy, S.A. & Carlo, G. (2011) Chapter 19: Moral identity, In *Handbook of Identity Theory and Research*, Schwartz et al. (eds.). DOI 10.1007/978-1-4419-7988-9_20

Harris, D. A. (2017). Doing research drawing on the philosophy of existential hermeneutic phenomenology. *Palliative & Supportive Care*, *15*(2), 267—269. DOI: https://doi.org/10.1017/S1478951516000377

Harris, B., & Birnbaum, R. (2015). Ethical and legal implications on the use of technology in counselling. *Clinical Social Work Journal*, *43*(2), 133—141. DOI 10.1007/s10615-014-0515-0

Harris, S. E., & Robinson Kurpius, S. E. (2014). Social networking and professional ethics: Client searches, informed consent, and disclosure. *Professional Psychology: Research and Practice*, *45*(1), 11—19. DOI: https://doi.org/10.1037/a0033478

Hayes, J. A., Nelson, D. L. B., & Fauth, J. (2015). Countertransference in successful and unsuccessful cases of psychotherapy. *Psychotherapy*, *52*(1), 127—133. DOI: https://doi.org/10.1037/a0038827

Heinonen, K. (2015). Van Manen's method and reduction in a phenomenological hermeneutic study. *Nurse Researcher*, *22*(4), 35. DOI: 10.7748/nr.22.4.35.e1326

Hitlin, S. (2011). Chapter 20: Values, personal identity, and the moral self. In *Handbook of Identity Theory and Research*, Schwartz et al. (eds.). DOI 10.1007/978-1-4419-7988-9_20

Hogg, M. A., Abrams, D., & Brewer, M. B. (2017). Social identity: The role of self in group processes and intergroup relations. *Group Processes & Intergroup Relations*, *20*(5), 570—581. DOI: https://doi.org/10.1177/1368430217690909

Hogg, M. Terry, D. & White, K. (1995). A tale of two theories: A critical comparison of identity theory with social identity theory. *Social Psychology Quarterly*, *58*(4), 255—269. DOI: 10.2307/2787127

Husserl, E. (1970). *The idea of phenomenology*. The Hague, The Netherlands: Nijhoff.

Jaffe, E. D., Kushnirovich, N., & Tsimerman, A. (2018). The Impact of Acculturation on Immigrants' Business Ethics Attitudes. *Journal of Business Ethics*, *147*(4), 821—834. DOI: https://doi.org/10.1007/s10551-017-3597-0

Jetten, J., Haslam, S. A., Cruwys, T., Greenaway, K. H., Haslam, C., & Steffens, N. K. (2017). Advancing the social identity approach to health and well-being: Progressing the social cure research agenda. *European Journal of Social Psychology*, *47*(7), 789—802. DOI: https://doi.org/10.1002/ejsp.2333

Jackson, D. (2018). Aesthetics and the psychotherapist's office. *Journal of Clinical Psychology*, *74*(2), 233—238.

Johnson, G. R. (2014). Toward uniform competency standards in telepsychology: A proposed framework for Canadian psychologists. *Canadian Psychology/Psychologie Canadienne*, *55*(4), 291—302. DOI: http://dx.doi.org/10.1037/a0038002

Joseph, N., & Alex, N. (1972). The uniform: A sociological perspective. *American Journal of Sociology*, *77*(4), 719-730. DOI: https://doi.org/10.1086/225197

Kadish, Y., Schön, J., Green, J., Hanson, S., & Kuhn, J. (2018). Psychotherapy in the age of technology: the ethical challenges of online treatments for South African clinicians. *Psycho-analytic Psychotherapy in South Africa*, *26*(1), 30—53.

Kauer, S. D., Mangan, C., & Sanci, L. (2014). Do online mental health services improve help-seeking for young people? A systematic review. *Journal of Medical Internet Research*, *16*(3). DOI: 10.2196/jmir.3103

Keirl, S., (2015), 'Global ethics, sustainability, and Design and Technology Education', in Stables, K. & Keirl, S., (Eds.), (2015), Environment, Ethics and Cultures: Design and Technology Education's Contribution to Sustainable Global Futures, pp. 33—52, Sense, Rotterdam. Retrieved from: https://research.gold.ac.uk/20276/1/Keirl%202015%20Ethics%20Ch%20KSSK.pdf

Kendall, M., Fronek, P., Ungerer, G., Malt, J., Eugarde, E., & Geraghty, T. (2011). Assessing professional boundaries in clinical settings: The development of the boundaries in practice scale. *Ethics & Behavior*, *21*(6), 509—524. DOI: https://doi.org/10.1080/10508422.2011.622186

Kohlberg, L. (1971). Stages of moral development. *Moral Education*, *1*(51), 23-92. Retrieved from: http://ericmazur.net/wp-content/uploads/2018/11/Kohlberg-Moral-Development.pdf

Kozlowski, J. M., Pruitt, N. T., DeWalt, T. A., & Knox, S. (2014). Can boundary crossings in clinical supervision be beneficial?. *Counselling Psychology Quarterly*, *27*(2), 109—126. DOI: https://doi.org/10.1080/09515070.2013.870123

Krebs, D. L., & Denton, K. (2005). Toward a more pragmatic approach to morality: a critical evaluation of Kohlberg's model. *Psychological Review, 112*(3), 629—649. DOI: https://doi.org/10.1037/0033-295X.112.3.629

Lacan, J. (1967). *L'objet de la psychanalyse*. École pratique des hautes études, Section des sciences économiques et sociales. (unpublished typescript).

Lal, S., & Adair, C. E. (2014). E-mental health: a rapid review of the literature. *Psychiatric Services, 65*(1), 24—32. DOI: https://doi.org/10.1176/appi.ps.201300009

Lamas, E., Salinas, R., Coquedano, C., Simon, M. P., Bousquet, C., Ferrer, M., & Zorrilla, S. (2017). The meaning of patient empowerment in the digital age: the role of online patient-communities. *Studies in Health Technology and Information,* 244, 43—7. DOI:10.3233/978-1-61499-824-2-43

Langarizadeh, M., Tabatabaei, M. S., Tavakol, K., Naghipour, M., Rostami, A., & Moghbeli, F. (2017). Telemental health care, an effective alternative to conventional mental care: a systematic review. *Acta Informatica Medica*, *25*(4), 240—246. DOI: http://doi.org/10.5455/aim.2017.25.240-246

Lapidot-Lefler, N., & Barak, A. (2015). The benign online disinhibition effect: Could situational factors induce self-disclosure and prosocial behaviors?. *Cyberpsychology: Journal of Psychosocial Research on Cyberspace*, *9*(2), Article 3. DOI: https://doi.org/10.5817/CP2015-2-3

Latkin, C. A., Mai, N. V. T., Ha, T. V., Sripaipan, T., Zelaya, C., Le Minh, N., ... & Go, V. F. (2016). Social desirability response bias and other factors that may influence self-reports of substance use and HIV risk behaviors: a qualitative study of drug users in Vietnam. *AIDS Education and Prevention*, *28*(5), 417—425. DOI: https://doi.org/10.1521/aeap.2016.28.5.417

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, *2*(3), 21—35.
DOI: https://doi.org/10.1177/160940690300200303

Leenaars, A. A. (2009). Suicide prevention in Canada: a history of a community approach. *Canadian Journal of Community Mental Health*, *19*(2), 57—73.
DOI: https://doi.org/10.7870/cjcmh-2000-0015

Levitt, D., Farry, T., & Mazzarella, J. (2015). Counselor Ethical Reasoning: Decision-Making Practice Versus Theory. *Counseling and Values*, 60(1), 84—99. DOI 10.1002/j.2161-007X.2015.00062.x.

Levitt, H. M., Lu, E. C., Pomerville, A., & Surace, F. I. (2015). Pursuing the question of reflexivity in psychotherapy and qualitative methods: The contributions of David L. Rennie. *Counselling and Psychotherapy Research*, *15*(1), 3—11.
DOI: https://doi.org/10.1002/capr.12021

Library of Congress. (n.d.). *Sigmund Freud papers*. Retrieved from: https://www.loc.gov/collections/sigmund-freud-papers/about-this-collection/

Lloyd-Hazlett, J. & Foster, V. (2016). Student counselors' moral, intellectual and professional ethical identity development. *Counseling and Values, 62*, 90—105.
DOI: https://doi.org/10.1002/cvj.12051

Lusgarten, S.D. (2016). New threats to client privacy. *Monitor on Psychology: A Publication of the American Psychological Association, 47*(1), 66. Retrieved from: http://www.apa.org/monitor/2016/01/ce-corner.aspx

Lustgarten, S. D., & Colbow, A. J. (2017). Ethical concerns for telemental health therapy amidst governmental surveillance. *American Psychologist*, *72*(2), 159. DOI: https://doi.org/10.1037/a0040321

Ma, Y. (2015). Lacan on Gaze. *International Journal of Humanities and Social Science*, *5*(10), 1.

MacKinnon, L. (1993). Systems in settings: The therapist as power broker. *Australian and New Zealand Journal of Family Therapy*, *14*(3), 117—122. DOI: https://doi.org/10.1002/j.1467-8438.1993.tb00952.x

Madej, A., Sendler, D., & Makara-Studzińska, M. (2016). Online psychotherapy: A challenge for ethics, *Psychotherapia*, 3(178), 31—36. Retrieved from: http://www.psychoterapiaptp.pl/uploads/PT_3_2016/ENGver31Madej_Psychoterapia%203%202016.pdf

Matua, G., & Van, D. (2015). Differentiating between descriptive and interpretive phenomenological research approaches. Nurse Researcher, 22(6), 22—27. DOI: doi.org/10.7748/nr.22.6.22.e1344

May, H. (2010). *Aristotle's ethics: Moral development and human nature*. Bloomsbury Publishing.

May, D. R., Chang, Y. K., & Shao, R. (2015). Does ethical membership matter? Moral identification and its organizational implications. *Journal of Applied Psychology*, *100*(3), 681—694. DOI: https://doi.org/10.1037/a0038344

McCord, C. E., Saenz, J. J., Armstrong, T. W., & Elliott, T. R. (2015). Training the next generation of counseling psychologists in the practice of telepsychology. *Counselling Psychology Quarterly*, *28*(3), 324—344. DOI: https://doi.org/10.1080/09515070.2015.1053433

McLean, K. C., & Syed, M. (Eds.). (2014). *The Oxford handbook of identity development*. Oxford Library of Psychology, 11—25.

Mental Health Commission of Canada. (2014). E-mental health in Canada: Transforming the mental health system using technology (a briefing document). Retrieved from: https://www.mentalhealthcommission.ca/sites/default/files/MHCC_E-Mental_Health-Briefing_Document_ENG_0.pdf

Millham, M. H., & Atkin, D. (2018). Managing the virtual boundaries: Online social networks, disclosure, and privacy behaviors. *New Media & Society*, *20*(1), 50—67. DOI: https://doi.org/10.1177/1461444816654465

Ministry of Health and Long-Term Care. (2017, Dec. 21). New Psychotherapy Requirements to Support Patient Care and Safety. Retrieved from: http://www.health.gov.on.ca/en/news/bulletin/2017/hb_20171221.aspx

Mishna, F., Bogo, M., & Sawyer, J. L. (2015). Cyber counseling: Illuminating benefits and challenges. *Clinical Social Work Journal*, *43*(2), 169—178. DOI: https://doi.org/10.1007/s10615-013-0470-1

Moffett, L. A., Becker, C.-L. J., & Patton, R. G. (2014). Fostering the ethical sensitivity of beginning clinicians. *Training and Education in Professional Psychology*, 8(4), 229—235. DOI: https://doi.org/10.1037/tep0000054

Morse, J. (1991). Strategies for sampling. In Morse, J. M. *Qualitative nursing research: A contemporary dialogue* (pp. 127-145). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781483349015

Moss, J. M., Gibson, D. M., & Dollarhide, C. T. (2014). Professional identity development: A grounded theory of transformational tasks of counselors. *Journal of Counseling & Development*, *92*(1), 3—12. DOI: 10.1002/j.1556-6676.2014.00124.x

Moustakas, C. (1994). *Phenomenological research methods*. Sage.

Muzio, D., Faulconbridge, J., Gabbioneta, C., & Greenwood, R. (2016). Bad apples, bad barrels and bad cellars: A "boundaries" perspective on professional misconduct. In D. Palmer, K. Smith-Crowe, & R. Greenwood (Eds.), *Organizational Wrongdoing: Key Perspectives and New Directions,* Cambridge: Cambridge University Press, p. 141—175, Doi:10.1017/CBO9781316338827.007

National Suicide Prevention Lifeline (NSPL) (2017). Infographic. Retrieved from: https://suicidepreventionlifeline.org/wp-content/uploads/2017/06/AFSP-Hill-Day-2017-1-pager.pdf

O'Connor, P. (2019). Power in the Counseling Relationship: The Role of Ignorance. *Journal of Human Services: Training, Research, and Practice*, *4*(2), 3. Retrieved from: https://scholarworks.sfasu.edu/jhstrp/vol4/iss2/3

Office of the Surgeon General (US); National Action Alliance for Suicide Prevention (US). (2012). *National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention. Washington (DC): US Department of Health & Human Services (US); 2012 Sep. Appendix C, Brief History of Suicide Prevention in the United States*. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK109918/

Ostrowski, J., & Collins, T. P. (2016). A Comparison of Telemental Health Terminology Used Across Mental Health State Licensure Boards. *Professional Counselor: Research & Practice, 6*(4). DOI: 10.15241/jo.6.4.387

Padget, D.K. (2013). Chapter 9: Strategies for rigor. In Padgett, D. K. *Qualitative and mixed methods in public health* (pp. 203-220). Thousand Oaks, CA: SAGE Publications, Inc. DOI: 10.4135/9781483384511

Palesjö, C., Nordgren, L., & Asp, M. (2015). Being in a critical illness-recovery process: a phenomenological hermeneutical study. *Journal of Clinical Nursing*, *24*(23-24), 3494—3502. DOI: https://doi.org/10.1111/jocn.13002

Perle, J. G., Langsam, L. C., & Nierenberg, B. (2011). Controversy clarified: An updated review of clinical psychology and tele-health. *Clinical Psychology Review, 31*(8), 1247—1258. DOI:10.1016/j.cpr.2011.08.003

Pilarska, A. (2017). Effects of self-concept differentiation on sense of identity: The divided self revisited again. *Polish Psychological Bulletin, 48*(2), 255—263.

Prentice, J. L., & Dobson, K. S. (2014). A review of the risks and benefits associated with mobile phone applications for psychological interventions. *Canadian Psychology/Psychologie canadienne*, *55*(4), 282—290. DOI: https://doi.org/10.1037/a0038113

Rashotte, J., & Jensen, L. (2007). Validity in hermeneutic phenomenological inquiry: Towards an ethics of evaluation. *Canadian Journal of Nursing Research*, *39*(4), 94—115. Retrieved from: https://cjnr.archive.mcgill.ca/article/view/2093/2087

Ravitch, S. M., & Carl, N. M. (2015). *Qualitative research: Bridging the conceptual, theoretical, and methodological*. Sage Publications.

Recupero, P. R. (2005). E-mail and the psychiatrist-patient relationship. *Journal of the American Academy of Psychiatry and the Law Online*, *33*(4), 465—475. Retrieved from: https://pdfs.semanticscholar.org/e018/3a05ce0fb42bee1a643e3282d32f4479f10e.pdf

Regan, P. (2012). Hans-Georg Gadamer's philosophical hermeneutics: Concepts of reading, understanding and interpretation. *Meta: Research in hermeneutics, phenomenology, and practical philosophy*, *4*(2), 286—303. Retrieved from: http://metajournal.org/articles_pdf/286-303-regan-meta8-tehno-r1.pdf

Rubin, H. J., & Rubin, I. S. (2011). Qualitative interviewing: *The art of hearing data*. Sage.

Salmona, M., Lieber, E., & Kaczynski, D. (2019). *Qualitative and Mixed Methods Data Analysis Using Dedoose: A Practical Approach for Research Across the Social Sciences*. SAGE Publications, Incorporated.

Sanghvi, P., & Pandey, S. (2019). Ethical and Legal Constraints in Psychotherapy. *Journal of Psychosocial Research*, *14*(1). DOI: 10.32381/JPR.2019.14.01.2

Sánchez-Fernández, J., Muñoz-Leiva, F., Montoro-Ríos, F. J., & Ibáñez-Zapata, J. Á. (2010). An analysis of the effect of pre-incentives and post-incentives based on draws on response to web surveys. *Quality & Quantity*, *44*(2), 357—373. DOI: https://doi.org/10.1007/s11135-008-9197-4

Sansom-Daly, U. M., Wakefield, C. E., McGill, B. C., Wilson, H. L., & Patterson, P. (2016). Consensus among international ethical guidelines for the provision of videoconferencing-based mental health treatments. *Journal of Medical Internet Research, Mental Health*, *3*(2). DOI: 10.2196/mental.5481

Sartre, J. P., & Elkaïm-Sartre, A. (1943). *L'être et le néant: essai d'ontologie phénoménologique* (Vol. 56). Paris: Gallimard.

Schachter, J., & Kächele, H. (2010). The couch in psychoanalysis. *Contemporary Psychoanalysis*, *46*(3), 439—459. DOI: https://doi.org/10.1080/00107530.2010.10746071

Schore, A. N. (2001). Minds in the making: Attachment, the self-organizing brain, and developmentally-oriented psychoanalytic psychotherapy. *British Journal of Psychotherapy*, *17*(3), 299—328.

Searles, H. F. (2017). Concerning Transference and Countertransference. *Psychoanalytic Dialogues*, *27*(2), 192—210. DOI: https://doi.org/10.1080/10481885.2017.1285167

Sheehan, S. (2014). A conceptual framework for understanding transcendental phenomenology through the lived experiences of biblical leaders. *Emerging Leadership Journeys*, *7*(1), 10—20. Retrieved from: https://www.regent.edu/acad/global/publications/elj/vol7iss1/2ELJ-Sheehan.pdf

Shepler, D. K., Ho, M. A., Zoma, P. N., Bober, C. C., & Dluzynski, J. L. (2016). Perceptions of the therapist in a virtual world: An exploratory analog study. *The Humanistic Psychologist*, *44*(2), 164. DOI: http://dx.doi.org/10.1037/hum0000025

Sikora, K. (2017). Client welfare in psychologists' ethics codes. *Roczniki Psychologiczne/Annals of Psychology*, *16*(4), 603—616. Retrieved from: file:///Users/taliasinger/Downloads/477-Article%20Text-2695-1-10-20190404.pdf

Skountridaki, L. (2019). The patient–doctor relationship in the transnational healthcare context. *Sociology of Health & Illness*. 41(8), 1685—1705. DOI: https://doi.org/10.1111/1467-9566.12995

Sommers-Flanagan, J. (2015). Evidence-based relationship practice: Enhancing counselor competence. *Journal of Mental Health Counseling*, *37*(2), 95—108. DOI: https://doi.org/10.17744/mehc.37.2.g13472044600588r

Simpson, S., Richardson, L. K., & Pelling, N. (2015). Introduction to the Special Issue "telepsychology: Research and Practice". *Australian Psychologist, 50*(4), 249—251.

Sloan, A. & Bowe, Brian (2014). Phenomenology and hermeneutic phenomenology: the philosophy, the methodologies and using hermeneutic phenomenology to investigate lecturers' experiences of curriculum design. *Quality & Quantity*, 48(3), p.1291—1303. DOI:10.1111/ap.12146

Smith, R. T., & True, G. (2014). Warring identities: Identity conflict and the mental distress of American veterans of the wars in Iraq and Afghanistan. *Society and Mental Health*, *4*(2), 147—161. DOI: https://doi.org/10.1177/2156869313512212

Smythe, E., Hennessy, J., Abbott, M., & Hughes, F. (2018). Do professional boundaries limit trust?. *International Journal of Mental Health Nursing*, *27*(1), 287—295. DOI: https://doi.org/10.1111/inm.12319

Statistics Canada. (2014, November 19). Infographic: Internet use and e-commerce -Data for the 2012 Internet use survey. Retrieved from: https://www150.statcan.gc.ca/n1/pub/11-627-m/11-627-m2014003-eng.htm

Stets, J. & Burke, P. (2000). Identity theory and social identity theory. *Social Psychology Quarterly*, *63*(3), 224—237. DOI: 10.2307/2695870

Stryker, S. (1968). Identity Salience and Role Performance: The Relevance of Symbolic Interaction Theory for Family Research. *Journal of Marriage and Family*, *30*(4), 558—564. DOI:10.2307/349494

Stryker, S., & Serpe, R. T. (1982). Commitment, identity salience, and role behavior: Theory and research example. In *Personality, roles, and social behavior* (pp. 199—218). Springer, New York, NY.

Suler, J. (2004). The online disinhibition effect. *Cyberpsychology & Behavior*, 7(3), 321—326. DOI: https://doi.org/10.1089/1094931041291295

Tappin, B. M., & Capraro, V. (2018). Doing good vs. avoiding bad in prosocial choice: A refined test and extension of the morality preference hypothesis. *Journal of Experimental Social Psychology*, *79*, 64—70.

Tajfel. H. (1969) Cognitive aspects of prejudice. *Journal of Social Issues*, *25*(4), 79—97. DOI: https://doi.org/10.1017/S0021932000023336

Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. *The Social Psychology of Intergroup Relations*, *33*(47), 74.
Retrieved from: http://ark143.org/wordpress2/wp-content/uploads/2013/05/Tajfel-Turner-1979-An-Integrative-Theory-of-Intergroup-Conflict.pdf

Tracy, S. J., & Hinrichs, M. M. (2017). Big tent criteria for qualitative quality. *The International Encyclopedia of Communication Research Methods*, 1—10.
DOI: https://doi.org/10.1002/9781118901731.iecrm0016

Tarvydas, V., Vazquez-Ramos, R., & Estrada-Hernandez, N. (2015). Applied participatory ethics: Bridging the social justice chasm between counselor and client. *Counseling and Values*, *60*(2), 218—233.
DOI: https://doi.org/10.1002/cvj.12015

University of Toronto School of Continuing Studies. (2018). Foundations of Cybercounselling. Retrieved from: https://learn.utoronto.ca/interactive-course-search#/profile/3262

Valkenburg, P. M., & Peter, J. (2011). Online communication among adolescents: An integrated model of its attraction, opportunities, and risks. *Journal of Adolescent Health*, *48*(2), 121—127. DOI: https://doi.org/10.1016/j.jadohealth.2010.08.020

van Manen, M. (2016). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing*. Routledge, New York: New York.

Van Manen, M. (2017). Phenomenology in its original sense. *Qualitative Health Research*, 27(6), 810-825. DOI:10.1177/1049732317699381

Waterman, A. (2011). Chapter 16: Eudaimonic Identity Theory: Identity as Self-Discovery. In *Handbook of Identity Theory and Research*, Schwartz et al. (eds.). DOI 10.1007/978-1-4419-7988-9_20

Weatherford, P. C., Brooks, D., & Allred, L. B. (2016). Keeping up with the Times: Improving the Modern Counselor through Professional Identity Development, Technological Policy, and Positive Risk Taking. *Journal of Counseling and Psychology*, *1*(1), 2. Retrieved from: https://digitalcommons.gardner-webb.edu/cgi/viewcontent.cgi?article=1001&context=jcp

Williams, C. S. A. C., & Izaak, L. (2018). Practice-based conundrums and existentialist quandaries of a professional code of ethics. *Journal of Human Services: Training, Research, and Practice*, *3*(1), 1.

Retrieved from:
https://scholarworks.sfasu.edu/cgi/viewcontent.cgi?article=1028&context=jhstrp

Wilson, A. (2015). A guide to phenomenological research. *Nursing Standard (2014+), 29*(34), 38. DOI:10.7748/ns.29.34.38.e8821

Witt, K. J., Oliver, M., & McNichols, C. (2016). Counseling via avatar: Professional practice in virtual worlds. *International Journal for the Advancement of Counselling*, *38*(3), 218—236.
DOI: https://doi.org/10.1007/s10447-016-9269-4

Woo, H., Lu, J., Harris, C., & Cauley, B. (2017). Professional Identity Development in Counseling Professionals. *Counseling Outcome Research and Evaluation*, *8*(1), 15—30. DOI: https://doi.org/10.1080/03054985.2017.1297184

Wu, S., Lin, T. C., & Shih, J. F. (2017). Examining the antecedents of online disinhibition. *Information Technology & People*, *30*(1), 189—209.
Retrieved from:
https://tclin.mis.nsysu.edu.tw/paper/tclin/Examining%20the%20antecedents%20of%20online%20disinhibition.pdf

Yablon, C. M. (1995). Judicial Drag: An Essay on Wigs, Robes and Legal Change. *Wis. L. Rev.*, 1129.

Zur, Ofer. (2009). Power in Psychotherapy and Counseling: Exploring the "inherent power differential" and related myths about therapists' omnipotence and clients' vulnerability. *Independent Practitioner*. 29. 160-164.

Appendix A: Letter of Organizational Recruitment

University of Toronto, Factor-Inwentash Faculty of Social Work
Cyber Counselling Course, Therapy Online Providers

Date

Dear ___ :

This letter is a request for your assistance with a doctoral study I am conducting as part of my PhD in the Department of Psychology and Counselling at Walden University under the supervision of Dr. _____. The title of my study is "The Lived Experiences of Online Therapists Maintaining Ethical Boundaries" and explores the knowledge gap in the practical ethical dilemmas that arise for practitioners when working in a virtual treatment setting.

Knowledge from this study may help to address the lack of specificity in addressing ethical challenges in online practice standards, which in turn can improve practice and safety of both clinician and client in an online treatment setting.

I am hoping to invite potential participants and recruit 6-8 individuals who are enrolled or graduated from the Cyber Counselling course, are licensed health care workers in Ontario, and have been using online therapy modalities for a period of one year. This is phenomenological study that involves a 60-90 minute face-to-face interview and a potential 30 minute follow up meeting. Knowledge gained from these interviews will be shared with participants and stakeholders such as yourselves, and other community members with an interest in this topic.

For the intention of respecting privacy I do not intent to contact individuals directly, but rather, request permission to post a recruitment blurb with a link through your organizational email or website. My contact information will be contained in the blurb and any interested participants may contact me directly for more information on this study. Participation is completely voluntary and participants may terminate or revoke their contribution and association at any time. To further protect privacy, each participant will be given a pseudonym and will not be identified by any other characteristic such as age or gender directly in the study. Direct quotes will be used in support of the findings,

however, participants have the opportunity to review transcripts from the interviews and the final analysis in order to change any statement they wish.

If the University of Toronto, Factor-Inwentash Faculty of Social Work, or Therapy Online do not wish to be identified directly a pseudonym will be assigned (i.e. Educational Organization in Toronto). All field notes, transcripts, and consent forms will be kept in an online secured file with a double password. This file will be retained for 5 years and then destroyed. Only myself and my thesis advisor, Dr. R. Piferi at Walden University will have access to the original transcripts and any identifying information. This study has been vetted by the Internal Review Board at Walden University and any decision to participate is solely in the hands of the organization and their members.

Risks to participating in this study include provision of information that is included in the Mandatory Reporting Obligations covered by the College of Psychotherapists of Ontario. Any potential participants will be made aware of this potential risk in their recruitment and prior to the interview commencing.

It is my hope that the results of this doctoral research study can benefit your organization and the broader mental health practitioner community by providing evidence of practical experiences of ethical challenges in the online therapy environment and how to apply practice standards to the best of our abilities as practitioners.

If you have any questions regarding this study or would like additional information please do not hesitate to contact me at XXX-XXX-XXXX or by email at XXX@waldenu.edu. You may also contact my supervisor, Dr. X. XYZ by email ***[supervisor's email].***

I look forward to speaking with you further about your assistance with this project.
Yours sincerely,

XXX
Doctoral Candidate
Department of Psychology and Counseling
Walden University

Appendix B: Recruitment Blurb for Organizational Website

Attn: Registered Psychologists, Social Workers, Mental Health Nurses, and Psychotherapists registered in Ontario

Are you a licensed health professional providing psychotherapy online in Ontario? Do you have at least one year experience providing psychotherapy online? If so, you are invited to participate in a 60-90 minutes interview on your experience as an online therapists in maintaining ethical boundaries. This is a study in fulfillment of a PhD in Psychology and Counseling at Walden University. There is no compensation for this study. If you are interested in contributing your knowledge and experience, please contact XXX at XXX@waldenu.edu

Appendix C: Email Recruitment of Participant

Hello,

I am a PhD student working under the supervisions of Dr. X. in the Department of Psychology and Counseling, Social Psychology specialization at Walden University. I am recruiting participants for a study investigating the lived experiences of mental health professionals licensed in Ontario who are practicing online (in-part, or entirely).

To participate in this study you must be:

1. Registered with a licensed health profession in Ontario that is qualified to practice psychotherapy such as: a medical doctor, a mental health nurse, a registered psychotherapist, a registered social worker, or a clinical psychologist.
2. Have used online means to provide therapy and counselling for 1 year.

Study Involvement:

Participation entails meeting face to face for 60-90 minutes at a time, date, and location that works for you between the dates (m/d/y) to (m/d/y).
Tasks involve:

a. Reflecting on your experiences with online therapy and sharing only what you feel comfortable with me.
b. With your permission, the conversation will be recorded.
c. Reviewing the transcripts/analysis to ensure that your thoughts and experiences are conveyed accurately.

This study has been reviewed and received permission to proceed through the Walden University Institutional Review Board approval. Your participation is voluntary and may be discontinued or revoked at any time without penalty.

If you are interested in participating, please contact me at XXX@waldenu.edu and provide a date and time that is convenient for you. I will send you a confirmation email and provide more detailed information on the study.

Sincerely,

XX
Doctoral Candidate
Walden University

Appendix E: Interview Protocol

Using Bevan's (2014) interview structure, the following open-ended questions are divided into three sections:

Context

1. Describe the experience from your own point of view of practicing therapy in an online environment.
    a. Tell me more about what modes of online therapy you use and why.
    b. Describe to me your office set-up.
    c. What does the client see, hear, touch in their environment when they are in session with you?
    d. What do you see, hear, touch in your environment when you are in a session?

Modes of Appearing

2. Tell me what a typical encounter with an online client is like from beginning to end.

3. Describe your approach with maintaining boundaries with your online clients.
    a. What do you prepare ahead of time?
    b. How do you prepare for an emergency?
    c. How do you prepare for a technological malfunction?

4. Tell me about a typical boundary issue you may encounter.

5. Tell me about an atypical boundary issue you have encountered

6. Describe how it made you feel: physically, emotionally, and psychologically.

Clarifying the Phenomenon (Imaginative Variation)

In this section, the Boundaries in Practice Scale (BID) will be used to further expand on scenarios encountered in practice (Kendall et al., 2011).

7. Describe a particular example in detail and try to recall the details surrounding it such as where you were and how you were feeling, what you were seeing, or what you did as a result.
    a. How did you feel about your level of **knowledge** to approach this issue online in this scenario?
    b. How did you feel about your level of **comfort** to approach this issue online in this scenario?
    c. How did you feel about your resulting **ethical decision making** in approaching this issue online in this scenario?
    d. How did you feel about your level of **experience** in approaching this issue online in this scenario?

Summary Question

8. Describe how participating in this study makes you feel. Does this topic bring up any feelings or thoughts you wish to share?

Guiding References

Bevan, M. T. (2014). A method of phenomenological interviewing. *Qualitative Health Research,* *24*(1), 136-144. DOI: 10.1177/1049732313519710.

Kendall, M., Fronek, P., Ungerer, G., Malt, J., Eugarde, E., & Geraghty, T. (2011). Assessing professional boundaries in clinical settings: The development of the boundaries in practice scale. *Ethics & Behavior*, 21(6), 509-524.