# Patient-Targeted "Googling:" When Therapists Search for Information About Their Patients Online

Camila de Araujo Reinert and Clarice Kowacs

*Abstract:* The ubiquitous nature of the internet and of online social networking has created new opportunities but also challenges for the psychotherapist. Former notions of anonymity and privacy are now infeasible as a result of massive information sharing through electronic media. The clinical repercussions of these changes are being extensively debated, but issues involving patient privacy and anonymity have not been sufficiently explored. Although several aspects of the impact of the internet on therapeutic setting—such as the need for psychotherapists to exercise caution when making personal information available online—have been addressed in the literature, there has been comparatively little discussion on psychotherapists seeking information about their patients on the internet, a phenomenon known as "patient-targeted googling" (PTG).

*Keywords:* patient-targeted googling, psychoanalytical psychotherapy, social media, privacy, setting, boundary violations, enactment

Despite the growing incidence of this phenomenon, its potential impacts on treatment, and its ethical implications, research on PTG is scarce. The present study reviews the latest clinical data and proposes a discussion of the countertransferential aspects involved in such information-searching and of the possibility of virtual enactments. The authors also reflect on how the information obtained can interfere with the analytic field, focusing on cases in which PTG is done without the patient's knowledge or consent. The main limitations of this review are the still-incipient nature of the discussion on PTG and the scarcity of specific literature.

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The internet age is changing how we perceive ourselves, both as individuals and as a society. The digital revolution has changed the world, and this cannot be ignored: "The self has changed to a cyberself" (Gabbard, 2012; Turkle, 2012). As noted in a 2010 New York Times article, "the web means the end of forgetting" (Rosen, 2010). Traumas, triumphs, trip-ups, and everyday moments are no longer confined to an individual's past; conversely, they are on display for all to see, forever. In a world in which most people may be—and are actually expected to be—online around the clock, it is increasingly difficult to distinguish what is exclusively personal (Sisti, Caplan, & Hila, 2013). As psychoanalytical psychotherapists, we can no longer remain as mere spectators of the changes taking place in our traditional space: "All of us now leave a digital footprint" (Sfoggia et al., 2014). Search engines have altered the concepts of privacy, anonymity, and self-disclosure in the clinical setting. Even therapists who do not wish to expose themselves on social networking websites find that all sorts of information about their private lives are but a search away (Gabbard, Kassaw, & Perez-Garcia, 2011). They must learn to deal with the consequences of online exposure and virtual presence—whether voluntary or involuntary.

The availability of detailed personal and professional information at the click of a mouse has redefined anonymity and privacy for everyone (Gabbard et al., 2011). The internet has changed the practice of medicine. Both patients and physicians now routinely search for medical and personal information online. The use of social networks also appears to have become inevitably present in the relationship between therapists and patients, whether in psychoanalysis or psychoanalytical psychotherapy (Sfoggia et al., 2014). Searching for information about patients online, a practice known as patient-targeted googling (PTG), occurs amongst all medical specialties (Clinton, Silverman, & Brendel, 2010; Gabbard et al., 2011; Sisti et al., 2013). The present article will focus on specific aspects of online searching conducted in the patient's absence and without consent.

## CLINICAL DATA ON PATIENT-TARGETED GOOGLING (PTG)

Consistent with the trends toward ubiquitous internet use, the practice of PTG is becoming commonplace among the new generation of therapists who are used to using search engines and relationship websites as part of their daily lives (Clinton et al., 2010).

A study of 187 psychiatry residents recruited from the American Psychiatric Association mailing list revealed that 95% had active Facebook profiles, 9% had received friend requests from patients, and 18%

admitted to viewing patient profiles on Facebook. Reasons given for searching for patient data included curiosity, checking up on a patient who was missing sessions, follow-up after treatment termination, and looking for evidence of suicidal ideation (Ginory, Sabatier, & Eth, 2012).

Another U.S. study found that 81% of a sample of 302 psychology students (85% of whom were from different doctoral programs) reported using social media, while approximately 27% of psychotherapists and therapists in training had searched online for information about their patients (Lehavot, Barnett, & Powers, 2010).

In Germany, a recent study of 207 psychotherapists showed that 39.6% had already searched online for information about their patients and that an impressive two-thirds of those who had done so felt that PTG could play a positive role in treatment (Eichenberg & Herzberg, 2016).

Aiming to assess attitudes regarding the acceptability of PTG, a study questioned 854 U.S. and Canadian doctoral students and found that 766 (89%) had sought online information about patients at least once in the last year. Paradoxically, 522 of these 766 therapists (67%) stated that the practice is generally or universally unacceptable (DiLillo & Gale, 2011).

Therapists trained in psychoanalytical psychotherapy are more likely than cognitive-behavioral therapists to believe that PTG is not justifiable. As the practice of PTG is rarely ever discussed during training, these differences in attitude must reflect broader aspects of their positioning toward the therapeutic relationship, such as the concepts of therapeutic alliance, abstinence, and privacy (Eichenberg & Herzberg, 2016).

In their arguments against PTG, some therapists state that the bond of trust may be damaged and that patients must have the right to decide which information they are willing to share. Further, authors have called into question the real advantages of PTG and the real utility of information thus obtained (Eichenberg & Herzberg, 2016).

Psychotherapists in training are concerned with their ability to make ethical decisions involving patient contact through social networks, and less than half report feeling comfortable when making such decisions (Asay & Lal, 2014). However, discussion of this matter during training programs or in clinical supervision appears to be infrequent; there appears to be a gap in regulation of “whether” and “how” psychotherapists can use the internet to search for their patients’ digital footprints (Ashby et al., 2015). Therefore, psychotherapy training should include discussions on the dilemmas and potential boundary violations that are increasingly present in the daily routine of the therapist’s office due

to the influence of social networks and search engines (Gabbard et al., 2011).

The few clinical PTG examples found in the literature are mostly negative. Despite being rare, there are some situations where conducting PTG appears to be valid, like safeguarding vulnerable adults online, checking conflicting and falsified information, and clarifying delusional ideas (Ashby et al., 2015). One of those situations was found in the following vignette presented by Sfoggia and colleagues (2014). A psychotic patient who has been undergoing psychoanalytical psychotherapy for several years presents to a scheduled session in a highly disorganized, anxious state, expressing a mixture of idealization and shame in relation to his mother, whom he now claims was once a famous actress who appeared nude in some films. The therapist wonders whether to consider the patient's report as a psychotic symptom or acknowledge it as the disclosure of a family secret. After some reflection, the therapist confirms through PTG that the patient's report is true, affecting the therapist's treatment plan (Sfoggia et al., 2014).

## THE DUAL RELATIONSHIP ONLINE

The practice of PTG is particularly fraught with complications when it occurs in psychoanalytical psychotherapy, which is based primarily on the interpersonal relationship, and in which the concepts of transference and countertransference are key elements of treatment (Sisti et al., 2013). The possibility of professional boundary crossings or violations is always present, and maintaining such boundaries under different "extra-setting" circumstances is challenging. So-called extra-therapeutic contact has always occurred: accidentally running into a patient at a restaurant or social event, for instance. Such meetings, which are usually unexpected and sometimes embarrassing, must be dealt with in a manner that respects patient privacy and seeks to avoid ethical violations, such as breaches in confidentiality. These contacts trigger transferential and countertransferential experiences that invade the analytic field and mobilize the dyad, in different levels, at the moment and during upcoming sessions. We believe the same applies to virtual encounters and online searches for information. The ubiquity of the internet and the universal use of search engines such as Google have made it feasible for therapists to search for information on their patients without considering ethical concerns and the extent to which this practice can interfere with the professional relationship. The instantaneous nature of online information means that the therapist's action bypasses the filters of reflection and contemplation (Turkle, 2012); it takes far less

effort and pondering to look for a photo of a patient's house on Google Earth than to drive to his or her address—which would be indubitably considered a boundary violation (Clinton et al., 2010). Online activities dilute responsibility and lull the user into a false sense of security, insofar as the risk of being exposed or found out—during something that would clearly constitute a boundary violation "in real life"—is much lower on the web.

On the internet, there is essentially no latency between a desire and its fulfillment: "virtual milk gushes as soon as it is craved" (Kowacs, 2014). Such instantaneity, as noted above, may reinforce the omnipotent aspects of therapists, allowing them to invade the patient's life in a matter of seconds, whether driven by a conscious motivation to "help" or simply to sate his or her curiosity. We believe that, in many cases, the therapist feels a sense of ownership over the patient and, mirroring the parent–child relationship, cannot accept being shut out, which ultimately leads to spying on the patient through a virtual peephole.

By engaging in PTG rashly, therapists may obtain theretofore unknown information about patients and their family members. However, how can the therapist manage this information and store it in his or her mind in such a way as to prevent contamination of what is already known about the patient? Will the therapist hide this knowledge? Mention it to the patient? Or even confront the patient with information thus obtained? And how should the therapist act when the patient decides to share knowledge the therapist had already learned through PTG? Confess to prior knowledge of the facts and admit to how they were obtained? Feign ignorance or surprise, thus breaking the essential rule of being honest and truthful with the patient? These questions, which simply did not exist until recently, have deep-reaching technical and ethical implications that must be considered.

Generally, supervisors and advisors are "digital immigrants," and thus relatively inexperienced in matters of online reality. Ferro (2016) reveals a disturbing finding from surveys of psychoanalytic societies: the average age of their members is in the 70s. Conversely, their students and therapists in training are increasingly "digital natives" [i.e., born in the 1990s or later, as defined by Prensky (Prensky, 2001)]; this leads to divergences in opinion and concerns as to which guidance should be provided regarding their online behaviors (Sisti et al., 2013; Turkle, 2012).

Many digital immigrants still believe that staying away from the web is the best way of preventing disclosure of personal information. Even though ignorance of an individual's online presence does not mean that no such presence exists—and much information is available to patients with or without the therapist's consent (Gorrindo & Groves,

2008)—some psychotherapy instructors suggest that their psychotherapists in training cease all participation in blogs, social networks, and relationship websites. On the other hand, digital natives view this abstinence from web use as entirely infeasible. For the younger generation, having a digital identity not only serves a recreational purpose, but is an integral part of how one lives and connects with colleagues, family, and friends. This generational mismatch between supervisors as digital immigrants and trainees as digital natives creates difficulties for training programs to administer supervision and training on how to integrate the trainees' online presence with the development of their professional identities (Kolmes, 2012; Wester, Danforth, & Olle, 2013).

According to Gabbard, "The countertransference varies widely, but we are all anxious now about the invasion of our privacy. We worry that patients can find out where we live, how much we paid for our house, photos on Facebook, children, parents, and events in our lives that bring us shame. We may feel violated by the disappearance of analytic anonymity" (Gabbard et al., 2011).

The possibility of immediate access to information about therapists' private lives online can modify the characteristics of the therapeutic relationship and affect the therapeutic setting (Sfoggia et al., 2014).

Just as therapists are concerned when their privacy is invaded, so should they be concerned by the possibility of invading the privacy of their patients (Gorrindo & Groves, 2008). Digital immigrants involved in the training of psychotherapists should not only discuss ways of preserving anonymity and privacy in the clinical setting, but also be concerned with the anonymity and privacy of patients, with how to avoid situations of countertransference, and with how to identify and manage "virtual enactments." If interaction with patients in the "real world" is discussed and taught during therapist training, interactions taking place in the "virtual world" should receive the same attention and ways to identify and deal with virtual enactments should be looked for.

## VIRTUAL ENACTMENT

In a therapy session, a patient describes in detail his passion for the "perfect" woman, whom he eventually met after years of widowhood, including the frequent trips they take together, the sexual synchrony between them, and her beauty, refinement, and sensuality. The therapist becomes curious about the patient's girlfriend and, after a session, catches himself searching for her online under the pretext of knowing what she really looks like. This triggers him to feel envious and curious

and involves him in an Oedipal plot where the therapist is the third party excluded from an exciting and idealized relationship. He realizes that his dissatisfaction with his own marriage and the resulting feelings of failure make him vulnerable to this type of enactment.

Enactment, from a psychoanalytic point of view, is an unpredictable and inevitable phenomenon in which the psychotherapist and patient become involved in an unconscious pattern of interaction and communication: a pattern that must be set within a scene, as the patient is unable to express it otherwise (Bohleber et al., 2013). The therapist acts unwittingly, actualizing unconscious wishes for both himself or herself and the patient; further, the therapist's own insufficiently worked-out conflicts may not only predispose to the occurrence of enactments but also induce them (Bohleber et al., 2013).

We believe the online search for information often takes place as an "acting out" of a countertransferential experience that, instead of being recognized through a process of reflection, appears through this behavior, in what might be called virtual enactment. Enactment represents a rupture in the analyst's conscious experience of himself or herself; a deviation from the normal pattern of interpersonal experience (Bohleber et al., 2013). There is a certain pressure on the psychotherapist to act, which is neither perceived nor understood at the time of the action. The professional boundaries that delimit which behavior is adequate in the clinical setting are crossed; these crossings are generally benign, isolated, attenuated events, and tend to be examined by the therapist (Gabbard, 2005).

Although many authors regard enactment as a problem that should be avoided, it has long been understood as a common event in the patient–therapist relationship. Although revealing the occurrence of an online search may be necessary and beneficial in some situations, addressing enactment does not imply confessing to have sought information about patients online. However, there is broad agreement as to the importance of what follows an enactment, that is, it is most important that the enactment be identified and understood by the therapist, allowing further work by the therapeutic dyad.

A borderline patient with multiple acting-out behaviors and a history of lies threatened to self-mutilate and often reported suicidal thoughts. On a Friday night, he sent desperate messages to the therapist and finally sent a farewell message in the early morning, which his therapist read right after waking up. Subsequently, the patient "disappeared" and stopped answering phone calls. The therapist started to panic, because he had experienced suicidal threats from his depressed mother during his childhood, but he eventually searched for the patient online and found that he was alive and having fun with friends after express-

ing his anxiety and suffering to the therapist. The therapist understood that the patient made him experience the feeling of abandonment, which was what he (the patient) felt on weekends, when the therapist "disappeared" from the office. When confronted with the fact that he had disappeared because he felt angry and helpless, the patient admitted to having manipulated the therapist so as to take revenge for the "abandonment" and make the therapist remain concerned with him also on the weekend.

Acknowledgment of the enactment may allow the collusion to come undone (Cassorla, 2004): When properly identified, it provides clues as to what is happening within the dyad, allowing both therapist and patient to address difficult aspects related to the analytic field. Therefore, the therapeutic setting is continuously under threat and being rebuilt; it is this dynamic that allows the analytical process to progress (Kowacs, 2014).

When the act of seeking information about patients online occurs repetitively and with different patients and is clearly harmful to the patients but gratifying to the therapist, it may represent a boundary violation by the psychotherapist. Boundary violations, unlike enactments and boundary crossing, seek to fulfill the therapist's unconscious needs and desires, and the therapist tends to discourage any discussion of the matter. Therapists who engage in a boundary violation exploit the patient's emotional vulnerability, actively or deliberately ignoring the patient's subjectivity as a patient, as they unconsciously or purposely transform the patient into an object, completely nullifying consciousness of the patient's distinct needs (Slochower, 2010). Violations should not be viewed as a pattern of communication, but rather as a harmful breakdown of the trust between therapist and patient (Gabbard, 2005).

According to Brown, appropriate boundaries in therapy are a reflection of race, class, culture, setting, and most importantly, the specific and unique relation between the dyad. A boundary that works and facilitates treatment with one patient may be experienced as invasive by another, or as cold and punitive by a third. Brown proposes a way to reduce risks for boundary violations by understanding three characteristics of a violation and then learning to ask whether those characteristics are present in a particular instance: (1) the client is "objectified"; (2) the therapist's impulses are gratified through the behavior; and (3) the needs of the therapist are made paramount over those of the client (Brown, 1994).

Psychotherapists must be willing to forgo self-gratification in the interest of helping their patients. During this honest assessment of his or her own desire to seek out information about a patient, the psychotherapist may be faced with inner curiosities and voyeuristic interests,

which, instead of being fulfilled, should be addressed during the therapist's own personal psychotherapy and clinical supervision (Clinton et al., 2010), to prevent clinical errors and ethical misconduct that might cause harm to the patient. Remaining within the professional boundaries of the therapeutic relationship creates an atmosphere of security and predictability that helps patients benefit from treatment (Gabbard, 2005).

## RECOMMENDATIONS REGARDING PTG

Curricula should be updated to promote understanding of professionalism online and potential therapeutic boundary issues (Gabbard et al., 2011), emphasizing principles and concepts rather than the use of specific internet tools (DeJong et al., 2012). In regard to recommendations for developing formal training and how to make ethical decisions, psychotherapy training should include (DeJong et al., 2012; DiLillo & Gale, 2011):

1. Discussion of clinical dilemmas. Discuss vignettes familiar to the residents' experience, encourage open discussion of cases that include liability, confidentiality, privacy, libel, and defamation.
2. Clinical supervision. Help think through a decision-making process while it is happening; supervisors shouldn't assume that trainees can recognize professionalism issues but should make them explicit in case discussion.
3. Development of policies for professional use of social media. Institutional guidelines provide references through codes of ethics and offer recommendations for maintaining a professional online identity.

Clinton proposed a framework to assist in decision-making regarding PTG (Clinton et al., 2010). It consists of six questions the therapist should ask to reflect on his or her potential action, always considering whether to obtain consultation or supervision:

## FINAL CONSIDERATIONS

The internet has become an integral part of our daily lives, and the debate on the issue of extra-therapeutic contact online can no longer be postponed. The practice of patient-targeted googling has become wide-

| QUESTION | REFLECTION |
|---|---|
| 1. Why do I want to conduct this search? | If it is for curiosity, voyeurism, prurient interest, or exploitation—do not go forward. |
| 2. Would my search advance or compromise the treatment? | If another approach or strategy (e.g., talking with a patient's family member) might achieve the desired benefits—do not go forward (only googling when there is no other option). |
| 3. Should I obtain informed consent from the patient prior to searching? | Discuss the risks, including breaches of patient privacy and the potential for harm to the psychotherapeutic relationship. |
| 4. Should I share the results of the search with the patient? | Consider benefits and burdens of sharing and the effects on the psychotherapeutic relationship. |
| 5. Should I document the findings of the search in the medical record? | In general, psychiatrists should aim to document all relevant clinical data in the record accurately. |
| 6. How do I monitor my motivations and the ongoing risk-benefit profile of searching? | Reflect continually on your own needs, desires, drives, and emotions. |

*Note*. Adapted from Clinton et al., 2010.

spread among therapists worldwide, and the ethical issues involved must be discussed wherever psychotherapists are trained. The objective should be to preserve the therapeutic setting, regardless of whether the psychotherapist is in a real space or in a virtual one.

Challenges may appear when professors are less skillful at fully understanding the use of the internet and online social networking, while trainees may be less aware about the crafting of one's professional identity. The authors think it is as important to develop formal training on how to make ethical decisions online and how to manage an online presence as it is to teach students how to manage transference, countertransference, and boundaries issues that appear in the clinical setting.

This topic must be addressed in greater depth and with a cautious stance before therapists can answer the question, "Should I google my patient?" with certainty and on firm scientific footing, so as to preserve the confidentiality of patient, the setting, and good therapeutic practices.

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