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Patient-Targeted Googling: A Mixed-Methods Examination of Psychologists' Perceptions and Practices

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by

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ABSTRACT

PATIENT-TARGETED GOOGLING: A MIXED-METHODS EXAMINATION OF PSYCHOLOGISTS' PERCEPTIONS AND PRACTICES

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Patient-targeted Googling (PTG) refers to a healthcare professional searching their patient's name or other identifying information on the Internet. Existing research is inconclusive regarding the prevalence and perceptions of PTG among psychologists, and the American Psychological Association (APA) Ethics Code lacks guidance on the topic. The present study used a mixed-methods approach with two arms of data collection (online survey, $N = 94$; and virtual focus groups, $N = 36$) to clarify PTG practices, explore PTG attitudes, and understand training and ethical guidance needs of psychologists and psychology trainees. Results revealed that 47.9% of psychologists and trainees reported having engaged in PTG. A thematic analysis revealed that PTG is used rarely and situationally, and PTG is more commonly used with forensic populations and in emergency rooms. Approximately half (52.1%) of psychologists and trainees reported that they do not perceive PTG as ethical. However, more agreed that it is ethical in emergency situations (59.6%) than for routine matters (7.5%) supporting that perceptions of the ethicality of PTG change on a case-by-case basis. Psychologists and trainees identified some clinical benefits of PTG, including for use in emergencies, information gathering, and avoiding dual relationships. They identified many detriments of PTG including breaching client rights, negatively impacting the therapeutic relationship, and crossing professional boundaries. Half (50.0%) of psychologists and trainees reported no prior PTG training. Existing PTG training and

guidance were described as minimal and often taking an abstinence approach. However, psychologists and trainees perceived nuanced training as more helpful. A majority (80.9%) were in favor of receiving PTG guidance from APA in the upcoming version of the APA Ethics Code. The study also tested associations among PTG practices and attitudes and personal determinants of moral agency through the lens of Social Cognitive Theory. PTG practices and attitudes were found to be unrelated to moral disengagement, empathy, and moral identity. However, males reported more PTG and more liberal PTG attitudes than females. Recommendations include a call for ethical and practical guidance from APA, increased PTG discourse and training, and a consistent PTG definition and more accurate terminology, such as “patient-targeted browsing.”

This dissertation is dedicated to the love of my life, Sebastian, who has provided me unwavering support throughout the entirety of my graduate studies. He is always available to answer my questions, sit next to me while I work, and wipe my tears.

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INTRODUCTION

In season four of the popular drama television series "This Is Us," 40-year-old Randall Pearson hesitantly attends his first psychotherapy session. Being city councilman in Philadelphia, there is plenty of readily available press on the Internet about Randall's campaign, his family, and various decisions he has made as a local politician. Nearing the end of his second session, Randall begins to share about his relationships with his late fathers, William and Jack, when his therapist cuts him short and reveals that she already knows about his upbringing. Already skeptical of therapy and feeling betrayed Randall states, "You broke the rules."

This scenario highlights an important change in the psychologist-client relationship in the digital age. The Internet has introduced many new ways for psychologists to communicate with clients and have relationships with them outside of clinical settings. Like in Randall's situation, the Internet also offers new avenues for psychologists to obtain information about their clients. Patient-targeted Googling (PTG) is a term used to describe any behavior in which healthcare professionals search on the Internet with the goal of obtaining information about their clients (Thabrew et al., 2018). Though the term refers to "Googling," Frampton and Fox (2021) describe this as a misnomer since PTG can be done using any search engines, social networking sites (SNS), or other avenues for searching an individual's name on the Internet. PTG can lead to obtaining a variety of information about clients including, but not limited to, employment history, criminal history, personal information, group involvement, and social media activity. Macauley et al. (2021) point out that PTG can generate information either directly from the patient via their own posts, blogs, or websites or from third-party sources via others' posts, blogs, news articles, or websites. The accessibility, validity, and clinical relevance of such information available on the Internet about any given individual varies, and the ethicality of the

behavior is also in question. Zur (2010) defines PTG as a group of behaviors that can lie on a spectrum from acceptable to criminal cyberstalking.

PTG is largely undiscussed in psychology training programs, and the American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct (henceforth referred to as the APA Ethics Code; 2017) lacks guidance on the topic. There has been limited empirical research specific to psychologists on the topic of PTG, and most PTG research is descriptive or conceptual in nature; thus, the present study aims to achieve the following among clinical and counseling psychologists and trainees: 1) clarify current PTG practices, 2) explore PTG attitudes, 3) understand training and ethical guidance needs, and 4) examine the relationship between personal determinants of moral agency and PTG using a social cognitive framework.

Existing PTG Research

Research on the Internet's impact on psychotherapy initially focused on online privacy of therapists or therapist-targeted Googling (TTG; Barnett, 2010; Kolmes, 2010; Zur et al., 2009) and on the ethical and clinical considerations surrounding client-therapist online interactions (e.g., email, instant messaging, social media; Belkofer & McNutt, 2011; Kolmes, 2010; Lehavot, 2009; Zur et al., 2009). In a sample of therapy clients, Eichenberg and Sawyer (2016) found that 44.5% of a sample of therapy clients ($N = 238$) reported having searched for information about their therapists on the Internet. The most common justification provided was to get to know the therapist better, and TTG was found to be associated with phases of treatment in which the client felt progress had ceased. Most clients found no information on their therapist and refrained from telling their therapist about the search. However, it is a common perspective among practitioners that it is the client's right as a consumer to research their provider online (Scarton, 2010).

Regarding social media interactions with clients, there is a consensus in the literature that psychologists should not friend, follow, or elicit communication with clients on a SNS to avoid breaching client confidentiality and privacy or engaging in multiple relationships (Dike et al., 2019; Kolmes, 2010; Zur, 2010). It is also now common practice that clinicians have policies prohibiting social media interaction with current and previous clients (Kolmes, 2012). However, PTG is a much less commented on and researched topic. Early commentaries suggest an attitude discrepancy as some describe PTG as a way to find clinically useful information about clients and gain greater insight into their lives (Barnett, 2010; Neimark et al., 2006) where others argue that PTG is a questionable practice that comes with a laundry list of ethical dilemmas (Kolmes, 2010; Kolmes & Taube, 2010; Zur, 2010). Empirical research on the topic of PTG prior to the onset of the COVID-19 pandemic was extremely limited, and the majority of the literature at that time was conceptual, providing clinical case scenarios and commentary on the potential benefits and pitfalls of PTG. Though still limited, an influx of articles on the topic of PTG were published in 2021 while the current study was being conducted, including a narrative review of the PTG research about psychotherapists (Cox et al., 2021). Researcher interest in TTG continues today as the ease of online searching has likely altered both client and provider expectations of privacy. Trub and Magaldi (2021) found that in general, many therapists engage in PTG and believe that their clients engage in TTG, creating an air of secrecy in the therapeutic relationship. PTG articles published in 2021 largely focused on the inconsistent operationalization of PTG, identifying practices and clinician perceptions of ethicality, and further discussing specific ethical considerations as discussed below (Framptom & Fox, 2021; Macauley et al., 2021; Wu & Sonne, 2021).

Prevalence of PTG

The rate of PTG among practitioners remains unclear. For example, Lehavot et al. (2010) found that 27% of psychology doctoral students reported engaging in PTG. This finding was supported by Asay and Lal (2014) who found that 25.6% of a psychology graduate student sample had engaged in PTG. However, DiLillo and Gale (2011) found that almost an entire sample of doctoral psychology students had engaged in PTG (97.8%). This finding was similar to Gershengoren (2018), who found that 93% of psychiatrists and 94% of psychiatry residents reported engagement in PTG. In another sample of psychotherapists with varied educational backgrounds, about half (53.4%) reported engaging in PTG, but only 10.3% of the sample reported having ever received any education or training surrounding PTG (Thabrew et al., 2018). Most recently, it was found that 48.4% of a sample of licensed psychologists reported that they had engaged in PTG (Wu & Sonne, 2021). A recent review of the literature on psychological therapists' engagement in PTG, which included some of the aforementioned articles, found prevalence rates that ranged from 20% to 98% (Cox et al., 2021).

With no validated measure of PTG, it is possible that participants of PTG studies are being asked to report on slightly different behaviors or have misunderstood the behaviors they were being asked about. For instance, clinicians may be indicating that they search for information about their clients' symptoms or diagnoses as opposed to PTG, which refers to entering their clients' names into a search engine. Frampton and Fox (2021) discuss how little effort has been applied towards clarifying and conceptualizing online information seeking behaviors. Though PTG is becoming a more widespread term used by researchers in the fields of Psychology and Medicine, the literature includes different interpretations of what exactly constitutes PTG, sometimes even within the same article. For example, some articles define PTG

as “gathering information about patients using Google” but later broaden the definition to using social media sites as well. Frampton and Fox (2021) opine that the inclusion of “Googling” in the term confounds its meaning, which generally refers to the more general practice of online searching not specific to Google. The inclusion of the word “patient” may also be problematic and confusing with many psychologists referring to their customers as “clients.” Without conceptual clarity and consistent operationalization, rates of PTG remain inconsistent and unclear (Cox et al., 2021). Other limitations include that the literature has disproportionately examined the practices of graduate students or those very early in their career and has largely been conducted in the U.S. (Cox et al., 2021). Overall, the literature indicates that many clinicians are engaging in PTG with little to no education or professional guidance.

Varied PTG Practices and Attitudes

To inform field-wide ethical guidelines and expectations surrounding PTG, it is important to consider the existing complex and varied practices and perceptions among psychologists and psychology trainees. The complete array of motivators that psychologists have for engaging in PTG remain unclear, and even more unclear are which motivators may ethically justify the act (e.g., crisis/emergencies, severity of diagnosis). In a sample of U.S. psychiatry residents, many justifications were reported for viewing a client’s Facebook profile, including intrinsically motivated reasons such as curiosity and habit, as well as extrinsically motivated, clinically focused reasons such as checking on a patient who had missed sessions, following-up after termination, and seeking evidence of suicidality in at-risk clients (Ginory et al., 2012). Gershengoren (2018) found that curiosity and obtaining information for client care were the reasons provided most often by a sample of psychiatrists with the least common reason being that the patient requested them to do the search. Cox et al., (2021) identified the most common

motivators identified in the PTG literature as curiosity, to gather new information, and to verify existing information. Macauley et al., (2021) identified PTG motivators for pediatricians including a desire to understand more about their patients, gauging patient adherence to a treatment plan, curiosity, voyeurism, and habit. It also appears that clinical setting may influence PTG practices and attitudes. Gershengoren (2018) found that psychiatrists were most likely to engage in PTG in psychiatric emergency room, psychiatric inpatient, and private practice settings compared to outpatient clinics and consultation/liaison service settings. Hamm (2021) suggests that PTG may be most common in emergency psychology where obtaining collateral information is often necessary when patients are involuntarily hospitalized or are unable or unwilling to provide information due to their mental state. Overall, the effect of practice setting on PTG needs more research.

It is also important to consider informed consent processes, psychologist-client transparency regarding the information obtained as a result of PTG, and documentation procedures. In Gershengoren (2018), the majority of the sample indicated “rarely” or “never” when asked if they discuss their searches with their clients suggesting that client informed consent is often not being obtained. This finding was supported in a similar study, in which 83.8% of counseling and psychology students who reported engagement in PTG indicated that they never obtained informed consent prior to their search (Harris & Robinson Kurpius, 2014). A review of PTG literature found rates of engaging in PTG without client consent ranging from 60% to 84% (Cox et al., 2021). However, in DiLillo and Gale (2011), 82% of the participants who reported engagement in PTG also reported that their clients were aware of the searches, but no information was collected regarding whether they were made aware of the search before or after PTG occurred. Regarding documentation, research suggests that clinicians tend not to

document their PTG or the information obtained from their searches. In a sample of counseling and psychology graduate students, one study found that 86.5% who reported engagement in PTG indicated that they did not document their searches in client files (Harris & Robinson Kurpius, 2014). Overall, there is limited information provided about informed consent, transparency, and documentation as it relates to PTG (Clinton et al., 2010; McNary, 2014). These topics require further discussion and research.

Research suggests that clinicians hold varied attitudes regarding whether PTG is ethical, unethical, beneficial, or detrimental to care. In a sample of German psychotherapists, 39.6% reported engagement in PTG, and two-thirds of the sample reported that the information obtained through PTG could play a positive role in treatment (Eichenberg & Herzberg, 2016). Wu and Sonne (2021) found that 31% of a sample of licensed psychologists rated PTG as "unquestionably unethical," 48.4% rated PTG as "ethical under rare circumstances," and 10.3% reported being "not sure" about the ethicality of PTG. In the same study, frequency of engagement in PTG did not predict ethicality ratings, indicating a mismatch between practices and perceptions. This mismatch can be seen in other samples. In a sample of U.S. and Canadian doctoral psychology students where almost the entire sample (97.8%) reported engagement in PTG, a majority (67%) also reported that they perceive the practice as "unacceptable" (DiLillo & Gale, 2011). These paradoxical findings provide further evidence that behaviors and attitudes surrounding PTG vary greatly with some perceiving PTG as beneficial to treatment with others defining PTG as an unacceptable behavior. In summary, the literature suggests that clinicians are engaging in PTG with little to no training, and many clinicians have not thought carefully through the associated clinical, ethical, or legal implications (Eichenberg & Herzberg, 2016).

This sheds light on the importance of providing training and specific ethical guidelines regarding seeking online information about clients.

Potential Benefits and Detriments of PTG

The Internet undoubtedly creates opportunities for clinicians, but it also creates potential dilemmas (Macauley et al., 2021). Specifically, PTG poses many potential benefits and detriments to psychologists, the services they provide, and their clients. Thus, it is important to consider the pros and cons of PTG to inform ethical guidelines.

Potential Benefits of PTG

A long-term client with severe depression has weekly therapy appointments with a clinical psychologist. The client has shared that she regularly posts about her feelings and her experience with mental illness on her Facebook and Twitter profiles. With this information, the psychologist begins to check the client's Facebook profile between sessions. One day, the psychologist comes across recent posts that describe self-harm behaviors and suicidal thoughts. The client is immediately called to come in for a session that day so that a thorough risk assessment can be conducted. The assessment confirmed that the client was actively suicidal, and she was able to receive the appropriate care.

This case example modified from Ashby et al. (2015) demonstrates how PTG can be beneficial to treatment and clients' wellbeing in certain situations. Potential benefits of PTG include providing collateral client information (particularly in emergency situations and situations that involve client risk/safety), safeguarding vulnerable clients, and building rapport with younger clients.

The Internet as a Collateral Informant. Dike et al. (2019) argue that online data can be a useful supplement to information disclosed by the client in certain scenarios. For example,

Ashby et al. (2015) discuss how the Internet can act as a form of additional history to verify whether disclosures provided by a client who experiences manic episodes are delusions of grandeur or representative of reality. Further, as depicted in the previous case example, social media can be a helpful tool to uncover risk behaviors, track symptoms, and generally monitor the mental health of clients (Ashby et al., 2015). The practice of using Internet data to inform client care has expanded beyond Google searches. Fisher and Applebaum (2017) discuss that mental health professionals (academics and those in the private sector) are beginning to develop applications to collect patient information for clinical purposes. Electronic activities including communications (e.g., emails, texts), metadata about communications (e.g., times, frequencies of communication), Internet browsing/search behavior, location data through GPS tracking, and proximity to others through wireless connection tracking are all examples of the types of data that can be collected via applications as collateral client information. The authors discuss how these data can be useful when clients omit or misrepresent information about their personal history or minimize the severity of their symptoms in session for impression management purposes. Other benefits, such as uncovering problems or addictions directly related to the Internet (e.g., gambling, pornography, gaming) or using natural language processing (NLP) to predict a variety of clinical concerns (e.g., depression, schizophrenia, suicidality; Cheng et al., 2017; Coppersmith et al., 2018; Mitchell et al., 2015; Tadesse et al., 2019) are also mentioned. However, there are no guidelines or best-practice recommendations for obtaining and using such information. Fisher and Applebaum (2017) discuss risks associated with using applications to gather client data similar to those related to PTG, which include the accuracy of the data, the effectiveness/impact on treatment, the time and cost associated with obtaining and reviewing the data, breaching client privacy, and crossing boundaries of the therapeutic relationship. The

American Psychiatric Association (2017) recommends relying on more legitimate sources of online information such as birth records or criminal records instead of less legitimate sources of information such as news articles, popular press articles, blogs, or social media pages. Additionally, they state that online information should always be corroborated by a more legitimate source before being used to inform treatment or added to a patient's medical record.

Emergencies and Client Safety. Another apparent benefit of PTG is that it presents a way to obtain client information in emergency situations. Neimark et al. (2006) were among the first to describe the Internet as a helpful collateral informant in emergencies and situations where client safety is a concern. For example, in the case of an unresponsive client (e.g., catatonic, unconscious), PTG may prove helpful in finding necessary information such as a client's next of kin (Deen et al., 2013). As depicted in the earlier case example, PTG may also be a beneficial in the case that a client posts content online that suggests suicidal or homicidal ideation. Another example is engaging in PTG to confirm a suspected relapse of a client with Substance Use Disorder in order to ensure the client is receiving the appropriate care (Ashby et al., 2015). Dike et al. (2019) argues that such emergency situations or high-risk clients may necessitate and justify PTG but recommends that PTG cease once the information being sought is obtained.

Since PTG may be beneficial in situations where client safety is a concern, Dike et al. (2019) emphasizes that clinicians be aware of the mandated reporting laws in their state or region of practice. There may be instances where PTG results in clinician knowledge of abuse and/or neglect of minors, elderly individuals, or individuals with disabilities for which clinicians are mandated reporters. For example, if a clinician finds that someone is posting pornographic photos of a minor client online, the clinician has the ethical and legal obligation to report this information (Clinton et al., 2012). It is important that clinicians are cognizant of all the potential

ethical and legal consequences involved in obtaining such sensitive information online. The informed consent process provides an opportunity for clinicians to outline and discuss with clients how they will handle instances of finding information on the Internet that by law requires a breach in confidentiality.

Safeguarding Vulnerable Clients. Online searches may be beneficial in protecting vulnerable clients from abuse, manipulation, or cyberbullying online. Ashby et al. (2015) provides the example of a hospitalized client with paranoid schizophrenia who finds it frustrating that nobody believes what he writes about on his blog. With consent, the client's blog is used not only to provide information about the development and content of his delusional thoughts, but his care team is also able to consult the client about removing blog posts that include sensitive, personal information (i.e., home address, social security number) that make him vulnerable to other web users. In another example, a client with an eating disorder discusses giving and receiving weight-loss encouragement to and from others in social media groups and online chat forums. For more holistic recovery, the clinician views the dialogue in order to help the client weigh the pros and cons of engaging in such online groups and conversations that may adversely affect treatment progress. These examples exemplify situations in which a clients' online presence may be used by psychologists to help to safeguard vulnerable individuals and potentially assess their risk to others as well (Ashby et al., 2015).

Building Rapport with Young Clients. Just as psychologists hold different views on PTG, clients also embrace different perspectives regarding clinicians viewing their online presence (Wilkinson & Thelwall, 2011). Some clients may want or even expect their clinician to put the thought and effort into looking them up online, especially younger clients (Dike et al., 2019). Some adolescents and young adults may appreciate that their psychologist has viewed

their social media posts, which can help to build rapport (Asay & Lal, 2014), and research supports that clinician Internet and social media literacy are correlated with strong therapeutic alliance with teen clients (Meyers, 2018). Tunick et al. (2011) discuss how PTG sometimes occurs at the request of child and adolescent clients who want their therapist to see their social media profiles. However, psychologists should remain cognizant of appropriate therapeutic boundaries in the light of these requests. Though some clients may react neutrally or positively to PTG, there is consensus in the literature that clinicians should ponder the possible risks and benefits of the search in all scenarios (Clinton et al., 2010; Dike et al., 2019; Harris & Robinson Kurpius, 2014; Kuhnel, 2018).

Potential Detriments of PTG

A client shares with his therapist that he is struggling financially. He begins deferring payments and accrues a large bill. Skeptical of the client's inability to pay, the therapist decides to search for the client's address on Google maps and discovers that he lives in a mansion in a very wealthy neighborhood. In the next session, the therapist confronts the client about this discrepancy, and the client reveals that he rents a small room in the home in exchange for performing manual labor on the property. After this exchange, the client decides to search for another provider.

This case example modified from Clinton et al. (2010) highlights a situation in which PTG was harmful to treatment. Certain factors, such as engaging in PTG without client knowledge and/or consent or doing so without a clinically or therapeutically relevant reason may heighten the ethical ambiguity of PTG and increase its detrimental potential (Wu & Sonne, 2021). Potential detriments of PTG include breaches of client privacy and confidentiality,

discrimination, professional boundary crossing, quality of online data, adverse impacts on the therapeutic relationship, and emerging third party practices.

Client Privacy and Confidentiality. Of the ethical concerns related to PTG, client confidentiality and privacy are at the forefront. APA Ethics Code standard *3.10 Informed Consent* from the Human Relations section and standard *4.04 Minimizing Intrusions on Privacy* from the Privacy and Confidentiality section are particularly relevant (APA, 2017). If client informed consent to conduct PTG is not received, the psychologist may not be upholding their professional obligation to obtain informed consent from their client in all of their procedures, and depending on the rationale for the search, PTG may be an unnecessary intrusion on client privacy.

The Health Insurance Portability and Accountability Act (HIPAA) protects individuals from the misuse of their private health information by healthcare providers. However, PTG is not explicitly addressed in HIPAA because HIPAA was enacted in 1996 before the existence of Google and social media (Fitz, 2020). Some argue that healthcare providers have the right to review information online because it is in the public domain (Geppert, 2017). However, others argue that the act of typing a patient's name into a search engine or SNS is in itself a violation of HIPAA because it breaches confidentiality and abuses knowledge obtained from a patient record or relationship. Further, the information gained from the search may be a violation of privacy because the information was not provided directly by the patient who may perceive the online information as private (Fitz, 2020).

The impact of PTG may depend heavily on the informed consent process (Ginory & Sabatier, 2012; Gabbard et al., 2011). One theme of the PTG literature is that many clinicians engaging in PTG fail to disclose the search or the information gained from the search to their

clients (Ben-Yakov et al., 2015). When a client does not consent to PTG prior to the search, this may be perceived as a clear invasion of privacy and damage client trust (Clinton et al., 2010; Dike et al., 2019; Gershengoren, 2018). This was depicted in the previously discussed case scenario when the therapist failed to discuss PTG with the client prior to the search. Thus, it may be vital that psychologists be transparent with clients about their search prior to PTG to prevent violating client privacy and trust, and some commenters argue that PTG should be included in the informed consent process (Kolmes, 2012; Zur, 2010). Dike et al. (2019) also argue that exceptions to confidentiality as they apply to PTG should also be discussed in the informed consent process to prepare for instances where PTG leads to information that by law requires a breach in confidentiality.

Justice and Discrimination. PTG may lead to discrimination in some instances. One of the general principles in the APA Ethics Code is *Justice*, which describes how psychologists should aim to recognize that all individuals are entitled to equal quality in the processes, procedures, and services conducted by psychologists (APA, 2017). However, some have argued that PTG violates a patient's right to justice (Fitz, 2020). For example, it may be that a clinician is only engaging in PTG with certain clients (e.g., criminals, women), which does not uphold clients' entitlement to equal quality in the process and procedures of their treatment. A standard of care recommendation is to search every client on the Internet for clinically relevant information or to search no clients in order to uphold the principle of *Justice* (Fitz, 2020).

Crossing Professional Boundaries. Applebaum and Kopelman (2014) discuss how the Internet has blurred professional boundaries, which poses ethical challenges for psychologists. There is consensus in the field of psychology that sending or accepting a friend request from a client on a SNS crosses an ethical boundary (Dike et al., 2019). However, the ethical and

professional boundary crossing in PTG is currently more ambiguous. Boundary crossing may depend on the rationale for the search. The American Psychiatric Association (2017) warns that PTG without a well-articulated clinical rational has a high likelihood of crossing professional boundaries, which adversely impacts the therapeutic relationship. In a sample of students in counseling and psychology graduate programs, Harris and Robinson Kurpius (2014) found that curiosity was the most commonly reported justification for PTG. Such PTG with weak or no clinical rationale crosses ethical and professional boundaries based on the general principle of *Respect of the Dignity and Worth of all People*, which states that "psychologists respect the rights of individuals to privacy, confidentiality, and self-determination" (APA, 2017, p. 6). This means that psychologists should aspire to respect their clients' choice to disclose information and avoid engaging in activities that can unnecessarily bias their work, such as voyeurism, casual checking out of habit, and attempts to verify information disclosed by the client (Ginory et al., 2012; Gabbard et al., 2011). Well-articulated clinical rationales may justify PTG and do not necessarily indicate that professional boundaries have been crossed. For example, PTG in emergencies (American Psychiatric Association, 2017) and PTG to ensure that a client is not already within a psychologist's own social circle (i.e., has mutual friends on SNS; Kolmes & Taube, 2014) may remain within the limits of professional and ethical boundaries. However, this topic requires further research and discussion, and PTG ethical guidelines would help to delineate where boundaries lie.

Quality of Online Data. A major concern of PTG is that online information may not be reliable or valid. The quality of data accessible on the Internet about any given individual is highly variable. Thus, information obtained through PTG should be assessed carefully for its legitimacy (Dike et al., 2019). Some have argued that PTG is a useful method to corroborate

information, especially for younger clients who are more likely to openly post about their experience with mental illness on social media (Applebaum & Kopelman, 2014; Neimark et al., 2006; Pirelli et al., 2016;). However, concerns about the quality of data, especially on social media, cannot be underestimated. Behnke (2008) describes a "slippery slope" when psychologists begin to act as their clients' private investigators. For instance, a clinician treating a client with Alcohol Use Disorder may not realize that photos recently posted on social media of their client partying and drinking alcohol were actually taken many years ago. Other concerns regarding the quality of online information include the lack of nonverbal cues, potential sarcasm, lack of context, roleplaying (common in some online contexts), and the impulsive, non-reflective nature of many social media posts (DeJong et al., 2012). Clinicians should also remain cognizant that information published online about their clients, particularly on blogs and social media, could be defamation, misleading, or simply false (DeJong et al., 2012).

Adverse Impact on the Therapeutic Relationship. Dike et al. (2019) warn that PTG may have damaging effects on the therapeutic relationship. Specifically, using PTG as a way to collect information about one's clients may negatively impact the clients' trust towards their therapist. Inherent to the general principle of *Integrity* in the APA Ethics Code, psychologists have a fiduciary duty to clients, which PTG may not fulfill (APA, 2017). In the previously discussed case scenario, the information about the client's place of residence could have been collected in a face-to-face conversation. Volpe et al. (2013) describes PTG as a way for clinicians to bypass direct communication and withdraw from the here-and-now relationship in session. For example, some clinicians may lack trust in their clients' disclosures and wish to use PTG as a shortcut to gain information about their clients' lives as opposed to relying on direct face-to-face communication. Also depicted in the case scenario, the PTG appeared to create a

rupture in the therapeutic alliance, which ultimately resulted in the client prematurely ending treatment. Gershengoren (2018) argues that because the therapeutic alliance is a critical aspect of treatment adherence, PTG may be related to negative treatment outcomes through its adverse impact on the therapeutic alliance. Because of this, many have argued that PTG may not only damage the client-therapist relationship but also be harmful to a clients' wellbeing given its potential impact on premature, client-initiated termination (Clinton et al., 2010, Gabbard et al., 2011, Geppert, 2017). The authors also warn that frequent and casual PTG may pose a harm to the general public's perception and trust in the confidential and good-faith nature of mental health professionals, making individuals wary to enter into a therapeutic relationship.

Emerging Third Party Practices. Third party tech companies have already begun to collect and monetize patient online data to sell to physicians (Hsieh, 2019). Data brokers such as LexisNexis and Acxiom are equipped to sell online patient information, such as criminal records, online purchasing histories, retail loyalty programs, and voter registration data. This is a gross misuse of online information that could lead to discrimination in healthcare. For example, LexisNexis markets their service on their website by stating that "Liens, evictions, and felonies indicate that individual health may not be a priority." and "Individuals showing engagement in their community may be more likely to engage in their own health." Further, they advertise their ability to aggregate, link, analyze, and validate patient information as a way to "expand market penetration" and "transform sales" in pharmacy and healthcare services (LexisNexis, 2020). The information being sold by tech companies is not the information healthcare providers are typically privy to via medical records and can create mistrust among clients/patients and present opportunities for prejudice and discrimination in healthcare (Ravindranath, 2018). These ever

advancing and popularizing practices highlight the immediate need for more dialogue, research, training, and ethical guidelines on the topic of PTG and related practices.

Existing PTG Training and Ethical Guidance

Despite the potential ethical, clinical, and legal implications of PTG, few governing ethics bodies have provided guidelines or commentary on the topic. The American Psychiatric Association documented their opinions on PTG in their 2017 edition of the annual *Opinions of the Ethics Committee* after learning that psychiatry residents were routinely conducting Internet searches about their patients. The committee determined that PTG is an ethical practice so long as searches are done "in the interest of promoting patient care and wellbeing and never to satisfy the curiosity or other needs of the psychiatrist (American Psychiatric Association, 2017, p. 5)." They also recommended that clinicians always consider how the information will impact treatment and document the source of the information obtained through PTG in the patient's medical record. Further, they cautioned psychiatrists about the validity of information gained from PTG and stated that assuming such information as fact in the treatment process can result in malpractice. The committee encouraged psychiatrists to corroborate any information obtained online and to rely on more legitimate online sources, such as birth records as opposed to sources such as social media pages or news articles. It is clearly stated that face-to-face interviews, medical records, and patient family members are the preferred sources of obtaining patient information, but the overall tone of the document suggests that the American Psychiatric Association perceives PTG as an ethical way to obtain patient information if a clinical rationale is provided. The topic of PTG has not since been revisited in any publications from the American Psychiatric Association's Ethics Committee.

Not all ethics bodies share the same views on the topic of PTG. Eight members of the UNC Hospital Ethics Committee were jointly consulted to understand the nuanced perspectives of a panel of experts surrounding PTG (Fitz, 2020). Though there was disagreement at first, ultimately, the committee agreed that PTG is a violation of HIPAA that breaches patients' rights to privacy, confidentiality, and justice and is also detrimental to the patient-provider relationship. The UNC Hospital Ethics Committee determined that PTG guidelines should be established and agreed that healthcare providers should avoid PTG. These recommendations do not align with the perspective of the American Psychiatric Association (2017). Cox et al., (2021) conclude their recent review of the PTG literature with a call for more research specifically to develop PTG professional guidelines and training given the increase in telehealth services since the COVIC-19 pandemic.

Many professionals have published and presented recommendations for ethical practice on the topic of PTG that are informed by case scenarios/clinical vignettes, experience in the field, and clinical or ethical expertise. Zur (2010) was one of the first psychologists to publish proposed guidelines for clinicians regarding PTG. He urged clinicians to first explore and understand their personal attitudes surrounding Internet searches of themselves, their friends/family members, and then their clients. He argued that considering not only PTG attitudes, but attitudes about others conducting online searches of them and their loved ones provides helpful clarity regarding how they truly feel about the ethicality of the act. Next, he recommended that PTG have a well-articulated clinical rationale. Similar to the aforementioned recommendations from the American Psychiatric Association (2017), he states that in no instances should PTG be motivated by habit, curiosity, or voyeurism. Next, he warned clinicians to be cognizant of the fact that PTG may result in knowledge that changes one's view of their

client and subsequently their therapeutic relationship or treatment approach. He emphasized the importance of remaining self-reflective to avoid biased or suboptimal care as a result of PTG. He also recommended that a "Social Media Policy" and "Use of Search Engines Policy" be included in the informed consent paperwork that is reviewed and signed by every client (or their parent/legal guardian in the case of minors). He also strongly recommended discussing online searches with clients prior to the search to receive additional verbal consent and promote transparency in the relationship.

Clinton et al. (2010) introduced a pragmatic model for considering whether or not to engage in PTG that includes similar recommendations as Zur (2010). They suggest that clinicians consider six essential questions before engaging in PTG that require reflection of their PTG motivations and rationales, potential positive and negative impacts on treatment, and precautionary practices (e.g., informed consent, transparency, documentation). The authors also provide three case vignettes describing diverse clinical scenarios to be used for training purposes. Using the model from Clinton et al. (2010) and recommendations from the American Psychiatric Association (2017), the Behavioral Health Ethics Committee at Catholic Health Initiatives (CHI Health) developed a tool for clinicians called Together Take a Pause and Ponder (TTaPP; Kuhnel, 2018; See Appendix A). This tool is designed to help clinicians engage in critical thinking to weigh their intentions and motivations prior to PTG. Singer (2019) discusses the importance of using a tool such as TTaPP to avoid harming the therapeutic relationship, crossing professional boundaries, jeopardizing trust with clients, and introducing false or inaccurate information into treatment or clients' medical records. Similar to Clinton et al. (2010), the TTaPP tool provides a series of questions for clinicians to ask prior to PTG. However, TTaPP emphasizes the importance of consultation prior to PTG and recommends critically thinking

through the questions with the help of other professionals. With each question, the TTaPP tool provides a series of follow-up questions to help elicit deeper critical thinking. Tools such as TTaPP may be helpful in the contexts of PTG training, education, and practice. Overall, psychologists lack access to such resources and lack sufficient support for exploring their motivations, curiosities, and urges that result in PTG (Trub & Magaldi , 2021).

Asay and Lal (2014) highlight that only about half of psychology graduate students reported having discussed ethical issues related to the Internet (e.g., social media presence, online correspondence with clients) in their graduate training programs, and only about a quarter reported having discussions about such issues at their clinical practicum training sites. They provide suggestions for graduate training, including program disclosure of Internet policies to students, discussion of online ethics before trainees begin their first clinical practicum experience, role plays of clinical and ethical issues related to the Internet, and supervisor-initiated discussions of online ethics. Dejong et al. (2012) also argue that "netiquette" (professional standards for online behavior) is lacking in many healthcare-related graduate training programs and recommend that this be infused into all aspects of training. These recommendations could be applied to PTG ethical training in clinical, counseling, and combined psychology graduate programs. The use of clinical vignettes in PTG training is also strongly recommended (Ashby et al., 2015; Clinton et al., 2010; Dejong et al., 2012).

Call for Guidance from APA

The APA has not published on the topic of PTG, and there are currently no ethical standards in the APA Ethics Code relevant to seeking information about clients on the Internet. The current APA Ethics Code was developed almost two decades ago in 2002 and was later amended in 2010 and 2017 with changes unrelated to the impact of technology on clinical and

ethical practice. It is understandable and made clear in the document that the APA Ethics Code does not provide guidance to all possible ethical dilemmas. For example, the Introduction section of the APA Ethics Code (2017, p. 4) states that, "The ethical standards are written broadly…and their application may vary depending on the context." It is further stated that the ethical standards are not exhaustive and that there may be unethical behaviors that are not addressed in the document. However, in the Preamble, it is stated that the document is "intended to provide specific standards to cover most situations encountered by psychologists (APA, 2017, p. 5)." It is common knowledge that practicing psychologists are using the Internet daily for professional duties. Thus, it seems the APA Ethics Code fails to address very common situations that occur in online contexts encountered by psychologists. The APA Committee on Professional Practice and Standards (COPPS) is currently seeking input from practitioners to inform guidelines for optimal use of social media in professional psychological practice (APA, 2016), and the APA Ethics Code Task Force (ECTF) emphasizes the impact of technology in their quarterly meetings (APA, 2018). However, PTG remains undiscussed.

The absence of ethical standards addressing online contexts may contribute to the lack of consensus in the field of psychology regarding the ethicality of PTG. Ethics experts in the APA ECTF posit that the general principles and ethical standards presented in the APA Ethics Code can be generalized and applied to online contexts and web-based interactions with clients (APA, 2018). However, the existing standards may not provide sufficient guidance as research demonstrates a wide variety of PTG attitudes and behaviors (Asay & Lal 2014; DiLillo & Gale, 2011; Gershengoren, 2018; Ginory et al., 2019; Lehavot et al., 2010). Like any behaviors that have potential ethical, clinical, and legal implications for psychologists, it is important that the

field of psychology move towards a place of consensus and understanding regarding the ethicality of PTG.

With no clear standard of care in regard to PTG, Hsieh (2019) provides an important perspective on why casual and commonplace PTG is concerning. He posits that, in many ways, the standard of care within any given field is developed by the community of practitioners themselves. This holds particularly true for behaviors such as PTG for which clinicians have little to no training or guidelines. What most clinicians in the field do becomes the standard of care, and the research to date suggests that the majority of clinicians may be engaging in PTG (DiLillo & Gale, 2011; Gershengoren, 2018; Harris & Robinson Kurpius, 2014). If the use of online patient information becomes the standard of care in clinical and counseling psychology, this may present new opportunities for accusations of malpractice. For example, if a client's Facebook posts suggest suicidal intent, and a clinician fails to see or use this information to inform treatment, they have not upheld the standard of care and could be sued for malpractice if the patient attempts or completes suicide. Such impacts on the culture of the field and shifts in the standard of care are important consequences to consider and discuss. This supports an immediate call for ethical guidance from APA.

Personal Determinants of PTG

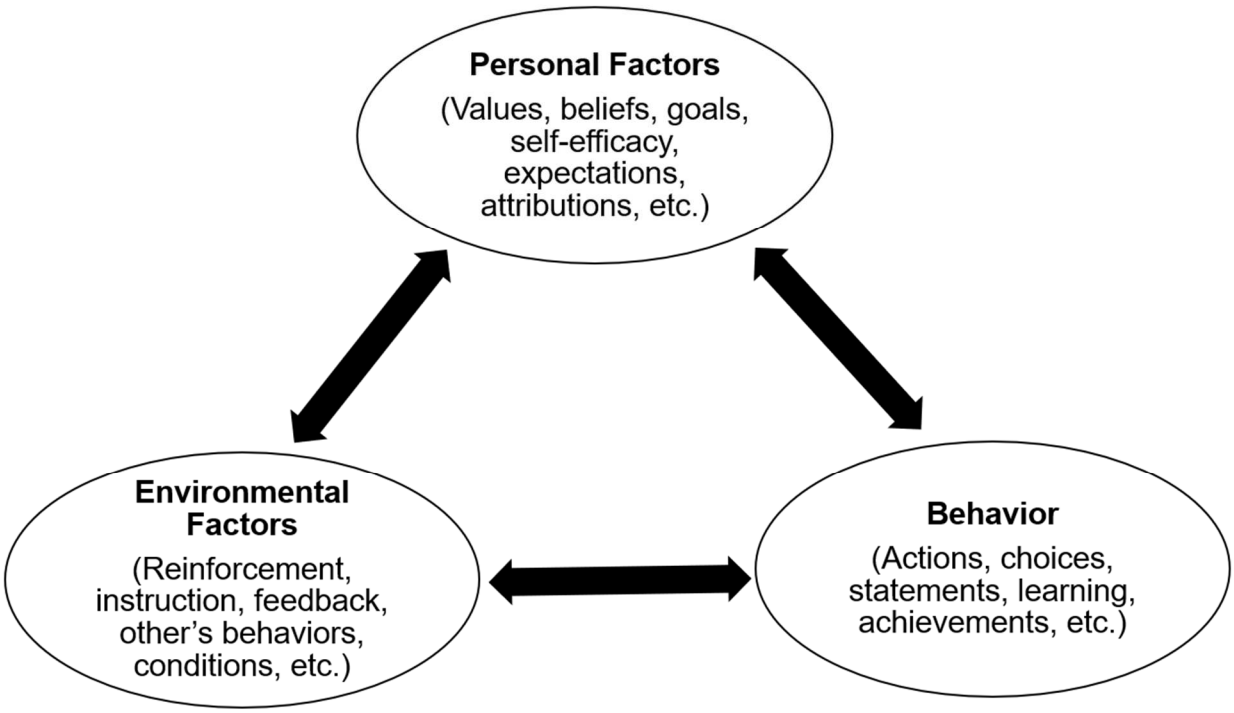
As education and training surrounding PTG are largely not provided (Eichenberg & Herzberg, 2016), other personal factors likely influence PTG practices and attitudes. The present study considers the potential influence of personal factors including moral disengagement, empathy, moral identity, social media use, and gender on PTG attitudes and behaviors.

Social Cognitive Theory (SCT; Bandura, 1991) provides a theoretical framework through which researchers can understand the factors that influence ethical and moral attitudes and

behaviors. Unlike other theories of moral behavior that prioritize sophistication of moral reasoning (Kohlberg, 1969; Piaget, 1932; Rest, 1979), SCT purports a more holistic, agentic model of moral behavior (Bandura, 1999b). The theory assumes moral agency, in which individuals' self-regulation, personal standards, and self-sanctions influence their attitudes and behaviors. In SCT, one's traits are not thought to unidirectionally predict behavior, but rather personal determinants (including personal determinants of moral agency), environmental determinants, and behaviors all reciprocally influence one another. Bandura (1999b) explains this phenomenon with the triadic model of reciprocal determinism (See Figure 1).

Figure 1

Triadic Model of Reciprocal Determinism



Note. Visual adapted from Walker (2018)

Moral agency is an important personal factor in SCT, and the theory discusses moral agency at three levels: 1) direct/personal agency, 2) proxy agency (efforts of other individuals), and 3) collective agency (group or population level efforts; Bandura, 2001). With no group level standards or ethical guidelines for PTG, the present study focuses on direct/personal moral agency, which is characterized by core features including self-reactive, vicarious, and cognitive aspects of human development and functioning (Bandura, 1999b). Self-reactivity refers to cognitive processes that allow for self-direction, internal motivation, and agency in behavior. Individuals are self-reactive beings who use self-determined moral standards and self-sanctions to guide, motivate, and deter behavior. Moral disengagement is an example of a self-reactive process that influences one's attitudes and behaviors. Vicarious learning refers to one's ability to learn through social modeling and experience how their actions affect others. Empathy is an example of vicarious learning that influences one's attitudes and behaviors. Cognitive aspects refer to how humans interpret themselves and their environments, which provides structure, meaning, and continuity to their lives. An example of how one interprets themself is the development of their moral identity (i.e., how an individual conceptualizes his or her own moral beliefs and practices), which influences their attitudes and behaviors. The present study will explore associations between the following personal determinants of moral agency and clinician PTG practices and attitudes: 1) moral disengagement, 2) empathy, and 3) moral identity.

Moral Disengagement

In SCT, Bandura (1991) proposes an agentic model of human behavior in which individuals exercise control over their behavior through self-regulatory processes. One of the most discussed and researched cognitive, self-regulatory processes through which humans control their behavior is moral disengagement. Moral disengagement is an extension of SCT that

refers to a dissonance-reducing process of self-regulation through which an individual feels freed from the guilt and self-sanctions associated with violating their own moral standards. In other words, the ethical self-regulatory processes that normally prevent unethical behavior are deactivated (Bandura, 1999a; 2015).

Normally, individuals engage in ethical self-regulation to ensure that their behaviors align with their moral standards. However, everyone behaves at times in ways that do not align with their moral standards. Moral disengagement provides insight as to how individuals are able to justify and rationalize their own unethical behavior. PTG provides an example of a behavior among clinicians that does not necessarily align with the ethical standards psychologists are obliged to uphold. For example, DiLillo and Gale (2011) found that 97.8% of doctoral psychology students reported engagement in PTG. However, 67% reported that they perceive the practice as "unacceptable." This suggests that some self-regulatory process may occur during the practice of PTG to suppress or reduce feelings of cognitive dissonance.

Bandura (2015) theorizes that in order for individuals to engage in amoral or unethical behavior yet still act in a way that is consistent with their personal moral standards, they must alter some combination of their perceptions of the behavior itself, their responsibility, the target of the behavior, and/or the outcomes of the behavior. These alterations are defined as the different mechanisms through which moral disengagement can occur. The eight theorized mechanisms include 1) moral justification, 2) euphemistic labeling, 3) advantageous comparison, 4) displacement of responsibility, 5) diffusion of responsibility, 6) distorting consequences, 7) dehumanization, and 8) attribution of blame (Bandura 1999a). See Table 1 for definitions of the eight mechanisms of moral disengagement.

Table 1

Theorized Mechanisms of Moral Disengagement

Mechanisms of Moral Disengagement	Definition
Moral justification	Minimizing the severity or cruelty of behavior by portraying it in a socially worthy light
Euphemistic labeling	Minimizing the severity or cruelty of behavior through verbal manipulation
Advantageous comparison	Minimizing the severity or cruelty of behavior through comparison to worst acts.
Displacement of responsibility	Reducing personal responsibility for an amoral behavior by placing the responsibility for the behavior and its consequences elsewhere
Diffusion of responsibility	Reducing personal responsibility for an amoral behavior by sharing the responsibility for the behavior and its consequences with others
Distorting consequences	Minimizing the severity or cruelty of behavior by distorting or falsely altering the effects of the behavior
Dehumanization	Minimizing the severity or cruelty of behavior by dehumanizing the victim
Attribution of blame	Reducing personal responsibility for an amoral behavior by placing blame on the victim

Note. Definitions from De Caroli and Sagone (2014)

High levels of moral disengagement have been shown to reduce engagement in prosocial behaviors (Bandura et al., 1996) and predict both serious ethical transgressions, such as supporting acts of war and terrorism (McAlister, 2001) and more minor and common ethical

infractions, such as undermining others and spreading rumors about co-workers (Duffy et al., 2005). Research demonstrates that individuals tend to rationalize small ethical transgressions that may benefit them, and moral disengagement allows them to do so without having to reevaluate and update their moral standards and self-concept (Gino et al., 2009; Shalvi et al., 2011). PTG and related behaviors (i.e., not obtaining client consent prior to PTG, not documenting information obtained through PTG) could be conceptualized as small ethical transgressions that are easily justified through the different mechanisms of moral disengagement.

Bandura's SCT (1991) also emphasizes the influences of the environment or social context on behavior. Research on cyberbullying and cyberaggression suggests that online contexts may enable specific mechanisms that facilitate moral disengagement. Runions and Bak (2015) posit that online contexts provide affordances for certain mechanisms of moral disengagement more than in-person contexts. The authors discuss how online contexts allow individuals to more easily disregard and/or distort the consequences of their behavior and dehumanize the target of their behavior. For example, it may be easier for clinicians not to consider potential breaches of client privacy and confidentiality or potential adverse effects when engaging in PTG because the task is simple, quick, and often done in private. Alternatively, clinicians may focus more heavily on how the information obtained from PTG may help the client and their treatment and ignore the harm that could result from the search. Further, language prevalent in the literature justifying PTG such as "the Internet is public information" or needing to "verify what the client disclosed" may represent specific mechanisms such as euphemistic labeling or attribution of blame. Runions and Bak (2015) state that individuals may label behaviors as "not a big deal" online that would seem like obvious ethical transgressions in different contexts. For example, calling third party sources without consent to obtain client

information is an obvious breach of client privacy and confidentiality, but searching for the same information online by entering the client's name into a search engine may be labeled as "corroborating clinical information." This provides an example of the potential euphemistic labeling that may occur when clinicians engage in PTG. The PTG literature suggests that mechanisms of moral disengagement including dehumanization, distortion of consequences, euphemistic labeling, and attribution of blame may be particularly relevant to PTG.

Empathy

Empathy is another personal determinant of moral agency that influences attitudes and behavior. It is difficult to understate the importance of empathy in a clinician's work with their clients. Empathy has been defined as the degree to which an individual notices and is concerned about the emotional needs of others (Eisenberg & Miller, 1987; Batson et al., 1989; Miller & Eisenberg, 1988). Through the lens of SCT, empathy represents the forethought and vicarious capabilities (considering and learning from behavioral consequences related to others' feelings and concerns) that individuals utilize in their behavioral self-regulation (Bandura, 1999b). One understanding of empathy is through a series of cognitive processes, which involve recognizing and understanding others' thoughts and feelings. Kohlberg (1969) first described these cognitive processes as "role-taking" and proposed role-taking as an essential piece of individual moral development and moral judgment. Another understanding of empathy takes an affective approach and emphasizes an individual's ability to feel others' emotions. Rest (1986) suggested that gut-level empathic emotions tend to occur just before a moral judgement is made, which increases an individual's sensitivity to the moral nature of any given situation.

Individuals higher in empathy are more likely to consider the concerns of others. Bok (1998) proposes that empathy forms the very basis of morality as individuals must first perceive

the feelings of others to move towards feeling a responsibility towards them. Bandura (1986) shows that high levels of empathic personalization (an example of vicarious capability) motivate the helping of others and reduce the harm of others. Batson (1991) provided support for trait empathy in that individuals differ in their concern for others, which emerges in childhood and remains stable over time (Eisenberg et al., 1999). Dispositional empathy suggests that individuals are differently predisposed to using behavioral forethought and vicarious capabilities in their self-regulatory, behavioral decision-making processes (Bandura, 1999b; Detert et al., 2008). This is supported by Detert et al. (2008), which found that individuals high in trait empathy were less likely to engage in moral disengagement and were more likely to broadly engage in ethically-sound decision making. Detert et al. (2008) suggest that this finding may generalize to more specific ethical behaviors. Trait empathy as it relates to PTG has not been previously examined.

Moral Identity

Moral identity is another personal determinant of moral agency that influences behavior. Aquino and Reed (2002) define moral identity as one's self concept regarding their moral traits, which includes their moral concerns and moral commitments. Markus and Kunda (1986) propose that one's sense of self is composed of a number of hierarchically organized identities. Those identities at the top of an individual's hierarchy are most salient and most strongly influence the individual's thoughts, feelings, and behaviors. Thus, Aquino and Reed (2002) consider those whose morality is central to their self-concept to have highly self-important moral identity. In other words, individuals whose self-concept is more organized around their moral beliefs are thought to have more highly self-important moral identity compared to those whose self-concepts are less organized around their moral beliefs. Like other social identities that people

embrace, one's moral identity is associated with certain attitudes and behaviors, particularly when moral identity is highly self-important. Although trait-level moral identity has been shown to be relatively stable over time, one's moral identity may assume greater or lesser importance over time as a function of social and emotional development and life experience (Hart et al., 1998). Additionally, like other social identities, moral identity may be activated or suppressed in certain contexts, but when one's moral identity is highly self-important, it is more likely that this identity will be activated in a wide range of situations and will be more strongly associated with attitudes and behaviors.

In SCT, moral identity is conceptualized as a symbolic representation of the self that influences an individual's moral agency and ability to self-regulate in ethical decision making (Bandura, 1999b). Detert et al. (2008) found that individuals with highly self-important moral identity were less likely to engage in moral disengagement. Further, moral identity has been found to be a robust predictor of ethical behavior and attitudes broadly (Aquino & Reed, 2002; Aquino et al., 2007). This relationship may generalize to more specific ethical behaviors. However, the relationship between moral identity and PTG has not been previously studied.

Other Personal Factors

Social Media Use. Clinician social media use may be related to PTG practices. One study found that medical students with high social media use were 1.83 times more likely to have engaged in PTG than students with lower levels of (or no) social media use (Chester et al., 2017). A similar relationship between years of social media use and PTG was found in a sample of counseling and psychology graduate students ($B = 0.014$, $p < .001$; Harris & Robinson Kurpius, 2014). This relationship requires further examination.

Gender. One study to date has identified a relationship between gender and PTG practices. In a sample of licensed psychologists, gender was found to predict frequency of PTG in that males were less likely to endorse higher engagement in PTG than females (Wu & Sonne, 2021). However, gender did not predict psychologists' perceptions of the ethicality of PTG. Additionally, client gender nor the interaction of psychologist gender and client gender predicted neither frequency of PTG nor ethicality ratings of PTG. Wu and Sonne (2021) posited that gender as a predictor for frequency of PTG may have simply reflected broader gender differences in social media use between males and females. Alternatively, they speculated that female psychologists may be more vigilant regarding their physical safety in the presence of clients than male psychologists making them more likely to check their client's history.

More broadly, gender has been shown to correlate with unethical decision making and many personal determinants of moral agency. For example, research suggests that males are more likely than females to morally disengage (Detert et al., 2008). Additionally, females have been found to have more empathy, more highly self-important moral identity, and engage in more broad ethical decision making and moral reasoning than males (Ambrose & Schminke, 1999; Aquino & Reed, 2002; Detert et al., 2008; Gephart et al., 2007; O'Fallon & Butterfield, 2005). Ultimately, the relationship between gender and PTG requires further examination.

Theoretical Orientation. A clinician's therapeutic orientation, or their individual approach to how they conceptualize and treat their clients, impacts their attitudes towards therapeutic boundaries and their role in the therapist-client relationship. Because of this, De Araujo and Kowacs (2019) posit that theoretical orientation may impact how psychologists view the ethicality of PTG. Eichenberg and Herzberg (2016) found that behavioral therapists were more likely to indicate that certain scenarios justify PTG compared to psychodynamic therapists

who held more abstinence views. Kravis (2017) suggests that psychoanalytic and psychodynamic therapists may be hesitant to embrace information that comes from outside the physical therapist-client relationship, which theoretically corrupts the analysis of here-and-now transference and countertransference. Process-orientated therapists may similarly oppose seeking outside data from online searches as it compromises the integrity of the therapeutic process (Epstein, 1994). Contrarily, Kolmes and Taube (2014) found that psychodynamic or integrative therapists were actually more likely to engage in PTG than CBT therapists. Wu and Sonne (2021) found that psychologist theoretical orientation did not their predict frequency of PTG or their ethical ratings of PTG. This is a topic in need of further research as existing findings are contradictory.

Clinical Experience and Age. There is no known empirical support for a relationship between age and PTG (Cole, 2016; Harris and Robinson Kurpius, 2014). Regarding clinical experience, Wu and Sonne (2021) did not find years of clinical experience to predict frequency of PTG. However, they did find years of clinical experience to predict ethicality ratings of PTG. Specifically, moderately experienced psychologists (those with 10,000 to 14,999 hours of professional clinical experience) were more likely to rate PTG as unethical compared to the least experienced therapists (those with less than 4,999 hours of professional clinical experience). However, the moderately experienced therapists did not differ statistically from those with 5,000 to 9,999 hours of experience or the groups with greater than 14,999 hours of experience. It is important to note that this was not a predictor of PTG attitudes for very experienced psychologists. Wu and Sonne (2021) speculate that psychologists with the most clinical experience are also the least familiar with technology as a group and may view PTG with more caution for this reason. This is supported by a review of adult computer usage, which found that

age was negatively related to computer experience, computer attitudes, and confidence in computer knowledge (Wagner et al., 2010).

Similarly, Harris and Robinson Kurpius (2014) found that years of clinical experience was not related to PTG practices. However, this may be due to range restriction in their student sample who had limited clinical experience. They did find that students who had progressed further in their graduate programs (i.e., reported more academic credits completed) were more likely to engage in PTG. This may be because students early in their graduate training had not yet provided enough direct hours of psychological services for the topic of PTG to be relevant. Overall, the relationship between clinician age and experience and PTG practices and attitudes requires further examination

The Present Study

The PTG literature is relatively young (approximately 12 years old). Existing studies disproportionately use entirely student samples, report inconsistent rates of PTG, and discuss a variety of attitudes surrounding the ethicality and utility of PTG. The existing literature is also largely comprised of conceptual papers in which professionals present opinions, concerns, and recommendations surrounding PTG. Though empirical research on PTG has increased in the last two years, more research specific to the field of psychology is needed. Thus, in a sample of counseling and clinical psychologists and trainees, the present mixed-methods study aims to 1) clarify PTG practices, 2) examine PTG attitudes, 3) understand PTG training and ethical guidance needs, and 4) test the relationship between personal determinants of moral agency and PTG practices and attitudes.

Aims and Hypotheses

Underlying the four aims of the present study are research questions and hypotheses. Since PTG is a fairly new area of research and the existing literature is non-conclusive, the research questions underlying the first three aims are exploratory in nature. For such research questions, specific hypotheses are not presented.

Aim 1: Clarify PTG Practices. The existing literature reports rates of PTG among healthcare providers in different disciplines from as low as 16.9% (Chester et al., 2017) to as high as 97.8% (DiLillo & Gale, 2014). However, many rates are outdated and/or describe student samples or interdisciplinary samples including mental health counselors, psychiatrists, nurses, and physicians. The present study will recruit only licensed psychologists and post-doctoral and doctoral-level psychology trainees. The first aim is to clarify the current PTG practices among this population. To achieve this aim, the present study seeks answers to the following descriptive and exploratory questions:

1) What proportion of counseling and clinical psychologists and trainees engage in PTG?

2) How often do counseling and clinical psychologists and trainees engage in PTG?

3) What are the PTG-related practices for informed consent, transparency, and documentation among counseling and clinical psychologists and trainees?

Aim 2: Examine PTG Attitudes. The existing literature reveals discrepancies in how interdisciplinary clinicians perceive PTG. For example, some define PTG as "ethical" (Thabrew et al., 2018), where others describe PTG as "unacceptable" (DiLillo & Gale, 2011; Eichenberg & Herzberg, 2016). Some clinicians argue that PTG helps treatment, where others believe it is detrimental to treatment (Eichenberg & Herzberg, 2016). The second aim is to understand how

the population of interest perceives the ethicality and utility of PTG. To achieve this aim, the present study seeks answers to the following descriptive exploratory questions:

1) Do counseling and clinical psychologists and trainees perceive PTG as ethical?

2) How do counseling and clinical psychologists and trainees feel that PTG impacts the client, treatment, and the therapeutic relationship?

Aim 3: Understand PTG Training and Ethical Guidance Needs. One theme of the PTG literature is that many clinicians are engaging in PTG without training or ethical guidance (Thabrew et al., 2018). For example, one study found that even though 39.6% of the sample of psychotherapists reported engagement in PTG, 84.5% of the sample had never considered the ethicality of PTG, and only 2.4% had received any ethical training or education on the topic (Eichenberg & Herzberg, 2016). Additionally, in a sample of medical students, 53.7% favored more explicit guidance on the issue of PTG (Chester et al., 2017). The lack of ethical guidance in the APA Ethics Code and the rare mention of PTG in clinical training indicate a potential need for more training and ethical guidance. Thus, the third aim of the present study is to understand the current training and ethical guidance needs regarding PTG in the population of interest. To achieve this aim, the present study seeks answers to the following exploratory questions:

1) Have counseling and clinical psychologists and trainees received training (e.g., continuing education training, graduate course) or ethical guidance (e.g., from professors, supervisors, colleagues, consultants) on PTG?

2) What is the quantity and quality of the training/ethical guidance that counseling and clinical psychologists have received on PTG?

3) Do counseling and clinical psychologists and trainees feel they would benefit from more training and/or ethical guidance in the APA Ethics Code on PTG?

Aim 4: Examine the Association Between Personal Determinants of Moral Agency and PTG. There are few existing studies that examine the influence of personal factors on PTG. Using SCT (Bandura, 1991) as the theoretical framework, the final aim of the present study is to examine associations between personal determinants of moral agency and PTG practices and attitudes. Identifying factors that are related to one's propensity to engage in or abstain from PTG or hold more/less strict PTG attitudes may be helpful in 1) further understanding the varied behavioral and attitudinal discrepancies among practicing psychologists, 2) informing recommendations for future training and ethical guidelines, and 3) serving as a proof of concept for applying SCT and moral disengagement to PTG practices and attitudes. To achieve this aim, the present study seeks answers to the following research questions:

1) Are clinician moral disengagement, empathy, and moral identity associated with PTG practices?

2) Are clinician moral disengagement, empathy, and moral identity associated with PTG attitudes?

Hypotheses for the research questions underlying aim four are as follows: Hypotheses 1a through 1c refer to hypothesized associations between personal determinants of moral agency and PTG practices. Hypotheses 2a through 2c refer to hypothesized associations between personal determinants of moral agency and PTG attitudes.

Hypothesis 1a: Holding constant empathy, moral identity, gender, and social media use, clinician moral disengagement will be positively correlated with PTG in that individuals with higher levels of moral disengagement will be more likely to engage in PTG.

Hypothesis 1b: Holding constant moral disengagement, moral identity, gender, and social media use, clinician trait empathy will be negatively correlated with PTG in that individuals with higher levels of empathy will be less likely to engage in PTG.

Hypothesis 1c: Holding constant moral disengagement, empathy, gender, and social media use, clinician moral identity will be negatively correlated with PTG in that individuals with more highly self-important moral identity will be less likely to engage in PTG.

Hypothesis 2a: Holding constant empathy, moral identity, gender, and social media use, clinician moral disengagement will be positively correlated with PTG attitudes in that individuals with higher levels of moral disengagement will be more likely to endorse PTG as ethical.

Hypothesis 2b: Holding constant moral disengagement, moral identity, gender, and social media use, clinician trait empathy will be negatively correlated with PTG attitudes in that individuals with high levels of empathy will be less likely to endorse PTG as ethical.

Hypothesis 2c: Holding constant moral disengagement, empathy, gender, and social media use, clinician moral identity will be negatively correlated with PTG attitudes in that individuals with highly self-important moral identity will be less likely to endorse PTG as ethical.

METHOD

The present study's aims involved investigating PTG-related practices, attitudes, and training and ethical guidance needs in addition to examining the relationship among PTG practices, attitudes, and personal determinants of moral agency. To achieve these aims, clinical and counseling psychology practitioners and post-doctoral and doctoral-level trainees were recruited to participate in one of two arms of the present study: 1) virtual focus groups or 2) an online survey. Eligible and interested clinicians had the option to participate in either a virtual focus group or the online survey, but not both.

Participants and Recruitment

Participants

A targeted sample of counseling and clinical psychologists and graduate and post-graduate trainees of counseling psychology, clinical psychology, and combined psychology were recruited. Combined programs are those that provide training that integrate some combination of clinical, counseling, and school psychology, and students from such programs were eligible for participation. These disciplines were chosen because they adhere to APA ethical guidelines. The present study was the first known to target a broader population of professional and student clinicians in the fields of counseling and clinical psychology. Studies investigating PTG have typically recruited only students (Asay & Lal, 2014; DiLillo & Gale, 2011; Harris & Robinson Kurpius, 2014; Lehavot et al., 2010). Thus, the inclusion of both licensed psychologists and those still in training, as well as both counseling and clinical psychologists helped to cast a wider net in terms of years of experience, perspectives on the field, and practice settings represented among the sample.

Inclusion Criteria. Participants were screened using screening questions to ensure participants met eligibility criteria. Participants were required to be one of the following: 1) a licensed psychologist, 2) a graduate student enrolled in a clinical psychology, counseling psychology, or combined psychology doctoral program, or 3) a post-doctoral level psychologist in counseling or clinical psychology. Participants were also required to be currently or recently providing direct psychological services (e.g., therapy, assessment, consultation) within the last 12 months to ensure that participant input represented current day practice. Additionally, participants were required to have provided at least 100 hours of direct psychological services to ensure that participants had enough relevant experience to provide input on PTG.

Recruitment

After obtaining approval from the Institutional Review Board (IRB) at Eastern Virginia Medical School in December 2020, a targeted sample of licensed psychologists, graduate students enrolled in counseling, clinical, or combined psychology doctoral programs, and post-doctoral fellows were recruited for participation in the present study. Participants were recruited through email invitations sent to training directors of clinical, counseling, and combined psychology doctoral programs across the United States. In January 2021, 209 training directors were contacted and asked via email to forward the invitation to their current students, program alumni, and colleagues. The email invitation was also distributed via listservs to members of two willing state boards of psychology and professional psychological associations, which included the Neuropsychology (NPSYCH) Discussion List and the American Academy of Clinical Neuropsychologists (AACN) Community Discussion List. The NPSYCH Discussion list is a private mailing list open only to neuropsychologists. The AACN Community Discussion List is

open to active, affiliate, senior, and student members of the AACN. This recruitment method resulted in 268 responses during a three-and-a-half-week period.

Both arms of the study were advertised in the recruitment materials, and recruitment for the virtual focus groups and online survey occurred simultaneously. It was clearly advertised that interested and eligible participants were only able to participate in one arm of the study, not both. A URL was provided in the recruitment materials, which led interested participants to answer screening questions and indicate their preferred method of participation. For individuals who did not meet the study participation criteria, their participation ended here, and they were not asked their preferred method of participation.

Those who indicated interest in a virtual focus group were redirected to an information page where they were asked to enter their name and contact information (e.g., email address, phone number) so that they could be reached for scheduling purposes. It was also explained on the page that the researcher would contact the interested individual promptly to schedule their participation in a virtual focus group since scheduling through direct communication is thought to increase attendance. Participants were contacted by email with the dates and times of the focus groups and were asked to select which (if any) they would like to attend. This process continued until all five virtual focus groups were filled. One to two additional participants were scheduled for each focus group in anticipation of some participants not attending during their scheduled slot. Once a participant was scheduled, they were sent a confirmation email, and another reminder email was sent approximately 24 hours before the focus group. There was an excess of interest in participation, and once the survey and focus groups slots were filled, a waitlist was created for those interested in participating in a focus group in case of cancellations or additional

focus groups being required. Forty-four individuals were scheduled for participation in one of the five virtual focus, and 36 individuals attended and participated.

Those who indicated interest in taking the online survey were redirected to a page with study information and the elements of informed consent to review before beginning the electronic survey. A total of 95 participants completed the online survey.

Participant Compensation. An internal funding source provided the funds to compensate research participants. For participation in a virtual focus group, participants were compensated a $35 Amazon e-gift card. For participation in the online survey, participants were compensated a $5 Amazon e-gift card. The e-gift cards were sent to their provided email addresses. Participants were given the choice not to provide their email address and not receive compensation for their participation. Names and email addresses collected for gift card distribution were not stored or associated with data.

Procedure

Virtual Focus Groups Procedure

Due to the COVID-19 pandemic, virtual focus groups were planned as an alternative to in-person focus groups. Virtual focus groups have been found to perform as well as in-person focus groups in their ability to elicit information from group participants (Stewart & Shamdasani, 2016). Guest et al. (2017) provide an empirically supported recommendation that three to six focus groups are required to reach 90% of themes. This finding was further supported by Namey et al. (2016) who found that three to five focus groups were required to reach 80% to 90% saturation. Thus, five virtual focus groups were initially scheduled with the understanding that data collection would continue until the point of saturation when the groups no longer generated new ideas as determined by the discretion of the researcher (Braun & Clarke, 2013; Guest et al.,

2017; Namey et al., 2016). After five virtual focus groups, it was determined by the research team that the focus groups were resulting in similar data with apparent themes having formed and that the point of saturation had been met. Recruiting six to eight participants for each focus group (approximately 30 total) is recommended by Nyumba et al. (2018) in their review of two decades of focus group methodology research. Thus, eight to nine participants were scheduled for each focus group in anticipation of some absenteeism. A total of 44 individuals were scheduled, 36 of whom participated, and participation in each focus group ranged from five to nine participants (mean = 7.2).

Each focus group meeting lasted between one and 1.5 hours. Groups were held on a secure online meeting platform called BlueJeans Video Conferencing, which provided easy connection via a variety of devices with both video and audio options. Given the virtual nature of the focus groups, a waiver of the documentation of consent was granted from the IRB at Eastern Virginia Medical School so that participants were able to consent verbally instead of with a signature. After scheduling, participants were emailed the consent form for review along with a link to a secure Qualtrics software questionnaire containing a series of demographic items (see Appendix B). At the beginning of the focus group, the facilitator went over the elements of informed consent in detail to ensure that participants understood the nature of their participation and their rights as participants. The opportunity for questions was afforded at this time as well. Participants were then asked to provide verbal consent to participate or choose to leave the focus group. All participants provided verbal consent at this time. It was not required that participants utilize the video function to participate in the virtual focus groups to protect individual privacy and respect the desired confidentiality of individual participants. Ultimately, many participants chose to have their camera on, while others chose to keep their camera off.

The researcher facilitated the virtual focus groups, and a notetaker was also present who took notes regarding the content of the focus group discussions. The notetaker, a researcher from Eastern Virginia Medical School, was introduced to the participants upon their arrival to the focus group and kept their audio and camera features off at all times. The researcher facilitated the virtual focus groups using a semi-structured moderator's guide (see Appendix C) with pre-determined questions that assess PTG practices, attitudes, and training and ethical guidance needs. After reviewing the elements of consent, the facilitator read aloud the ground rules as scripted on the moderator's guide. The ground rules encouraged participants to share their honest opinions and reactions. Participants were also reminded during this time that they did not have to share; however, they were notified that all participants would be invited to participate throughout the discussion by the principal investigator to promote diversity of thought. The opportunity for questions was afforded again during this time. Then, the facilitator read aloud an overview of the topic, which is also scripted on the moderator's guide. The topic overview included a definition of PTG and brief background information from the existing literature. Then, the facilitator began to read the questions from the guide one at a time allowing the opportunity for each participant to share their opinions and reactions after each question. The moderator's guide also included suggested follow-up prompts that were used as needed to help clarify participant input and promote open-ended discussion. Once the group provided their input to all of the pre-determined questions, the facilitator read aloud the closing statement from the guide, which included thanking the participants for their participation in the study. At this time, the facilitator turned off the recorder and thanked participants for attending. Following each focus group, the facilitator proceeded to distribute the e-gift cards to participants via email. Participants were also provided the contact information of the researcher in the event that they have any questions or concerns

about the study, their participation, or the overall findings. Lastly, they were also be provided the TTaPP tool (Kuhnel, 2017; See Appendix A) for educational purposes via email. All virtual focus groups were recorded, transcribed, and uploaded into NVivo for analysis.

Focus Groups Data Protection. The virtual focus groups were thought to pose minimal to no harm to participants. Access to audio recordings and transcribed data remained limited to the principal investigator and additional coder(s) on the research team. All audio and data files were stored in a password protected file on a password protected computer. Upon completion of data analysis, the audio files were deleted.

Online Survey Procedure

Eligible participants who chose to take the online survey instead of participate in a focus group were redirected from the screener questions to enter the survey on the secure Qualtrics survey software. The first page of the survey was an information sheet displaying information about the research and the basic elements of consent. There was no time limit on the survey, so participants were able to move through the survey items at their preferred pace. All participants took an identical survey with the exception of the items being presented in a randomized order. At the end of the survey, participants were thanked for their participation and provided the contact information of the researcher in the event that they have any questions or concerns about the study, their participation, or the overall findings. They were also provided a link to the TTaPP tool (Kuhnel, 2017) for educational purposes. Lastly, they were redirected to a separate survey where they were provided the opportunity to provide their name and email address if they would like to receive a $5 e-gift card for their participation.

Survey Data Protection. The online survey was thought to pose minimal to no risk to the participants. The data was collected via secure Qualtrics survey software and was completely

anonymous. The data was downloaded directly from Qualtrics into SPSS for analysis. Qualitative survey data was additionally pasted into NVivo for thematic analysis. No identifiers were collected or recorded with the data, including but not limited to name, phone number, and email address. All data were stored in a password protected file on a password protected computer.

Measures

Demographic Variables

In both arms of the study, demographic information collected included age, gender identity, and racial/ethnic identity. Relevant demographic items were used as screener items to determine participant eligibility including items about participant education status, whether they currently or recently provided psychological services, and whether they have provided at least 100 hours of direct psychological services. More professional information relevant to their experience as a psychologist or trainee were also collected, such as their professional status (e.g., licensed psychologist, post-doctoral fellow, or graduate student), discipline, and number of years of experience providing psychological services. Participants taking the online survey were also asked about the type of clinical setting in which they currently (or most recently) work, the types of psychological services they provide, their primary client population, and their self-ascribed theoretical orientation. Items used to collect demographic information in both study arms are displayed in Appendix B.

Virtual Focus Group Moderator's Guide

In the virtual focus groups arm of the study, a series of predetermined questions were used to facilitate discussion about PTG practices, attitudes, and ethical guidance and training needs. A semi-structured moderator's guide was used by the facilitator, which included ground

rules, an overview of PTG, a series of questions, and closing statements to promote sameness among the facilitation of the different focus group meetings. The moderator's guide helped to address potential threats to internal validity related to the way the researcher facilitated the focus groups. As recommended by Braun and Clarke (2013), the semi-structured guide helped to provide opportunities for all members' reactions and comments. The guide included nine predetermined questions informed by inconsistencies and gaps in the existing PTG literature and tapped into the questions underlying the first three aims of the study: 1) clarify PTG practices, 2) examine PTG attitudes, and 3) understand PTG training and ethical guidance needs. To ensure that topics from all exploratory research questions were discussed, follow-up prompts included in the moderator's guide were used as needed. An example of a question that was asked to clarify PTG practices is, "Tell me some initial thoughts you have when I say patient-targeted Googling." An example of a question that was asked to examine PTG attitudes is, "What are your thoughts about the ethicality of PTG?" A question that was asked to better understand PTG training and ethical guidance needs is, "What has been your experience with receiving training or ethical guidance on PTG?" The full moderator's guide is included in Appendix C.

Online Survey Measures

The online survey collected data on participant PTG, moral disengagement, trait empathy, moral identity, and social media use. The survey also included attention check items.

PTG Survey Items. Data on PTG practices, attitudes, and training/ethical guidance needs were collected using a combination of rating scale questions, multiple choice, and open-ended questions. As there is no previously validated measure of PTG, the survey items were either adopted from previously conducted PTG research (Asay & Lal, 2014; Brisson et al., 2015;

Chester et al., 2017; Eichenberg & Herzberg, 2016; Harris & Robinson Kurpius, 2014) or newly constructed as described below.

PTG Practices. Eleven items were used to assess PTG practices, which included one multiple choice item, one open-ended item, and nine items borrowed from Harris and Robinson Kurpius (2014) that were measured on a five-point, Likert-type scale from 1 *(never*) to 5 (*always*). An example of a PTG behavior item is, "I have searched online for information about a client." Modeling after Harris and Robinson Kurpius (2014), PTG practices were operationalized for quantitative analyses by averaging scores on three behavior items (items one through three) resulting in a score from one to five with higher scores indicating greater frequency of PTG. In an interdisciplinary sample ($N = 315$), these items achieved a Cronbach's alpha reliability estimate of 0.73 (Harris & Robinson Kurpius, 2014). Six items were also included that tapped into supplementary PTG practices, such as obtaining informed consent and documentation. These items achieved a Cronbach's alpha reliability estimate of 0.93 in the same sample. A multiple-choice item was also included to assess how often clinicians engage in PTG, and an open-ended item was included to qualitatively assess how clinicians engage in PTG. These items are displayed in Appendix D.

PTG Attitudes. Eight items were used to assess PTG attitudes, which included seven items rated on a five-point, Likert-type scale and one open-ended item. Five of the rating scale items were used in previous PTG studies (Asay & Lal, 2014; Brisson et al., 2015). An example of a PTG attitudes item borrowed from Brisson et al. (2015) is, "Searching for client information online is ethical." This item is rated on a scale from 1 (*strongly disagree*) to 5 (*strongly agree*). For quantitative analyses, PTG attitudes were operationalized by averaging three attitude items from Brisson et al. (2015) resulting in scores from one to five with higher scores indicating more

liberal attitudes surrounding PTG (i.e., that PTG is ethical). There were also two newly constructed items that tapped into perceptions of whether PTG crosses ethical boundaries and impacts treatment and the therapeutic relationship. A panel of six advanced doctoral students in clinical psychology and a licensed clinical psychologist assisted with the construction, selection, and editing of these items. After narrowing down from an over-representative item pool, two items were left for inclusion in the study. All panel members indicated high face validity of the items. The open-ended item was included to qualitatively assess clinicians' opinions on PTG. These items are displayed in Appendix D.

PTG Training and Ethical Guidance Needs. Six rating scale items and one open-ended item were used to assess training and ethical guidance needs in regard to PTG. Two items were adapted from a previous study about PTG among medical students (Chester et al., 2017). Item wordings were modified as needed to apply to a sample of psychologists. For example, in one item, "medical curriculum" was substituted with "APA Ethics Code." Four items were newly constructed as there is no known questionnaire of training/ethical guidance needs related to PTG. The items tapped into what training and ethical guidance clinicians are currently receiving and what training and guidance they need. The items were rated on a five-point, Likert-type scale from 1 (*strongly disagree*) to 5 (*strongly agree*). A panel of six advanced doctoral students in clinical psychology and a licensed clinical psychologist assisted with the construction and editing of these items. After narrowing down from an over-representative item pool, four items were left for inclusion in the study. All panel members indicated high face validity of the items. An example item is, "I have received ethical guidance on searching my clients online." An open-ended item was also included to qualitatively assess current PTG training and ethical guidance

needs. All survey items used to assess PTG training/ethical guidance needs are displayed in Appendix D.

Moral Disengagement Scale. The Moral Disengagement Scale (MDS; Bandura et al., 1996) was used to measure moral disengagement. The 32-item scale includes four items to assess each of the eight theorized mechanisms through which moral disengagement occurs including moral justification (MJ), euphemistic labeling (EL), advantageous comparison (AC), displacement of responsibility (DISR), diffusion of responsibility (DIFR), distortion of consequences (DC), attribution of blame (AB), and dehumanization (DEH). Because the scale was initially developed for use with children and adolescents, the items have been adapted to fit the population of the present study. Identical modifications to the item wordings were made in Detert et al. (2008), which used the MDS with a sample of university students. For example, one item was modified to "It is unfair to blame a *person*…" instead of, "It is unfair to blame a *child*…" In the directions, participants are asked to read each statement and respond with the extent they agree or disagree with the statement. An example item from the MDS used to assess one's tendency to morally disengage through AC is, "Stealing some money is not too serious compared to those who steal a lot of money." The items are rated on a five-point, Likert-type scale from 1 (*strongly disagree*) to 5 (*strongly agree*). The MDS items are displayed in Appendix E. All item scores were averaged resulting in scores from one to five with higher scores indicating a greater tendency to morally disengage.

The MDS has been widely used in research, particularly to test moral disengagement as a mechanism through which relationships between personal determinants and a variety of behaviors occur (i.e., unethical decision making, aggression, delinquency; Detert et al., 2008; Pelton et al., 2004). In the scale's initial development and validation, Bandura et al. (1996)

conducted an exploratory factor analysis (EFA) that revealed a one-factor structure with all items loading on a principal factor, which was further supported by a later validation study (Bandura et al., 2001). In both studies, the MDS achieved a sufficient Cronbach's alpha reliability estimate of 0.82 and 0.86, respectively. In the validation sample of Italian adolescents ($N = 799$), the MDS (self-report) was shown to positively correlate with aggression ($r = 0.36$, $p < .001$) and delinquency ($r = 0.45$, $p < .001$) and negatively correlate with prosocial behavior ($r = -0.28$, $p < .001$; Bandura et al., 1996). Further, these relationships corresponded with teacher, peer, and parent ratings of the variables as well. Pelton et al. (2004) replicated these findings in an American sample of children with an EFA revealing a one-factor structure, a Cronbach's alpha reliability estimate of 0.82, and correlations with the aforementioned variables in the expected directions.

In a sample of adolescents ($N = 384$), the MDS achieved a Cronbach's alpha reliability estimate of 0.95 and correlated negatively with self-regulation ($r = -0.43$, $p < .001$) and engagement in prosocial behaviors (i.e., charity; $r = -0.17$, $p < .05$), and positively with rule breaking ($r = 0.52$, $p < .001$; Hardy et al., 2015). In a sample of adults ($N = 307$), the MDS (with item wordings modified for use with adults) achieved an overall Cronbach's alpha reliability estimate of 0.87 (Detert et al., 2008). The reported fit statistics for a maximum-likelihood estimated model indicated that a one-factor model fit the data (root-mean-square error of approximation = .05; non-normed fit index =.95; comparative fit index = .96; root-mean-square residual = .06). This further supports results of Bandura et al. (1996; 2001) that moral disengagement should be measured as a unilateral higher order concept and provides support for its validity and reliability in a sample of American adults. Further, expected correlations emerged between moral disengagement and cynicism ($r = 0.30$, $p < .001$), empathy ($r = -0.27$, $p < .001$),

and gender in that males were more likely to morally disengage than females ($r = 0.30$, $p < .001$), providing support for the validity of the MDS in an adult sample (Detert et al., 2008).

Empathy Subscale. The Empathy Subscale, a facet of Agreeableness from the International Personality Item Pool (IPIP; Goldberg, 2001), was used to measure trait empathy. The subscale measures one's willingness to consider others' problems and emotions both affectively and cognitively and represents a general disposition of empathy. This subscale includes 10 items that are rated on a seven-point, Likert-type scale from 1 *(strongly disagree)* to 7 *(strongly agree).* The directions ask the participants to use the rating scale to indicate how accurately each statement describes them. An example item on the IPIP Empathy subscale is, "I suffer from others' sorrows." Six of the items on the subscale are reverse coded. For example, a reverse coded item is, "I am not interested in other people's problems." The IPIP Empathy subscale items are displayed in Appendix F.

Detert et al. (2008) used the IPIP Empathy subscale to assess trait empathy in a sample of business and education college students ($N = 307$). The 10-item scale achieved a Cronbach's alpha reliability estimate of 0.81. Empathy subscale scores were correlated with moral identity ($r = 0.22$, $p < .001$), gender ($r = -0.34$, $p < .001$) in that females obtained significantly higher scores than males, and field of study ($r = -0.26$, $p < .001$) in that education students obtained significantly higher scores than business students. Results also showed that Empathy subscale scores were negatively correlated with inversely related variables, such as moral disengagement ($r = -0.27$, $p < .001$) and unethical decision making ($r = -0.21$, $p < .001$). This provides evidence for the concurrent validity of the IPIP Empathy subscale. In a sample of employees ($N = 452$), Guenole and Chernyshenko (2005) found that the Empathy subscale was positively correlated with organizational citizenship behavior ($r = 0.27$, $p < .05$) further supporting the convergent

validity of the subscale. Similar to Detert et al. (2008), the subscale achieved a Cronbach's alpha reliability estimate of 0.88 in the sample.

Moral Identity Subscale. Aquino and Reed's (2002) Internalization subscale was used to measure moral identity. This five-item subscale captures the degree to which an individual's moral traits are central to their self-concept. The items are rated on a five-point, Likert-type scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Prior to responding to the items, participants are provided the following list of descriptors: "Caring, Compassionate, Fair, Friendly, Generous, Helpful, Hardworking, Honest, and Kind." Then, they are asked to visualize in their mind the kind of person who has these characteristics and imagine how that person would think, feel, and act. With that mental visualization, participants are asked to respond to the five items. An item example is, "Being someone who has these characteristics is an important part of who I am." Two of the items are reverse coded. An example of a reverse coded item is, "I would be ashamed to be a person who has these characteristics." The Internalization subscale items are displayed in Appendix G.

As theorized in SCT (Bandura, 1991; 1999b), moral identity influences moral agency and ethical decision making. Moral identity as measured by the Internalization subscale has been found to be a robust predictor of psychological and behavioral ethicality. The scale was even found to be a better predictor of ethics-related attitudes and behaviors than the Symbolization subscale, which captures the extent to which one's moral traits are reflected in their actions (Aquino & Reed, 2002; Aquino et al., 2007). In the initial validation study, which utilized a community sample of adults ($N = 347$), the Internalization subscale achieved a Cronbach's alpha reliability estimate of 0.82 and correlated with the Symbolization subscale ($r = 0.44$, $p < .001$) in support of the subscale's convergent validity. In a sample of adolescents ($N = 384$), the scale

achieved a Cronbach's alpha reliability estimate of 0.80 and positively correlated with engagement in prosocial behaviors, such as charity ($r = 0.39$, $p < .001$) and civic engagement ($r = 0.27$, $p < .001$; Hardy et al., 2015). Detert et al. (2008) also used the Internalization subscale in a sample of education and business students ($N = 307$), which achieved a Cronbach's alpha reliability estimate of 0.77 in the sample. Again, the theorized relationships emerged as the subscale was positively correlated with empathy ($r = 0.22$, $p < .001$) and negatively correlated with moral disengagement ($r = -0.24$, $p < .001$) and gender in that females reported their moral identity as more highly self-important than males ($r = -0.16$, $p < .01$). This further supports the reliability and validity of the Internalization subscale.

Social Media Use Item. One item was included to assess participant social media use. This item from the Pew Research Center Internet Use Survey Items (2014) is answered on a six-point Likert-type scale from 1 (*never*) to 6 (*almost constantly*) with higher scores indicating more social media use. Participants were primed to think about the social networking sites they use before responding. The item states, "About how often do you visit or use social networking sites?" Pew Research Center reports that the margin of error for all adults is +/- 2.5 percentage points. This item is displayed in Appendix H.

Attention Check Items. To ensure that participants navigated the survey carefully and deliberately, two attention check items were included. These items were used to detect careless or rushed response styles. Attention check items were modeled after those from a previous study (Will et al., 2017) and tailored to the topic of the present study. An example of an attention check item is, "I have heard of Google." The items were answered on a five-point Likert-type scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Acceptable responses included 4 (*agree*) and 5 (*strongly agree*). Attention check items are displayed in Appendix I.

RESULTS

Participant Demographics

A national sample of 131 doctoral-level trainees, post-doctoral fellows, and licensed psychologists participated in one of two arms of data collection: virtual focus group or online survey. For the focus group arm, five 90-minute virtual focus groups were conducted between February 22, 2021 and March 15, 2021. Between five and nine participants ($M = 7.2$) participated in each focus group resulting in a total of 36 participants. Ninety-five additional licensed psychologists and doctoral or post-doctoral trainees were recruited to take the online survey. One case was deleted for failing both attention check items, and the total survey sample size included for analysis was 94 participants.

All participants were asked to report demographic information related to their personal and professional identity. They were asked to provide information about their age, years of clinical experience, gender identity, racial identity, ethnicity, professional status, discipline, clinical services they provide, primary client population, practice setting, and theoretical orientation. Focus group demographics were collected prior to the date of the focus group. Thus, demographic information includes one participant who did not attend the focus group after sign up. Unfortunately, there is no way of knowing which participant did not attend, as the data were collected in a way that protects client confidentiality and privacy. Survey participant demographics were collected at the onset of the survey. Demographic data for both the virtual focus group sample and the online survey sample are presented in Table 2 and discussed below.

Table 2

Participant Demographics

	Focus Group Participants	Survey Participants
N	37	94
Age (*M, SD)*	30.10 (4.99)	35.10 (10.94)
Years of Experience (*M, SD)*	5.68 (3.70)	8.52 (8.48)
Gender Identity		
Male	4 (10.8%)	16 (17.0%)
Female	32 (86.5%)	77 (81.9%)
Transgender/Non-binary	1 (2.7%)	1 (1.1%)
Racial Identity		
White	20 (54.1%)	69 (73.4)
Asian	7 (18.9%)	13 (13.8%)
Black/African American	3 (8.1%)	1 (1.1%)
Middle Eastern	2 (5.4%)	2 (2.1%)
Native American	0 (0%)	1 (1.1%)
Mixed Race/Multiracial	5 (13.5%)	7 (7.4%)
Ethnicity		
Hispanic/Latino/a	5 (13.5%)	7 (7.4%)
Professional Status		
Doctoral Student	30 (81.1%)	45 (47.9%)
Post-doctoral Fellow	2 (5.4%)	15 (16.0%)
Licensed Psychologist	5 (13.5%)	34 (36.2%)
Discipline		
Clinical Psychology	29 (78.4%)	76 (80.9%)
Counseling Psychology	8 (21.6%)	16 (17.0%)
Combined Psychology	0 (0%)	2 (2.1%)
Clinical Services		
Therapy/Counseling	35 (94.6%)	77 (81.9%)
Psychological Assessment	29 (78.4%)	71 (75.5%)
Consultation	15 (40.5%)	32 (34.0%)
Supervision	1 (2.7%)	0 (0%)
Coaching	1 (2.7%)	0 (0%)
Outreach Programming	0 (0%)	1 (1.1%)

Table 2 Continued

	Focus Group Participants	Survey Participants
Client Population		
Adults	26 (70.3%)	63 (67.0%)
Adolescents	5 (13.5%)	9 (9.6%)
Children	3 (8.1%)	10 (10.6%)
Whole Lifespan	3 (8.1%)	12 (12.8%)
Practice Setting		
Medical Center/Hospital	13 (35.1%)	29 (30.9%)
Outpatient Clinic	8 (21.6%)	19 (20.2%)
Private Practice	2 (5.4%)	13 (13.8%)
University Counseling Center	3 (8.1%)	5 (5.3%)
Veteran's Affairs	3 (8.1%)	8 (8.5%)
Prison/Correctional Facilities	3 (8.1%)	2 (2.1%)
Community Mental Health	2 (5.4%)	10 (10.6%)
University Training Clinic	1 (2.7%)	0 (0%)
University Outreach Program	1 (2.7%)	0 (0%)
Outpatient Forensic Setting	1 (2.7%)	0 (0%)
Rehabilitation Center	0 (0%)	2 (2.1%)
Psychiatric Facility	0 (0%)	2 (2.1%)
Learning Center	0 (0%)	1 (1.1%)
Nursing Home	0 (0%)	1 (1.1%)
Forensic Hospital	0 (0%)	1 (1.1%)
Theoretical Orientation		
Cognitive-Behavioral	16 (43.2%)	59 (62.8%)
Integrated/Eclectic	16 (43.2%)	20 (21.3%)
Psychodynamic/Psychoanalytic	2 (5.4%)	1 (1.1%)
Humanistic/Existential	1 (2.7%)	4 (4.3%)
Multicultural	1 (2.7%)	3 (3.2%)
Behavioral	1 (2.7%)	0 (0%)
Empirical	0 (0%)	1 (1.1%)
Biopsychosocial	0 (0%)	1 (1.1%)
No Orientation	0 (0%)	5 (5.3%)

Note. Some participants did not disclose certain aspects of their identity. For Clinical Services, participants were asked to select all that currently or recently apply.

Age

The mean age of the focus group sample was 30.1 years (*SD* = 4.99). The age range represented in the focus group sample was 25 to 49 years. The survey sample was five years older on average with a mean age of 35.1 years (*SD* = 10.94). The age range represented in the survey sample was 23 to 69 years. The median age of the survey sample was 31 years and may be a more accurate depiction of the sample given the broad range of ages represented.

Years of Experience

The mean years of experience providing psychological services in the focus group sample was 5.68 years (*SD* = 3.70). The range of years of clinical experience represented in the focus group sample was two to 22 years of experience. The mean years of clinical experience reported in the focus group sample was approximately three years less than the mean years of experience reported in the survey sample with a mean of 8.52 years (*SD* = 8.48). The range of years of experience represented in the survey sample was one year to 44 years. The median experience reported in the survey sample was five years and may be a more accurate depiction of the sample given the broad range of experience represented.

Gender Identity

The majority of the focus group sample identified as female (86.5%). The remainder of the focus group sample identified as male (10.8%) and transgender or non-binary (2.7%). Females were overrepresented and males were underrepresented in the focus group sample compared to the current gender breakdown in the psychology workforce and doctoral programs (Fowler et al., 2018; Lin et al., 2018a). The gender breakdown of the survey sample was similar. The majority identified as female (81.9%), and the remainder identified as male (17.0%) and gender non-binary/gender non-conforming (1.1%). The gender distribution of the survey sample

more closely aligns with the current breakdown in clinical psychology doctoral programs (78% female, 22% male; Fowler et al., 2018).

Racial Identity/Ethnicity

Approximately half of the focus group sample identified as white (54.1%), 18.9% identified as Asian, 8.1% identified as Black or African American, 5.4% identified as Middle Eastern, and 13.5% identified as mixed race or multiracial. No participants identified as Native American or Pacific Islander. When asked about ethnicity, 13.5% of the sample identified as Hispanic or Latino/a. One focus group participant chose not to report their ethnicity. The focus group sample was more racially/ethnically diverse than the survey sample, and many minoritized racial groups including Asian, Black, Hispanic/Latino/a, and multiracial individuals were more represented in the focus groups than they are in the U.S. psychology workforce (Lin et al., 2018a).

The majority of the survey sample (73.4%) reported being white, 13.8% Asian, 7.4% biracial or multiracial, 2.1% Middle Eastern, 1.1% Native American, and 1.1% Black or African American. One participant did not disclose their racial identity. When asked about ethnicity, only 7.4% of the survey sample reported being Hispanic or Latino/a. The survey sample was generally representative of the U.S. psychology workforce, which is 86% white, 5% Asian, 5% Hispanic or Latino/a, 4% Black, and 1% multiracial (Lin et al., 2018a). Asian psychologists were overrepresented within the survey sample, and Black psychologists were underrepresented.

Professional Status

The majority of the focus group sample identified as doctoral students (81.1%). The remainder of the sample identified as either licensed psychologists (13.5%) or post-doctoral fellows (5.4%).The focus group sample had greater representation of doctoral students than the

survey sample. Approximately half of the survey sample (47.9%) reported being doctoral students, 36.2% reported being licensed psychologists, and 16.0% reported being post-doctoral fellows.

Discipline

Most of the focus group sample reported receiving their graduate training from a Clinical Psychology program (78.4%), and the rest reported a Counseling Psychology program (21.6%). No focus group participants reported receiving their training from a Combined Psychology program. Similarly, the majority of the survey sample (80.9%) reported that their graduate training was from a Clinical Psychology program. The remainder of the survey sample reported their graduate training as being from a Counseling Psychology (17.0%) or Combined Psychology program (2.1%). Thus, both samples largely represented those with a clinical background.

Clinical Services

The majority of the focus group sample reported providing therapy or counseling services (94.6%) and/or psychological assessment (78.4%). Many focus group participants also reported providing consultation services (40.5%). Additionally, one participant reported providing supervision (2.7%), and one participant reported providing coaching services (2.7%). In the survey sample, 81.9% reported providing assessment services, 75.5% reported providing therapy/counseling services, 34.0% reported providing consultation services, and 1.1% reported doing outreach programming.

Client Population

The majority of the focus group sample reported primarily working with adult clients (70.3%). Other focus group participants reported primarily working with adolescents (13.5%) or children (8.1%), and the remainder reported working with clients across the lifespan (8.1%).

Similarly, 67% of the survey sample reported working primarily with adults, 10.6% with children, 9.6% with adolescents, and 12.8% reported working with clients across the lifespan.

Practice Setting

The practice settings most represented in the focus group sample were medical centers (35.1%), outpatient clinics (21.6%), university counseling centers (8.1%) Veteran's Affairs (8.1%), and prisons/correctional facilities (8.1%). Other practice settings represented by either one or two focus group participants included community mental health centers (5.4%) , private practices (5.4%), university training/psychology department clinics (2.7%), university wellness outreach programs (2.7%), and outpatient forensic settings (2.7%). In the survey sample, 30.9% reported practicing in a medical center or hospital, 20.2% in an outpatient clinic, 13.8% in private practice, and 10.6% in community mental health centers. Other practice settings represented in the survey sample include Veterans Affairs (8.5%), university counseling centers (5.3%), rehabilitation centers (2.1%), prisons or correctional facilities (2.1%), psychiatric facilities (2.1%), learning centers (1.1%), nursing homes (1.1%), and forensic hospital (1.1%). One survey participant did not disclose their practice setting. Medical centers/hospitals and outpatient clinics were the most common practice settings represented in both samples.

Theoretical Orientation

The theoretical orientations most represented in the focus group sample were Cognitive-Behavioral (43.2%) and Integrated/Eclectic (43.2%). Other orientations represented among the focus group sample include Psychodynamic/Psychoanalytic (5.4%), Humanistic/Existential (2.7%), Multicultural (2.7%), and Behavioral (2.7%). Similarly, in the survey sample a majority of participants reported their theoretical orientation as Cognitive-Behavioral (62.8%), and the next most popular was Integrative/Eclectic (21.3%). Other theoretical orientations represented in

the survey sample included Humanistic/Existential (4.3%), Multicultural (3.2%), Psychodynamic/Psychoanalytic (1.1%), Empirical (1.1%), and Biopsychosocial (1.1%), Additionally, 5.3% of the survey sample reported that they did not have a theoretical orientation. Cognitive-Behavioral and Integrated/Eclectic were the most popular theoretical orientations in both samples.

Data Approach

Qualitative Data Approach

The qualitative data analysis steps outlined in Braun and Clarke (2006) were followed. Two to three investigators coded each data file independently and ultimately reached a consensus together in generating, naming, and organizing themes. Coders included a doctoral candidate in Clinical Psychology, a doctoral candidate in Health Psychology, and an undergraduate research assistant. Data were analyzed by identifying patterns, resemblances, and regularities in participant responses to generate conclusions in the form of themes. After independently coding a data file, a series of meetings were held among coders until agreement was met on all pieces of text or dialogue assigned to nodes. To avoid confirmation bias, coders incorporated discussion into their meetings of issues such as how background knowledge of the existing PTG literature and personal perceptions of PTG may be impacting data interpretation. After all data files were coded, the coders held another series of meetings to finalize the themes present in the data. During this time, the themes were also refined and organized to target the exploratory research questions of the three aims. The coders worked together to display and summarize themes in text, table, and diagram formats in pursuit of the most reader-friendly method.

Quantitative Data Approach

In addition to examining descriptive and correlational statistics, survey data were cleaned, and preliminary analyses were conducted in preparation for conducting two regression

models aiming to examine the relationship between personal determinants of moral agency and PTG practices and attitudes. Regression models were theoretically informed by SCT (Bandura, 1991), which purports that human attitudes and behavior are influenced by self-regulatory processes (i.e., moral disengagement) and other personal determinants of moral agency (e.g., empathy, moral identity). Regression analyses served as a proof of concept to see if SCT is applicable to understanding variations in PTG practices and attitudes among psychologists. Data cleaning, reliability checks, checks of statistical assumptions, and preliminary analyses were conducted prior to conducting main analyses.

Data Preparation

Qualitative Data Preparation

Audio recordings from virtual focus groups were transcribed verbatim using the Otter: Transcribe Voice Notes application. All transcriptions were reviewed twice by two reviewers to ensure accurate transcription. No identifiers were included in the transcriptions. Alphanumerical codes representing each participant were used in place of names, including when names were used within the dialogue. All audio files were deleted after the transcription and data analysis process. Transcription files and the text from qualitative survey items were imported into NVivo 12 software for analysis, and the data were subjected to a computer-assisted thematic analysis.

Reviewers read through the data thoroughly before beginning the coding process. Then, based on the exploratory research questions, the existing PTG literature, and having read through the data, the coders collaboratively created a node map of general topics represented in the data. The node map served as a coding guide that evolved significantly throughout the coding process with many nodes being added, removed, conjoined, and separated.

Quantitative Data Preparation

Survey Data Cleaning. Ninety-five total survey responses were obtained. Two attention check items were checked to ensure participants were engaged and reading the items and response choices when taking the survey. One case was deleted for failing both attention check items. Four cases failed one of the two attention checks, and it was determined to include them in the analyses since they all had a variety of responses, limited or no missing data, and provided meaningful qualitative responses. The total sample size included for analysis was 94.

Next, patterns of missingness were examined using SPSS Missing Value Analysis, which revealed no patterns of missingness. Specifically, no survey item had more than 1.1% missingness. Little's missing completely at random (MCAR) test was not significant (χ^2= 277.953, *df* = 249, *p* = .100), so the data were assumed to be MCAR, and missingness was assumed not to interfere with analyses. It was determined that listwise deletion of observations with missing values was appropriate given the number of missing values was so minimal (Little, 1988). Lastly, necessary item reversals were recoded prior to analyses.

Reliability. Scales used in the primary analyses including PTG Practices and PTG Attitudes were assessed for reliability. In the survey sample, the three-item PTG Practices Scale achieved a Chronbach's alpha of 0.85 indicating sufficient reliability. Inter-item correlations ranged from 0.55 to 0.87. See Table 3 for the inter-item correlation matrix of the PTG Practices Scale items.

Table 3

Inter-Item Correlation Matrix of PTG Practices Scale Items

Item	1	2	3
1. I have searched online for information about a client.	1.00		
2. I have conducted a Google search to find information about a client.	0.87	1.00	
3. I have conducted a search on a social networking site to find information about a client.	0.55	0.57	1.00

The reliability of the PTG Attitudes Scale was also examined. In the survey sample, the three-item PTG Attitudes Scale achieved a Chronbach's alpha of 0.76 indicating sufficient reliability. Inter-item correlations ranged from 0.44 to 0.65. See Table 4 for the inter-item correlation matrix of the PTG Attitudes Scale items.

Table 4

Inter-Item Correlation Matrix of PTG Attitudes Scale Items

Item	1	2	3
1. Searching for client information online is ethical.	1.00		
2. For routine matters, it is ethical to look up a client online.	0.65	1.00	
3. In emergency situations, it is ethical to look up a client online.	0.46	0.44	1.00

The reliability of all preexisting scales used in the online survey were all also examined. In the survey sample, the 32-item Moral Disengagement Scale achieved a Chronbach's alpha of 0.83 indicating sufficient reliability, and inter-item correlations ranged from -0.17 to 0.61. The ten-item Empathy Subscale achieved a Chronbach's alpha of 0.73 indicating sufficient reliability, and inter-item correlations ranged from -0.19 to 0.42. The five-item Moral Identity Subscale achieved a Chronbach's alpha of 0.78 indicating sufficient reliability, and inter-item correlations ranged from 0.26 to 0.68.

Preliminary Analyses. The survey data were examined prior to conducting the main analyses. First, the distributions of all scales were visually assessed using frequency distributions, and skewness and kurtosis metrics were examined. There were no deviations from normality based on absolute skewness and kurtosis criteria suggested by George and Mallery

(2010). Many other scholars recommend equal or less conservative criteria (Byrne, 2010; Hair et al., 2010; Kline, 2010). See Table 5 for skewness and kurtosis values of all scales included in the model. Detrended Q-Q Plots further support that there were no other deviations from normality based on the cutoff score of plus or minus 1.96 as determined by Garson (2012). See Figures 2 and 3 for the frequency distribution and detrended Q-Q plot of PTG Practices Scale data respectively, Figures 4 and 5 for PTG Attitudes Scale data, Figures 6 and 7 for the Moral Disengagement Scale data, Figures 8 and 9 for the Empathy Subscale data, and Figures 10 and 11 for the Moral Identity Subscale data.

Table 5

Skewness and Kurtosis Values for Outcome and Dependent Variables

Scale	Skewness	Kurtosis
PTG Practices	1.23	1.13
PTG Attitudes	0.18	0.17
Moral Disengagement	-0.18	-0.54
Empathy	-0.47	-0.32
Moral Identity	-1.19	0.76

Figure 2

Frequency Distribution of Self-Reported PTG Practices

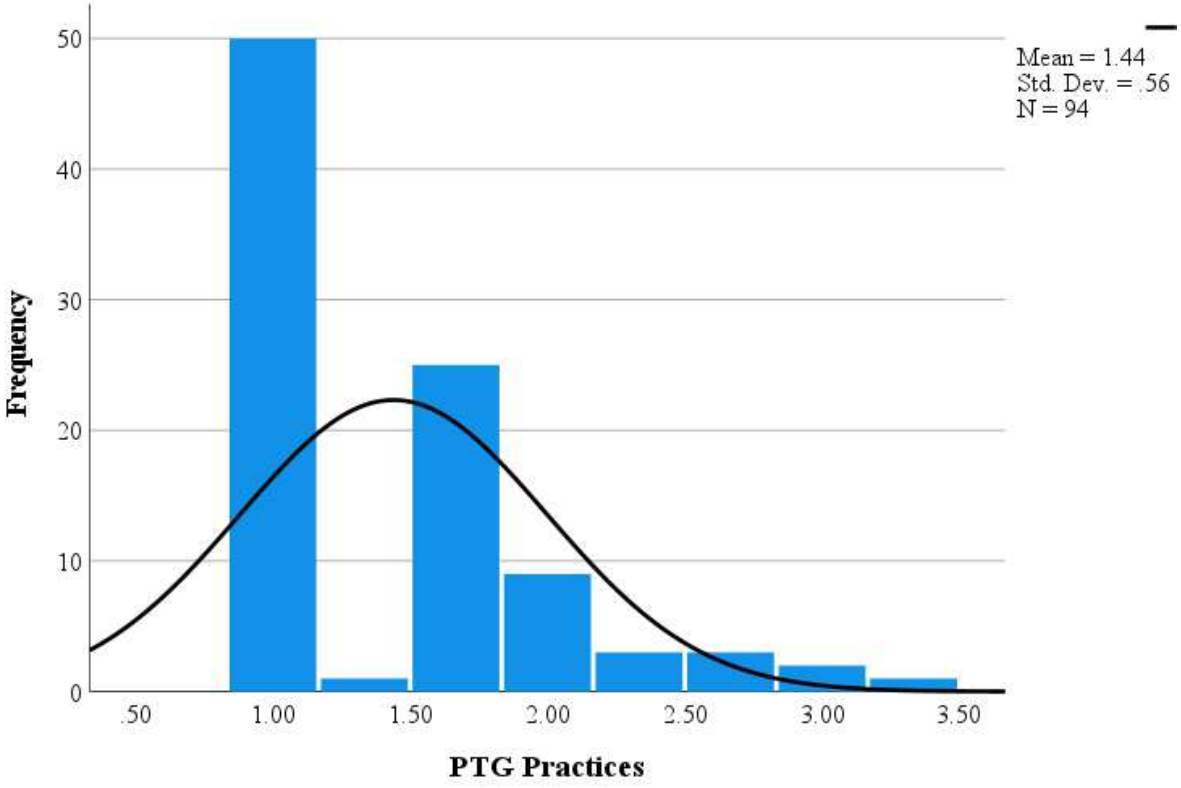


Figure 3

Detrended Normal Q-Q Plot of Self-Reported PTG Practices

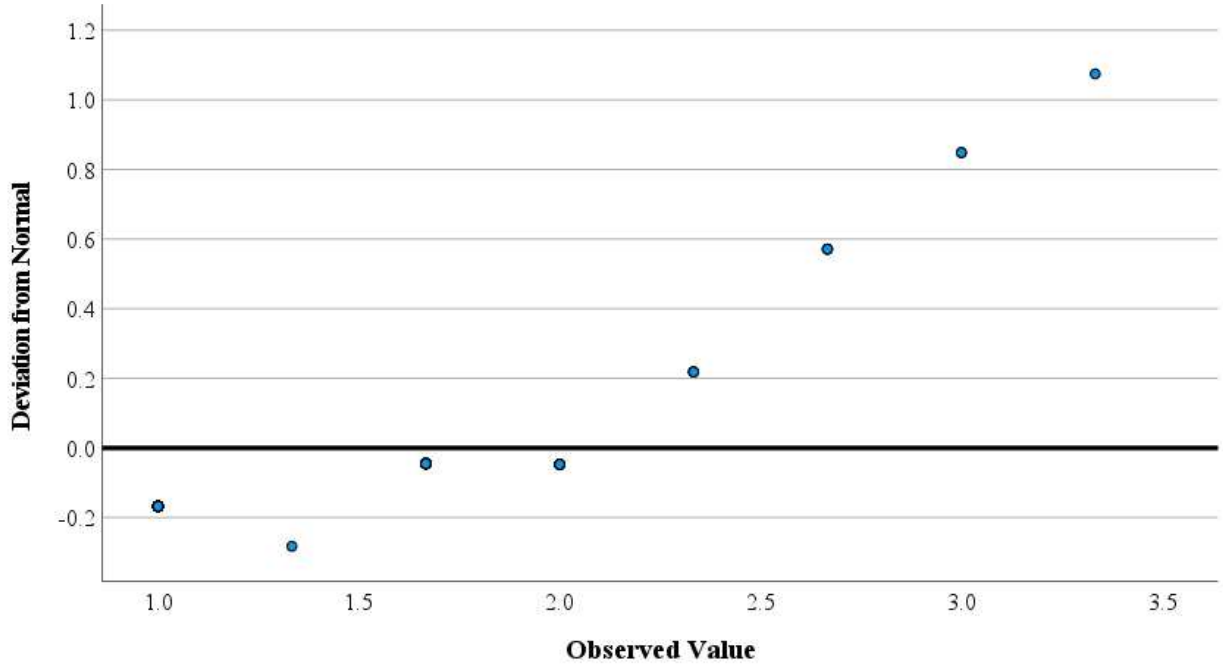


Figure 4

Frequency Distribution of Self-Reported PTG Attitudes

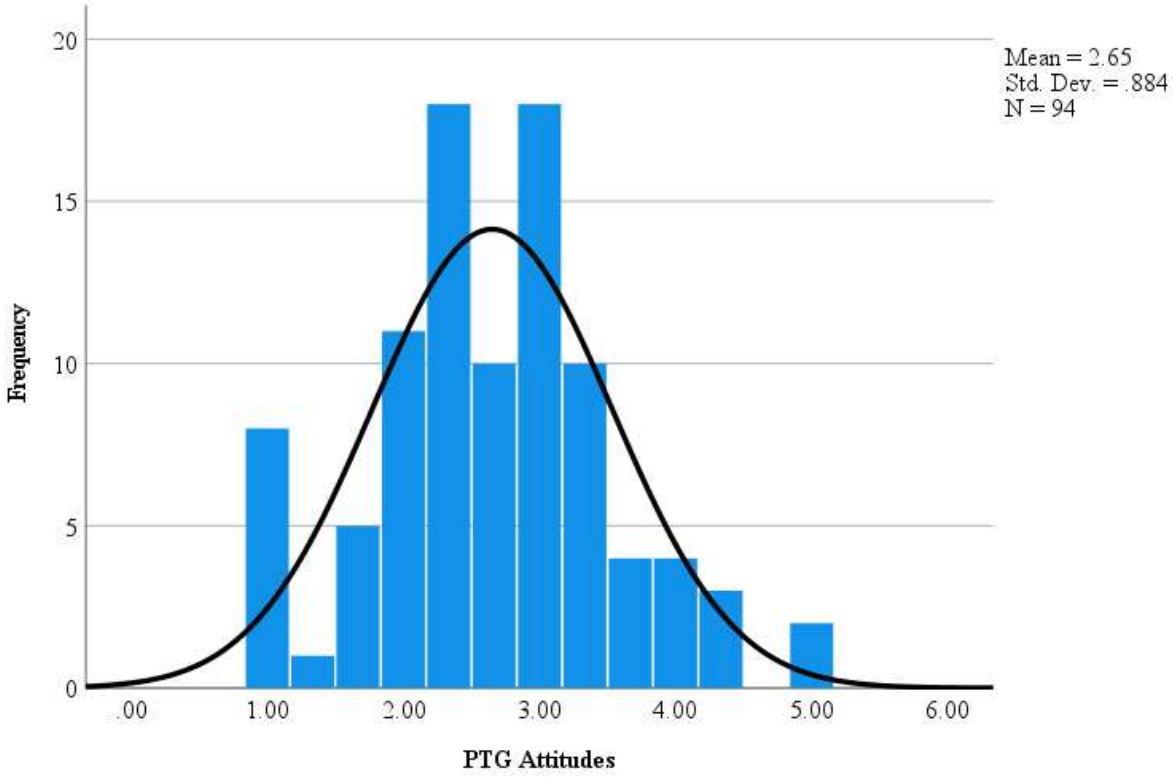


Figure 5

Detrended Normal Q-Q Plot of Self-Reported PTG Attitudes

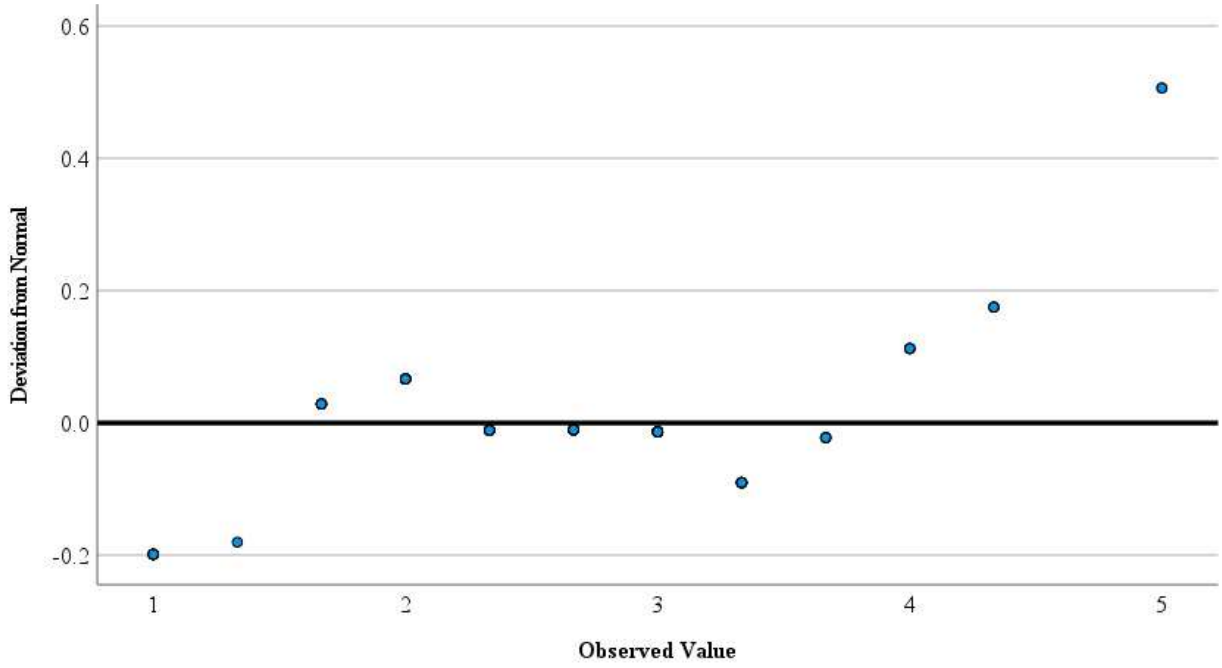


Figure 6

Frequency Distribution of Self-Reported Moral Disengagement

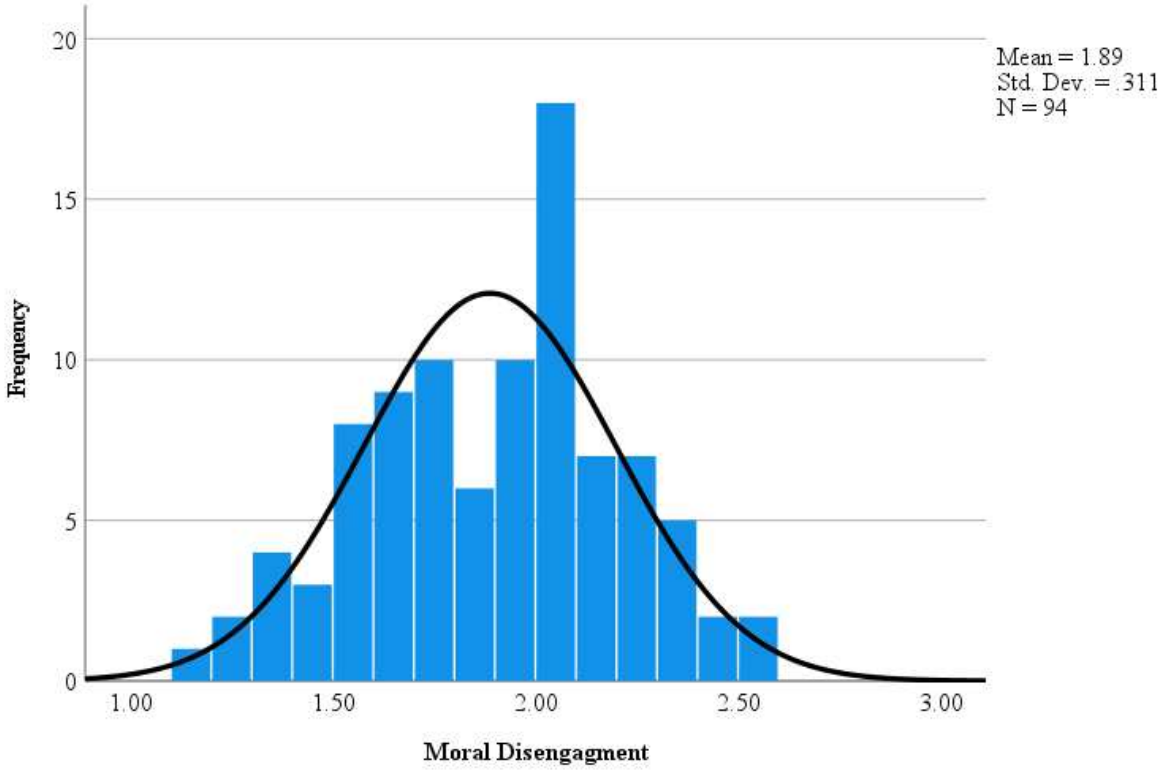


Figure 7

Detrended Normal Q-Q Plot of Self-Reported Moral Disengagement

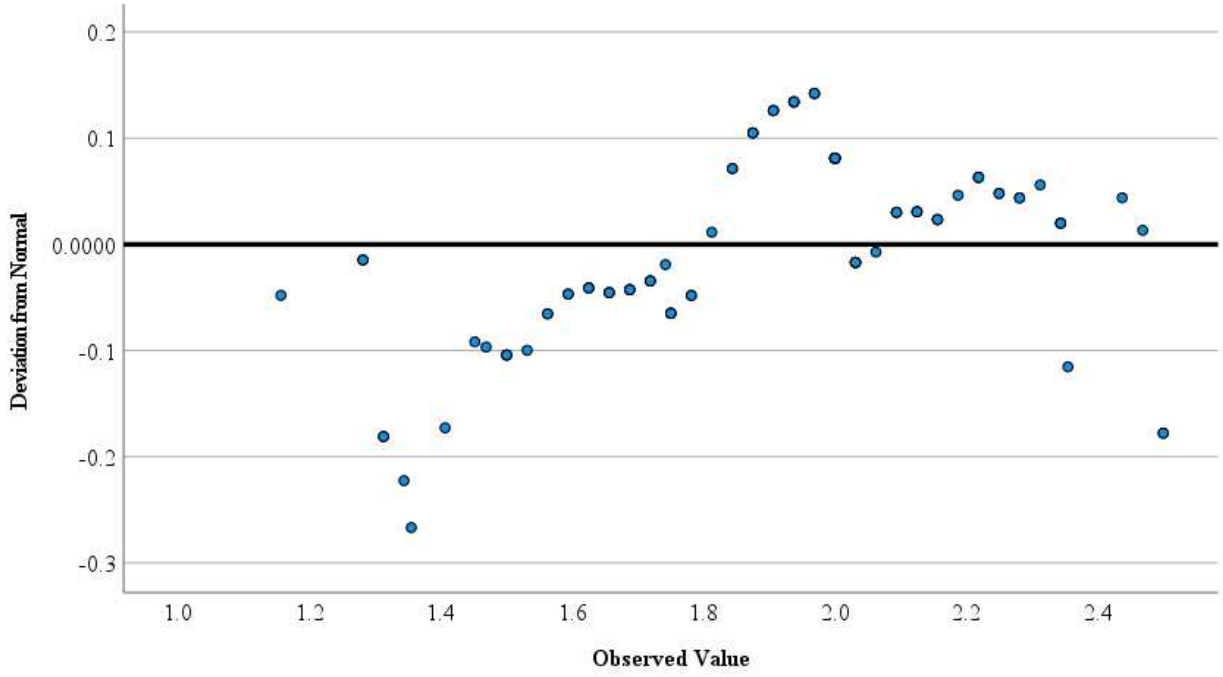


Figure 8

Frequency Distribution of Self-Reported Trait Empathy

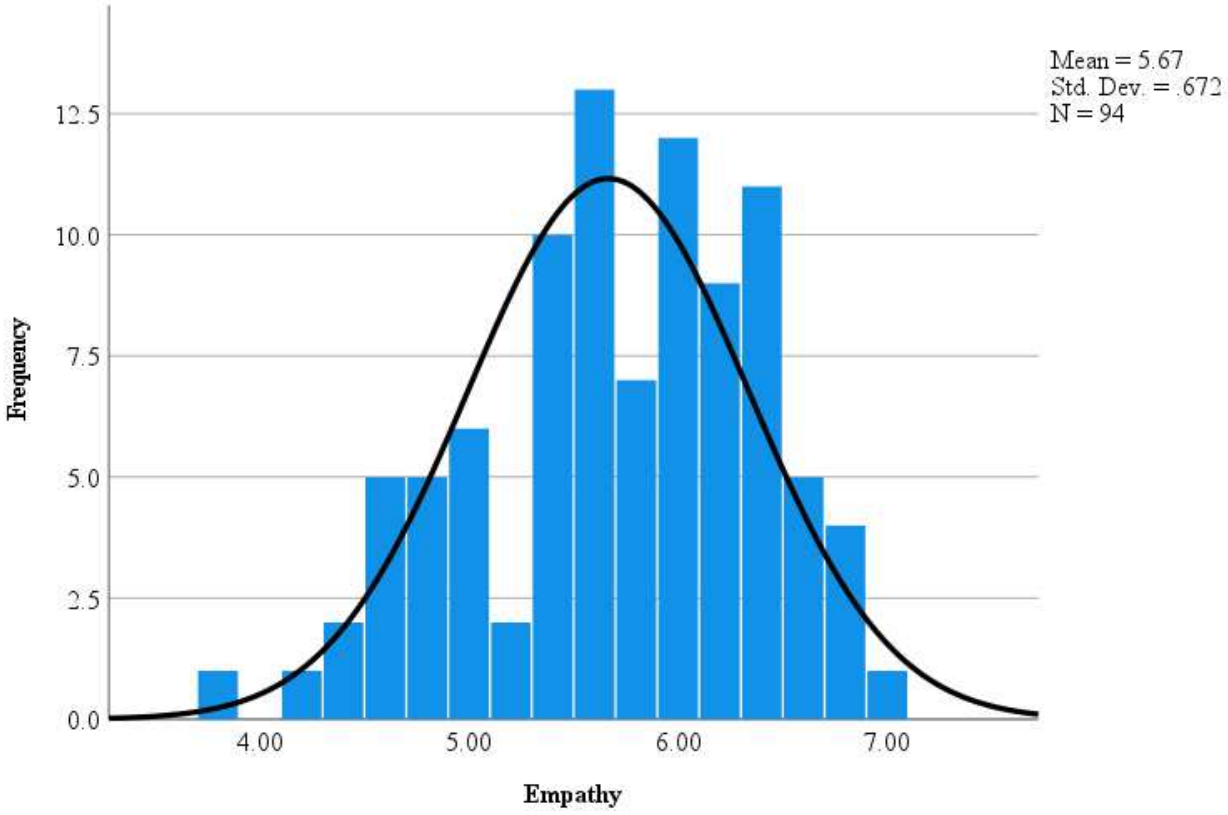


Figure 9

Detrended Normal Q-Q Plot of Self-Reported Trait Empathy

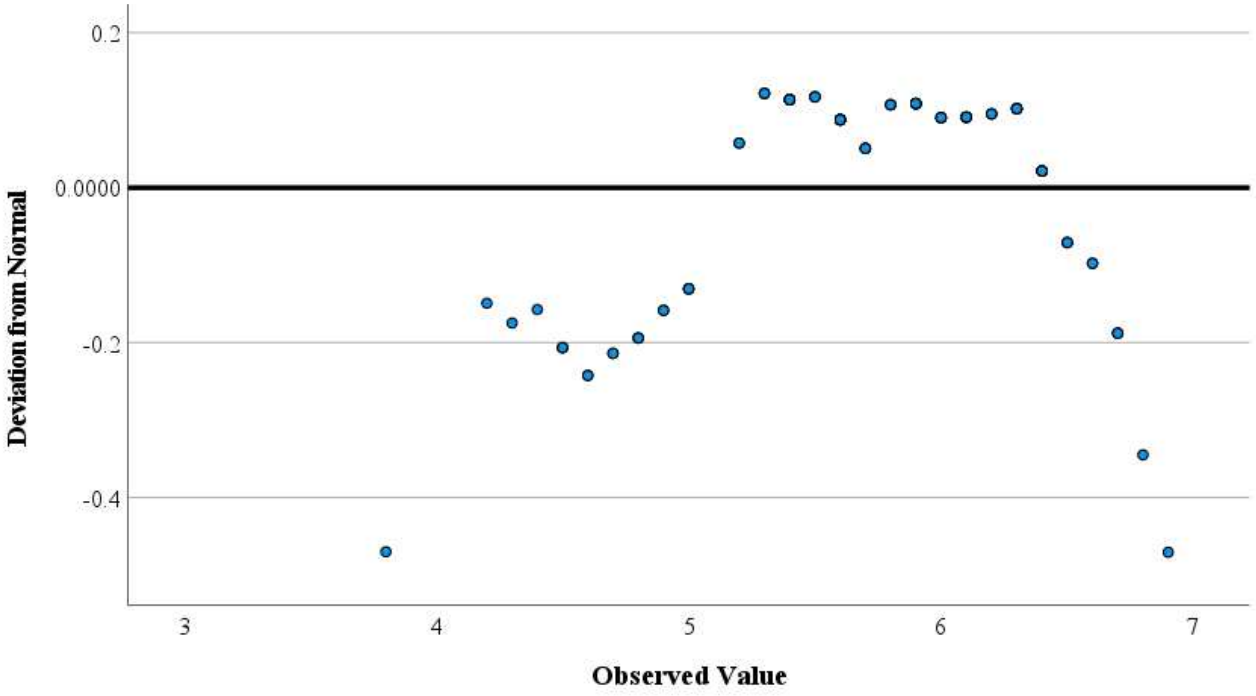


Figure 10

Frequency Distribution of Self-Reported Moral Identity

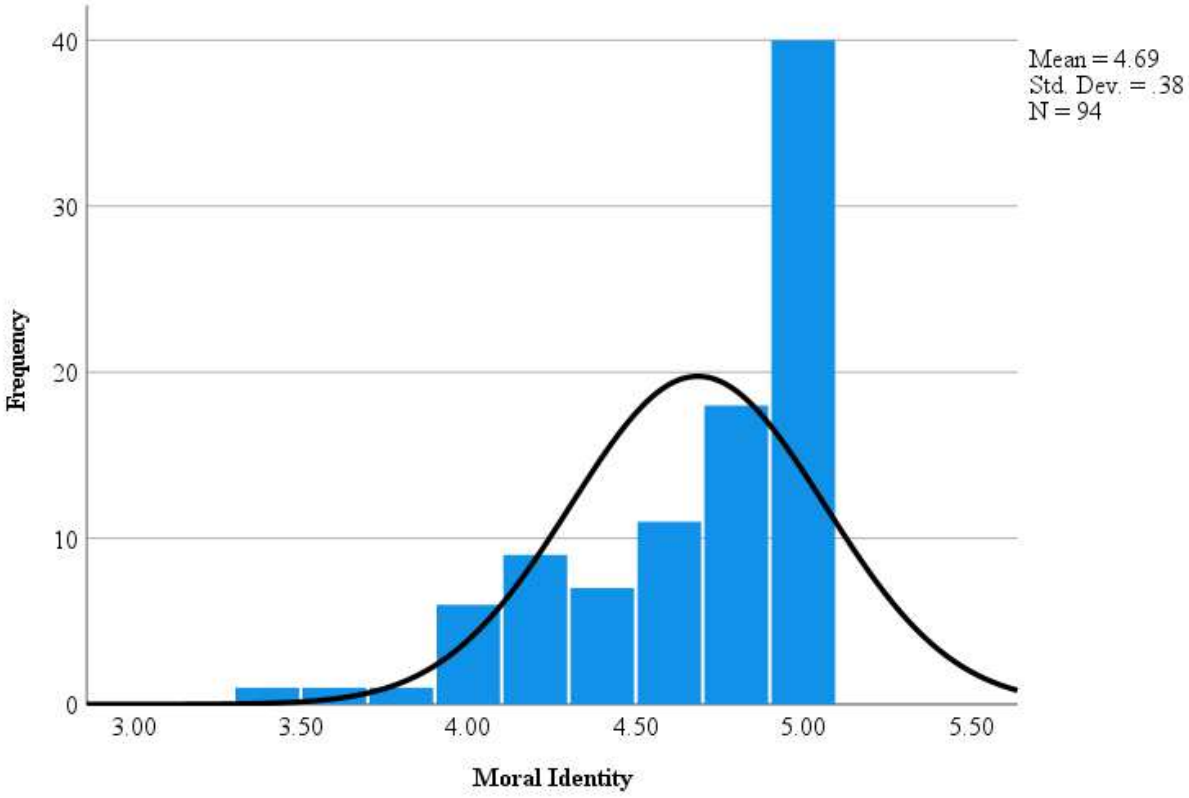
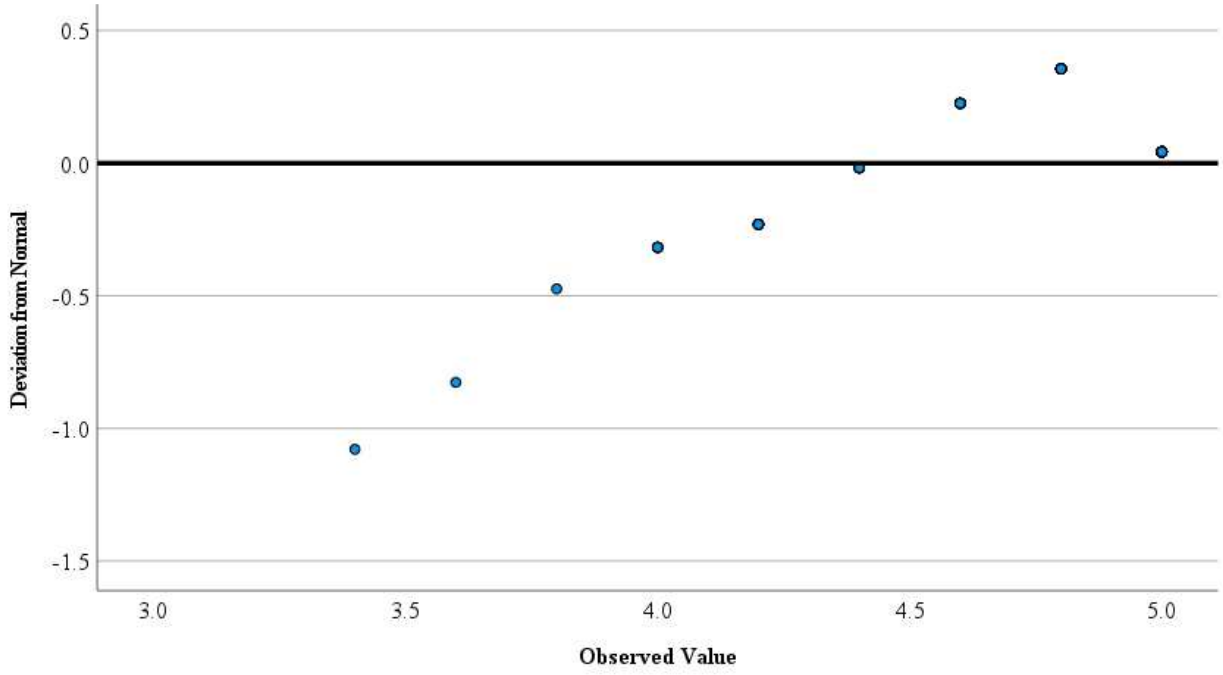


Figure 11

Detrended Normal Q-Q Plot of Self-Reported Moral Identity



Next, significant outliers were examined for all scales using boxplots. For PTG practices, three outliers were identified (see Figure 12). For PTG attitudes, two outliers were identified (see Figure 13). No outliers were identified for moral disengagement (see Figure 14). For empathy, one outlier was identified (see Figure 15). For moral identity, one outlier was identified (See Figure 16). Significant outliers identified for PTG attitudes, empathy, and moral identity were winsorized using the plus or minus one rule prior to analyses.

Figure 12

Boxplot of PTG Practices Scale Scores Showing Three Outliers

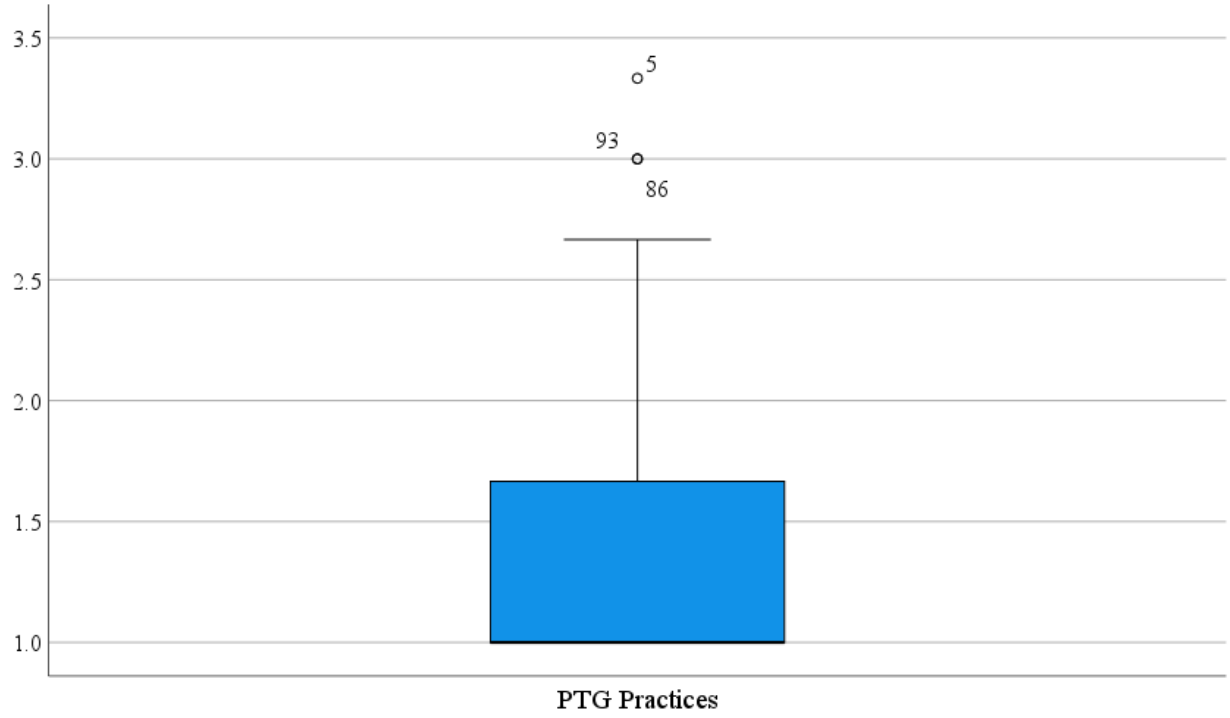


Figure 13

Boxplot of PTG Attitudes Scale Scores Showing Two Outliers

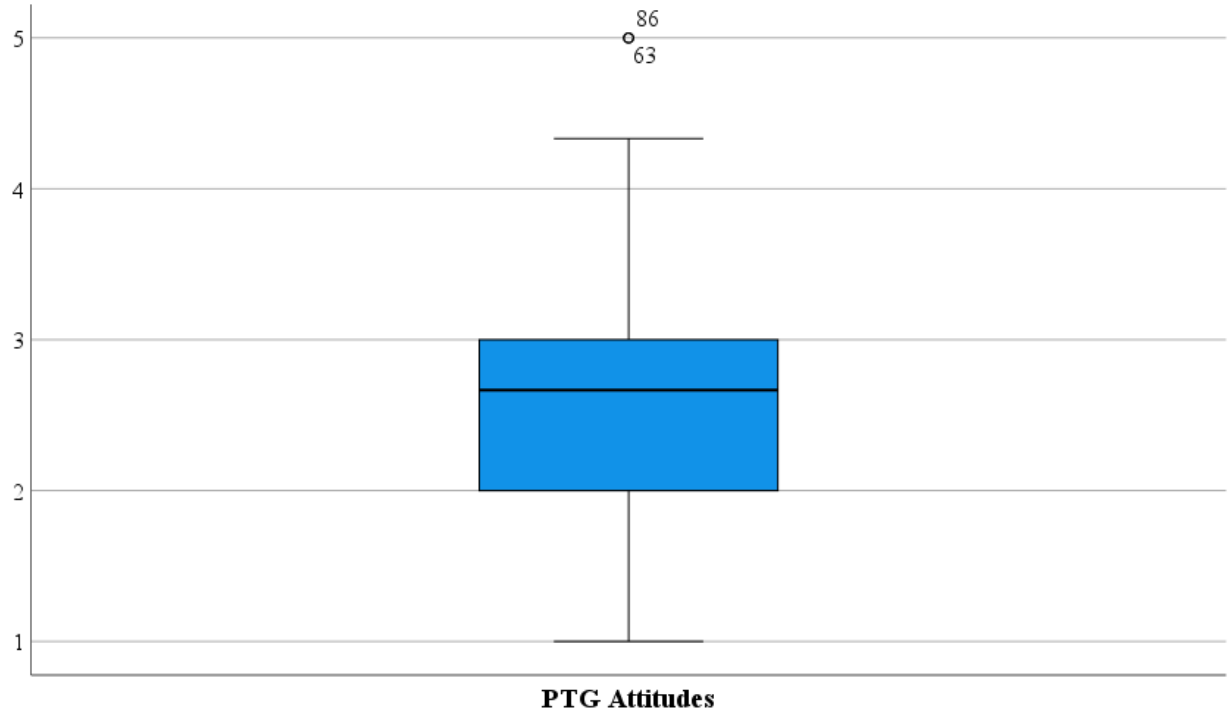


Figure 14

Boxplot of Moral Disengagement Scale Scores Showing No Outliers

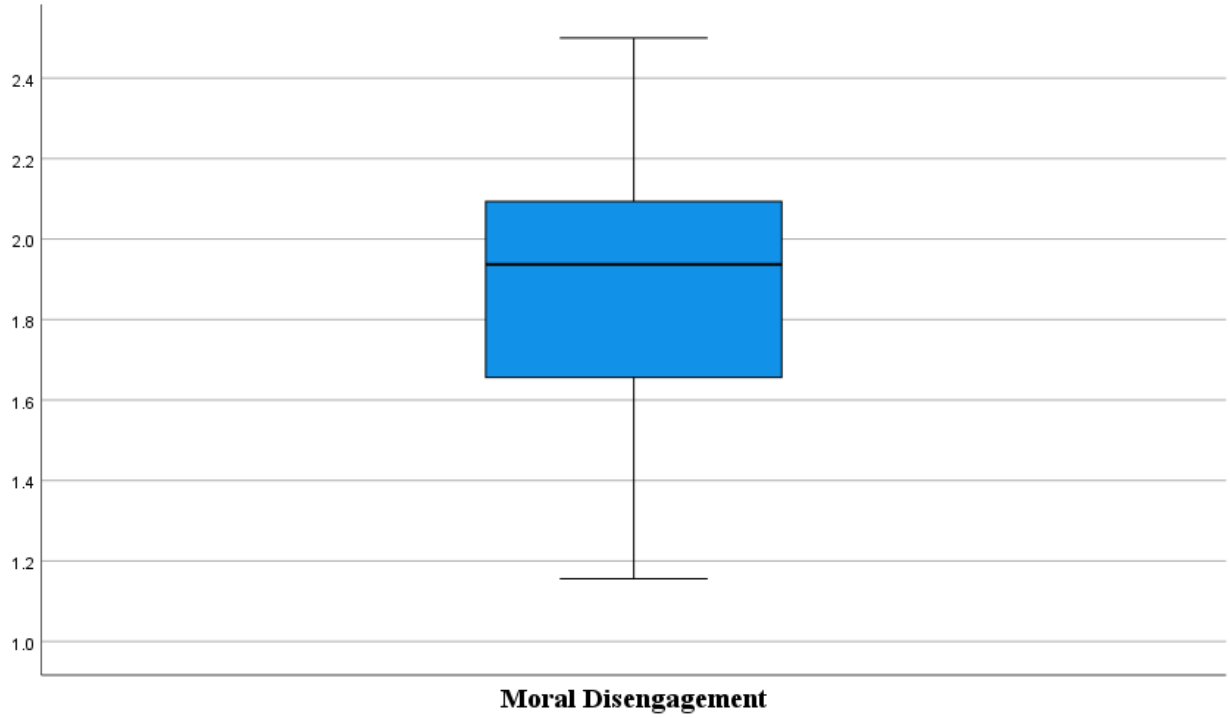


Figure 15

Boxplot of Empathy Subscale Scores Showing One Outlier

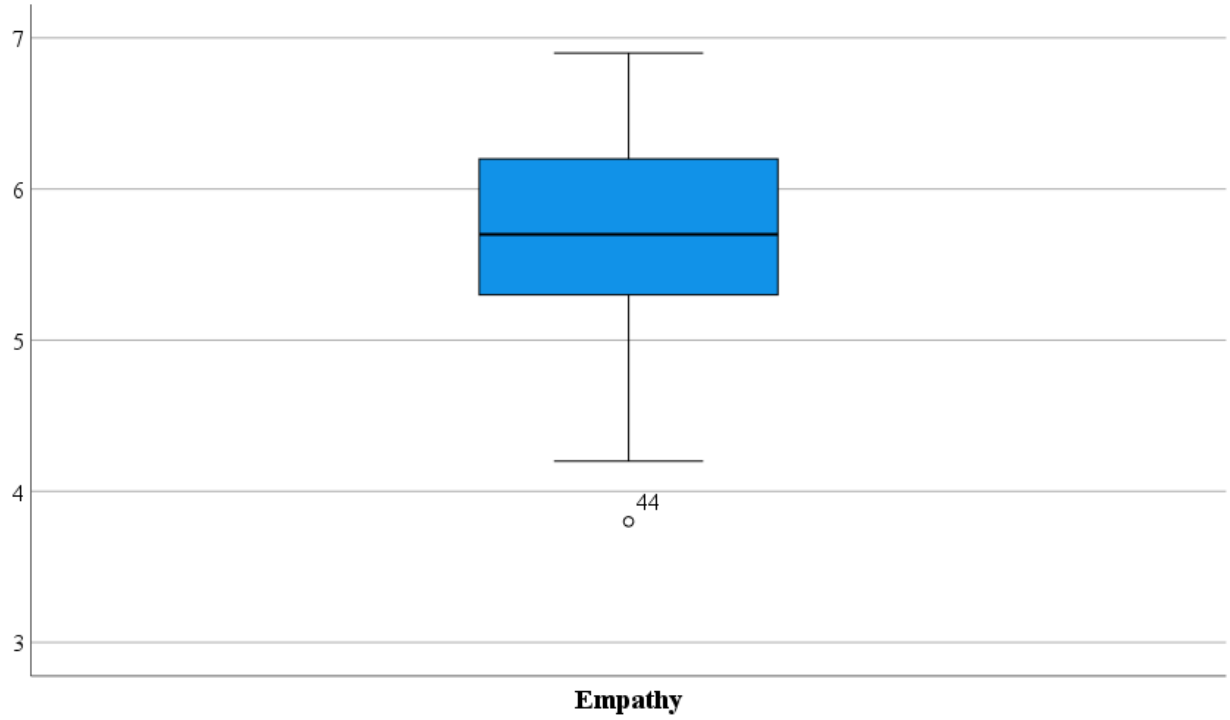
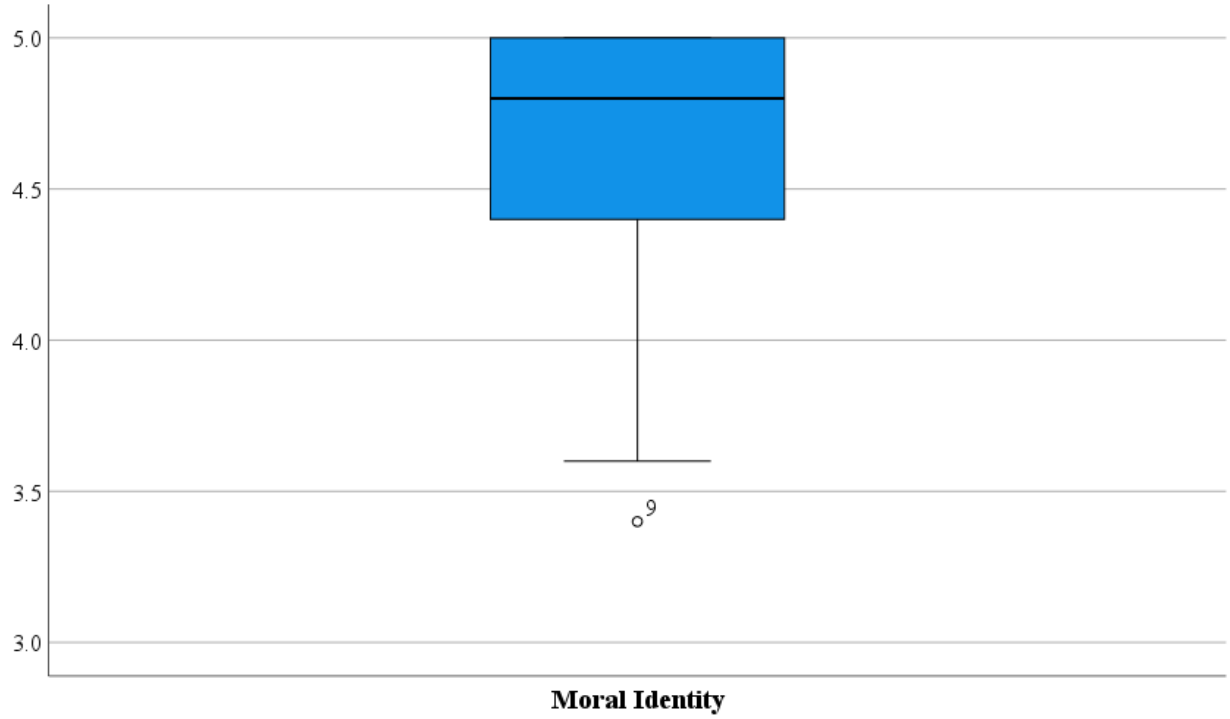


Figure 16

Boxplot of Moral Identity Subscale Scores Showing One Outlier



Descriptive Statistics. All survey responses related to PTG practices, attitudes, and training and ethical guidance needs were examined in addition to moral disengagement, empathy, moral identity, and social media use scale scores. On a scale from 1 (never) to 5 (always), the mean score for PTG practices was 1.44, indicating that the sample on average never to rarely engages in PTG. On a scale from 1 (strongly disagree) to 5 (strongly agree), the mean score for PTG attitudes was 2.65 indicating that the sample on average falls between perceiving PTG as unethical and being neutral about the ethicality of PTG. The mean score for moral disengagement on a scale from 1 (strongly disagree) to 5 (strongly agree) was 1.89 indicating that the sample on average has a low propensity to morally disengage. The mean score for

empathy was 5.67 on a scale from 1 (strongly disagree) to 7 (strongly agree) indicating the sample on average is highly empathic. The mean score for moral identity was 4.69 on a scale from 1 (strongly disagree) to 5 (strongly agree) indicating that the sample on average has a very highly self-important moral identity. The mean response for social media use was 4.40 on a scale from 1 (never) to 6 (almost constantly) indicating that on average the sample uses social media between one and several times a day (but not constantly). See Table 6 for means and standard deviations at the scale level. Additional descriptive findings regarding PTG practices, attitudes, and training needs are discussed in more depth under results for aims 1 through 3.

Table 6

Survey Mean Scale Scores

Scale	Mean	SD
PTG Practices	1.44	0.56
PTG Attitudes	2.65	0.88
Moral Disengagement	1.89	0.31
Empathy	5.67	0.67
Moral Identity	4.69	0.38
Social Media Use	4.40	1.19

Note. PTG Practices were measured on a scale from 1 (never) to 5 (always) with lower scores indicating less engagement in PTG. PTG Attitudes were measured on a scale from 1 (strongly disagree) to 5 (strongly agree) with lower scores indicating more conservative attitudes. Moral Disengagement was measured on a scale from 1 (strongly disagree) to 5 (strongly agree) with lower scores indicating a lower propensity to morally disengage. Empathy was measured on a scale from 1 (strongly disagree) to 7 (strongly agree) with lower scores indicating lower trait-level empathy. Moral Identity was measured on a scale from 1 (strongly disagree) to 5 (strongly agree) with lower scores indicating less self-important moral identity. Social Media Use was measured on a scale from 1 (never) to 6 (almost constantly) with lower scores indicating fewer social media use.

Scale and Item Correlations. Correlational relationships between variables were examined. There was a significant, positive correlation between PTG practices and PTG attitudes ($r = 0.49$, $p < 0.001$) indicating high convergent validity. Interestingly, neither PTG practices nor PTG attitudes were found to be significantly correlated with any other survey scales including the Moral Disengagement Scale, Empathy Subscale, or Moral Identity Subscale. See Table 7 for a correlation matrix demonstrating relationships between all survey scales. Although the full

scales were not found to be related to PTG practices or attitudes, select items were. One item on the Empathy Subscale, "I believe in an eye for an eye," was related to both PTG practices (r = 0.25, p = 0.017) and PTG attitudes (r = 0.22, p = 0.034). This indicates that as one's agreement with that statement increased, so did their engagement in PTG and liberal PTG attitudes. The Moral Disengagement Scale item, "Some people deserve to be treated like animals," which taps into an individual's tendency to justify their behavior through dehumanizing others, was also positively related to PTG practices (r = 0.25, p = 0.017). This indicates that as one's agreement with that statement increased, so did their engagement in PTG.

Moral disengagement was found to be negatively correlated with moral identity in that as one's morality becomes a more highly important part of their identity, their propensity to morally disengage decreases (r = -0.24, p = 0.02). Trait empathy was found to be positively correlated with moral identity in that as one's morality becomes a more highly important part of one's identity, their trait empathy increases (r = 0.49, $p < 0.001$). Having received more formal PTG training was positively correlated with having received PTG ethical guidance (r = 0.77, $p <$ 0.001). PTG training was negatively correlated with feeling like they would benefit from more training and guidance (r = -0.28, p = 0.007) as was PTG ethical guidance (r = 0.28, $p < 0.005$). This indicates that participants with previous PTG ethical training and/or guidance experiences expressed less need for more training and guidance. However, correlations between PTG training and PTG attitudes (r = -0.08), PTG practices (r = 0.05), and wanting more explicit guidance from APA (r = 0.02) were negligible.

Table 7

Correlation Matrix of Scales

Scale	1	2	3	4	5
1. PTG Practices	1				
2. PTG Attitudes	0.49**	1			
3. Moral Disengagement	0.01	0.02	1		
4. Empathy	-0.06	0.03	-0.18	1	
5. Moral Identity	-0.08	0.06	-0.24*	0.49**	1

Note. Statistical significance at the $p < 0.05$ level is indicated by *, and statistical significance at the $p < 0.01$ is indicated by **.

Relationships Between Participant Factors and PTG Practices. Relationships between participant factors and PTG were examined. A one-way ANOVA was conducted to examine the effect of gender on PTG practices. Gender was recoded (0 = male, 1 = female, 2 = gender non-binary/gender non-conforming). Only one participant reported a gender identity other than male or female and thus was unable to be included in the analysis to allow for appropriate and generalizable comparisons. The homogeneity of variances assumption was met ($F = 0.07$, $p = 0.79$). The ANOVA revealed a significant main effect for gender, F (1, 91) = 6.96, $p = 0.01$ indicating that males on average reported engaging in significantly more PTG than females.

A one-way ANOVA was conducted to examine the effect of professional status (e.g., doctoral student, post-doctoral fellow, licensed psychologist) on PTG practices. The homogeneity of variances assumption was met ($F = 1.49$, $p = 0.23$). A significant main effect

was revealed for professional status, F (2, 91) = 1.32, p = 0.01. Post-hoc tests revealed a significant difference between doctoral students' and post-doctoral fellows' reported engagement in PTG. On average, post-doctoral fellows reported significantly more engagement in PTG than doctoral students. However, no significant differences were found between doctoral students and licensed psychologists or between licensed psychologists and post-doctoral fellows.

Besides gender and professional status, no other participant factors were found to be related to PTG practices. Participant age and years of clinical experience were strongly, positively correlated with one another at the $p < .001$ level (r = 0.90). However, the correlations between PTG practices and participant age (r = 0.08) and years of clinical experience (r = 0.09) were negligible. The correlation between PTG practices and social media use (r = -0.07) was also negligible. This means that in the survey sample, participant self-reported social media use, age, and years of clinical experience were all found to be unrelated to self-reported PTG practices and thus, will not be included in the regression model. Additionally, a series of one-way ANOVA tests revealed no significant main effects for theoretical orientation, F (7, 86) = 5.84, p = 0.06; client population, F (3, 90) = 0.31, p = 0.40; clinical setting, F (10, 83) = 0.48, p = 0.11; or discipline (e.g., clinical psychology, counseling psychology), F (1, 90) = 0.01, p = 0.84 on PTG practices.

Because the effect of theoretical orientation on PTG was trending towards positive (p = 0.06), group means and post-hoc tests were examined to uncover a potential relationship between theoretical orientation and PTG practices that may have been unable to be captured in the small, proof-of-concept sample. Post-hoc comparisons using Tukey's test indicated no significantly different mean scores between groups. All group means fell between 1.17 and 1.46 indicating very low frequency of PTG on average for all theoretical orientations. However, the mean score

for neuropsychologists who did not identify with a theoretical orientation was 1.80. Although not significantly different from the other groups, this may allude to a practical difference of more PTG among neuropsychologists than other clinical and counseling psychologists.

Relationships Between Participant Factors and PTG Attitudes. A one-way ANOVA was conducted to examine the main effect of gender on PTG attitudes. The assumption of homogeneity of variances was met ($F = 0.14$, $p = .71$). A significant main effect of gender was revealed, $F\ (1, 91) = 4.04$, $p < 0.05$ indicating that males on average reported significantly more liberal attitudes towards PTG than females. Given the representative gender breakdown in the sample and the significant effect of gender on PTG attitudes, gender will be included as a covariate in the regression model.

Besides gender, no other participant factors were found to be related to PTG attitudes. The correlations between PTG attitudes and social media use ($r = 0.002$), age ($r = 0.06$), and years of experience ($r = 0.14$) were all negligible. This means that in the survey sample, participant self-reported social media use, age, and years of clinical experience were all found to be unrelated to self-reported PTG attitudes and will not be included in the regression model. A series of one-way ANOVA tests revealed no significant main effects for professional status (e.g., doctoral student, post-doctoral fellow, licensed psychologist), $F\ (2, 91) = 1.95$, $p = 0.15$; theoretical orientation, $F\ (7, 86) = 1.77$, $p = 0.10$; client population, $F\ (3, 90) = 1.31$, $p = 0.28$; clinical setting, $F\ (10, 83) = 0.74$, $p = 0.69$; or discipline (e.g., clinical psychology, counseling psychology), $F\ (1, 90) = 1.33$, $p = 0.25$ on PTG attitudes.

Review of Study Aims and Research Questions

The present study aimed to 1) clarify PTG practices, 2) examine PTG attitudes, 3) understand PTG training and ethical guidance needs, and 4) test the relationship between

personal determinants of moral agency and PTG practices and attitudes. Underlying the four aims of the present study are research questions and hypotheses. The research questions underlying the first three aims were exploratory in nature, and thus, specific hypotheses were not formed. See Table 8 for a review of aims 1 through 3 with their corresponding exploratory research questions. See Table 9 for a review of aim 4 and the specific research questions, hypotheses, and the statistical tests used to test each.

Table 8

Aims 1 Through 3 and Research Questions

Aim	Exploratory research questions
Clarify PTG Practices	• What proportion of counseling and clinical psychologists and trainees engage in PTG? • How often do counseling and clinical psychologists and trainees engage in PTG • What are the PTG-related practices for informed consent, transparency, and documentation among counseling and clinical psychologists and trainees?
Examine PTG Attitudes	• Do counseling and clinical psychologists and trainees perceive PTG as ethical? • How do counseling and clinical psychologists and trainees feel that PTG impacts the client, treatment, and the therapeutic relationship?
Understand PTG Training and Ethical Guidance Needs	• Have counseling and clinical psychologists and trainees received training (e.g., continuing education training, graduate course) or ethical guidance (e.g., from professors, supervisors, colleagues, consultants) on PTG? • What is the quantity and quality of the training/ethical guidance counseling and clinical psychologists and trainees have received on PTG? • Do counseling and clinical psychologists and trainees feel they would benefit from more training and/or ethical guidance in the APA Ethics Code on PTG?

Table 9

Aim 4 Research Questions, Hypotheses, and Statistical Tests

Research Questions	Hypotheses	Statistical Tests
1. Are clinician moral disengagement, empathy, and moral identity associated with PTG behavior?	**1a:** Holding constant empathy, moral identity, gender, and professional status, clinician moral disengagement will be positively correlated with PTG in that individuals with higher levels of moral disengagement will be more likely to engage in PTG. **1b*:*** Holding constant moral disengagement, moral identity, gender, and professional status clinician trait empathy will be negatively correlated with PTG in that individuals with higher levels of empathy will be less likely to engage in PTG. **1c:** Holding constant moral disengagement, empathy, gender, and professional status, clinician moral identity will be negatively correlated with PTG in that individuals with more highly self-important moral identity will be less likely to engage in PTG.	**Analysis:** Binary logistic regression **Independent Variables:** moral disengagement, empathy, moral identity **Covariates:** gender, professional status **Outcome Variable**: PTG practices (endorsed engagement in PTG or did NOT endorse engagement in PTG)
2. Are clinician moral disengagement, empathy, and moral identity associated with PTG attitudes?	**2a:** Holding constant empathy, moral identity, and gender, clinician moral disengagement will be positively correlated with PTG attitudes in that individuals with higher levels of moral disengagement will be more likely to endorse PTG as ethical. **2b:** Holding constant moral disengagement, moral identity, and gender, clinician trait empathy will be negatively correlated with PTG attitudes in that individuals with high levels of empathy will be less likely to endorse PTG as ethical. **2c:** Holding constant moral disengagement, empathy, and gender, clinician moral identity will be negatively correlated with PTG attitudes in that individuals with highly self-important moral identity will be less likely to endorse PTG as ethical.	**Analysis:** Multiple linear regression **Independent Variables:** moral disengagement, empathy, moral identity **Covariate:** gender **Outcome Variable**: PTG attitudes

Qualitative data from the virtual focus groups and three open-ended response items from the online survey were subjected to a computer-assisted thematic analysis using NVivo software to answer the exploratory questions underlying aims 1) clarify PTG practices, 2) examine PTG attitudes, and 3) understand training and ethical guidance needs. The quantitative study further attempted to answer the exploratory research questions of aims 1 through 3 by examining descriptive statistics. The quantitative study additionally aimed to answer the research questions and test the hypotheses of aim 4: Are personal determinants of moral agency including moral disengagement, empathy, and moral identity associated with PTG practices and/or attitudes?

Aim 1 Results: Clarify PTG Practices

The thematic analysis and descriptive statistics were used to answer the following exploratory questions to help clarify psychologist PTG practices: 1) What proportion of counseling and clinical psychologists and trainees engage in PTG?, 2) How often do counseling and clinical psychologists and trainees engage in PTG?, and 3) What are the PTG-related practices for informed consent, transparency, and documentation among counseling and clinical psychologists and trainees?

1) What proportion of counseling and clinical psychologists and trainees engage in PTG?

Approximately half of the survey sample reported having engaged in PTG (46.8%), and the rest reported having never engaged in PTG (53.2%). Focus group participants felt that the actual rate of PTG among psychologists is likely higher than what is self-reported due to social desirability effects. The thematic analysis revealed a major theme that psychologist and trainee perceptions of the prevalence of PTG vary greatly among individuals. When asked what percentage of psychologists they believe engage in PTG, participant responses ranged from 0% to 90% with a mean response of 55%. Some participants felt that very few if no psychologists have engaged in PTG where others felt that PTG is something in which most psychologists have

engaged. Participants hypothesized that the number of psychologists engaging in PTG likely increased with the upsurge in telehealth services during the COVID-19 pandemic.

Another major theme is that the most common source of PTG is Google to search for information such as criminal history, public records, legal history, and court reports. Other commonly mentioned sources included news reports, various social media platforms including Facebook and LinkedIn, and websites created by the client. Survey data further supports that Google is used for PTG more than social media platforms. Almost half of the sample (42.6%) reported having used Google to search for information about a client, and only 18.1% reported having used a social networking site.

2) How often do counseling and clinical psychologists and trainees engage in PTG?

Another major theme derived from the data is that PTG is used rarely and situationally rather than routinely. When asked if they had searched online for information about a client in general, on Google, or on social networking sites, mean survey sample responses fell between "never" and "rarely" for all items indicating that participant PTG frequency is generally low. When asked about the frequency of their engagement in PTG, qualitative responses ranged from "never" to "with each client." However, the most common responses included "never," "once," "twice," and "less than once a year." Thus, PTG is typically used sparingly in specific situations. Many participants shared that only a few specific situations or clients have warranted PTG in their careers. Only a small minority indicated that they routinely use PTG when working with clients. This finding was further supported by the quantitative data. When asked to describe the frequency or regularity in which they search for information about clients online, approximately half of the survey sample (52.1%) reported "never." However, those who did report engagement in PTG typically reported very low frequency. For example, 11.7% of the sample reported "once

per year," 11.7% reported "twice per year," and 6.4% reported "once per month." This is compared to only 1.1% of the sample who reported "multiple times per week" and 2.1% who reported "once per week." The remainder of the sample (14.9%) reported "other" writing in responses, such as "one to three times in my career," "less than once a year," "once every other month," and less specific responses, such as "only if clinically indicated" or " in specific situations." Qualitative responses also suggest that PTG is more common and occurs more frequently in certain settings such as forensic and emergency room settings where the client populations tend to have criminal histories, more severe pathology and safety concerns, or be unable to provide answers to urgent questions. See Table 10 for item-level means of PTG practices survey items. See Table 11 for a list of themes related to PTG practices with direct participant quotes supporting the themes.

Table 10

Means and Standard Deviations: PTG Practices Scale Items

Item	Mean	SD
I have searched online for information about a client.	1.59	0.73
I have conducted a Google search to find information about a client.	1.53	0.70
I have conducted a search on a social networking site to find information about a client.	1.20	0.45

Note. All items were measured on a scale from 1 (never) to 5 (always) with lower scores indicating less engagement in PTG.

Table 11

Themes and Participant Quotes Related to PTG Practices

Themes	Direct Participant Quotes
Perceptions of PTG prevalence vary greatly.	"Maybe 90% of professionals have done it...I think more people have at least dabbled than would admit to it." "I would say 80% because the trainees that I supervise in our program, they use Google all the time." "I think it's probably around 50/50." "I would lean towards a very, very small number if none of my colleagues. I think my colleagues are avoiding it at all costs…"
PTG is used rarely and situationally, not routinely.	"I typically do this one to three times a year." "I have done this once for a specific patient to obtain more history." "I have only done this twice in my career."
PTG is more commonly used with forensic populations and in emergency rooms settings.	"I work in an emergency room with neurologically impaired patients who cannot always provide accurate details surrounding their accidents. I have looked up news at times such as when a patient has been a crime victim or when they could not remember any details surrounding their accident…I was searching for any info to help inform my diagnosis and treatment recommendations." "If you're seeing a forensic psych case you might want to understand the circumstances surrounding whatever event that your client was involved in, so if there's a news story then you might want to get that data as well if you don't have time to cover that in your one-hour clinical interview..." "Googling criminal history is something that we have to do for forensics. I look at the county courts' websites... I'm not just Googling the sensational news stories about what happened. I really try to stay away from doing that..."

Table 11 Continued

Themes	Direct Participant Quotes
Google is the most common PTG source.	"I use Google all the time."
	"Google to find public records."
	"News websites or court reportings.
	"Facebook to get a sense of who the client's parents were and to get a sense of their financial background."
	"Google to see if they're currently incarcerated."

3) What are the PTG-related practices for informed consent, transparency, and documentation among counseling and clinical psychologists and trainees?

Another theme derived from the data is that overwhelmingly, participants felt that certain practices should occur in tandem with PTG in order for it to be considered an ethical practice. Examples include practices related to informed consent, consultation, documentation, transparency, self-reflection/self-monitoring, and using caution with technology. However, quantitative data supports that psychologists who engage in PTG rarely to never obtain verbal or written consent to engage in PTG, discuss PTG with their clients, or document their searches.

A majority of participants felt that psychologists should obtain client informed consent prior to engaging in PTG. Participants were split regarding whether written or verbal consent should be obtained. Some felt that psychologists who engage in PTG should obtain written consent and include PTG in their consent paperwork with information about the benefits and drawbacks of PTG and its parameters so that clients are informed from the onset. Suggested

parameters include the boundaries of the individual clinician's PTG practices such as indicating why PTG would be utilized, which online sources will or will not be accessed, and which online practices will or will not be used, such as direct messaging or social media friend requests remaining off limits. However, others felt that obtaining verbal consent to engage in PTG from clients is adequate. A small minority suggested that PTG be presented as optional in consent documents so that clients can choose to consent to PTG or not (client opt in/opt out). Some participants held a dissenting view that obtaining consent to engage in PTG is unnecessary and/or uncomfortable with certain client populations, particularly if the purpose of the search is to verify the validity of information provided by the client or look up information about prior criminal offenses.

Although most participants felt that consent should be obtained, survey data indicates that psychologists and trainees are not obtaining consent prior to PTG. Survey participants who self-reported engagement in PTG (46.8%) were asked how often they obtain written or verbal consent from the client before engaging in PTG. Almost all (91.1%) indicated that they never obtain written consent, and 82.2% reported that they never obtain verbal consent. Only 2.2% of participants reported that they sometimes obtain written consent, and nobody reported that they often or always do. Only 2.2% reported that they always obtain verbal consent, 4.4% often do, and 2.2% sometimes do. This indicates that psychologists and trainees are more likely to obtain verbal consent than written consent to engage in PTG, but the majority never obtain consent. When asked if they discuss the benefits and drawbacks of PTG with clients, 86.7% reported that they never do, and no one reported that they always or often do. Thus, there is a discrepancy between what psychologists and trainees recommend and their reported behavior when it comes to informed consent.

Participants overwhelmingly agreed on the importance of consultation prior to engaging in PTG to ensure clinical relevance and receive support in weighing the pros and cons. Ongoing consultation with colleagues or clinical supervisors may also be helpful to navigate ethical dilemmas that may arise from PTG. Participants felt that consultation would likely help psychologists check their motivations and intentions for wanting to engage in PTG and hold them accountable for their behavior. Some participants felt that consultation sessions related to PTG should also be documented. It was also suggested that supervisors initiate conversations about PTG with trainees to create an environment that welcomes supervisees seeking consultation about PTG.

A majority of participants were in support of documenting PTG searches in some way. Some participants exhibited very conservative views and felt that legally every search should be documented including information such as why the search was conducted, where, when, which online sources were used, the limitations of those sources, what information was uncovered, and the impact of the information on diagnosis, conceptualization, or treatment. Those in favor of documenting PTG felt that this would help to hold psychologists accountable for their behaviors and protect them in court if they were asked to justify their PTG. Some participants, however, felt that documentation is only necessary when clinically relevant information is obtained through the search. For example, some felt that it would only be necessary to document if something revealed through PTG is discussed with the client, which would then be incorporated into the session note or progress note.

Although, most participants were in support of documenting PTG, the quantitative data indicates that psychologists and trainees are not documenting PTG. Survey participants who reported engagement in PTG were asked if they document their PTG searches, and 86.7%

reported that they never do this. Only 8.9% reported that they always document their searches. They were also asked if they document the information they obtain through PTG, and 80.0% reported that they never do this. Again, only 8.9% reported that they always document the information they find. This indicates that psychologists and trainees largely do not document their searches revealing another discrepancy between their recommendations and reported practices.

A majority of participants also felt that being transparent with clients regarding PTG is of paramount importance ethically and to maintain therapeutic rapport. Specifically, participants felt that clients deserve to be told when PTG has occurred and what information has been uncovered to maintain openness and trust in the therapeutic relationship. However, a minority of participants felt that client transparency is not necessary in certain instances of PTG such as regular monitoring, when no relevant information is uncovered, or with certain populations such as clients experiencing psychosis or forensic populations. For example, psychologists who work with clients with more severe pathology reported that transparency would not be helpful and may actually escalate their clients at times. A few participants shared that they felt it would be cumbersome and time consuming to be transparent about every routine search when PTG is being used regularly to monitor client social media activity as part of treatment.

Although participants largely advocated for client transparency, quantitative data supports that psychologists and trainees are not being transparent with their clients about PTG. Participants who reported engaging in PTG were asked if they discuss information obtained through PTG with their clients, and 84.4% reported that they never do this. Only 4.4% reported that they always do this indicating that psychologists and trainees are mostly not being

transparent with clients about PTG. This reveals another discrepancy between psychologist and trainee practice recommendations and reported practices.

Participants also overwhelmingly agreed on the importance of self-reflection and self-monitoring when engaging in PTG. Specifically, self-reflection regarding one's intentions and motivations for engaging in PTG and assessing pros and cons before each search were recommended. Participants suggested that prior to engaging in PTG, psychologists should ask themselves whether the information being sought out could be collected directly from the client instead. Additionally, participants discussed the importance of maintaining awareness of the biases that may be introduced into the therapeutic relationship as a result of PTG.

Lastly, a majority of participants felt that psychologists should use technology with caution if engaging in PTG. Specifically, participants suggested not engaging in PTG on personal devices, utilizing private web browsers (e.g., Incognito mode, InPrivate), and deleting search histories to avoid breaching clients' rights to privacy and confidentiality. These practices were thought to prevent other users of the device from uncovering client information and minimize the extent to which the client and clinician are linked online. Some participants were concerned with PTG searches resulting in clients being recommended friends on social media platforms. See Table 12 for survey item means related to supplementary PTG practices. See Table 13 for an overview of the practices that participants feel should occur in tandem with PTG and direct participant quotes supporting these ideas.

Table 12

Means and Standard Deviations: Supplementary PTG Practices Items

Item	Mean	SD
I obtain written informed consent from my client before searching for them online.	1.11	0.38
I obtain verbal informed consent from my client before searching for them online.	1.36	0.91
I discuss with my clients the benefits and drawbacks of conducting an online search about them.	1.18	0.49
I discuss with my clients the information that was found about them as a result of my online search.	1.31	0.90
I document my online search.	1.42	1.18
I document the client information obtained from the online search.	1.51	1.20

Note. Only participants who reported engagement in PTG answered these items (N = 44). Participants who reported no PTG engagement did NOT answer these items. All items were measured on a scale from 1 (never) to 5 (always) with lower scores indicating less engagement in the behavior.

Table 13

Participant Quotes Exemplifying Practices That Should Occur in Tandem with PTG

Practice Recommendations	Direct Participant Quotes
Obtain Client Consent to Engage in PTG.	"I think getting consent would make it less of a gray area ethically, but that sounds like a really weird conversation to have, like, I don't believe your story, so now I want to Google it. Do you mind if I do that?" "I think the patient has the right to know what we are doing related to their care." "I think it would be important to have informed consent. There may be clients who aren't comfortable with that, and I think that's something that maybe there could be an option. If you consent to this, this may be something that could be used for therapeutic value…..and if they don't consent, respect that."
Consult Prior to PTG with Colleague(s).	"Consult with a colleague to find out if your judgement is accurate about whether it would be clinically relevant." "After weighing the pros and cons of the situation and also consulting with a peer so that I don't make a mistake, and I could document, like okay, upon consultation with a peer it was decided that this was the most prudent thing to do."
Document PTG and Information Obtained via PTG.	"If you Google something, and nothing came of it, it's just between you and your computer, but if something came out of it… then you would incorporate into your session note why you did your Google search, what were the results, how it was discussed with the client, and what was the client's reaction." "If I do feel the need to Google a client, I feel more comfortable documenting the search and the reason why I'm doing it…It acts like a self-check measure. In a courtroom if I'm being asked for a justification for why I Googled, I better have a good reason." "The dates and times you are doing the search, the dates of when the information was placed online, and also who contributed to the information and whether it's been edited because the information online may not be accurate, and we're not the judges of that, so we have to document the limitations of the online source as well.

Table 13 Continued

Practice Recommendations	Direct Participant Quotes
Be Transparent with Clients about PTG.	"I think if you go online looking for a specific answer, then you should tell the client what you found. If you are looking for more of a monitoring sense, it could become cumbersome to say I saw you talk to this person and this person, but you could if monitoring for cyberbullying or something becomes a regular part of therapy." "Telling a psychotic patient that you Googled them wouldn't be very helpful necessarily." "When I look up a client's criminal history or information for my own safety, I don't think I would disclose afterwards especially if I search how far away they lived from me. That's not something I would disclose."
Engage in Self-reflection and Self-Monitoring.	"We should think about what is the purpose, why are we doing this, is it helpful, and linking that to the work you're doing with the person...Is this a conversation we could have instead and just being able to bring that in the room." "Ask yourself why you are engaging in that behavior." "I would weigh the pros and cons very carefully…to make sure that I'm not fooling myself when I make a decision."
Use Caution with Technology.	"If you are logged into Facebook, your search will be recorded and collected as data by the platform." "Avoid using your personal devices to Google patients…if I Google something on a personal device, and then my son uses it that same day, he'll see not just my search history but probably the tabs that are still open. "Googling should take place out of a private browser." "You should do it on incognito mode, which I'm like that's sneaky, but I think that if you accidentally slipped up and liked something or friended them, then they have your information."

Aim 2 Results: Examine PTG Attitudes

The thematic analysis and descriptive statistics were also used to answer the following exploratory questions about psychologist attitudes surrounding PTG: 1) Do counseling and clinical psychologists and trainees perceive PTG as ethical? and 2) How do counseling and clinical psychologists and trainees feel that PTG impacts the client, treatment, and the therapeutic relationship?

1) Do counseling and clinical psychologists and trainees perceive PTG as ethical?

A major theme derived from the data is that psychologists and trainees largely feel that the ethicality of PTG can only be determined on a case-by-case basis. Perceptions of the ethicality of PTG varied greatly among individuals and appeared to lie on a continuum from very conservative beliefs that PTG is always unethical to very liberal beliefs that PTG is always ethical. However, the majority felt that the ethicality of PTG depends on the situation and the clinician's intent and motivation. A very small minority reported perceiving PTG as ethical in all situations. It is important to note that approximately half of the focus group sample reported either never having heard of or never having actively thought about PTG prior to their participation in the study. Another major theme is that across all focus groups, shifts in participant attitudes were observed as a result of their engagement in the discussion about PTG with their peers and colleagues. When asked about the ethicality of PTG, most participants initially reported perceiving PTG as unethical or being unsure. However, as the focus group discussions unfolded, the majority of participants, regardless of their original stance, appeared to develop a more moderate attitude. Since many participants entered the focus group with little to no knowledge or education about PTG, this shift in attitudes is thought to represent training effects that occurred as a result of the discussions that occurred during the focus groups.

Quantitative data also provides evidence for largely conservative to moderate PTG attitudes among psychologists and trainees. The survey sample's PTG attitudes were measured on a scale from 1 to 5 with lower scores indicating more conservative views. When responding to statements about PTG being ethical, the sample mean was 2.65 falling between "disagree" and "neither agree nor disagree." Specifically, approximately half (52.1%) of the sample reported that they either strongly disagree or disagree that it is ethical to look up a client online. About a third of the sample (29.8%) indicated that they "neither agree nor disagree" with the statement, and the rest (18.1%) indicated that they agree or strongly agree that PTG is ethical. When asked how concerned they feel about the ethical implications of PTG, the mean was 3.04, which indicates that they are "somewhat concerned" on average. When asked how comfortable they feel engaging in PTG, the mean was 1.76 indicating that they feel on average "slightly comfortable" with PTG. Quantitative data also further supports that psychologists and trainees perceive the ethicality of PTG differently depending on the situation. They were asked if it is ethical to engage in PTG in emergencies and for routine matters. Over half of the survey sample (59.6%) agreed or strongly agreed that PTG is ethical in an emergency, but only 7.5% agreed or strongly agreed that PTG is ethical for routine matters. This demonstrates that psychologists and trainees are more inclined to perceive PTG as ethical in emergency situations than for routine matters and further supports that the ethicality of PTG can only be determined on a case-by-case basis.

To demonstrate the full diversity of thought that was revealed in the study, participant ideas are categorized into four types of attitudes: 1) conservative: perceiving PTG as always unethical, 2) moderate: determining the ethicality of PTG on a case-by-case basis , 3) liberal: perceiving PTG as always ethical, and 4) undecided: being unsure about the ethicality of PTG.

Conservative Attitudes. Some participants perceived PTG as always unethical and provided a variety of reasons as to why they believe PTG does not align with the principles and standards in the current APA Ethics Code. For example, they felt that PTG breaches client trust and rights to privacy, confidentiality, and informed consent. A few participants also felt that PTG may result in unfair or differential treatment of certain clients and suggested that clients belonging to certain groups may be more likely to be subjects of PTG due to psychologist explicit or implicit bias. Additionally, some participants felt that PTG represents an abuse of psychologists' power and privilege in the psychologist-client relationship. Lastly, participants expressed that engagement in PTG could be a means for license suspension or revocation. It appeared that most participants perceiving PTG as always unethical seemed to be operating under the assumption that psychologists are not obtaining client consent to engage in PTG.

Moderate Attitudes. A majority of participants perceived PTG as being in an "ethical gray area," and felt that the ethicality can only be determined on a case-by-case-basis. A popular attitude was that PTG is ethical only in specific, emergency situations such as when the client's safety is a concern, when there is a duty to warn, or when working with a client with memory deficits. Many participants identified these emergency situations as the only times they would consider engaging in PTG. Additionally, some participants perceived PTG as being more ethical in certain clinical settings and when working with certain client populations where these types of situations may be more common. For example, one participant provided an example from their experience working in an emergency room in which a client was in crisis, their emergency contact could not be reached, and PTG was used to contact another family member. Participants also felt that the clinicians' intentions and motivations for engaging in PTG are another important factor in determining its ethicality. Specifically, participants felt that PTG motivated

by curiosity or voyeurism is not ethical. Additionally, some participants perceived PTG as ethical only when other precautionary practices occur in tandem, such as those discussed in the results of aim 1 (e.g., obtaining client consent, documenting searches). Participants with moderate attitudes generally felt that PTG, although acceptable in certain situations and under certain conditions, introduces additional ethical concerns. For example, participants raised concerns with the difficulty in navigating informed consent, how to handle finding information that requires reporting, and increased psychologist liability. As mentioned previously, many participants were observed to develop more nuanced perceptions as they engaged in the focus group discussion and were exposed to others' examples and perceptions.

Liberal Attitudes. A small minority of participants felt that PTG is always an ethical practice. A few participants reported perceiving PTG as ethical because the Internet is publicly available information for anyone to access. One participant identified PTG as "just another avenue to help their clients," which they felt aligns with the Beneficence principle in the APA Ethics Code stating to strive to benefit clients. Some psychologists felt that PTG is an ethical practice because it can be used to avoid dual roles. For example, a small number of participants who work within smaller communities such as rural towns or on a university campus reported looking up their clients on social media to avoid entering into a therapeutic relationship with someone whom they have a previous connection. Interestingly, participants with more liberal PTG attitudes believed that psychologist perceptions of PTG will gradually evolve to become more accepting just as attitudes towards other practices such as therapist self-disclosure and teletherapy have evolved over time.

Undecided. Some participants reported being unsure about the ethicality of PTG. They shared that they did not have an opinion or were undecided because they had never heard of,

thought about, and/or discussed this topic before. Participants who initially reported being unsure or undecided were often observed to develop clearer attitudes after engaging in the focus group discussion for some time. A few participants felt that PTG cannot be deemed ethical or unethical until guidance from APA or PTG-specific policies are introduced. See Table 14 for item-level means of all PTG attitude survey items. See Table 15 for direct participant quotes exemplifying the different types of attitudes regarding the ethicality of PTG.

Table 14

Means and Standard Deviations: PTG Attitudes Items

Item	Mean	SD
1. Searching for client information online is ethical.	2.53	1.03
2. For routine matters, it is ethical to look up a client online.	2.01	1.02
3. In emergency situations, it is ethical to look up a client online.	3.42	1.18
4. Searching for a client online crosses ethical boundaries.	3.50	0.96
5. I feel _____ about the ethical implications of searching my clients online.	3.04	1.19
6. I feel _____ about searching my clients online.	1.76	0.99
7. Searching for client information online impacts treatment and the therapeutic relationship.	2.41	0.65

Note. Items 1 through 4 were measured on a scale from 1 (strongly disagree) to 5 (strongly agree). Item 5 was measured on a scale from 1 (not at all concerned) to 7 (extremely concerned). Item 6 was measured on a scale from 1 (not at all comfortable) to 7 (extremely comfortable). Item 7 was measured on a scale from 1 (strong negative impact) to 5 (strong positive impact). Lower scores on all items indicate more conservative PTG attitudes except for item 5, "I feel ___ about the ethical implications of searching my clients online" in which lower scores indicate more liberal PTG attitudes.

Table 15

Participant Quotes Exemplifying Different PTG Attitudes

Attitudes	Direct Participant Quotes
Conservative Attitudes: PTG is unethical.	"I think it's downright unethical." "This is creepy. There's no good reason to search for a client online…It's a gross ethical violation to just search your clients online." "It has no therapeutic use, and it's for your curiosity. That has no room within the therapeutic relationship, and that's why I don't think that Googling your patient is at all ethical."
Moderate Attitudes: The ethicality of PTG is determined on a case-by-case basis.	"Depends on the reason. There's a lot of gray area here." "I suppose it depends why you are searching and what you are searching for." "I don't think it should be a common practice, but it can be used in emergencies when there are no other options."
Liberal Attitudes: PTG is ethical.	"I'm perfectly fine with Googling whoever comes into my office." "I'm very liberal with it. I guess the approach I've always had is whatever it takes to help a client. If me looking you up on Google is going to help me either A) connect with you, B) make sure that there's not a dual relationship, and C) help me answer questions that I otherwise couldn't answer, and if that gives you the best treatment outcomes then I'm all for it."
Undecided: Unsure about the ethicality of PTG.	"I don't know if it's ethical or not." "I'm not sure if the act of looking up information in the public domain is an ethical violation."

Note. The thematic analysis revealed moderate PTG attitudes to be most common. Training effects were observed in which participant attitudes shifted from conservative and undecided to moderate.

2) How do counseling and clinical psychologists and trainees feel that PTG impacts the client, treatment, and the therapeutic relationship?

Participants identified many reasons for and against engaging in PTG that highlight the potential clinical benefits and detriments of PTG. These ideas demonstrate how psychologists and trainees believe that PTG has the potential to both positively and negatively impact the client, treatment, and the therapeutic relationship. More detriments were identified than benefits.

Reasons for Engaging in PTG. Participants identified many clinically beneficial reasons for engaging in PTG, such as to address safety concerns, gather or verify client information, avoid dual relationships, build therapeutic rapport, and when working with forensic populations.

PTG is thought to be a useful tool in emergency situations. Emergencies related to client safety were the most frequently identified hypothetical and real justifications for engaging in PTG. PTG was identified as a helpful way to monitor or assess risk-related client symptoms including suicidal ideation and intent, self-harm, and homicidal ideation and intent. Many participants also referenced the Tarasoff versus Regents of the University of California case, which determined that mental health professionals have a duty to protect individuals who are being physically threatened by their client. Thus, participants believed that PTG may be a helpful tool to obtain information such as client proximity to a victim or contact information of a potential victim when a client is threatening to harm someone. Participants also suggested that PTG could be a way to find a client's next of kin in emergency room settings. As previously mentioned, 59.6% of the survey sample agreed or strongly agreed that it is ethical to engage in PTG in emergencies.

Participants also identified PTG as a clinically useful tool for collecting client data. Specifically, participants mentioned the potential benefits of using PTG for general information

gathering, verifying information, and progress monitoring. Participants who engage in psychological, neuropsychological, and forensic assessment discussed using PTG as a collateral informant to uncover information including client lifestyle, risk-related symptoms, criminal records/legal history, social media presence, name pronunciation, address, occupational title, educational history, financial history, or news stories portraying client experiences (e.g., car crashes). These practices were deemed particularly useful when working with clients experiencing psychosis, clients with limited ability to provide information, high risk clients, or clients with a presenting concern related to the Internet, such as cyberbullying. For example, a few participants identified the potential benefit of monitoring social media activity of clients who have Internet-related presenting concerns (e.g., gambling addiction) in order to inform treatment and track progress.

Another potential clinical and ethical benefit of PTG is to avoid dual roles. As mentioned previously, some participants shared their own experience with using PTG as a means to avoid entering into multiple relationships with clients. One participant shared their experience providing psychological services in a university counseling center where they previously held other roles at the university (i.e., professor, academic mentor, resident assistant); thus, they shared that they look up each client on social media at the onset of the therapeutic relationship to ensure they have not had a previous relationship with them. Another participant shared their experience working in a rural town where they are more likely to have personal connections with clients or their families. They shared their experience looking up clients on Facebook to check their "mutual friends" as a way to avoid entering dual roles.

PTG was also thought to potentially help with building rapport with certain client populations, such as adolescents or clients who request PTG for a variety of reasons. In these

instances, participants felt that PTG could occur collaboratively with the client in session to show genuine interest in getting to know them and begin establishing rapport. Examples include clients wishing to share their digital art, YouTube channel, or some other online content with their therapist, which provides a unique opportunity to gain insights about a client. Participants indicated that this would be dependent on the client and indicated that PTG would not be an appropriate or effective means to build therapeutic rapport with all clients.

Lastly, PTG was thought to be clinically useful when working with forensic populations. Specifically, participants felt that PTG can be a helpful tool for fact checking when a client is experiencing psychosis or is suspected of lying about past offenses or some other information related to their mental illness, crime, or court hearing/trial. Participants with experience working with forensic populations consistently indicated that it is normal and expected to engage in PTG to obtain information including criminal record, legal history, court proceedings, and (for some) news reports. However, some psychologists working with this population stated that they avoid certain sources including news reports and social media posts to evade inaccurate or sensationalized accounts of what occurred. See Table 16 for an overview of the clinical benefits of PTG identified by participants and direct participant quotes that support these ideas.

Table 16

Participant Quotes Exemplifying Perceived Clinical Benefits of PTG

Examples	Direct Participant Quotes
For use in emergencies when client safety is a concern	"When issues of risk are present, there may be a necessity for an online search." "I do not think it is appropriate unless there is a matter of safety involved."
Gathering and verifying client information	"I feel sleazy for having done this but felt I needed confirmation about events that were reported as having happened." "I think online information could be clinically useful." "I have done this to verify public information such as if the client were in an accident and the severity/details." "With clients who have been hospitalized for psychiatric reasons, you need to sort of monitor their mental state. If they have access to technology or any form of communication with other individuals, I would venture to say it's okay."
Avoiding entering into a dual relationship	"I search clients to make sure I am not accidentally engaging in a dual role. I live in a small city, and there is often overlap between personal and professional roles. I want to be sure I don't accidentally work with a client where a dual role could exist."
For building therapeutic rapport	"It might be sometimes good for rapport. If a client says, 'I've been baking so much. You should look on my Pinterest to see all the things I've made.'…and If over time the client is wondering whether or not you've looked at it, and you're consistently saying, 'No,' it could potentially cause a rupture." "I've had younger clients who are artists and want to share their art or other content online, so they might have asked me to Google that. I guess they know what's going to show up and want me to see it to better understand them."

Table 16 Continued

Examples	Direct Participant Quotes
When working with forensic populations	"I have to search clients' legal histories online for forensic competency evaluations." "I work with a forensic population, and sometimes when they're not being honest about past offenses, and I don't have legal documentation, I look up their legal history." "This can be justified when trying to assess the validity of a client's statement during a forensic assessment. In a therapy context, I feel more conflicted." "This is not appropriate for clinical cases, but I was directed by my supervisor to do a search for legal cases to understand the media portrayal and implications for trial."

Reasons Against Engaging in PTG. Many detriments or reasons against engaging in PTG were also identified, many of which appear to be related to the perception that PTG is unethical. Examples include that it can negatively impact the therapeutic relationship, introduce bias, cross professional boundaries, breach client rights, be motivated by curiosity, uncover reportable information, lead to invalid data, represent a misuse of power, fail to model healthy communication, and exacerbate client symptoms.

The most frequently mentioned reason to avoid PTG was concerns with breaching client rights including confidentiality, privacy, informed consent, and autonomy. Participants mentioned a variety of ways in which PTG could result in breaching client confidentiality including data leaks, other device users seeing their name in the search history, and online activity being traced. Regarding client rights to privacy and autonomy, many participants felt

that PTG may result in obtaining information that the client did not want to disclose or was not ready to disclose; thus, PTG disregards the client's right to choose what information the clinician is privy to. In this way, PTG was described by some participants as potentially intrusive even when informed consent has been obtained. Because of concerns with breaching client rights, participants felt that psychologists are not ethically justified to engage in PTG if they do not have informed consent from the client.

Another commonly perceived detriment of PTG is the negative impact it can have on the therapeutic relationship. Participants felt that PTG could break client trust, cause ruptures in the therapeutic relationship, or even lead to a harmful/early termination if a client were to feel particularly upset or betrayed. Many participants worried about the possibility of uncomfortable interactions if a clinician were to accidentally say or allude to something in session that they learned via PTG that the client had not disclosed to them. Participants also raised concern about the potential of accidentally "liking" a client's social media post in the process of PTG and how that would be challenging and uncomfortable to process in session and would likely decrease trust. Participants were concerned with these negative impacts particularly in instances when the clinician did not obtain client consent for PTG and/or is not being transparent with the client about the searches. Quantitative data also supports that psychologists and trainees believe that PTG negatively impacts the therapeutic relationship. Survey participants were asked what type of impact PTG has on the therapeutic relationship, and over half (54.3%) indicated that it has a strong negative or negative impact. Only 2.2% of the sample indicated that PTG has a positive impact on the therapeutic relationship.

Another perceived detriment of PTG is the introduction of bias. A majority of participants felt that information found through PTG leads to unnecessary bias that could impact

a clinician's ability to remain nonjudgmental and have unconditional positive regard towards their clients. Additionally, participants felt that PTG may not only bias clinicians' perception of their clients but could also clinically impact their conceptualizations, diagnoses, and treatment plans depending on the information that is accessed and how it is interpreted.

Another perceived reason to avoid PTG is that it blurs the boundaries of the therapeutic relationship, which is professional in nature. Across focus groups, many participants felt that PTG crosses professional boundaries and has the potential to make the therapeutic relationship more personal than professional. For example, some participants described PTG as hovering, monitoring, or investigatory behavior, which they thought to be outside the scope of their professional role. PTG was compared by a minority of participants to cyberstalking, but more participants felt that there are different extents of PTG and emphasized that it can be done both appropriately and inappropriately. This idea was also supported by quantitative data. Survey participants were asked whether PTG crosses ethical boundaries, and approximately half (52.1%) agreed or strongly agreed that it does.

Participants also indicated that PTG motivated by curiosity should be avoided. Across focus groups, participants overwhelmingly felt that clinician curiosity does not justify PTG. PTG motivated by curiosity or voyeuristic tendencies was identified as potentially harmful, self-serving, and not clinically useful.

Another identified reason to avoid PTG is because clinicians may uncover information that requires reporting. Participants discussed the additional ethical and legal dilemmas associated with finding information online that requires reporting, and most felt unsure how to responsibly and ethically navigate coming across certain information. This was a particularly popular concern for psychologists and trainees working with children and adolescents who were

aware of the possibility of finding information related to child neglect or abuse. Because of this issue, participants felt that PTG introduces more labor, stress, and liability for clinicians that can be easily avoided by abstaining.

Another perceived detriment of PTG is the amount of invalid information on the Internet. A majority of participants agreed that the validity of online information is a concern if engaging in PTG. Many participants expressed concern with accessing information from certain sources, such as news reports, blogs, or social media posts, which may be sensationalized, misrepresentative, or untrue. Some participants shared their own experiences avoiding such sources and reported that they access more reliable sources, such as public records or court reports.

Another identified reason to avoid PTG is that it represents a misuse of the power and privilege that psychologists and trainees possess within their relationships with clients. Some participants shared that they feel it is unethical to use their professional role to look someone up online. One participant described PTG as a blatant abuse of power and privilege given the amount of intimate information psychologists have about clients that they would not be privy to without their professional role. Another participant felt that PTG reinforces an uneven power dynamic in which the therapist can choose to monitor the client.

Participants also felt that PTG does not align with psychologists' responsibility to model open and healthy communication with their clients. PTG was described as "taking a short cut," "avoidant," and "lazy." Some participants expressed concern and confusion as to why psychologists are choosing to collect data via PTG as opposed to directly from their clients. For example, they wondered whether psychologists engaging in PTG are embarrassed to ask certain questions or are aiming to avoid difficult conversations with clients.

A final perceived detriment of PTG is that it may exacerbate symptoms for anxious or paranoid clients. A few participants shared their experience working with clients with paranoid ideation and imagined how PTG could increase their paranoia and distress, reduce trust within the therapeutic relationship, and negatively impact the effectiveness of their treatment. Because of this potential harm, some participants felt that PTG violates the ethical principal of Nonmaleficence in the APA Ethics Code, which states to strive to do no harm. See Table 17 for direct participant quotes exemplifying the perceived detriments of PTG.

Table 17

Participant Quotes Exemplifying Perceived Detriments of PTG

Examples	Direct Participant Quotes
Breaches client rights	"This is unethical primarily due to violating confidentiality. Your search history is not secure." "Not allowing clients to choose what they want to share with me feels like a violation of trust and privacy and undermines their free will." "I think it's unethical because I'm just kind of using my power to get information on someone that they didn't disclose or necessarily want me to know."
Negatively impacts therapeutic relationship	"This is an issue in that it may affect the therapeutic relationship." "Client information learned through an online search could detrimentally impact the therapeutic relationship as the clinician would potentially have knowledge about the client that the client themselves did not share."
Introduces bias	"I believe that this could implicitly bias you." "I think it could create bias and mistrust in the therapeutic relationship."
Crosses professional boundaries	"It moves the professional relationship to one that is more personal."
Motivated by curiosity	"It seems like the only reason someone would do that is personal curiosity, and that's not acceptable." "I would never condone searching for clients' names online just for the sake of curiosity."

Table 17 Continued

Examples	Direct Participant Quotes
May uncover information that requires reporting	"I would not do this for the fear that I would accidentally find out something that is reportable." "There was an issue with one of my [minor] patients having posted photographs on social media that were not appropriate. My concern is if there's something posted where the patient is not wearing clothing and issues of child pornography or stalking come up, that's not something I would want to ever to involved with...I just want to be very mindful about that because that can get you in real trouble and the patients." "Working with children, you'd have to be prepared to file a CPS report…That seems like extra risk and labor."
Poor validity of information online	"I wouldn't go online looking for client data because there is a lot of inaccurate information out there." "You can't believe everything on the Internet."
Represents a misuse of psychologist power/privilege	"It reinforces sort of the power dynamic. Like I'm hovering over you. I'm looking at what you're doing/monitoring you. At least that's the way I perceive that." "It's a little bit of an abuse of power because as a person who has a lot of information about my clients…I'm in a position of power to know a lot of their personal information like their first name, last, name, social security, address, and whatnot."
Does not model healthy and open communication with clients	"Kind of strikes me as taking a short cut. If there's something you want to know about a client, and you can't ask them, like, that's important data for you to have. It feels like almost avoidance." "It makes me wonder why therapists are doing that? Are they embarrassed to ask certain information?"
May exacerbate client symptoms	"I have several clients who have paranoid ideation, so I can see that contributing and then negatively impacting the therapeutic relationship and causing harm." "If I have a client who has paranoid ideation, and they've discovered that I've been looking them up that might contribute to their distress and paranoid symptoms.

Aim 3 Results: Understand PTG Training and Ethical Guidance Needs

The thematic analysis and descriptive statistics lastly aimed to answer the following exploratory questions about psychologist PTG training and ethical guidance: 1) Have counseling and clinical psychologists and trainees received training (e.g., continuing education training, graduate course) or ethical guidance (e.g., from professors, supervisors, colleagues, consultants) on PTG?, 2) What is the quantity and quality of the training/ethical guidance that counseling and clinical psychologists have received on PTG?, and 3) Do counseling and clinical psychologists and trainees feel they would benefit from more training and/or ethical guidance in the APA Ethics Code on PTG?

1) Have counseling and clinical psychologists and trainees received training or ethical guidance on PTG?

A major theme derived from the qualitative data is that approximately half of psychologists and trainees have never received any PTG training or guidance. Among those who had not received training or guidance, many reported that the focus group was their first exposure to the topic of PTG. Commonly reported sources of PTG training and guidance included graduate ethics courses, clinical supervisors, and graduate program resources or policies, such as the student handbook or program-wide social media policies. Less popular sources included discussions with program faculty, group supervision in forensic settings, ethics consultants, clinic directors, workplace policies, workplace trainings, and an APA conference workshop. Quantitative data further supports that about half of psychologists and trainees have never received any PTG training or guidance. Exactly fifty percent of survey participants reported never having received PTG training, and 51.1% reported never having received PTG guidance.

2) What is the quantity and quality of the training/ethical guidance that counseling and clinical psychologists and trainees have received on PTG?

Another major theme derived from the data is that existing PTG training and guidance is informal, minimal, and largely takes an abstinence approach. Most participants who reported having received PTG training and/or ethical guidance described being instructed or guided by a professor, supervisor, or policy never to engage in PTG. One participant described receiving only a "finger shake" from a supervisor not to engage in PTG. Another participant reported that they created a PTG abstinence policy for their clinic but were unable to provide a concrete or research-based reason as to why they created the policy. However, a few participants had been exposed to policies or received ethical guidance that was more nuanced. For example, they were told to abstain from PTG unless the client requests it, the client is present, or it is deemed clinically and ethically appropriate by a supervisor. A few participants reported receiving guidance to engage in PTG in emergency rooms, forensic settings, or university counseling centers to access information, better understand the media portrayal of a client going to trial, or to avoid dual roles. One participant shared that their previous clinical supervisor modeled PTG in supervision sessions as a means to obtain client information such as educational history and socioeconomic status on Facebook. When asked exactly how much training they had received, almost all participants who shared indicated a minimal amount. Responses included "one conference workshop," "one discussion in class," and "one assigned article to read." A few participants shared having regular discussions related to PTG with their supervisor.

Another major theme is that psychologists and trainees perceive nuanced PTG training and guidance as more helpful than an abstinence approach. For participants who had received training and/or ethical guidance on PTG, they were split regarding whether the training had been

helpful. This was further supported by quantitative data. When survey participants were asked whether their PTG training/guidance was helpful, 28.3% indicated that they disagree or strongly disagree, and 32.0% indicated that they agree or strongly agree. Participants who had been taught to abstain from PTG largely found the guidance unhelpful. They shared that the abstinence approach to their training left them feeling unable to ask questions or consult about PTG. Other participants expressed confusion after receiving mixed guidance from different supervisors who hold different perspectives on the topic. One participant felt like their professors and supervisors, although clinically very experienced, have outdated views on the topic due to limited knowledge regarding technology. However, participants with more nuanced training and guidance generally seemed to describe it as helpful. This appeared to be particularly true for those who reported having opportunities to discuss PTG or weigh the pros and cons of PTG in different cases with faculty or supervisors.

3) ***Do counseling and clinical psychologists and trainees feel they would benefit from more PTG training and/or guidance in the APA Ethics Code?***

Another major theme of the data is that psychologists and trainees have favorable impressions of receiving more training and ethical guidance on the topic. Specifically, results strongly support a call for guidance from APA. Many participants expressed a desire for the APA Ethics Code to directly address PTG and other online behaviors that psychologists engage in, such as having a professional or educational presence on social media platforms. Participant recommendations for content of such guidelines included more explicit and intentional guidance, statements of opposition with an outline of exceptions, delineation of when PTG is ethical versus unethical, and how to use PTG ethically in emergencies. Participants also requested guidance from APA surrounding PTG-related practices, such as informed consent procedures,

transparency with clients, and documentation. This theme is further supported by quantitative data. The survey sample was asked if they would like explicit guidance on PTG in the APA Ethics Code, and 80.9% of the survey sample agreed or strongly agreed, only 4.3% of the sample indicated that they would not, and the remaining 14.9% were neutral. When asked if they would benefit from more PTG training and guidance, the survey sample mean was 3.73 leaning towards agreeing with this statement on average. However, is noteworthy that within the survey sample, a minority of participants reported that they have no PTG training needs, described it as common sense, and felt that the issue is not pressing enough to be incorporated into ethics curriculum or guidelines. This was not congruent with the attitudes of focus group participants who overwhelmingly were in support of more training and guidance. However, some participants identified potential issues with having specific PTG guidelines in the APA Ethics Code related to how they could become outdated very quickly with evolving technology and social media platforms.

Another major theme is that psychologists and trainees have many recommendations for future education/training, research, and practice. When asked about ideas for next steps, many participants provided recommendations including more open discourse surrounding PTG, PTG trainings available for trainees and licensed psychologists, incorporating discussions about PTG into informed consent processes, and updating the APA Ethics Code to address PTG and other online behaviors. Participants advocated for more opportunities to have transparent and nuanced conversations about PTG in graduate programs, supervision meetings, and among colleagues. Participants felt that if more conversations about PTG were initiated by authority figures in the field (e.g., graduate professors, clinical directors, clinical supervisors), the topic would be less taboo, and psychologists and trainees would be more informed. Regarding trainings, many

participants felt that nuanced trainings that use case examples and discussion would be more helpful than using an abstinence approach. Participants recommended more formal training opportunities for psychologists across the career span. Specifically, they recommended continuing education for licensed psychologists and incorporating PTG into graduate ethics curriculum for trainees. Participant recommendations for the content of trainings included the use of vignettes and case examples, discussions of ethics related to PTG and other online behaviors, discussions of the pros and cons of PTG, discussions of the limitations of information obtained through PTG, encouragement of self-reflection, the application of ethical decision making models to PTG, and decision trees tailored to PTG. Participants desired trainings that provide explicit guidance regarding when PTG is ethical versus unethical, how to appropriately document, and how to navigate informed consent and being transparent with clients when engaging in PTG. Participants recommended that PTG trainings be updated as technologies and social media platforms evolve. Many participants were also interested about the client perspective on PTG and felt that this would be an important topic for future research. See Table 18 for item-level means of survey items related to PTG training and ethical guidance. See Table 19 for an overview of the themes related to PTG training and guidance needs with direct participant quotes.

Table 18

Means and Standard Deviations: PTG Training/Ethical Guidance Items

Item	Mean	SD
I have received ethical training about searching my clients online.	2.70	1.34
I have received ethical guidance on searching clients online.	2.65	1.28
I have received adequate ethical training on searching clients online.	2.54	1.28
The training I received on searching clients online was helpful.	2.92	1.11
I would benefit from more ethical training and guidance about searching clients online.	3.73	0.88
I would like the APA Ethics Code to provide explicit guidelines on searching clients online.	4.06	0.83

Note. All items were measured on a scale from 1 (strongly disagree) to 5 (strongly agree) with lower scores indicating less PTG training and ethical guidance experiences or less interest in receiving PTG training and ethical guidance.

Table 19

Themes and Participant Quotes Related to PTG Training Needs & Experiences

Themes	Direct Participant Quotes
About half of psychologists and trainees have received no PTG guidance.	"Training is non-existent." "I have not been trained on this, so I would like to hear whatever the best practices are." "It was never discussed in any coursework or anything like that." "In my training program, there were conversations about social media, but not any specifically about this topic." "I'm on the west coast, and there's been an uptick in this type of training because the Bay Area is so tech heavy."
Existing PTG training and guidance is minimal and often takes an abstinence approach.	"In the context of our clinic, I have a written policy where we're not allowed to Google clients, but I didn't really think a whole lot about why. I wrote that policy, but I don't have a lot to back it up." "Throughout my graduate training, I was told not to Google clients." "We never had any formal training on Googling our clients other than a finger shake of you probably shouldn't do that."
Nuanced PTG training and guidance is more helpful than the abstinence approach.	"In my individual supervision, we had talked about why I wanted to search that person and what was the reason behind it." "I've been able to talk with supervisors about it, and they've been able to help me weigh the pros and cons of each specific case where I thought about doing it…They're really supportive on an individual client by client basis, but I don't think there's any systematic training we get on this." "Conversations and guidance from others have been helpful because, I can't remember who said it, but they asked me if I would feel comfortable saying I did it in a courtroom, and I was forced to consider that."

Table 19 Continued

Themes	Direct Participant Quotes
Psychologists/trainees are in favor of receiving more training and guidance, specifically from APA.	"The APA Ethics Code of Conduct needs to be updated to address technology and online information." "Any guidance from APA would be very helpful." "I think this could be helpful to receive in a didactic training." "I would like formal guidelines from APA around online searches. However, this should come with cultural considerations." "A discussion of ethical implications would be helpful to make informed decisions depending on the situation." "I need to know what a consent form for this should look like."

Aim 4 Results: Examine the Association Between Personal Determinants of Moral Agency and PTG

1) Are clinician moral disengagement, empathy, and moral identity associated with PTG behavior?

A logistic regression model was conducted to answer the first research question underlying study aim 4: Are clinician moral disengagement, empathy, and moral identity associated with PTG practices among psychologists and psychology trainees? It was hypothesized that clinicians with higher levels of moral disengagement would be more likely to engage in PTG (hypothesis 1a), clinicians with higher levels of trait empathy would be less likely to engage in PTG (hypothesis 1b), and clinicians with a more highly self-important moral identity would be less likely to engage in PTG (hypothesis 1c). Reference Table 13 in the

Review of Study Aims and Research Questions section for an overview of aim 4 research questions and hypotheses.

Assumptions of Logistic Regression. It was initially proposed that a linear multiple regression would be conducted to achieve aim 4. The sample distribution of PTG practices scores has a skewness value of 1.23 and a kurtosis value of 1.13, which fall within the acceptable range between -2.0 and +2.0 according to George and Mallery (2010). Although the data statistically meet the assumption of normality, the data are organically dichotomized into two relatively equal groups (those who reported engagement in PTG and those who did not). Thus, the decision was made that the appropriate statistical test would be a binary logistic regression. See Figure 2, Figure 3, and Figure 12 in the Data Preparation section for a frequency dialogue, detrended normal Q-Q plot, and boxplot of the PTG practices data respectively.

When asked if they had searched their client online in general, via Google, or via social media, approximately half (53.2%) of the sample reported "never" to all three items. Thus, the sample was organically dichotomized into two groups: those who reported having engaged in PTG ($N = 44$) and those who reported having never engaged in PTG ($N = 50$). All participants with a PTG Practices score of "1" indicating that they had "never" engaged in PTG were recoded as "0." All participants with a PTG practices score greater than "1" were recoded as "1" to indicate that they reported having engaged in PTG. The assumptions of logistic regression including sample size, multicollinearity, and outliers were checked. Fifty participants comprised the "never PTG" group, and 44 participants comprised the "ever PTG" group making the groups similar in sample size. To test for the absence of multicollinearity, collinearity diagnostics were examined. For all variables, tolerance values ranged from 0.74 to 0.97 indicating no concerns with multicollinearity. Additionally, for all variables, the variance inflation factors (VIF) were

below two indicating no concerns with multicollinearity in the model. After winsorization of outliers in the independent variables, no outliers were found in the model. See Figures 14 through 16 in the Data Preparation section for boxplots demonstrating all outliers that were winsorized for Moral Disengagement, Empathy, and Moral Identity.

As previously discussed in the Data Preparation section, a one-way ANOVA revealed a significant main effect for gender on PTG practices, F (1, 91) = 6.96, p = 0.01 indicating that on average, males reported engaging in significantly more PTG than females. Given the representative gender breakdown in the sample and the significant effect of gender on PTG practices, gender was included as a covariate in the regression model. Male was coded as "0," and female was coded as "1." Additionally, a significant main effect was revealed for professional status on PTG practices, F (2, 91) = 1.32, p = 0.01. Post-hoc tests revealed a significant difference between doctoral students' and post-doctoral fellows' reported engagement in PTG. On average, post-doctoral fellows reported significantly more engagement in PTG than doctoral students. However, no significant differences were found between doctoral students and licensed psychologists or between licensed psychologists and post-doctoral fellows. Because of this main effect, professional status was included as a covariate in the regression model as well. Because post-doctoral fellows were found to engage in PTG significantly more than students, post-doctoral fellows were recoded as the reference group "0," doctoral students were recoded as "1," and licensed psychologists were coded as "2."

Results of Logistic Regression Model. A binary logistic regression was performed to examine the effects of a number of factors on psychologists' and trainees' PTG practices. The model contained three independent variables (moral disengagement, empathy, and moral identity) and two data-driven covariates (gender and professional status). Group means for moral

disengagement, empathy, and moral identity among those who had and had not reported engaging in PTG were comparable (See Table 20). Bivariate correlations between PTG practices and the independent variables were also examined. Moral disengagement, empathy, and moral identity were all found to be unrelated to PTG practices. See Table 21 for point-biserial correlations between the independent variables in the model and PTG practices.

Table 20

PTG Practices Group Means for Moral Disengagement, Empathy, and Moral Identity

Independent Variable	Have not Engaged in PTG	Have Engaged in PTG
Moral Disengagement	1.88	1.90
Empathy	5.69	5.65
Moral Identity	4.72	4.65

Note. Moral Disengagement was measured on a scale from 1 (strongly disagree) to 5 (strongly agree) with lower scores indicating a lower propensity to morally disengage. Empathy was measured on a scale from 1 (strongly disagree) to 7 (strongly agree) with lower scores indicating lower trait-level empathy. Moral Identity was measured on a scale from 1 (strongly disagree) to 5 (strongly agree) with lower scores indicating less self-important moral identity.

Table 21

Point-Biserial Correlations Between PTG Practices and Moral Disengagement, Empathy, and Moral Identity

Independent Variable	Correlation with PTG Practices
Moral Disengagement	0.04
Empathy	-0.03
Moral Identity	-0.09

The non-significant Hosmer-Lemeshow Test of model fit provides support for the model with a chi-square value of 5.67 and a significance level of 0.68. The omnibus test of model coefficients provides an overall indication of how well the model performs above and beyond when none of the predictors are entered into the model (i.e., goodness of fit test). The full model containing all predictors was statistically significant ($\chi^2(6, N = 94) = 22.24, p = 0.001$) indicating that the model was able to distinguish between respondents who did and did not report engagement in PTG. The model as a whole explained somewhere between 21.3% (Cox and Snell R square) and 28.4% (Nagelkerke R square) of the variance in PTG practices and correctly classified 68.8% of the cases. Specifically, 79.6% of those who reported not having engaged in PTG were correctly classified, and 56.8% of those who reported having engaged in PTG were correctly classified.

As shown in Table 22, neither moral disengagement ($\chi^2(1, N = 94) = 0.41, p = 0.615$), empathy ($\chi^2(1, N = 94) = 0.35, p = 0.423$), nor moral identity ($\chi^2(1, N = 94) = -0.36, p = 0.631$) made a unique, statistically significant contribution to the model when accounting for all other variables. Thus, none of the proposed hypotheses (1a through 1c) were supported. However, gender did make a statistically significant contribution to the model when accounting for all other variables ($\chi^2(1, N = 94) = -1.44, p = .038$), recording an odds ratio of 0.24. This indicates that participants who identify as female are 0.24 times less likely to report engagement in PTG than participants who identify as male. Also, when comparing doctoral students to post-doctoral fellows, professional status made a statistically significant contribution to the model when accounting for all other variables ($\chi^2(1, N = 94) = -2.73, p = .001$), recording an odds ratio of 0.07. This indicates that doctoral students were 0.07 times less likely to report engagement in PTG than post-doctoral fellows. However, when comparing licensed psychologists to post-

doctoral fellows, professional status did not make a statistically significant contribution to the model when accounting for all other variables ($\chi^2(1, N = 94) = -1.61, p = .059$).

Table 22

Results of Logistic Regression Model Predicting Self-Reported Engagement in PTG

Variable	*B*	Standard Error *B*	Wald	*df*	*p*	Odds ratio	95% confidence interval odds ratio
Moral Disengagement	0.41	0.82	0.25	1	0.62	0.24	0.30-7.52
Empathy	0.35	0.44	0.64	1	0.42	1.42	0.60-3.34
Moral Identity	-0.36	0.74	0.23	1	0.63	0.70	0.16-3.01
Gender	-1.44	0.69	4.32	1	0.04*	0.24	0.06-0.92
Professional Status (fellows)	-	-	11.96	2	0.003	-	-
Professional Status (students)	-2.73	0.85	10.33	1	0.001**	0.07	0.12-0.35
Professional Status (psychologists)	-1.61	0.86	3.56	1	0.06	0.20	0.04-1.07
Constant	1.93	3.85	0.25	1	0.62	6.87	-

Note. Statistical significance at the $p < 0.05$ level is indicated by *, and statistical significance at the $p < .01$ level is indicated by **.

A Closer Look at the Effect of Professional Status on PTG Practices. Results indicate that doctoral students are not as likely to engage in PTG compared to post-doctoral fellows when accounting for moral disengagement, trait empathy, moral identity, and gender. It is noteworthy that within the sample, 86.7% of post-doctoral fellows reported having engaged in PTG compared to only 28.9% of doctoral students and 52.9% of licensed psychologists. However, the groups were not of equal size. The sample was comprised of 45 doctoral students, 34 licensed psychologists, and only 15 post-doctoral fellows. Since the thematic analysis revealed PTG to be more commonly used in emergency room and forensic settings, crosstabs of professional status and practice setting were examined to see if the post-doctoral fellows in the sample largely worked in these settings. However, a similar percentage of students (24.4%), fellows (33.3%), and psychologists (38.2%) reported working in hospital settings, and no post-doctoral fellows reported working in prisons/correctional facilities. Crosstabs of professional status and PTG training experiences were also examined, and a similar percentage of students (46.7%), fellows (46.7%), and psychologists (55.9%) reported having never received PTG training. Given the limited number of post-doctoral fellows in the sample and the small odds ratio (0.07), it is possible that the results are a product of sample characteristics and not representative of a true difference in the general population.

2. Are Clinician Moral Disengagement, Empathy, and Moral Identity Associated with PTG Attitudes?

A multiple linear regression was conducted to answer the second research question underlying study aim 4: Are clinician moral disengagement, empathy, and moral identity associated with perceptions of PTG among psychologists and psychology trainees? It was hypothesized that clinicians with higher levels of moral disengagement would be more likely to

endorse PTG as ethical (hypothesis 2a), clinicians with higher levels of trait empathy would be less likely to endorse PTG as ethical (hypothesis 2b), and clinicians with a more highly self-important moral identity would be less likely to endorse PTG as ethical (hypothesis 3c). See again Table 13 in the Review of Study Aims and Research Questions section for an overview of aim 4 research question and hypotheses.

Tests of Assumptions of Multiple Linear Regression. The assumptions of multiple linear regression were tested including normality, outliers, linearity, homoscedasticity, the absence of multicollinearity, and independence. First, the assumption of normality was assessed by visually assessing histograms and detrended Q-Q plots for all variables in the model. Additionally, skewness and kurtosis metrics were examined. There were no deviations from normality based on absolute skewness and kurtosis criteria of +2.0 or -2.0 as suggested by George and Mallery (2010), and many other scholars recommend equal or less conservative criteria (Byrne, 2010; Hair et al., 2010; Kline, 2010). See Table 5 in the Data Preparation section for skewness and kurtosis values of all scales included in the model. Detrended Q-Q Plots further support that there were no other deviations from normality based on the cutoff score of plus or minus 1.96 as determined by Garson (2012). See the Data Preparation section for frequency dialogues and detrended Q-Q plots of all scales included in the model (Figures 4 and 5 for PTG Attitudes Scale, Figures 6 and 7 for Moral Disengagement Scale, Figures 8 and 9 for Empathy Subscale, and Figures 10 and 11 for Moral Identity Subscale).

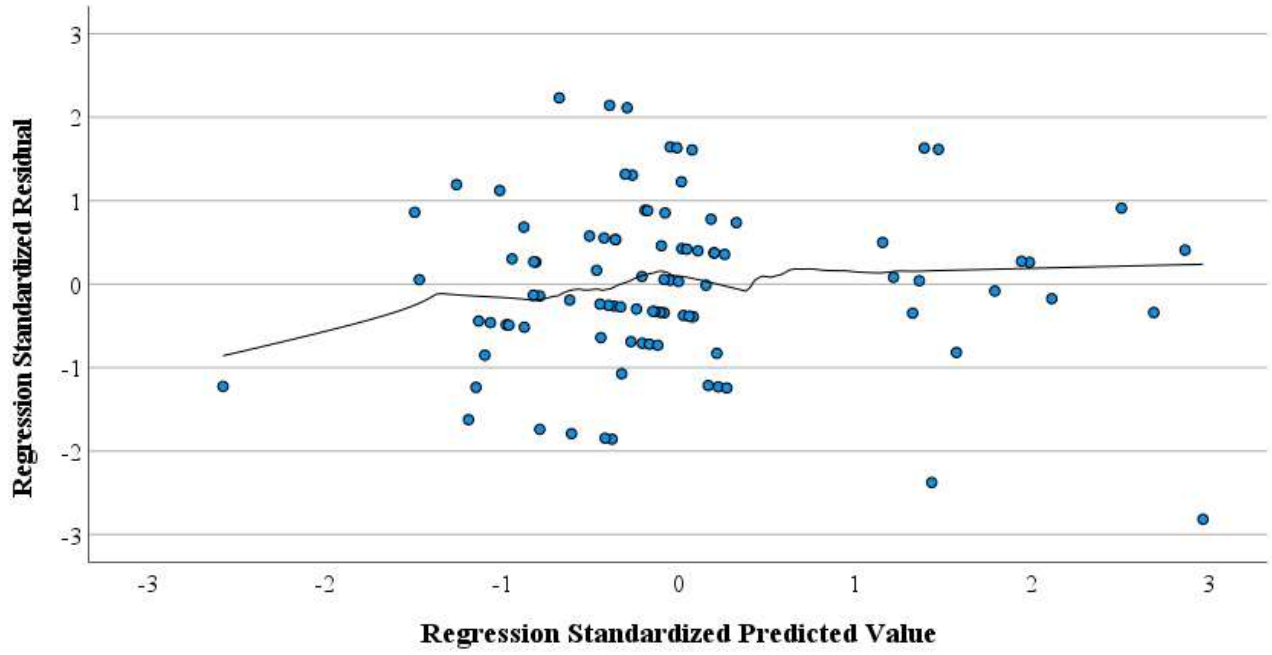
Next, significant outliers were identified for all variables in the model using boxplots. For PTG attitudes, two outliers were identified (see Figure 13 in the Data Preparation section). No outliers were identified for moral disengagement (see Figure 14). For empathy, one outlier was identified (see Figure 15). For moral identity, one outlier was identified (See Figure 16).

Significant outliers identified for PTG attitudes, empathy, and moral identity were winsorized using the plus or minus one rule prior to analyses. No outliers were found in the model.

To test the assumption of homoscedasticity, standardized predicted values for PTG attitudes were plotted with standardized residuals. Figure 17 shows that the amount of error remains consistent along the fit line and provides support for homoscedasticity. Moving up and down the line, the datapoints appear to roughly remain the same distance from the line, and the residuals are roughly rectangularly distributed with most cases concentrated in the center. Further, the scatterplot supports the absence of outliers in the model with no cases having a standardized residual of more than 3.3 or less than -3.3 (Tabachnick & Fidell, 2013).

Figure 17

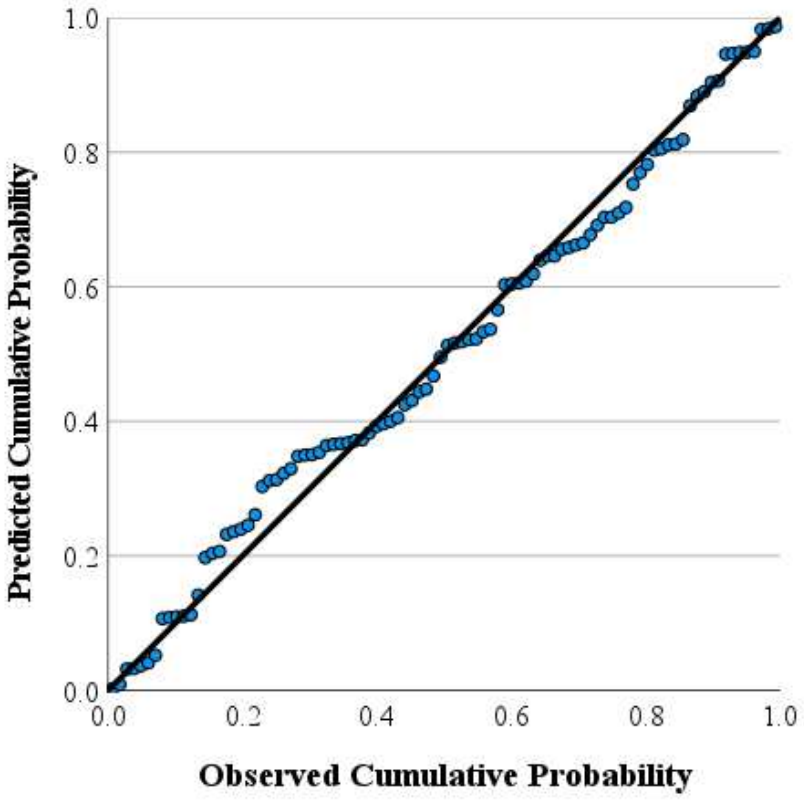
Relationship Between Standardized Residuals and Predicted Values for PTG Attitudes



To test the assumption of linearity, probability plots were visually examined. A probability plot of the residuals is a scatter plot that visualizes the predicted (i.e., population level) percentiles of a normal distribution on the x-axis and the observed sample percentiles of the residuals on the y-axis. Sample residual percentiles were evaluated as to whether they deviated significantly from expected residual percentiles. As shown in Figure 18, sample residual percentiles do not appear to deviate from expected residual percentiles. Because no deviation in the residual percentiles is present, the model meets the linearity assumption.

Figure 18

Normal Probability Plot of Standardized Residuals for Self-Reported PTG Attitudes



To test the absence of multicollinearity assumption, collinearity diagnostics including the tolerance and VIF metrics were examined among the independent variables and covariates in the model. For all variables, tolerance values were above 0.10 ranging from 0.74 to 0.94. Additionally, VIF metrics for all variables were below two ranging from 1.06 to 1.36 indicating no concerns with multicollinearity in the model.

The assumption of independence is assumed for all variables, as the observations are individual from one another. To further support that this assumption is met, Figure 17 (see above) demonstrates that there is not a linear relationship between the standardized residuals and predicted values for PTG attitudes. Thus, the residuals of the model do not depend on the predicted values, and the independence assumption is met. A lowess line was plotted to emphasize the lack of a linear relationship between the residuals and predicted values.

As previously described in the Data Preparation section, a one-way ANOVA revealed a significant main effect of gender on PTG attitudes, F (1, 91) = 4.04, p = 0.05. This indicates that on average, males reported significantly more liberal attitudes towards PTG than females. Given the significant effect of gender on PTG attitudes and the representative gender breakdown in the sample, gender was included as a covariate in the regression model.

Results of Multiple Linear Regression Model. A multiple linear regression was performed to assess the predictive value of a number of factors on psychologists' PTG attitudes. The model contained three independent variables (moral disengagement, empathy, and moral identity) and one data-driven covariate (gender). The model as a whole explained only 8.1% of the variance in PTG attitudes and was not statistically significant (R^2 = 0.081, F (4, 89) = 1.96, p = 0.11).

As displayed in Table 23, none of the independent variables made a unique, statistically significant contribution to the model except for gender. Moral disengagement ($\beta = 0.06$, $t(93) = 0.52$, $p = 0.60$), empathy ($\beta = 0.08$, $t(93) = 0.68$, $p = 0.50$), and moral identity ($\beta = 0.09$, $t(93) = 0.75$, $p = 0.45$) were all non-significant. However, gender did make a statistically significant contribution to the model ($\beta = -0.28$, $t(93) = -2.66$, $p = 0.009$). This means that when accounting for moral disengagement, empathy, and moral identity, male psychologists/trainees on average hold more liberal PTG attitudes (or perceive PTG as more ethical) than females. Specifically, when moving from male to female, PTG attitudes scores reduce by 0.28 indicating more conservative views.

Table 23

Results of Linear Regression Model Predicting Self-Reported PTG Attitudes

Variable	Unstandardized B	Standard Coefficients Beta	*T*	*p*	95% confidence interval odds ratio
Constant	1.92	-	1.37	0.18	-1.45-4.08
Moral Disengagement	0.15	0.06	0.52	0.60	-0.42-0.72
Empathy	0.10	0.08	0.68	0.50	-0.20-0.41
Moral Identity	0.20	0.09	0.75	0.45	-0.33-0.74
Gender	-0.60	-0.28	-2.66	0.009**	-1.05-0.15

Note. Statistical significance at the $p < 0.01$ level is indicated by **.

A Closer Look at the Effect of Gender on PTG Practices and Attitudes

Gender was the only variable found to contribute a statistically significant contribution to both regression models. The logistic regression indicated that males are 0.24 more likely to report engagement in PTG than females. Additionally, a one-way ANOVA revealed a statistically significant difference between males and females for PTG practices at the $p < 0.01$ level with males reporting more PTG than females, $F(1, 91) = 7.80$, $p = 0.006$. Mean scores for both males (M =1.75, SD = 0.58) and females (M = 1.36, SD = 0.49) indicate low frequency of PTG. However, 75.0% of males reported engagement in PTG, and only 41.6% of females did. A one-way ANOVA also revealed a statistically significant difference at the $p < 0.05$ level for PTG attitudes with males reporting more liberal PTG attitudes than females, $F(1, 91) = 4.04$, $p = 0.047$. The mean PTG Attitudes Scale score for males indicates neutral attitudes regarding the ethicality of PTG (M = 3.06, SD = 1.03) where the mean score for females indicates slightly more conservative attitudes (M = 2.59, SD = 0.82). Additionally, a one-way ANOVA revealed that males perceive that PTG has a lesser impact on treatment and the therapeutic relationship than females, $F(1, 89) = 7.68$, $p = 0.007$. Although gender was not correlated with the Moral Disengagement Scale overall, males were more likely to endorse items on the Moral Disengagement Scale related to distorting the consequences of their behavior and dehumanizing others. For example, males agreed with the statements, "People don't mind being teased because it shows interest in them," $F(1, 91) = 6.02$, $p = 0.016$, "Teasing someone does not really hurt them," $F(1, 91) = 7.49$, $p = 0.007$, "Insults don't really hurt anyone," $F(1, 19.54) = 5.76$, $p = 0.027$, and "It's ok to treat badly someone who behaved like a worm," $F(1, 90) = 6.80$, $p = 0.011$, significantly more than females. Note that Welch's test was used instead of a one-way ANOVA to examine the main effect of gender for, "Insults don't really hurt anyone," as Levene's Test revealed that the homogeneity of variance assumption was not met ($p = 0.022$). Gender was also

revealed as a main effect for the Empathy Subscale, in that females reported significantly higher trait-level empathy on average than males, $F(1, 91) = 5.734$, $p = 0.019$. Specifically, females were more likely to report valuing cooperation over competition than males, $F(1, 91) = 9.38$, $p = 0.003$. Gender was not related with the Moral Identity Subscale overall, but females indicated desiring to have characteristics, such as being caring, compassionate, fair, friendly, generous, helpful, hardworking, honest, and kind significantly more than males, $F(1, 90) = 5.35$, $p = 0.023$. Thus, overall, results support some gender differences that may provide insight as to what engenders PTG.

DISCUSSION

The present study represents the first known multi-method empirical examination of PTG practices, attitudes, and training needs among a national sample of psychologists and doctoral-level psychology trainees. The study provided information via five virtual focus groups and an online survey that helped to clarify PTG practices, examine PTG attitudes, and understand ethical training and guidance needs.

Results show that approximately half (46.8%) of a national sample of clinical and counseling psychologists and trainees reported having engaged in PTG. However, perceived prevalence rates of PTG vary greatly in that some psychologists and trainees believe that almost none of their colleagues engage in PTG, where others estimate that almost all do. PTG was revealed to be a rare and situational practice with only a small minority reporting engaging in PTG routinely. However, PTG occurs more frequently in certain settings, such as in emergency rooms, and with certain client populations, such as forensic clients. Clinical and counseling psychologists and trainees largely feel that when psychologists engage in PTG, they should receive client consent to do so, document their searches, be transparent with their clients regarding what information is revealed, consult with colleagues, self-reflect on their motivations and intentions, and use caution with technology. The most popular source of PTG is Google to search for information related to criminal history, and other common sources include news, social media platforms, and websites created by the client.

Results also show that most psychologists feel that the ethicality of PTG can only be determined on a case-by-case basis. When asked if PTG is ethical, approximately half of psychologists and trainees indicated that the disagree (52.13%), 29.79% indicated that they "neither agree nor disagree," and 18.09% agreed. However, psychologists and trainees perceive PTG as more ethical in emergencies than for routine matters. Over half (59.57%) agreed that

PTG is ethical in emergencies, but only 7.45% agreed that it is ethical when used routinely. Qualitatively, it was revealed that a majority of psychologists and trainees feel that the ethicality of PTG is dependent upon many factors including clinician motivation, client consent, and whether it is an emergency. Some perceive PTG as unethical and feel that no situations warrant the behavior. A small minority feel that PTG is always ethical because of its clinical utility and the public nature of online information. Focus group discussions resulted in training effects as conservative and undecided attitudes often shifted to more moderate attitudes. Psychologists and trainees identified a variety of reasons and situations in which PTG is clinically beneficial including in emergencies, for information gathering and verifying, when working with forensic populations, for dual relationship avoidance, and to help with building therapeutic rapport. However, they identified more reasons to avoid PTG including that it breaches client rights, negatively impacts the therapeutic relationship, introduces bias, crosses professional boundaries, can uncover information that requires reporting, results in invalid information, represents a misuse of power, fails to model healthy communication to clients, and can worsen client symptoms.

Half of psychologists and trainees reported having received no PTG training (50%) and/or ethical guidance (52.1%). Those who had received prior PTG training or guidance described it as informal and minimal, and many reported that they had simply been told not to engage in PTG. Many participants shared that their involvement in the study was their first exposure to the topic. On average, psychologists and trainees neither agree nor disagree that their PTG training was helpful. However, more nuanced training and guidance that involves discussion and weighing pros and cons was perceived as more helpful than abstinence guidance not to engage in PTG. Focus group participants were in favor of receiving more training and

guidance and had many ideas for the future including more open discourse about PTG and trainings available to psychologists and trainees across the career span. Psychologists and trainees were also in favor of receiving PTG guidance from APA, and 80.9% of the survey sample indicated that they would like explicit guidance on PTG in the APA Ethics Code. Despite wanting guidance from APA, some psychologists and trainees indicated on the survey that they do not see a need for PTG training, but this was not an attitude shared by focus group participants.

The study further examined the relationships between personal determinants of moral agency and PTG to serve as a proof of concept for applying SCT to understand psychologist PTG practices and attitudes. The PTG practices and attitudes scale items used in the present study performed well in the sample achieving adequate internal consistency and were correlated with one another indicating good convergent validity. Personal determinants of moral agency including moral disengagement, empathy, and moral identity were found to be unrelated to PTG practices and attitudes. Gender was the only variable found to contribute a unique and statistically significant contribution to both regression models with males being more likely to engage in PTG and have more liberal attitudes surrounding PTG. Professional status was also found to be related to PTG practices in that post-doctoral fellows indicated more PTG than doctoral students. No other participant factors were related to PTG practices or attitudes. Results of the study suggest that PTG is largely unrelated to moral agency and is likely engendered by other unstudied factors. Results support that male psychologists and trainees perceive PTG as more ethical, believe that it has a lesser impact on the therapeutic relationship, have less empathy, and value cooperation less than female psychologists and trainees. This combination of beliefs, values, and traits paired with a greater tendency to distort consequences of actions may

lead to a tendency to ignore the potential negative impacts of PTG (e.g., breaking client's trust, harming therapeutic rapport, breaching client rights) and focus on the potential benefits of PTG (accessing and verifying information, avoiding dual roles, monitoring client, etc.). These differences may provide some insight as to why gender was related to PTG practices and attitudes and what values and traits may engender PTG. PTG practices and attitudes were also found to be associated with a specific item on the Empathy Subscale: "I believe in an eye for an eye," and PTG practices were also found to be associated with an item on the Moral Disengagement Scale related to dehumanization: "Some people deserve to be treated like animals." This further supports that specific traits and values, such as lower empathy and competitiveness, may in part engender PTG.

Professional status was found to provide a unique and statistically significant contribution to the PTG practices regression model. Although doctoral students were found to report less PTG than post-doctoral fellows, this finding is thought to be impacted by sample characteristics of the small sample of post-doctoral fellows and may not generalize to the population. No other explanations, such as differences in clinical practice setting or PTG training experiences were uncovered.

Strengths of the Present Study

A strength of the present study is that it represents the first known multi-method empirical examination of PTG practices, attitudes, and training needs from a national sample of psychologists and psychology trainees. This is in contrast to previous works on PTG which have been conceptual in nature or recruited largely student samples. Additionally, many previous PTG studies have recruited multidisciplinary samples or targeted practitioners in other fields, such as nurses, physicians, or counselors. The present study specifically enrolled only psychologists who

either are currently or have received doctoral-level training in a health service psychology field and are legally and ethically obligated to abide by the APA Code of Ethics (2017), resulting in one of the first examinations of PTG practices and attitudes specifically within the field of psychology.

Another strength is that the qualitative research provided rich and diverse perspectives about PTG, a topic that many participants reported they had never had the opportunity to discuss prior to their participation. The 90-minute discussions that occurred during the virtual focus groups were also reported and observed to have an educational and sometimes transformative impact on participants' knowledge and perceptions of PTG. This highlights the importance of having opportunities for safe and transparent dialogue about ethics, particularly ethically ambiguous topics, among psychologists. The present study confirms that PTG practices and attitudes vary greatly among psychologists, and this may be impacted by the lack of training, dialogue, and ethical guidance in the fields of Clinical and Counseling Psychology surrounding PTG and ethics related to the Internet in general. Circumstances such as the COVID-19 pandemic highlight the importance of having more dialogue regarding ethical issues related to technology and the Internet that can quickly arise and evolve.

Limitations of the Present Study

A limitation of the present study is that results may not be fully generalizable. The mean age of the focus group sample was 30.1 years, and the mean age of the survey sample was 35.1 years. However, the mean age of the psychology workforce is 50 years (Lin et al., 2018b). Although research suggests that the mean age of psychologists is steadily declining, the present study samples were still significantly younger than the current population of psychologists in the U.S. Thus, the findings may not adequately represent practices, attitudes, and training needs of

older and more experienced psychologists. The samples as a result may not have adequately captured the effect of factors such as clinical experience and age on PTG practices and attitudes.

Another limitation of the present study is the survey sample size. Because the regression models conducted in the present study served as a proof of concept for applying SCT to understand psychologist PTG practices and attitudes, the sample size did not provide full power needed to test the models. However, correlations between PTG and moral disengagement, empathy, and moral identity were negligible. Thus, statistically significant contributions to the models would not be expected in a larger sample.

Another significant study limitation is that presently there is no validated measure of PTG practices or attitudes. Although the PTG practices and attitudes scale items used in the present study achieved adequate internal consistency and convergent validity in the sample, there are concerns with how participants may have interpreted the items. As written, some of the survey items may be misinterpreted as inquiring about searching for information related to a client, such as information about their medical diagnosis or cultural identity, instead of directly looking up a client using their name or identifying information. Thus, item wordings may require refinement to operationalize PTG more accurately. A definition of PTG was displayed on the screen when participants were responding to PTG-related items, but there was no attention check directly assessing whether they had carefully read the definition or item assessing their understanding of the definition, which may be warranted in future attempts to measure PTG.

Lastly, it is possible that selection bias and/or method effects impacted the findings of the present study. Psychologists and trainees who volunteered to participate in a study on “clinical ethics in the digital age” may have been interested in the general topic and eager to share their thoughts and opinions, which may differ from those who are less interested. However, the

financial incentive to participate may have motivated those less interested in the topic to participate. Additionally, it is noteworthy that within the online survey data, although most participants indicated wanting PTG guidance form APA, some participants indicated no desire or need for PTG training. For example, participants reported that they have no training needs in this area, described it as common sense, and felt that the issue is not pressing enough to be incorporated into curriculum. Interestingly, this attitude was not present in the virtual focus groups. This is the only theme that appeared to be specific to the method through which it was collected. It is possible that having a lengthy and nuanced discussion about PTG practices and attitudes with a group of peers may have increased participant perceptions that psychologists would benefit from PTG training and ethical guidance. Further, it is possible that in a focus group format, participants felt unable to express the view that training and ethical guidance is not needed. However, some other dissenting viewpoints were shared during the focus groups. Another possibility may be the age difference between the two samples. The survey sample was on average older and more experienced than the focus groups. The focus group sample was largely comprised of doctoral students who may be more open to receiving training and guidance than those further along in their career.

Recommendations for Future Research

The number of peer-reviewed publications about PTG has increased in recent years. However, the literature is still relatively young and focused on uncovering prevalence rates of PTG and discussing ethical considerations. The following recommendations are provided for future PTG research:

1. The next step in PTG research should entail validating a scale for measuring PTG practices and attitudes. Scale items should clearly and accurately target PTG and should

not allude to more general information seeking behaviors. Incorporating a way to assess one's understanding of PTG prior to reporting their PTG practices and attitudes may increase scale validity.

2. Future PTG research should explore which groups may be most negatively impacted by PTG. The present study revealed that psychologists feel that PTG can introduce bias into the therapeutic relationship. Many ideas regarding how this bias could impact treatment were shared including impacting clinicians' ability to have unconditional positive regard towards their clients and creating mistrust within the therapeutic relationship. However, details regarding which groups may be most negatively impacted by PTG and how were not discussed. It is possible that clients from marginalized or minoritized groups including those who have been convicted of a crime, LGBTQIA+ individuals, females, Black, indigenous, and people of color (BIPOC), or other groups may be disproportionally targeted for PTG due to clinician implicit or explicit bias.
3. Future PTG research should examine client perceptions of PTG, specifically how they feel about being searched online by their psychologist. Information about client perceptions of PTG may provide helpful insights regarding the clinical impact of PTG, such as how it impacts the client, their perceived quality of the therapeutic relationship, and the perceived effectiveness of their treatment. Further, it could provide a crucial perspective in regards to determining the ethicality of the behavior and developing best practice recommendations.
4. Future PTG research should continue to explore what engenders psychologist engagement in PTG. The present study only revealed significant relationships between PTG practices and two other variables: gender and professional status. Similarly, the only

variable significantly related to PTG attitudes was gender. Moral disengagement, empathy, and moral identity were not related to PTG. Thus, it remains unclear what engenders engagement in PTG and what factors help to explain the differences in PTG practices and attitudes that currently exist among psychologists. Through the lens of SCT, other possible factors to be explored in future research may include self-regulation, self-efficacy, values, or specific types of moral disengagement, such as dehumanization or distortion of consequences. Other individual factors, such as quantity and quality of relevant training experiences may be particularly important to examine.

Recommendations for Guidance, Training, and Practice

The present study revealed that current education, training, and ethical guidance do not provide psychologists with clarity regarding the ethicality of PTG, resulting in a variety of practices and perceptions. Many psychologists generally do not feel adequately equipped to ethically navigate digital contexts. The following recommendations for future PTG guidance, training, and practice are proposed:

1. The American Psychological Association should provide a stance on the ethicality and appropriateness of PTG and provide practical guidance for psychologists to promote a consistent standard of care. Psychologists would greatly benefit from APA disseminating standards or guidelines related to PTG that include explicit guidance, delineation of when PTG is ethical versus unethical, and how to navigate PTG ethically in emergencies. The new APA Ethics Code to be completed by the end of 2022 should address PTG directly. It seems necessary to include a new section of the APA Ethics Code that focuses on technology and digital contexts.

2. A consistent definition and more accurate terminology should be adopted. The term "PTG" is used consistently in the existing literature, but its definition is inconsistent. The following definition is recommended: a healthcare provider searching a patient's/client's name (or some other piece of identifying information) on the Internet through any search engine, social media platform, website, or application. This definition should evolve as more avenues for searching are created. The definition may additionally explain which information-seeking behaviors do not constitute PTG, such as searching for information related to a client's diagnosis or culture. Part of the confusion regarding the definition is that the term patient-target "Googling" is a misnomer; PTG refers to looking up a client through any online avenue, not just Google. Moving forward, a more accurate term for PTG should be popularized, such as "patient-targeted browsing."
3. Leaders in the field such as professors, clinical directors, and clinical supervisors, should initiate more discussions surrounding PTG, particularly with their trainees. Candid conversations initiated by authority figures should help to reduce stigma surrounding the topic within the field. Participants in the present study who were told not to engage in PTG felt like the topic was taboo and reported feeling uncomfortable consulting or initiating conversations with their supervisor. The present study supports a desire from psychologists and trainees for more opportunities to engage in transparent and nuanced conversations about PTG in graduate programs, in supervision, and among colleagues.
4. More formal PTG training opportunities should be available for psychologists across the career span including continuing education and trainings embedded in graduate programs. The focus group discussions in the present study were observed and reported to have an educational effect on participants. Thus, discussion-based training approaches

are recommended and may include the use of vignettes and case examples, discussions of ethical considerations related to PTG and other online behaviors, discussions of pros and cons of PTG, discussions about the limitations of information obtained through PTG, self-reflection exercises, the application of ethical decision-making models to PTG, and decision trees tailored to PTG. It is especially important that PTG trainings encourage self-reflection and emphasizes psychologists' awareness of their own online behavior, presence, and values. For example, psychologists may benefit from being challenged to consider how certain online behaviors would potentially impact clients from ethical, legal, and clinical standpoints. Trainings should also introduce the related concept of digital boundary crossing and provide psychologists guidance on how to discuss digital boundary crossings with clients. Increased trainings may work to decrease the potential harm of PTG. The content of trainings should be updated as technologies and social media platforms evolve and as APA provides more guidance on the topic.

5. Psychologists choosing to engage in PTG should be advised by APA to incorporate PTG into the informed consent process to avoid breaching client rights. This should include discussing the benefits, drawbacks, and parameters of PTG and answering any questions the client may have. Additionally, clinicians should document PTG searches including what motivated the search, when it was conducted, what sources were accessed, what information was obtained, and how this information impacts diagnosis, conceptualization, or treatment if relevant.
6. Just as psychologists discuss with clients how to navigate accidental in-person interactions to anticipate and minimize harm, it is recommended that they also initiate conversations with clients about the possibility of digital interactions and how those will

be handled. This conversation should ideally occur during the informed consent process and include a discussion regarding any policies and parameters relevant to the sharing of and searching for information online. Further, it may be beneficial during this conversation to invite clients to share any discoveries they have made through therapist-targeted Googling and their reactions. This may be received as a very comfortable invitation for clients whom the online social world has always existed and may encourage transparency within the relationship.

Final Statements: A Call for Guidance from APA

Other organizations including the American Psychiatric Association (2017) have provided specific PTG guidance for psychiatrists. Results of the present study strongly support a call for guidance from the American Psychological Association regarding the ethicality and appropriateness of PTG and practice recommendations for psychologists. The APA Ethics Code Task Force (ECTF) is currently engaged in the process of drafting a new ethics code. Their April 2021 meeting involved discussion of possibly adding a new section of the code focusing on technology. A draft of the new ethics code is scheduled to be sent out for public comment in July of 2022 for a 60-day period. Information regarding PTG and other gaps in addressing online behaviors and technology can be provided to the ECTF during this time for incorporation into the code. Some focus group participants identified valid issues with having specific PTG guidelines in the APA Ethics Code related to how they could be misinterpreted or become outdated very quickly with evolving technology and social media platforms. Whether or not PTG is directly addressed within the new version of the APA Ethics Code to be completed by the end of 2022, it is important that APA provides PTG guidance for psychologists sooner rather than later through some format. Other options include APA creating a PTG task force with the goal of

answering specific PTG-related questions and publishing an article or webpage summarizing their findings and conclusions. Guidance from APA is not only desired by psychologists and trainees but is absolutely crucial to promote a consistent standard of care, provide clarity surrounding the ethicality of PTG, and provide practical guidance for psychologists moving forward.

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APPENDIX A

TTAPP TOOL

TTaPP

Together Take a Pause and Ponder

Should I Search Online?

We live in a networked world, and sensitive information about the people you serve may be a just a tap on a keyboard or cell phone away. Though it can be tempting – and even helpful – to search Google, Facebook, Twitter and other online and social media sources to find out more, online searches on your work or personal computers and electronic devices have the potential to:

- Compromise the integrity of the therapeutic relationship.
- Cross professional boundaries.
- Jeopardize trust between patients and their care team
- Introduce false or inaccurate information.

The general guidelines is NOT to search online for patient information, before you do the following:

- FIRST, talk with your manager, another team member, and/or your patient's provider
- THEN, Together Take a Pause and Ponder (TTaPP) the following questions.

Questions to Ponder Together

1) How is my decision to search for online information guided by our Mission, Core Values, and Standards of Conduct?

- Would this search demonstrate or compromise my reverence for this person?
- Does this search demonstrate hospitality, collaboration and respect for the dignity of this person?
- Does this search demonstrate or compromise my integrity or the integrity of others caring for this person in terms of honesty, humility and stewardship?
- How might this search strengthen or compromise my compassion for this person?
- Does this search illustrate our commitment to person-centered care, creating healing environments and advocating for others?
- Does an online search cross professional boundaries with this person or compromise the requirements of my professional licensure?

2) Why do I want to search online for information about this person?

- Am I concerned about this person's immediate safety and well-being, or am I just curious to find out what might be online?
- Do I believe this online information is critical to providing effective treatment for this person?
- Is my desire to search for online information based on my assumptions about this person, or influenced by any sources of stigma?
- Does this online search cross professional boundaries within my relationship with this person?
- How does this online search compare to other types of information-gathering activities? For example:
  - searching in a phone book
  - looking through a purse or wallet
  - reading a diary or journal
  - listening in on a personal conversation
- How will I know if any information I might find online is true and accurate?
- Is there no other way to find out this information (including directly talking with the person)?

3) Could my online search either advance or compromise treatment?

- How will I use the information I find online within the treatment setting?
- How will I keep this information private (or should I keep it private)?
- How would any online information I might find impact this person's treatment plan?

This information was adapted by the CHI Health Behavioral Healthcare Ethics Committee from information found in the following resources:

- *Clinton, B.K., Silverman, B. C., & Brendel, D. H. (2010).*
- *Ethics Committee of the American Psychiatric Association. (2017). Opinions of the Ethics Committee on the Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry. Arlington, VA: American Psychiatric Association.*
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CHI Health

Together **T**ake **a** **P**ause and **P**onder

For more information and assistance contact the Ethics Services department at **EthicsServices@alegent.org or 402-343-4476.**

- How might this online search be of benefit or cause harm to this person? To our therapeutic relationship?
- Is there a different way I could find the information I am searching for online that would pose less risk to this person's confidentiality and privacy?
- Is there something about this situation that would justify searching for information online? For example:
  - Looking for an otherwise-unknown emergency contact.
  - Concern for the immediate safety and wellbeing of this person.
  - Concern for the immediate safety and well-being of others as a result of my interactions with this person?

4) Should I ask for permission from this person before searching online for information?

- Would asking this person about the situation or for permission before searching open up discussions about my concerns?
- Are there compelling reasons **not** to ask permission before searching for information online?
- Will this person feel hurt, angry or violated if I search online without permission?
  - *If there is a low likelihood of benefit and a high likelihood that this person will feel angry or violated, then you should probably not search for information online.*
- How can I preserve privacy and maintain trust with this person if I search for online information without permission?

5) Should I share online search results with this person?

- If I decide to search online for information, should I share what I found with this person and/or with others?
- What if I didn't ask for permission to search online before-hand? What should I think about before I decide to tell this person about my online search after I've found something?
  - *Consider talking with a legal, risk management or privacy specialist, or requesting an ethics consultation, to help you with this decision.*
- If I decide not to tell this person that I searched online for information, or not to share the information I found, how will it change my interactions with this person?
- If I decide to tell this person about my online search, how can I do so in a way that preserves trust within our relationship?

Whenever you are pondering whether or not to proceed with an online search for information, be sure to **Together Take a Pause and Ponder (TTaPP)** and ask yourself these questions. Stop and talk to a peer or supervisor, and **if you are not the direct provider for the patient, be sure to talk with the provider before proceeding with any search.** Consider consulting with a legal, risk management, privacy or ethics resource before proceeding with any online search for information about your patient.

6) If I do search online, should I document any information I find in this person's medical record?

- Is the information I found online relevant to the treatment plan?
- Have I considered that this person has a right to read information in the medical record?
- How might this person's relationship with other members of the current or future treatment team be impacted by this information?
- How might unverified information found online and placed in a medical record impact this person's current and future treatment and well-being?
  - For example, might documentation about a photo of this person holding a cigarette lead to a false assumption that this person smokes; and how might that impact future insurance coverage or employment opportunities?

7) How do I monitor my motivations along with the risks and benefits of searching online for information?

- Have I checked in with my manager or supervisor, another colleague or the primary provider before searching online for more information about this person?
- Have I identified and acknowledged my motivations for wanting to search online for more information about this person?
- Can I justify my desire to search online from a clinical and/or therapeutic perspective, or am I just being curious or "nosy"?
- Have I carefully considered how this person will be impacted by any information I find by searching online?
- Have I carefully considered how my perceptions will be impacted by information I find by searching online?

Your answers to the questions above will help you decide whether or not you should search for information online.

APPENDIX B

DEMOGRAPHIC ITEMS

Please answer the following demographic questions as completely, carefully, and honestly as possible. Be sure to answer all questions.

1. Have you earned a doctoral degree in Counseling Psychology, Clinical Psychology, or Combined Psychology? (Screener)
   a. Yes, I have a doctoral degree in Counseling Psychology
   b. Yes, I have a doctoral degree in Clinical Psychology
   c. Yes, I have a doctoral degree in Combined Psychology
   d. No

(If a-c, they proceed to question 3; If d, proceed to question 2)

2. In what year of your doctoral training are you currently in? (Screener)
   a. 1st year
   b. 2nd year
   c. 3rd year
   d. 4th year
   e. 5th year
   f. 6th year or greater
   g. I am not in a doctoral program for Clinical Psychology, Counseling Psychology, or Combined Psychology

(If g, survey ends here; if a through f, proceed to question 3)

3. Have you provided psychological services (i.e., therapy/counseling, assessment, consultation) in the past 12 months? (Screener)
   a. Yes
   b. No

(If b, survey ends here; if a, proceed to question 4)

4. In your life, have you provided at least 100 hours of direct psychological services (e.g., therapy/counseling, assessment, consultation)?
   a. Yes
   b. No

(If b, survey ends here; if a, participant is eligible and proceeds to the remainder of the demographic questions)

5. Where are you currently in your professional journey?
   a. I am a graduate student
   b. I am a postdoc (unlicensed)
   c. I am a licensed psychologist

6. What discipline describes your training?
    a. Clinical Psychology
    b. Counseling Psychology
    c. Combined Psychology

7. What is your gender?
    a. Male
    b. Female
    c. FTM Transgender
    d. MTF Transgender
    e. Gender non-binary/Gender nonconforming
    f. Other: _____
    g. Prefer not to answer

8. Are you Hispanic or Latino?
    a. Yes
    b. No

9. What best describes your racial identity? Choose one or more races to indicate how you identify.
    a. American Indian or Alaskan Native
    b. Asian
    c. Black or African American
    d. Native Hawaiian or Other Pacific Islander
    e. White
    f. Other: _____

10. How old are you? _____

11. How many years of experience do you have providing psychological services?

12. Which of the following best describes the clinical setting in which you primarily practice? (APA, 2020)
    a. Medical Center/Hospital
    b. Outpatient Clinic
    c. Inpatient
    d. Private Practice
    e. Community Mental Health Center
    f. Schools
    g. University Counseling Center
    h. Veteran's Affairs
    i. Rehabilitation Center
    j. Prison/Correctional Facilities
    k. Psychiatric Facility
    l. Learning Center
    m. Integrative Health Environment
    n. Other: _____

13. What psychological services do you provide? Select all that apply:
    a. Therapy/Counseling
    b. Assessment
    c. Consultation
    d. Other: _____

14. With which population do you primarily work with?
    a. Children
    b. Adolescents
    c. Adults
    d. All of the above

15. What is your theoretical orientation? (Worthington & Dillon, 2003)
    a. Cognitive-behavioral
    b. Psychodynamic/Psychoanalytic
    c. Humanistic/Existential
    d. Family Systems
    e. Feminist
    f. Multicultural
    g. Integrated/Eclectic
    h. Other (Please specify): _____

Note: Items 1-4 will be used in recruitment for both study arms as screener items to determine participant eligibility. Items 5-11 will be presented to all participants in both the virtual focus group arm and the online survey arm. Items 12 through 15 will only be presented to participants in the online survey arm.

APPENDIX C

VIRTUAL FOCUS GROUP MODERATOR'S GUIDE

PTG Virtual Focus Groups
Moderator Guide and Questions

Begin by reviewing the elements of consent. Ask if there are any questions about their rights as participants or the nature of their participation. Receive verbal consent from each participant before initiating discussion.

Ground Rules
As a reminder, there are no right or wrong answers; I want to hear your honest opinions. I want to know what you really think. If you want to follow up on something that someone has said, you want to agree, or disagree, or give an example, feel free to do that. Please do not be shy because I want to hear from everyone. Don't feel like you have to respond to me all the time. I am here to ask questions, to listen, and make sure everyone has a chance to share. I'm interested in hearing from each of you. So, if you're talking a lot, I may ask you to give others a chance. And if you aren't saying much, I may call on you. I just want to make sure that I hear from all of you. I'd like you each to be mindful if there is noise in the background to please mute yourself. Any questions before we start?
Turn on recorder

Topic Overview
Today we will be talking about patient-targeted Googling. Before we begin, I will give you some background information on the topic. Patient-targeted Googling is a term used to describe healthcare providers searching on the Internet with the goal of obtaining information about their clients. Patient-targeted Googling refers specifically to searching a current client's name on search engines, such as Google, on social networking sites, such as Facebook, Twitter, or Instagram, or any other Internet search. Patient-targeted Googling does not refer to looking up information related to your clients, such as their diagnosis or culture or looking up past clients to whom you are no longer providing services. Research suggests that many mental healthcare providers engage in patient-targeted Googling. The ethicality of patient-targeted googling is not universally agreed upon, and many hold opposing viewpoints about this topic. The American Psychological Association has not provided any guidelines on patient-targeted Googling. I am seeking your honest reactions and opinions on this topic.

1. Tell me some initial thoughts you have when I say "patient-targeted Googling?"
2. What percentage of psychologists do you think are searching their clients online?
    - Rare or common practice?
3. What are the potential benefits of patient-targeted Googling?
4. What are the potential detriments of patient-targeted Googling?
5. What are your thoughts about the ethicality of patient-targeted Googling?
    - Professional boundaries?
    - Privacy and confidentiality?
6. With what types of clients and under what circumstances do you feel PTG is ethically

justified?
    - Younger/older clients?
    - Feel in danger/threatened by a client?
7. What, if any, precautions should be taken by psychologists when patient-targeted googling?
    - What about informed consent?
    - What about transparency with the client?
    - What about documentation?

Now I'm going to ask you some questions about training and ethical guidance as research indicates variability in training. I am seeking your honest reactions and opinions here.

8. What has been your experience with receiving training or ethical guidance on patient-targeted Googling?
    - Source of training/ethical guidance?
    - What was taught/recommended?
    - Helpful/not helpful?
9. What are your thoughts about the training and ethical guidance needs of psychologists related to patient-targeted Googling?
    - What are your opinions on having explicit PTG guidelines in the APA Ethics Code?
    - What PTG ethical guidelines do you think would be appropriate?
10. Do you have anything else you'd like to add about patient-targeted Googling?

Closing Statements
That's it for today. I want to thank each of you for your open and honest opinions. This will help us to better understand psychologists' behaviors, attitudes, and training needs regarding patient-targeted Googling.

IMPORTANT REMINDERS FOR FACILITATOR:
Turn off recorder
Distribute e-gift cards via email
Distribute TTaPP tool flyer via email
Distribute study phone numbers for questions via email

APPENDIX D

PTG ONLINE SURVEY ITEMS

The following items ask you to report on looking up your clients online.

The items in this survey are specifically asking about **SEARCHING A CLIENT'S NAME on Google, social media, or any other form of online search.**

This **DOES NOT** refer to looking up past clients to whom you are no longer providing services or looking up information related to your client, such as their diagnosis or culture.

Again, we are specifically asking about searching a current client's name on the Internet.

Research suggests that many mental healthcare providers look up their clients online. The ethicality of this behavior is not universally agreed upon, and many hold opposing viewpoints about this topic. The American Psychological Association has not provided any guidelines on this. I am seeking your honest opinions and experiences surrounding this topic.

Please respond as honestly and accurately as possible. Please be sure to read the items fully before providing a response.

PTG BEHAVIOR COMPOSITE (items 1-3)

	Never	***Rarely***	***Sometimes***	***Often***	***Always***
1. I have searched online for information about a client. (BEH) (Harris & Robinson Kurpius, 2014)	1	2	3	4	5
2. I have conducted a Google search to find information about a client. (BEH) (Harris & Robinson Kurpius, 2014)	1	2	3	4	5
3. I have conducted a search on a social networking site to find information about a client. (BEH) (Harris & Robinson Kurpius, 2014)	1	2	3	4	5

4. If applicable, describe other ways you have searched for client information on the Internet: (BEH)

Textbox for qualitative responses.

ADDITIONAL PTG BEHAVIOR DESCRIPTIVE ITEMS

5. Describe the frequency or regularity in which you search for information about clients online. (BEH) (Eichenberg & Herzberg, 2016)

a. every day
b. multiple times per week
c. once per week
d. once per month
e. twice per year
f. once per year
g. never
h. Other: _____

	Never	***Rarely***	***Sometimes***	***Often***	***Always***
6. I obtain written informed consent from my client before searching for information about them online. (BEH) (Harris & Robinson Kurpius, 2014)	1	2	3	4	5
7. I obtain verbal informed consent from my client before searching for information about them online. (BEH) (Harris & Robinson Kurpius, 2014)	1	2	3	4	5
8. I discuss with my clients the benefits and drawbacks of conducting an online search about them. (BEH)	1	2	3	4	5

(Harris & Robinson Kurpius, 2014)					
9. I discuss with my clients the information that was found about them as a result of my online search (BEH) (Harris & Robinson Kurpius, 2014)	1	2	3	4	5
10. I document my online search. (BEH) (Harris & Robinson Kurpius, 2014)	1	2	3	4	5
11. I document the client information obtained from the search. (BEH) (Harris & Robinson Kurpius, 2014)	1	2	3	4	5

The following items ask you to report on your feelings and opinions about searching for client information on the Internet.

"Searching clients online" and "searching online for client information" refer to searches on Google, social media, and any other form of online search. **Specifically, this means entering your client's name into a search bar to find information about them.**

Please respond as honestly and accurately as possible. Please be sure to read the items fully before providing a response.

PTG ATTITUDE COMPOSITE (items 1-3)

	Strongly Disagree	***Disagree***	***Neither Agree nor Disagree***	***Agree***	***Strongly Agree***
1. Searching for client information online is ethical. (ATT) (Brisson et al., 2015)	1	2	3	4	5
2. For routine matters, it is ethical to look up a client online. (ATT) (Brisson et al., 2015)	1	2	3	4	5
3. In emergency situations, it is ethical to look up a client online. (ATT) (Brisson et al., 2015)	1	2	3	4	5

ADDITIONAL PTG ATTITUDE DESCRIPTIVE ITEMS

	Strongly Disagree	***Disagree***	***Neither Agree nor Disagree***	***Agree***	***Strongly Agree***
4. Searching for client information online crosses ethical boundaries. (ATT)	1	2	3	4	5

	Not at all Concerned	***Slightly Concerned***	***Somewhat Concerned***	***Moderately Concerned***	***Extremely Concerned***
5. I feel _____ about the ethical implications of searching for information about my clients online. (ATT) (Asay & Lal, 2014)	1	2	3	4	5

	Not at all Comfortable	***Slightly Comfortable***	***Somewhat Comfortable***	***Moderately Comfortable***	***Extremely Comfortable***
6. I feel _____ about searching for information about my clients online. (ATT) (Asay & Lal, 2014)	1	2	3	4	5

	Strong Negative Impact	***Negative Impact***	***Neither negative nor positive impact***	***Positive Impact***	***Strong Positive Impact***
7. Searching for client information online impacts treatment and the therapeutic relationship. (ATT)	1	2	3	4	5

8. Describe your opinions on searching for client information online: (ATT)

Textbox for qualitative responses.

The following items ask you to report on you training experiences and needs.

Please respond as honestly and accurately as possible. Please be sure to read the items fully before providing a response.

PTG ETHICAL TRAINING/GUIDANCE DESCRIPTIVE ITEMS

	Strongly Disagree	***Disagree***	***Neither Agree nor Disagree***	***Agree***	***Strongly Agree***
1. I have received ethical training (e.g., continuing education training, graduate course, etc.) about searching my clients online. (TRA)	1	2	3	4	5
2. I have received ethical guidance on searching clients online. (TRA)	1	2	3	4	5

3. I have received adequate ethical training on searching clients online. (Chester et al., 2017) (TRA)	1	2	3	4	5
4. The training I received on searching clients online was helpful. (TRA)	1	2	3	4	5
5. I would benefit from more ethical training and guidance about searching clients online. (TRA)	1	2	3	4	5
6. I would like the APA Ethics Code to provide explicit guidelines on searching clients online. (Chester et al., 2017) (TRA)	1	2	3	4	5

7. Please describe your needs regarding training and ethical guidance on the topic of searching for client information online: (TRA)

Textbox for qualitative responses.

Key:
BEH: PTG behavior/practices
ATT: PTG attitudes
TRA: PTG training and ethical guidance needs

Scoring:
To operationalize PTG practices for quantitative analyses, BEH items 1-3 are averaged resulting in a score from 1 to 5 with higher scores indicating more engagement in PTG.

To operationalize PTG attitudes for quantitative analyses, ATT items 1-3 are averaged resulting in a score from 1 to 5 with higher scores indicating more liberal attitudes surrounding PTG (i.e., that PTG is ethical).

APPENDIX E

MORAL DISENGAGEMENT SCALE

Read each statement, decide if you agree or disagree, and then circle your response.

	Strongly Disagree	***Disagree***	***Neither Agree nor Disagree***	***Agree***	***Strongly Agree***
1. It is alright to fight to protect your friends. (MJ)	1	2	3	4	5
2. It's ok to steal to take care of your family's needs. (MJ)	1	2	3	4	5
3. It's ok to attack someone who threatens your family's honor. (MJ)	1	2	3	4	5
4. It is alright to lie to keep your friends out of trouble. (MJ)	1	2	3	4	5
5. Sharing test questions is just a way of helping your friends. (EL)	1	2	3	4	5
6. Talking about people behind their backs is just part of the game. (EL)	1	2	3	4	5
7. Looking at a friend's homework without permission is just "borrowing it". (EL)	1	2	3	4	5
8. It is not bad to "get high" once in a while. (EL)	1	2	3	4	5
9. Damaging some property is no big deal when you consider that others are beating up people. (AC)	1	2	3	4	5
10. Stealing some money is not too serious compared to those who steal a lot of money. (AC)	1	2	3	4	5
11. Not working very hard in school is really no big deal when you consider that other people are probably cheating. (AC)	1	2	3	4	5
12. Compared to other illegal things people do, taking some things from a store without paying for them is not very serious. (AC)	1	2	3	4	5

13. If people are living under bad conditions, they cannot be blamed for behaving aggressively. (DISR)	1	2	3	4	5
14. If the professor doesn't discipline cheaters, students should not be blamed for cheating. (DISR)	1	2	3	4	5
15. If someone is pressured into doing something, they shouldn't be blamed for it. (DISR)	1	2	3	4	5
16. People cannot be blamed for misbehaving if their friends pressured them to do it. (DISR)	1	2	3	4	5
17. A member of a group or team should not be blamed for the trouble the team caused. (DIFR)	1	2	3	4	5
18. A student who only suggests breaking the rules should not be blamed if other students go ahead and do it. (DIFR)	1	2	3	4	5
19. If a group decides together to do something harmful, it is unfair to blame any one member of the group for it. (DIFR)	1	2	3	4	5
20. You can't blame a person who plays only a small part in the harm caused by a group. (DIFR)	1	2	3	4	5
21. It is ok to tell small lies because they don't really do any harm. (DC)	1	2	3	4	5
22. People don't mind being teased because it shows interest in them. (DC)	1	2	3	4	5
23. Teasing someone does not really hurt them. (DC)	1	2	3	4	5
24. Insults don't really hurt anyone. (DC)	1	2	3	4	5
25. If students misbehave in class, it's their teacher's fault. (AB)	1	2	3	4	5
26. If someone leaves something lying around, it's their own fault if it gets stolen. (AB)	1	2	3	4	5

27. People who are mistreated have usually done things to deserve it. (AB)	1	2	3	4	5
28. People are not at fault for misbehaving at work if their managers mistreat them. (AB)	1	2	3	4	5
29. Some people deserve to be treated like animals. (DEH)	1	2	3	4	5
30. It is ok to treat badly someone who behaved like a "worm." (DEH)	1	2	3	4	5
31. Someone who is obnoxious does not deserve to be treated like a human being. (DEH)	1	2	3	4	5
32. Some people have to be treated roughly because they lack feelings that can be hurt. (DEH)	1	2	3	4	5

Select items wordings were modified from the original MDS (Bandura et al., 1996) for use with an adult sample as done in Detert et al. (2008)

Key: MJ = moral justification; EL = euphemistic labeling; AC = advantageous comparison; DISR = displacement of responsibility; DIFR = diffusion of responsibility; DC = distortion of consequences; AB = attribution of blame; DEH = dehumanization

Scoring: Item scores are averaged resulting in a score from 1 to 5 with higher scores indicating greater propensity to morally disengage.

APPENDIX F

INTERNATIONAL PERSONALITY ITEM POOL EMPATHY (SYMPATHY) SUBSCALE

Please use the rating scale below to describe how accurately each statement describes you and circle your response.

	Strongly Disagree			***Neither Disagree or Agree***			***Strongly Agree***
1. I sympathize with the homeless	1	2	3	4	5	6	7
2. I feel sympathy for those who are worse off than myself	1	2	3	4	5	6	7
3. I value cooperation over competition	1	2	3	4	5	6	7
4. I suffer from others' sorrows	1	2	3	4	5	6	7
5. I am ***not*** interested in other people's problems (Reverse code)	1	2	3	4	5	6	7
6. I tend to dislike soft-hearted people (Reverse code)	1	2	3	4	5	6	7
7. I believe in an eye for an eye (Reverse code)	1	2	3	4	5	6	7
8. I try ***not*** to think about the needy (Reverse code)	1	2	3	4	5	6	7
9. I believe people should fend for themselves (Reverse code)	1	2	3	4	5	6	7
10. I can't stand weak people (Reverse code)	1	2	3	4	5	6	7

Scoring: Item scores are averaged resulting in a score between 1 and 7 with higher scores indicating greater trait-level empathy.

APPENDIX G

INTERNALIZATION (MORAL IDENTITY) SUBSCALE

Listed below are some characteristics that might describe a person:

Caring, Compassionate, Fair, Friendly, Generous, Helpful, Hardworking, Honest, and Kind

The person with these characteristics could be you, or it could be someone else. For a moment, visualize in your mind the kind of person who has these characteristics. Imagine how that person would think, feel, and act. When you have a clear image of what this person would be like, answer the following questions.

	Strongly Disagree	***Disagree***	***Neither Disagree or Agree***	***Agree***	***Strongly Agree***
1. It would make me feel good to be a person who has these characteristics.	1	2	3	4	5
2. Being someone who has these characteristics is an important part of who I am.	1	2	3	4	5
3. I would be ashamed to be a person who has these characteristics. (Reverse code)	1	2	3	4	5
4. Having these characteristics is ***not*** really important to me. (Reverse code)	1	2	3	4	5
5. I strongly desire to have these characteristics.	1	2	3	4	5

Scoring: Items are averaged with higher scores indicating more self-important moral identity.

APPENDIX H

PEW RESEARCH CENTER INTERNET USE SURVEY ITEMS

Think about the social networking sites you use. This includes Facebook, Twitter, Instagram, Snapchat, LinkedIn, Reddit, Pinterest, TikTok, or any other social networking sites you use.

	Never	***Less Often***	***Several Times a Week***	***About Once a Day***	***Several Times a Day***	***Almost Constantly***
1. About how often do you visit or use social networking sites?	1	2	3	4	5	6

The margin of error for all adults is +/- 2.5 percentage points.

Scoring: Item one is averaged resulting in scores from 1 to 6 with higher scores indicating more use of social networking sites/social media.

APPENDIX I

ATTENTION CHECK ITEMS

	Strongly Disagree	***Disagree***	***Neither Agree nor Disagree***	***Agree***	***Strongly Agree***
1. I have heard of Google.	1	2	3	4	5
2. I have not heard of Facebook.	1	2	3	4	5

Scoring:

Item 1: Acceptable responses for item 1 include 4 (agree) and 5 (strongly agree). Unacceptable answers include 1 (strongly disagree), 2 (disagree), and 3 (neither agree nor disagree).

Item 2: Acceptable responses for item 2 include 1 (strongly disagree) and 5 (disagree). Unacceptable answers include 3 (neither agree nor disagree), 4 (agree), and 5 (strongly agree).

Response validity criteria: Participants must indicate acceptable responses for both items to be included in analyses.

VITA

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Education

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Published Abstracts

England, K., Edwards, A., Gordon, E., **Putnam, E. L.**, Dobyns, T., Springer, C. (2021). Barriers and opportunities for messaging parents about rear-facing car seats: A mixed-methods evaluation. In McKyer, L. (Ed.), "The American Academy of Health Behavior 2021 Virtual Scientific Meeting." *Health Behavior Research, Vol. 4 (3),* p. 54-55.

England, K., Edwards, A. L., Paulson, A. C., Harrell, P. T., Gordon, E., **Putnam, E. L.** (2020). Health Provider Knowledge and Practices Regarding Teen E-cigarette Use. In L. McKenzie (Ed.), "The American Academy of Health Behavior 2020 Annual Scientific Meeting." *Health Behavior Research: Vol. 3 (2),* p. 33.

Posters & Presentations

Putnam, E. L., Edwards, A. L., Gordon, E., Springer, C., Dobyns, T., & England, K. J. (2021, April). *Parent perceptions of the "Boost 'em in the Back Seat" intervention: A mixed methods examination* [Conference presentation]. Bi-Annual Scientific Meeting of the Society for Advancement of Violence and Injury Research 2021 Conference, Virtual.

England, K., Edwards, A., Gordon, E., **Putnam, E. L**., Dobyns, T., Springer, C. (2021, March). *Barriers and opportunities for messaging parents about rear-facing car seats: A mixed-methods evaluation* [Conference presentation]. Annual Scientific Meeting of the American Academy of Health Behavior, Virtual.

England, K. J., Edwards, A. L., Paulson, A. C., Harrell, P. T., Gordon, E., **Putnam, E. L.** (2020, March) *Health provider knowledge and practices regarding teen e-cigarette use.* Annual Scientific Meeting of the American Academy of Health Behavior, Napa Valley, CA

Putnam, E. L. (2019, April). *Proposed risk communication strategies in child passenger safety utilizing message framing strategies and normative feedback.* Poster presented at CHKD Pediatric Research Day, Norfolk, VA.

Putnam, E. L. (2018, October). *Effective risk communication in child passenger safety.* Poster presented at Eastern Virginia Medical School Research Day, Norfolk, VA.