Ethics and Online Behaviors:

Challenges Among Counseling and Psychology Graduate Students

by

Sara Elisabeth Harris

A Thesis Presented in Partial Fulfillment
of the Requirements for the Degree
Master of Counseling

Approved June 2012 by the
Graduate Supervisory Committee:

Sharon Robinson Kurpius, Chair
Terence Tracey
Richard Kinnier

ARIZONA STATE UNIVERSITY

August 2012

ABSTRACT

Technology is rapidly evolving, and mental health professionals are increasingly using technology in their clinical work. In reaction to this shift, it is important that research examines the ethical implications of online behaviors. The current study examined the online practices of graduate students in the mental health field and generated prediction models for online client searches and best practices in informed consent and online disclosure.

The sample consisted of 316 graduate students in counseling, clinical, and school programs. Of those with clinical experience, a third had utilized the Internet to find information about their client. Progress in the participants' program, as measured by credits completed or in progress, and years of social networking experience were positively related to online client searches. The vast majority (over 80%) of individuals who conducted an online search did not obtain informed consent prior to the search. Curiosity was the most frequent reason given for conducting a client search. Previous professional discussions and belief that information online is private were not significant predictors of obtaining informed consent. The final analysis examined disclosure of client information and found that lower scores on ethical decision-making and years of social networking experience predicted online disclosure.

This study is an important step in understanding the implications of the intersection of technology use, ethics, and clinical practice of graduate mental health professionals.

DEDICATION

There are several people that I would like to recognize in helping me complete my thesis and take the next step in my academic journey. I am deeply indebted to my family, who stressed the importance of education and provided constant encouragement as I progressed through the program. I am especially grateful for my father's ability to provide perspective and humor during challenging times and my mother's ability to help me remain focused and to realize that each step I took forward in the process was a reason to celebrate. I am deeply appreciative of my advisor, Dr. Sharon Robinson Kurpius. Her love of research, attention to detail, and seemingly boundless energy was inspiring. I also would like to give special mention to Dr. Terence Tracey and Dr. Richard Kinnier, who provided constructive feedback and helped me to view things from a different angle.

TABLE OF CONTENTS

Chapter 1

PROBLEM IN PERSPECTIVE

Overview of Social Networking

Social networking sites such as Facebook, Google+, Myspace, Twitter, Classmates.com, Linkedin, LiveJournal, and many others are forming every day, and their membership is continuously expanding. These websites provide a new medium for people to meet, reconnect, find others with similar interests, network with professionals, share information, and find love. Social networking is increasingly interwoven into today's social and business world. When one peruses these sites, they can expect to find universities, Fortune 500 companies, advocacy groups, and even churches.

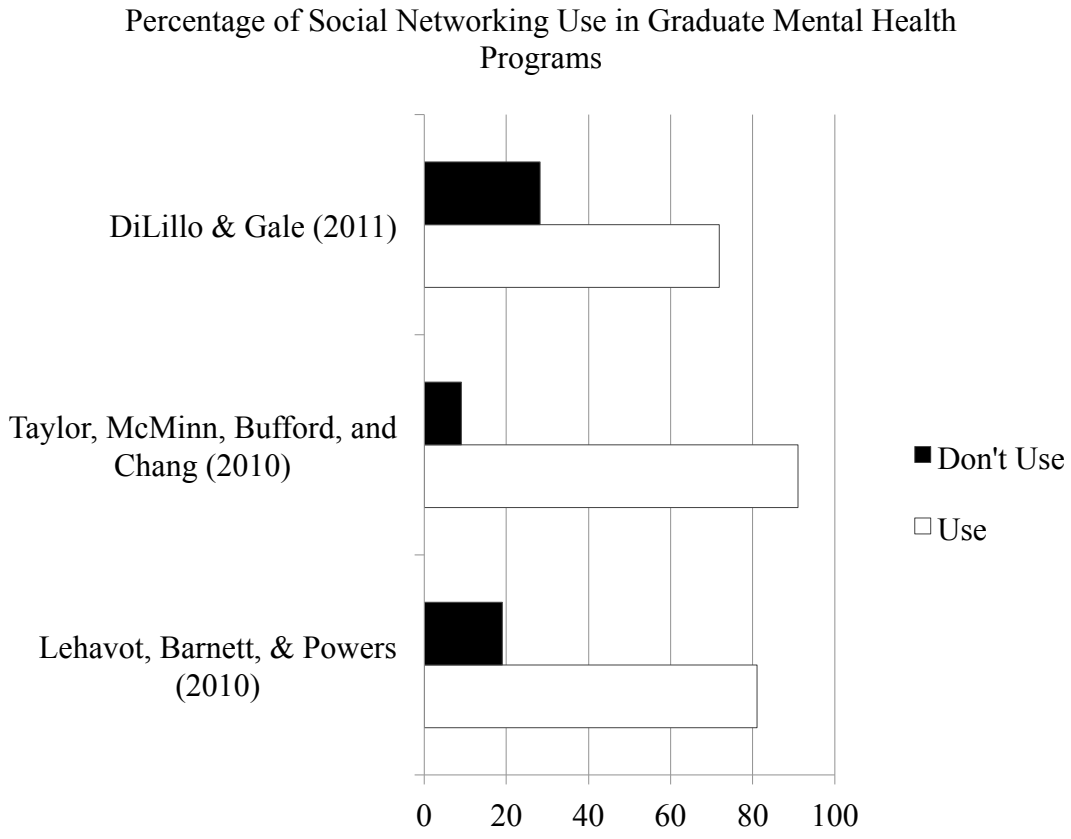
Facebook, which was originally founded in 2004 for students at Harvard, now permits membership to anyone over the age of 13 and is one of the largest social networking sites (Statistics, Facebook.com, 2010). Currently, there are over 500 million active users, and 50% of these users access their account daily (Statistics, Facebook.com, 2010). Tunick and Colleuges (2011) asserted that the popularity of such sites is likely to continue and to heighten. To track the growth of social networking use in the United States, the Pew Research Center has been collecting yearly data on social networking membership since 2005. The most recent data collection in May 2011, consisting of over 2000 individuals aged 18 and over, found that the percent of online adults who participated in social networking rose from 61% last year to 65% (Madden & Zickuhr, 2011). Of those users, 43% reported accessing their account every day. The majority of users

with online access who participate in social networking are females (i.e., 7 in 10 women vs. 6 in 10 males) aged 18 to 29. While membership for the 18-29-year-old age group remained relatively steady from 2010 to 2011, 86% to 83% respectively, membership is continuing to increase for older individuals (Madden & Zickuhr, 2011). For example, membership of online users with social networking sites for the 50-64 year old group has risen from 61% in 2010 to 70% in 2011, and membership for the 65+ groups has grown from slightly over 26% in 2010 to 33% in 2011. This suggests that the older generation, which originally had less of a presence on social networking, is beginning to join. Membership on such networks is becoming a cultural norm rather than exception, which underscores the importance of conducting research related to this new medium.

Mental health professionals are no exception to the trend of social networking use. For example, in a study of 302 student members of the American Psychological Association (APA) Divisions 29 (Psychotherapy) and 42 (Psychologists in Independent Practice), 81% of these students kept a social networking site (Lehavot, Barnett, & Powers, 2010). A larger study conducted by DiLillo and Gale (2011) of 854 students in counseling, clinical, and school psychology programs reported that 71.8% of students had a social networking site. Another study of 695 participants, comprised of graduate students in doctoral level psychology programs (91%), of licensed psychologists (9%), and of doctoral level psychologists yet to be licensed (5%), found that 77% reported maintaining a social networking page (Taylor, McMinn, Bufford, & Chang, 2010). Among the 528 participants who were under the age of 30, 85% reported

participating in social networking. In contrast, none of the 15 respondents over the age of 54 used a social networking site. These data suggests that the next wave of young mental health professionals will be active members of social networking sites. Figure 1 illustrates data from studies on percentages of graduate students who maintain a social networking site.

Figure 1. Percentages of Graduate Mental Health Students that Use Social Networking.



Despite the high level of participation in social networking, research on social networking is glaringly sparse in the fields of counseling and psychology. As evidence of this, social media was identified as one of the focus topics of the 2011 American Psychology Association (APA) convention (Vasquez, 2011). In

spite of this push for research, relatively few comprehensive studies on social networking are present in literature. Even fewer studies focus on the ways mental health professionals are using these sites and the implications this usage has on their clinical work. This illustrates a need for research to assess how mental health professionals use social networking sites and what behaviors they believe are ethical in regards to online behavior. Many questions remain unanswered about "correct" social networking etiquette for mental health professionals. In reaction to this lack of clarity, this study will gather information from counseling, counseling psychology, clinical psychology, and school psychology graduate students regarding their beliefs and behaviors online. Information from the study will be used to examine areas of concern and identify potential ethical pitfalls.

Potential Problems

Mental health professionals should carefully consider the ethical implications of participation in social networking sites and take time to reflect on how this participation affects their professional life. Because social networking is relatively new, it is often not an area in which students and new professionals can turn to their supervisors or university officials for advice. In a recent survey of APA Council of Representatives and division presidents, for whom the average age was 58.5 years, no member over the age of 54 maintained a social networking site (McMinn, Hathaway, Woods, & Snow, 2009).

Furthermore, very few universities have developed guidelines for social networking for students or faculty and staff. The University of California- Santa Barbara (UCSB) has established a set of guidelines for faculty and staff that

states, “The university’s name, university telephone numbers, university email addresses, and university images are not to be posted on social network profiles for academic and staff employees for personal purposes. However, an academic or staff employee, or student government officer, or registered campus organization may use their University title for identification purposes” (UCSB Policies, 2011, p. 1). Although UCSB does not have formal policies in place for student users, it does provide a section entitled “Social Networking On-Line We Care Tips” under the policy section of their website for student reference. Loyola College-Maryland also has guidelines for social media usage for graduate and undergraduate students, but their guidelines do not address faculty etiquette (Mills, 2008). Compounding the problem of lack of professional reference and university guidance, relatively few scholarly investigations have been conducted around the topic of best practices of social networking for mental health professionals.

In the age of instant gratification and instant online technologies, it is imperative that ethical issues related to social networking are addressed before potential damage is done to clients, to the mental health professional, and to the profession. Ignoring the presence of social networking could cause the mental health profession to take a reactive stance to solve emerging ethical challenges, and this could lessen the publics’ trust in the confidential nature of the counseling relationship and the professional demeanor of mental health professionals. Having professional ethical guidelines for social networking would help mitigate

ethical challenges in the lives of mental health professionals who are presented with the emergence of the digital age.

Not only should potential ethical challenges related to involvement in social networking be proactively identified and examined, but ethical solutions should also be proposed. To examine this issue fully, it is necessary to obtain a representative sample of the online behaviors that mental health professionals are exhibiting. After this information is obtained, ethical implications of this behavior can be identified. Arguably, the most important component of this proactive action is eliciting discussions on what constitutes ethically appropriate interactions for mental health professionals and educating graduate students in the mental health profession about the potential benefits and drawbacks of using online features such as social networking sites in their clinical work.

Lack of Ethical Guidance

While there are no standards within the current ethical guidelines provided by the American Psychological Association (APA, 2010) or American Counseling Association (ACA, 2005) that specifically address professional standards for social networking sites, the standards should provide a broad framework in which social networking behaviors can be considered. The APA Ethical Principals of Psychologists and Code of Conduct (hereafter referred to as Ethics Code) asserts that the "application of an Ethical Standard may vary depending on the context" (p.1). Furthermore, they emphasized, "The fact that a given conduct is not specifically addressed by an Ethical Standard does not mean that it is necessarily either ethical or unethical" (APA, 2010, p.1). No general consensus exists on

whether the APA organization should create specific guidelines on this topic for mental health professionals. Taylor et al., (2010) found, however, that there was a slight correlation between the age of respondents and the likelihood that they would favor APA involvement in providing set standards. Surprisingly, younger participants were more likely to favor involvement on implementing specific rules and guidelines for social networking sites, which suggests that a portion of the younger generation is looking for specific guidelines to help guide their online conduct. APA's avoidance of specific ethical standards for social networking may be coming to an end. Martin (2010), a staff member of the APA's magazine The Monitor, stated with a "high degree of confidence" that the area of social media will be factored into the next rendition of the APA ethical code.

The ACA (2005) Code of Ethics is under revision as of April 2011, and a final draft is intended for release in March 2014 (Rollins, 2011). While the wide use of social networking is not the sole reason for the revision, social media applications were posited as a catalyst for beginning revisions sooner (Rollins, 2011). ACA President Marcheta commented that social media stands out as an area of new concern stating that, "With Twitter and Facebook, there are some ethical boundary issues just floating out there with counselors" (Rollins, 2011, p. 1). The concern of both the APA and ACA highlights the importance of gathering information on mental health professionals' behaviors related to social networking, so that potential ethical issues can be addressed.

Since the ethical standards related to professional online behaviors are not explicitly stated, it is tempting to form the argument that mental health trainees do

not understand that certain behaviors (e.g., online client search) are ethically questionable. One study found that there was significant uncertainty among individuals in private practice regarding ethical use of various aspects of technology (McMinn, Bearse, Heyne, Smithberger, & Erb, 2011*)*. For example, 45.1% of the practitioners in McMinn et al. study were unsure whether it was appropriate to allow a client limited access to their social networking site. This study should be interpreted cautiously in the context of the current study as the average age of participants was 54.3 years (*SD* = 12.2).

Social networking creates many complex ethical dilemmas that do not have clear-cut answers. For example, ethical dilemmas related to privacy, confidentiality, informed consent, and multiple relationships are of concern. However, as Kaslow and collogues pointed out, "The fact that there are no explicit standards in this arena does not mean we are free to violate basic ethical principles of confidentiality, informed consent, privacy, trust in relationships, and best interest of our clients" (Kaslow, Patterson, & Gottlieb, 2011, p. 110).

It is critical that psychologists and counselors have an understanding of ethical concepts and subsequent boundaries and are able to transfer this understanding to their professional behaviors. Therefore, it is important to explore these professional issues with respect to online behaviors.

Right to Privacy, Confidentiality, and Informed Consent

Privacy grants individuals the right to decide how much of their behaviors, thoughts, and feelings they share with others (Koocher & Keith-Spiegel, 2008). General ethical principles are not enforceable rules; rather they are a reflection of

the moral values of the profession that are meant to guide psychologists (C. B. Fisher, 2008). Both the ACA and APA have ethical guidelines in place to protect the client's right to privacy in the counseling relationship. APA (2010) Principle E states, psychologists should "respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination." The ACA (2005) Standard, B.1.b (Respect for Privacy) also mandates that, "Counselors respect client's right to privacy. Counselors solicit private information only when it is beneficial to the counseling process." Both the APA and ACA underscore the importance of respecting the clients' choice to disclose information and also emphasize that psychologists and counselors should try to minimize or not knowingly participate in activities that will bias their work. For example, learning about a unique facet about the client's identity through a social networking site without processing this new information with the client may introduce bias into the therapeutic relationship and compromise the client's fundamental right to autonomy and privacy.

Social networking raises interesting questions about respecting a client's right to privacy. The boundary separating public information and private information is often convoluted. While users may or may not be aware of the level of detailed information that is collected and stored by social networking sites, an argument could be made that since these disclosures are made in a public forum they cannot be considered private.

Despite these ethical risks, a startling number of young mental health professionals are reportedly conducting searches online for their clients. Reported

rates of these online searches range from 27%-97.8% of student psychotherapists seeking out client information through the Internet (DiLillo & Gale, 2011; Lehavot et al., 2010). It is important to note that Lehavot and colleagues (2010) did not specify whether students in their survey were currently seeing clients, which may account for some of the discrepancy between reported statistics. DiLillo and Gale's (2011) study of 854 graduate students in counseling, clinical, and school doctoral programs found that 97.8% searched for at least one client's using search engines (e.g., Google) and 94.4% searched for at least one client's information using social networking websites. However, of those who endorsed searching their clients online, 66.9% also reported that it was either always or usually unacceptable to do so. When the entire sample in DiLillo and Gale's (2011) study was examined at, 67% endorsed searching for online client information was never or usually not acceptable and 76.8% reported that is was never or usually not acceptable to search social networking sites for client information. There appears to be a disconnect regarding what mental health professionals believe is ethical behavior and what they are actually doing. DiLillo and Gale (2011) found that there was no significant correlation between mental health trainee age and perceived acceptability of searching for a client using a search engine, but a positive partial correlation was found between year in program and acceptability of searching for client information, r (773) = .12, p = .001. Mental health professionals need to question their motives behind conducting these searches and should carefully consider whether there is any underlying desire to satisfy personal curiosity (Lehavot et al., 2010).

Privacy, confidentiality, and informed consent are closely related but separate entities. Koocher and Keith-Spiegel (2008) noted that it is important to recognize that confidentiality and privileged communication are both encapsulated under the umbrella of privacy. In the broad context of professional conduct, confidentially refers to the general standard of not discussing information about a client with anyone without the client's consent (Koocher & Keith-Spiegel, 2008). The APA Ethics Code (2010) confidentiality principle states that "Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship" (p. 7). The ACA Code of Ethics (2005) states that, "Counselors do not share confidential information without client consent or without a sound legal or ethical justification" (p. 7). Said differently, when confidentiality is viewed in the context of an ethical principle, it refers to a contract or promise that is made between the mental health professional and the client that information about the client will not be revealed except under certain circumstances that are discussed ahead of time (Koocher & Keith-Spiegel, 2008). The ethical standards for APA and ACA both emphasize that clients have a right to be provided with an explanation of the limits of information obtained by the counselor and that this information will not be disclosed without a sound legal or ethical reason.

Despite ethical guidelines, issues surrounding confidentiality create some of the most challenging and confusing ethical dilemmas (M. Fisher, 2008; Koocher

& Keith-Spiegel, 2008). M. Fisher argued that difficulties with confidentiality might stem from a lack of a coherent ethical framework on which to organize increasingly complex information. While both the APA (2010) and ACA (2005) ethical guidelines stress the clients' right to know about the limits of confidentiality from the beginning of the therapeutic relationship, the amount of information that is disclosed, what information is considered reasonably identifiable, and when the appropriate time to breach confidentiality may create situations in which guidelines are less clear. A counter argument could be made that this lack of structure allows for flexibility and permits the mental health professionals to assess what information is considered confidential on a case-by-case basis (C. Fisher, 2002). Social networking adds another layer to an already complex topic.

The responsibility for handling information that is indirectly obtained through social networking is ambiguous, which underscores the importance of openly discussing the intended or proposed use of social networking in the counseling relationship. If going through a client's social networking page is deemed appropriate by both clinician and client, it is important that the mental health professional be familiar with the state laws regarding when to breach confidentiality and explores appropriate reactions with the client if potentially sensitive information is encountered. The ACA (2005) states that mental health professionals "do not share confidential information without client consent or without sound legal or ethical justification" (p. 7). When a closer look is taken at the wording of the APA's (2010) Ethical Standard on confidentiality, it clearly

states that information obtained through *any medium* is protected under the umbrella of confidentiality. The APA states that mental health professionals "have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium" (APA, p. 7). This suggests that information obtained about a client through social networking websites could be considered protected and confidential. Prior to beginning any counseling relationship and as new circumstances warrant, mental health professionals must inform clients of the limitations of confidentiality and get client informed consent for therapy. The ACA Code of Ethics states that mental health professionals conduct "ongoing discussions with clients as to how, when, and with whom information is to be shared" (p. 7). Similarly, the APA Ethics Code states that "the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant" (p. 7). Conducting online client searches (i.e., search engine or social network) would warrant a new discussion on how confidentiality is maintained and the limits of confidentiality.

The client's right to informed consent captures the importance of the client autonomy in the therapeutic relationship (Somberg, Stone, & Claiborn, 1993). In fact, the first sentence in the ACA Code of Ethics (2005) relays that "Clients have the freedom to choose whether to enter into or remain in a counseling relationship" (p. 4). The APA (2010) goes on to state that mental health professionals "obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person" (p. 6). Without presenting informed consent in a manner the client can comprehend, the client's

ability to make an informed choice is diminished and thus the client's fundamental right to autonomy is compromised. Neither the APA (2010) nor the ACA (2005) conceptualizes informed consent as a static element, but rather one that should be readdressed as new circumstances warrant.

Before searching for client online information, it is critical that mental health professionals consider the scope and type of obtained client informed consent and how the online search meets the needs of the clinical relationship (Martin, 2010). Was this consent obtained verbally or in writing? Were the limitations of this search discussed? Are there certain elements of the social networking site that the client does not want or anticipate the mental health professional seeing? How will the information be processed in session? After informed consent is obtained, it is important to document this consent in the client's file.

Reviewing informed consent verbally is an imperative first step in the informed consent process. This verbal discussion allows the mental health professionals to assess client understanding and provides the client with the opportunity to ask questions. Verbal informed consent alone, however, is not sufficient. The ACA (2005) Ethical Standard A.2.a., Informed Consent, states, "Counselors have an obligation to review in writing *and* verbally with clients the rights and responsibilities of both the counselor and the client" (p. 4). The APA (2010) Ethics Code states, "Psychologists appropriately document written or oral consent, permission, and assent". If reviewing a client's social networking page is deemed to be beneficial by both the mental health professional and client

informed consent should be documented in the client's record prior to online client search. The rational for the search, the potential benefit, and anticipated consequences should be carefully thought through, discussed with the client, and documented in the client's file prior to conducting any online search.

There has been little research conducted on what factors predict not obtaining informed consent and no research that has examined what factors predict obtaining informed consent for online client searches. Somberg and collogues (1993) conducted a study that addressed reasons why mental health professionals did not obtain informed consent. They found that some of the most common reasons for not obtaining informed consent were perceived low importance of the issue and perceived low level of risk. Current beliefs regarding perceived importance and perceived level of risk for not obtaining informed consent prior to online client search have not been explored by current research.

The newest version of the ACA (2005) Code of Ethics added a section on technology applications that provides further insight into ethically appropriate actions when using technology in the therapeutic relationship. The ACA Code of Ethics states that, "Counselors inform clients of the benefits and limitations of using information technology applications in the counseling process" (p.6). Not obtaining informed consent and discussing the benefits and limitations before viewing a client's social networking site can engender unique dilemmas for mental health professions, especially if information on the client's page indicates intent to hurt self or others. If clients invite their counselor to view their social networking page, it is important to discuss the specific limits of confidentiality

and discuss that certain circumstances may permit or mandate that mental health professionals breach confidentiality for valid purposes. For example, the ethical guidelines for both APA (2010) and ACA (2005) permit disclosure of confidential client information to protect the client/patient, mental health professional, or others from harm.

Some have argued that certain instances (e.g., issues pertaining to safety of a client, verification of information) may warrant an examination of a client's social networking page (DiLillo & Gale, 2011; Martin, 2010). For example, viewing a social networking page of a suicidal client who has missed recent sessions may provide some insight into the client's whereabouts and state of mind. On the other hand, extreme caution should be used when interpreting information obtained on social networking. Information obtained could be inaccurate and may negatively bias the therapeutic relationship. It is important to keep in mind that information obtained may also be out of context. For example, if a client was being treated for severe alcohol dependence, pictures of him/her "partying" with several drinks in hand could cause the therapist to feel alarmed. However, the timeline of these pictures may be misleading. The context of the conversation could change drastically if it was revealed that the pictures were taken several years ago versus last weekend. Not going through this new information in collaboration with the client could cause the mental health professional to miss an opportunity to benefit the therapeutic process (Lehavot et al, 2010.; Zur et al., 2009). Behnke (2008) provides a cautionary statement to individuals who chose to search for client information online, warning that,

"There is a 'slippery slope' to seeking and relying on such information that risks turning psychologists into private investigators" (p. 75). Conducting a search on the client without discussing and obtaining consent from the client could not only be considered a potential breach of ethics, it could signal a lack of trust and could damage the therapeutic relationship.

Both APA (2010) and ACA (2005) ethical guidelines provide specific standards related to disclosure of client information. The APA mandates that disclosure of confidential information should not be given without informed consent. The APA states that mental health professionals "disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law" (p. 7). There are a few instances were the APA permits disclosure outside of legal mandates. These instances include "(1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose" (p. 7). As a part of the informed consent process, clients should be made aware of limits to confidentiality and, where possible, should be a part of the decision-making process regarding disclosure. These instances should be discussed prior to online client search to ensure that the client is aware that there are certain circumstances in which non-disclosure cannot be guaranteed. The ACA Code of Ethics relays that "At initiation and throughout the counseling process, counselors inform clients of the limitations of confidentiality and seek to identify foreseeable

situations in which confidentiality must be breached" (p. 7). The ACA goes on to emphasize that, "To the extent possible, clients are informed before confidential information is disclosed and are involved in the disclosure decision-making process" (p. 7). Both APA and ACA Ethical Standards emphasize that disclosures should reveal the minimal amount of information possible. Inappropriate disclosures of client information, which is a breach of client confidentiality, can carry heavy consequences including damaging the clinical relationship, fines, disruption of services, malpractice suits, and licensure loss (Fisher, 2009).

Not only should mental health professionals be concerned about client privacy, they should also be cautious about personal information they might share online. As the new wave of young professionals becomes increasingly acculturated into this new way of communicating, a sense of familiarity and comfort can be found within a once unfamiliar mode of communication. This familiarity may promote lax practices in online conduct. Frye and Dornish (2010) found that experience with social networking communication tools was correlated to an increased level of comfort in disclosing information, regardless of the perceived level of privacy. The researchers speculated that the weak correlation between privacy concerns and online disclosure may be attributed to individuals' perceived level of knowledge surrounding privacy settings and the belief that others would be unlikely to intercept their communication. Zur, Williams, Lehavot, and Knapp (2009) proposed a slightly different explanation and argued that since young professionals have grown up with the internet, personal

disclosures on this medium have become so ingrained as a part of life that the action is almost automatic. They warned that students might need support in thoroughly examining their disclosures through a clinical perspective.

While sharing information on personally identifying information about a client without the client's consent would be a clear violation of both APA (2010) and ACA (2008) ethical codes, other disclosures may not be as definitive. For example, would it be acceptable casually to express displeasure online by stating that an unnamed client missed an appointment? Issues surrounding appropriate disclosures have already caused significant legal problems in the field of medicine. For example, a recent court case, Doe v. Green, involved a paramedic who disclosed details on a social networking site that he thought did not overtly identify (e.g., name) the victim of a rape (Clark, 2010). While Green's intentions may have been to warn other potential victims, he provided information on his social networking website that the survivor of the attack thought was identifiable, which resulted in a lawsuit (Clark, 2010). Such risk exists for all professionals who have an ethical and legal obligation surrounding confidentiality, which includes client identity. It is important to increase awareness of the possible damages that can be caused by a metaphorical slip of the finger. Even with adequate consent, Koocher and Keith-Spiegel (2008) still recommend that professional judgment should be utilized before sharing any information through a news outlet. This begs the question of what, if any, client information is acceptable to disclose online?

It is clear that issues surrounding privacy, confidentiality and informed consent are closely intertwined. These ethical elements could be considered the foundation in establishing trust in the therapeutic relationship. Thus, it is important to maintain their integrity and proactively examine how technology can impact clinical practice.

Multiple Relationships

Another important aspect that affects the integrity of the therapeutic relationship is the separation of multiple professional and/or personal roles. The APA (2010) defines a multiple relationship as maintaining a professional role and "(1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person" (p. 6). The ACA (2005) Code of Ethics states that the "counselor–client nonprofessional relationships with clients, former clients, their romantic partners, or their family members should be avoided, except when the interaction is potentially beneficial to the client" (p.5). Multiple relationship violations warrant additional focus because ethical complaints surrounding multiple relationships often account for the majority of licensing board complaints, and are a leading cause of malpractice suits (Koocher & Keith-Spiegel, 2008). In fact, according to APA's 2011 report of total ethical complaints opened in 2010, an alarming 70% were classified as dual relationship violations (APA, 2011).

Perhaps one reason why this type of ethical infraction is reported most frequently is that ambiguity regarding assessment of potentially beneficial multiple roles exists. The APA (2010) Ethics Code provides a general ethical standard to help mental health professionals judge the appropriateness of the potential additional relationship, stating that "A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists" (p. 6). The ACA (2005) Code of ethics provides several examples of potentially beneficial interactions, stating that, "Examples of potentially beneficial interactions include, but are not limited to, attending a formal ceremony (e.g., a wedding/commitment ceremony or graduation); purchasing a service or product provided by a client or former client (excepting unrestricted bartering); hospital visits to an ill family member; mutual membership in a professional association, organization, or community" (p. 5).

While the ethical boundaries regarding entering into a sexual relationship with a current client are clearly prohibited by both organizations, there is a large amount of subjectivity that goes into assessing the appropriateness of a non-sexual relationship. This calls into question how a mental health professional assesses potentially beneficial interaction. Secondary relationships should be generally avoided with past clients if the therapeutic relationship was long standing and/or termination was unclear (Barnett et al., 2007). In addition,

consultation with a trusted colleague is advisable in order to assess the ethical appropriateness of the secondary relationship.

Clearly extreme caution and forethought should be given before deciding to enter into multiple or secondary roles with a client. Younggren and Gottlieb (2004) presented a list of treatment-oriented questions that practitioners should address before deciding for or against entering into a multiple relationship.

- Is entering into a relationship in addition to the professional one necessary, or should I avoid it?
- Can the dual relationship potentially cause harm to the patient?
- If harm seems unlikely or unavoidable, would the additional relationship prove beneficial?
- Is there a risk that the dual relationship could disrupt the therapeutic relationship?
- Can I evaluate this matter objectively?

One study found that social interactions and events were the most frequently presented form of secondary relationship that mental health professionals encounter (Lamb, Catanzaro, & Moorman, 2004). Social networking adds an additional dimension to social relationships. "Friending" a client can cause serious potential conflicts and threaten the integrity of the therapeutic relationship; even after the official therapy session has ended. For example, Taylor et al. (2010) believed that information shared through by social networking websites could be viewed as too personal and potentially damaging to the clinical relationship. Social networking sites are often filled with detailed

personal information such as birthdate, pictures, list of interests and hobbies, and personal posts from friends. In addition, elements such as the ability instantly to post personal statuses on daily activities, thoughts, and emotions could be inappropriate and/or damaging to the therapeutic relationship. Since the user does not see the reaction of individuals after making a post or comment, they miss in-person cues such as body language or tone of voice that could indicate discomfort.

Social networking applications are available for most smart phones. Behnke (2008) pointed out that it only takes seconds to pull out a cell phone and share information that would have otherwise remained private. Digitally connected users can also easily update a status (a message letting other users know about their activities/feeling/thoughts) or upload the picture to their social networking site via their cell phone, allowing users to post at their convenience. With this ease of access also comes potential risk of revealing confidential information. It is imperative that mental health professionals reflect on disclosures in the context of their professional role.

Mental health professionals should not add current clients to their personal social networking page. An in-person friendship with a current client is considered a dual relationship. As previously mentioned, one definition the APA (2010) Ethics Code provides for a multiple relationship is a "psychologist is in a professional role with a person and at the same time is in another role with the same person" (p. 6). While the context of the friendship changes (in-person vs. online) the violation remains the same. Great risk also exists for mental health professionals who choose to add former clients to their social networking page.

By adding former clients, mental health professionals run the risk that these individuals may infer that current "friends" may have been past clients. Additionally, adding friends to a social network may illuminate connections that may have otherwise remained dormant (e.g., friends with past romantic partner or close mutual friend). The decision to add a former client as a member or friend to one's social networking should be carefully assessed to examine whether it is in the client's best interest. Any rationale behind the decision to add or decline a former client's friend invitation should be carefully thought through and documented in the client's file.

Importance of Awareness of Privacy Settings

In addition to assessing mental health professionals' views on ethically appropriate behavior on social networking, it is important to assess how aware they are of their privacy settings. As Clark (2010) pointed out, "few people understand that that their blogs, postings, e-mails, and other digital clutter may be subject to evidentiary discovery" (p. 105). In other words, if a lawsuit is brought to court, items found on social networking sites could be brought to the publics' attention. In a recent case featured as recommended reading on APA's website and published in *The Washington Post*, a 35 year old woman was subpoenaed by the court to give Wal-Mart corporation full access to her Facebook (Cha, 2010). This meant that every photo, comment, and private message was fully viewable by the company (Cha, 2010). Facebook's statement of rights and responsibilities, last revised in October of 2010, states "For content that is covered by intellectual property rights, like photos and videos ("IP content")...you grant us a non-

exclusive, transferable, sub-licensable, royalty-free, worldwide license to use any IP content that you post on or in connection with Facebook" (Facebook, Privacy Policy, 2010). Depending on the user's privacy settings, Facebook can share and use information provided. In fact, Facebook states that, "Certain types of communications that you send to other users *cannot be removed*, such as messages" (Facebook, Privacy Policy, 2010).

Whether or not users are aware of it, their actions are likely being tracked. Yahoo keeps chat and instant message logs with their associated IP addresses and time for 45 to 60 days (Cha, 2010). Facebook creates a log on everything the users does while logged on, such as what IP address accessed an account, the date, time, what or who the user clicked on, and every action that the user does such as poking, messaging, "liking", or choosing to attend an event. (Facebook, Privacy Policy, 2010).

The application feature also is an area of high risk. As Facebook's Privacy Policy points out, its "privacy policy covers all of Facebook. It does not, however, apply to entities that Facebook does not own or control, such as applications and websites using Platform." This means that other games or applications can use the information they gather on individuals based on their own set of privacy settings. Thus, before adding access to any additional applications, it is important to review the entities' policies regarding disclosure of personal information. According to Langheinrich and Karjoth (2010), "As of today, record management and digital archiving of information for social networking sites do not yet exist " (p. 5). These risks highlight the need to access mental health

professionals' awareness and use of privacy setting on their social networking pages.

Summary and Rational for Current Study

The previous sections highlighted the key areas of ethical concern regarding social networking, specifically privacy, confidentiality, informed consent, and multiple relationships, and the importance of awareness of privacy settings were addressed. Koocher and Keith-Spiegel (2008) identified "inadequate anticipation" as one of the "risky conditions" that can lead to serious ethical dilemmas and emphasized that the field of psychology will be held responsible for not taking adequate precautionary measures (p.16). Thus, it is important that potential ethical dilemmas related to social networking sites are addressed in graduate training and current professional behaviors and beliefs surrounding social networking participation are explored. While previous research has primarily been descriptive of online behaviors, this study not only replicated previous descriptive studies but also gathered information on individual differences (e.g., year in program, experience with social networking, use of professional consultation) that potentially relate to online behaviors (e.g., online client search). The current study examined the online practices of graduate students in the mental health field and generated prediction models for online client searches and best practices in informed consent and disclosure.

Since previous research (DiLillo & Gale, 2011) found a positive partial correlation between year in program and acceptability of searching for client information using a search engine graduate credit hours, completed or in progress,

was examined as a part of hypothesis one. Credit hours were selected, as opposed to year in program. This measure was chosen because it is likely more reflective of actual time the individual has spent in the program. Although not addressed in the literature, it is reasonable to believe that clinical experience, specifically direct client hours, may also be related to online behaviors. Furthermore, individuals who have been members of social networking sites for many years may be more familiar with how to navigate through these websites and feel more comfortable conducting a search through this medium. Membership on social networking may encourage the individuals to spend more time on the computer, which potentially could increase the probability that they utilize search features that are readily available to them. Thus, years on social networking websites may also be related to online clients searches.

As previously mentioned, few studies have examined factors related to mental health professionals obtaining client informed consent. Somberg et. al. (1993) suggested that reasons for not obtaining consent commonly fall under perceived low importance of the issue and perceived low level of risk of not obtaining informed consent. As noted above, there is an ongoing debate in the mental health field regarding whether or not information posted online by the client is considered public or private. If mental health professionals view information posted online as being public then they may not believe it is necessary to obtain informed consent. The Internet has brought new ethical challenges that are not explicitly discussed in the APA (2010) or ACA (2005) ethical standards and may not be discussed in graduate training programs and/or

supervision. Professional consultation regarding social networking use in clinical practice could increase mental health graduate students awareness of potential ethical dilemmas such as obtaining informed consent prior to online client search. If professional consultation is related to obtaining informed consent, then discussion of ethically correct online behaviors could be easily implemented in clinical training. The relationship between online behaviors and each of the variables is addressed in hypothesis two.

The final hypothesis examined potential correlates to online disclosure of client information. As noted in the literature review, experience with social networking has been correlated to an increased comfort with self-disclosure, regardless of the perceived level of privacy (Frye & Dornish, 2010). It is unclear, however, whether this relation also exists for disclosing client information online. Research that assesses individuals' self-efficacy related to controlling privacy settings and their years of social networking experience could help illuminate their rational for disclosure. Zur, Williams, Lehavot, and Knapp (2009) believed that since young professionals have grown up with the Internet, personal disclosures on this medium could be a social norm, thus years of social networking experience may also be related to online disclosure of client information. Additionally, individuals who share information about their clients (overtly or covertly) online may also be at greater risk of violating professional boundaries, regardless of knowledge of privacy setting. Knowledge of privacy settings, experience with social networking, and ethical decision-making were examined in the third hypothesis.

The current study examined the online behaviors of graduate student in the mental health field and tested three hypotheses. These hypotheses were:

H1: Years of social networking experience will be positively related to endorsement of online searches of clients over and above and credits, number of clients, and total direct client hours.

H2: Professional consultation on social networking practices and belief that information online is private will be positively related to obtaining informed consent when conducting an online search of client information.

H3: Lower scores on ethical decision-making, greater experience with social networking, and more perceived knowledge of privacy settings will be related to more disclosure of client information on social networking sites.

Chapter 2

METHOD

Recruitment and Participants

After approval from the Institutional Review Board was obtained (See Appendix A), graduate students in counseling, counseling psychology, clinical and school psychology programs in the United States were recruited for participation. Participants were recruited in multiple ways: 1) by sending emails through to directors of clinical training (DCT) through the counseling psychology DCT listservs and contacting CACREP liaisons through the CACREP website; 2) by sending individual emails to DCT obtained via the Council of University Directors of Clinical Psychology website; and 3) by sending individual emails to APA accredited school psychology programs listed on APA's website. A recruitment e-mail that presented a brief description of the study was given along with a request for them to forward the survey link to their students (See Appendix B). Interested participants were directed to Survey Gizmo website, where they gave consent to participate before completing the questionnaire (see Appendix C). After consent was given they continued on to complete the survey (see Appendix D).

In order to estimate required participants to achieve significance, G*Power analyses were conducted for each proposed hypothesis. Several were generated in G*Power analyses were run for each equation in order to estimate minimum number of recommended participants to reach statistical significance at given effect size measures with a .80 minimum power level and alpha of .05 (see Table

1). Based on the information provided by the G*Analyses, the proposed study should obtain a sample of at least 77 participants in order to achieve statistical significance with an alpha of .05, a power level of .80, and a .15 effect size.

Table 1

Sample Size for Hypotheses based on Power Analyses

(Alpha = .05 and Power = .80)

Hypothesis	Effect Size		
	Small (.02)	Medium (.15)	Large (.35)
Hypothesis 1	395	50	25
Hypothesis 2	485	65	31
Hypothesis 3	550	77	36

There were 316 participants who completed the survey. Regions in which the participants resided were diverse, with 35 states represented. Highest completion rates were from participants in Florida, Texas, and Wisconsin. Of the 316 participants, 264 (83.5%) identified as female, 49 (15.5%) identified as male, and 2 (< .01%*)* did not provide information regarding their sex. The average age of the participant was 28.4 years (*SD* = 6.21), with the age of the participants ranging from 29-51 years. Of the sample, 20 (6.3%) identified as Asian/Pacific Islander, 17 (5.4%) identified as Black/African American, 248 (78.5%) identified as Caucasian/Euro-American, 18 (5.7%) identified as Hispanic/Latino/a, 2 (.6%)

identified as Native American/Alaska Native, and 11 (3.4.%) identified as Other/Multi-Racial.

The majority of participants (56.6%) were enrolled in a doctoral program, and 43.4% of the participants were enrolled in a master's program. The majority of the sample was comprised of counseling graduate students (54.6%), followed by school (27.6%) and clinical (17.8%) programs.

Of the 316 participants 297 (94%) reported having an account on a social networking site, whereas 19 (6%) reported that they did not belong to any social networking site. Of the 297 participants that reported using a social networking site, 292 (98.6%) participants had social networking pages on Facebook, 96 (32.8%) on LinkedIn, 91 (30.6%) on YouTube, 87 (29.3%) on Google+, 76 (25.5%) on Twitter, 25 (8.4%) on Myspace, 20 (6.7%) on Yelp, and 32 (10.8%) on other social networking sites. Of the participants who belonged to a social network, 236 (79.5%) accessed at least one of their accounts on a daily basis, 39 (13.1%) on a weekly basis, 16 (5.4%) on a monthly basis, 2 (.01%) every 3 months, 3 (.01%) every 6 months, and 1 (<.01%) once a year. The average time that participants had maintained a social networking page was 5.8 years (SD = 2). The average number of social network memberships was 2.43 (SD = 1.5).

Measures

Thirteen variables were examined. The independent or outcome variables were frequency of online client searches, informed consent, and online disclosure of client information. The dependent or endogenous variables were years of social networking experience, number of social networks, year in the program,

total client hours, direct client hours, number of clients, the ethical decision-making subscale of the boundaries in practice scale, professional consultation of ethically appropriate online practices, knowledge of privacy settings, and belief that information that clients share online is private versus public.

Online Client Searches

Two items measured participant frequency of online client searches. These items included: "I have conducted a Google Search to find out or verify information about my client" and "I have conducted a social networking search to find out or verify information about my client." Each item was assessed on a 6-point Likert-type scale with 1 = *Never*, 2 = *Very Rarely*, 3 = *Rarely*, 4 = *Occasionally*, 5 = *Frequently*, 6 = *Very Frequently*. Responses to the two items were summed to form a total scores that could range from 2 to 12, with higher scores indicate greater frequency of client online searches. For the study sample, the Cronbach's alpha was .73 and scale mean was 2.86 (*SD* = 1.57).

Informed Consent

Five items were used to measure informed consent, the degree to which participants followed ethical guidelines with respect to client informed consent. The five items were derived from the APA (2010) and ACA (2005) ethical standards to assess best practices in informed consent for online client searches. Additionally, items that Somberg et al. (1993) identified as important elements of informed consent (i.e., limits of confidentiality, potential risks of therapy, length of treatment, possible procedures used, and alternatives to therapy) were considered when constructing items. These items include: "I obtained informed

consent from my clients prior to conducting an online search (e.g., Social networking, Google)"; "I discussed with my client the benefits and drawbacks of conducting an online search about them"; "I discussed with my client how I would handle information obtained from my online search that required a breach of confidentiality"; "I discussed with my client alternatives to conducting an online search of their information"; and "I documented obtaining informed consent for an online search in my client's file". Items were responded to on a 6-point Likert-type scale with 1 = *Never*, 2 = *Very Rarely*, 3 = *Rarely*, 4 = *Occasionally*, 5 = *Frequently*, 6 = *Very Frequently*. Total scores were calculated by summing response scores, with higher scores indicating use of more informed consent practices. Total scores could range from 5 to 30. For the current sample, the scale mean was 7.25 (*SD* = 5.33). Internal reliability was strong with a Cronbach's alpha of .93.

Online Disclosures

Eight items were used to measure the extent to which participants disclosed of client information online. These items included, "I have expressed positive thoughts/feelings (e.g., happiness, optimism, hopefulness, etc.) online about a client but did not provide information that I believe could readily identify the client"; "I have expressed negative thoughts/feelings (e.g., disappointment, frustration, sadness, etc.) online about a client but did not provide information that I believe could readily identify the client"; "I have posted an update online that indirectly referenced positive thoughts/feelings (e.g., happiness, optimism, hopefulness, etc.) I was having about a client"; "I have posted an update online

that indirectly referenced negative thoughts/feelings (e.g., disappointment, frustration, sadness, etc.) I was having about a client"; "I have expressed positive thoughts/feelings (e.g., happiness, optimism, hopefulness, etc.) online about something my client said in session"; "I have expressed negative thoughts/feelings (e.g., disappointment, frustration, sadness, etc.) online about something my client said in session"; "I would warn my online friends about a client who is dangerous"; and "I would share with my online friends if my client got a special recognition/achievement". Participants rated each item on a 6-point Likert-type scale with 1 = *Never*, 2 = *Very Rarely*, 3 = *Rarely*, 4 = *Occasionally*, 5 = *Frequently*, 6 = *Very Frequently.* Total scores, which could range from 8 to 48, were calculated by summing responses across the items. Higher scores reflect greater frequency of disclosure. For the current sample, the scale mean was 9.81 (*SD* = 3.68). Cronbach's alpha internal reliability was .84.

Ethical Decision-Making

Responses to 10 scenarios were used to measure ethical decision-making. An example scenario was "You have been under a lot of personal stress and the client asks you what is wrong. You find yourself telling the client about your problems." For each scenario the participant was asked "How ethical is this decision?" Questions were responded to on a 4-point Likert-type format, with anchors ranging from Never Ethical (4) to Always Ethical (1). In addition, a second item, "You begin therapy with a client and you find that you are attracted to each other" was presented for the sexual attraction scenario. This resulted in an 11-item scale. Kendall and Froneketal (2011) established content and face

validity was developed using expert panel rating. They reported a Cronbach's alpha of .86. The Cronbach's alpha for the current study was .75 and the scale mean was 38.87 (*SD* = 2.99).

Privacy Settings

Four items were used to measure perceived knowledge of privacy settings. These items included: "I feel confident about my knowledge of privacy settings on my social networking sites"; "I am aware of what information is viewable by the public (i.e., non-friends) on my social networking site"; "There may be information on my social networking page that can be viewed by the public that I did not intend to be publicly viewable"; and "I do not know what information the public can view on my social networking site". Items were responded to on a 6-point Likert-type scale, with anchors ranging from Strongly Disagree (1) to Strongly Agree (6). The last 2 items were reversed coded prior to summing the responses to form a total score. Higher total scores indicate more reported knowledge of privacy settings. The mean total score was 17.90 (*SD* = 3.78) for the current sample. The Cronbach's alpha was .81.

Beliefs about Public Versus Private Information

Three items were used to measure participants' beliefs about the public versus private nature of online content posted by clients. These items included: "Information posted by clients online is private"; "If the public can readily access information posted by the client online then the information is not private"; and "If the client has their social networking page set as publicly viewable then information on that site is not private". Participants' agreement with each

statement ranged from Strongly Disagree (1) to Strongly Agree (6), with higher ratings indicating greater beliefs in the privacy of this information. After reverse coding the last two items, total scores were derived by summing responses to the three items. The scale mean for the current sample was 6.91 (SD = 3.61) and the Cronbach's alpha was .79.

Previous Professional Discussions

Three items will be used to measure the previous professional discussions about ethically appropriate online networking practices. These items include: "I have discussed social networking use related to my clinical work with my clinical supervisor"; "I have discussed social networking use related to my clinical work with another student in my program"; and "I have discussed social networking use related to my clinical work with faculty member in my program". Items are assessed on a 6-point Likert-type scale with 1 = Never, 2 = Very Rarely, 3 = Rarely, 4 = Occasionally, 5 = Frequently, 6 = Very Frequently. Total scores derived by summing responses across the three items. Total scores can range from 3 to 18 with higher scores indicating more professional discussions about ethically appropriate online networking practices. For the study sample, the scale mean was 7.55 (*SD* = 3.37) and the internal reliability Cronbach's alpha was .84.

The remaining dependent measures include years of social networking experience, credit hours completed or in progress, and number of direct client hours. Each of these is a continuous. All quarter credit hours were translated into semester credit hours by multiplying by 2/3.

Procedures

Permission was obtained to use Kendall and Froneketal's (2011) Boundaries in Practice Scale (See Appendix D). Over 180 individual recruitment emails were sent to directors of training, program directors, or CACREP liaisons. This email was forwarded to graduate students. Participants completed the study on the Survey Gizmo website. As incentive for completing the questionnaire, participants were offered the opportunity to win one of four $20 Visa gift cards. It is nearly impossible to approximate how many of the recruitment emails were forwarded onto graduate students. Of those who clicked on the link to begin the survey, completion rate was 77.51%.

Analysis Plan

Prior to testing the hypotheses, regression diagnostics were conducted to identify outliers and to assess violation of assumptions. As a result, five outliers were removed from the sample.

In order to test the first hypothesis a hierarchical regression analysis following the guidelines to test the gain in prediction was carried out (Cohen, Cohen, West, & Aiken, 2003). The equation used to calculate the *F* gain is shown bellow.

$$F_{\text{Gain}} = \frac{n-k-m-l}{m} \times \frac{r^2_{y.all} - r^2_{y.set1}}{1 - r^2_{y.all}}$$

The analysis consisted of a hierarchical regression analysis. In the first regression model, number of credits, number of clients seen, and number of total

direct clinical clock hours were tested for their ability to predict online client searches. Then, years of social networking experience was added to the regression model (set 2). An *F* test was generated for each of the models to assess if prediction was significant using a one tailed directional hypothesis with an alpha set at .05.

To test the second and third hypotheses, stepwise regression analyses were conducted since the hypotheses were exploratory in nature. Stepwise regression was selected because there is inadequate theory to determine the order in which variables should be entered. The first stepwise regression tested whether professional consultation of ethically appropriate online practices and belief that information online is private would predict best practices in informed consent. The second stepwise regression used composite score on ethical decision-making scale, experience with social networking, and knowledge of privacy settings as predictors of disclosure of client information on social networking sites. An *F* test was generated for each of the hypotheses to assess the models using a one tailed directional hypothesis with an alpha set at .05.

Missing data

As a whole, the data set had relatively little missing data. Researchers generally recommend 3 to10 imputations, unless the rate of missing information is very high, and note that aside from time needed to run the algorithm, there is no pronounced disadvantage in running more (Rose & Fraser, 2008; Rubin, 1987; Wayman, 2003). In order to duplicate results under identical conditions, for the current data a seed number was set and saved in syntax.

Prior to testing the first hypothesis, multiple imputation was used to account for missing data. It is recommended to include all variables in the subsequent intended analysis, outcome measures, and auxiliary variables that correlate to either variables that are missing or correlate to reason for missingness in the multiple imputation model (Rose & Fraser, 2008; Sinharay, Stern, & Russell, 2001; Wayman, 2003). Variables for hypothesis one that had missing data were: Credits (n = 6, 2.7%), direct client hours (n = 8, 3.5%), and number of clients with whom the participant had worked (n = 10, 4.4%). Additional variables included in the multiple imputation were selected based on their correlation to one or more of the missing variables (See Table 2). A missing value analysis was conducted for each of the variables (including auxiliary variables) to determine the extent to which data were absent and to analyze possible patterns in data loss. The relation between total clock hours and number of clients approached significance (p = .051), further justifying inclusion in the multiple imputation algorithm. Variables used in the multiple imputation included credits, total clock hours, number of clients participant has seen, direct client hours, total clinical experiences (i.e., semesters of practicum, internship, field placement), years of social networking experience, and online client search. Imputed variables had constraints placed on generated output values to ensure that values were within possible data range (e.g., direct clock hours cannot be negative). Number of imputed data sets was set at ten, and pooled statistics are reported in Results.

Table 2

Correlations Among Auxiliary Variables and Missing Variables

Measure	Credits	Clients	Direct Hours	Total Hours
Credits	1.00			
Clients	.35***	1.00		
Direct Hours	.59***	.44***	1.00	
Total Hours	.57***	.37***	.85***	1.00
Clinical Experiences	.21***	.05	.28***	.39***

Note. ***p<.001

Multiple imputation was not used for the second and third hypotheses. Hypothesis two had 1 (1%) data points missing for informed consent measure and 1 (1%) data point missing for the professional consultation measure. The third hypothesis had no variables missing for years of social networking experience or perceived knowledge of privacy settings. Four scores (1.8%) were missing for ethical boundaries scale, and two scores (.9%) were missing for total online disclosure. Missing-value analysis did not find significance related to any of the variables in the proposed regression equation and reason for missingness. Additionally, if multiple imputation algorithm was generated for use in the third hypothesis, special consideration would have to be given to insure composite scores and corresponding scale items did not result in linear dependence (Rose & Fraser, 2008). Given that the anticipated benefit (e.g., power increase, reliability

of population parameters) was minimal for the second and third hypotheses, multiple imputation procedures were not conducted.

Chapter 3

RESULTS

Online Behaviors

Of the 316 participants 297 (94%) reported having an account on a social networking site, whereas 19 (6%) reported that they did not belong to any social networking site. Of the participants who endorsed maintaining a social networking website, 237 (79.7%) access at least one of their accounts daily. By the end of each week, 276 (92.9%) accessed at least one of their social networking websites.

Of the 226 participants who endorsed having clinical experience, 75 (33.2%) have utilized the Internet to find out information about their client, with 44 (19.5%) using social networking websites (e.g., Facebook) to obtain information and 66 (29.2%) using a search engines (e.g., Google) to obtain information.

Of the 75 participants who conducted an online client search, 74 provided information regarding their informed consent practices. The majority, 62 (83.8%) reported that they did not discuss how they would handle information that required a breach of confidentiality, 62 (83.8%) reported never obtaining informed consent prior to online client search, and 64 (86.5%) indicated that they did not document the online search in the client's file. Of the participants who reported conducting a client search, 14 (18.7%) reported that they never discussed social networking use related to their clinical work with their clinical supervisor and the remaining 61 (81.3%) reported that they had done so very rarely.

Participant's endorsement of disclosure items was analyzed for the 226 graduate students who had clinical experience. As previously noted, two participants did not respond to every question. In general, endorsement of disclosure was slightly higher for items that indicated positive disclosure in comparison to items that were similarly worded but had a negative connotation. For example, 20 (8.9%) participants endorsed expressing positive thoughts/feelings online about something their client said in session in comparison to 12 (5.3%) participants who endorsed expressing negative thoughts/feelings online about something their client said in session. Endorsement of disclosure was higher when item specified that the participant "did not provide information that I believe could readily identify the client". In fact, 41(18.2%) participants endorsed posting an update online that indirectly referenced positive thoughts/feelings (e.g., happiness, optimism, hopefulness, etc.) they were having about a client.

Descriptive Statistics

Descriptive statistics were analyzed prior to testing the hypotheses to determine differences among the programs using Welch's *t* test (see Table 3). When the variables were compared across the three programs, significant differences were found for age, with the counseling students older than students in the other two groups, for credits with school counseling students having earned more credits that students in the counseling or clinical groups, and for disclosure with student in the school group reporting more disclosure on line than did the students in the other two groups.

Table 3

Descriptive Statistics for Programs

Variable		Counseling	Clinical	School	Total
Age	M	29.44***	26.82***	27.32***	28.39
	(*SD)*	(7.28)	(3.59)	(4.83)	(6.23)
Credits	M	50.48*	47.28*	63.21*	53.39
	(*SD)*	(31.07)	(24.90)	(38.81)	(32.92)
Years SNW	M	5.18	5.83	5.82	5.49
	(*SD)*	(2.44)	(2.32)	(2.33)	(2.37)
Online Searches	M	2.81	2.65	3.01	2.85
	(*SD)*	(1.46)	(1.31)	(1.81)	(1.55)
Informed Consent	M	6.95	6.85	7.71	7.17
	(*SD)*	(5.11)	(4.98)	(6.02)	(5.34)
Disclosure	M	9.51***	8.35***	11.08***	9.82
	(*SD)*	(3.17)	(.75)	(4.84)	(3.68)

Note *p<.05, **p<.01, ***p<.001

Analyses were conducted to see if online behaviors (i.e., online search of client information, obtaining informed consent for online search, and online disclosure of client information) were significantly correlated with age. Participant age was not related to any of the online behaviors and, thus, was not included as a covariate.

Hypothesis Testing

To test the first hypotheses that years of social networking experience would be positively related to endorsement of online searches of clients over and above credits, number of clients, and direct client hours, a hierarchical multiple regression was calculated. Only the 226 graduate students who reported having clinical experience were included in this analysis. Multiple imputation was used to account for missing data. Prior to entering credits completed, number of clients, and direct client hours in step one, the pooled correlations among the variables for this hypothesis were calculated. Credits, number of clients and direct client hours were positively related (see Table 4). These three were not, however, related to years of social networking.

Table 4

Correlations and Mean Differences for Predictors and Outcome Measure (N=226)

Measure	*M*	*SD*	Credits	Direct Hours	Clients	Years Social Networking
Credits	64.45	31.45	1.00			
Direct Hours	361.56	415.32	.59***	1.00		
Clients	56.57	102.37	.35***	.39***	1.00	
Years Social Networking	5.49	2.32	.004	-.001	.01	1.00
Online Client Search	2.85	1.55	.16**	.04	.08	.13*

Note *p<.05, **p<.01, ***p<.001

Since multiple imputation had been used to account for missing data for the first hypothesis, the pooled results are reported. Tests for multicollinearity indicated that a very low level of multicollinearity was present, with no variable displaying a *VIF* > 1.70. Based on these data, hypothesis one was partially supported. When the first set (credits, direct hours, and number of clients) was entered as a cluster to predict online client searches, they were statistically significance, $R^2 = .032$, $F(3, 222) = 2.71$, $p = .033$. Beta coefficients for the three predictors were: Credits, $\beta = .009$, $t = 2.23$, $p = .026$; direct client hours, $\beta < -.001$, $t = -1.13$, $p = .258$; and clients, $\beta = .001$, $t = .78$, $p = .438$. When years of social networking experience was entered at step two, the $R^2 = .049$, $F(4, 221) = 2.86$, $p = .025$. The beta coefficient for years of social networking experience was significant, $\beta = .088$, $t = 2.00$, $p = .045$. The addition of social networking experience improved prediction over and above the original set of predictors ($\Delta R^2 = .017$, $\Delta F(1, 221) = 4.02$, $p = .046$. A summary of the results from the first hypothesis is provided (see Table 5).

The second hypothesis assessed if receiving previous professional discussions on social networking as it relates to clinical practice and belief that information online is private would be positively related to obtaining informed consent when conducting an online search of client information. The analysis was conducted only using graduate students who endorsed conducting an online client searches. Correlations, means, and standard deviations for each of the variables in the analysis were reported (see Table 6).

Table 5

Results Hypothesis One (N=226)

Variables	R^2	ΔR^2	β	*t*
Set 1	.032*			
Credits			.009*	2.23
Clients			.001	.78
Direct Hours			<.001	-1.13
Set 2	.049*	.017*		
Years Social Networking			.088*	2.00

Note *p<.05

Professional consultation on social networking practices and belief that information online is private, as opposed to public, failed to account for a significant portion of the variance , $R^2 = .004$, $F(2, 70) = .14$, $p = .869$. Beta coefficients for the two predictors were belief that information online is private, β = -.091 -, $t = -.51$, $p = .609$, and professional consultation on social networking practices, β = -.039, $t = -.18$, $p = .857$. Based on these data, hypothesis two was not supported. A summary of the results from the second hypothesis is provided (see Table 7).

Table 6

Correlations and Mean Differences for Predictors and Outcome Measure (N=73)

Measure	*M*	*SD*	Belief that Information Online is Private	Professional Discussion
Belief that Information Online is Private	7.21	3.66	1.00	
Professional Discussion	8.30	2.97	-.10	1.00
Informed Consent	7.23	5.39	-.06	-.02

Note *p<.05,

Table 7

Results Hypothesis Two (N=73)

Variables	R^2	β	*t*
	.004		
Professional Discussion		-.039	-.18
Belief that Information Online is Private		-.091	-.51

Note *p<.05

To test the third hypotheses that posited that lower scores on ethical-decision making scale, experience with social networking, and knowledge of privacy settings would be positively related to disclosure of client information on

social networking sites, a stepwise regression was conducted. Correlations, means, and standard deviations for each of the variables in the analysis were reported (see Table 8). Knowledge of privacy settings did not significantly predict disclosure; however, ethical-decision making and experience with social networking accounted for a significant portion of the variance in disclosure, R^2 = .101, F (2, 218) = 12.20, p <.001. The Beta coefficient was -.315 (t = -4.74, p = <.001) for ethical-decision making scale. There was a significant negative correlation for participants who had lower scores on ethical-decision making in relation to higher endorsement of disclosure items r = -.29, p < .001. The Beta coefficient was.189 (t = 2.00, p = .046) for years of social networking experience. Based on these data, hypothesis three was partially supported. A summary of the results from the third hypothesis is provided (see Table 9).

Table 8

Correlations and Mean Differences for Predictors and Outcome Measure (N=221)

Measure	*M*	*SD*	Ethical Decision-Making	Knowledge of Privacy Settings	Years Social Networking
Ethical Decision-Making	64.45	31.45	1.00		
Knowledge of Privacy Settings	16.79	5.74	.19**	1.00	
Years Social Networking	5.74	2.33	.13*	.57***	1.00
Online Disclosure	9.73	3.39	-.29***	.003	.09

Note *p<.05, **p<.01, ***p<.001

Table 9

Results Hypothesis Three (N=221)

Variables	R^2	β	*t*
	.101***		
Ethical Decision-Making		-.315***	-4.74
Years Social Networking		.189*	2.00

Note *p<.05, **p<.01, ***p<.001

Post Hoc Analyses

To better understand hypothesis two the reasons for informed consent were examined. In the study participants were prompted to give their primary reason for conducting the search. Options included therapeutic concern about client welfare, gathering information for intervention, verifying what the client has told them, curiosity, or 'other' category in which the participant could write a response. Curiosity was the most frequently endorsed reason for conducting an online client search (41.3%), followed by verifying what the client has told them (24.0%), therapeutic concern about client welfare (14.7%), gathering information for intervention (13.3%), and other reason (6.7%). A follow up analyses was conducted to see if reason for client search was a significantly correlated to obtaining informed consent. Reason for online search was coded (.5 = curiosity, -.5 = reason other than curiosity). Reason for search was highly correlated to obtaining informed consent, r = -.31, p = .004, with curiosity negatively related to obtaining informed consent.

Chapter 4

DISCUSSION

The purposes of this study were to explore social networking use among mental health graduate students, to investigate variables that potentially correlated with online behaviors, and to identify areas of possible ethical concern. The study findings indicate that the vast majority of graduate mental health students maintain a social networking website and that they, on average, belong to at least two social networking websites. As expected, graduate mental health students are active members of social networking website communities.

The Internet has made information increasingly easier to obtain. In response to an inquiry, search engines such as Google can generate thousands of results within seconds. This ease may well account for the fact that a third of the study sample who had clinical experience sought client information online. This finding is consistent with Lehavot et al.'s (2010) findings that approximately a fourth of student psychotherapists seek out client information through the Internet. DiLillo and Gale's (2011) finding that over 90% of graduate students had conducted at least one search may be related to differences in the two studies' samples and recruitment model. Both Lehavot et al. (2010) and DiLillo and Gale (2011) had samples comprised largely of clinical doctoral students. The current study, in contrast, included both master and doctoral students from a diversity of programs. While the current study's recruitment procedure was most similar to that of DiLillo and Gale (2011), sample composition was different. The current study had a higher percentage of counseling participants versus clinical

participants. The current study, however, found no significant differences in online client searches across programs. DiLillo and Gale's (2011) finding could be related to the phrasing of the survey question. The current study assessed frequency (e.g., never, rarely, frequently), whereas DiLillo and Gale used a dichotomous (yes or no) response format.

The current study explored possible correlates to online searches of client information, including number of credit hours, direct client hours, number of clients seen, and years of social networking experience. Credits and years of social networking were significantly related to online client searches. Direct client hours and number of clients seen were not. DiLillo and Gale (2011) reported a positive partial correlation between year in program and endorsement of obtaining information using a search engine and social networking website. The current study had a similar finding. Credit hours, a measure of progress in ones' program, were positively related to online client searches. A possible reason for this finding could be related to the passage of time, meaning that the further along individuals are in their program the greater likelihood that they will have engaged in online client searches.

Interestingly, while credit hours were significantly correlated to online searches, direct client hours were not. Since the sample consisted of graduate students, the range of direct client hours is likely truncated when compared to direct client hours of practitioners in the field. Of those students with supervised clinical experience, most had completed or were currently enrolled in only one clinical experience (e.g., practicum only). This suggests that these direct client

hours were likely accrued over the course of one semester or one year. Future studies with individuals in clinical practice and utilizing a longitudinal design could help illuminate whether greater experience as reflected over time predicts online client searches.

Years of social networking experience predicted online searches over and above the other variables in the equation. Perhaps familiarity or a comfort with technological mediums is related to a greater likelihood of utilizing these mediums in clinical practice. While online client searches are not inherently unethical, it is important that mental health students evaluate how their search for client information affects their client's right to privacy and ensure that clients are provided with informed consent.

Of the participants who conducted an online client search, over 80% did not obtain client consent, did not document the search, and did not consider the possibility of having to breach confidentiality. This finding is alarming in that it suggests ethical violations are occurring. Both the APA (2010) and the ACA (2005) conceptualize informed consent as a fluid rather than static element that should be readdressed as new circumstances warrant. In fact, the ACA Code of Ethics (2005) explicitly addresses elements of informed consent that must be discussed when using technology applications in practice. The ACA ethical standards state, "Counselors inform clients of the benefits and limitations of using information technology applications in the counseling process" (p. 6). Of those who conducted an online search, the vast majority reported never discussing the benefits and drawbacks of conducting an online search with their client.

Previous professional discussions and the attitude that a client's social networking page is private as opposed to public were hypothesized to be positively related to obtaining informed consent. Although the data analysis failed to reveal significant relationships, the implications of the findings are of note. Participants in the study tended to favor the belief that information online is public. The belief about information on client's social networking website being public/private, was not related to obtaining client informed consent. Also, of the 75 participants who reported conducting a client search, discussing social networking use related to their clinical work with their clinical supervisor was done so very rarely. By not discussing how to handle client searches with their clinical supervisor, students may be placing themselves at increased risk of violating the client's right to informed consent and potentially jeopardizing their supervisor's clinical license.

When reasons for online searches of clients were examined, curiosity was the most endorsed reason. Individuals conducting client search for curiosity were less likely to endorse obtaining informed consent. While participants' beliefs about the ethical nature of the decision not to obtain informed consent was not gathered in this study, the positive relationship between conducting an online client search for 'curiosity' and not obtaining informed consent may indicate that the students are aware that their actions may not be viewed favorably by their client. As noted in the literature review, conducting an online client search to satisfy personal curiosity would be unethical. The second most reported reason was to verify what the client had said in session. This could signal a lack of trust

in the client's truthfulness or ability to convey information accurately. Furthermore, if the mental health student did not obtain informed consent before the search and did find a discrepancy in client's in-session reports and information obtained online, potential damage to the therapeutic alliance could result.

This potential discrepancy underscores that mental health professionals must examine the purpose of the search. Some have argued that information online is public and, therefore, clients cannot expect their online behaviors to be private. Whether or not the client has an expectation of privacy, the intentionality of the counselor needs to be considered. While it would be considered reasonable to bring up in therapy a chance in-person encounter where the client was observed doing behaviors related to their therapy (e.g., see client who is being treated for substance abuse at a bar drinking), it would generally be considered unethical to observe clients without their knowledge and consent. This also holds true for the online environment. Even though mental health professionals may unintentionally encounter information about their clients online (e.g., client is featured in an online news article and this is the lead story on Yahoo), purposefully searching out information without client consent is a violation of client's rights. Future studies that assess beliefs regarding acceptability of not obtaining informed consent and gather additional qualitative data on reasons for online client search could help illuminate graduate students' rationale for not obtaining informed consent prior to online client search.

Across the graduate students in this study, the average disclosure level was low, which suggests that the majority are refraining from directly or indirectly

sharing client information online. However, there were significant differences in between participants who completed their clinical experience in the school program and those in clinical or counseling programs, with those in school doctoral programs endorsing higher levels of disclosure of client information. This difference may be related to differences in norms for clinical sites. For example, school psychologists may be part of a school's multidisciplinary team (i.e., member of a group for child's individualized education plan) and be responsible for conveying test results to parents and appropriate school personnel. Level of interaction and interconnectedness among personnel of a school setting verses a community clinic or hospital may influence perceptions on acceptability of disclosure. Furthermore, school psychologists are working with minors on behalf of the school; therefore, they are expected to share information with relevant school personnel as well as parents. It is possible that this results having more lax boundaries with respect to sharing client information, in person and online. Research, both quantitative and qualitative, examining these potential reasons needed.

As predicted, lower scores on the ethical decision-making scale correlated with higher levels of disclosure. While some of the questions in the ethical boundaries scale were blatantly unethical (e.g., planning a relationship with current client), others involved scenarios that were not as clear-cut (e.g., coming back after your shift is over to check on a client that recently shared distressing information in session). Individuals who drew a firm line (i.e., endorsed never ethical) for the hypothetical in-person scenarios may be more likely to transfer

this stringent practice to their online behaviors. However, it should be noted that these are self-reported behaviors and beliefs. If self-reported online behaviors are accurate measures of participants' actual behaviors online, it is still unclear if these individuals are inherently less likely to engage in ethically questionable behavior (e.g., personality trait) or if this difference is better attributed to additional training/coursework related to ethics in practice. Tjeltveit and Gottlieb (2010) caution that the "profession has focused too much on logical and quasi-legal reasoning to analyze the development of such (ethical) transgressions" (p. 100). In fact, presence of formal ethics coursework was not related to any of the outcome variables. This training, while necessary to professional development, could be potentially augmented by including scenarios that encourage the application of the ethical code in cases that are less clearly defined legally or by respective ethical standards (i.e., APA, 2010 or ACA, 2005) as "right" or "wrong".

Similarly to Frye and Dornish's (2010) finding that experience with social networking was related to self-disclosure, this study found that years of social networking was correlated to disclosing client information online. The hypothesis that individuals' perceived level of knowledge with privacy settings would correlate to higher levels of disclosure was not supported by the current study.

Even though participants may not believe that the information they share online could reveal client identity, it is difficult to distinguish what degree of disclosure would cross the boundary as identifiable. As previously noted, malpractice suits have been brought against members of the medical field for

releasing information that the patient felt could identify them. Furthermore, it is becoming increasingly common for clients to conduct an online search of their mental health professional. Lehavot et al. (2010) found that the majority (70%) of mental health trainees seeing clients were informed by a client that they had obtained information about them through the internet. Imagine the potential damage a therapeutic alliance could suffer if the client was able to access information that the mental health professional posted online that they believed referenced them. Any level of disclosure, even disclosure that the trainee does not feel is identifiable, runs the risk of violating ethical boundaries. Graduate students need to examine what purpose this online disclosure is serving and whether there is a potential to cause harm to the client. Professional organizations and graduate schools need to address the question of what, if any, client information is acceptable to disclose online.

Limitations and Future Research

While the current study generated new descriptive findings related to online disclosure and informed consent practices and found several variables that were significantly correlated to online client search and disclosure, several limitations need to be mentioned. While it has become increasingly common to administer surveys online, there is inherent bias in doing so. Since the study measured online behaviors and gathered descriptive findings on social networking use, the frequency in which online behaviors were endorsed is likely slightly higher than if the survey were administered in person. Said differently, in order to complete the survey, the participant had to have a basic familiarity and comfort with navigating

the Internet. In contrast, the use of survey methods and self-report data can be subject to under reporting due to social desirability. It is also important to note that with the exception of the boundaries in practice scale, measures for online behavior were created by the researcher. While the Cronbach's alphas indicated adequate internal consistencies for the measures, the construct validity could be strengthened by implementation of expert raters and having an external sample of practitioners rather than students. Additionally, the dependent variables could have been transformed in order to reduce non-normality of residual distributions. Furthermore, observed effect sizes were also a limitation. Determination of the delegation of label "small", "medium" or "large" to the effect size measures should be considered in context to type of research (e.g., experimental design vs. quasi-experimental design) and number of predictors in a set ($k = 5$ vs. $k = 15$) (Cohen et al.; 2003). Cohen et al. recommends the using R^2 effect size of .02 .13, and .26 as measures of small, medium, and large effect sizes (See Cohen, 1988 for full discussion). While credit hours and years of social networking were correlated to online client searches, the effect size was small and accounted for approximately 5% of the variance. Ethical boundaries and years of social networking were significantly related to online disclosure and accounted for approximately 10% of the variance, which approached moderate effect size. Finally, the sample was comprised entirely of graduate students; therefore, results cannot be generalized to individuals who are in clinical practice.

Future research or a follow up study that explores online behaviors of individuals in clinical practice would add to the literature. In addition, while

credit hours were positively related to online disclosure, it is unclear why this relationship exists. In order to verify researchers' hypothesis that passage of time increases the likelihood that mental health professionals will conduct an online client search a longitudinal design should be utilized. Furthermore, qualitative information would enhance understanding as to why individuals choose not to obtain informed consent when conducting client searches and could shed light rationale behind online disclosures of client information.

Conclusion

While use of technological tools in clinical practice has increased, professional organizations and graduate programs have not adequately addressed ethical use of technology in clinical practice. In light of the findings of this study, it is clear that graduate mental health students are engaging in activities that are ethically questionable (e.g., conducting an online search without informed consent). Of the 315 study participants, over half reported that they did not believe that their graduate program adequately addressed professional social networking guidelines and slightly under half endorsed that they did not believe their professional organization adequately addressed professional social networking guidelines. It is clear that many graduate students are looking for guidance on how to handle new ethical dilemmas engendered by social networking.

The descriptive findings related to professional consultation also illustrate differences in who graduate mental health professionals are turning to in order to receive consultation regarding social networking use in their clinical work.

Survey results revealed that graduate students seldom seek consultation from their clinical supervisors or faculty members regarding their social networking related to their clinical work. Paradoxically, discussions with clinical supervisors were found to be the least frequent form of consultation graduate students sought out regarding social networking use in their clinical work. Instead, around half of the participant's endorsed occasional to very frequent consultation with graduate peers regarding social networking related to their clinical work. Reasons for this are unclear. Perhaps faculty members and clinical supervisors do not bring up the topic of social networking as it relates to clinical practice as frequently as do graduate peers. Alternatively, graduate students may not feel comfortable bringing the topic of social networking up with faculty and clinical supervisors.

In order to minimize or avoid ethical and legal infractions regarding online behaviors, mental health graduate students should seek professional consultation from their clinical supervisors, keep careful documentation, and thoughtfully consider alternatives. Results of this study indicate that social networking use in the clinical practice of mental health graduate students warrants further attention from both professional organizations and their training programs. Discussing technology use in clinical practice and encouraging critical thinking regarding ethically questionable behaviors may reduce potential harm to clients and help maintain the publics' trust in the confidential and non-maleficent nature of the mental health professional-client relationship.

REFERENCES

American Psychological Association. (2010). *American Psychological Association ethical principles of psychologists and code of conduct*. Retrieved October 16, 2011, from http://www.apa.org/ethics/code/index.aspx

American Psychological Association. (2011). Report of the ethics committee, 2010. *American Psychologist, 66*(5), 393-403. doi:10.1037/a0024003

Barnett, J. E., Lazarus, A. A., Vasquez, M. J. T., Moorehead-Slaughter, O., & Johnson, W. B. (2007). Boundary issues and multiple relationships: Fantasy and reality. *Professional Psychology: Research and Practice,* 38(4), , 401-405. Retrieved from http://login.ezproxy1.lib.asu.edu/login?url=http://search.proquest.com/docview/614722279?accountid=4485

Behnke, S. (2008). Ethics in the age of the internet. *Monitor on Psychology*, 39, 74-75.

Cha, A. E. (2010). What sites such as Facebook and google know and who they tell. *The Washington Post*. Retrieved October 29, 2010, from http://www.washingtonpost.com/wp-dyn/content/article/2010/05/28/AR2010052804853.html?hpid=topnews&sid=ST2010052805140

Clark, J. R. (2010). Social media and privacy. *Air Medical Journal*, 29, 104-107. doi:10.1016/j.amj.2010.02.005

Cohen, J. Cohen, P., West, S. G., Aiken, L. S. (2003). *Applied multiple regression/correlation analysis for the behavioral sciences* (3rd ed.). Mahwah, N.J: Lawrence Erlbaum Associates.

Cohen, J., (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Mahwah, N.J: Lawrence Erlbaum Associates.

DiLillo, D., & Gale, E. B. (2011). To google or not to google: Graduate students use of the internet to access personal information about clients. *Training and Education in Professional Psychology, 5*(3), 160-166. doi:10.1037/a0024441

Fisher, C. B. (2002) *Decoding the ethics code: A practical guide for psychologists*. Thousand Oaks, CA: Sage Publications.

Fisher, C. B. (2008). The APA ethics code and the need for balanced confidentiality and disclosure decisions in psychotherapy. *Professional Psychology: Research and Practice, 39*(3), 375-376. http://login.ezproxy1.lib.asu.edu/login?url=http://search.proquest.com/docview/614724008?accountid=4485

Fisher, M. A. (2008). Protecting confidentiality rights: The need for an ethical practice. *American Psychologist,* 63, 1-13.

Fisher, M. A. (2009). Ethics-based training for nonclinical staff in mental health settings. *Professional Psychology: Research and Practice, 40*(5), 459-466. doi:10.1037/a0016642

Frye, N. E., & Dornisch, M. M. (2010). When is trust not enough? the role of perceived privacy of communication tools in comfort with self-disclosure. *Computers in Human Behavior, 26*(5), 1120-1127. doi:10.1016/j.chb.2010.03.016

Hamilton, J. C., & Spruill, J. (1999). Identifying and reducing risk factors related to trainee–client sexual misconduct. *Professional Psychology: Research and Practice, 30*(3), 318-327. doi:10.1037/0735-7028.30.3.318

Kaslow, F. W., Patterson, T., & Gottlieb, M. (2011). Ethical dilemmas in psychologists accessing internet data: Is it justified? *Professional Psychology: Research and Practice, 42*(2), 105-112. doi:10.1037/a0022002

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

Koocher G. & Keith-Spiegel P. (2008). *Ethics in psychology and the mental health professions: standards and cases* (3rd ed.). New York: Oxford University Press.

Lamb, D. H., Catanzaro, S. J., & Moorman, A. S. (2004). A preliminary look at how psychologists identify, evaluate, and proceed when faced with possible multiple relationship dilemmas. *Professional Psychology: Research and Practice, 35*(3), 248-254. doi:10.1037/0735-7028.35.3.248

Langheinrich, M. & Karjoth G. (2010). Social networking and the risk to companies and institutions. *Information Security Technical Report*, doi:10.10.1016/j.istr.2010.09.001.

Lehavot, K. (2007). *Myspace or yours? The ethical dilemma of graduate students' personal lives on the internet.* Presentation at the Annual Convention of the American Psychological Association, San Francisco, CA

Lehavot, K., Barnett, J. E., & Powers, D. (2010). Psychotherapy, professional relationships, and ethical considerations in the myspace generation. *Professional Psychology: Research and Practice, 41*(2), 160-166. doi:10.1037/a0018709

Madden, M. & Zickuhr, K. (2011). 65% of online adults use social networking sites: Women maintain their foothold on SNS use and older Americans are still coming abroad. *Pew Research Center.* Retrieved October 25, 2011, from http://www.pewinternet.org/~/media//Files/Reports/2011/PIP-SNS-Update-2011.pdf

Martin, S. (2010). The internet's ethical challenges: should you google your clients? Should you friend' a student on Facebook? APA's ethic's director Stephen Behnke answers those questions and more. *Monitor on Psychology*, 41, 32.

McMinn, M. R., Bearse, J., Heyne, L. K., Smithberger, A., & Erb, A. L. (2011). Technology and independent practice: Survey findings and implications. *Professional Psychology: Research and Practice, 42*(2), 176-184. doi:10.1037/a0022719

McMinn, M. R., Hathaway, W. L., Woods, S. W., & Snow I. N. (2009). What American Psychological Association leaders have to say about Psychology of Religion and Spirituality. *Psychology of Religion and Spirituality*, 1, 313.

Mills, K. I. (2008) Too much information? With so many web sites listing personal information, our privacy is evaporating. *Monitor on Psychology*, 39, 57.

Nosko, A., Wood, E., Molema, S. (2010) All about me: Disclosure in online social networking profiles: The case of Facebook. *Computer in Human Behavior,* 26, 406-418.

Roblyer, M. D., McDaniel, M., Webb, M., Herman, J. & Witty, J. V. (2010). Findings on Facebook in higher education: A comparison of college faculty and student uses and perceptions of social networking sites. *Internet and Higher Education*, 13, 134-140.

Rogerson, M. D., Gottlieb, M. C., Handelsman, M. M., Knapp, S., & Younggren, J. (2011). Nonrational processes in ethical decision making. *American Psychologist, 66*(7), 614-623. doi:10.1037/a0025215

Rollins, J. (2011) ACA kicks off major revision of profession's code of ethics. *Counseling Today.* Retrieved November 5, 2011 from http://ct.counseling.org/2011/06/aca-kicks-off-major-revision-of-professions-code-of-ethics/

Rose, R. A., & Fraser, M. W. (2008). A simplified framework for using multiple imputation in social work research. *Social Work Research, 32*(3), 171-178. doi:10.1093/swr/32.3.171

Privacy policy (2011). Facebook.com. Retrieved January 10, 2011, from http:// www.facebook.com/policy.php

Sinharay, S., Stern, H. S., & Russell, D. (2001). The use of multiple imputation for the analysis of missing data. *Psychological Methods, 6*(4), 317-329. doi:10.1037/1082-989X.6.4.317

Smith W. P., Kidder, D. L. (2010) You've been tagged! (Then again, maybe not): Employers and Facebook. *Business Horizons*, 53, 491-499. doi:10.1016/j.bushor.2010.04.004

Statement of rights and responsibilities. (2011). *Facebook.com*. Retrieved January 10, 2011, from http://www.facebook.com/policy.php

Statistics. (2010). Press room: statistics. *Facebook.com*. Retrieved October 29, 2010, from http://www.facebook.com/press/info.php?statistics

Somberg, D. R., Stone, G. L., & Claiborn, C. D. (1993). Informed consent: Therapists beliefs and practices. *Professional Psychology: Research and Practice, 24*(2), 153-159. doi:10.1037/0735-7028.24.2.153

Taylor, L., McMinn, M. R., Bufford, R. K., & Chang, K. B. T. (2010). Psychologists' attitudes and ethical concerns regarding the use of social networking web sites. *Professional Psychology: Research and Practice*, 41(2), 153-159. doi:10.1037/a0017996

Tjeltveit, A. C., & Gottlieb, M. C. (2010). Avoiding the road to ethical disaster: Overcoming vulnerabilities and developing resilience. *Psychotherapy: Theory, Research, Practice, Training, 47*(1), 98-110. doi:10.1037/a0018843

Tunick, R. A., Mednick, L., & Conroy, C. (2011). A snapshot of child psychologists social media activity: Professional and ethical practice implications and recommendations. *Professional Psychology: Research and Practice, 42*(6), 440-447. doi:10.1037/a0025040

University of California Santa Barbara Policies. (2011). Social networking on the internet: Guide for UCSB employees, departments, and registered organizations. *University of California, Santa Barbara*. Retrieved January 31, 2011, from http:/www.policy.ucsb.edu/policies/advisory-docs/social-networking-guide.pdf

Vasquez, M. (2011). APA President details highlights of upcoming convention. American Psychological Assosication. Retrieved September 8, 2011, from http://www.apa.org/convention/about/vasquez-attend-convention.aspx

Wayman, J. C. (2003) Multiple imputation for missing data: What is it and how can I use it? Presentation at Annual Meeting of the American Educational Research Association, Chicago, IL. Retrieved May 28, 2012, from http://www.csos.jhu.edu/contact/staff/jwayman_pub/wayman_multimp_aera2003.pdf

Younggren, J. N., & Gottlieb, M. C. (2004). Managing risk when contemplating multiple relationships. *Professional Psychology: Research and Practice, 35*(3), 255-260. doi:10.1037/0735-7028.35.3.255

Zur, O., Williams, M. H., Lehavot, K., & Knapp, S. (2009). Psychotherapist self-disclosure and transparency in the internet age. *Professional Psychology: Research and Practice, 40*(1), 22-30. doi:10.1037/a0014745

APPENDIX A

IRB APPROVAL

To:	Sharon Kurpius EDB
From:	Mark Roosa, Chair Soc Beh IRB
Date:	03/15/2012
Committee Action:	**Exemption Granted**
IRB Action Date:	03/15/2012
IRB Protocol #:	1203007593

The above-referenced protocol is considered exempt after review by the Institutional Review Board pursuant to Federal regulations, 45 CFR Part 46.101(b)(2) .

This part of the federal regulations requires that the information be recorded by investigators in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. It is necessary that the information obtained not be such that if disclosed outside the research, it could reasonably place the subjects at risk of criminal or civil liability, or be damaging to the subjects' financial standing, employability, or reputation.

You should retain a copy of this letter for your records.

APPENDIX B

RECRUITMENT SCRIPT

I am a graduate student under the direction of Dr. Sharon Robinson Kurpius in the Counseling and Counseling Psychology program at Arizona State University. I am conducting a study to examine mental health graduate students' behaviors and attitudes regarding online social networking.

I am recruiting current graduate students in either a master's or doctoral program in counseling, counselor education, counseling psychology, clinical psychology, or school psychology that are at least 18 years of age to participate in an online survey. This survey will take approximately 10-15 minutes.

Your participation in this study is voluntary. Additionally, you can choose to provide your email address to be eligible for a **lottery for one of four $20 Visa gift cards.** Your email address will not be linked to your responses to the survey. If you have any questions concerning the research study, please call me at (480) 965- 2951. You may also contact the research team at: Sara.E.Harris@asu.edu or Sharon.kurpius@asu.edu.

If you would like to be a part of the study, please click the link below to access the online survey:
http://edu.surveygizmo.com/s3/881053/Social-Networking-Survey

APPENDIX B

INFORMED CONSENT

Dear Participant,

I am a graduate student in the Counseling and Counseling Psychology program at Arizona State University. Under the direction of Dr. Sharon Robinson Kurpius, I am conducting a study to examine mental health profession graduate students' behaviors and attitudes regarding online social networking. I am inviting your participation, which will involve filling out a set of questions online. It takes approximately10 minutes to fill out the survey.

Your participation in this study is voluntary. You can skip question if you wish. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. You must be a current graduate student in either a master's or doctoral program in counseling, counselor education, counseling psychology, clinical psychology, or school psychology and be at least 18 years of age. Your response to the survey may shed light on beliefs and behaviors of students preparing to become mental health professionals regarding social networking websites. Additionally, you can choose to provide your email address to be eligible for a lottery for one of five $20 Visa gift cards. Your email address will not be linked to your responses to the survey. There are no foreseeable risks or discomforts related to participation.

Your responses will be anonymous. The results of this study may be used in presentations or publications. Results will only be shared in the aggregate form. Data collection for the study is expected to be completed by May of 2012.

If you have any questions concerning the research study, please contact the research team at Sara.E.Harris@asu.edu or Dr. Sharon Robinson Kurpius, who is supervising this study, Sharon.kurpius@asu.edu. If you have any questions about your rights as a participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788.

Checking the box below will acknowledge that you have read and understand the informed consent letter and this will be considered your consent to participate.

Sincerely,

Sara Elisabeth Harris

APPENDIX C

SURVEY

1) What degree are you working toward?
( ) Masters
( ) Doctoral

2) What type of graduate program are you in?
( ) Clinical
( ) School
( ) Counseling

3) What is your sex?
( ) Male
( ) Female

4) What is your race/ethnicity?
( ) Asian/Pacific Islander
( ) Black/African-American
( ) Caucasian/Euro-American
( ) Hispanic/Latino/a
( ) Native American/Alaska Native
( ) Other/Multi-Racial

5) How old are you?

_____

6) What system does your school use?
( ) Semester
( ) Quarter

7) How many credits will you have completed toward your graduate degree by the end of the current semester/quarter?

_____

8) Check courses that you have completed or are currently enrolled in (select all that apply).
[ ] Practicum
[ ] Internship
[ ] Field placement
[ ] None of the above

9) Have you served as a clinical supervisor?
( ) Yes
( ) No

If you have served as a supervisor, how many individuals have you supervised?

_____

10) Do you have an account on a social networking site (e.g., Facebook, Twitter, LinkedIn, etc.)?
( ) Yes
( ) No

11) To which of the following professional organizations do you belong (check all that apply)?
[ ] APA
[ ] APS
[ ] ACA
[ ] AMHCA
[ ] ASCA
[ ] ACES
[ ] NASP
[ ] Other
[ ] None

12) How many total clock hours (e.g., direct client hours, supervision, case notes etc.) of practicum/internship/field placement have you completed by the end of the current semester/quarter?

_____

13) How many total direct client hours (e.g., individual therapy, group, testing, intake, etc.) have you completed by the end of the current semester/quarter?

_____

14) How many total clients have you worked with in your practicum/internship/field placement by the end of the current semester/quarter?

_____

Check all social networking sites you belong to.
[ ] Facebook
[ ] Twitter
[ ] LinkedIn
[ ] Google+
[ ] Myspace
[ ] YouTube
[ ] LiveJournal
[ ] DeviantArt
[ ] MyLife
[ ] Yelp
[ ] Other

For the social networking page you have maintained the longest, how many years have you had the account?

_____

How frequently do you access at least one of your social networking accounts?
( ) Daily
( ) Weekly
( ) Monthly
( ) Every 3 Months
( ) Every 6 Months
( ) Once a Year

15) I feel confident about my knowledge of privacy settings on my social networking sites.
( ) Strongly Disagree
( ) Moderately Disagree
( ) Slightly Disagree
( ) Slightly Agree
( ) Moderately Agree
( ) Strongly Agree

16) I am aware of what information is viewable by the public (i.e., non-friends) on my social networking site.
( ) Strongly Disagree
( ) Moderately Disagree
( ) Slightly Disagree
( ) Slightly Agree
( ) Moderately Agree
( ) Strongly Agree

17) There may be information on my social networking page that can be viewed by the public that I did not intend to be publicly viewable.
( ) Strongly Disagree
( ) Moderately Disagree
( ) Slightly Disagree
( ) Slightly Agree
( ) Moderately Agree
( ) Strongly Agree

18) I do not know what information the public can view on my social networking site.
( ) Strongly Disagree
( ) Moderately Disagree
( ) Slightly Disagree
( ) Slightly Agree
( ) Moderately Agree
( ) Strongly Agree

19) Information posted by clients online is private.
( ) Strongly Disagree
( ) Moderately Disagree
( ) Slightly Disagree
( ) Slightly Agree
( ) Moderately Agree
( ) Strongly Agree

20) If the public can readily access information posted by the client online then the information is not private.
( ) Strongly Disagree
( ) Moderately Disagree
( ) Slightly Disagree
( ) Slightly Agree
( ) Moderately Agree
( ) Strongly Agree

21) If the client has their social networking page set as publicly viewable then information on that site is not private.
( ) Strongly Disagree
( ) Moderately Disagree
( ) Slightly Disagree
( ) Slightly Agree
( ) Moderately Agree
( ) Strongly Agree

22) Clients are aware that posted information online (e.g., blogs, social networking, etc.) may be publicly viewable.
( ) Strongly Disagree
( ) Moderately Disagree
( ) Slightly Disagree
( ) Slightly Agree
( ) Moderately Agree
( ) Strongly Agree

23) I have discussed social networking use related to my clinical work with my clinical supervisor.
( ) Never
( ) Very Rarely
( ) Rarely
( ) Occasionally
( ) Frequently
( ) Very Frequently

24) I have discussed social networking use related to my clinical work with another student in my program.
( ) Never
( ) Very Rarely
( ) Rarely
( ) Occasionally
( ) Frequently
( ) Very Frequently

25) I have discussed social networking use related to my clinical work with faculty member in my program.
( ) Never
( ) Very Rarely
( ) Rarely
( ) Occasionally
( ) Frequently
( ) Very Frequently

26) I have used a search engine (e.g., Google, Bing, etc.) to find out or verify information about my client.
( ) Never
( ) Very Rarely
( ) Rarely
( ) Occasionally
( ) Frequently
( ) Very Frequently

27) I have used a social networking site (e.g., Facebook, Twitter, etc.) to find out or verify information about my client.
( ) Never
( ) Very Rarely
( ) Rarely
( ) Occasionally
( ) Frequently
( ) Very Frequently

28) The primary reason I conducted an online search (e.g., Google, Social Networking) was:
( ) Curiosity
( ) Verify what the client has told me
( ) Therapeutic concern about client welfare
( ) Gather information for intervention
( ) Other: _____
( ) Have not conducted search

29) I obtained informed consent prior to conducting an online client search (e.g., Google, Social networking site).
( ) Never
( ) Very Rarely
( ) Rarely
( ) Occasionally
( ) Frequently
( ) Very Frequently

30) The type of informed consent I receive prior to conducting an online search is most often:
( ) Written
( ) Oral
( ) Both

31) I discussed with my client the benefits and drawbacks of conducting an online search about them.
( ) Never
( ) Very Rarely
( ) Rarely
( ) Occasionally
( ) Frequently
( ) Very Frequently

32) I discussed with my client how I would handle information obtained from my online search that required a breach of confidentiality.
( ) Never
( ) Very Rarely
( ) Rarely
( ) Occasionally
( ) Frequently
( ) Very Frequently

33) I discussed with my client alternatives to conducting an online search of their information.
( ) Never
( ) Very Rarely
( ) Rarely
( ) Occasionally
( ) Frequently
( ) Very Frequently

34) I documented obtaining informed consent for an online search in my client's file.
( ) Never
( ) Very Rarely
( ) Rarely
( ) Occasionally
( ) Frequently
( ) Very Frequently

35) I have expressed positive thoughts/feelings (e.g., happiness, optimism, hopefulness, etc.) online about a client but did not provide information that I believe could readily identify the client.
( ) Never
( ) Very Rarely
( ) Rarely
( ) Occasionally
( ) Frequently
( ) Very Frequently

36) I have expressed negative thoughts/feelings (e.g., disappointment, frustration, sadness, etc.) online about a client but did not provide information that I believe could readily identify the client.
( ) Never
( ) Very Rarely
( ) Rarely
( ) Occasionally
( ) Frequently
( ) Very Frequently

37) I have posted an update online that indirectly referenced positive thoughts/feelings (e.g., happiness, optimism, hopefulness, etc.) I was having about a client.
( ) Never
( ) Very Rarely
( ) Rarely
( ) Occasionally
( ) Frequently
( ) Very Frequently

38) I have posted an update online that indirectly referenced negative thoughts/feelings (e.g., disappointment, frustration, sadness, etc.) I was having about a client.
( ) Never
( ) Very Rarely
( ) Rarely
( ) Occasionally
( ) Frequently
( ) Very Frequently

39) I have expressed positive thoughts/feelings (e.g., happiness, optimism, hopefulness, etc.) online about something my client said in session.
( ) Never
( ) Very Rarely
( ) Rarely
( ) Occasionally
( ) Frequently
( ) Very Frequently

40) I have expressed negative thoughts/feelings (e.g., disappointment, frustration, sadness, etc.) online about something my client said in session.
( ) Never
( ) Very Rarely
( ) Rarely
( ) Occasionally
( ) Frequently
( ) Very Frequently

41) I would warn my online friends about a client who is dangerous.
( ) Strongly Disagree
( ) Moderately Disagree
( ) Slightly Disagree
( ) Slightly Agree
( ) Moderately Agree
( ) Strongly Agree

42) I would share with my online friends if my client got a special recognition/achievement.
( ) Strongly Disagree
( ) Moderately Disagree
( ) Slightly Disagree
( ) Slightly Agree
( ) Moderately Agree
( ) Strongly Agree

43) It would be acceptable to add a former client as a friend on a social networking site.
( ) Strongly Disagree
( ) Moderately Disagree
( ) Slightly Disagree
( ) Slightly Agree
( ) Moderately Agree
( ) Strongly Agree

Consider each of the following 10 situations and circle the appropriate response from each of the four response choices. Please imagine you are the person in each scenario.

1a. A mother of a client is very distressed. She is a nice woman and you really like her. She asks you to have dinner with her one night.

How would you rate your level of knowledge for dealing with this situation?	No Knowledge	Limited Knowledge	Sound Knowledge	Excellent Knowledge
How comfortable would you feel in dealing with this situation?	No discomfort	Low discomfort	Medium discomfort	High discomfort
Have you ever actually experienced this situation?	Never	Once	A few times	Many times

b. She needs some cheering up so you invite her home for dinner.

How ethical is this decision?	Never ethical	Ethical under some conditions	Ethical under most conditions	Always ethical

2a. You begin therapy with a client and you find that you are attracted to each other.

How would you rate your level of knowledge for dealing with this situation?	No Knowledge	Limited Knowledge	Sound Knowledge	Excellent Knowledge
How comfortable would you feel in dealing with this situation?	Nil discomfort	Low discomfort	Medium discomfort	High discomfort
Have you ever actually experienced this situation?	Never	Once	A few times	Many times

b. You plan a relationship while the person is still a client.

How ethical is this decision?	Never ethical	Ethical under some conditions	Ethical under most conditions	Always ethical

c. You plan a relationship after the client is discharged.

How ethical is this decision?	Never ethical	Ethical under some conditions	Ethical under most conditions	Always ethical

3a. You have been under a lot of personal stress and the client asks you what is wrong.

How would you rate your level of knowledge for dealing with this situation?	No Knowledge	Limited Knowledge	Sound Knowledge	Excellent Knowledge
How comfortable would you feel in dealing with this situation?	No discomfort	Low discomfort	Medium discomfort	High discomfort
Have you ever actually experienced this situation?	Never	Once	A few times	Many times

b. You find yourself telling the client about your problems.

How ethical is this decision?	Never ethical	Ethical under some conditions	Ethical under most conditions	Always ethical

4a. A client has just disclosed to you very distressing personal information and is visibly upset. You are just about to finish your shift.

How would you rate your level of knowledge for dealing with this situation?	No Knowledge	Limited Knowledge	Sound Knowledge	Excellent Knowledge
How comfortable would you feel in dealing with this situation?	Nio discomfort	Low discomfort	Medium discomfort	High discomfort
Have you ever actually experienced this situation?	Never	Once	A few times	Many times

b. You come back after your shift is over to make sure the client is OK.

How ethical is this decision?	Never ethical	Ethical under some conditions	Ethical under most conditions	Always ethical

5a. You discover that a work colleague is dating a client.

How would you rate your level of knowledge for dealing with this situation?	No Knowledge	Limited Knowledge	Sound Knowledge	Excellent Knowledge
How comfortable would you feel in dealing with this situation?	Nio discomfort	Low discomfort	Medium discomfort	High discomfort
Have you ever actually experienced this situation?	Never	Once	A few times	Many times

b. You choose to say nothing.

How ethical is this decision?	Never ethical	Ethical under some conditions	Ethical under most conditions	Always ethical

6a. You are working with a client who has a family situation similar to your own. You can really understand what this person is going through.

How would you rate your level of knowledge for dealing with this situation?	No Knowledge	Limited Knowledge	Sound Knowledge	Excellent Knowledge
How comfortable would you feel in dealing with this situation?	No discomfort	Low discomfort	Medium discomfort	High discomfort
Have you ever actually experienced this situation?	Never	Once	A few times	Many times

b. You offer advice based on your own personal experiences.

How ethical is this decision?	Never ethical	Ethical under some conditions	Ethical under most conditions	Always ethical

7a. You have a client who tries to cheer everyone up with potentially offensive jokes. Everybody finds him funny.

How would you rate your level of knowledge for dealing with this situation?	No Knowledge	Limited Knowledge	Sound Knowledge	Excellent Knowledge
How comfortable would you feel in dealing with this situation?	Nio discomfort	Low discomfort	Medium discomfort	High discomfort
Have you ever actually experienced this situation?	Never	Once	A few times	Many times

b. You tell some similar jokes.

How ethical is this decision?	Never ethical	Ethical under some conditions	Ethical under most conditions	Always ethical

8a. You are working with someone in the community and you start to feel very responsible for their well-being.

How would you rate your level of knowledge for dealing with this situation?	No Knowledge	Limited Knowledge	Sound Knowledge	Excellent Knowledge
How comfortable would you feel in dealing with this situation?	Nio discomfort	Low discomfort	Medium discomfort	High discomfort
Have you ever actually experienced this situation?	Never	Once	A few times	Many times

b. You find yourself doing extra things for that person that they could do themselves.

How ethical is this decision?	Never ethical	Ethical under some conditions	Ethical under most conditions	Always ethical

9a. You are meeting a group of friends at a nightclub. You feel sorry for one of your young clients and feel a night out would do them good.

How would you rate your level of knowledge for dealing with this situation?	No Knowledge	Limited Knowledge	Sound Knowledge	Excellent Knowledge
How comfortable would you feel in dealing with this situation?	Nio discomfort	Low discomfort	Medium discomfort	High discomfort
Have you ever actually experienced this situation?	Never	Once	A few times	Many times

b. You invite the client to come along.

How ethical is this decision?	Never ethical	Ethical under some conditions	Ethical under most conditions	Always ethical

10a. You overhear a colleague threaten to ignore a client's request for care because the client was not being cooperative. You can understand your colleague's frustration.

How would you rate your level of knowledge for dealing with this situation?	No Knowledge	Limited Knowledge	Sound Knowledge	Excellent Knowledge
How comfortable would you feel in dealing with this situation?	No discomfort	Low discomfort	Medium discomfort	High discomfort
Have you ever actually experienced this situation?	Never	Once	A few times	Many times

b. You keep it to yourself.

How ethical is this decision?	Never ethical	Ethical under some conditions	Ethical under most conditions	Always ethical

44) Have you completed a formal ethics course in your graduate program?
( ) Yes
( ) No

If you did complete ethics, did you discuss any of the following in your ethics course (check all that apply)?
[ ] Confidentiality
[ ] Informed Consent
[ ] Dual/Multiple Relationships
[ ] When to Breach Confidentiality
[ ] Therapist Self-Disclosure

If you completed ethics coursework, did the class discuss appropriate professional behavior related to online behaviors.
( ) Strongly Disagree
( ) Moderately Disagree
( ) Slightly Disagree
( ) Slightly Agree
( ) Moderately Agree
( ) Strongly Agree

46) I believe my graduate program adequately addresses professional social networking guidelines.
( ) Strongly Disagree
( ) Moderately Disagree
( ) Slightly Disagree
( ) Slightly Agree
( ) Moderately Agree
( ) Strongly Agree

47) I believe my professional organization (e.g., APA, ACA, etc.) adequately addresses professional social networking guidelines.
( ) Strongly Disagree
( ) Moderately Disagree
( ) Slightly Disagree
( ) Slightly Agree
( ) Moderately Agree
( ) Strongly Agree

APPENDIX D

PERMISSION FOR BOUNDARIES SCALE

Dear Sara,

I have attached the scale for you. Melissa Kendall and I would be happy for you to use the scale though it may need adapting to an on-line environment. Melissa would be the best person to contact if you have specific questions regarding the scale.

Good luck with your thesis. It sounds extremely interesting.

Kind Regards,

Tricia Fronek

--
Dr Patricia Fronek
Senior Lecturer
School of Human Services and Social Work
Griffith University, Gold Coast Campus
Queensland 4222 Australia

Phone: +61 (0)7 55529345
Fax: +61 (0)7 55528562
p.fronek@griffith.edu.au

http://www.griffith.edu.au/health/school-human-services-social-work/staff/dr-patricia-fronek
http://griffith.academia.edu/PatriciaFronek
View my research on my SSRN Author page:
http://ssrn.com/author=1518628
Twitter:@triciafronek