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Therapists' Willingness to Access Client Social Media Accounts in the Context of Suicide Risk

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by

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Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

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ABBREVIATIONS

APA	American Psychological Association
SM	Social Media
US	United States
CDC	Centers for Disease Control and Prevention
VA	Veteran's Administration
ORS	Oregon Revised Statutes
OHA	Oregon Health Authority
NASW	National Association of Social Workers
ACA	American Counselor's Association
ApA	American Psychiatric Association
CNN	Cable News Network
CPA	Canadian Psychological Association
CCEP	Canadian Code of Ethics for Psychologists
CA	California
M	Arithmetic Mean
SD	Standard Deviation
MLR	Multiple Linear Regression
CBT	Cognitive Behavioral Therapy
IRB	Institutional Review Board
DBT	Dialectical Behavior Therapy
REBT	Rational Emotive Behavior Therapy

ABSTRACT

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Doctor of Philosophy, Graduate Program in Clinical Psychology
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The past two decades has seen a proliferation of social media use, leading to a growing body of research on the potential utility for clinical contexts. In the current study, we examine willingness of psychologists to utilize client social media to inform suicide risk-assessment and risk-related treatment decisions, and the ethical principles they used to guide their considerations. Participants were asked of the likelihood they would engage in 1) a social media-informed risk assessment, where the therapist uses client social media to inform their initial determination of risk level, and 2) a digital welfare check, where the therapist accesses an at-risk client's social media page to determine if they are in immediate danger and require further protective measures. Participants' likelihood of engaging in these behaviors was assessed using two fictional clinical vignettes. The ethical principles they used in their deliberations were assessed using the General Ethical Principles Questionnaire, in which participants rated the relative contribution of each general ethical principle (Beneficence and Nonmaleficence, Respect for Peoples' Rights and Dignity, Integrity, Justice, and Fidelity and Responsibility) to their responses on the vignettes. Therapist factors including

professional status (licensed vs. in-training), digital literacy, and theoretical orientation were examined in terms of how they influenced likelihood ratings for each vignette. Overall, most participants reported being unlikely to engage in either a social media-informed risk assessment or a digital welfare check. Results also indicated participants were more likely to conduct a digital welfare check than a social media-informed risk assessment. Interestingly, relative value placed on Beneficence positively predicted likelihood to engage in both forms of social media checks, and Respect for Peoples' Rights and Dignity negatively predicted likelihood to engage in a digital welfare check, but not a social media-informed risk assessment. Professional status, digital literacy and identification with any specific theoretical orientation did not predict likelihood to engage in either form of therapist accessing clients' social media. We conclude with a discussion of how psychologists can effectively and ethically incorporate social media into their practice and potential implications for the development of future ethical standards and guidelines related to digital practice.

CHAPTER ONE

Literature Review

Introduction

The proliferation of social media (SM) has propelled society into a new age of digital communication, leading social scientists, researchers, and clinicians to develop new ways to utilize the vast amount of data provided by SM content. SM offers users a platform to share their thoughts, emotions, behaviors, and experiences with the public. Researchers and clinicians have only just begun to explore the potential uses of SM as one of the richest sources of information regarding human language and behavior. As we continue to learn more about what SM users choose to post and why, as well as the level to which individuals' posts are indicative of their psychosocial functioning, there is an opportunity for mental health providers to use this growing knowledge-base to develop novel clinical approaches and interventions unique to this increasingly digital age.

In the present study, we examine clinicians' attitudes regarding using SM to preserve client safety. Specifically, we examine participants' likelihood to engage in two different ways of using client SM data to inform treatment decisions related to client risk of suicide: (a) social media-informed risk assessment and (b) digital welfare checks. We also examine whether certain clinician demographic and professional characteristics influence that likelihood. This introduction begins with a general discussion on the growth of SM the expansion of psychology in the digital sphere, particularly regarding online dissemination of psychoeducation, online assessment and intervention, and online communication with potential and existing clients. A brief review of current trends in suicide rates and a discussion of various clinical, ethical, and legal considerations related

to the management of suicidal patients follow. Next, some of the barriers and shortcomings of current suicide risk assessment procedures are presented. A discussion regarding the effects that the proliferation of SM has had on patterns of client disclosure of suicidal ideation outside of therapeutic contexts comes next. Then, current aspirational ethical principles and guidelines for psychologists, and ethical standards from other mental health disciplines regarding the therapist's accessing of clients' SM are presented and applied to the specific context of client suicidal risk. An argument is then offered for clinicians' use of at-risk clients' SM information through (a) social media-informed risk assessment and (b) digital welfare checks. The introduction concludes with a review of research findings related to therapists' accessing and use of clients' SM, as well as therapist characteristics that predict those behaviors, noting the dearth of literature on therapist online behavior in the context of client suicide risk.

Growth of Social Media

SM use has exploded over the past two decades, leading to its emergence as a burgeoning arena for psychosocial research. According to a series of surveys conducted by the Pew Research Institute from 2005 to 2019, only 5% of American adults reported using at least one social media platform in 2005. By 2011, half of American adults reported using at least one social media platform; this number now sits at 72% as of 2019. This increase has been observed in US adults in all age groups. The largest increase has been among US adults aged 18-29, with SM use in this age bracket increasing from 7% in 2005 to 90% in 2019. The percentage of adults aged 30-49 who report using at least one SM platform increased from 6% in 2005 to 82% in 2019. SM use among older

adults has also increased substantially over the same time period, from 4% in 2005 to 69% in 2019 for US adults aged 50-64, and from 3% in 2005 to 40% in 2019 for US adults 65 and older. Furthermore, SM use has become a staple in the daily routine of US adults; three quarters of Facebook users and 63% of Instagram users report using the platform at least once daily (Pew Research Institute, 2019).

Expansion of Psychologists' Presence in the Digital Sphere

Given the rapid expansion of SM users and the evolving manner in which SM is used for communication and personal expression, an evaluation of how SM may be utilized to improve clinical practice is warranted. In what ways can psychologists utilize SM for clinical purposes, while adhering to ethical standards and principles? The answer to this question depends on a clinicians' reason for venturing into the digital sphere. Psychologists can improve and expand their services by using SM and the internet for four purposes: (a) to communicate with current and prospective clients, (b) to disseminate psychoeducational material, (c) to access information that may inform psychosocial status/functioning assessment and treatment decisions, and (d) to deliver interventions in clinical and forensic settings. Each of these are discussed below.

Communication with Potential and Existing Clients

An increasing number of psychologists are developing websites to facilitate their practice, many of which are readily available when prospective clients search for various selection factors (Kolmes & Taube, 2016). Additionally, platforms like PsychologyToday's "Find a Therapist" allow individuals interested in or seeking mental

health care to enter their location and be provided with the names of all of the therapists within a predetermined distance who have a profile on PsychologyToday. Therapists can use such platforms to identify their specialty areas, theoretical orientation, accepted insurance carriers, fees, experience working with clients of diverse social groups based on age, gender, gender identity, race, ethnicity, culture, nation origin, religion, sexual orientation, disability, and language to name a few, and their own demographics. Individuals in search of a therapist have the option to sort and filter their options based on these factors. Many therapists on PsychologyToday also provide information regarding their education background, photos of their office, and a description of their services and clinical style. Researchers have also demonstrated that clinicians often search for their clients on the internet to obtain relevant contact information (Kolmes & Taub, 2014). Further, many psychologists use e-mail and texting to coordinate services with their clients (Mahue & Gordon, 2000).

Dissemination of Psychoeducation

SM also represents a new platform in which psychologists can disseminate psychoeducation on a wide range of mental health topics. For example, many users on YouTube post psychoeducation videos for the general public to access. Though there still exists a significant amount of misinformation on YouTube regarding topics related to mental health (Gordon, Miller, & Collins, 2015), providing high-quality, empirically-supported psychoeducational material through SM can increase access to mental health services and information among ethnic minorities, as well as reduce stigma related to help-seeking (Lam, Tsiang, & Woo, 2017). Pursuant to the goal of bridging the gap

between psychology and the online world, the American Psychological Association currently has a YouTube channel (with 24,100 subscribers), where it runs a video series, "Speaking of Psychology," in which psychologists of varying specialties give lectures on mental health topics.

Online Assessment and Intervention

Psychological assessments and interventions have made their way into the digital sphere largely through the increased use of telehealth services. The APA defines telehealth as “the provision of medical care services using technological modalities in lieu of, or in addition to, traditional face-to-face methods.” The term telehealth also encapsulates telepsychology and tele-mental health. Telepsychology provides the opportunity for individuals to receive mental health care that otherwise may have been inaccessible (Hopps, Pepin, & Boisvert 2003). For example, individuals with physical disabilities may not be able to attend in-person sessions. Also, the COVID-19 pandemic has made digital access to services all the more important.

Investigators have examined the efficacy, accuracy, and ethical implications of conducting assessments through technology compared to face-to-face. Schopp, Johnstone, & Merrell (2000) found no significant group differences between a sample of 49 clients who underwent neuropsychological tele-assessment and matched controls in their satisfaction and interpersonal ratings of the tele-assessment session. More recent studies have examined the ethics of online assessment, with authors identifying multiple aspects of telehealth assessment that warrant special ethical considerations (Fisher & Fried, 2003; Luxton, Pruitt, & Osenbach, 2014). Furthermore, in the midst of the

COVID-19 pandemic, the APA published an article providing recommendations for tele-assessment, addressing issues such as test security, adaptations to testing protocol, data quality, and the widening of confidence intervals (Wright, Mihura, Pade, & McCord, 2020). Some clinicians have raised concerns that, for some diagnoses (e.g., autism), assessments restricted to online administrations may be ultimately invalid, and thus worse than no assessment (Shropsire Live, 2020).

Some researchers have shown that telepsychology interventions produce outcomes for clients that are comparable to face-to-face therapy (Mohr, Ho, Duffecy, Reifler, Sokol, Burns, Jin & Siddique, 2012). Other studies have demonstrated that SM can be used to supplement interventions for mental disorders such as major depression, bipolar disorder, and schizophrenia, with favorable results (Naslund, Aschbrenner, Marsch, McHugo, & Bartels, 2018; Lam, Tsiang, & Woo, 2017).

Research findings also suggest that suicide risk assessment and intervention may be enhanced when supplemented with online resources. For example, investigators have begun to explore different approaches to digitized risk assessment, describing various implementations and protocols related to such assessments, as well as some associated ethical issues (see e.g., Luxton, O'Brien, & Pruitt 2014). There is evidence for the feasibility of augmenting traditional case monitoring services for Veterans with suicidal ideation with a digital case monitoring application (Kasckow, Zickmund, Gurklis, Luther, Fox, Taylor, Richmond, & Hass, 2016). The next three sections of this Introduction outline the public health crisis revealed in suicide rates in the United States, discuss the ethical and legal standards of care, and present common barriers to in-person suicide risk assessment and intervention.

Suicide as a Public Health Crisis

The age-adjusted suicide completion rate in the United States increased 30% from 2000 to 2016, with rates climbing for all age groups among both men and women (Centers for Disease Control and Prevention, 2017). This increase was particularly significant for youth and young adults, specifically young women aged 10-14, young women aged 15-24, and young men aged 15-24. Young women aged 10-14 expressed by far the largest increase in suicide rates, jumping from 0.6 in 2000 to 1.7 in 2016 (a 183% increase). Data from 2018 published by the CDC echoes these trends (Center for Disease Control and Prevention, 2020). In 2018, 1.4 million Americans age 18 and older attempted to die by suicide. Furthermore, 132 Americans died by suicide per day, amounting to 48,344 suicide deaths that year, up from 42,773 in 2014. In 2018, suicide was the tenth leading cause of the death in the United States, further solidifying its designation as a national public health crisis, rather than a specialized issue reserved for mental health clinicians (Center for Disease Control and Prevention, 2020).

Standards of Care for In-Person Suicide Risk Assessment and Prevention for Psychologists

Legal and Ethical Duty to Protect

Given that the country has identified suicide as a public health issue, legal statutes related to suicide prevention are in national and state law. For example, the Joshua Omvig Veterans Suicide Prevention Act (2007) formally acknowledged that suicide prevention amongst veterans is a pressing health issue, and put in place a comprehensive

suicide prevention program which has since been disseminated to VAs around the country. Recently, various national health organizations statewide have increased their partnership with the federal and state governments to develop suicide prevention policies. In 2017, the CDC published *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (CDC, 2017), which identifies empirically-supported strategies to be considered in the development of federal and statewide suicide prevention legislation. State laws and case precedence have also established the clinician's responsibility to competently assess risk and intervene appropriately to prevent client suicide. In some states, clinicians are mandated to report a client at risk for suicide under specific circumstances to appropriate authorities (e.g., Suicide Attempts by Minors, Oregon law [ORS 441.750{1}{b}] requires hospital staff to report suicide attempts of persons under 18 to OHA/Public Health). In the majority of states, therapists are legally permitted to break confidentiality to ensure the safety of a suicidal patient (e.g., California Civil Code 56.10 and Evidence Code 1024). Further, some states require that therapists-in-training complete specific coursework in the assessment and treatment of suicidal clients as a prerequisite to licensure (e.g., California AB 89).

Specific to the field of psychology, the American Psychological Association (APA) has ethical principles and standards that delineate best practice (APA, 2017). In the context of in-person risk assessment and suicide prevention, several general ethical principles and standards are relevant. Five aspirational ethical principles provide a framework for the ethical navigation of risk situations: Beneficence and Nonmaleficence, Fidelity and Responsibility, Integrity, Justice, and Respect for People's Rights and Dignity.

Arguably the most important ethical duty of a psychologist is the preservation of client welfare, a duty that is clearly delineated in the general principle of Beneficence and Nonmaleficence: "psychologists seek to safeguard the welfare and rights of those with whom they interact professionally, and other affected persons" (APA, 2017, p. 3). The preservation of a client's life can be reasonably interpreted as a fundamental application of this principle. When it is apparent that a client's life may be in immediate danger, the psychologist must take appropriate and proactive measures to mitigate this risk, through standard-of-care procedures such as safety planning, consultation with colleagues and supervisors, welfare checks, and voluntary or involuntary hospitalization.

Additional ethical principles inform suicide risk assessment and intervention. For example, the principle of Fidelity and Responsibility refers to the psychologist's duty to establish and maintain a relationship of trust with clients. As such, psychologists "clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage potential conflicts of interest that could lead to exploitation or harm" (APA, 2017; p. 4). The general ethical principle of Integrity states that psychologists should "promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology" (APA, 2017, p.4), while the general principle of Respect for People's Rights and Dignity admonishes psychologists to "respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination" (APA, 2017; p. 5). A relevant application of these three principles in the context of suicide risk assessment and intervention pertains to the informed consent process. Ethical standards of care require that individuals undergoing psychological assessment or treatment be fully informed regarding the nature of the services provided,

the roles and obligations of the provider, and the limits of confidentiality and privacy. After understanding this information, patients must then decide whether to proceed with the services as described. Rudd et al. (2009) argue that the informed consent process for patients with histories of suicidal ideation and behavior should include a clear statement regarding risks inherent in the services provided and the therapist's procedures for managing those risks.

The general principle of Justice also requires psychologists to "exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to unjust practices" (APA, 2017; p 5). Clearly, in the domain of suicide risk assessment and management, clinician competence is of crucial importance.

Enforceable ethical standards based on these aspirational principles define the ethical standard of care for suicide risk assessment and intervention in clinical contexts. Examples include: Standards 2.01 (Boundaries of Competence), 2.02 (Providing Services in Emergencies), 2.03 (Maintaining Competence), 3.04 (Avoiding Harm), 3.09 (Cooperation with Other Professionals), 3.10 (Informed Consent), 4.01 (Maintaining Confidentiality, 4.02 (Discussing Limits of Confidentiality), 4.05 (Disclosures), 4.06 (Consultations), 6.01 (Documentation of Professional and Scientific Work and Maintenance of Records), 9.01 (Bases for Assessments), 9.02 (Use of Assessments), 9.03 (Informed Consent in Assessments, and 10.01 (Informed Consent to Therapy).

Conflicts Between Ethical and Legal Standards

Clinically navigating client suicide risk often presents the therapist with an "ethical dilemma," which the APA defines as "arising when two or more of the values found in the ethical principles conflict," (Behnke, 2005). In the context of client danger to self, therapists are faced with an ethical dilemma that they must attempt to navigate using best practice procedures delineated in the APA's Ethical Principles of Psychologists and Code of Conduct (APA, 2017). The most central ethical dilemma related to preserving client safety is the relative weighing of the general principle of Beneficence and Nonmaleficence, and the general principle of Respect for People's Rights and Dignity. As described above, the general principle of Beneficence and Nonmaleficence calls on psychologists to protect the welfare of their clients, while the general principle of Respect for People's Rights and Dignity admonishes psychologists to "respect the rights…of individuals to…self-determination," (APA, 2017, p. 4). When it is apparent that a client's life may be in immediate danger, the psychologist must take appropriate and proactive measures to mitigate this risk, through standard procedures such as safety planning, consultation with colleagues and supervisors, welfare checks, and voluntary or involuntary hospitalization. Such interventions, however, may be in conflict with the patient's desires. For example, a patient may object to safety planning procedures or voluntary hospitalization, and the clinician's pursuit of an intervention designed to safeguard the patient's welfare may impinge on their autonomy.

Another type of conflict may arise between an ethical principle (Beneficence and Nonmaleficence), and another principle (Respect for People's Rights and Dignity) and the law. The United States Constitution alludes to the right to privacy in the 4th

Amendment, which identifies “the right of the people to be secure in their persons, houses, papers, and effects, against unreasonable search and seizures.” The California Constitution explicitly gives each citizen an “inalienable” right to pursue and obtain privacy. In psychology, the general principle of Respect for People’s Rights and Dignity requires psychologists to “respect the rights…of individuals to privacy (and) confidentiality…” (APA, 2017, p. 4). In other words, clients are afforded the rights to privacy and confidentiality under the ethics code, as well as national and statewide law. However, many suicide prevention measures necessitate a violation of privacy or a breach of confidentiality. For example, a decision to involuntarily hospitalize a suicidal client or call the police to perform a welfare check in accordance with the principle of Beneficence and Nonmaleficence may also represent a subversion of Respect for Peoples' Rights and Dignity, and may carry legal considerations.

Barriers to In-person Suicide Risk Assessment and Intervention

Given the trends in suicide rates and the clinician’s ethical and legal responsibilities to the client, accurate and thorough suicide risk assessment has become all the more necessary to protecting vulnerable clients and providing appropriate care. The current norm in risk assessment is that it is conducted using information given by the client during therapy, as well as previous records or reports from others, if available or authorized by the client. However, this method has been shown to have barriers and confounds that decrease the accuracy of the assessment, and the effectiveness of subsequent intervention, which, in turn, can adversely impact the client's health and/or the therapeutic alliance (Brown, Jones, Betts, & Wu, 2003).

For example, a common assumption across all theoretical orientations is that clients disclose information related to their distress with their therapist. However, some researchers have demonstrated that individuals may be resistant to disclosing negative symptoms and behaviors to their therapist (Bauman & Hill, 2015; Hook & Andrews, 2005). Farber, Blanchard, & Love (2019) found that psychotherapy clients tended to not only conceal distress levels and symptom severity from their therapists, but that an alarmingly high percentage lied about their suicidal thoughts. Apter, Horesh, Gothelf, Graffi, & Lepkifker (2001) found that suicide behavior severity was a major negative factor in participants' willingness to disclose their experiences to their clinicians; the more severe the behavior, the less likely it was disclosed. Given that interpersonal isolation is a risk factor for suicide, client levels of disclosure become even more crucial in the context of suicide prevention; nondisclosure of suicidal ideation by clients may reinforce the feelings of isolation and lead to more severe suicide behaviors (Orf, 2014).

The quality of the therapeutic alliance is among the most robust predictors of client disclosure (Orf, 2014). It has been demonstrated that strong therapeutic alliance leads to increased client disclosure (Hall & Farber, 2001). Conversely, the results of another study indicated that clients who reported having held a clinically relevant secret from their therapist rated their therapeutic alliance with their therapist as lower than clients who made such disclosures (Kelley & Yuan, 2009). Shea (2002) demonstrated that the way clinicians probe for suicidal ideation and behavior may impact clients' willingness to disclose, while Dew, Morgan, Dowell, McLeod, Bushnell, & Collings (2007) and Farber et al. (2019) found that fears of certain practical outcomes (e.g., hospitalization, medication, job impact), clinician negative judgment, and facing their

distress "head on" are additional barriers to client disclosure. More specifically, Farber et al. (2019) found that clients were more inclined to make disclosures regarding suicidality if their therapists provided information and assurances regarding the consequences of the disclosure, enhancing their sense of predictability and the therapist's transparency.

Cultural and social factors also may contribute to client non-disclosure. Social stigma against suicidal individuals discourages disclosure (Keller, McNeill, Honea, & Miller, 2019), and Shea (2002) proposes that cultural values may discourage disclosure of suicidal ideation or behavior, given that suicidality is seen in some cultures as being sinful, taboo, or a sign of weakness.

Other hurdles are present during the in-person risk assessment process. Even when disclosed, information provided by the client can often be ambiguous, and it may be difficult to identify the appropriate suicide risk level. Accurate risk assessment is contingent upon multiple factors, such as clinician competency, and the ability to discern level of intent based on information provided by the client (Harrison, Stritzke, Fay, & Hudaib, 2018), as well as varying psychometric properties of any formal assessment measures used in the process (Chan, Bhatti, Meader, Stockton, Evans, O'Connor, & Kendall, 2016).

There are also barriers to effective in-person intervention with a patient determined to be at risk for suicide. For example, researchers have demonstrated that a psychologist's response to a given safety risk situation is often heavily influenced by factors such as fear of losing their client to suicide, or, conversely, a fear misusing clinical resources or damaging rapport by depriving a client of their rights (Bryan & Rudd, 2006). Furthermore, Thelen, Rodriguez, & Sprengelmeyer (1994) found that, when

navigating issues related to the breach of confidentiality (as sometimes is necessary to safeguard a suicidal client), psychologists often reference their own "personal code" when making these decisions. This self-reference standard may be partly responsible for differences between psychologists in how they weigh the importance of confidentiality, their beliefs about the risks and benefits of informing clients of the limits of confidentiality, and their actual decisions to breach confidentiality. However, this study also found that, despite these differences, most psychologists did not significantly differ in their actual knowledge of the relevant ethical principles.

Many of the factors that influence client disclosure of suicidality, accurate risk assessment, and effective intervention outlined above are specific to face-to-face psychotherapeutic environments. However, despite efforts to consider these factors and refine in-person risk assessment and management, an alarmingly high number of clients attempt suicide, even after explicit denial of any suicidal ideation during a risk assessment (Busch, Fawcett, & Jacobs, 2003). The grave statistics regarding suicide attempts and completions in the U.S., the mental health professionals' ethical, legal, and clinical responsibilities to prevent such tragedies, the barriers to in-person assessment and management of risk, and the recent research reports that suicide risk assessment and intervention may be enhanced when supplemented with online resources provide support for the recommendation that researchers and clinicians explore the use of patients' digital information to enhance care. The next two sections below outline the information potentially available on SM regarding patients' risk status, and the specific ethical implications of clinicians' use of that information to assess and manage suicidal patients.

Clients' Expressions of Suicidality on Social Media

Psychology's increasing presence on the internet and SM undoubtedly represents a positive step toward blending the in-person and digital social worlds to make effective mental health information and services more flexible and deliverable for therapists, safer and more accessible for clients, and overall more adapted to this digital age. Still, in addressing the association between SM and suicidality disclosure, there are gaps in both the research and the clinical implications of this relationship. However, given that SM is a primary way that individuals share and discuss their experiences, researchers have begun to further investigate the role of SM in individuals' willingness to disclose that they are suicidal, as well as how they make the decision to disclose.

To this end, the expression and detection of suicidal ideation and behavior on SM has evolved into a leading area of research in suicide prevention (Vioulés, Moulahi, & Bringay, 2017). Numerous studies have demonstrated that, in the face of social stigma related to the disclosure of mental health struggles, even in a professional environment, people are increasingly using online platforms, like SM, to discuss their struggles (De Choudhury, Gamon, Counts, & Horvitz, 2013; Moreno, Jelenchick, Egan, Cox, Young, Gannon, & Becker, 2011). De Choudery et al. (2013) also found that the current knowledge surrounding the indicators and detection of depression, a symptom often associated with suicidal ideation and behavior, also translate to online environments. For example, depressed individuals use SM later at night, use more first-person pronouns, and interact less with other people online (De Choudery et al., 2013). There have also been many social computing and linguistic studies that have attempted to examine language patterns in the online profiles of individuals who are suicidal (Gunn & Lester,

2012; De Choudery et al., 2013; De Choudery, Kiciman, Dredze, Coppersmith, & Kumar, 2016). Furthermore, by using artificial intelligence in the form of machine learning and natural language processing, researchers have attempted to draw on these findings to describe and construct algorithmic models that can estimate level of suicide risk in individuals based on their SM language, and even identify individuals who may become at risk in the future (Coppersmith, Leary, Crutchley, & Fine, 2018).

One theory offered to explain why SM may facilitate disclosure of suicidality is rooted in traditional psychoanalytic theory. A central tenet of psychoanalysis is that the therapist should act as a "blank slate" -- that is, the therapist should attempt to suppress any facial expressions or body language in order to allow their clients to express themselves without fear of reaction or judgment from the therapist. In his classic article on the "Online Disinhibition Effect," Suler (2004) conceptualizes the blank slate as a form of "invisibility," which is one of the six factors that he describes as facilitating online communicative patterns. In other words, the social dynamics of online environments and the lack of immediate physical cues that indicate that the communicator is “visible” and another is receiving the information enhances individuals’ tendencies to share their innermost experiences.

Suler delineates other factors in addition to invisibility that lead to the disinhibition of online disclosures. "Minimization of authority" refers to the erosion of indicators of authority in online environments, which, again, allows people to express themselves without being intimidated by authority that might otherwise be present in face-to-face interactions.

Suler also states that the online experience can facilitate a feeling of escapism, since the "normal" rules of social interactions either do not apply or are significantly altered in online environments. Instead of seeing online interactions as an extension of face-to-face interactions, people can compartmentalize these different social domains, which can lead to increased disinhibition online; he labels this factor as "dissociative imagination."

"Dissociative anonymity" refers to the safety people feel to express themselves when they are able to remain anonymous on the internet. Further, the term "asynchronicity" is used to describe the fact that online interactions usually do not take place in real time, thus allowing people to post content without immediately seeing or feeling others' reactions to their posts. Finally, other individuals on the internet can become part of our own "psychic world"; in the absence of face-to-face cues, individuals read others' online content in their own heads, with their own voices. One's personal needs, desires, and biases influence how they experience others' online content, which can make others more familiar and comfortable to interact and share with; Suler (2004) labeled this factor "solipsistic introjection."

Suler's Online Disinhibition Effect (2004) provides some theoretical insight into why the social dynamics of online environments and SM may ease peoples' disclosure of suicidality. According to Suler (2004), these six factors refer to distinct characteristics of online communication that lead to behavioral disinhibition and a decreased consideration of social ramifications of personal disclosure. Though some of these factors may be more relevant than others to the understanding of SM disclosures, taken together, they can be conceptualized as a collection of social dynamics unique to the online environment that

loosen social conventions or constraints, and, thus, allow people to express themselves more freely. Considering the level of social stigma related to the expression of suicidality and the seeking out of mental health resources, as well as the role of stigma as a significant cultural barrier to suicide prevention (Keller et al., 2019), these factors make apparent the function that online environments may play in individuals' expression of suicidality on SM.

Ethical Implications of Digital Suicide Risk Assessment and Intervention for Psychologists

Researchers have begun to examine therapists' engagement in various online behaviors, both personally and related to their work with clients in crisis and non-crisis situations, as well as the clinical and ethical implications of such behaviors (Kolmes & Taube, 2014; Tunick, Mednick, & Conroy, 2011; Zur & Zur, 2011; Lehavot, Barnett, & Power, 2010;). However, there are, to date, no reports of research specifically designed to examine the use of client digital information to inform suicide risk-related assessment and intervention. Furthermore, while other mental health professional organizations (e.g., NASW and ACA) have included in their codes of ethics specific standards relevant to their digital behaviors, the Ethical Principles of Psychologists and Code of Conduct (APA, 2017) has not yet been modified to include such standards to guide psychologists' digital conduct. As such, psychologists must rely on APA's more general aspirational ethical principles and guidelines, as well as ethical standards presented by other mental health professions to inform such conduct. The next section will detail and discuss the implications of the following for digital suicide risk assessment and intervention: (1)

APA general ethical principles of Beneficence and Nonmaleficence, Fidelity and Responsibility, Integrity, Justice, and Respect for People's Rights and Dignity (APA, 2017); (2) APA Guidelines for the Practice of Telepsychology (APA, 2013); (3) specific relevant standards from the ethics codes of the National Association of Social Workers (NASW, 2017) and the American Counseling Association (ACA, 2014), and 4) aspirational guidelines from the American Psychiatric Association (ApA, 2016) and forensic psychologists.

APA General Ethical Principles

As discussed above regarding in-person suicide assessment and intervention, psychologists' decisions regarding engagement in digital suicide risk assessment and/or intervention may be similarly guided by the APA's aspirational ethical principles of Beneficence and Nonmaleficence, Fidelity and Responsibility, Integrity, Justice, and Respect for People's Rights and Dignity. However, there are some additional implications of the general principles raised by accessing and using clients' SM to assess and intervene in the context of suicide risk.

First, with regard to the general principle of Beneficence and Nonmaleficence, the potential of acquiring additional information by accessing clients' SM that may inform the clinician's assessment and management of suicide risk certainly upholds the professional's ethical responsibility to safeguard the welfare of the client. Second, the mandates to establish and maintain relationships of trust with clients, to promote accuracy, honesty, and truthfulness in the practice of psychology, and to ensure client self-determination that are captured by the ethical principles of Fidelity and

Responsibility, Integrity, and Respect for People's Rights and Dignity carry implications for the importance of fully informing the client regarding the practice of accessing SM in the context of suicide risk. Kaslow, Patterson, & Gottlieb (2011) explored some special considerations for the informed consent process in the context of psychologists' professional use of digital resources. Their discussion highlighted the importance of explicitly addressing the therapist's digital practices during the informed consent process with clients. The authors noted, however, the inclusion of these potential digital boundary crossings in the informed consent process does not preclude such crossings from being professionally unsound and potentially damaging to the therapeutic alliance for individual clients. Therefore, including issues related to psychologists' digital presence, especially in the context of safety risk, should be approached proactively and intentionally, with the overall goal of doing everything possible to maintain the trust and respect the rights of each individual client, rather than with the goal of meeting minimum professional requirements. To this end, an informed consent document that thoroughly addresses issues related to client SM access would include, but is not limited to, the professional rationale for conducting a client SM search, specifying what types of situations may indicate a SM-informed risk assessment or digital welfare check, what SM platforms and features of those platforms the therapist would attempt to use, whether or not the therapist uses a personal or professional SM profile to conduct the check, the scope of the online access, how the therapist would determine when they have obtained sufficient information to end the access, how the information obtained may be acted upon, and how the client may be informed of the access process and outcome. Clients also must be made fully aware of the risks and benefits of an appropriately conducted

SM-informed risk assessment or digital welfare check. Finally, the client must have the right to deny the psychologist access to their SM page, even if there is a safety concern.

Further, the general principle of Justice in the context of a SM-informed risk assessment or digital welfare checks becomes relevant in two ways. First, it is not possible for a clinician to filter a client's SM page only for information relevant to the purpose of the check. Therefore, it is virtually guaranteed that the clinician will encounter information about their client that the client did not disclose in person and is irrelevant to client safety. Seeing, interacting with, or using this information may not only lead to a violation of client privacy, but also the discovery of elements of the client's social life or personal identity that may lead to the development of new biases. For example, research suggests that psychotherapy has become increasingly "value-laden," which can lead to therapists' social and political views (and their congruence or incongruence with that of their client) influencing diagnosis, intervention, and treatment (Woolfolk, 1998). Therefore, it is important for any clinician conducting a SM-informed risk assessment or a digital welfare check to maintain awareness of and address any biases or countertransference reactions that may arise during or after the check.

The principle of Justice also requires psychologists to practice in accordance with their level of competency and limitations of their expertise (APA, 2017). Given that SM is a relatively new and ever-evolving social environment, there may be a learning curve for some therapists in how to access and navigate these sites. The digital realm may also consist of abbreviations, acronyms, slang terms, and other patterns of communication that may be more difficult to understand and derive relevant clinical information from, compared to traditional therapeutic interactions. In order to mitigate this, psychologists

who wish to conduct SM-informed risk assessments or digital welfare checks need to have an adequate understanding of how online and in-person communication may differ, and should strive to maintain a certain level of digital literacy and skill.

Finally, the general principle of Respect for People's Rights and Dignity carries unique implications for the protection of the client's privacy and confidentiality in the context of accessing client SM information online. SM-informed risk assessment and digital welfare checks each potentially provide the clinician with crucial information that is less likely to involve the release of confidential information to others (e.g., the police or family members). There is, however, also the consideration noted above that the clinician, while accessing a client's SM for information relevant to risk assessment and/or intervention, may come across other information about the client that the client has not shared in session. In addition to dealing with any potential countertransferential reactions or triggered biases, the clinician must also be clear with the client about the possibility of accessing such information, and whether and how the clinician will bring the discovery into session for future discussion.

It is also important to note that the general principle of Respect for Peoples' Rights and Dignity stipulates that "special safeguards may be necessary to protect the rights and welfare of persons….whose vulnerabilities impair autonomous decision making" (APA, 2017, p. 5). Suicidal patients are often seriously depressed, psychotic, and/or under the influence of substances and, arguably, are suffering from diminished abilities to make rational decisions. The clinician must determine the level of suicide risk, including the client's level of impulsivity and/or diminished cognitive functioning. And, in addition to the technical and interpersonal skills required to discern suicide risk

level in clients, risk situations also involve choosing or not choosing to take protective action based on that level of risk; they must determine whether additional safeguards that require an imposition on the client's self-determination and/or a breach of confidentiality or violation of privacy is necessary for a client's protection. Increasing the amount of risk-relevant information through accessing the client's SM information potentially can improve risk assessment procedures. In turn, more accurate risk assessment can enhance subsequent risk-related treatment decisions, and the decisions are more likely to be centered around objective data. Therefore, the decision will be less likely to impose unnecessarily on the client's self-determination regarding intervention options.

APA Guidelines for the Practice of Telepsychology

The APA's Guidelines for the Practice of Telepsychology (APA, 2013) contain guidance that can reasonably be applied to the potential acquisition and use of client SM to mitigate suicide risk. The Guidelines state that psychologists should strive to maintain ethical and professional standards of care while providing teletherapy (APA, 2013). This would include determining the appropriateness or utility of teletherapy with a given client, continuously evaluating the safety and efficacy of teletherapy with that client, and considering relevant demographic and cultural factors that may impact the efficacy of teletherapy. The APA also states that informed consent must specifically address unique concerns related to the provision of teletherapy, and abide by applicable national or statewide laws. This would include explicitly addressing with the client the risks and benefits of using teletherapy. These guidelines can be informative for the identification of ethical concerns and the development of future ethical standards related to expanding

psychological services in the digital sphere. For example, in applying the teletherapy guidelines to the potential use of client SM to preserve safety, it would need to be clinically justified to do so, based on factors like client demographics, level of risk, and the nature of the specific situation.

Ethical Standards of Other Mental Health Professions

The National Association of Social Workers (NASW) has published a handbook titled "Technology in Social Work Practice," which provides standards related to a wide range of topics relevant to the professional and ethical practice of Social Work in the digital sphere (NASW, 2017). Some of these standards may be of particular relevance when they are applied to SM-informed risk assessment or digital welfare checks. For example, Standard 2.10 specifically states that social workers should provide their clients with a social media policy in order to maintain clear boundaries and protect private information. Clinicians uphold this standard by clearly outlining the difference between clinical and personal usage of social media, and the different rules and boundaries that apply to each. Standard 2.05 states that social workers should actively assess for how their clients use social media, meaning that therapists who wish to incorporate SM-informed risk assessment or digital welfare checks into their practice should attempt to identify the clinical utility of their client's SM page, ideally before any check is conducted. Standard 3.06 requires social workers to take measures to ensure the credibility and accuracy of any information obtained online. This standard then implies that therapists should discuss with and confirm information retrieved from a clients' SM page with the client. The NASW also specifically addresses the gathering of client

information online using search engines, stating in Standard 3.09 that using online sources to gather information on a client should only be done for "compelling professional reasons," and with the client's consent (NASW, 2017).

The American Counseling Association also added a section to their ethics code (ACA, 2014) that outlines specific ethical standards related to the practice of counseling in the digital sphere. These standards address multiple aspects of counselors' online presence, both professionally and personally. For example, standard H.1. (p. 17) specifically requires counselors "who engage in the use of technology and/or social media [to] develop knowledge and skills regarding related technical, ethical, and legal considerations." Standard H.2. (p. 17) discusses special considerations for informed consent related to the digital practice of counseling, explicitly stating that clients reserve the right to choose whether technology is incorporated into their counseling. More specific to the mitigation of risk through SM, standard H.6.b. requires counselors to discuss with their clients the benefits, limitations, and boundaries of their SM use (p. 18), while standard H.6.c. requires counselors to respect the online privacy of their clients, except in situations where the client has given consent to review their SM profiles.

The American Psychiatric Association (ApA) also provided similar guidelines in 2016. For example, the ApA's Ethics Committee recommends that online searches of clients only be conducted after obtaining the client's informed consent, "except in emergencies" (Dike, Candilis, Kocsis, Sidhu, & Recupero, 2019). The committee also has called upon psychiatrists to maintain awareness of any personal motivations they may have in conducting a client search. Also recommended is the sensitive handling of any

private information gathered during an online search of a client, as well as careful consideration of any potential influence that a client search may have on rapport.

Of particular relevance to SM-informed risk assessment and digital welfare checks is the American Psychiatric Association's recommendation that information gathered online, when interpreted cautiously, may be informative in forensic situations. Indeed, forensic psychologists have also examined numerous ethical implications of utilizing SM data to inform treatment decisions. There appears to be a consensus among forensic psychologists that gathering information on a client from an online source is appropriate under certain conditions, and even a standard of practice (Griffith, 2018).

In summary, psychologists have yet to develop specific ethical standards related to their general digital presence, and more specifically regarding using SM to augment assessment and interventions with clients at risk for suicide. However, there is ethical guidance available for psychologists to thoughtfully develop approaches to the appropriate use of client SM that strike a balance between professional ethical and legal responsibility to clients and clinical utility. There is potentially much to be gained from suicide risk assessment and management using client SM.

Potential Benefits of Social Media-Informed Risk Assessment and Digital Welfare Checks

The designation of suicide as a public health crisis has substantially affected how suicide is approached by researchers and clinicians. Specifically, primary prevention has become a main focus in suicide prevention. Public health officials, clinicians, and legislators have adopted a more proactive, population-focused approach to addressing

suicide and suicide risk through assessing both proximal and distal risk factors. (CDC, 2019). Part of this ideological shift involves an increased effort by professionals to identify and mitigate risk early on in at-risk individuals. Expanding the way in which relevant information for at-risk individuals is obtained and used represents a potential next step in achieving this goal. In an era where digital platforms are at the forefront of human interaction and expression, the utilization of client information obtained by clinicians via SM, when guided by ethical, legal, and clinical standards of care, may lead to improvement in how mental health professionals identify suicide risk and undertake risk-related treatment interventions. Thus, the task for mental health researchers and clinicians is to identify ways that SM can be ethically drawn upon to inform clinical decisions in situations where the client's safety may be at risk. Specifically, because of the unique role that SM may play in freeing people up to disclose their innermost struggles, the clinician may be remiss not to consider the potentially valuable, and conventionally untapped, information available for accurate suicide risk assessment and effective prevention. Two possible novel methods of assessment and intervention involving SM include: (1) a "SM-informed risk assessment," where clinicians use information on clients' SM profiles to inform risk level and (2) a "digital welfare check," whereby clinicians gain access to and use information found on an at-risk individuals' SM page in order to determine whether additional safety interventions are clinically indicated.

Social Media-Informed Risk Assessment

Identification of suicide risk is a complex process that requires professional judgment, and is subject to error in both the identification of the risk level itself, and

subsequent clinical decisions based on that risk. For example, current research suggests that clinicians tend to err on the side of caution when conducting risk assessments (Bongar & Sullivan, 2013), which may lead to inaccurate appraisals of risk and unnecessary hospitalizations. Given that suicide prevention is a cornerstone of mental health care, psychologists should always be striving to refine the risk assessment process by considering alternative or supplemental approaches to risk assessment. The use of SM as an additional resource of information related to suicide risk may represent such an approach. If a client consents, and understands what kind of information the clinician is seeking and accessing, a focused review of the client's SM profile may reveal information that can be helpful in making an accurate determination of risk level, such as language or media indicative of a suicide plan or intent. Conversely, a SM-informed risk assessment may provide evidence of strong social support for the client, a protective factor against suicide.

If conducted in a manner that is aligned with ethical principles and applicable legal statutes, there may be some potential benefits to psychologists accessing clients' SM profiles. Given the evidence that suggests that some clients do attempt suicide, despite explicit denial of suicidal ideation during a risk assessment, there is a need for refining, modifying, or potentially expanding risk assessment procedures. This is the first potential benefit of accessing a client's SM; with the addition of information from SM may come an increase in the accuracy of risk assessments and, thus, the determination of interventions that are appropriate for the situation, minimizing risk to both the client and the clinician. For example, information derived from a SM-informed risk assessment conducted on a client with an ambiguous level of risk may reveal that they have access to

lethal means, or that they have articulated a suicide plan online. Conversely, the SM information may reveal strong social support for the client or the client's frequent engagement in pleasant activities.

Digital Welfare Checks

In an effort to make suicide-preventative treatment decisions that are both clinically indicated and ethically justified, a digital welfare check is another specific type of SM access that may also be beneficial in situations where the client has already been determined to be at high-risk, and there is legitimate concern for the immediate safety of that client. A "digital welfare check" is conducted by clinicians who gain access to and use information found on an at-risk individuals' SM page in order to determine whether additional safety interventions are clinically indicated. A digital welfare check resembles an in-person welfare check, which is an established protective measure available to psychologists when there is sufficient concern for the client's immediate safety, but the client cannot be reached. During a welfare check, the psychologist informs authorities (e.g., the police or emergency response team) of their concern for their client's safety, and provides identifiable information in order for the authorities to physically check in on the client, typically at their residence. The authorities then respond to the client's home to ensure that they are safe, and report back to the therapist.

Though the goal of a digital welfare check closely resembles that of a traditional welfare check—to gather information that informs risk level and ensure the safety of the individual—a key part of an in-person welfare check is that it necessitates a breach of confidentiality. If a clinician contacts the authorities and asks for a welfare check to be

conducted on one of their clients, the clinician is required to provide identifying information on their client, their physical location, and the reason for requesting the welfare check. A digital welfare check represents an intermediate step in ensuring client safety by obtaining potentially relevant information, without a breach of confidentiality to another person. As previously discussed, a breach of confidentiality to ensure client safety creates a tension between the ethical principles of Beneficence and Nonmaleficence, and Respect for Peoples' Rights and Dignity, that may disrupt the therapeutic alliance and subject the clinician to ethical and professional scrutiny. For example, if a high-risk client does not show up for an appointed therapy session and cannot be reached by the therapist on the phone, or via text or email (and there is prior consent to having their SM profile checked if there is a safety concern), a digital welfare check may reveal an innocuous reason for the no-show, such as a spontaneous vacation or another medical appointment. In this case, the clinician would be able to obtain relevant information regarding the client that indicates that no further action would be warranted, and the information was obtained without any breach of confidentiality, and under conditions that were previously agreed upon by the clinician and client. Conversely, if a client does not show up for a therapy session and cannot be reached, and the psychologist discovers disclosures or other information suggesting suicidal intent or behavior during the digital welfare check, further protective measures would then be clinically indicated, which would justify the breach of confidentiality inherent in a traditional safety check.

It is also worth noting that involuntary hospitalization can damage rapport and leave clients with a decreased sense of control over their lives (Katsakou & Priebe, 2007),

and can actually have deleterious effects on the emotional and cognitive functioning of people with severe mental illness (Rüsch, Müller, Lay, Corrigan, Zahn, Schönenberger, Bleiker, Lengler, Blank, & Rössler, 2013). Given these findings, psychologists should be striving to reserve psychiatric hospitalization for only the most urgent situations, and a digital welfare check may help clinicians in determining whether involuntary hospitalization is necessary for a client's safety. Finally, there are documented incidents of officer-related homicides occurring during welfare checks, especially involving individuals who are severely mentally ill or are a danger to self or others (CNN, 2019). A digital welfare check may help in avoiding such tragic outcomes.

Research Regarding Therapist Access and Use of Client Social Media Information

Therapist access and use of client SM information represent a potential new useful approach to suicide risk-assessment and intervention that can promote the clinician's ethical duty to protect clients and sustain the patient's privacy, confidentiality, self-determination, and trust. There is, unfortunately, a paucity of research literature regarding clinicians' access and use of their clients' SM profiles specifically for the assessment and prevention of suicide. However, several researchers have examined the frequencies with which clinicians conduct client searches online for other reasons and the outcomes of those searches. Furthermore, some researchers have attempted to identify clinician characteristics that are associated with therapist engagement in these online behaviors.

Online Client Searches: Frequencies, Reasons, and Disclosures to Clients

One recent survey study of 130 psychologists reported that 41.2% of therapist participants engaged in adult patient-targeted online searches at least "rarely" (Wu & Sonne, 2019). Similarly, Eichenberg & Herzberg (2016) reported that nearly 40% of the 207 therapists they surveyed acknowledged searching online for information about their clients, and two-thirds of those clinicians indicated that such conduct could benefit treatment.

Kolmes and Taube (2014) found that 48% of their 227 mental health professionals or professionals in training reported intentionally seeking information online about current clients in a noncrisis situation without the client's awareness; 81% did so to find information related to treatment or verification of information shared in the therapy session. The authors also reported that all searches among the 8% of participants who searched online for client information during a crisis were related to client safety or location. Of those respondents, more than half (53%) indicated that they found the information found was useful in resolving the crisis.

Ginory, Sabatier, & Eth (2012) surveyed 187 psychiatry residents recruited from the American Psychiatric Association and found that 18% acknowledged accessing client profiles on Facebook. Among the reasons given for the searches were checking on a client who had missed sessions and looking for evidence of suicidal ideation. And, Lehavot et al. (2010) found that 27% of the psychologists and therapists in training had searched the internet for information about their clients. Reporting a much higher percentage, DiLillo & Gale (2010) reported that 89% of the U.S. and Canadian doctoral students they surveyed had sought information about clients at least once in the last year.

Another early survey study of 246 psychologists and psychologists-in-training working with younger clients found that 32% of respondents reported accessing a client's online profile (Tunick et al., 2011). The authors also found that the respondents who did endorse conducting client online searches did so for various reasons. Notably, the largest proportion of respondents who endorsed searching for clients online did so out of therapeutic concern (41%). Furthermore, some respondents indicated that they indeed discovered information indicative of suicidal ideation on their clients' online profiles. Conversely, of the respondents who indicated that they have never engaged in online client searches, 29% reported that there has never been a need for them to do so, and 63% stated that they felt online client searches fell outside of appropriate therapeutic boundaries.

Tunick et al. (2011) also found that there were differences among respondents who endorsed conducting online client searches regarding how they navigated the situation with their clients. Approximately, 20% of these respondents conducted the search without explicit permission from their client, but did inform them that a search was conducted; 40% asked permission from their client to conduct the search prior to doing so; 22% reported that their decision to obtain client permission before conducting the search depended on the situation; and 18% did not ask for permission, nor inform their client that a search was conducted.

Though Tunick et al. (2011) did not specifically report how many respondents discovered suicidal content on their clients' pages and whether that content was discovered with or without client permission to conduct the search, the authors did find that suicidal content was indeed among the concerning content discovered by some of

these respondents. Furthermore, the authors found a significant correlation between the discovery of concerning online content, and the addressing of those concerns in face-to-face therapy sessions (Tunick et al., 2011). Therefore, like the respondents in the Kolmes & Taube (2014) study, many of those therapists who did discover suicidal content on their clients' SM found the information relevant and helpful in their efforts to safeguard the clients' welfare.

Therapist Characteristics Affecting Willingness to Conduct Online Client Searches

The studies cited above demonstrate heterogeneity among clinicians regarding their decisions to conduct online client searches, their reasons for doing so, how they used the information, and how they approached the issue with their clients. Some preliminary research has examined whether certain clinician characteristics, like therapist age, gender, and theoretical orientation, may explain some of that variance. However, to date, there is no research that has examined the degree to which therapists rely on each of the five APA general principles to guide decisions related to whether or not to conduct an online search; however, there is significant literature that suggests that psychologists' relative allegiance to each general ethical principle may too be a significant predictor of certain online behaviors, especially in the context of client safety risk.

Therapist Age

A German study found no significant effect of therapist age for the prediction of those who did vs. did not conduct online client searches (Eichenberg & Herzberg, 2016). Similarly, Kolmes & Taube (2014) found no significant age effects in their survey of

practicing clinicians and clinicians in training. In contrast, Jent, Eaton, Merrick, Englebert, Dandes, Chapman, & Hershorin (2011) surveyed behavioral health faculty and trainees regarding their accessing and use of client SM accounts and found that only trainees endorsed conducting an online client search. The authors posited that their result was likely due to the trainees' status as "digital natives," defined as younger individuals "whose online presence began primarily as a social one," and who were "born during or after the introduction of digital technology," (Jent, et al., 2011). The authors argued that a digital native is more likely to have been exposed to the complex culture and communicative patterns of SM sites, and this increased exposure could lead to more experiences in which they see a blending or overlap of peoples' online and offline selves. Therefore, digital native clinicians may be more likely to view SM as an accessible and valid indicator of their clients' current mental health and psychosocial functioning. The researchers' reasoning may explain the higher frequency of engagement in accessing client online information reported by DiLillo & Gale (2011) who surveyed a large group of doctoral students. Though the actual dynamics of online communication may differ from those found in face-to-face interactions (Suler, 2004), the notion shared among digital natives that SM can act as an available and valid resource for relevant clinical information is at least partially supported by numerous studies that suggest that peoples' online profiles represent an extension of their internal and social selves, rather than a compartmentalized or distinct version of either (Moreno et al., 2011; Gunn & Lester, 2012; De Choudhury et al., 2013; Coppersmith & Kumar, 2016; Coppersmith et al., 2018).

Therapist Gender

Survey studies by Eichenberg & Herzberg (2016) and Kolmes & Taube (2014) failed to find a significant effect of therapist gender on the frequency of searches for online client information. However, Wu and Sonne (2019) found that male therapists were likely to endorse less engagement in patient-targeted searches than did female therapists.

Therapist Theoretical Orientation

The effects of theoretical orientation on clinician online behaviors has also been examined; results have varied. For example, Wu & Sonne (2019) found no significant relationship between theoretical orientation and actual engagement in online client searches. However, Kolmes & Taube (2014) found that their therapist respondents with a CBT theoretical orientation were significantly less likely to intentionally search for client information on the internet than were respondents who self-identified as psychodynamic or integrative. Interestingly, although Eichenberg & Herzberg (2016) did not find that the therapists' theoretical orientation predicted actual behavior, they did report that therapists trained in psychodynamic or psychoanalytic therapy significantly more often perceived the behavior as unjustifiable in all situations.

Suler (2004) provides a rationale for the prediction that psychoanalytic therapists would perceive online client searches as unjustifiable and be less likely to engage in the conduct. Specifically, Suler states that online environments may facilitate what Ziv-Beiman (2013) describes as an "interpersonal void," similar to that which Freud argued should be characteristic of the analytic space, in order to facilitate the emergence of

unconscious conflicts and transferential projections (Strachey & Freud, 1957). In applying these arguments and concepts to how we currently approach psychological practice in the digital sphere, it may be that psychoanalytic/psychodynamic therapists' reluctance to self-disclose in in-person psychotherapy would extend to online behaviors that they might regard as contaminating the therapeutic relationship. In other words, psychoanalytic/psychodynamic therapists may be more ethically and interpersonally conservative than therapists of other orientations in how they conceptualize and navigate boundary issues related to clinical practice in the digital sphere. Thus, they may be less likely to use SM checks as a safety measure for at-risk clients (though they would conceivably avoid doing so based more on clinical reasons than ethical ones).

Therapist Reliance on General Ethical Principles

As previously discussed, the relative weighing of general ethical principles is inherent to navigating ethical dilemmas, like those inherent in suicide risk assessment and management. Research is sparse regarding trends in if or how American psychologists subjectively rank the general ethical principles, and the level to which those ethical rankings influence ethical decision-making. However, ranking of ethical principles is not only addressed in Canadian research; it is an instrumental part of their approach to developing their current ethics code. The Canadian Psychological Association's (CPA) approach to ethics is based on a consensus among Canadian psychologists that certain ethical principles are more important than others, and should be more heavily weighed during ethical decision-making (Sinclair, Poizner, Gilmour-Barrett, & Randall, 1987). The CPA has responded to this "collective wisdom" not only by including ethical

principles and standards based on how Canadian psychologists navigate ethical dilemmas, but also by embedding a rank of those principles into the Canadian Code of Ethics for Psychologists to guide decision-making (CCEP; CPA, 2000). The CCEP, which is widely regarded as one of the best and most influential ethics codes in the world (Hadjistavropoulos, 2011), presents the following rank order of their ethical principles (in descending order): Respect for the Dignity of Persons, Responsible Caring, Integrity in Relationships, Responsibility to Society.

An important part of these rankings is that they are based directly on responses from a sample of psychologists who indicated how they navigated certain situations where ethics were of concern (Sinclair et al., 1987); therefore, at the time of its publication, the ranking of the ethical principles were an accurate representation of general trends found in Canadian psychologists' actual ethical attitudes and decisions. Notably, research on the usefulness of a hierarchical ethics system remains limited, though there is some level of theoretical and empirical support for this system (Williams, Hadjistavropoulos, Malloy, Gagnon, Sharpe, & Fuchs-Lachelle, 2002). However, it is still unclear whether this ethical system results in increased consistency of ethical decision-making (Hadjistavropoulos, 2011), most likely because research indicates that Canadian psychologists' ethical decision-making is guided by both the ranking itself, and by contextual factors (Seitz & O'neill, 1996). Still, this approach to developing the CCEP was rooted in the goal of increasing consistency in ethical decision-making, especially in the case of ethical dilemmas (Hadjistavropoulos & Malloy, 2000).

The development of the APA ethics code followed a similar procedure to that of the CCEP, in that it was developed using qualitative data on how American psychologists

commonly make decisions with ethical considerations. However, the APA has not yet included a rank of its general principles. Therefore, in the absence of clear ethical standards or a ranking of general principles, clinicians often make ethical decisions in accordance with their own personal code (Thelen et al., 1994), which can be influenced by factors like seeking pleasure and avoiding pain for oneself, perceptions of others' values, potential consequences of a particular decision, and transrational factors like "gut-feeling" (Hodgkinson, 1996).

Though the study was conducted using the 1992 version of the APA ethics code, Canadian researchers Hadjistavropoulos & Malloy (1999) attempted to construct a theoretically-based ranking of the APA's general ethical principles by applying Hodgkinson's (1996) theoretical framework of morality, which aims to draw a distinction between what is morally "good" and morally "right," and further distinguishes among various "levels" of moral reasoning. The first level is preference, which essentially refers to the deciding party's personal moral values. The next level is consensus; moral and ethical decisions are evaluated and made based on whether the decision would reasonably line up with the majority. The third level is consequence, which takes a pragmatic approach to evaluating potential solutions to nomothetic problems, rather than individual ones. For example, a decision may be made based on the fact that it would benefit the field of psychology as a whole. The highest level of moral reasoning is principle, which can be understood as the collectively shared, internal "compass" of morality that encapsulates values and social conventions largely shared across peoples and cultures.

The authors also incorporated the concept of moral intensity (Jones, 1991) into their rankings in an effort to identify different dimensions of a situation that people may

draw upon to make moral and ethical decisions. For example, Jones identifies *magnitude of consequence* (the sum of the good or bad that would come from a particular decision), *probability of effect* (the likelihood of a good or bad effect coming from a particular decision), and *temporal immediacy* (the temporal urgency of the situation) as three of the main factors that influence peoples' decision-making. Of note, these are the three dimensions of his framework that are the most relevant in terms of clinicians' decisions regarding preserving client safety/privacy. For example, magnitude of consequence is important because a misstep in navigating client risk could result in the client dying by suicide (or a complete rupture in rapport). Probability of effect is important because ethical dilemmas require one to take the course of action that is most probable to have "good" results for the client (though the clinician's and client's idea of what is “good” may vary). Temporal immediacy is important because it captures the temporal urgency of risk-related situations and the importance of assessing and resolving the issue quickly.

Based on these two moral frameworks, Hadjistavropoulos & Malloy (1999) classified Respect for People's Rights and Dignity as the most important general principle, followed by (in descending order of importance) Concern for Others' Welfare, Competence, Integrity, Professional and Scientific Responsibility, and Social Responsibility. Despite the differences between the APA ethics code and the CCEP, as well as differences between general ethical principles found in each version of the APA ethics code, these findings support the presence of a somewhat uniform ranking of general ethical principles among Canadian and American psychologists. Furthermore, since the old principle of Concern for Others' Welfare most closely resembles the current general principle of Beneficence and Nonmaleficence, these findings highlight that the

two principles most commonly regarded as the most important are indeed the two ethical principles involved in the primary ethical dilemma related to preservation of client safety.

These studies are representative of an approach taken by some in field of psychology to identify the importance of each of the general ethical principles, in an effort to provide a guide to streamlined ethical decision-making. Less is known, however, about the extent to which reliance on each of the principles impacts ethical decision-making. One study (Patel & Sonne, 2020) examined the relationship between licensed clinicians' ranking of the APA general ethical principles, and their ability to recognize a potential nonsexual multiple relationship with a current client presented in a vignette. The authors asked participants to rank seven ethical principles from least important to most important in the process of their ethical decision-making in general: Beneficence, Nonmaleficence, Respecting Patient Rights and Dignity, Justice, Integrity, Individual Responsibility, and Professional and Scientific Responsibility to Society. Though the researchers found no relationship between participants' differential reliance on these ethical principles and their ability to detect a potential nonsexual multiple relationship, approximately one-third of the psychologists (32%) identified Nonmaleficence as the ethical principle on which they had the greatest reliance, followed by (in descending order): Integrity (18.2%), Beneficence (16.4%), Respecting Patient Rights and Dignity (13.4%), Professional and Scientific Responsibility to Society (7.4%), Individual Responsibility (5.9%), and Justice (1.1%; Patel & Sonne, 2019).

These findings, along with the findings from Hadjistavropoulos & Malloy (1999), suggest that Beneficence and Nonmaleficence and Respect for Peoples' Rights and Dignity (autonomy) are among the most important general ethical principles for both

Canadian and American psychologists in their clinical work. As previously discussed, these two principles are central to the most pressing ethical dilemma associated with preservation of client safety in high risk situations.

Rationale of Current Research and Hypotheses

There is a growing body of research that has examined therapists' willingness to intentionally access client online information, their reasons for doing so, how th use the information, whether they disclose their behaviors to their clients, and the outcomes of their conduct. There are also some findings that help to explain the considerable variance among therapists with regard to such behaviors. However, there is very limited research examining clinicians' willingness to access and use client SM material specifically to inform risk-related assessment and intervention decisions, and none regarding the predictors of doing so.

The present study was conducted in an effort to assess licensed and training psychologists' self-reported probability that they would 1) access and utilize client SM content to inform suicide risk-assessment and 2) conduct a digital welfare check when there is reasonable concern for their client's immediate safety. The likelihood of therapist engagement in these two behaviors was based on participant responses to two separate vignettes. Each vignette described a clinical situation in which the participant is asked to assume the role of therapist for a client who poses indications of potential suicide risk. The effects of the following predictors on that likelihood were investigated: participant digital literacy (level of experience and comfort navigating online social environments), professional status (licensed psychologist versus psychologist-in-training), theoretical

orientation, and the degree of reliance on each of the APA general ethical principles when responding to each vignette. The first two predictors (digital literacy and professional status) serve as alternative, and hopefully more explanatory, characteristics for participant age. The findings are discussed in terms of the potential ethical and clinical implications for practitioners and trainees, practice and training recommendations for psychologists, and suggestions for the revision of the APA Ethical Principles for Psychologists and Code of Conduct.

Hypotheses

Given the limited existing research regarding the frequency, reasons, and outcomes of clinicians accessing client online information through SM, as well as some of the therapist factors that predict them, and the relative dearth of research regarding such practices in the specific context of suicide risk, the following hypotheses were offered:

Hypothesis 1

Under the conditions of Vignette A (SM-informed risk assessment), participants as a whole would report being unlikely to conduct a SM-informed risk assessment. That is, 51% or more of all participants will rate their likelihood as 49% or lower. This hypothesis was based on previous research indicating that clinicians are generally reluctant to engage with their clients online for any reason (Kolmes & Taube, 2014; Tunick, Mednick, & Conroy, 2011; Wu & Sonne, 2019), as well as the lack of specific ethical standards for psychologists related to this issue.

Hypothesis 2

Under the conditions of Vignette B, participants as a whole would report a relatively low likelihood of conducting a digital welfare check. Specifically, 51% or more of all participants will rate their likelihood as 49% or lower. The rationale for this hypothesis was the same as hypothesis 1.

Hypothesis 3

There would be a significant difference between participant likelihood to conduct a SM-informed risk assessment and likelihood to conduct a digital welfare check. Specifically, it was hypothesized that participants would report being significantly more likely to conduct a digital welfare check, compared to a SM-informed risk assessment. This hypothesis was based on current ethical principles and standards (APA, 2017) and theoretical frameworks of morality (Jones 1991; Hodgkinson, 1996), that, when applied, suggest that the temporal urgency and potential consequences of a client being in immediate danger may increase the likelihood of the clinician intervening. In the case of a digital welfare check, the clinician already obtained information indicating that the client may be at immediate risk, whereas, in an SM-informed risk assessment, the clinician would access their client's SM profile to help them determine risk level, but without evidence of immediate risk.

Hypothesis 4

There would be an effect of digital literacy on participant likelihood that they would conduct both an SM-informed risk assessment and a digital welfare check. It was expected that the higher a participant rated their digital literacy, the higher their reported likelihood of conducting both forms of SM access would be. Digital literacy represents an elaboration on the concept of digital identity (digital native vs. digital immigrant), in that it aims to capture participants who may have been born or grew up before the mass introduction of social technology, but have since worked to develop their familiarity with and understanding of SM. This hypothesis was informed by research that suggests that digital natives are more likely to be familiar with online cultural norms (Jent et al., 2011; Kolmes & Taube, 2014), and, thus, may be more likely to view SM as an adequately valid resource for risk-related information.

Hypothesis 5

Participant professional status would significantly predict participant likelihood of engaging in both an SM-informed risk assessment and a digital welfare check. Training-level participants would be significantly more likely to conduct both forms of SM access, compared to licensed participants. This hypothesis was based on previous research from Jent et al. (2011) and DiLillo & Gale (2010), which found that training level clinicians are more likely to conduct online client searches.

Hypothesis 6

There would be a significant relationship between the degree of participant identification with each theoretical orientation, and their reported likelihood of engaging in both forms of SM access. Specifically, it was proposed that the more a participant identified as humanistic-experiential, the more likely they would be to conduct both forms of SM access. Conversely, the more a participant identified as psychodynamic/psychoanalytic or CBT, the less likely they would be to conduct both forms of SM access. This hypothesis was informed by core tenants of both psychoanalytic and psychodynamic theory and practice related to avoiding contamination of the therapeutic space with potential boundary crossings, as well as literature suggesting that psychoanalytic/psychodynamic therapists are less likely to engage in behaviors that may constitute a boundary crossing, while humanistic-experiential therapists are more likely to do so (Ziv-Beiman, 2013). Furthermore, this hypothesis was also based on the work of Kolmes & Taube (2014), who found that CBT therapists were less likely to intentionally search for clients online compared to psychodynamic therapists, as well as findings from Eichenberg & Herzberg (2016) that demonstrate that psychoanalytic and psychodynamic therapists were less likely to perceive online client searches as justifiable in any situation than CBT therapists.

Hypothesis 7

There would be a significant effect of the degree to which participants relied on two of the general ethical principles as they considered the vignettes posing a potential for a SM-informed risk assessment and a digital welfare check. Specifically, the higher a

participant rated Beneficence and Nonmaleficence in terms of importance to their decision-making, the more likely they would be to engage in both a SM-informed risk assessment and a digital welfare check. Conversely, the higher a participant ranked Respect for Peoples' Rights and Dignity in terms of importance to their decision-making, the less likely they would be to engage in both a SM-informed risk assessment, and a digital welfare check. It was proposed that there would be no significant effect of level of importance for all other general principles on willingness to engage in both a SM-informed risk assessment and a digital welfare check. These hypotheses were again informed by current ethical standards (APA, 2017), as well as Jones's (1991) and Hodgkinson's (1996) theoretical frameworks of morality that, when applied, suggest that individuals who rank Beneficence and Nonmaleficence at the top of their ethical rankings would be more likely to prioritize preservation of client safety, while participants who rank Respect for Peoples' Rights and Dignity at the top of their rankings would be more likely to prioritize preservation of client privacy and confidentiality.

CHAPTER TWO

Methods

Participants

In total, 139 individuals responded to recruitment invitations: 72 doctoral-level, licensed or certified psychologists, and 67 psychologists-in-training (in doctoral level graduate programs). They were recruited from four sources: 1) 13 email listservs from various professional psychology associations (see Appendix H for full list of listservs), 2) 100 Facebook groups whose members include doctoral level clinicians (i.e., with a Psy.D., Ph.D., or Ed.D. degree; see Appendix I for the full list of Facebook groups contacted), and 4) snowball sampling through five faculty in the Department of Psychology, School of Behavioral Health, Loma Linda, CA. Reminders were sent out until 139 participants are recruited; this number represented 41 additional participants over the number needed for the proposed statistical analyses (N = 98), in order to account for invalid responses and incomplete questionnaires.

Measures

Social Media-Informed Risk Assessment Vignette (Vignette A)

Participants were presented with a fictional vignette and asked to imagine that they are the therapist in the situation (See Appendix C). The vignette depicted a situation in which, during an intake session, a young adult client endorses some risk factors for suicide, but is hesitant to discuss the issue further, leaving the client's risk-level ambiguous. The fictional client also endorsed heavy and frequent social media use. Based on situational factors of the vignette, the participants were asked how likely (on a scale of

0 to 100) they would be, based on the information presented in the vignette, to search for and access their client's SM profile outside of the therapy session in an effort to gather additional information that could inform the determination of risk level.

Digital Welfare Check Vignette (Vignette B)

Participants were presented with a second vignette, where they were asked to imagine that they are working with a fictional young adult client previously determined to be at moderate-to-high risk for suicide (See Appendix D). The fictional client also endorsed heavy and frequent social media use. Participants were told that the client has been regularly attending weekly therapy for eight weeks, and that the client's suicidality has been a primary topic addressed during therapy. Participants were also told that, following a particularly emotion-laden session, the fictional client unexpectedly no-shows for the following session and that their attempts to contact the client by phone, email, and text were unsuccessful. Based on this information, participants were asked how likely (on a scale of 0 to 100) they would be to search for and access the fictional client's social media page, in an effort to obtain information that could help determine whether the client is at immediate risk for suicide, and if additional protective measures are clinically indicated.

General Ethical Principles Questionnaire

Following the completion of the second vignette, participants completed the General Ethical Principles Questionnaire (See Appendix E). Respondents read descriptions of each of the five APA General Ethical Principles and rated each principle

on a scale of 0 - 100, based on how much each influenced their reported likelihood of accessing the client's SM information under the conditions presented in each of the two vignettes. Participants were then prompted to ensure that their ratings for each principle add up to 100 for each of the two vignettes.

Vignette Follow-Up Questionnaire

On this questionnaire, participants were asked to complete one follow-up question for each vignette. Each question asked the degree to which the participant's likelihood rating would have changed if they had read in the vignette an explicit statement that the client had been informed of and agreed to the therapist's practice of accessing the client's social media profile in situations of possible suicide risk?

Therapist Characteristics Questionnaire

This questionnaire (see Appendix G) included items requesting information regarding participants' general demographic information (i.e., age, gender, ethnicity, educational degree level(s) and field(s), licensure status, and state of practice or training), theoretical orientation and digital literacy and use.

In addition to basic demographic information, participants were also asked to designate the degree of their use of the following theoretical orientations in the conceptualization and treatment of their clients (Likert scale 0 to 100): Humanistic-Experiential, Cognitive-Behavioral, Psychodynamic/Psychoanalytic, and other. Participants were prompted to ensure that their ratings of each option add up to a total of 100.

In addition, participants were asked to rate on a Likert scale (0-100) the level to which they understand and are comfortable navigating online social platforms and the communicative patterns found within those platforms (digital literacy). This construct represented an elaboration on the concepts of digital native vs. digital immigrant, in that it aimed to capture participants who may have been born or grew up before the mass introduction of social technology (making them digital immigrants), but have since worked to develop their digital knowledge and skills. Participants were also asked identify which digital SM platforms they currently use and how often per week.

Procedures

As described above, participants were recruited through the American Psychological Association listservs for professionals and graduate students, the APPIC listserv, Facebook groups with members who are both in training and doctoral level, practicing clinicians, and snowball sampling initiated by various faculty in the researcher's graduate department (See Appendix A). Participants were provided with a link that redirects them to a Qualtrics website that provides an informed consent document detailing the purpose and nature of the study, the approximate time required to complete the survey materials, the potential risks and benefits associated with participation in the study, and procedures for completing the survey (See Appendix B).

Upon reading the informed consent form and agreeing to participate (passive consent by proceeding to the study vignettes), participants were presented with Vignette A, and asked to rate their likelihood of engaging in a SM-informed risk assessment based on information in the vignette. Then participants were then presented with Vignette B and

asked to rate their likelihood of engaging in a digital welfare check of the client based on the information in the vignette. Participants then were administered the General Ethical Principles Questionnaire, followed by the Vignette Follow-up Questionnaire, and the Therapist Characteristics Questionnaire.

In sum, participant tasks were ordered as follows: Read and acknowledge the Informed Consent form, read Vignette A, rate likelihood that they would engage in a SM-informed risk assessment, read Vignette B, rate likelihood that they would engage in a digital welfare check, and complete the General Ethical Principles Questionnaire, the Vignette Follow-up Questionnaire, and the Therapist Characteristics Questionnaire. Any apparent invalid responses were eliminated from the study (e.g., random responding), and any survey that is not at least 80% completed will also be excluded from the data analyses process.

Data Analysis

The data was first analyzed for invalid responses. A survey questionnaire was determined invalid if it appeared that individual responses were randomly produced or if the participant failed to respond to 80% of questions. The data set was then analyzed for missing responses. Finally, some demographic variables were redefined due to low response frequency.

Invalid Data Analyses

A total of 139 individuals responded to the initial invitation for participation and engaged with the Qualtrics survey. In order to minimize invalid data, the Qualtrics survey was structured in a manner that did now allow respondents to advance unless the item

was answered in a valid manner (e.g., ethical principle ratings needed to add up to a sum of 100 before respondents could advance to the next item). Overall, 23 questionnaires were excluded due to the participants apparently discontinuing the survey and failing to respond to at least 80% of the questions. The final total sample consisted of 116 respondents who submitted valid questionnaires, 66 licensed and practicing psychologists and 50 in doctoral level graduate training programs.

Missing Data Analysis

Overall, two participants did not disclose their ethnicity, one did not disclose their most advanced degree, four did not disclose their geographic location, and one did not disclose their digital literacy.

Demographic Variable Transformations

Two demographic variables were transformed due to low response frequencies. First, only two participants identified as "Asian/Indian Subcontinent." Therefore, that ethnicity category was combined with the "Asian/Southeast Asia or Far East" category, and the variable was relabeled "Asian." There were also low response frequencies for some participants' reported state of practice. Therefore, states were assigned to their respective US Census Bureau geographic region and participants from those states were grouped together into their respective region. Participants who reported practicing in California, Arizona, Utah, and Washington were relabeled "West"; participants who reported practicing in Illinois, Iowa, and Ohio were relabeled "Midwest"; participants who reported practicing in Texas, Arkansas, Delaware, Virginia, and North Carolina

were relabeled “South”; and participants practicing in New York, Pennsylvania, New Jersey, New Hampshire, and Massachusetts were relabeled “Northeast.”

CHAPTER THREE

Results

Sample Characteristics

Demographic data for the final total sample of participants using transformed demographic variables are presented in Table 1.

Table 1

Demographic Data for Respondents

Demographic Characteristics	(N = 116) *M*	*(SD)*
Age (years)	34.40	9.15
Digital Literacy	79.46	20.92
Theoretical Orientation		
CBT	55.72	28.64
Humanistic-Experiential	20.28	20.45
Psychodynamic/Psychoanalytic	7.46	10.65
Other	16.54	15.88
	N	%
Gender		
Male	29	25.0
Female	83	71.6
Transgender and Nonconforming	2	1.7
Prefer not to answer	2	1.7
Professional Status		
Licensed	66	56.9
In-training	50	43.1
Ethnicity		
Asian	17	14.6
Middle Eastern	5	4.3
Black or African American	5	4.3
Hispanic/Latino	7	6.0
White or Caucasian	70	60.3
Mixed	10	8.7
Missing	2	1.7
Most Advanced Degree		
Bachelors	4	3.4
Masters	29	25.0
Ph.D.	42	36.2
Psy.D.	40	34.5
Missing	1	0.9

U.S. census bureau/location		
Northeast	14	12.1
Midwest	2	1.7
South	9	7.8
West	87	75.0
Missing	4	3.4

Frequency Analyses and Likelihood Comparisons

In order to explore hypotheses 1 and 2, frequency analyses were conducted to identify how many participants reported being likely to conduct (1) a social-media informed risk assessment and (2) a digital welfare check (based on the information presented in vignettes 1 and 2, respectively). A participant was defined as "likely" to conduct either form of social media check if they reported a likelihood of 50% or greater (out of 100%), and they were defined as "unlikely" if their reported likelihood score was 49% or less (continuous likelihood was dichotomized accordingly). Overall, the majority of respondents reported being unlikely to conduct either a social media-informed risk assessment or a digital welfare check. Results are reported in Table 2.

Hypothesis 3 proposed that participants would report being significantly more likely to conduct a digital welfare check compared to a SM-informed risk assessment. Due to a violation of the assumption of normality for both the social media-informed risk assessment and the digital welfare check likelihoods, a Wilcoxon Signed Ranks Test was conducted to test this hypothesis. A Wilcoxon Signed Ranks Test indicated that participants were significantly less likely to conduct a social media-informed risk assessment ($M = 19.34$, $SD = 27.24$) than a digital welfare check ($M = 26.22$, $SD = 34.75$), $z = -3.54$, $p < .001$.

Table 2

Results of Frequency Analysis of Participants' Likelihood Ratings

Vignette Type		n (%)
Vignette 1 (Social Media-Informed Risk Assessment)	Likely	22 (19.0%)
	Unlikely	94 (81.0%)
Vignette 2 (Digital Welfare Check)	Likely	31 (26.7%)
	Unlikely	85 (73.3%)

Note: "Likely" is defined as a likelihood score of 50 or greater; "unlikely" is defined as a likelihood of 49 or less

Multiple Linear Regression Analyses

In order to test hypotheses 4 through 7, two separate multiple linear regression (MLR) analyses were initially proposed in order to test the effects of allegiance to each ethical principle, digital literacy, professional status, and theoretical orientation on participant likelihood to (1) conduct a social media-informed risk assessment and (2) conduct a digital welfare check.

Due to violations of assumptions of normality and collinearity, as well as difficulties with model fit, some of the variables included in the proposed analyses were excluded from the final MLR analyses. The final regression model for both dependent variables met all statistical assumptions, and consisted of (1) importance rating of Beneficence, (2) importance rating of Respect for Peoples' Rights and Dignity, (3) digital literacy (4) professional status (dichotomized; licensed vs. unlicensed), (5) participant identification with CBT theoretical orientation, (6) participant identification with Psychodynamic/Psychoanalytic theoretical orientation, and (7) participant identification with Humanistic/Experiential theoretical orientation.

Results for Social Media-Informed Risk Assessment

Using the enter method, the results of the MLR analysis revealed that participants' importance rating of Beneficence and Respect for Peoples' Rights and Dignity, digital literacy, professional status, and identification with CBT, Psychodynamic/Psychoanalytic, and Humanistic/Experiential theoretical orientations explained a significant amount of the variance in likelihood to conduct to a social media-informed risk assessment, ($F(7, 108) = 9.04$, $p < .001$, $R^2 = .37$).

Furthermore, the analysis showed that Beneficence significantly (positively) predicted likelihood of conducting a social media-informed risk assessment ($b = .532$, $t(108) = 4.76$, $p < .001$); a .532 increase in Beneficence resulted in a 1 point increase in likelihood of conducting a social media informed risk assessment. Participant likelihood of conducting a social media-informed risk assessment was not significantly predicted by Respect for Peoples' Rights and Dignity, digital literacy, professional status, or identification with any of the theoretical orientations entered into the analysis (CBT, Psychodynamic/Psychoanalytic, Humanistic/Experiential). Results are presented in Table 3.

Table 3

Results of Multiple Linear Regression Analysis for Social Media-Informed Risk Assessment

Predictor	*b*	*beta*	sr^2	Fit
(Intercept)	7.180	-	-	
Beneficence*	.532	.477	.132	
Respect for Peoples' Rights and Dignity	-.149	-.131	.010	
Professional Status	3.401	.062	.004	
Digital Literacy	-.050	-.032	.001	
CBT	.017	.018	<.001	
Humanistic/Existential	.166	.124	.006	
Psychodynamic/Psychoanalytic	-.147	-.057	.002	
				$R^2 = .369$*

* indicates $p < .001$

Results for Digital Welfare Check

The same multiple linear regression model was used to predict participants' likelihood to conduct a digital welfare check. Using the enter method, the results indicated that participants' importance rating of Beneficence and Respect for Peoples' Rights and Dignity, digital literacy, professional status, and identification with CBT, Psychodynamic/Psychoanalytic, and Humanistic/Experiential theoretical orientations explained a significant amount of the variance in likelihood of conducting a digital welfare check, ($F(7, 108) = 11.68$, $p < .001$, $R^2 = .43$).

Furthermore, the analysis again showed that Beneficence significantly (positively) predicted the likelihood of conducting a digital welfare check ($b = .667$, $t(108) = 5.01$, $p < .001$). Specifically, a 1 point increase in Beneficence resulted in a .667 point increase in likelihood to conduct a digital welfare check. Respect for Peoples' Rights and Dignity also significantly (negatively) predicted likelihood of conducting a digital welfare check ($b = -.274$, $t(108) = -1.99$, $p < .05$); a 1 point increase in Respect for Peoples' Rights and Dignity results in a .274 point decrease in likelihood to conduct a digital welfare check. Participant likelihood of conducting a digital welfare check was not significantly predicted by digital literacy, professional status or identification with any of the analyzed theoretical orientations. Results are presented in Table 4.

Table 4

Results of Multiple Linear Regression Analysis for Digital Welfare Check

Predictor	*b*	*beta*	sr^2	Fit
(Intercept)	3.618	-	-	
Beneficence**	.667	.482	.132	
Respect for Peoples' Rights and Dignity*	-.274	-.192	.020	
Professional Status	8.335	.119	.013	
Digital Literacy	.120	.072	.004	
CBT	-.103	.085	.002	
Humanistic	.035	.021	<.001	
Psychodynamic/Psychoanalytic	-.524	-.161	.015	
				$R^2 = .431$**

** indicates $p < .001$; * indicates $p < .05$

CHAPTER 4

Discussion

Current Study

This study was designed to explore the ethical attitudes of psychologists and psychologists-in-training ethical toward utilizing clients' online data to aid clinical navigation of suicide risk situations. Specifically, participants were asked to rate their likelihood of engaging in two distinct forms of gathering client digital data. The first was a social media-informed risk assessment, where the clinician accesses the client's social media profile to inform determination of suicide risk level, especially when risk-related information acquired in-person is ambiguous or incomplete. The second was a digital welfare check, where the clinician accesses the client's social media profile in an effort to determine the location and condition of a client previously determined to be at high suicide risk. Moreover, participants were asked to identify the general ethical principles that most aided their likelihood determination for both forms of social media checks, as well as their relative identification with four major theoretical orientations (CBT, Humanistic/Existential, Psychodynamic/Psychoanalytic, and Other), in order to explore whether the variables had any effect on those likelihood ratings. Finally, participants were asked to complete items related to basic demographics, digital literacy, and several professional characteristics, such as if they are licensed and in what state they practice.

This study was conducted as an extension and elaboration of many previous bodies of research. First, we attempted to expand on information regarding clinicians' willingness to check clients' social media profiles, especially in risk situations (DiLillo & Gale, 2010; Eichenberg & Herzberg, 2016; Ginory, Sabatier, & Eth 2012; Kolmes and

Taube, 2014; Lehavot et al., 2010; Tunick et al., 2011; Wu & Sonne, 2019). We also aimed to add to the current literature regarding different ways that clinicians could potentially use clients' social media to inform client risk level (Coppersmith, Leary, Crutchley, & Fine, 2018; De Choudery et al., 2016; De Choudhury et al., 2013; Gunn & Lester, 2012; Moreno et al., 2011; Vioulés, Moulahi, & Bringay, 2017). And, we aimed to continue the investigation of ethical, professional, and moral considerations relevant to potentially breaching client confidentiality in risk situations, and how these considerations can potentially inform future discussions within the field of psychology regarding the development of new ethical guidelines (Gottlieb, 2011; Hadjistavropoulos, 2011; Hodgkinson, 1996; Jones, 1991; Kaslow, Patterson, & Malloy et al., 2002; Sinclair et al., 1987; Thelen et al., 1994; Williams et al., 1996; Woolfolk, 1998). Finally, our findings can be especially relevant, given the recent expansion of telehealth in response to the COVID-19 pandemic for two reasons. First, it is likely that helping professionals will increasingly find themselves exploring virtual methods of securing the safety of their clients, and second, helping professionals should strive to remain abreast of the rapidly evolving ethical and professional considerations related to digital practice.

The results for the seven hypotheses are discussed first below. Then, the limitations of the study are outlined. Finally, the Discussion concludes with the potential implications of this study for clinical training and for future research.

Discussion of the Results of the Hypotheses

Generally, psychologists and other mental health professionals have expressed hesitance to utilize client social media, for both personal and professional reasons

(Eichenberg & Herzberg, 2016; Ginory, Sabatier, & Eth, 2012; Wu & Sonne, 2019). The results of this study further support those findings, as well as our own hypotheses, in that the majority of participants reported that they were unlikely to conduct a social media informed-risk assessment or a digital welfare check, even after it was made clear that the fictional clients in each vignette may be at risk for suicide.

Despite participants' general low likelihood of conducting either form of social media checks, results indicated that participants were significantly more likely to conduct a digital welfare check than a social media-informed risk assessment. This is most likely due to the importance of clients' actual risk level in deciding whether to conduct a social media check. Vignette B was written to illustrate a higher level of risk for the fictional client than in vignette A, which may have led participants to feel more obligated to intervene to ensure the safety of the client. In contrast, participants may have found that the risk level conveyed in vignette A was not severe enough to justify checking the client's social media profile. Indeed, this explanation is at least partially supported by Jones' (1991) and Hodgkinson's (1996) theoretical frameworks of morality. In applying these frameworks to clinical work, temporal urgency and the magnitude of consequence are primary factors relevant to clinicians' decisions related to navigating suicide risk. Thus, the temporal urgency and magnitude of consequence may have been more salient to participants while reading vignette B, where risk level was already established and the fictional client's behaviors were especially concerning, compared to vignette A, where risk-relevant information was more ambiguous.

The overall regression models significantly predicted therapists' and therapists'-in-training likelihood of conducting both a social media-informed risk assessment and a

digital welfare check. More specifically, the results indicated, as hypothesized, that participants' relative value placed on the general ethical principle of Beneficence (duty to protect) significantly predicted their likelihood to conduct both forms of social media checks, in that the higher the participant rated Beneficence, the more likely they were to conduct either check. This would be expected, given that Beneficence is an especially important ethical principle in the context of navigating client suicide risk, and a higher allegiance to Beneficence would reasonably lead a clinician to be more liberal with protective actions. Interestingly, according to the research (Hadjistavropoulos [2011], Hadjistavropoulos & Malloy [1999], and Seitz & O'Neill [1996]), the duty to protect ranks high among Canadian psychologists, as well as in the Canadian Psychological Association's code of ethics, which further supports the importance of Beneficence in clinicians' general clinical and ethical decision-making.

As hypothesized, participants' relative value placed on the general ethical principle of Respect for Peoples' Rights and Dignity significantly (negatively) predicted their likelihood of conducting a digital welfare check, in that the higher the value placed on Respect for Peoples' Rights and Dignity, the lower their likelihood to conduct a digital welfare check. Value placed on Respect for Peoples' Rights and Dignity also negatively predicted likelihood of conducting a social media-informed risk assessment, though this result was not significant. These results are expected, given that Respect for Peoples' Rights and Dignity is also a particularly important ethical principle, both in its relation to general ethical decision-making and especially in situations involving client suicide risk. Respect for Peoples' Rights and Dignity encapsulates a clinician's obligation to respect a client's privacy and protect their confidentiality, unless it is necessary to violate privacy

or breach confidentiality to ensure the safety of a client. Currently, methods of determining and responding to suicide risk level for clients are highly subject to clinician judgment. Therefore, whenever clinicians are deciding whether or not to violate privacy or breach confidentiality in the case of an at-risk client, they are considering both the circumstantial factors of the case, as well as weighing the general ethical principle of Respect for Peoples' Rights and Dignity against the principle of Beneficence.

As noted, while Respect for Peoples' Rights and Dignity was negatively associated with therapists' likelihood of conducting a social media-informed risk assessment as hypothesized, the association was not significant. This result may again be due to the therapist's perception of actual risk to the client as posed in vignette B compared to vignette A. Participants may have been more intentional in their consideration of all of the ethical principles while responding to vignette B, compared to vignette A, given that risk posed by the fictional client in vignette B was more magnified.

Despite these findings regarding the relative value of Beneficence and Respect for Peoples' Rights and Dignity in the prediction of psychologists' conduct of social media checks, some significant caveats exist related to these results. Though the effects of the principles of Integrity, Justice, and Fidelity and Responsibility could not be analyzed due to statistical limitations, some participants provided qualitative information underlying their likelihood scores for both forms of social media checks. Specifically, some participants' text responses indicated the importance of a lack of informed consent as described in the vignettes to determining their likelihood scores. Some participants wrote that the fact that the fictional clients were not made aware beforehand of the possibility of them conducting a social media-informed risk assessment or a digital welfare check was

the primary reason they provided a low likelihood score. Given that informed consent is an issue that has implications across multiple ethical principles, it is possible that the lack of informed consent superseded all other ethical considerations for some participants, and thus diluted some of the variance in the ratings of the general ethical principles. More formal statistical and qualitative analyses would be needed to further explore this possibility. Additionally, some participants wrote that conducting a social media check of any kind runs the risk of compromising professional boundaries and contaminating the therapeutic relationship, another issue that could have affected likelihood scores that touches multiple ethical principles.

None of the analyzed theoretical orientations had any significant effect on likelihood scores for either form of social media check. These results conflict with our hypothesis that identification with a Humanistic theoretical orientation would significantly positively predict likelihood for both forms of social media check, and that identification with CBT or Psychodynamic/Psychoanalytic theoretical orientations would significantly negatively predict likelihood to conduct both forms of social media check. A potential explanation for these findings is that, though clinicians of different theoretical orientations may approach assessing suicide risk differently, navigating client suicide risk and ensuring client safety is more of an issue of general ethics than an issue of specific therapeutic approach and technique. Therefore, it is a reasonable that participants' likelihood scores may have been more influenced by ethical considerations and the circumstances of the vignettes, rather than this particular professional factors.

Results also indicated no significant relationships between professional status (i.e. being licensed vs. unlicensed) and self-reported digital literacy, and the two social media

checks. Regarding professional status, it is possible that both licensed and unlicensed (in training) clinicians were equally sensitive to the circumstantial factors and ethical considerations associated with each vignette, and, thus, responded similarly in terms of likelihood scores. Digital literacy was most likely not a significant predictor due to a lack of variance; the vast majority of respondents identified themselves as having a high level of digital literacy. This would be expected, as digital immigrant clinicians are likely to have learned how to navigate and use social media (and other technologies) over time in their professional work and personal lives.

Implications for Clinical Work

Based on the findings of this study, it remains true that clinicians generally are reluctant to access clients' digital information to inform clinical decision-making, even in cases of elevated suicide risk. Results also indicate that relative allegiance to general ethical principles have a greater bearing on willingness to digitally violate privacy or breach confidentiality, rather than any demographic or professional factors.

The most immediate implication of this study relates to procedural practices in clinical work, especially in situations where elevated suicide risk is a factor. Participants appear to be willing to consider conducting a social media-informed risk assessment or a digital welfare check, depending on the urgency of the risk situation and their ethical sensitivities. However, it may be argued that all clinicians, regardless of baseline willingness to conduct a social media check, may benefit from incorporating such practices into their practice. Given the findings that suggest that individuals are turning to social media to discuss their innermost struggles, as well as the increasing digitization of

helping professions, both during the COVID-19 pandemic and beyond, adding social media checks to one's clinical work can assist in providing the best possible care and ensuring the safety of at-risk clients. Importantly, however, consistent with some participants' narrative responses, therapist access to clients' social media must be included informed consent documents, in order to ensure the ethicality of the practice. Overall, our results, along with current ethical principles and standards, suggest that there may be ways to incorporate social media accessing into clinical practice, but that the circumstances underlying such access, the scope of the access, and the therapist's final clinical decision based on the results of the access remain subject to clinical judgment. Therefore, access to clients' social media represents an opportunity to increase the safety of their clients, while still reasonably protecting client privacy and confidentiality.

The informed consent process for the use of a client's social media in the context of potential suicide risk must clearly outline the clinician's approach to accessing the social media, the scope of the check, and exactly how the information accessed may be used. For example, a clinician who wishes to use social media in their practice would need to clearly outline to their clients whether or not they would bring other potentially clinically relevant issues into therapy after conducting the access, even if those issues are not relevant to the client's suicide risk. Furthermore, clinicians would need to set boundaries with their clients regarding how often they would conduct a check and how much content would be reviewed. And, finally, clinicians would need to clearly think through the potential clinical, ethical, and legal issues inherent in opening a whole domain of information regarding their client for which they may then be professionally

responsible, but may not be able reasonably monitor given time and other situational constraints.

A second implication of this study relates to the codification of general ethical principles or ethical standards regarding digital practice. Currently, other mental health professions have explicit standards or recommendations related to digital practice. One aim of this study was to spark conversations in the field of psychology, in order to prompt the profession to create and publish digitally-informed principles and standards in future iterations of the ethics code. Doing so would provide clinicians who want social media to play a more active role in their clinical work more concrete ethical and professional guidance, as well as help them identify and reduce the risks of doing so.

Finally, this study was also conducted as an exploration into whether clinicians' attitudes toward the utility of social media matches empirical findings regarding that utility of social media in assessing or predicting suicide risk. As previously discussed, research suggests that people are becoming increasingly transparent on social media, and other researchers have already begun investigating other ways that social media can be used to assess suicide risk. For example, computer scientists and linguists are developing algorithmic models for assessing or even predicting suicidality based on individuals' online language patterns, and these models have been validated and found to be accurate. Of note, these models represent a more objective approach to understanding the relationship between suicidality and online behaviors, while social media checks conducted by clinicians are largely subjective, both in the determination of actual risk based on the gathered information, and subsequent clinical decision-making. However, there may be opportunities in the future to blend these two approaches and mitigate the

limitations of each. For example, clinicians may learn to utilize some of these models to more accurately assess risk, in order to minimize ethical ambiguity and the role of subjective judgment. They would then be able to use the privileges afforded by the therapeutic relationship to make more accurate and appropriate clinical decisions. Finally, psychologists may benefit from developing and validating objective measures of social media use, reasons for social media use, and the degree to which clients' social media behaviors mirror their real-life behaviors.

Limitations and Future Directions

This study was conducted with multiple limitations, particularly statistical in nature. As previously discussed in the results section, many of the variables did not meet statistical assumptions for analysis. Of particular importance was the exclusion of the general ethical principles of Integrity, Justice, and Fidelity and Responsibility. It is possible that the relative value placed on these principles also had an effect on likelihood scores, and follow-up studies should be conducted that either transform variables that do not meet statistical assumptions, or that modify the operationalization of the principles to facilitate analysis.

There are also limitations related to recruitment and the sample itself. The APA has noted that many psychologists are not members of an APA division, and even psychologists who are members of a division do not subscribe to the division's listserv. As such, caution must be used in generalizing the findings to all psychologists. Furthermore, the APA notes that many members of an APA division are not doctoral-level clinicians or clinicians in doctoral training. Though this study attempted to exclude

non-doctoral clinicians or trainees, it is possible that non-doctoral clinicians or trainees in a Masters program completed the survey. Future studies may extend recruitment beyond those used in this research to obtain a more general sample of practicing psychologists and those in training.

Regarding the characteristics of the sample itself, the majority of respondents identified as White. Furthermore, the majority of respondents reported that they practice in the western region of the United States. The majority of participants also identified as Female. Future studies should be conducted that attempt to gather a more heterogenous sample in regards to gender, ethnicity, and geographic location.

Another possible limitation of this study may have resulted in the failure to find theoretical orientation of the therapist as a predictor of either type of accessing social media. We chose to operationalize theoretical orientation as we did in order to accommodate therapists who are influenced by more than one in their practice. Unfortunately, this method likely diluted the variance associated with each. Future research may introduce other creative ways to operationalize this variable. Finally, future studies should be conducted in order to elaborate on other factors that may influence digital behaviors, such as years in clinical practice, training in professional technology practices, primary population with which therapist participants work (e.g., youth vs. adult clients), and the potential influences the current COVID-19 pandemic may have on their willingness to engage in such behaviors.

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APPENDIX A

Listserv and Snowball Email Recruitment Notice to Participants

Hello:

You are invited to participate in an important study on decision-making in practice regarding the use of client online information in the context of potential suicide risk. The study is my Dissertation research project. The study has been approved the Loma Linda University IRB.

INFORMATION ABOUT THE STUDY:
This study will examine how therapists make decisions in their practice regarding accessing client information online. The intent is to examine psychologists' inclinations to engage in such conduct and the impact of certain psychologist characteristics in their decision-making process. You were selected to participate due to your standing as a *currently practicing licensed or certified psychologist with a doctoral degree (i.e., Ph.D., Psy.D., Ed.D.), or as a psychology trainee in a doctoral graduate program currently engaged in supervised training.* ***If that is not the case, please do not proceed with the study.***

HOW TO GET INVOLVED:
Please go to the following website to access the survey:

https://llu.co1.qualtrics.com/jfe/form/SV_9uDwj2plDPRi1SZ

It will take approximately 15 minutes of your time. You will be asked to read two short clinical vignettes and then answer one question following each vignette. You will then be asked to respond to a questionnaire that poses two questions regarding what may have contributed to each of your vignette answers. You will then complete some demographic information and other questions regarding your clinical practice experiences.

Please take a few minutes now to visit the website and complete the survey.

In addition, I invite you to forward this email to any licensed psychologist colleagues or doctoral level clinical psychology graduate students who meet the criteria for inclusion in this study and might be willing to participate.

THANK YOU IN ADVANCE FOR VISITING THE STUDY WEBSITE!

Sincerely,

Jacob Vermeersch, M.A.
Loma Linda University
Loma Linda, California

Facebook Recruitment Post

Hello everyone!

Please consider helping me with my dissertation research study investigating therapists' decision-making in practice regarding the use of client online information in the context of potential suicide risk. Participation is expected to take only about 15 minutes of your time.

I am a Ph.D. clinical psychology graduate student in the Department of Psychology at Loma Linda University. I am recruiting *doctoral-level licensed or certified psychologists who are currently practicing and psychology trainees in a doctoral graduate program currently engaged in supervised training* to participate in my dissertation survey study, chaired by Dr. Janet Sonne.

Here is a link to the study: https://llu.co1.qualtrics.com/jfe/form/SV_9uDwj2plDPRi1SZ

This study has been approved by Loma Linda University's IRB.

Thank you very much for your time,

Jacob Vermeersch, M.A.
Loma Linda University
Loma Linda, California

APPENDIX B

Informed Consent Form

LOMA LINDA UNIVERSITY

Dear Licensed or Certified Psychologist or Psychologist-in-training:

My name is Jake Vermeersch and I am currently enrolled in the Clinical Psychology Ph.D. program at Loma Linda University. I am conducting a research project for my Doctoral Dissertation requirement that will investigate your decision-making in clinical practice regarding the accessing and use of client online information in the context of a client's potential suicide risk. The purpose of this letter is to inform you about this research project and to invite you to participate. You were selected to participate due to your current status as a practicing licensed or certified clinical psychologist in the U.S. with a doctoral degree or a doctoral student in a clinical psychology graduate program currently engaged in supervised clinical training. Before deciding to give your consent to participate, please read through the following information carefully and ask any questions you may have (Please see contact information below).

Purpose of this Study:
The purpose of this study is to collect information concerning how psychologists make decisions in their practice regarding the accessing and use of client online information in the context of a client's potential suicide risk. The intent is to examine psychologists' inclinations to engage in such conduct and the impact of certain psychologist characteristics in their decision-making process.

Procedure:
Participation will take approximately 15 minutes of your time. You will be asked to read two short clinical vignettes and then answer one question following each vignette. You will then be asked to respond to a questionnaire that poses two questions regarding what may have contributed to each of your vignette answers. You will then complete some demographic information and other questions regarding your clinical practice experiences.

Risks:
The risks of participating in this study are minimal, no greater than those encountered when you consider and make decisions in your everyday life. Any risks potentially stem from recalling and disclosing some relatively personal information. There may be times while completing the survey that you feel uncomfortable while remembering unpleasant events that may have occurred recently, such as your interactions with a challenging client or difficult professional decisions you needed to make. If you begin to feel

uncomfortable you have the right to stop at any time during the process if you choose to do so.

Benefits:
Although there is no direct benefit to you for participating in this study, you will be providing valuable information that may be beneficial to the understanding of the decision-making processes inherent in the clinical interaction between therapist and client, specifically when there is a concern regarding the client's potential suicide risk.

Participant's Rights:
Your participation is voluntary; there is no penalty for not participating and you can choose to withdraw at any time.

Confidentiality:
Confidentiality will be maintained at all times. Neither your name, your email address, nor IP address will be linked to your survey responses in any way. The answers you provide will be combined with other participants' answers in order to conduct group analyses. Any publications or presentations resulting from this study will refer only to the grouped results.

Costs/Reimbursement:
There are no costs for taking part in this study nor will you be compensated or reimbursed for participation.

Impartial Third Party Contact:
If you wish to contact an impartial third party not associated with this study regarding any concerns you may have about this study, you may contact the Office of Patient Relations, Loma Linda University Medical Center, Loma Linda, CA 92354, by phone (909) 558-4647 or e-mail patientrelations@llu.edu for information and assistance.

Informed Consent:
If you have any questions about this project, please do not hesitate to contact me, Jake Vermeersch at (909) 499-0391 or jvermeersch@llu.edu, or Dr. Janet Sonne (Jsonne@llu.edu) Research Committee Chair.

If, you decide to discontinue the survey at any time, for any reason, you are free to do so. If you have any questions regarding this study, we will be happy to answer them. You are also free to print out the informed consent document for your own review.

Thank you for your time and consideration.

Informed Consent Statement

I have read the contents of the consent form and have been given the opportunity to ask questions concerning this study. I have been provided an option to print a copy of this form.

I hereby give my voluntary consent to participate in this study. Filling out this survey acknowledges my passive consent to participate in this study. This does not waive my rights nor does it release the investigators or institution from their responsibilities. I may contact Dr. Sonne (jsonne@llu.edu) if I have additional questions or concerns.

Janet Sonne, Ph.D.
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APPENDIX C

Vignette A (Social Media-Informed Risk Assessment):

Your client has presented to an intake session reporting symptoms of anxiety and depression stemming from a recent break-up of a romantic relationship, familial conflict, and academic struggles. The client reports sometimes feeling hopeless about the future and having frequent thoughts about death and dying. When you reach the topic of suicide, your client states that they have no prior suicide attempts or hospitalizations, but have recently been having active suicidal ideation. You begin conducting a risk-assessment, during which your client states that they experience suicidal ideation "a few times a week." Your client also denies any concrete suicide plan, but says that they have been thinking recently about "what the easiest or most painless way to do it would be, if things get too bad." Your client also denies having any suicidal intent at this time, but says that "it is not clear how things will turn out if things don't start looking up soon." Your client endorses having a small group of friends, though admits still feeling "lonely a lot of the time." Your client reports use of social media to "try and stay connected to people and have somewhere to just say what I want to say." Concerned about your client's remarks, you attempt to further assess for risk and protective factors. Your client interrupts you and says "I don't want to talk about this anymore." Your client asks to end the session early and declines to complete a safety plan. However, your client assures you that they are safe, and will try to attend a follow-up session next week.

Based on the information presented, please rate, from **0 (Totally unlikely) to 100 (Totally likely),** how likely you would be to conduct a **social media-informed risk assessment** by checking your client's social media profile outside of the therapy session, in order to obtain more information with which to assess current suicide risk? Please respond 0-100: _____

APPENDIX D

Vignette B (Digital Welfare Check)

Your client presented to therapy with symptoms of depression related to struggles with sexuality. During the intake session seven weeks ago, your client endorsed having frequent active suicidal thoughts. Your client also endorsed having made a suicide plan about a year ago, but denied ever having suicidal intent. Your client acknowledged owning a firearm, and spending a lot of time on social media to "keep (my) mind off things." Since then, you have established good rapport with your client, and your client has not yet missed any of the weekly appointments with you. During the course of therapy, your client has shown minor improvement of depressive symptoms, but continues to experience active thoughts of suicide, an issue you address through recurrent risk-assessment and regular completion of a safety contract. Following a particularly emotional session last week, your client unexpectedly no-shows for the appointment with you today, despite agreeing to attend the week before. You attempt to reach your client by phone and text during the hour of the appointment, but you are unable to connect. You begin worrying about your client's safety and start thinking about whether you should intervene by calling on someone to do a safety check. You remember, however, that your client reported being a "very private person," and that people "cannot know" about the therapy.

Based on the information presented, please rate, **from 0 (Totally unlikely) to 100 (Totally likely),** how likely you would be to conduct a **digital welfare check** by accessing your client's social media profile outside of the therapy session, in order to obtain more information in order to ensure the client's safety? Please respond 0-100:

_____

APPENDIX E

General Ethical Principles Questionnaire

Please complete the following questions regarding the vignettes:

1. **Regarding Vignette A**: Given the descriptions of each of the APA General Ethical Principles (APA, 2017) listed below, please rate each one according to how much influence the principle had on your rating of your ***likelihood to check your client's social media profile, in order to obtain more information with which to assess current suicide risk***, as depicted in the first vignette.

   Your rating of each principle should be on a scale from ***0 (No influence at all) to 100 (Total influence)*** AND ***all 5 ratings must TOTAL 100.***

   - **Beneficence and Nonmaleficence** (i.e., duty to protect, do good and avoid harm)

     Rating 0 to 100: _____

   - **Respect for Peoples' Rights and Dignity** (i.e., confidentiality, privacy, self-determination)

     Rating 0 to 100: _____

   - **Fidelity and Responsibility** (i.e., clarifying professional role, establishing trust with the client)

     Rating 0 to 100: _____

   - **Justice** (i.e., managing potential biases and maintaining competence)

     Rating 0 to 100: _____

   - **Integrity** (i.e., promoting honesty and truthfulness in practice)

     Rating 0 to 100: _____

   Please check to be sure that all 5 of your ratings TOTAL to 100.

2. **Regarding Vignette B**: Given the descriptions of each of the APA General Ethical Principles (APA, 2017) listed below, please rate each one according to how much influence the principle had on your rating of your ***likelihood to check your client's social media profile, in order to obtain more information in order to ensure their safety***, as depicted in the second vignette.

   Your rating of each principle should be on a scale from ***0 (No influence at all) to 100 (Total influence)*** AND ***all 5 ratings must TOTAL 100.***

   - **Beneficence and Nonmaleficence** (i.e., duty to protect, do good and avoid harm)

     Rating 0 to 100: _____

   - **Respect for Peoples' Rights and Dignity** (i.e., confidentiality, privacy, self-determination)

     Rating 0 to 100: _____

   - **Fidelity and Responsibility** (i.e., clarifying professional role, establishing trust with the client)

     Rating 0 to 100: _____

   - **Justice** (i.e., managing potential biases and maintaining competence)

     Rating 0 to 100: _____

   - **Integrity** (i.e., promoting honesty and truthfulness in practice)

     Rating 0 to 100: _____

   Please check to be sure that all 5 of your ratings TOTAL to 100.

APPENDIX F

Vignette Follow-Up Questionnaire

Please complete the two follow-up questions regarding the vignettes below:

1. Would your likelihood rating for Vignette A (regarding using social media information to contribute to your assessment of suicide risk) have changed if you had read in the vignette an explicit statement that the client had been informed of and agreed to your (as the therapist) practice of accessing their social media profile in situations of possible suicide risk?

   Yes: _____ No: _____

   If Yes: Why would your likelihood rating have changed?

   If Yes: What likelihood rating would you have given (0-100)?: _____

2. Would your likelihood rating for Vignette B (regarding doing a digital welfare check) have changed if you had read in the vignette an explicit statement that the client had been informed of and agreed to your (as the therapist) practice of accessing their social media profile in situations of possible suicide risk?

   Yes: _____ No: _____

   If Yes: Why would your likelihood rating have changed?

   If Yes: What likelihood rating would you have given (0-100)?: _____

APPENDIX G

Therapist Characteristics Questionnaire

ABOUT YOU:

1. Your gender:

Female _____
Male _____
Gender Variant/non-conforming _____
Prefer not to answer _____

2. Your age (in years): _____

3. To what racial group/ethnicity do you most identify?:

American Indian or Alaska Native _____
Asian/Southeast Asia or Far East _____
Asian/Indian Subcontinent _____
Middle Eastern _____
Black or African American _____
Hispanic or Latino _____
Native Hawaiian or Other Pacific Islander _____
White or Caucasian _____
Mixed _____
Other _____

4. Your most advanced educational degree and field of degree:

B.A. _____
B.S. _____
M.A. _____
M.S. _____
Ph.D. _____
Psy.D. _____
Ed.D. _____
Other _____

Field in which you received the above degree:

_____

5. Are you currently practicing as a licensed or certified psychologist?

Yes _____
No _____

5.a. **If Yes**, for how many years have you been licensed? _____

6. Are you currently being supervised in a doctoral-level psychology training program?

Yes _____
No _____

6.a. **If Yes**, for how many years have you been in supervision? _____

6.b. **If Yes**, what year of doctoral-level psychology graduate program are you in? _____

7. Please indicate the state where your clinical practice (if you are a licensed psychologist) or doctoral-level training program (if you are a psychologist-in-training) is located:

_____

8. Please indicate the approximate percentage of adult clients and child/adolescent clients in your current caseload. **Please be sure that your two responses add up to 100%.**

Adult clients: _____%
Child/Adolescent clients: _____%

9. Using a total of 100 "points," please rate, **from 0 to 100**, how much you draw upon each of these major theoretical orientations in your conceptualizations of and interventions with your clients. **Please be sure that the total of your responses is 100.**

a. Cognitive-Behavioral (e.g. CBT, DBT, REBT)

_____

b. Humanistic-Existential (e.g. Gestalt therapy, Emotion-Focused therapy, Logotherapy, Person-Centered Therapy, Reality Therapy)

_____

c. Psychoanalytic/Psychodynamic (Classical Psychoanalysis, Jungian Therapy, Adlerian Psychology, Neo-Freudian, Object Relations)

_____

d. Other (e.g. Systems Theory, Structural Family Therapy, Solution-Focused Therapy, Motivational Interviewing, Interpersonal Psychotherapy, Feminist Therapy)

_____

10. Is this statement **True** or **False** for you?

For most of my childhood, I was surrounded by and used Internet- and computer-based tools such as smartphones, e-mail, and social media.

True _____
False _____

11. Please rate how comfortable you currently are with understanding and navigating modern social media platforms and communications on a scale from **0 (Not at all comfortable) to 100 (Totally comfortable)**: _____

12. Please indicate (by an X) all of the social media platforms that you use on a regular basis. For each platform that you do indicate, please identify how many **days per week** you use that platform:

Platform:		**Days per Week:**
Twitter	_____	_____
Facebook	_____	_____
Instagram	_____	_____
Reddit	_____	_____
Snapchat	_____	_____
LinkedIn	_____	_____
WhatsApp	_____	_____
Tumblr	_____	_____
TikTok	_____	_____
Pinterest	_____	_____

13. To what degree (from 0 to 100) have you received training (through didactics, supervision, or consultation) regarding therapist online conduct (e.g., having personal or professional Facebook accounts, accidentally or intentionally accessing client online information), **where 0 = None at all and 100 = Extensive**: _____

14. Do you think your likelihood rating for either vignette was influenced by changes to the current general practice of psychology in response to the current COVID-19 pandemic?

Yes _____ No _____

If Yes, how?:

15. In the 6 months before the COVID-19 pandemic hit in March 2020, how much of your therapy practice was conducted in-person vs. via teletherapy (0-100%)? **Please be sure that your two responses add up to 100%**

In-person: _____%. Teletherapy: _____%

16. Since March 2020, how much of your therapy practice has been conducted in-person vs. via teletherapy (0-100%)? **Please be sure that your two responses add up to 100%**

In-person: _____%. Teletherapy: _____%

APPENDIX H

Listserv Recruitment Sites

APA Divisions
- Military Psychology 19
- Society for Humanistic Psychology 32
- Society of Group Psychology and Group Psychotherapy 49
- Society for the Psychology of Women 35

State-specific psychological associations
- California Psychological Association
- California Psychological Association - Early Career Psychologist
- California Psychological Association - Graduate Students
- Hawaii Psychological Association
- Hawaii Psychological Association - Early Career Psychologist
- New York State Psychological Association
- New York State Psychological Association - Early Career Psychologist
- Oregon Psychological Association
- Pennsylvania Psychological Association

APPENDIX I

Social Media (Facebook) Recruitment Sites

ACT for ABA Practitioners
ACT Made Simple - Acceptance & Commitment Therapy for Practitioners
Addiction Therapists Group
APA ATI in Research Methods with Diverse Racial & Ethnic Groups Alumni
APA Division 45
APA Division 7 - Developmental Psychology
Asian American Psychology Student Association (AAPSA)
Association for the Psychoanalysis of Culture and Society
Attachment-Based Therapists
Austin Mental Health Professionals
AZ Mental Health Professionals
Bay Area MFT/PsyD & PhD Collective
Become a More Effective Therapist
California Licensed Psychologists
California Psychotherapists in Private Practice
CBT Practitioner Network
Christian Counselors in Private Practice
Christian therapists
Clinicians of Color in Private Practice
Cognitive Behavior Therapy
Contextual Behavioral Science (CBS)
Counselling and Psychotherapy Networking
Counsellors & Psychotherapists Worldwide
CSULB Marriage and Family Therapy
DC Therapist Connect
Division on South Asian Americans (DoSAA)
Early Career Feminist Psychologists
East Texas Therapy Network
EMDR Therapist Resources
Emotion-Focused Family Therapy (EFFT)
Filipino American Mental Health Professionals
Florida Mental Health Professionals
Florida Therapist Network (Mental Health Counselors)
Florida Therapists in Private Practice and Referral Resources
Greater Houston Mental Health Professionals
IFS (Internal Family Systems) Community Group
IPA in Health. International psychoanalytical
LA Therapists (Psychotherapists, Psychologist, LCSW)
Latinx Counselors & Therapists
Latinx Doctoral Psychology Students and Early-Career Psychologists
Latinx Therapists
LGBQIA and Trans Affirming Therapists

LGBTQ-Affirming Mental Health Resources
The Site for Contemporary Psychoanalysis
Marriage and Family Therapists of Washington State
Marriage and Family Therapists
Melanin & Mental Health Professionals
Mental health professionals
Mental Health Professionals of Fairfield County, CT
MFT & PCC: Dual licensure in California
MFT Guide
MFT Resource Group
Midsouth Therapist Network Page
MilSpouse Network for Mental Health Professionals
Mindfulness Practitioners of Color
Mississippi Mental and Behavioral Health Professionals
MN LGBTQ+ Therapists Network
Montana Mental Health Professionals
Muslim Mental Health Professionals and Students
My Private Practice Collective
DC Therapist Connect
Nevada Association of School Psychologists (NVASP)
North Texas Therapists Network
NYC Area therapists in private practice
Omaha Therapist Network (OTN)
Online Psychologist
Online Therapists of Texas
Orange County Shrinks Clinical Group
Play Therapy and EMDR Therapy Conversations
Professional Mental Health Counselors, Social Workers, & Psychologists
Psychiatry and Clinical Psychology
Psychological scales, tests and researches group
Psychology Workshops and Events
Psychotherapist Training Resource Page
Psychotherapy: Cognitive Behavioral Therapy within an Integrative Approach
Real Therapists Of New York And New Jersey
Resilience Based Psychotherapists - Supporting Families in Tough Times
Respectful Relationships ~ Therapists & Counselors
SD Mental Health Professionals
Self Care for Therapists
South Florida Psychotherapists
The Couples Therapist Couch
The Modern Therapists Group
The Organized Therapist
The Profitable Practice for Healers
The Sandtray Movement
The Testing Psychologist Community
The Trauma Treatment Collective

Therapist and Educators Market Place Buy/Sell/ Trade
Therapists in Corvallis & Albany
Therapists in Private Practice (TIPP)
Therapists Support LGBTQ in OC
Therapists who ROCK
Therapy in Color Clinicians
Therapist community
Trauma Psychotherapy
Inland Empire Shrinks
Traveling Therapists Jobs Nationwide
Vegan Therapists & Mental Health Professionals
Ventura County Mental Health Professional