



FOCUS ON  
**HEALTH**

## **Professional Ethics**

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#### **Topic**

“Patient- Targeted Googling” (PTG)

#### **Article(s)**

Patient- targeted googling by psychological therapists: A narrative review of the literature and ethical implications

#### **Purpose**

The purpose of this activity is to explore the principles of bioethics in “Patient-Targeted Googling” (PTG) by psychological therapists, focusing on the prevalence of PTG, how often consent is sought from the patient, and the motivations for and consequences of PTG. As the world turns more and more to technology and online communication it is important to understand the ethical implications of online activity in clinical practice.

In the past we have covered topics such as, telemedicine, online counselling, social media, and crowdfunding to provide practitioners with the tools of knowledge which they can apply should they ever find themselves in these situations.

This activity is approved for **THREE (3) Ethics** Continuing Education Units (CEU’s)

# Patient-targeted googling by psychological therapists: A narrative review of the literature and ethical implications

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## Abstract

**Background:** “Patient-Targeted Googling” (PTG) refers to a healthcare professional using the Internet to discover information about a patient. The present review explores PTG by psychological therapists. The review focused on the prevalence of PTG, how often consent is sought from the patient, and the motivations for and consequences of PTG.

**Method:** A narrative literature review of published PTG studies was undertaken. Potentially eligible studies were identified by searching PsycINFO, PsycARTICLES, Psychology and Behavioural Sciences Collection, and MEDLINE. Results were screened for suitability for inclusion in the sample ( $n = 9$ ). All studies were appraised for quality using a structured tool developed for this review.

**Results:** PTG prevalence rates ranged from 20% to 98%, with rates of non-consent ranging from 60% to 84%. Motivations for PTG included curiosity, to gather new information and to verify existing information. Consequences of PTG included enhancing the therapist's sense of safety and causing harm to the therapeutic relationship.

**Discussion:** Current literature on PTG is limited and focussed largely in the United States. This review revealed no published PTG studies including UK-based psychological therapists, as well as issues in defining and operationalising PTG. Further research is needed to understand the prevalence of PTG by UK-based psychological therapists, as well as the motivations behind, and consequences of, PTG. This evidence base will inform the development of PTG professional guidelines and training, neither of which currently exist for therapists practising in the UK. Both would be timely given the increasing move of the therapeutic frame to the online environment due to the COVID-19 pandemic.

## KEYWORDS

patient-targeted googling, therapeutic relationship, professional ethics, professional practice

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## 1 | INTRODUCTION

“Patient-Targeted Googling” (PTG) refers to a healthcare professional using the Internet in any way to discover information about a patient (Clinton et al., 2010). PTG can unearth sources relating to a patient, such as videos, photographs, criminal records and credit reports (DiLillo & Gale, 2011); news stories (Clinton et al., 2010); social media profiles, blog posts, planning permission applications or objections, and satellite images of the patient's home. The information such sources could convey about a patient are “virtually limitless” (DiLillo & Gale, 2011, p. 1) and include the patient's political affiliations, religious beliefs and property values (DiLillo & Gale, 2011); details of financial status, intimate relationships, sexual activity and substance misuse (Clinton et al., 2010); current or historical location, and possible suicidality (Lehavot, Ben-Zeev & Neville, 2012).

It is noteworthy that a consensus has not been reached regarding whether PTG describes searching online for current patients only, or whether the term also encompasses searching for an ex-patient. Nor has a consensus been reached regarding whether PTG encompasses searching for people in a patient's social network who have been mentioned in therapy, such as family members, ex-partners or colleagues. Given these definitional issues, it is perhaps unsurprising that there is currently no standardised measure of PTG behaviour.

Despite these issues of definition and operationalisation, the existence of PTG has been documented among medical professionals (e.g., Jent et al., 2011; Omaggio et al., 2018) and psychotherapists (e.g., Eichenberg & Herzberg, 2016), although the implications of PTG are likely to vary depending on professional group. For example, PTG by a medical professional could reveal that the patient is misusing substances, which may, for example, lead the medical professional to decide against the provision of treatment for which substance misuse is a contraindication. That is, PTG by a medical professional could impact on whether a certain treatment is recommended or prescribed in the first place. Whilst disclosure of PTG in this case might impact patient trust, it would not prevent any previously prescribed medication from having an effect. Conversely, if a psychological professional conducted PTG and disclosed this to a patient, trust could be reduced and, whilst this might cause a rupture repair and constitute a valuable opportunity for growth in the therapeutic relationship (Safran et al., 2011), it might also harm the therapeutic relationship. This is crucial given extensive evidence that the therapeutic relationship makes significant and consistent contributions towards therapy outcome, explaining at least as much of the variance in outcome as the therapeutic model used (Norcross & Wampold, 2011). Even if a therapist decided against disclosing PTG, they would nonetheless have acquired knowledge that impacts their own experience of the therapeutic relationship and their capacity to be authentic. PTG by a psychological professional could therefore be especially significant because it may affect the therapeutic relationship and, by extension, treatment outcomes.

Psychological professionals could use their clinical supervision to explore issues relating to PTG. However, notably, Kolmes and Taube (2014) found that almost three-quarters of a sample of mental health

### Implications for practice and policy

- Issues of PTG may increase as the therapeutic frame moves from the office to an online environment, for example during the COVID-19 pandemic. Therefore, up-to-date training and guidelines are needed for qualified and trainee professionals alike.
- When a patient discloses information during a therapy session which indicates significant risk to themselves or others, the therapist's responsibilities are clear, but this is not so when information is located outside of the therapeutic context through PTG (Clinton et al., 2010). This raises complex ethical dilemmas that require professional guidelines, training and supervision.
- Guidelines and training could support therapists to consider the risks and benefits of carrying out PTG, how to open up a conversation about PTG with a patient, how to obtain informed consent, the circumstances under which PTG without consent could be ethically justified, whether and where PTG findings should be formally documented, how PTG issues could be explored in clinical supervision, and how disclosures of PTG may impact the therapeutic relationship.

professionals who had conducted PTG did not explore this in supervision. Feelings of shame, or fear of disciplinary proceedings, are likely to act as strong barriers to disclosure given the evident ethical issues associated with PTG.

Codes of ethics outside of the UK make specific reference to PTG issues. For example, the Ethical Principles of Psychologists and Code of Conduct published by the American Psychological Association (APA) state that in their work, psychologists should uphold the principles of beneficence and non-maleficence (APA, 2016), from which it can be extrapolated that before conducting PTG, psychologists should consider whether PTG would provide any benefit for the patient and be confident the patient would not be harmed as a result. The principle of fidelity and responsibility (APA, 2016) suggests that psychologists should consider whether PTG would impact on trust in the relationship, whilst the principle of integrity (APA, 2016) suggests that in upholding honesty and truthfulness in their practice, psychologists should disclose their wish to carry out PTG to a patient, explain the rationale and obtain informed consent.

Within the UK, the Code of Ethics and Conduct published by the British Psychological Society (BPS) details the ethical standards which members are expected to uphold, with the aim of guiding the decision-making of psychological professionals (BPS, 2018). Similar frameworks exist for specific professional groups within the psychological profession, for example the Ethical Framework for the Counselling Professions, published by the British Association for Counselling and Psychotherapy (British Association for Counselling & Psychotherapy, 2018). The Code of Ethics and Conduct (BPS, 2018)

details several ethical issues, which are central to PTG. In accordance with the principle of respect (BPS, 2018), professionals should consider issues of consent, and therefore should obtain informed consent from the patient before carrying out PTG. As well as serving to maintain respect, obtaining informed consent may result in other benefits. For example, Cole (2016) argues that obtaining informed consent from the patient prior to PTG maintains honesty in the therapeutic relationship, informs patients of the risks and benefits of searching and provides the patient with an opportunity to disclose any of the sought-after information on their own terms.

According to the respect principle (BPS, 2018), professionals should also consider issues of power, and therefore should be cognisant that PTG could be a misuse of power in that it reduces a patient's sense of agency and autonomy in a relationship where there is an inherent power imbalance. The Code of Ethics (BPS, 2018) also states professionals should be aware of issues of privacy and self-determination, suggesting professionals should remain mindful that PTG could equate to an invasion of patient privacy, whilst also ridding the patient of their right to self-determine what they share and when they share it.

In line with the principle of responsibility (BPS, 2018), professionals are accountable for their decision-making. Consequently, professionals who do undertake PTG may have a professional duty to act on any evidence that the patient themselves is at risk or presents a risk to others; a scenario which could be further complicated if informed consent was not obtained prior to the search.

In accordance with the principle of integrity (BPS, 2018), professionals are expected to show honesty, openness and candour. In the context of PTG, this may equate to the professional openly explaining to the patient why they want to undertake PTG before obtaining informed consent and then, if consent is provided, sharing candid feedback with the patient after the search. In cases where consent was not obtained and PTG was undertaken regardless, a professional could demonstrate honesty, openness and candour by, after weighing up the risks and benefits to the patient, disclosing PTG in to the patient. Also in line with the integrity principle (BPS, 2018), professionals are expected to avoid exploitation and conflicts of interest (including self-interest), suggesting that PTG should not be undertaken if this is solely in the interests of the professional, such as to satisfy their personal curiosity.

The context of the COVID-19 pandemic is likely to increase the prevalence of PTG for several reasons. For instance, it is likely more therapists are using the Internet as part of their clinical practice, and that those who were using the Internet as part of their clinical practice prior to the pandemic may be using it even more during the pandemic. Simultaneously, increased therapeutic encounters online (e.g., via online therapy platforms and video call software) means that the resources required to carry out PTG (such as privacy and Internet access) are more accessible to professionals in their working day. Additionally, increased remote working during the pandemic may result in professionals having a reduced confidence in their clinical conclusions and a consequent increase in PTG to verify patient-related information and, further, moving therapeutic encounters

to the online world may shift the therapist's representation of the patient to being that of a "virtual one" and make PTG more likely. Notwithstanding the expectation that the change to therapeutic delivery necessitated by the pandemic will be time-limited, it is likely that some therapists and clients may wish to continue with online therapy indefinitely.

Given the ethical issues inherent in PTG, compounded by the context of the COVID-19 pandemic, and the possibility that remote delivery of therapy may continue indefinitely, a review of the PTG literature is both crucial and timely. Understanding the prevalence of PTG, both with and without consent, would be one way to assess the level of need for professional guidelines in this complex and evolving area. It would also inform the curricula of professional therapeutic training programmes and continuing professional development courses.

The review focused on the following question: what is the prevalence of PTG amongst psychological therapists, how often is consent sought, and what are the motivators and consequences of it?

## 2 | METHOD

Given methodological variability, a narrative literature review was undertaken (Popay et al., 2006). Papers were not selected for review based on methodological quality since one aim of the review was to identify methodological issues pertaining to this sensitive topic.

### 2.1 | Study selection

The study selection strategy followed PRISMA guidelines (Moher et al., 2009), the outcome of which is reported in Figure 1.

#### 2.1.1 | Publication status

Only studies published in peer-reviewed journals were included.

#### 2.1.2 | Databases

The Psychology Cross-Search function in EBSCO was used to locate relevant articles indexed in PsycINFO, PsycARTICLES, Psychology and Behavioural Sciences Collection, and MEDLINE.

#### 2.1.3 | Search terms

Search terms were kept broad to increase the likelihood of locating relevant literature. Level 1 terms were as follows: "patient-targeted googling" OR "patient targeted googling" OR Google OR Googling OR "internet search" or "online search." Level 2 terms were: psychologist OR psychotherapist OR therapist OR counsellor OR counselor

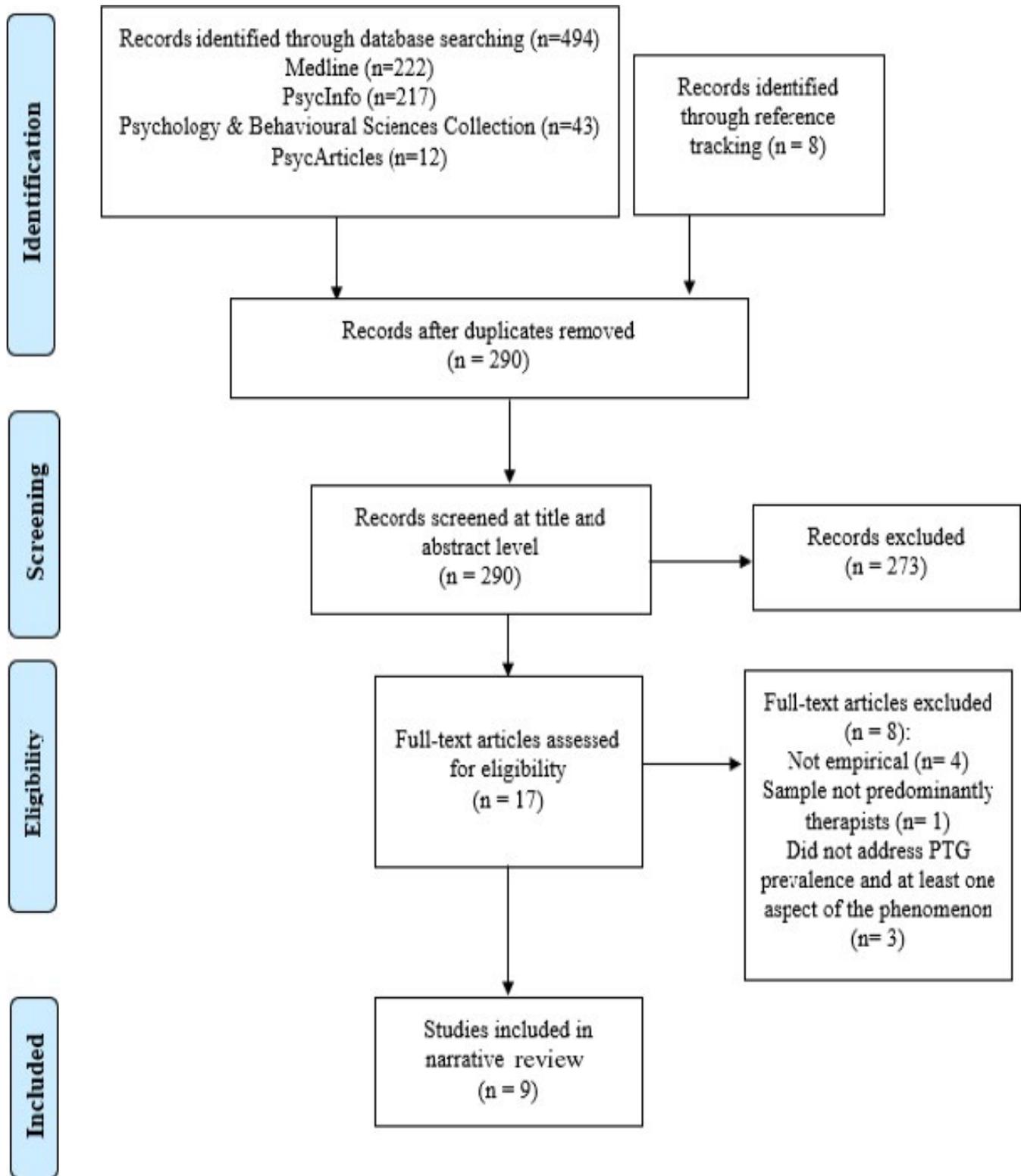


FIGURE 1 Study selection process

OR psychiatrist OR “mental health practitioner” OR “mental health professional”. Level 1 and level 2 terms were combined in a single search using AND between the levels. Records were limited to peer-reviewed publications available in English. Searches were conducted in October 2020.

#### 2.1.4 | Inclusion and exclusion criteria

Studies were eligible for inclusion if: (a) they reported primary data from an empirical study; (b) they sampled healthcare professionals who deliver psychological therapy designed to alleviate distress and

promote wellbeing under the auspices of a regulatory professional body; and (c) the explicit or implied aims of the research included assessing the prevalence of PTG, *as well as* either the motivations behind PTG and/or the perceived or actual consequences of it. Studies with samples featuring other healthcare professionals were excluded. No limits were placed on the date range.

### 2.1.5 | Study selection process

One author read through all titles and abstracts generated by the search terms. The inclusion and exclusion choices were then verified by the second author. At initial title and abstract screening, articles were excluded because either they did not focus on PTG (e.g., PTG referred to Post-Traumatic Growth) or were not empirical studies. Nine studies were eligible for inclusion (Figure 1).

## 2.2 | Quality assessment of studies

All eligible studies had a cross-sectional survey design. In the absence of a single tool to assess the quality domains relevant to the sample of papers, several criteria were selected from existing tools or were devised specifically for this review. Items relating to the study aims and design were drawn from the "Quality Assessment Tool for Observational Cohort and Cross-sectional Studies" (National Heart, Lung, & Blood Institute, 2019). Sample size was not included in the assessment because the data relevant to the review question were descriptive. This tool was supplemented with quality criteria considered specific to the set of papers. Two of these supplemental criteria related to open-ended data: "if open-ended data were collected, is the analysis method clear in the paper?" and "is there enough information in the paper to justify the themes that were identified from open-ended responses?". Three further criteria were added which related to the ethical issues inherent in conducting a PTG study; these were "was there discussion of the ethics surrounding the study itself?", "was participant anonymity clearly stated?" and "was there an acknowledgement that the validity of the data was reliant on participants feeling safe enough to disclose PTG?". Each of the applicable criteria was rated either as Yes or No. A total score was not computed as this implies all items of quality should be treated equally (O'Connor et al., 2015).

## 2.3 | Data extraction and analysis

Data were extracted from the results sections of each paper by the lead author. The extracted data were confirmed by one of the co-authors. A data extraction form was created with a column for each aspect of data being collected. In addition to publication details (authors, year and country), other descriptive features extracted were as follows: design, recruitment method, sample size, gender composition, mean age and age range, measure(s) and data analysis

methods. Data extracted relevant to the review question were as follows: PTG prevalence and consent rates, perceived and actual motivators of PTG, and perceived and actual consequences of PTG.

For the purposes of this review, PTG prevalence is defined as the percentage of professionals in each sample who reported ever having engaged in PTG. PTG prevalence (%) was reported descriptively. These data were not aggregated as three studies did not report overall sample prevalence (DiLillo & Gale, 2011; Gershengoren, 2018; Kolmes & Taube, 2014). The proportion (%) of participants who conducted PTG without consent was reported descriptively. These data were not aggregated as two studies did not clearly state the prevalence of non-consent (DiLillo & Gale, 2011; Gershengoren, 2018), whilst a further three did not report any consent data (Deen et al., 2013; Kolmes & Taube, 2014; Lehavot et al., 2010). Regarding motivations, some studies reported frequency of endorsement of predefined motivations, whilst others reported themes, which were identified through quantitative content analysis of open-ended questions. Different motivations reported across studies were grouped together based on semantic similarity, and the frequency of these across studies was reported. The consequences of PTG that were reported across studies were grouped into two meta-themes of positive and negative consequences. Within each of these meta-themes, the frequencies of each type of consequence across studies were reported.

## 3 | RESULTS

### 3.1 | Characteristics of included studies

All studies were conducted in countries with developed economies, with seven of the nine studies conducted in the United States. Given the distinct nature of the US private healthcare system, conclusions drawn and their applicability to countries with state healthcare systems must be tentative. Sample sizes ranged between 82 and 783. Participants across the studies were diverse in professional group and included trainee and qualified child psychologists, psychiatrists, psychology doctoral students and qualified psychotherapists. All studies which reported sample gender comprised more females than males (52%–84%). If there are gender differences in PTG, then this overrepresentation of females reduces the applicability of the findings to male therapists. Whilst the mean age varied across samples, only one study reported the sample age range (23–80 years; Kolmes & Taube, 2014) and it is unclear whether other studies had a similarly wide age range. Given the relatively young mean ages (Table 1), it is not possible to be confident that older therapists were sufficiently represented. Older therapists are arguably more likely to have trained or practised at a time when the Internet was less central to daily life. By extension, the prevalence and features of PTG may be different amongst older therapists.

All nine studies administered cross-sectional surveys. Six of these contained both closed and open questions (Deen et al., 2013; DiLillo & Gale, 2011; Eichenberg & Herzberg, 2016; Kolmes &

**TABLE 1** Characteristics of included studies

Lead author (year)	Country	Sample <sup>a</sup> (N)	Profession	Gender % female	Age M (SD)	Survey questions
Deen (2013)	USA	130	Psychiatrists and Psychologists	NR	NR	Open and closed
DiLillo (2011)	USA	783	Psychology doctoral students	81	28.07 (4.92)	Open and closed
Eichenberg (2016)	Germany	207	Psychotherapists	68	45.00 (10.49)	Open and closed
Gershengoren (2018)	USA	82	Trainee (T) and Qualified (Q) Psychiatrists	52	T: 29.0 (NR) Q: 46.0 (NR)	Closed
Harris (2014)	USA	75	Psychology and Counselling graduate students	84	28.40 (6.21)	Closed
Kolmes (2014)	USA	227	Mental health professionals	74	40.55 (12.73)	Open and closed
Lehavot (2010)	USA	302 <sup>b</sup>	Graduate Psychology students	NR	NR (NR)	NR
Thabrew (2018)	New Zealand	88	Psychiatrists, Clinical Psychologists, Psychotherapists	83	44.85 (10.84)	Open and closed
Tunick (2011)	USA	246	Qualified and Trainee Child Psychologists	79	37.4 (NR)	Open and closed

Abbreviation: NR, not reported.

<sup>a</sup>With clinical experience.

<sup>b</sup>Of which 82% had clinical experience (exact *n* NR).

Taube, 2014; Thabrew et al., 2018; Tunick et al., 2011). A further two (Gershengoren, 2018; Harris & Robinson Kurpius, 2014) used Likert scale questions, and the other study (Lehavot et al., 2010) did not include any information regarding the specific types of questions asked. Full study characteristics are given in Table 1.

### 3.2 | Quality appraisal

Table 2 summarises the findings of the quality appraisal. None of the studies used a standardised measure of PTG, and there was considerable variability in the scope and length of the surveys. For example, Gershengoren (2018) reported using a 19-item survey about frequency of, and reasons for, searching patients using Google, whilst Kolmes and Taube (2014) used a 107-item survey enquiring about Internet use and intentional and accidental discovery of information about patients. Question formats were also variable. Given this variability, the findings of this review need to be seen in the context of an evident lack of a validated and consistent operationalisation of PTG.

Of the seven studies which gathered open-ended data, just two (Eichenberg & Herzberg, 2016; Thabrew et al., 2018) clearly explained how it was analysed. Four of the seven studies extracted themes from the qualitative data. Of these, Kolmes and Taube (2014) did not present a clear analytic method and the themes reported were not illustrated by extracts. Lehavot et al. (2010) provided illustrative extracts to justify the themes presented, although the process of analysis was not clear. The remaining two studies (Eichenberg & Herzberg, 2016; Thabrew et al., 2018) reported both how the open-ended data were analysed (content analysis) and

provided illustrative quotes to support their themes. Relatively more confidence can therefore be placed in the themes reported from open-ended data in these two studies.

Five of the nine studies explicitly stated that participant anonymity was preserved (Deen et al., 2013; Gershengoren, 2018; Kolmes & Taube, 2014; Thabrew et al., 2018; Tunick et al., 2011). Given the implications of anonymity for disclosure of a sensitive topic like PTG, increased confidence can be placed in the findings of these studies relative to the others. Of note, none of the nine studies presented a consideration of potential influences on participant reporting of PTG that might impact data quality such as social desirability, fears regarding consequences or shame.

### 3.3 | PTG prevalence

Self-reported PTG showed considerable variation, ranging from 20% to 98% (Table 3). Within this, Gershengoren (2018) reported similar rates of PTG between qualified (93%) and trainee (94%) psychiatrists. DiLillo and Gale (2011) reported prevalence based on whether the participant used social media (95%) or a search engine (98%). Kolmes and Taube (2014) assessed occurrence of PTG in “non-crisis situations” only (48%). As noted above, relatively more confidence may be placed in those studies that assured participant anonymity (Deen et al., 2013; Gershengoren, 2018; Kolmes & Taube, 2014; Thabrew et al., 2018; Tunick et al., 2011). Rates in these studies ranged from 20% to 94%. However, the rate of PTG across the studies needs to be seen in the context of considerable sample variability in terms of qualified status, professional group, sample size and operationalisation of PTG.

TABLE 2 Quality assessment

Quality criterion	Lead author & year									
	Deen (2013)	DiLillo (2011)	Eichenberg (2016)	Gershengoren (2018)	Harris (2014)	Kolmes (2014)	Lehavot (2010)	Thabrew (2018)	Tunick (2011)	
Clear question/objective	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	
Study population defined sufficiently	No	Yes	No	Yes	Yes	No	No	Yes	Yes	
Recruitment method defined sufficiently to replicate	Yes	Yes	No	Yes	No	No	Yes	Yes	Yes	
Method of open-ended data analysis clear	No	No	Yes	NA	NA	No	No	Yes	No	
Themes justified by data presented	NT	NT	Yes	NA	NA	No	Yes	Yes	NT	
Study ethics discussed	No	No	No	No	No	No	No	No	No	
Participant anonymity stated	Yes	No	No	Yes	No	Yes	No	Yes	Yes	
Data bias in relation to anonymity considered	No	No	No	No	No	No	No	No	No	

Abbreviations: NA, not applicable (e.g., no open-ended data); NT, no themes (i.e., open-ended data but not analysed thematically). Quality appraisal is based upon information contained within the papers themselves.

### 3.4 | PTG and consent

Of the four studies which directly addressed the question of gaining patient consent (Eichenberg & Herzberg, 2016; Harris & Robinson Kurpius, 2014; Thabrew et al., 2018; Tunick et al., 2011), the rates of conducting PTG without consent ranged from 60% to 84% (Table 3). Gershengoren (2018) asked whether PTG was “discussed” with the patient, rather than whether informed consent was obtained prior to PTG; a “clear majority” reported that they had never done so (Gershengoren, 2018, p.4). Another study reported the proportion of patients who had provided consent, rather than the proportion of professionals who conducted PTG without consent (DiLillo & Gale, 2011). The remaining three studies did not report any data about consent (Deen et al., 2013; Kolmes & Taube, 2014; Lehavot et al., 2010).

### 3.5 | Motivations for PTG

In three studies, participants were asked about the motivation for actual PTG (Kolmes & Taube, 2014; Lehavot et al., 2010; Tunick et al., 2011), whilst two studies focused on motivations for hypothetical PTG (Deen et al., 2013; Eichenberg & Herzberg, 2016). In the other four studies, it was unclear from the paper itself whether participants were asked about hypothetical or actual PTG, or both. Studies utilised various open and closed questions to enquire about motivations for PTG. These were grouped based on conceptual similarity to generate the motivation categories presented in Table 4. For example, Eichenberg and Herzberg (2016) enquired about hypothetical reasons for conducting PTG and classified a proportion of responses as “if there was a reasonable suspicion the client was lying”, whilst Kolmes and Taube (2014) reported a motivation of “verification of details shared in psychotherapy”. Both these were aggregated into the motivation category “verify known information”. Table 4 indicates these, alongside to “obtain new information” and “curiosity”, were the most common motivation categories.

Greater confidence can be placed in the data from studies that explicitly stated that participants were asked about their motivations behind actual incidents of PTG, of which there were three (Kolmes & Taube, 2014; Lehavot et al., 2010; Tunick et al., 2011). Confidence in these three studies can be further increased if the types of questions asked to obtain motivation data were made clear in the paper. This was the case in one study (Lehavot et al., 2010), in which participants were asked open-ended questions about their historical PTG. Motivations reported were curiosity and to verify known information. However, it was not clear in the paper whether an inductive or deductive method of analysis was used.

### 3.6 | Consequences of PTG

In six studies, participants were asked to consider the actual (Lehavot et al., 2010; Tunick et al., 2011) or hypothetical consequences (Deen

**TABLE 3** PTG prevalence and consent data

Lead author (year)	Sample profession	% PTG by those who practised clinically	% non-consent of those who disclosed PTG
Deen (2013) <sup>a</sup>	Psychiatrists and Psychologists	20	NR
DiLillo (2011)	Psychology doctoral students	Google: 98 SNS: 95	Unclear
Eichenberg (2016)	Psychotherapists	40	76
Gershengoren (2018) <sup>a</sup>	Qualified and trainee Psychiatric Professionals	93 (qualified) 94 (trainee)	NQ
Harris (2014)	Psychology and Counselling graduate students	33	84
Kolmes (2014) <sup>a</sup>	Mental health professionals	48 <sup>b</sup>	NR
Lehavot (2010)	Graduate psychology students	27	NR
Thabrew (2018) <sup>a</sup>	Practising Psychiatrists, Clinical Psychologists and Psychotherapists	53	68
Tunick (2011) <sup>a</sup>	Qualified and trainee Child Psychologists	32	60

Abbreviations: NQ, not quantified; NR, not reported; SNS, social networking site.

<sup>a</sup>Specified in paper that participant anonymity assured.

<sup>b</sup>In a non-crisis situation rather than across both crisis and non-crisis situations.

**TABLE 4** PTG motivation categories

Lead author (year)	Verify known information	Obtain new information	Curiosity	Patient or family requested	Reduce risks	Improve care quality	Clarify contact details	Screen, e.g., for dual relationships
Deen (2013)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
DiLillo (2011)	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	
Eichenberg (2016)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Gershengoren (2018)			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
Harris (2014)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			
Kolmes <sup>a</sup> (2014)	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>
Lehavot <sup>a</sup> (2010)	<input type="checkbox"/>		<input type="checkbox"/>					
Thabrew (2018)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Tunick <sup>a</sup> (2011)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

<sup>a</sup>Question asked about motivations for actual PTG undertaken in the past (other studies focused on hypothetical PTG motivations).

et al., 2013; Eichenberg & Herzberg, 2016; Thabrew et al., 2018) of PTG, or both (Kolmes & Taube, 2014). Studies utilised various open and closed questions to enquire about the consequences of PTG. In a similar way to the motivation data, the consequences data were grouped based on conceptual similarity to generate the consequences categories presented in Table 5. The consequences were sub-divided into those that may be considered broadly positive or negative. One study (Kolmes & Taube, 2014) contributed to the consequence categories more than others. This study focused on both actual and hypothetical PTG, and this might explain the seemingly contradictory findings (e.g., that PTG can both improve and harm the therapeutic relationship). The most convincing data perhaps come from Tunick et al. (2011). Not only was it one of the three studies that enquired about actual consequences of PTG, as opposed to purely hypothetical consequences, it was the only study that gave a clear account in the paper of the questions asked, as well as the

analytic method. This study reported that PTG can improve overall care quality but that it can make the therapist aware of information about the patient that might raise a cause for concern.

## 4 | DISCUSSION

This review aimed to summarise the literature on the prevalence of, motivations for, and consequences of PTG in professionals delivering psychotherapeutic interventions. The review suggests that there are several difficulties with the literature that limit the ability to estimate with confidence the prevalence of PTG per se, as well as that which occurs in professionals outside of the United States. Moreover, the review raises a question about the applicability of current evidence to psychotherapeutic practitioners who are male and more senior in age.

**TABLE 5** PTG consequences categories

	Deen (2013)	Eichenberg (2016)	Kolmes (2014) <sup>a</sup>	Lehavot (2010) <sup>a</sup>	Thabrew (2018)	Tunick (2011) <sup>a</sup>
<b>Positive consequences</b>						
Improves care quality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improves understanding of patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Increases therapist's sense of safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Reduces risks					<input type="checkbox"/>	
Therapist can address concerning information						<input type="checkbox"/>
Improves therapist's objectivity			<input type="checkbox"/>			
Improves therapeutic relationship			<input type="checkbox"/>			
Helps treatment progress			<input type="checkbox"/>			
<b>Negative consequences</b>						
Harms the relationship, e.g., reduces trust		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Therapist experiences uncomfortable affect	<input type="checkbox"/>		<input type="checkbox"/>			
Removes patients' rights, e.g., privacy		<input type="checkbox"/>			<input type="checkbox"/>	
Therapist obtains inaccurate information		<input type="checkbox"/>			<input type="checkbox"/>	
Therapist finds concerning information						<input type="checkbox"/>
Therapist burdened with information			<input type="checkbox"/>			
Impairs therapist objectivity			<input type="checkbox"/>			
Hinders treatment progress			<input type="checkbox"/>			

<sup>a</sup>Question asked about consequences of actual PTG that had been undertaken in the past (other studies focused on hypothetical PTG).

#### 4.1 | PTG prevalence

The considerable variation in prevalence rates across the nine studies may be influenced by several factors, a significant one of which is the lack of consistent operationalisation of PTG in surveys and there being evident variability in survey length and focus. There are also definitional issues, such as whether PTG research focuses on current patients only or also includes past patients. Whilst Kolmes and Taube (2014) broke down their PTG prevalence data according to whether the search was for a current or ex-patient, none of the remaining studies specified whether their definition of PTG included or excluded patients with whom therapy had ended at the time of the search.

Another factor impacting on the confidence placed in prevalence estimates is lack of explicit reporting of participant anonymity or any mechanisms in place should participants disclose unethical practice. When focussing on the five studies that did state participants were assured of anonymity, prevalence rates vary from one in five qualified professionals sampled (Deen et al., 2013) to almost all of them (Gershengoren, 2018). No study discussed the impact of anonymity on bias in the data due to shame or professional censure fears. Generally, discussion of research ethics was limited.

Finally, it is important to note that the data collection for the studies in the sample spanned approximately 10 years and it is important to acknowledge that PTG prevalence rates may have changed during this timeframe.

#### 4.2 | Consent

It is not possible to obtain an estimate of non-consented PTG across the sample of papers because five did not enquire about this. Moreover, the previously noted variability in definition and measurement impacts on the validity of aggregating across studies. In the four studies that enquired about patient consent in actual cases of PTG (Eichenberg & Herzberg, 2016; Harris & Robinson Kurpius, 2014; Thabrew et al., 2018; Tunick et al., 2011), non-consent was high. Whilst this suggests that most practitioners either did not consider it necessary or relevant to gain patient consent, or did not do so because they considered PTG inappropriate and therefore something to be concealed, there is little in the literature to indicate decision-making regarding consent. This is recommended as a focus for further research.

#### 4.3 | Motivations and consequences

Motivations for PTG were similar for both hypothetical and actual instances of PTG. The one exception was "to improve care quality", which was only reported in two studies of hypothetical PTG (Gershengoren, 2018; Thabrew et al., 2018). The most common motivations were to verify known information, to obtain new information, or curiosity. These findings, whilst limited and not without methodological limitations, are interesting. When PTG is motivated

by a desire to verify known information, one could argue that even when informed consent has been obtained, there is still no need to carry out PTG to verify information given that historically professionals practised without access to such a resource. However, this argument neglects the possibility that PTG could be used to verify information and ultimately enhance care quality, providing of course that informed consent was obtained from the patient beforehand. In contrast, curiosity, which was another common motivation for PTG, is arguably centred on the needs of the professional, rather than the patient, and contravenes the ethical principle of not acting solely out of self-interest (BPS, 2018). A further motivator for actual and hypothetical PTG was that it increases therapist safety. It is possible that the need to verify/obtain information and curiosity might be a way to enhance feelings of safety and, as such, may be a powerful motivator for PTG for trainees and qualified practitioners. Further research is recommended that explores motivations in more depth so that these issues can be addressed in an ongoing way in training, supervision and professional guidelines.

A further need to consider motivations for PTG in more depth arises from the consequence data. Whilst positive aspects of PTG were reported to be increased safety, improved care and enhanced understanding of the patient, a common negative consequence was perceived to be harm to the therapeutic relationship, such as by damaging trust in the therapist. Collaborative relationships with patients require mutual trust and are facilitated by involving patients in treatment decisions and giving them choice (Spencer et al., 2019). Not only does non-consensual PTG violate the ethical principles of consent and self-determination (BPS, 2018; DiLillo & Gale, 2011), revealing PTG in such a case (e.g., because a risk issue was uncovered) may harm the therapeutic relationship and even result in disengagement from therapy. It is also noteworthy that even when non-consensual PTG remains concealed from the patient, the information learned may nonetheless impact processes of transference and countertransference (Clinton et al., 2010) and thereby undermine the therapeutic relationship.

#### 4.4 | Implications

Notwithstanding the methodological issues outlined, focussing just on the studies that indicated participation was anonymous, the lower (i.e., most conservative) estimate of PTG was one in five of a sample of psychologists and psychiatrists (Deen et al., 2013). This is not an insubstantial rate. Several ethical, practice, research and training-related implications arise from the findings. Not least that when a patient discloses information during a therapy session which indicates significant risk to themselves or others, the therapist's responsibilities are clear, but this is not so when information is located outside of the therapeutic context through PTG (Clinton et al., 2010). This is just one issue in the PTG field which raises complex ethical dilemmas that require professional guidelines, training and supervision.

Issues of PTG may increase as the therapeutic frame moves from the office to an online environment, for example during and the COVID-19 pandemic. Therefore, up-to-date training and guidelines

are needed for qualified and trainee professionals alike. Some suggestions for guidelines exist in the literature; these include only using search terms that limit the chances of obtaining information that is not central to the question being investigated (McNary, 2014), and that if information is found that affects clinical decision-making, this information should be discussed with the patient to give them an opportunity to correct it if necessary (Cole, 2016). However, these suggestions do not mitigate the potential impact of non-consensual searching on the relationship.

## 5 | FUTURE RESEARCH

This review established an absence of PTG studies on UK-based therapists. Future research should seek to evaluate the prevalence of PTG by UK-based therapists, which will in turn identify the extent of a need for professional practice guidelines. This review also established that in some studies, PTG was motivated by a desire to find out and/or verify information. Future studies should explore what motivates actual incidents of PTG, what it is about the work with the patient that precludes obtaining information from them directly, and how to otherwise manage concerns about the veracity of patient-volunteered information. Such a study could also explore the consequences of actual incidents of PTG, including whether it was disclosed and what the implications of this were for the therapeutic relationship. This work may be enhanced by exploring what patients themselves think about PTG.

Future research might also explore the feasibility of developing a contract with patients to gain consent for locating information outside of the session, the circumstances in which this would be appropriate, and what information would be acted on and how. This would then allow the patient to exercise choice and self-determination and, ultimately, make it less likely that mutual trust is eroded. Another avenue worthy of exploration would be the benefits and risks of using the aforementioned approach (PTG by the therapist outside of the therapeutic space) versus the benefits and risks of carrying out PTG together within the therapeutic space, as a shared activity.

In order to carry out research in these areas in a methodologically robust way, a consensus should be reached regarding whether the "patient" in PTG includes searching for people in the patient's life who have been mentioned in therapy, and whether the term encompasses current patients only, or also extends to patients with whom therapy has been ended. Although it might be speculated that the motivations are less related to patient care for those who have ended therapy, empirical work on this topic is needed given that professional practice guidelines in other areas of activity relate to both current and past patients.

## 6 | CONCLUSION

This review found no published studies of PTG conducted by psychological therapists practising in the UK. This highlights a previously unidentified gap in the literature which warrants exploring,

especially as this review also found that PTG is common across professional groups within the psychological professions, and in samples diverse in age and qualification status.

Further research is needed to reach an evidence-based consensus on how PTG can be best defined and operationalised, and to understand the motivations for, and consequences of, actual incidents of PTG in more depth. Future research should also seek to explore patients' own attitudes towards PTG and the experiences of therapists who disclosed their PTG to the patient concerned, to understand the impact that this had on the therapeutic relationship. This research would inform the development of a model that captures the variability in PTG phenomenology. Such a model might be used as the basis for PTG-specific professional practice guidelines and training, for psychological professionals practising in the United Kingdom. Such guidelines and training could support therapists to consider the risks and benefits of carrying out PTG, how to open up a conversation about PTG with a patient, how to obtain informed consent, the circumstances under which PTG without consent could be ethically justified, whether and where PTG findings should be formally documented, how PTG issues could be explored in clinical supervision, and how disclosures of PTG may impact the therapeutic relationship.

## CONFLICTS OF INTEREST

We have no conflicts of interest to disclose.

## ETHICAL APPROVAL

We have no ethical approval statement, patient consent statement or data availability statement, as this was not a primary research study.

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# QUESTIONNAIRE

## PE5(22)

### Patient- targeted googling by psychological therapists: A narrative review of the literature and ethical implications

#### INSTRUCTIONS

- Read through the article and answer the multiple-choice questions provided below.
- **Some questions may have more than one correct answer;** in which case you must mark **all** the correct answers.

**Question 1:** There is agreement that PTG includes which of the following?

- A:** Searching online for current patients only
- B:** Searching for an ex-patient
- C:** Searching for people in a patient's social network who have been mentioned in therapy
- D:** **Incorrect**, there is not yet a consensus on whether PTG includes all the above

**Question 2:** If PTG is disclosed to the patient it could disrupt which crucial factor of therapy that makes significant and consistent contributions towards therapy outcome?

- A:** Affirmation
- B:** Empathy
- C:** Positive regard
- D:** Trust

**Question 3:** Before conducting PTG, psychologists should consider whether PTG would provide any benefit for the patient and be confident that the patient would not be harmed as a result. This refers to which ethical principles?

- A:** Beneficence
- B:** Justice
- C:** Non-maleficence
- D:** Autonomy

**Question 4:** Which of the following refer to the principle of respect?

- A:** Obtaining informed consent from the patient prior to PTG maintains honesty in the therapeutic relationship
- B:** Obtaining informed consent from the patient prior to PTG informs patients of the risks and benefits of searching and provides the patient with an opportunity to disclose any of the sought-after information on their own terms
- C:** Being aware that PTG could be a misuse of power in that it reduces a patient's sense of agency and autonomy in a relationship where there is an inherent power imbalance
- D:** None of the above

**Question 5:** Which of the following can contribute to the increase of PTG?

- A:** Internet use as part of the clinical practice
- B:** In-person therapeutic encounters
- C:** Remote working
- D:** Shift in representation of the patient to being that of a "virtual one"

**Question 6:** Is it **TRUE** that studies were eligible for inclusion if the explicit or implied aims of the research included assessing the prevalence of PTG, *as well as* either the motivations behind PTG and/or the perceived or actual consequences of it?

- A:** YES
- B:** NO

**Question 7:** Which criteria were added later that were related to the ethical issues inherent in conducting a PTG study?

- A:** "Was the analysis method clear in the paper?"
- B:** "Was participant anonymity clearly stated?"
- C:** "Was there a discussion of the ethics surrounding the study itself?"
- D:** "Was there an acknowledgement that the validity of the data was reliant on participants feeling safe enough to disclose PTG?"
- E:** "Was there enough information in the paper to justify the themes that were identified from open-ended responses?"

**Question 8:** Which of the following are **TRUE** regarding the characteristics of included studies?

- A:** All studies were conducted in countries with developed economies
- B:** All studies which reported sample gender comprised more males than females
- C:** The prevalence and features of PTG may be different amongst older therapists
- D:** Less than half of the included studies administered cross-sectional surveys

**Question 9:** Is it **TRUE** or **FALSE** that none of the nine studies presented a consideration of potential influences on participant reporting of PTG that might impact data quality such as social desirability, fears regarding consequences or shame?

- A:** TRUE
- B:** FALSE

**Question 10:** Self-reported PTG prevalence showed which of the following?

- A:** *Gershengoren* reported higher rates of PTG in qualified psychiatrists than trainee psychiatrists
- B:** *DiLillo and Gale* reported a higher prevalence of using a search engine than using social media
- C:** *Kolmes and Taube* reported a 48% occurrence of PTG in "non- crisis situations"
- D:** None of the above

**Question 11:** Which of the following were the most reported motivation categories?

- A: Obtain new information
- B: Curiosity
- C: Verify known information
- D: Improve care quality
- E: Clarify contact details

**Question 12:** Which of the following were positive consequences of PTG?

- A: Care quality was improved
- B: Therapist's understanding of patients was improved
- C: Therapist's sense of safety was increased
- D: Reduced risks
- E: None of the above

**Question 13:** Which one of the following were reported as negative consequences of actual cases of PTG?

- A: Harms the relationship
- B: Therapist experiences uncomfortable affect
- C: Removes patients' rights
- D: Therapist obtains inaccurate information
- E: Therapist finds concerning information

**Question 14:** Is it **TRUE** that consent was high in the four studies that enquired about patient consent in actual cases of PTG?

- A: YES
- B: NO

**Question 15:** After an online counselling session you feel it necessary to find out information about your patient, but before attempting to search for the information you consider which of the following?

- A: Only use search terms that limit the chances of obtaining information that is not central to the question being investigated
- B: If information is found that affects clinical decision-making, this information should be discussed with the patient to give them an opportunity to correct it
- C: Suggestions and guidelines regarding PTG do not diminish the potential impact of non-consensual searching on the therapeutic relationship
- D: None of the above

**END**



MEMBER INFO

(Complete sections marked with an asterisk \*)

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\*HPCSA number

ID number

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I hereby declare that the completion of this document is my own effort without any assistance.

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DATE:

This activity is accredited for **THREE ETHICS** CEU'S. You have to achieve **70%** to pass this activity.

ANSWER SHEET

PE5(22)

Patient- targeted googling by psychological therapists: A narrative review of the literature and ethical implications

	*Time spent on activity					hour					min				
	A	B	C	D	E	A	B	C	D	E	A	B	C	D	E
1						8									
2						9									
3						10									
4						11									
5						12									
6						13									
7						14									
						15									

How relevant was the content of this activity to your scope of practice?			
Not at all	Somewhat	Mostly	Extremely

RETURN ANSWER SHEET TO

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