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NOVEMBER 2013 • UPDATE

Minor Changes in HIPAA Privacy Rule

Minor changes to the HIPAA Privacy Rule became effective on September 23, 2013. Psychologists who belong to APA and pay the Special Assessment can use the materials from APA to comply with these changes. (July 25, 2013, issue of *Practice Update*). PPA members who do not belong to APA can go to the PPA website and find suggested language that they can add to their business associate contracts or Privacy Notices. The amended notice requires provisions concerning breach notification, patient access to electronic records, and standards concerning releases of information. Only new patients (or patients who started treatment after September 23, 2013) have to get a copy of the new Privacy Notice, although psychologists must make the new Privacy Notice available to all patients, if they so request it.

Licensure Renewal Deadline Coming Up

PPA urges all psychologists to make sure that they have completed the mandatory continuing education requirements before the current biennial licensure period ends on November 30. The State Board of Psychology has disciplined psychologists for failing to get the necessary continuing education or for falsely stating that they had completed their CE requirements. Psychologists who need more CE hours for this renewal period may want to attend PPA's Fall CE and Ethics Conference, October 31 and November 2, at the Holiday Inn Harrisburg East. In addition, psychologists can order home studies from PPA by calling 717-232-3817 or by downloading them from www.PaPsy.org.

All psychologists in Pennsylvania will be sent renewal notices from the State Board of Psychology this fall. Psychologists who practice after December 1, 2013, without a license may be in violation of the Professional Psychologists Practice Act and subject to prosecution by the State Board of Psychology.

Doing Good Work

A Review of *Blind Spots* by Max Bazerman and Ann Tenbrunsel with Commentary on Ethical Behavior Among Psychologists

Sam Knapp, EdD, ABPP[1], Director of Professional Affairs

Dr. Samuel Knapp

Perhaps nowhere has the explosion in research in ethics occurred more than in the field of business ethics. Although this interest may have increased as a response to scandals such as Enron or the Wall Street meltdown of 2008, a dedicated core of psychologically trained scholars have studied issues related to business ethics for many years.

In *Blind Spots* (Bazerman & Tenbrunsel, 2011), business ethicists Max Bazerman and Ann Tenbrunsel describe why well-meaning people may act unethically. They argue that traditional approaches to improving ethical conduct (developing ethics codes and requiring attendance at lectures on ethics) are unlikely to improve conduct unless attention is paid to the contextual and psychological processes involved in decision making. People may overestimate the extent to which they will act ethically because of their "blind spots" or "ethical sinkholes" that are usually outside of their own conscious awareness.

Bazerman and Tenbrunsel also note that an organization's culture can impact ethical conduct. Although these organizations may have a code of ethics and other formal ethical structures, they also have a "hidden culture." That is, the day-to-day

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[1]Appreciation to Dr. Ed Zuckerman who read a previous version of this review.

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Record Keeping Practices in High-Risk Situations

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Record keeping is an essential part of professional practice. It especially is important in high-risk situations, such as instances in which a patient threatens suicide. In such high-risk situations, psychologists should document the contents of the session and the interventions clearly and concretely.

Many mental health professionals are hesitant to record treatment sessions in detail. Often, there is a fear that the greater the detail, the higher the probability that harm will come to the patient or the therapist. This hesitation often results in a *less is more* approach to record keeping.

In a legal setting, however, this minimal approach to record keeping can result in greater legal exposure of the mental health professional. Courts commonly assume that what is written down is what actually occurred in treatment. That is, if the professional is required to defend the treatment in question, it is difficult to explain why pertinent information is missing from the written record. In this regard, consideration should be given to adopting a *more is more* approach to record keeping.

The written record should tell the story of treatment. The reader should be able to understand the issues being discussed, the interventions being instituted, and the reactions of the patient (Knapp, et. al., 2013). For example, if clinical terms are used, there also should be a description of the patient's behavior. That is, there is nothing wrong with stating that the patient appeared depressed or engaged in a suicidal gesture (if term is clearly explained; Heilbron, et al., 2010). This observation, however, should be clarified with specific detail and information. The treating professional may know when the patient presents in a depressed manner, but the details of this behavior must be conveyed to the reader in a transparent and concrete manner.

In high-risk situations, such as thoughts of suicide, the problem-solving steps considered and instituted by the treating professional should be clear-cut in nature. Once again, *a more is more* approach should govern the record keeping practices. The record should clarify the patient risk factors, identify the possible treatment interventions, describe why the professional chose one option over another, describe any consultations with outside professionals, and indicate what follow-up procedures will be employed. Often, it is helpful to include patient quotes as part of the documentation process.

If the intervention is successful, and the threat of suicide subsides, this observation should be noted in follow-up session notes. If self-destructive impulses re-emerge during treatment, psychologists should note these feelings again in the written record, as well as the steps instituted to address this clinical issue. In essence, the concept of continuity of care should govern record keeping practices, not the fear that someone might read what I did and why I did it. The record tells the story.

Record keeping is an integral part of professional practice. It provides continuity of care for the current provider and the potential future provider. It is an important element in providing good clinical care. From a risk management viewpoint, good record keeping can be a major component in advocating an early discharge from any wrongdoing. Clear, concrete, comprehensive session notes tell the story of treatment. Comprehensive records, coupled with the professional's training, expertise, and, if necessary, oral testimony, can show that proper care was provided to the patient. Comprehensive record keeping, therefore, is an important practice in all clinical situations, but especially in high-risk situations.

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Why Paul Meehl Didn't Attend Case Conferences

Revisiting Common Thinking Errors in Clinical Reasoning

Claudia J. Haferkamp, PhD

Dr. Claudia J. Haferkamp

I was in a meeting of the Academic Standards Committee listening as a Psychology major described how her life had spun out of control the previous semester, resulting in failing grades. She was facing suspension, so there was a lot riding on her appeal to this committee. I was the only psychologist present and I knew that she had bipolar disorder and had struggled to manage her shifting moods and energy levels. I was reasonably sympathetic to her plight, unlike my colleagues who appeared bored or frustrated by her rambling answers to our questions. As she described her long daily commute, tangential details started creeping into her story. She said, "It was such a long drive...Every time there was a manhole cover in the road, I had to swerve around it...Why do they place the manhole covers in exact line with where you need to drive? I don't know why they do that in Pennsylvania..." and her voice trailed off. Although she had lost her train of thought at a critical moment, I was impressed by her perceptiveness and common sense because I have also been annoyed with the placement of manhole covers in the roads. Why ARE they always in line with where one needs to drive? It was a pet peeve I had mulled over many times. But I knew she was a smart and capable student with a mood disorder, so I told the committee that she deserved a second chance if she would cooperate with getting psychiatric support and counseling. Her academic appeal was granted.

Later I began to second guess myself. Had I committed a clinical judgment error? Had I let her eminently sensible manhole cover opinions soften my judgment of her poor coping and academics? I recalled something from Paul Meehl's entertaining 1977 article, "Why I Do Not Attend Case Conferences." He would have said that I had fallen victim to the "Me-too fallacy" by failing to see the inappropriateness of behaviors/opinions because I have done/thought the same thing. The student's emotional instability was mitigated by what I perceived as her uncommon good sense about those manhole covers. Sadly, knowing about clinical judgment errors does not inoculate one from committing them. As Rogerson, Gottlieb, Handelsman, Knapp and Younggren (2011) observed in their article, Nonrational Processes in Ethical Decision Making, anything that evokes strong affective responses can cause us to make decisions that ignore more objective information.

His article is a treasure that deserves unearthing.

Paul Meehl's article was ahead of its time in identifying peculiar failures to objectively process clinical information. It was a sarcastic and often hilarious attack on the illogical, empirically unsupported, and just plain stupid remarks offered up by seemingly well educated and intelligent persons at case conferences. He believed that persons "...experience a twenty point decrement in functional IQ" (p. 230) in these meetings and "...this illustrates one of the generic features of case conferences in psychiatry, namely, the tendency to mention things that don't make any difference one way or the other..."(p. 231). His article is a treasure that deserves unearthing. In this article I will discuss some of the biases and distortions he mentions, relate them to other clinical biases and distortions, and present his recommendations for minimizing their impact.

Distortion #1: All evidence is equally good: It has been widely observed that people often fail to distinguish facts derived from controlled, scientific studies from anecdotal evidence based on personal or vicarious experiences. The availability heuristic indicates that people have better recall of personal, vivid information over data-based information. Years before the availability heuristic was widely researched, Meehl observed how we often ignore the reliability and validity of data. An example is when my graduate student described a meeting at her workplace where the case of a teen boy diagnosed with conduct disorder was reviewed. A long record of repeated verbal and behavioral offenses was presented, combined with information on school fights, chronically poor grades, and psychological testing that revealed serious learning deficits. The objective evidence painted a serious and deteriorating clinical picture. But after this information was presented, a ward staffer said that the child was "kind and loving" because he sometimes shared his iPod with other kids on the unit. Subsequent remarks in the meeting took on a more charitable slant, possibly fueled by emotions activated by the remark about the boy's kindness. This highlights a related distortion noted by Meehl: **failure to differentiate between the consistency of a sign and the diagnostic weight of that sign.** The kindness remark about the child was presented without regard to its frequency and diagnostic weight against the multi-year history of documented hostility and aggression. The rarity of his kindness was never discussed. Meehl noted that people often have inadequate behavior samples for making trait attributions. And colorful anecdotes may be useless precisely because they highlight unusual and infrequent reactions (e.g., "My uncle smoked for 50 years and never got lung cancer.") But increasing the number of anecdotes does not improve the intrinsic quality of

the information. Or as Roger Brinner is alleged to have said, "The plural of anecdote is not data."

On the issue of the diagnostic relevance, Meehl stated (p. 231): "...In order to be worth mentioning, the statement must not only be true but be *differentially* relevant, i.e., it must argue for one diagnosis, outlook or treatment rather than another." Meehl cited an example of a staff member who, in response to a schizophrenic patient's reported hallucinations of a man, said that it was "... not uncommon to have imaginary friends as a child." No one present bothered to point out that; (a) childhood imaginary friends and paranoid hallucinations have little in common with each other; (b) childhood imaginary friends are much more common than hallucinations; or (c) childhood imaginary friends are irrelevant to the case.

Distortion #2: "Me too" fallacy: My manhole cover story amply illustrated the tendency to minimize pathology that one can relate to. Meehl gave an example of a medical resident saying that a patient's temper tantrum over a no smoking rule was "...no big deal because a 3PM cigarette rule was just silly..." Meehl said (pg. 230)... "If you find yourself minimizing a recognized sign or symptom of pathology by thinking, 'Anybody would do this,' think again. Would just anybody do it? What is the objective probability of a mentally healthy person behaving just this way?" Indeed, it is with some embarrassment that I ask myself now, "How many people during an important interview before a panel of professors where they must account for why they flunked a semester's worth of classes would complain about the placement of manhole covers in the Pennsylvania roads?" Asked that way, it now seems ludicrous that I minimized her weirdly tangential rambling.

Distortion #3: Assuming that dynamics explain why a person is abnormal: It is tempting to assume that negative events in the past may cause pathology. For example, many clinicians assume, and research suggests, that child abusers were often abused or neglected as children or that persons with alcoholic parents are at greater risk for developing substance abuse problems. But Meehl says that we must look for differentiating causal agents, i.e., things that are true for the patient that are not true of others who remained healthy under similar circumstances. This is where a cognitive case conceptualization model is most helpful. While critical developmental experiences may be the origins of certain vulnerabilities, they are not necessarily the causal mechanisms that maintain pathology in the present. Having been abused as a child is not necessarily sufficient to cause abusive behavior later without other mechanisms operating such as toxic core beliefs triggering dysregulated emotions, etc. The origins of problems shouldn't be confused with their causal mechanisms but many of us miss this distinction.

Distortion #4: Asking pointless questions: Meehl says case conference participants often ask questions that make no difference and that invite unfounded speculation and time-consuming detours from the agenda. When discussing clinical cases in class, I've noticed that some students will ask interesting but largely rhetorical questions that have no clear answer and are irrelevant to the case. Once after a student presented a detailed case, a classmate asked, "I wonder how different his life would have been had his mother not left his father when he was 8?" While I am not immune to the desire to speculate about "the path not taken," the facts of what happened in the patient's life—as opposed to what did not happen—were all we had to work with. When intriguing but pointless questions are asked, my usual approach is to politely validate the student's curiosity and redirect them by saying, "It's fascinating to consider how things could have been different. But given the facts of his life and what did happen, perhaps a better question for us is: how can we best help him now?" Meehl said that he once knew a law professor who would respond to speculative questions with a blank stare and then pointedly ask, "And therefore?" But as a psychologist, I prefer a gentler approach.

At the end of his article, Meehl provided suggestions to improve the quality of information presented and discussed at case conferences. I mention only a few here:

(1) If you have nothing worthwhile to say, shut up. Meehl quoted Dr. Howard Horns who said (p. 284): "Most peoples' thoughts are worth their weight in gold." And if it doesn't make a material difference to the handling of the case, do we really need to hear it?

(2) Form your clinical impressions before testing, not after. Meehl's point is that objective test data are less likely to be "distorted" by our clinical impressions but our clinical impressions can be easily skewed by test data. I have tried to reduce the potentially biasing impact of pre-existing information by refraining from reading previous records until after an initial interview. While there are obvious disadvantages to this approach, it does help one conduct an interview that is less affected by one's confirmatory biases.

(3) Social history information should be presented in written, not oral, form. Meehl believed that it took too much time to present this data well, especially when done by what he called "poorly prepared people." I would add that the information sources' credibility and the reliability and validity of the data provided should be considered and perhaps even rated so that personal opinions about the patient are presented not on a par with the facts about him/her.

(4) Have follow-up case meetings to assess the accuracy of impressions. This would help professionals learn which diagnostic impressions and hunches were accurate and which weren't based on later data. It suggests an empirical approach which may be lacking in our meetings.

Not attending case conferences is probably not an option for most clinicians, but perhaps we can attend them armed with a commitment to prefer data over anecdotes and facts over speculation. And if we have nothing worthwhile to say, perhaps in silent tribute to Paul Meehl, we can choose not to say it.

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Continued from page 1

behavior within an organization is influenced more by the immediate context or the numerous private interactions and comments that occur among members of the organization. The real rules governing the organization may not necessarily be found in the formal ethics code found on the organization's website, but are embedded in the stories that employees tell, the euphemisms that they use to describe issues, or the socialization rituals that employees undergo. What is not talked about can be as important as what is talked about. Bazerman and Tenbrunsel note that "formal systems are the weakest link in an organization's ethical infrastructure" (p. 118).

Fortunately, Bazerman and Tenbrunsel offer specific strategies to help the readers avoid "ethical sinkholes." They ask the readers to consider, for example,

Ethical misconduct is less likely to occur in organizations that have climates that reinforce ethical reflection and expect adherence to ethical principles...

how a problem is defined (e.g., Is this a business decision, an engineering decision, or an ethical decision?); if prejudices outside of their immediate awareness may motivate their behavior; if the organization has informal or unwritten forces that encourage employees to ignore or minimize the ethical implications of a decision; or if isolation, uncertainty, or time pressures will increase the likelihood of an unethical decision.

In a separate detailed review of research in business ethics, Kish-Gephart, Harrison and Treviño (2010) concluded that multiple factors can influence ethical choices in business organizations including both personality and situational factors. Ethical misconduct is more likely to occur among individuals who are quick to obey authority figures, who hold highly relativistic moral philosophies, or who have a Machiavellian (cynical) view of human nature. Ethical misconduct is less likely to occur in organizations that have climates that reinforce ethical reflection and expect adherence to ethical principles (consistent with the conclusions of Bazerman and Tenbrunsel).

Social psychologist Philip Zimbardo (2007) refers to this sensitivity to the potential impact of environmental influences as being "frame vigilant." In his book, *The Lucifer Effect*, Zimbardo gives details based on his personal experience in the Stanford prison experiment, and as a consultant to survivors of the Jonestown massacre and to accused army officers at Abu Gharib. Although Zimbardo does not absolve anyone for their actions, he urges readers to consider the impact that immediate environmental factors had on the behavior of individuals involved in poor practices. Implicitly he cautions that all of us have the potential to act poorly when placed in situations where we lack sensitivity to the ways that the immediate environment is influencing our behavior. Fortunately, Zimbardo also identifies ways that we can use this knowledge of social influences to help us improve our behaviors.

The work of Bazerman and Tenbrunsel prompts me to reflect on what we know about ethical conduct and misconduct in health care. We do know that many reported misconduct or substandard practice among physicians is related to poor relationships with patients (Hickson, et al., 2008), failure to belong to professional associations (Kilmo et al., 2000), a lack of teamwork (Erickson et al., 2010), and fatigue (Harvard Work Group, 2004).

Data on psychologists is more limited. However, we do know that the rate of being disciplined by the state board of psychology in Pennsylvania is more common among non-members of PPA (Knapp & VandeCreek, 2009). We also know that exemplary behavior is more likely to occur among psychologists who have strong social ties to professional groups and their own social network, and who feel a passionate commitment to their profession (Coster & Schwebel, 1997; Dlugos & Friedlander, 2001).

What can we conclude from this research? If we extrapolate the robust findings in business ethics and medicine to psychology, we can conclude that ethical conduct should be related to: having a positive view of human nature (avoiding cynicism); having a centered and principled sense of ethics (avoiding extreme relativism), being self-reflective, avoiding fatigue (maintaining self-care), being embedded in protective and ethical social networks (or agencies that promote teamwork); attending to subtle influences to act unethically, slowing down decision making (if possible) in high pressure situations, deliberately making ethics a part of everyday decision making, and working in an organization that actively promotes ethical conduct.

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The Reviewing Psychologist

Sam Knapp, EdD, ABPP, Director of Professional Affairs

At times psychologists will be asked to review the testing results of another psychologist. This may occur, for example, where one party in a child custody evaluation expresses dissatisfaction with the conclusions or perceived that the process was unfair and wishes to have the results and process examined by another psychologist.

The goal of the reviewing psychologist in such a circumstance is to give an opinion as to whether the evaluation was conducted in accordance with generally acceptable standards of practice. The reviewing psychologist can comment about the methodology used in the evaluation (such as the selection of tests or the nature of the information generated in the interview) and the extent to which the conclusions were substantiated by the findings. Often the reviewing psychologist needs to have access to the raw data, including interview notes or test responses of the parties being evaluated.

If the original evaluator deviated substantially from generally accepted standards of practice, then the reviewing psychologist may conclude that the recommendations need to be reconsidered. This does not necessarily mean that the original recommendations were wrong; it is possible that an excellent evaluation would have reached the same result; but it does mean that the original recommendations cannot be warranted or justified on the basis of the process as described to the reviewer in the custody report or raw data.

The deviations have to be substantial, not trivial. It is possible, for example, that the psychologist made a basic arithmetic error and miscalculated the results of a psychological test. Although this is not good practice, this error does not negate the entire testing process, unless the error was so substantial that it led to an erroneous conclusion concerning custody.

It is not the job of the reviewing psychologists to give a diagnosis of the clients, to give conclusions as to who should have custody, or opine as to which client is the better parent. Rather their role is limited to determining if the custody evaluation was done according to generally acceptable professional standards.

A good reviewer considers the appropriateness of the tests or other sources of data which were used. For example, it is common for custody reports to include the outcome of interviewing collateral persons, such as family friends, teachers, or clergy. If the report included data from collateral contacts of father, but not mother, then it would be legitimate to ask why the evaluating psychologist did not contact or report on the contacts with mother's collateral contacts. Or, if mother offered no collateral contacts, then this should be mentioned in the report.

A good reviewer also considers whether the data in the report can substantiate its conclusions or recommendations. For example, if the report stated that the patient was paranoid, then the reviewing psychologist would expect to find evidence that supports this conclusion in the psychological testing, the interview, or collateral sources (or all three). If the report concluded that the client was paranoid, but included no data (or inadequate data) to support that conclusion, then the reviewers could conclude that the report had shortcomings.

It is possible that reviewers may find that they might not have conducted the evaluation in exactly the same way as the original evaluator. That fact, in and of itself, does not mean that the original report was substandard. Reviewers need to make allowances for differences in how professionals respond to the questions posed by the referral source. The fact that one psychologist prefers the MCMI does not mean that another psychologist has engaged in substandard practice by using the PAI, as long as the PAI is being used appropriately within the evaluation process. Instead, the goal of the reviewer is only to look for deviations from practice substantial enough to lead them to suspect that the conclusions could not be warranted.

Should Pennsylvania Ban Atempts to Alter Sexual Orientation in Minors?

Sam Knapp, EdD, ABPP, Director of Professional Affairs

Senator Anthony Williams has introduced Senate Bill 872 into the Pennsylvania Senate that would prohibit mental health professionals from engaging in sexual reorientation change treatments with a patient who is under the age of 18. The bill specifically states that it is not intended to prohibit identity exploration or sexual orientation-neutral interventions. California enacted a similar law two years ago.

This bill raises some fundamental issues concerning sexual orientation therapy. Almost every mental health organization has adopted a position that same sex attraction is not a mental illness and is a biologically determined (or influenced) orientation in most persons. Furthermore, a review of the literature on reorientation (or "reparative") therapy has shown that it seldom produces a lasting change in sexual orientation, and often produces or exacerbates psychological symptoms of distress or reinforces internalized feelings of homophobia. Proponents of the bill may argue that the evidence is so overwhelming that reorientation therapies are ineffective and potentially iatrogenic, that the practice should be banned, at least for adolescents who may be more vulnerable to misuses of power or less capable of making informed decisions concerning the relationship between their religious values and sexual orientation.

Nonetheless, some individuals oppose same sex behavior on religious grounds, and they argue that parents should have the right to seek treatments for their children, including attempts to change sexual orientation. Others may argue that adolescents themselves should be able to decide whether or not they want to try to change their orientation.

In addition, some psychologists who oppose sexual orientation therapy may oppose this bill because they fear that a disgruntled patient or adolescent will misuse the bill to file a complaint against a psychologist. The parent, or adolescent, may misconstrue orientation neutral discussions of sexuality or may even fabricate claims that the psychologist attempted to change their sexual orientation, even though no attempt took place.

This bill, which has four cosponsors, was referred to the Consumer Protection and Professional Licensure Committee. It is unlikely that the bill will be considered by that committee in the near future. Nonetheless, this is an issue that will likely be around for a while and the PPA Board of Directors may eventually need to make a decision about whether to support this bill. PPA members who have thoughts on this issue should contact Dr. Samuel Knapp (sam@PaPsy.org). Let us know if you believe PPA should support or oppose this bill (or stay neutral) and the reasons why.

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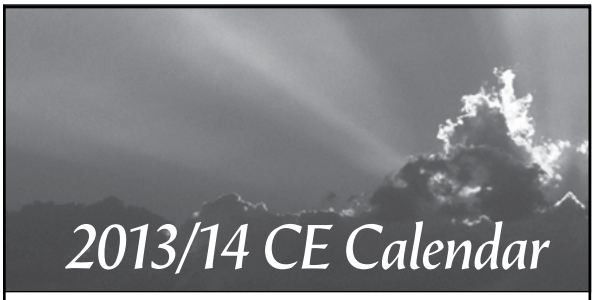

2013/14 CE Calendar

The following programs are being offered either through co-sponsorship or solely by PPA.

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For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit www.PaPsy.org/index.php/collaboration-communication/.

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If you have additional questions, please contact Marti Evans at the PPA office.

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