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Biological Biases Can Be Detrimental to Effective Treatment Outcomes

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During workshops on ethical decision-making, I typically take time to highlight cognitive and emotional factors that adversely affect clinical judgment and impede high-quality psychotherapy. In terms of cognitive heuristics that hamper effective treatment, the list includes the Fundamental Attribution Error, Trait Negativity Bias, the Availability Heuristic, and the Dunning-Krueger Effect. Emotionally, a psychologist's fear, anxiety, or disgust (also known as countertransference) can obstruct competent clinical judgment. A PowerPoint presentation providing more details on these topics is on my SlideShare account.

Research from cognitive science and moral psychology demonstrates many of these heuristics and emotional reactions are automatic, intuitive, and unconscious. The cognitive heuristics and emotional responses are shortcuts intended to evaluate and respond to environmental demands quickly and efficiently, which is not always conducive for optimal clinical judgment and ethical decision-making. For better or worse, these cognitive and affective strategies are part of what makes us human. It is incumbent upon psychologists to be aware of these limitations and work hard to remediate them in our professional roles.

Recent research by Lebowitz and Ahn (2014) provides insight into another cognitive bias that leads to potentially detrimental emotional responses. Their research illustrates how a clinician's

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Are Emails Part of a Patient's Record?

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Should psychologists keep all patient emails as part of their treatment records? What about patient productions, such as poems or artwork? The State Board of Psychology requires a record of every "service contact." In addition, it is prudent for psychologists to keep information that helps inform their professional decisions. So the question becomes: when does an email from a patient become a service contact or when does a production by a patient, such as artwork or poetry, help inform the clinical decisions of a psychologist?

No statute, court case, or regulation that I am aware of specifically answers these questions. Nonetheless, my opinion is that any email that contains

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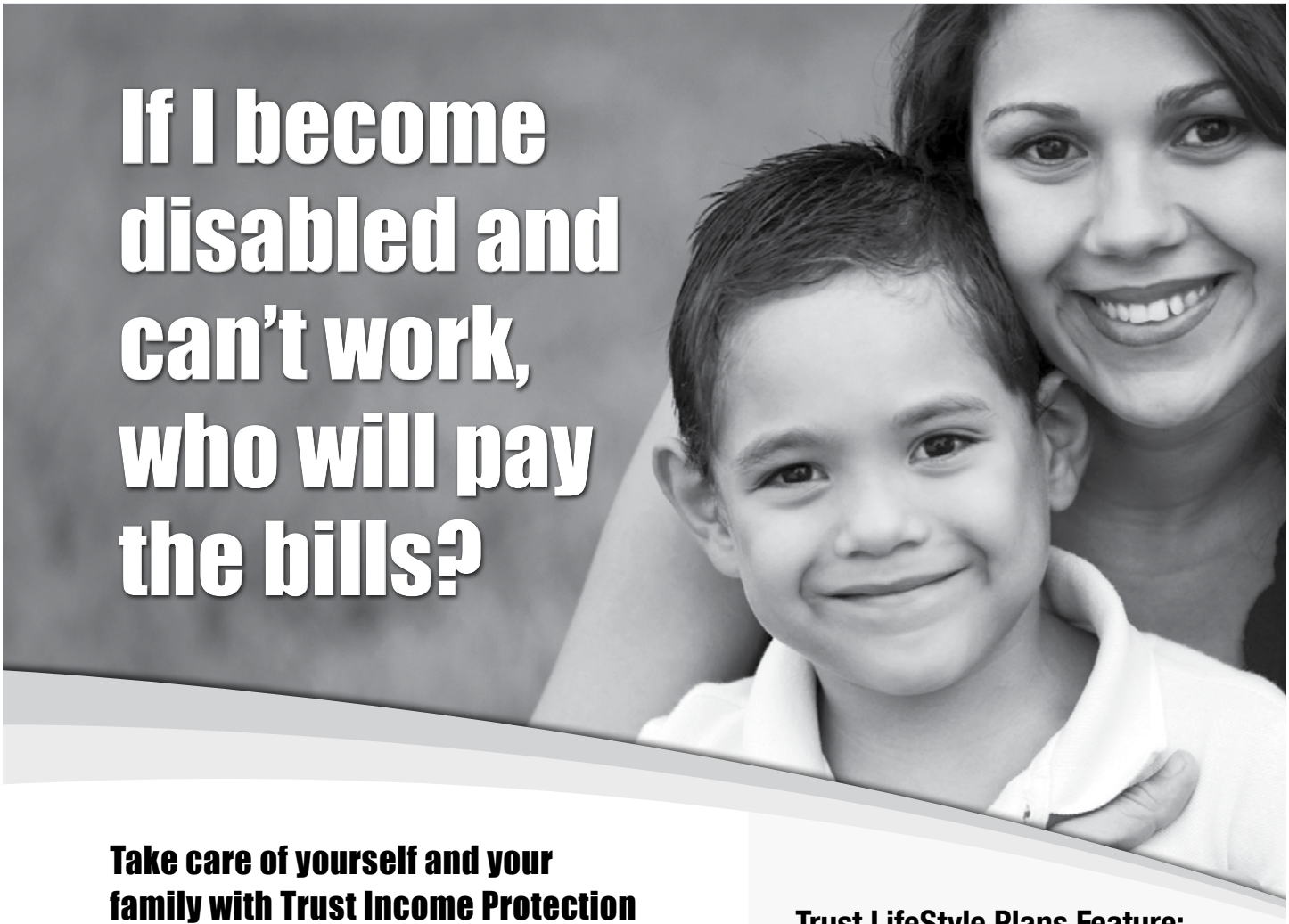

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Responding to a Risk Adjustment Audit

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Many psychologists have received letters from insurance companies (or intermediaries hired by insurance companies) to submit information about their patients. Sometimes the companies call these requests for information "audits," and sometimes they say that they are simply engaging in data collection. This article will give information about these types of audits (or data collection activities) and how psychologists can respond to them.

These kinds of data requests are called risk adjustment audits which are done with patients of health exchanges (sometimes abbreviated as "HX" plans) or Medicare Advantage (privatized Medicare) programs. Risk adjustment is the process that the Centers for Medicare and Medicaid Services (CMS) uses to determine the appropriate premiums that health exchanges are permitted to charge, or which determine the appropriate reimbursement that CMS will give to Medicare Advantage programs.

Health insurers vary substantially in their expenditures depending on the health status of the beneficiaries they insure. For example, CMS reimburses Medicare Advantage Plans on the basis of the health status of the population it covers and not on the basis of the average cost per Medicare beneficiary. If it failed to do so, then it would be possible for a particular Medicare Advantage Plan to solicit business from the healthiest senior citizens, such as those who are younger or who live in more affluent communities where the people tend to be healthier. The Medicare Advantage Plan could then have low expenditures, generate large profits, and leave the traditional (fee-for-service) Medicare program with the sicker and more expensive beneficiaries.

Early risk adjustment models were imprecise and based only on patient demographics (such as age or gender). Current risk adjustment models are based on the risk score for the beneficiary that includes the actual health status or health care utilization of the patients covered by the insurer. The risk adjustment process is complicated and includes coding and adjustments for many diagnostic categories according to degree of risk. Advantage plans must report to CMS diagnostic, demographic, and encounter (actual health care visit) data to CMS.

Unfortunately, a few Advantage Plans overrepresented the risk of their beneficiaries by including historical (not current) diagnoses or diagnoses that were presumed, but not based on a face-to-face encounter with a health care provider. The result is that CMS now requires information to ensure the accuracy of the risk adjustment data submitted by Medicare Advantage programs. These audits check the accuracy of the data submitted by the plans. In a similar manner, CMS gathers information on health exchange plans to ensure that the rates charged are reasonable given the health status of the population covered.

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These audits will occur yearly with a small sample of patients served by each plan on both physical and mental health services. The audits are meant to gather information on the health status of patients; they are not an inquiry into the quality of work of the health care professional.

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[1]We thank the staff of Legal and Regulatory Affairs of the American Psychological Association for providing background information to help us write this article.

RESPONDING TO A RISK ADJUSTMENT AUDIT

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How Should Psychologists Respond to These Data Collection Requests?

The data request letters typically state that HIPAA authorizes these requests for information and that no additional permissions by patients are required. Often they require health care professionals to submit a wide range of information including X-rays and laboratory tests. Most of these requests go to professionals who provide physical health services. Although their statements are accurate for professionals who provide physical health care services, the letters typically fail to account for the difference in confidentiality laws between physical and mental health.

It is true that HIPAA does permit health plans (or their intermediaries) to gather some health information in order to comply with the mandated reporting requirements of CMS. However, the letters typically fail to note that HIPAA contains the "minimum necessary rule" which requires that professionals send the minimum amount of information necessary to fulfill a request for information. Also, the letters typically fail to note that HIPAA grants psychotherapy notes greater protection than other health care information. Although a company may request and receive most protected health care information (PHI) based only on the signatures that beneficiaries made when they enrolled in a program, the release of psychotherapy notes (often called process notes) requires a specific written authorization by the patient.[2]

Consequently, we recommend that psychologists who keep two sets of notes (progress and process [psychotherapy] notes) can respond to these information requests by sending their progress notes alone. Psychologists who do not keep two sets of notes may respond by sending PHI which includes results of testing and a summary of the diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. The summary does not have to be exhaustive. The goal of these audits is to provide the company with information about the health status of their beneficiaries and a short, direct letter can fulfill that need. We could easily envision a matter-of-fact letter consisting of three paragraphs (or one or one and a half pages) fulfilling this requirement. Of course the letters for some patients where the psychologist had very limited contact could be even shorter.

No additional patient releases are needed to send PHI. However, psychologists should note this exception to confidentiality in their informed consent agreement. That is, they should include a sentence that they may be required to release limited information without the consent of the patient in response to insurance company audit.

[2]Psychologists may recall that HIPAA defines psychotherapy notes as "notes recorded (in any media) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or group, joint or family counseling sessions and that are separated from the rest of the individual's medical record." The definition of psychotherapy notes specifically excludes several items of information including "any summary of the following: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date." (45 C. F. R. 164.501).

Should I Have a Home Office?

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Sigmund Freud and other early analysts conducted psychotherapy out of their homes. This was at a time when many shopkeepers and physicians ran their businesses or practices out of their homes. (In the little town where I grew up in the 1950s our family physician had his office attached to his home). Today many psychologists are able to conduct their practices within their homes. However, doing so effectively and ethically requires some forethought.

Home offices have their critics. Maroda (2007) wrote that home offices are clinically contraindicated.

> Unexpected guests, children returning from school, a service person, friend or family member who arrives too late or too early, or a patient who has car trouble, are all personal events that the analyst cannot always control. These "accidents" combined with the patient's initial awareness of the analysts socioeconomic status, preferred style of living, make of car, and the presence of children's toys or jungle gyms, and variety of smells, all serve to flood with patient with images and information that may well be overwhelming" (p. 174-175).

I think she paints a "worst case scenario," although home offices do involve risks. Some psychologists who have home offices have reported problems such as littering by patients (e.g., cigarette butts left outside office door), intrusions by pets (one cat preferred to leave her dead mice on door step of the office); having cats, dogs, or children wander into the professional area; having smells from the kitchen intruding into the office area (giving patients information of the culinary preferences of their psychologist), or having patients see the family members or friends of the psychologist come and go. In addition, there are concerns that dangerous or intrusive patients now have information about the residence of the psychologist. The worst situation I heard of is that a frazzled parent (psychiatrist) sent her 8-year-old daughter outside to tell the patient to wait because she is running late.

Some psychologists who have home offices have reported problems such as littering by patients...or having cats, dogs, or children wander into the professional area. The worst situation I heard of is that a frazzled parent (psychiatrist) sent her 8-year-old daughter outside to tell the patient to wait because she is running late.

Despite these comments and experiences, conscientious psychologists have thought through these issues and identified ways to address them proactively. For example, they may create a physical barrier between the office and the rest of the house, including having a separate and clearly marked entrance for the office, so that patients know which entrance to use and do not wander into the living area unintentionally. The door on the home office may include signs that indicate if the office is opened or closed, state that services are by appointment only, or otherwise instruct would-be entrants of relevant information.

Also, prudent psychologists create a barrier so that sounds do not cross from the living into the patient area or vice versa. Sound leakage can be reduced by using solid doors, having door sweeps, having carpets, installing insulation above suspended ceilings, and using white noise or music in the waiting room. Having a separate phone for business and professional purposes seems essential.

It is true that having a home-attached office does involve some degree of inevitable self-disclosure in that patients can infer something about the socioeconomic status of their psychologists and, obviously, where the psychologists live. Psychologists who have home offices report that they almost always circumvent such safety problems by screening out patients with a risk of being dangerous or intrusive. Problems associated with the inadvertent self-disclosure of income or residence can be minimized by setting clear and appropriate therapeutic boundaries in treatment.

Having a home office may entail some practical considerations, such as looking into local zoning laws, a local business tax, or riders to one's homeowners insurance. It may be necessary to have a roof extension over the door step of the office to ensure that patients waiting for rides do not get drenched in a thunderstorm. In addition, the psychologist would need to be careful about snow removal and lawn maintenance. However these issues are entirely manageable.

These comments about managing a home office are suggestive and not intended to be comprehensive. Psychologists may need to make additional adjustments depending on their family circumstances or the uniqueness of their house or location. Nonetheless, psychologists should be able to address these issues proactively.

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The Evolutionary Roots of Morality and Professional Ethics

John D. Gavazzi, PsyD, ABPP

Every aspect of human existence stems from biological and cultural evolution. Even though evolutionary psychology is not a priority for clinical psychologists, the goal of this article is to highlight the evolutionary roots of human morals and professional ethics. At the broadest level possible, morality is defined as the ability to differentiate between right and wrong or good and bad. Most research in moral psychology highlights that many moral decisions are based on emotional responses and cognitive intuitions of right and wrong. Moral judgments are typically affective, rapid, instinctive and unconscious. The speedy cognitive processes and emotional responses are shortcuts intended to respond to environmental demands quickly and effectively. Most individuals do not take long to determine if abortion is right or not; or if same-sex marriage is right or not. How are our morals a function of evolution?

Primatologist Frans de Waal (2013) attempted to answer this question in his book, *The Bonobo and the Atheist*. The book is based on his work studying primates as well as other animals, like elephants. According to de Waal, morality originated within animal relationships first, prior to *homo sapiens* culture. He used observations to determine if there are any similarities between primates and humans in terms of morality. Both are social creatures who depend on relationships to function more effectively in the world. In order for primates to cooperate, form relationships, and work as groups, *reciprocity* and *empathy* are the two essential "pillars of morality" reported by de Waal. Reciprocity encompasses the bidirectional nature of relationships, including concepts such as give and take, returning favors, and playing fairly. Empathy, defined as the ability to understand and share the feelings of others, can occur at both the cognitive and affective levels. In terms of cognitive empathy, a person or a primate needs to have the mental capacity to understand another group members' perspective. People and primates also need to gauge or feel the emotions of others. As an example of empathy, humans and primates can both see emotional pain in others, demonstrate distress at what they are witnessing, and seek to console the sufferer.

As psychologists, we can relate to this experience as we can feel great empathy for our patients. Unfortunately, deep empathy plus extreme emotional pain multiplied by seven patients per day can contribute to emotional distress or professional burnout. Alternatively, empathy can spark the motivation for compassion in which one individual assists another, which can help both the psychologist and patient feel better. In many cases, empathy can be the negative aspect of feeling or witnessing another's emotional pain, while compassion can lead to both action and positive feelings about self and others. Many psychologists entered the field in order to help others, not necessarily to feel others' pain.

The two pillars of morality, reciprocity and fairness, are found in many primate populations. Behaviors such as grooming, food sharing, and alarm calls are all examples of fairness and reciprocity. Human cooperation and culture is vastly more complex than those enacted and created by primates. Therefore, human morality is more nuanced and multifaceted than primate morality. Nonetheless, reciprocity, fairness, empathy, and compassion are critical components to human morality. Without these characteristics, human morality, as well as human culture, would not exist.

With evolutionary principles of morality outlined, how are ethics different from morality? While there are number of different definitions of ethics, ethics involve a more systematic effort to codify what is right or wrong based

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THE EVOLUTIONARY ROOTS OF MORALITY AND PROFESSIONAL ETHICS

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on the values of a group, tribe, occupation, association or society. Ethics are a more complex cognitive exposition of beliefs and values about right and wrong. Ethical codes are typically based on principles, agreed upon by members, written out for all members to see, and provide a guide to members' behavior. If ethics codes are not specifically written, many humans groups or tribes have customs indicating how to behave, prepare food, treat the dead, organize their resources, and select mates.

For better or worse, we are members of American tribe of psychologists. The American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* is the document setting the standard of ethical behavior for members of our profession. Because psychologists have personal morals as well as professional ethics, we must strike a balance in order to provide high quality care.

Handelsman, Gottlieb, Knapp, and Young (2005) provide an insightful model to those who want to become part of the psychologist tribe. According to their *Acculturation Model,* an individual gradually becomes inducted into the ethical society of psychology through graduate education, internships, and supervision to become psychologists, in many ways like immigrants integrate into the culture of a new country. As a culture, psychology has a set of normative principles and behaviors related to ethical behavior and appropriate conduct. Psychology has a system of shared beliefs, distinctive norms and traditions as to what services a psychologist is to perform and how to behavior properly (what is right and wrong).

The APA code is based upon the principles of integrity, beneficence, nonmaleficence, dignity, fidelity and justice. Within these principles, it is easy to see pillars of primate morality proposed by de Waal: reciprocity and fairness. Fairness can be found within the principles of justice, nonmaleficence, and dignity. Compassion can be found in the principles of integrity, beneficence and nonmaleficence.

Bringing this full circle, it should not be a surprise that our professional code of ethics is a function of both biological and cultural evolution. Given that de Waal hypothesized morality originates within relationships, it should also be no surprise that our profession, which attempts to maximize the effectiveness of the therapeutic relationship, is grounded principles such as integrity, beneficence, nonmaleficence, dignity, fidelity and justice.

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MAY IS MENTAL HEALTH AWARENESS MONTH!

DID YOU KNOW?

According to the Pennsylvania Department of Human Services more than 250,000 Pennsylvanians have been diagnosed with a mental health challenge.

Many organizations across America are celebrating May as Mental Health Awareness Month, including PPA! In addition to our annual Advocacy Day in Harrisburg, PPA will hold a press conference to bring public awareness to mental health awareness and highlight the important role of psychologists in the continuum of mental health care.

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BIOLOGICAL BIASES

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perception as to the causes of mental health problems can undesirably influence his or her perceptions of patients. The authors chose to investigate clinicians' perceptions of patients when using a biological model of mental disorders. The biological model supports the belief that genetics play an important role in the creation of mental distress; that central nervous system dysfunction is the most important component of the mental health disorder; and, because of these biological origins, a patient's thoughts and behaviors are largely outside of the patient's control. Lebowitz and Ahn view the biological model gaining in popularity, citing President Obama's Brain Research through Advancing Innovative Neurotechnologies initiative as one of many examples.

Lebowitz and Ahn showed that clinicians who perceive mental health disorders as more biologically-based (versus psychosocial) are more likely to lose empathy for patients with mental disorders. Furthermore, the belief in the biological foundations of mental health issues correlate highly with more favorable ratings of medication and less favorable ratings for psychosocial interventions. The biological model of mental disorders can also prime clinicians to view patients as abnormal and less than fully human.

This research is surprising for a number of reasons. To start with the obvious, interpersonal warmth, acceptance, empathy, and trust are the foundations of a strong therapeutic alliance. A strong therapeutic alliance is correlated with positive outcomes in psychotherapy. If a mental health professional begins to believe that mental disorders are mainly biologically based, then there is a risk of less effective treatment due to lower levels of empathy, and perhaps helplessness due to ineffective treatment options. Worse yet, clinicians may believe patients' psychopathologies are predetermined, with limited hope for change.

The second concern is accepting the biological model as the most accurate conceptualization of mental health causes and treatments. In spite of the advances in genetics, neuroimaging, and computer modeling, neuroscience and genetic researchers have yet to show the dysfunctional component in the central nervous system and/or human DNA structure that can account for any mental health condition. There are many theoretical arguments as to what biological abnormalities create a mental disorder, such as excessive neurotransmitters, insufficient neurotransmitters, ineffective synaptic receptors, and genetic aberrations; however, all of these biologically-based explanations remain speculative and unproven.

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Most importantly, psychologists need to be aware of this potential bias, as it may negatively influence clinical judgment. There are many mental health professionals who believe that "chronic" conditions, such as bipolar disorder and schizophrenia, are mainly genetic in nature. As for proof of the biological origins of these disorders, mental health professionals will cite twin research because of the large number of studies demonstrating a genetic link to these disorders. In these studies, identical twins, loaded with the "schizophrenia gene," reared apart and in different environments, will both develop symptoms of schizophrenia. Psychologist Jay Joseph (2004), in his book *The Genetic Illusion*, detailed the faulty theoretical assumptions, statistical anomalies, and the methodological errors underlying the twin study research. In spite of Joseph's thorough debunking of the twin studies as junk science, mental health professionals continue to recite this well-entrenched meme that twin studies prove the genetic link to certain mental disorders.

Based on the research from Lebowitz and Ahn, the important conclusions are threefold. First, having a mainly or purely biological approach to mental health issues will likely decrease empathy for our patients. Second, this perception can adversely affect a clinician's empathy which may undermine treatment, even if the patient is only receiving medication from a prescriber (Krupnick, et al., 1996; Leuchter, et al., 2014). Third, regardless of the patient's diagnosis, the patient is a human being who is suffering. The treatment relationship holds primacy and needs to include empathy, compassion, and dignity. By using a more holistic understanding of the patient, a stronger therapeutic relationship can be built, which enhances the potential for more successful treatment outcomes regardless of treatment modality.

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meaningful information relevant to the treatment of the patient is a service contact and should be retained, and any patient production that helps formulate or support impressions of a patient should be retained or at least noted in the record. Of course, standards for forensic work are different and those evaluators typically keep every scrap of information, including emails, that would be considered routine in an ordinary treatment setting.

Consequently, an email from a routine patient saying that she will be 10 minutes late for her appointment would not be a service contact and not worth keeping. A lengthy email from a patient that describes many clinical symptoms and reactions probably would be considered a service contact and worth keeping. Some professional judgement may be required. For example, an apparently routine cancellation would be interpreted differently if it came from a difficult patient with problems keeping appointments because it could have clinical implications.

Many patients place high value on their artwork which has particular meaning for them in the context of their lives and relationships. However, from the standpoint of patient records, this artwork would only have to be kept if it helped the psychologist to understand the patient better or if it influenced the course of treatment. Even then, a notation describing the artwork, rather than keeping the artwork itself, would be sufficient. Usually the psychologist can then offer to return the artwork to the patient, if clinically indicated to do so.

If an email or artwork becomes part of the patient's record, then the usual record keeping requirements would apply. Nothing requires a paper version of records. It could be appropriate for the psychologist to keep all records electronically (even the artwork could be preserved as a PDF file). Prudent psychologists ensure backup and have security protections for electronic records. The State Board of Psychology requires keeping records for a minimum of 5 years since the last patient contact. Most commercial insurers require keeping records for 7 years beyond the last patient contact, as does fee-for-service Medicare. Medicare Medical Advantage plans require health care professionals to keep records for 10 years.

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