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Psychologists and Violence

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

Dr. Samuel Knapp

In our daily work as psychologists we strive to reduce violence by encouraging parents to adopt more effective and non-violent ways to raise children; and to reduce violence within families occurring either through child abuse, elder abuse, or violence that spouses direct against each other. Even in the area of animal training, psychologists are working to redirect dog trainers into more effective, non-violent ways to socialize dogs and other domestic animals (e.g., Van Fleet, 2011).

Efforts to reduce violence one patient at a time is challenging especially because, as a whole, many people tend to overrate the effectiveness of violence in achieving their goals. The fact is that most children do not stop undesired behavior as a result of corporal punishment, torture is seldom effective in getting prisoners to reveal accurate information, and wars often fail to achieve the intended political objectives of the winner.

Psychologists see this overvaluing of violence in their day-to-day work with patients and their families. Most psychologists have had the experience of working with a parent who adamantly defends the liberal use of corporal punishment on children, noting that they were raised the same way and turned out just fine. Psychologists are then challenged with the way to introduce more effective and positive parenting approaches without shaming the parents.

Unfortunately many Americans, including our patients, believe that violence is an inevitable or inherent quality of the human condition. It is part of our animal heritage, they might argue.

But are violence and war inevitable? Ethologist Frans DeWaal (2010) has documented that kindness and empathy are just as much a part of our animal heritage as violence and aggression. For every act of primate aggression, DeWaal can identify two, three, or more acts of kindness and cooperation. The abnormality of violence extends to human primates as well says Iraq war veteran and United States Military Academy at West Point graduate Paul K. Chappell. "Contrary to widely believed myths, it is not true that human beings are naturally violent. It is not true that war is inevitable" (2010, p. 3).

Furthermore, evidence suggests that the world is becoming less violent over the centuries.

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The Basics of Lethal Weapon Evaluations

Pennsylvania's Act 120 and Act 235[1]

Samuel Knapp, EdD, ABPP
Director of Professional Affairs

In addition to providing psychotherapy, many psychologists also evaluate police officers or others who seek to the authorization to carry lethal weapons as part of their employment (such as security guards). The standards for police are found in Pennsylvania's Act 120, while the standards for evaluating others who carry lethal weapons are found in Pennsylvania's Act 235.

Pennsylvania's Act 120 requires that police who carry lethal weapons must undergo a psychological evaluation to determine if there are personality traits that would make their use of firearms contraindicated. Regulations for Act 120 evaluations require that "the psychologist must personally interview the applicants, which interview shall include a summary of the applicant's personal, educational, employment, and criminal history, if any" (37 Pa Code 21.11 (4) (i)).

[1]The author thanks Drs. Richard Small, Donald McAleer, and Bruce Mapes for their review of an earlier draft of this manuscript.

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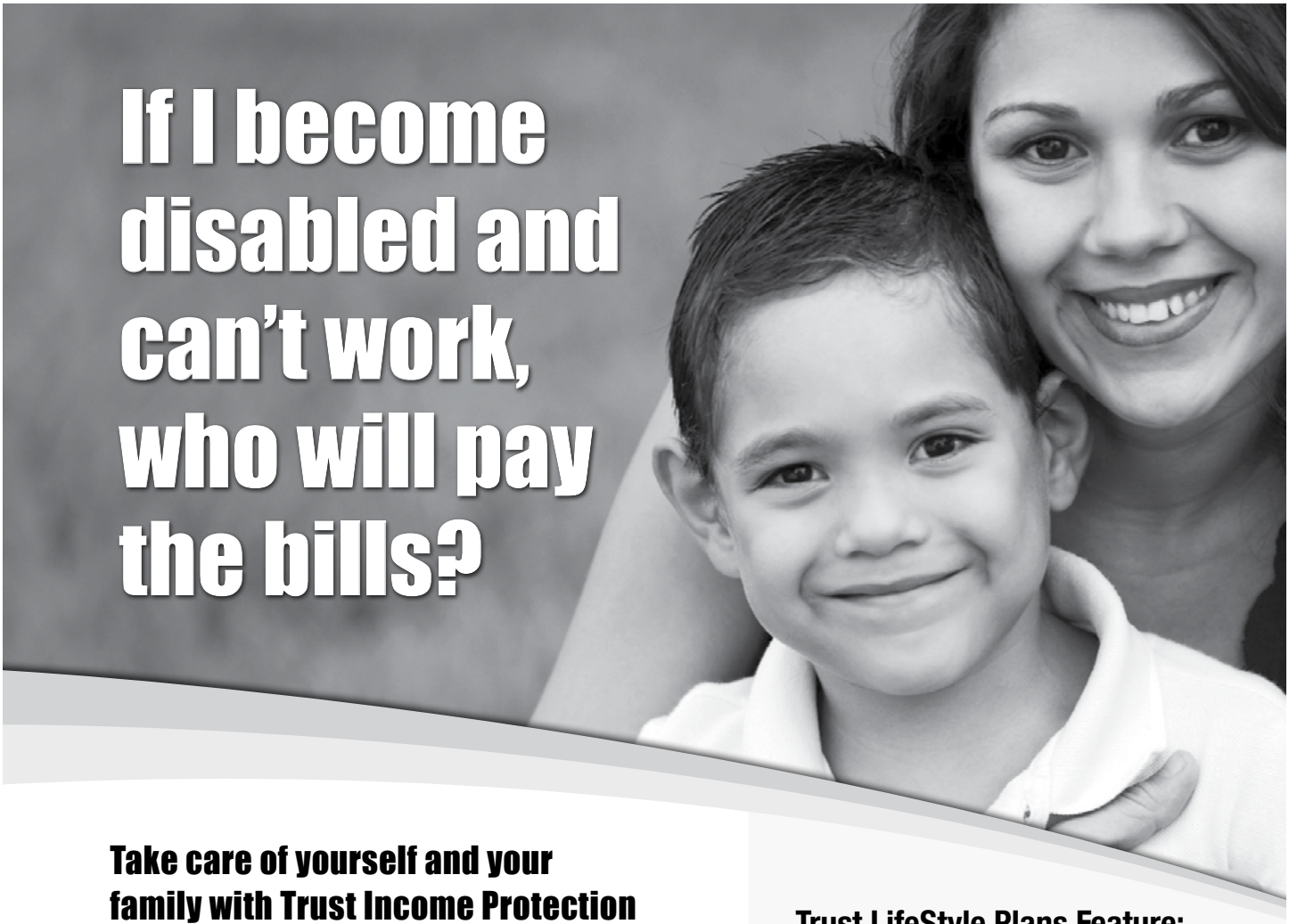

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Record-Copying Charges Changed for 2016

Rachael L. Baturin, MPH, JD; Director of Legal & Regulatory Affairs

Rachael Baturin

Under Pennsylvania's Act 26, known as 42 Pa.C.S.§6152 and 6155 (relating to subpoena of records and rights of patients), the Secretary of Health is directed to adjust annually the amounts that may be charged by a health care facility or health care provider upon receipt of a request or subpoena for production of medical charges or records. Because the law specifically references "health care providers," as opposed to just physicians, PPA believes that the law applies to psychologists. The amounts for 2016 vary only slightly from last year's amounts.

Effective January 1, 2016, the following payments may be charged in response to a subpoena:

	Not to Exceed
Search and Retrieval of Records	$21.69
Amount charged per page for pages 1–20	$1.46
Amount charged per page for pages 21–60	$1.08
Amount charged per page for pages 61–end	$0.36
Amount charged per page for microfilm copies	$2.16

In addition to the amounts listed, charges may also be assessed for the actual cost of postage, shipping, and delivery of the requested records.

In addition, a flat fee that can be charged by a psychologist for a claim or appeal under the Social Security Act or any federal or state financial needs-based benefit program is $27.48 plus charges for the actual cost of postage, shipping, and delivery of the requested records. The flat fee that can be charged for a request made by a district attorney is $21.69 plus charges for the actual cost of postage, shipping, and delivery of the requested records.

Requests from independent or executive branch agencies of the government are exempt from the record-copying fee requirements. This law does not apply to copying required by insurance companies to monitor services under an insurance contract. The rate is increased annually according to the Consumer Price Index.

The law does not alter the requirement that psychologists must have a signed release from the patient or a court order before releasing the information to a third party.

Evaluating the Affordable Care Act: Access, Affordability, and Quality

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

Has the Affordable Care Act (ACA) been effective? Does it expand health insurance to the uninsured? Does it control costs? Does it preserve or enhance the quality of health care? Such analyses are difficult because the impact of the ACA needs to consider that it occurred in the context of other governmental changes (including mandates for electronic health records, Medicare reform, mental health parity), and other societal changes (such as a population that is getting older and carrying more weight). This brief review can only give a broad overview of the impact of the ACA because it, and health care economics in general, are so complicated and involve many interacting factors.

I strive for objectivity in this analysis, despite the political polarity in the United States. For example, one case worker told me that her uninsured patients would curse at her when she suggested that they could qualify for health insurance under Obamacare. Yet the same patients would be very interested if she suggested that they could qualify for health insurance under the Affordable Care Act.

Despite a proliferation of assessment and quality enhancement instruments, it is still very hard to measure quality in health care.

Expanded Coverage

The goal of universal or near universal health care ended with the Supreme Court decision that allowed states the option of expanding Medicaid to low income uninsured adults (adults who make 138% of the poverty level). Nonetheless, between 14 and 16 million more Americans are covered with health insurance in 2015, compared to 2013 before the mandate went into effect (Sommers, 2015). Of course it is one thing to provide insurance to the public; it is another thing to provide insurance that allows meaningful access. The deductibles for the silver and bronze plans remain high (an average of $3,000 a year for silver plans and $5,200 a year for bronze plans; Sommers 2015). Also, some plans do not have extensive panels, thus limiting patient access and choice of providers.

Affordability

The rate of health care inflation decreased substantially following the passage of the Affordable Care Act in 2009. However, much of that decline occurred because Americans were simply spending less money (including less money on health care) during the Great Recession. About 25% of Americans reported delaying health care procedures for financial reasons in 2009 (compared to 23% in 2013; Claxton, 2015). Nonetheless, the Affordable Care Act did give incentives for insurers to set up medical homes or accountable care organizations (ACOs) with the goal of reducing costs (and improving quality) for the minority of very sick patients who consume a large amount of health care expenses. Medicare also found significant savings with its ACOs to the point where the per person in-patient cost of Medicare actually declined in terms of inflation adjusted costs from 1999 to 2013 (Krumholz et al., 2015).

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The health insurance marketplace plans saw an average of a 10% increase in premiums from 2014 to 2015, although changes in premiums varied from an 11% decrease to a 30% increase. However, this increase needs to be seen in context. From 2013 to 2014, the plans actually saw a very slight decrease in their premiums; meaning that the two year change in premiums has been around a 5% increase. In addition, if tax credits for the plans are factored in, the average American would have a lower financial burden for the health insurance under these plans in 2015 as they did in 2013 (Cox, 2015).

Improvements in Health

Despite a proliferation of assessment and quality enhancement instruments, it is still very hard to measure quality in health care. One metric might be the longevity of the population, but this is not a perfect measure because it is influenced by improved programs to reduce hunger (such as the food stamp program), public education, and other factors in addition to the quality of the health care system. The long range trend for mortality rates continue to decline but any impact from the quality of health care services probably has more to do with Medicare which is the primary insurer for persons most at risk to die. In any event, the United States still lags far behind the mortality rate in all of the other highly industrialized countries of the world. On the positive side, one of the expansions under the Affordable Care Act was to mandate a number of preventive services. Nonetheless the benefits of this expansion will be seen many years down the road. The ACA also mandates mental health parity, although its provisions have not yet been enforced with vigor.

Summary

Access to health care has increased, although 34 million Americans are still without health insurance. When averaged across all health plans, health care costs are stable, but there is wide variation among plans and part of the stability may be due to factors other than the ACA. Health outcomes, at least as measured by longevity, are improving, but this may be more due to changes in Medicare than in the changes that the ACA made in the commercial market. Any impact of mandated preventive services and expanded mental health parity on costs and health outcomes will take many years to measure.

The ACA has had a sufficient number of successes to allow its proponents to claim it has been a success. Nonetheless, there is sufficient ambiguity in the outcomes to allow its critics to claim it has been a failure. Time and future analyses will determine the extent to which the ACA will fulfill its promise.

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"Well Sir..."

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

During the last year I have had a job conducting continuing education programs for a nationwide CE provider. They will fly me into one city and then I will drive to two adjacent cities to the same continuing education program. Most of the workshop participants are licensed counselors or social workers, although I do get some psychologists and other professionals in attendance as well.

Usually before the program begins I try to take a few minutes to introduce myself to some of the workshop participants and ask them some questions about their practices and what, if anything, they would like to learn in the program. Every once in a while I will get a workshop participant who really wants to learn something about ethics. However, the large majority simply state that they are attending to fulfill their continuing education obligations required by their licensing board and have no particular interest in ethics. Fortunately, almost all of the workshop participants have a positive attitude and often say something along the lines of, "since I have to be here, I am going to try to get something of value from the day."

Nonetheless, I had one workshop participant who was not so positive. When I asked him what he wanted to get out of the program, he stated that he was only here because his licensing board was making him take an ethics course. When I responded that I hoped he would find something of value in the program today. He responded indignantly, "well sir, I have been counseling patients for 25 years now and I don't think there is much more that I need to learn about ethics. . . I have pretty much seen it all."

In a sense, he is correct. If ethics is defined as only the minimal requirements of an ethics code or a licensing board, then he very well may have nothing more to learn. Although I did not know the workshop participant outside of this brief encounter, I had no reason to think that he was particularly problematic as far as violating the ethics code is concerned. Nonetheless if ethics is defined more broadly, as a striving for our highest potential, then he was clearly wrong. We call this approach, positive ethics, and most of the workshops from the PPA Ethics Committee take a positive approach.

The goal of positive ethics is to help psychologists and other professionals do their absolute best; not just avoid being disciplined by a licensing board. We want participants to make the best ethical choices; not merely one that satisfies the minimal legal requirements. We want participants to think about ethical issues that are not covered by their profession's ethics code and we want them to show concern for their well-being of their fellow health care professionals, even if such caring is not required by an ethics code.

Unlike the workshop participant who believes he had seen it all, I always try to learn something from all of my continuing education programs. I can go through a program and identify where many of the ideas came from: Dr. Z gave me this idea; a workshop participant in San Antonio used this phrase; the conversations we had in Erie caused me to rethink this vignette, etc. Near the beginning of the program I include a gratitude slide in which I acknowledge my debts to some fellow scholars.

Most workshop participants respond well to the positive approach. The program often receives positive comments, such as, "I never thought ethics could be interesting," or, "This is the first time that ethics was presented in a way that was actually helpful to me," etc. This is not entirely surprising, because being relaxed and curious is so much more fun than being negative.

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British scholar Matthew Ridley (2010) has looked at numerous data sets across history (including murder rates in Medieval England) where the murder rate was 30 times what it is in England today. This is contrary to the perceptions of many Americans who, for example, view the bloody 20th century (with the first and second World Wars) as far worse than the 19th century which included the Napoleonic wars (1800–1815) and then a long period of relative peace in Europe. However, that perspective fails to account for the massive killings as a result of European expansion into Africa and Asia. It also fails to consider the Taiping Rebellion in China (1850–1870) which resulted in the death of perhaps up to 100 million Chinese, mostly civilians who died as a result of famine, but many died in wholesale massacres of Chinese cities. The impact was so great that the Chinese population did not recover its level of 1850 (400 million persons) until 1910.

Hatred and violence are far too prevalent. But are they inevitable?

What can psychologists do to further address violence as its causes?

First we need continued sensitivity to violence and intimidation in our everyday work with patients as we seek to identify violence when it occurs and intervene effectively both with victims and perpetrators of violence. We need to address violence when it occurs and foster the development of behaviors and attitudes that inhibit violence and promote positive relationships.

Second, we can strive to be non-violent in our everyday lives; not only in abstaining from violence, but also in actively searching for ways to maximize sensitivity and caring for others. The greatest moral challenge, according to psychologist/philosopher Joshua Greene (2013), is for moral agents to extend the moral realm and obligations to persons who differ from us.

Third, we need to support further research into the causes of violence, its impact, and ways to prevent it.

Finally, we need to study history; not just the self-congratulatory histories of the dominant group, but the real history of the lives of actual people. The history of the American Civil Rights Movement tends to get distorted. It overfocuses on the life of Dr. Martin Luther King, Jr. (and minimizes the contributions of others) and portrays Dr. King as some kind of moral super hero who was somehow immune from the anger, fear, and hatred that all of us feel sometimes. I think this does a disservice to Dr. King and others. His work and life tends to get distorted and sanitized. Dr. King was the most visible member of a large movement that involved thousands of activists and many other less active supporters.

So it is important to go back to his original works and the works of his colleagues to get a good feel for the times and the experiences, though there are top notch biographies, such as the work of Taylor Branch, which do justice to the struggle.

Hatred and violence are far too prevalent. But are they inevitable? Consider these events: In 2009, Mr. Elwin Wilson made an appointment with Congressman John Lewis, recounted how he had beaten him forty-eight years earlier when Lewis was a Freedom Rider, and said, "I am sorry for what I did that day. Will you forgive me?" When Mr. Wilson died several years later, he was able to count John Lewis as one of his friends.

In 1956, Hazel Bryan, a 16-year-old white student at Little Rock Central High School in Little Rock, Arkansas, shouted obscenities at Elizabeth Eckford, a black student, as she tried to enroll in the all-white high school. Years later Bryan enrolled in cultural sensitivity classes, volunteered to mentor young disadvantaged Black girls, and apologized, publicly and privately, to Ms. Eckford (Margolick, 2011).

Betty Williams, a Protestant, and Mairéad Corrigan, a Roman Catholic, worked together to secure peace in Northern Ireland.

While attending the funeral of one of his patients, psychologist Ray Naar (2007), a holocaust survivor, accepted the hug of her mourning father, a former soldier in the German army.

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Classifieds

THE BASICS OF LETHAL WEAPON EVALUATIONS

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In addition, the applicant must be given an MMPI. If the psychologist is unable to certify the psychological qualifications of the applicant on the basis of the data gathered from the interview and the MMPI, then the psychologist may use his judgment and administer other tests or techniques "deemed necessary to form his professional opinion." (37 Pa Code 21.11 (4) (iii)). Act 235 forms can be obtained from the Pennsylvania State Police website. Act 120 evaluations are typically post conditional, meaning that an offer of employment has been made conditional upon a successful screening of the applicant and completed Act 120 forms are sent directly to the referring police department.

Pennsylvania's Act 235 requires that security guards, night guards, private detectives, and other private individuals who need to carry lethal weapons as part of their employment, must similarly undergo a psychological evaluation. The standards for Act 235 are identical to those of Act 120 and also require an interview by a psychologist, an MMPI, and the option of additional tests if necessary. Act 235 forms are returned to the Pennsylvania State Police Lethal Weapons Training Program.

I found the *Pre-Employment Psychological Evaluation Guidelines* from the International Association of Chiefs of Police (2014) to be helpful especially for persons who are just starting to do these kinds of evaluations. The guidelines do not go into details of test administration or interpretation, but rather focus on broader issues such as the necessity for informed consent, topics to cover in the initial interview, need to avoid using specific ICD-10 diagnoses (unless clearly relevant to the decision).

A number of years ago, the field of police screening was unstandardized with little empirical data to guide decisions. Over the years, however, a body of data and experience has emerged to help guide these evaluation decisions (see for example, Kitaeff, 2011; Weiss, 2010). Although Pennsylvania does require psychologists to use the MMPI, the process does allow for some individual discretion on how to conduct these evaluations. For example, some psychologists use the MMPI-2, while others prefer to use the MMPI-RF. Most psychologists use a semi-structured interview format to ensure that they cover the required areas (education, criminal history, substance abuse, etc.), but some add screening instruments into that interview process.

Simply having an elevated score on one or more of the MMPI scales or an ICD diagnosis is not sufficient to reject an applicant.

Many of the evaluations are routine and no significant psychopathology or problems are noted. If warning signs emerge in the interview or through the MMPI, psychologists have the option of giving additional tests or conducting an additional interview. Some of the factors that could preclude a favorable evaluation include the presence of a serious or pervasive mental illness, problems in handling conflict or anger, inability to function well under stress, or impulse problems. An invalid MMPI profile would probably necessitate a second round of interviews. Interestingly enough, one study found that a high K scale was unrelated to subsequent police officer performance (Laguna et al., 2015), but an elevated L scale was (Weiss et al., 2013). Also, Bartol (1991) found than elevated L scale, in combination with other scales was related to poor performance as a police officer. Of course a high L score, in and of itself, should not disqualify a candidate, as it is ideal to base all decisions on convergent data.

Because a negative report means that applicants will not be able to follow their chosen careers, psychologists should be certain that they can justify the negative evaluations that they are giving. Simply having an elevated score on one or more of the MMPI scales or an ICD diagnosis is not sufficient to reject an applicant. The psychologist needs to show that any pathology is directly related to the applicants' functioning in their professional role.

Recent concerns have been expressed that the psychological testing unfairly discriminates against minority applicants. Avril (2015) reported that in Philadelphia 81% of White applicants passed the psychological examination, compared to 75% of Hispanics, 73% of Black, and 58% of Asian applicants. These differences reinforce the importance of interpreting tests and interview data with sensitivity toward cultural factors.

References and Resources

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12:00 – 1:30 pm

PPA Advocacy Day
Monday, April 4, 2016
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April 8, 2016
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May 13, 2016
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