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PRESIDENT'S WELCOME

Kalyani Gopal, Ph.D.

Please join us in welcoming Kalyani Gopal, the new President of Division 12. At present, Dr. Gopal is a Member of the National Register of Health Service Providers in Psychology. She has also served on the Board of Directors for APA, Society for Clinical Psychology, and Past President of Section IV, D12, APA, and Clinical Psychology of Women, and Past-President of the Illinois Psychological Association and. Furthermore, Dr. Gopal is founder and CEO of the SAFE Coalition for Human Rights, which has its Headquarters in Indiana. Most recently Dr. Gopal is the recipient of the Top 20 Woman of Global Excellence. She is known for her grassroots efforts to raise awareness about human trafficking and change the way people who are exploited by human traffickers are treated.

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LEAD ARTICLE

Emotion Regulation Flexibility: Recent Developments, Challenges, and Future Directions for Clinical Research

Alexandra H. Bettis, PhD

Vanderbilt University Medical Center

Department of Psychiatry & Behavioral Sciences

Alexandra H. Bettis, Ph.D.

The process of regulating emotions and managing responses to stress is thought to be central to psychological wellbeing. Emotion regulation (ER), the process by which individuals attempt to influence their experience and the trajectory of their emotions (Gross, 2015; Gross & Thompson, 2007), has been widely studied as a correlate of and risk/protective factor for psychopathology. Relatedly, coping, or the process of adapting specifically in the context of stressful circumstances, is a similar, although in some ways distinct construct (see Compas et al., 2017 for review). For the purposes of this article, I will be referring primarily to ER, although both coping and ER can often be used interchangeably (particularly in the context of measurement and interventions).

ER is a transdiagnostic process and has been studied widely across psychological disorders and symptom presentations. Indeed, decades of empirical research demonstrate consistent cross-sectional associations between both broad emotion (dys) regulation and specific ER skills and both internalizing and externalizing psychopathology (Aldao et al., 2010; Compas et al., 2017; Sheppes et al., 2015; Webb et al., 2012). However, effect sizes are generally small, both for broader ER and specific strategies or subsets of strategies. This may be due, in part, to the fact that much of the extant literature has focused solely on identifying specific skills or sets of skills deemed adaptive or maladaptive. Yet, accumulating theoretical and empirical research emphasizes that engaging in effective ER involves more than simply using adaptive strategies and not using maladaptive ones. Rather, regulation is considered a dynamic construct, which is highlighted in evolving definitions of ER, including the process model of regulation (Gross, 2015) and the regulatory flexibility framework (Aldao, 2013; Aldao et al., 2015; Bonanno & Burton, 2013). Similar lines of inquiry have also emerged in the coping literature (Cheng, 2001; Kato, 2012, 2017).

While psychological flexibility has been a longstanding construct in psychological research (Berg, 1948; Kashdan & Rottenberg, 2010), there is a growing interest in understanding flexibility in the context of regulating emotions. ER flexibility emphasizes the importance of regulation as a dynamic process that varies by context. Models of ER flexibility generally discuss the ability to evaluate a situation or context under which a person is regulating an emotion, the process of selecting from a repertoire of strategies that aim to change an emotional response, and the implementation of these strategies, including the degree to which they are effective and the ability to modify strategy use based on internal and external feedback (Aldao, 2013; Bonanno & Burton, 2013; Gross, 2015). A similar framework has been proposed with regard to coping, highlighting the importance of context and repertoire in psychological adjustment (Cheng et al., 2014). At the core of the regulatory flexibility framework is the fluid nature of this process – contexts are changing and evolving, sometimes on a momentary basis, as are our emotions. Further, as individuals select, implement, and modify skills, their choices of strategy may also change. Consistent with prior literature examining coping, ER, and psychopathology, preliminary evidence suggests that facets of ER flexibility demonstrate associations with psychopathology broadly, including generalized anxiety, depression, and stress (Bonanno et al., 2020; Chen & Bonanno, 2021b), social anxiety (O'Toole et al., 2017), and eating disorders (Dougherty et al., 2020).

Theoretical models of regulatory flexibility capture what many clinicians have known and been practicing for a long time. In my own clinical practice, I am in the position of assessing a patient's repertoire and implementation of ER skills – what are they using in their daily life and what is working for them? What is harmful and in what contexts? This clinical assessment is ongoing throughout treatment – unexpected contexts may arise in which a patient needs a new approach to manage their emotional responses. And not every skill is well-suited for every

patient. Despite this clinical knowledge that so many of us use in our regular practice, accurately measuring these constructs both in and outside of the context of interventions remains an important challenge for clinical research.

Below, I discuss progress and challenges related to the assessment of ER flexibility in clinical research. Next, I discuss the role of ER flexibility in interventions for psychopathology, and discuss outstanding questions and directions for future research in this area. Of note, given my background in child and adolescent psychology, much of the literature referenced in this article is focused on youth (although not exclusively). Ultimately, this article is by no means a comprehensive or scoping review of research in ER flexibility, but instead seeks to provide a general overview of the ER flexibility landscape. In doing so, I hope to spark interest in and excitement for incorporating these questions into your clinical research.

Measurement of ER flexibility.

In therapy, we do our best to understand and assess and patient's capacity for ER, and in many instances, to teach or reinforce skills to facilitate better regulation. Yet, systematically capturing the dynamic and nuanced way in which individuals engage in ER in their daily lives has proven to be a challenge for the field. Below, I review progress and challenges in measuring three key components of regulatory flexibility: context sensitivity, strategy selection/repertoire, and implementation effectiveness.

Context sensitivity. Understanding the context in which an individual is experiencing emotions, as well as accurately perceiving one's own emotional state, is a critical first step in ER (Bonanno & Burton, 2013). Misinterpreting or missing cues in the environment or in one's own emotional state could impact subsequent steps in the regulation process, setting someone up for unsuccessful regulation attempts. Comprehensively assessing an individuals' sensitivity to context is complex, and new measures have been developed over the past decade to improve our understanding of this construct.

Over the past several decades, coping literature has guided efforts to understand how individuals may employ different strategies in response to different stressors (Compas et al., 2001; Connor-Smith et al., 2000; Folkman & Moskowitz, 2004; Lazarus & Launier, 1978). Self-report measures of coping often focus on a specific stressor (e.g., Responses to Stress Questionnaire; Connor-Smith et al., 2000), providing insight into what strategies may be most adaptive in a specific stressor context. While these measures have provided important foundational information regarding strategy selection within a given context, these measures do not assess an individuals' ability to discern aspects of a given stressor or context to make the best decision about strategy selection. For example, controllability is a central feature of models of adaptive coping—data suggests that some strategies may be more effective when responding to controllable vs. uncontrollable stressful events or circumstances (Compas et al., 2017; Forsythe & Compas, 1987). However, most common coping and ER self-report measures skip the step of assessing an individual's capacity to identify and accurately appraise contextual clues, including controllability of a situation, and jump straight to assessing skill use. To address these limitations, self-report measures of context sensitivity have been developed. For example, the Context Sensitivity Index (CSI; Bonanno et al., 2018) is designed to capture individuals' ability to evaluate both the presence and absence of contextual clues in the environment. Recent studies have begun to use the CSI to better understand context sensitivity and how it relates both to other features of ER flexibility and to psychological outcomes (e.g., Chen & Bonanno, 2021a; Lenzo et al., 2021; Zimmer-Gembeck, 2021).

Similar to the limitations of traditional self-report measures noted above, experimental paradigms have also explored regulation in differing contexts. Paradigms commonly used most frequently assess the selection of and/or effectiveness of strategy use in different emotional contexts (e.g., in the presence of high vs. low emotional stimuli; Dixon-Gordon et al., 2015; Goldin et al., 2009; McRae et al., 2008; Ochsner et al., 2001). Often the goals of these tasks are to elicit a strong emotional response, and therefore rely on validated but not necessarily contextually relevant stimuli to assess regulation. Few studies have utilized stimuli that are relevant to the participants' real-life experiences (Bettis et al., 2018). Relatedly, even when employing ecologically-valid stimuli, these tasks are limited to a finite number of contexts, reducing their utility in understanding context sensitivity.

One approach that addresses some of the limitations of these self-report measures and laboratory paradigms is ecological momentary assessment (EMA), also referred to as experience sampling methods. EMA holds promise for assessing contexts that are most relevant to individuals, by sampling an individuals' context in real-time (Bettis et al., 2021; English & Eldesouky, 2020). Several studies have utilized EMA to assess stressors as a key context in which ER strategy selection occurs (e.g., Connolly & Alloy, 2017; Daniel et al., 2019), as well as the influence of social context on strategy selection (e.g., Aldrich et al., 2019). Findings from Southward and colleagues (2019) also highlight the importance of the emotion being regulated as a contextual factor. Employing EMA to assess ER in an undergraduate sample, they found that strategy selection differed as a function of the emotion experienced (Southward et al., 2019).

However, the use of EMA to capture context is not without challenges – while an EMA survey may relatively straightforwardly capture some aspects of a context from that person's perspective (e.g., the presence of a stressor or whom the individual is with), there will inevitably be aspects of contexts that go undetected by a given set of pre-determined EMA questions. Combining passive sensing devices with EMA may address some of these limitations (Bettis et al., 2021). For example, pairing EMA with geolocation technology, which is common to most smartphone devices, or wearable devices that monitor autonomic nervous system activity may provide greater detail about relevant contextual factors (e.g., Besoain et al., 2020; Pramana et al., 2018).

In summary, while there is no singular measure that will capture all features of context sensitivity, there are a number of promising approaches that together may bolster our understanding of how individuals' appraise emotion-evoking contexts. Future research combining measurement approaches may also inform which aspects of context are most useful to monitor in a clinical context.

Strategy selection and implementation effectiveness. The most common approach to assessing ER is the measurement of strategy use or selection and its association with psychopathology as an index of implementation effectiveness. Many well-documented self-report measures of ER (and coping) assess the use of specific strategies to regulate emotions or manage stress (see Mazefsky et al., 2021 for recent review of ER self-report measures for youth). As noted above, these measures provide valuable information about the strategies people use to manage both general stress and emotions, as well as in response to specific stressor contexts (Compas et al., 2017). The field of ER and coping has extensively assessed the use of a broad range of skills, including strategies often addressed in evidence-based psychotherapies such as cognitive reappraisal, distraction, acceptance/mindfulness, and avoidance, as they relate to psychological outcomes across the lifespan.

While this large literature has resulted in the categorization of common ER strategies as uniformly adaptive or maladaptive, a closer look at the empirical evidence suggests that the preference for and effectiveness of specific strategies likely varies as a function of context and individual differences. That is, a single "adaptive" strategy may not be effective across every stressful context, or even across every controllable vs. uncontrollable context. For example, in laboratory studies comparing distraction and reappraisal, findings suggest using distraction may be preferable in low-intensity contexts whereas using reappraisal in high-intensity contexts may be most effective (e.g., Dorman Ilan et al., 2018; Shafir et al., 2015; Sheppes et al., 2014; Van Bockstaele et al., 2019). Distraction is also an interesting example of one such strategy that may not always be effective or ineffective. While it is often categorized as a disengagement strategy (as some argue that distraction is akin to avoidance), several studies have found that distraction is associated with positive psychological outcomes (Compas et al., 2017). From a clinical perspective, it is one of the most straightforward and accessible skills that I teach patients, especially child and adolescent patients. Distracting with activities or pleasant thoughts is a powerful tool to get through periods of acute distress, especially when a patient may struggle to engage cognitive skills. It is also a core component of safety planning, a frontline brief intervention to mitigate acute suicide risk (Stanley & Brown, 2012). This thinking is in line with a recent theoretical framework which proposes the "thinking threshold", i.e., the emotional threshold at which cognitive strategies such as reappraisal and problem solving may be inaccessible or ineffective (Veilleux et al., 2022). Thus, applying an ER flexibility framework to the measurement of strategy selection and implementation effectiveness may help to unpack these important nuances.

Variability in strategy use over time is also important to consider. The capacity to select from a repertoire of strategies to regulate emotions is widely considered to be beneficial. Preliminary research employing EMA to assess variability in strategy use, both over time and across strategies, supports this thinking (Blanke et al., 2020). Further research is needed to clarify to what degree variability in strategy use is most effective.

Relatedly, research on implementation effectiveness also must take into account what happens when initial attempts at ER do not succeed. How well do individuals modify their strategy use in the face of ineffective ER attempts? Is there an order in which individuals deploy ER strategies, and if so, does order matter? To date, few studies have examined this final piece of the ER flexibility framework. In one laboratory study, participants had

the opportunity to switch between two pre-determined strategies (reappraisal and cognitive distraction) when viewing emotional stimuli (Birk & Bonanno, 2016). In this study, individuals switched strategies in response to internal feedback (i.e., affect intensity, corrugator, and heart rate response), and switching in response to this feedback was associated with psychological wellbeing. More research is needed to better understand the process of modifying strategy use after initial strategy selection and its role in psychological outcomes.

Taken together, there has been exciting progress over the past decade in the conceptualization and assessment of how individuals move through the ER process flexibly. Yet, many important questions remain regarding context sensitivity, strategy selection, implementation and modification. It is exciting to see researchers continue to tackle the complexities of the ER process using innovative methods and designs, as this line of research has great potential for informing clinical intervention (discussed further below).

The development of ER flexibility. Given much of my research is focused on children and adolescents, it is important to note that we still have much to learn about how these processes develop from infancy to adulthood. How and when youth learn to regulate their emotions has important implications, both for assessment and intervention targeting these processes. Research suggests that ER capacity develops from early childhood to late adolescence, with the ability to engage in more complex, cognitively focused strategies thought to coincide with the development of higher-order cognitive processes (Larsen & Luna, 2018; Silvers, 2022). However, each stage of the ER flexibility process develops is an outstanding question. Emerging evidence suggests that, similar to the ability to enact regulation strategies, processes of ER flexibility such as strategy switching may emerge at an early age. For example, Pararisa and colleagues (2019) found evidence of young children (ages 4-11) engaging in unprompted ER strategy switching while viewing emotional film clips. Assessing these processes at young ages may also be bolstered by the use of caregiver reports, behavioral paradigms, and passive sensing tools. Devices such as the TotTag, for example, may provide insight into early development of regulatory flexibility in young children who may not yet have the insight to report on their own regulation abilities (Salo et al., 2020).

Considering the role of caregivers and the family context. Existing measures for capturing the stages of ER flexibility are focused almost exclusively on the individual, and yet, for children and adolescents in particular, the family context is critically important. The development of ER is thought to be heavily shaped by caregivers (Morris et al., 2007). The concept of emotion socialization posits that children learn about emotions and their management through observing and interacting with their caregivers (Eisenberg et al., 1998; Hajal & Paley, 2020). As such, caregivers' own capacity for flexible regulation may provide important insights into how youth learn and engage in the regulation process. Yet, few studies have explored the caregiver or the broader family context in the development of ER flexibility. In one promising study assessing biological and behavioral indices of regulatory flexibility, child ER flexibility was enhanced in the context of a parent providing scaffolding and support around ER (Myruski & Dennis-Tiwary, 2021). Relatedly, in a study examining parent-child dyadic concordance in emotion dysregulation, assessed both behaviorally and physiologically, results suggests bidirectional associations between parent and child ER (Crowell et al., 2014). Understanding how caregivers' regulation responses impact their children and vice versa, as well as how caregivers can better support their children in engaging in flexible ER, is an important area for continued research, and will likely have important implications for child and adolescent ER interventions.

Applying the ER flexibility framework in research: Assessing proximal suicide risk. Approaches which both assess multiple components of ER flexibility and employ multiple methodologies to capture these components are particularly promising to move research in this area forward. As an example of such an approach, my current NIMH-funded research seeks to understand the role of ER flexibility in proximal risk for suicide in youth.

Suicide is the second leading cause of death among adolescents in the U.S., with the CDC reporting 17.3% of deaths in youths ages 10-24 were due to suicide (Curtin et al., 2016; Heron, 2018). Hospital encounters for adolescent suicidality have doubled in the past decade (Plemmons et al., 2018), and periods of transition from intensive services present a particularly high-risk period for suicidal thoughts and behaviors (Brent et al., 1998; Prinstein et al., 2008; Yen et al., 2013). Prominent theories of suicide identify difficulties in ER as a critical factor in the pathway to suicidal behavior (Brausch & Woods, 2018; Harris et al., 2018; Heffer & Willoughby, 2018; Horwitz et al., 2018). Indeed, evidence-based approaches for suicide prevention emphasize the importance of regulating emotional responses when under stress to maintain safety. This is significant, because while front-line interventions commonly rely on skills-based approaches (Asarnow et al., 2017; Calati & Courtet, 2016; Fox et al., 2020; Ougrin et al., 2015), no studies have empirically examined how adolescents' flexible use of these skills impacts proximal risk for suicide during important high-risk clinical transitions.

Notably, prior to hospital discharge, there is an emphasis on helping youth to develop safety or coping plans which explicitly outline what skills youth will use when they experience distress or urges to engage in self-harm (Stanley & Brown, 2012). Yet, we know remarkably little about the how flexible (or inflexible) ER may be associated with suicidal outcomes in periods of elevated risk, and whether specific ER deficits in the areas of context sensitivity, repertoire/strategy selection, or strategy implementation may predict these outcomes. Do these youth experience difficulties reading cues in their home or social environments? Do they struggle to select a skill appropriately suited to the context? Are they relying on the same skill frequently? Or do they find themselves trying many skills with no effect? Do they experience difficulties in these ER processes consistently, or do patterns vary? And does the ER process have direct relevance to periods of acute suicide risk? Unpacking the answers to these questions has critical clinical implications for how we can better support youth during clinical care transitions and ultimately reduce risk for suicide.

My currently funded study (K23-MH122737) seeks to explore these questions using a multi-method assessment approach. The study employs a combination of laboratory paradigms (ERT, Bettis et al., 2018; RIFT, Birk & Bonanno, 2016) including psychophysiological assessment of respiratory sinus arrythmia and electrodermal activity, self-report measures (CSI, Bonanno et al., 2020; Self-Perceived Flexible Coping with Stress Scale, Zimmer-Gembeck et al., 2018; Flexible Regulation of Emotional Expression scale, Burton & Bonanno, 2016), and momentary assessment of stressors, social contacts, and ER skill use via mobile phone surveys over a 2-week period. Through this comprehensive assessment of ER flexibility, I hope to better understand how adolescents engage in the ER process during periods of elevated risk for suicide. I am excited for the potential for this pilot study to move research in this area forward, and to unpack which components of the ER flexibility process may be most relevant to assess in this population to inform intervention.

Interventions and ER flexibility.

A large number of empirically-supported psychological interventions either directly or indirectly emphasize ER (and coping) skill building (Gratz et al., 2015; Sloan et al., 2017). This is true both for interventions that seek to prevent psychological disorders such as depression (Brunwasser & Garber, 2016; Compas et al., 2015; Weersing et al., 2016) and anxiety (Christensen et al., 2010), as well as treatments for psychopathology such as CBT for depression and anxiety (March et al., 2006; Podell et al., 2010; Weersing et al., 2017) and DBT-A for suicidality and self-harm (Asarnow et al., 2021; McCauley et al., 2018). In a recent meta-analytic review of ER interventions for adolescents, Eadeh and colleagues (2021) found an overall small effect for interventions' ability to reduce emotion dysregulation. Further, they found no overall effect for interventions' ability to improve adaptive ER skill use.

One of the primary challenges in examining the existing literature is that many studies of interventions teaching ER skills have not measured ER skill use, and of those that have assessed ER, many used measures that do not align with the skills taught in the tested intervention. Thus, it is difficult to draw firm conclusions about whether the intervention was effective in teaching the skills taught or which specific skills may have the most impact. This may also partially account for the small effect sizes found in this recent meta-analytic review (Eadeh et al., 2021). Consistently assessing the use of skills taught in treatment is critical to understand what works, for whom, and to inform ways we can enhance existing intervention protocols.

In addition, evidence for the impact of psychosocial interventions on each component of ER flexibility remains an important question for future research. While some studies have assessed regulation abilities pre- and post-treatment, when and how skill use changes during the course of an active intervention, is rarely assessed (Nauphal et al. 2021). Consistent with the idea of ER flexibility, Nauphal and colleagues (2021) outline the importance of assessing changes in skill use more frequently over the course of treatment (e.g., employing EMA to capture skill use and change in daily life) to provide greater granularity in these processes at the within-person level. Importantly, this type of approach has clear clinical translation, as providers seeing individual patients may benefit from periodic ecologically valid assessments of patient's ER capacity to inform treatment decisions (Nauphal et al., 2021). I also want to highlight an outstanding related conceptual review discussing the role of ER in intervention research (Southward et al., 2021). In this review, Southward and colleagues outline a thoughtful and practical framework for testing ER mechanisms in psychological intervention research, and make a strong case for the need to move beyond

traditional pre- to post-treatment self-report measures of broad emotion dysregulation to aide in developing more effective and efficient interventions (Southward et al., 2021).

As we make progress in understanding ER processes in the context of psychological interventions, I am hopeful that this work will both refine existing treatments for psychological disorders and expand our ability to deliver accessible, brief and effective interventions to reach more of the population. For example, as we work to clarify the role of ER, we may find that brief, even single-session ER-focused interventions could make a significant impact. Indeed, there is promising research in this area that suggests single-session interventions may be effective in reducing depression and anxiety symptoms (Schleider et al., 2020). It is plausible that a single-session intervention designed to address one or several aspects of ER flexibility may be sufficient to reduce risk for psychopathology. Research in ER flexibility also has strong potential to inform the development of just-in-time adaptive interventions, which are inherently dynamic and adaptive in their delivery (Nahum-Shani et al., 2015; Spruijt-Metz & Nilsen, 2014). Ultimately, in refining what aspects of ER flexibility are most relevant to specific psychological outcomes, we will have increasing opportunity to leverage findings to promote psychological health in exciting new ways.

Finally, in reflecting on the potential for ER flexibility research to improve how we assess and deliver mental health interventions, it is also essential to acknowledge the broader socio-cultural context in which we engage in regulation. Evidence-based psychosocial interventions tend to focus on the individual and building their capacity for ER. However, these approaches often ignore the significant impact of system-level contributions to psychological health. Specifically, we know that systems of oppression, including white supremacy and the patriarchal, ableist, anti-LGBTQ+ systems that both exist within and work to uphold white supremacy, directly and indirectly harm physical and mental health (e.g., Berger & Sarnyai, 2015; Harnett & Ressler, 2021; Kattari, 2020; Meyer, 2003; Wallace et al., 2016). While coping and ER strategies may help to mitigate or exacerbate the negative effects of discrimination and stigma (e.g., Anderson et al., 2018; Graham et al., 2015; Puckett et al., 2020; Toomey et al., 2018) on risk for psychopathology, it is evident that systemic problems will also require systemic solutions (Gee & Ford, 2011). While it is certainly worthwhile to investigate and invest in intervention approaches that bolster adaptive regulation in the face of discrimination and oppression, we must also use a critical lens when considering the study of ER at the individual level in racially and ethnically minoritized populations. These efforts must be accompanied by efforts to actively dismantle those systems which serve to maintain disparities in mental health outcomes, including looking at the disparities present within psychology and psychiatry research and practice (Elias & Paradies, 2021; Shim, 2021).

Conclusions.

The study of ER flexibility is growing, and the past decade has seen exciting and innovative work in both assessment and intervention targeting ER processes. Taking multi-method, team science approaches to answer these complex questions holds great promise for the future of this work. In summary, I am optimistic that this line of research will continue to advance our psychotherapy evidence base, and has the potential to inform the development of new or adapted interventions that are accessible and sustainable to provide maximum benefit and reach.

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Twenty-Five Years After the Passage of HIPPA, What Do We Know About Record Keeping and Privacy Protection?

Stephen M. Lange, Ph.D.

Psychologia, Incorporated

The United States passed its first national health information privacy law in 1996. Twenty-five years later, record keeping in US health settings is highly regulated at the state and Federal levels. This regulatory framework includes the Federal Centers for Medicare and Medicaid Services (CMS) regulations that require that documentation (1) meets state Medicaid requirements where psychologists practice, (2) document medical necessity for treatment, (3) reflect active treatment, (4) are complete, concise, and accurate, (5) are legible and signed, (6) are available for review, and (7) are coded correctly for billing.

In the United States, state licensing boards regulate the practice of psychology within their jurisdictions. The Oklahoma State Board of Examiners of Psychologists (Rules of the Board Title 575:10-1-10), for example, regulates record keeping by incorporating the American Psychological Association's (APA) (2016) Ethical Principles of Psychologists and Code of Conduct, known by its short title Ethics Code, and the Association of State and Provincial Psychology Boards (ASPPB) (2017) Code of Conduct into state law governing the practice of psychology. The APA Ethics Code's Section 6, Documentation of Professional and Scientific Work and Maintenance of Records, requires that psychologists conform to standards for confidentiality of records including their dissemination and disposal, patients' ability to access records for continuity of care, and accuracy of reports to payors. Similarly, the ASPPB Code of Conduct Section 7 requires that psychologists maintain records that include patient identifying information, presenting problems, fee arrangements, date and substance of each patient encounter, test results, notations of consults with other providers, communications though any medium, records of court or other agencies directing services, and HIPAA documentation and authorization.

Psychologists are also bound by their contractual relationships with payors which may prescribe record keeping standards. For example, Humana, a health insurance company, has very specific record keeping requirements - provider's records must include details such as the patient name or medical record number on each page of a patient's record, patient demographic information for every record, the date of every entry, and more substantive content such as presenting problem, risk of harm that is revised frequently, documentation of developmental history, assessment of substance use, abuse or dependence, mental status evaluation, and treatment plan. Finally, Humana requires evidence that patients receive empirically supported treatment.

In addition to law and regulation, professional organizations issue advisory documents that could, in an adversary proceeding such as a malpractice suit, be deemed to represent standard of care. For example, the American Health Information Management Association (AHIMA) (2016) guidelines require that records are characterized by integrity, denoting accuracy. The guidelines assert that documentation integrity implies the intention to provide ethical care. Guidelines issued by the National Committee for Quality Assurance (NCQA) add that records need to show a progression from data to diagnosis, to plan, and ultimately to treatment, with attention directed to unresolved problems experienced by patients.

In addition to its Ethical Code, the APA published Record Keeping Guidelines (APA, 2007). While this document is explicit that the guidelines are meant to be informative rather than prescriptive standards, this is a distinction might not protect a psychologist in an adversary proceeding. The guidelines' recommendations encompass fidelity to state and Federal law, personal responsibility for records, maintenance of accurate, current, and pertinent records, confidentiality of records, disclosure practices, organization of records, retention of records, disposition of records, and use of electronic health records (EHR's). These guidelines are similar to those of other organizations; however, the APA guidelines offer unique guidance including how to resolve conflicts between record keeping standards and exigent situations such as providing disaster relief, or reconciling organizational demands and professional and legal standards for record keeping when they differ.

From a practical, utilitarian standpoint, record keeping has a set of objectives related to treatment outcome. Lennert (2016) describes healthcare documentation, at its most fundamental level, as a cognitive aid to organize information in a manner to enhance clinicians' situational awareness of patient change during treatment, unexplained observations, outcomes that are contrary to predictions or expectations, risks and benefits of treatment, and the to assist clinicians in organizing data into diagnostic formulations and plans for treatment. Lennert describes the process of documentation as dynamic, offering clinicians over time the opportunity to "learn from the record." The essential learning tool, according to Lennert, is hypothesis testing. For example, based on the data present in a

record, a clinician could choose an intervention, such as exposure therapy for trauma, and hypothesize an outcome: in this case, reduced physiological and affective reaction to triggers for reexperiencing symptoms. Recording the details of the intervention and its results – in this example a decrease, lack of change, or increase in anxiety symptoms -- could support or disconfirm the clinician's diagnostic formulation or value of the selected intervention. Williams (2014) also emphasized the dynamic nature of recording patient care and change over time, and its ability to influence patient outcomes. Williams asserted that quality documentation over time improves evaluation and planning of treatment, communication between providers, continuity of care, accurate and timely claims processing, utilization review, and utility of data for research and education.

Poor documentation has organizational consequences when it prevents recognition and reporting of adverse events. Without accurate reporting of adverse events, root cause analysis and corrective action cannot take place (Zegers, Wagner, Bruijne & Groenewegen, 2011). At a macro- and meta-system level, poor record keeping can prevent subsequent providers from fully understanding and addressing patient needs, public health authorities from addressing population health problems, and researchers from reaching conclusions about effectiveness of interventions or risk factors for disorders (Integrity of the Health Record, 2013).

At the level of individual patient outcomes, incomplete documentation impairs follow- through on patient needs, and recognition of what further intervention a patient requires (Leventhal, 2014). Finally, patients are consumers of their own health information and HIPAA requires patient access to their records with few limitations. Consequently, documentation that is accurate and relevant is a potential tool for patient education and self-care (Schaeffer, 2016).

Poor documentation can have consequences for providers of care as well as patients. Documentation is a risk-management tool, and can provide evidence that supports decision making, provide transparency about how treatment was provided, document responses to intervention, and document awareness of risks and benefits of clinical choices such as level-of- care decision making. Poor documentation, on the other hand, is in of itself, evidence of a breach of standard of care (Gutheil, 2004).

Recognizing that record keeping and protecting the privacy of records is a legal and ethical requirement for psychologists, and that there are persuasive arguments for maintaining quality records, how much do we know about the value of records in mental health or other health care settings?

Abernathy et al. (2009) provided a worst-case example of poor documentation and its system-level consequences in a medical context. They described a review of 499 cancer patient records drawn from 13 different healthcare systems that found that patient sex was missing from 17% of records, race from 26%, age from 29%, stage of cancer from 62%, and pathology reports from 34%. Evaluation data confirmed the physicians' diagnoses in only 86% of records reviewed. The authors concluded that poor record keeping in this instance prevented adequate assessment of quality of patient care in the healthcare systems evaluated. Is this a normative finding or an outlier? What is typical for psychologists with respect to record keeping? Do we meet the standards set for us and those we set for ourselves?

With the proliferation of EHR's in mental health settings, psychologists face new challenges in maintaining quality records. EHR's may lack functions that support good documentation practice, such as date stamping entries, may have flaws or bugs, and may not match the needs of the organization or individual psychologist. Sometimes, functions designed to facilitate efficient record keeping sacrifice the integrity of the record. For example, EHR's that permit users to copy and paste information can allow inaccurate, redundant, or outdated information to propagate through records over time (Bowman, 2013). In deciding whether to adopt an EHR or continue to maintain paper records, there is a paucity of research on the effects of EHR adoption on patient outcomes, and an absence of research specific to psychological practice or mental health services, generally. Results of research evaluating EHR implantation within medical contexts are mixed. EHR adoption appears to reduce record keeping time, and reduce medical errors, but have no effect on patient mortality (Campenella et al., 2015), or other patient outcome measures such as complications or hospital readmissions (Yanamadala, Morrison, Curtin, McDonald, & Hernandez-Boussard, 2016). The use of EHR's during patient encounters has adverse effects on patient satisfaction including patient perception of physician respect for the patient, communication skill, and understanding of the patient's history. Observations of physician's during patient encounters reveal that physicians engage less with patients while using EHR's than prior to their implementation, and seldom share EHR data with patients.

Conclusion

Psychologists have compelling ethical obligations to maintain records that are characterized by integrity, completeness, conciseness, relevance, and clarity. These obligations are derived from law and regulation, contractual obligations with third parties, and from risks and benefits to patients associated with record keeping practices. Good record keeping is argued to be an essential tool for individual psychologists to understand patients and how they change over time, for interdisciplinary collaboration, and for continuity of care. Documentation of services is inarguably essential for transparency in billing, and in legal proceedings. At macro- and meso-system levels, quality assurance, utilization review, public health planning, and research depend on accurate patient data. The most compelling statement about record keeping may be the assertion that failure to keep adequate records is a breach of standard of care.

Despite the unambiguous requirement of record keeping from regulatory and legal perspectives, research describing the relationship between record keeping and quality of care does not have the same clarity. The empirical literature leaves a number of questions unanswered. First, and foremost, what are the normative record keeping and privacy protection practices of psychologists across the variety of settings in which they may be employed? We also do not have evidence that records kept by psychologists influence treatment processes such as interdisciplinary collaboration or patient outcomes. We do not know whether and how patients learn from their records. HIPAA ensures that patients have access to their health records, but do we know how often mental health patients access their records? Do we know whether patient access has benefits and/or risks for patients? How do culture or socio-economic status interact with patient access to their records? For example, if patients of a psychologist's practice have access to records through a patient portal, but a fraction of those patients cannot afford internet services or devices, is the system discriminatory? Are patients who have limited English proficiency at a disadvantage in accessing their records? How do differences in health literacy or computer literacy affect the utility of records for patients?

It is possible that there are adverse effects of quality record keeping. Are there cultural groups that are less accepting of electronic record keeping than others? Are there patients whose suspicions that records could be misused avoiding mental health treatment? Do privacy concerns surrounding record keeping affect patient self-disclosure? Similarly, while there is a limited literature about how electronic health records affect record keeping and quality of care, technology has long surpassed the electronic health record. Patients and psychologists have multiple devices that can be used for communication. How do psychologists in practice settings manage records that reside on multiple devices and media with varying degrees of privacy protection?

In summary, 25 years after the passage of HIPPA, we have limited data to support the regulatory framework governing record keeping and privacy protection. We know little about what is normative with respect to record keeping, and we do not know to what extent records fulfill their intended functions. This statement does not abrogate psychologists' responsibility to maintain quality records; rather it means that psychology, as a profession, needs to develop empirical evidence about how records are maintained and used in real-world settings in order to inform practice and policy about record keeping.

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