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
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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 similar although in some ways distinct (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 and should 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 has demonstrated 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, 2012b), 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 context. While this is true for ER, it is likely true for many skills. The ability to be flexible in one’s use of strategies, to choose strategies that are contextually appropriate, is central to psychological wellbeing. Emotion regulation and flexibility are important constructs that need further study and investigation.
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 Measurement of ER flexibility.

In therapy, we do our best to understand and assess what works or doesn’t 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. Clinical research has encountered significant challenges in measuring three key components of regulatory flexibility: context sensitivity, strategy selection/reertoire, and implementation effectiveness.

Context sensitivity. Understanding the context in which ER strategy selection occurs, 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 oneself (e.g., emotional self-contemplation) can impede 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 recently 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 stressors. Compas et al. (2017) have extensively assessed the use of a broad range of context and individual differences. While these measures have provided important foundational information regarding strategy selection within a given context, these measures do not assess an individual’s ability to discern aspects of a given 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 stressors (e.g., Connolly & Alloy, 2017; Forsyth & 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 one of the most 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 stress situations, whereas in high-intensity situations, strategies contexts may be most effective (e.g., Dormanian 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) as well as in response to specific stressor contexts.

Strategy selection and implementation effectiveness. The most common approach to assessing ER is the measurement of strategy use and its association with psychopathology as an index of implementation effectiveness. Many well-documented self-report measures of ER (and coping) assess ER in broad and aggregate terms, including global strategies such as distraction and reappraisal, or more specific strategies such as emotion-focused coping or problem-solving strategies. 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 psychopathologies such as cognitive behavioral therapy (e.g., distraction, acceptance/mindfulness, and avoidance, as they relate to psychological outcomes across the lifespan.

LEAD ARTICLE: Emotion Regulation Flexibility (continued)
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 the intensity of the stimulus (e.g., through observation 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 ER process. In order to explore this, the study focused on the caregiver or the broader family context in the development of ER flexibility. In this study, the focus is on children and adolescents, 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 (Larson & Almeida, 2022). However, much of the research into the specific stages of the ER flexibility process develops is an outstanding question. Emerging evidence suggests that, similar to the ability to enact regulation processes, the development of the ER flexibility process may be most relevant to young children (ages 4-11) engaging in unprompted switch strategies, processes of ER flexibility such as strategy selection, or strategy implementation may 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 a framework, 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., and 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 suicide have doubled in the past decade (Plemmons et al., 2018), and this increase in suicidal thoughts and behaviors (Brent et al., 2016; Fox et al., 2020; Ougrin et al., 2015), no studies have 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 developing safety plans for adolescents and in our study, we specifically explored the caregiver or the broader family context in the development of ER flexibility. In this population, suicide risk has been examined in the context of caregivers’ ability to reduce emotion dysregulation. Further, they found no overall effect for interventions’ ability to reduce 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 line of research (Brent et al., 2016; Southward 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 to the 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 these skills are used post 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 intervention protocols in suicide prevention, particularly in the context of suicidal crisis management. This includes increasing the frequency of EMA assessments (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 it allows for the assessment of interventions’ ability to reduce emotion dysregulation.

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 (Hollon & Garber, 1990; Weersing et al., 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 (Clark et al., 2016; Cowen et al., 2010; Weersing et al., 2017) and DBT-A for suicidality and self-harm (Asamow et al., 2021; McCauley et al., 2018). In a recent meta-analytic review of ER interventions for adolescents, Eadeh and colleagues (2020) suggest following the same set of standards, outcomes, overall care, and assessment of how individuals move through the ER process as the gold standard.

Considering the role of caregivers and the family in children’s development of ER flexibility, 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 (Larson & Almeida, 2022). However, much of the research into the specific stages of the ER flexibility process develops is an outstanding question. Emerging evidence suggests that, similar to the ability to enact regulation processes, the development of the ER flexibility process may be most relevant to young children (ages 4-11) engaging in unprompted switch strategies, processes of ER flexibility such as strategy selection, or strategy implementation may have important implications for child and adolescent ER interventions.
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 (Elías & Paradis, 2021; Shim, 2021).

Conclusions.

The study of ER flexibility is growing, and the promise has seen exciting and important 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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HIPPA, Record Keeping, and Privacy Protection

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, course and content of treatment, procedures and arrangements, and other relevant information for every record, the date of every entry, and 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 that patients 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
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 and stage of cancer were documented from 26%, age from 29%, stage of cancer from 62%, and pathology reports from 34%. Evaluation data confirmed the physician's self-assessment of record completeness. The authors concluded that poor record keeping in this instance prevented adequate assessment of quality of care and patient care in the healthcare systems evaluated. Is record keeping a risk-management tool, and can provide evidence that 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 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 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 impact of EHR implementation on patient outcomes, and an absence of research specific to psychological practice or mental health settings (Schaeffer, 2016). Often, generally results of research evaluating EHR implantation within mental health contexts are mixed. EHR adoption appears to reduce record keeping time, and reduce medical errors, but have no effect on patient outcomes (Campbell, 2016), or other patient outcome measures such as complications or hospital readmissions (Yanamadala, Morrison, Curtis, McDonald, & Hernandez-Boussard, 2016). The use of EHR’s during a patient encounter has adverse effects on patient satisfaction including physician 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, 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. Good documentation practice is 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 minimum, medical record 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. There are relatively fewer number of questions unanswered. First, and foremost, 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 cause adverse patient outcomes. We do not know whether and how patients learn from their records. HIPAA requires patient access to their health records, but do we know how often mental health patients and/or their families 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 HIPAA and their records? For example, if patients of a psychologist’s practice have access to EHR’s through a patient portal, but a fraction of those patients cannot afford internet services or devices, is documentation to the system discriminatory? Are patients with limited English proficiency at a disadvantage in accessing their records? Do these differences in health literacy or computer literacy affect the utility of records for patients?

Is it 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 cause harm or is this a myth? Do privacy concerns surrounding record keeping affect patient self-disclosure? Similarly, while there is a limited literature about how electronic health records affect quality and care of patients, 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 HIPAA, we have limited data to support the regulatory framework governing about the value of privacy protection. Do we know little about what is normative with respect to record keeping, and do we 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 we meet the standards set for us and those we set for ourselves.

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HIPPA, Record Keeping, and Privacy Protection

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 and reduced adverse sequelae. The results—in this example a decrease, lack of change, or increase in anxiety symptoms—could support or disconfirm the clinician’s hypothesis or information. In practice settings, clinicians are required to maintain records that are characterized by integrity, completeness, conciseness, 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. Good documentation practice is 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 minimum, record 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.

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**Suicidal Behavior**
Richard McKeon
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