Families, Systems, & Health
2018, Vol. 36, No. 4, 528–534

© 2018 American Psychological Association
1091-7527/18/$12.00 http://dx.doi.org/10.1037/fsh0000352

Primary Care Integration in Rural Areas: A Community-Focused Approach

Emily M. Selby-Nelson, PsyD
Cabin Creek Health Systems, Charleston, West Virginia

Joshua M. Bradley, PsyD
Tri-Area Community Health, Laurel Fork, Virginia

Rebekah A. Schiefer, MSW
Oregon Health & Science University

Alysia Hoover-Thompson, PsyD
Stone Mountain Health Services, Jonesville, Virginia

Current and developing models of integrated behavioral health service delivery have proven successful for the general population; however, these approaches may not sufficiently address the unique needs of individuals living in rural and remote areas. For all communities to benefit from the opportunities that the current trend toward integration has provided, it is imperative that cultural and contextual factors be considered determining features in care delivery. Rural integrated primary care practice requires specific training, expertise, and adjustments to service delivery and intervention to best meet the needs of rural and underserved communities. In this commentary, the authors present trends in integrated behavioral health service delivery in rural integrated primary care settings. Flexible and creative strategies are proposed to promote increased access to integrated behavioral health services, while simultaneously addressing patient care needs that arise as a result of the barriers to treatment that are prevalent in rural communities.

Keywords: integrated behavioral health, integrated primary care, rural, rural health

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

The need for integrated health care is well documented. Nearly 70% of primary care appointments include issues associated with psychosocial factors (Gatchel & Oordt, 2003). Many patients would prefer to receive behavioral health services in their primary care provider's office, as opposed to a specialty mental health setting (Lang, 2005). Patients in primary care offices are also more likely to follow through with a behavioral health referral when that service is provided in the same office (Slay & McCleod, 1997). Overall, integrated behavioral health services have been shown to successfully enhance health care services and yield improvements in medical and behavioral health conditions (Kwan & Nease, 2013).

Integrated care models may be especially impactful in areas where access to specialty care is limited, such as rural communities. However, a discussion of the adjustments warranted when developing integrated behavioral health services in rural practice settings is all but absent in the literature. Significant treatment needs in rural areas, combined with poor availability of referral-based services in rural communities, require effective integrated primary care (IPC) to be provided in a flexible, patient-tailored, and community-focused manner. In this paper, we aim to outline the special considerations necessary for conducting IPC in rural communities wherein behavioral health providers (BHPs) may struggle to balance individual- and popu-

This article was published Online First August 2, 2018.

Emily M. Selby-Nelson, PsyD, Cabin Creek Health Systems, Charleston, West Virginia; Joshua M. Bradley, PsyD, Tri-Area Community Health, Laurel Fork, Virginia; Rebekah A. Schiefer, MSW, Department of Family Medicine, Oregon Health & Science University; Alysia Hoover-Thompson, PsyD, Stone Mountain Health Services, Jonesville, Virginia.

Correspondence concerning this article should be addressed to Emily M. Selby-Nelson, PsyD, Cabin Creek Health Systems, Sissonville Health Center, 1635 Sissonville Drive, Charleston, WV 25312. E-mail: enelson@cchcwv.com

lation-based demands. As a diverse group of BHPs working in four different rural primary care clinics, we plan to provide insights and guidance into the nuances of rural IPC.

Rural Communities

Vulnerabilities

Significant mental health disparities exist between rural residents and urban dwellers in the United States. Rural residents remain disproportionately at risk for suicide (Hirsch & Cukrowicz, 2014), substance abuse, and chronic illness (Wagenfeld, 2003). Rates of mood and anxiety disorders, trauma, and developmental and psychotic disorders are at least as high as the rates in urban areas (Roberts, Battaglia, & Epstein, 1999). Further, high rates of mental health comorbidities exist in this population (Smalley et al., 2010). The impact of these disparities on the daily functioning of rural residents is magnified by barriers to availability, accessibility, and acceptability of mental health treatment (Human & Wasem, 1991; U.S. Department of Health & Human Services, 2005).

Availability

Many rural areas have few, if any, mental health providers (Helbok, Marinelli, & Walls, 2006; Schank & Skovholt, 2006), with 60% of rural Americans living in mental health professional shortage areas (U.S. Department of Health and Human Services, 2012). Rural community health centers often are smaller because of dispersed population and therefore may have fewer medical providers (Rosenblatt & Hart, 2000; U.S. Department of Health and Human Services, Health Resources and Services Administration, 2012).

Accessibility

Residents of rural communities may face a multitude of social and environmental challenges which include limited access to employment, scarce resources, high poverty rates, less formal education, and higher illiteracy rates (Campbell, Kearns, & Patchin, 2006; Wagenfeld, 2003). These challenges have the potential to limit awareness of when services are needed, what is available, and how to use those services (Smalley et al., 2010). Mental health services may be difficult to access because of a dearth of public transportation, financial burden associated with maintaining a personal vehicle, and transportation complications related to challenging geographic terrain and seasonal weather further exacerbating existing access issues.

Acceptability

Factors contributing to lower acceptability of mental health services among rural populations include increased stigma and decreased anonymity in using mental health services (U.S. Department of Health & Human Services, 2005). These perceptions represent risk factors that may influence participation in health care and mental health services (Bradley, Werth, Hastings, & Pierce, 2012; Schank & Skovholt, 2006). Rural individuals may possess strong kinship ties with family residing in the same community, a tendency toward family based support, hesitancy to share personal information with strangers or professionals (Bradley et al., 2012), and a strong sense of self-reliance that can be a potential barrier preventing outsiders from gaining the trust of community members (Schank & Skovholt, 2006). As a result of these barriers to mental health care, rural Americans use primary care providers (physicians and other medical providers) for behavioral and mental health services more than their urban counterparts (Crosby, Wendel, Vanderpool, & Casey, 2012).

Rural Integrated Primary Care

Existing and emerging models of integrated behavioral health, although effective for many primary care patients, may insufficiently address the needs of individuals living in rural and underserved areas where mental health treatment availability, accessibility, and acceptability are low. Rural integrated primary care remains true to the philosophy of behavioral health integration, while adjusting service delivery to suit the unique needs of rural communities through population-based care in the context of underserved settings. Similar to BHPs in urban settings, rural BHPs tend to have various roles and responsibilities, including behavioral health consultant, psychotherapist, educator or trainer, scholar, administrator, and leader. To complicate matters, rural BHPs often practice

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

these roles across multiple clinics throughout their rural health care system, with each clinic striving to meet distinct needs in different communities. BHPs practicing in multiple clinics may have practices that vary by site, requiring flexibility and heterogeneity in practice style. Because of the typical absence of specialty mental health treatment options, rural integration warrants the inclusion of resources beyond in-person treatment such as distance access approaches to adequately address the depth, breadth, and magnitude of mental health needs of rural residents.

Rural integrated primary care leads BHPs to strike a balance between answering the consultation needs of a primary care clinic and the greater community's need for continued longer term services. This task is challenging as BHPs risk overbooking their schedule with follow-up care, adversely affecting their open access availability. Current integrated primary care models are based strongly on the expectation of, and reliance on, referrals to specialty mental health services. However, such referrals are typically impractical, if not impossible, because of the dearth of accessible mental health services in rural areas.

As a result of the underserved nature of rural areas, individuals seeking care in these regions may present with mental health problems that have gone untreated for some time, leading an integrated BHP to treat patients who have significant mental health needs with either limited access or no access to mental health referral options. BHPs face the decision to provide more traditional mental health care with evidence-based interventions in the primary care setting, or to refer when options are available and hope the patient completes the referral despite treatment barriers.

Community-Focused Practice Implications

In their June 2016 commentary Mauksch and Fogarty discussed their vision for a "perennial philosophy" to guide the field of integrated behavioral care as it moves forward. Their philosophy highlights the central value of maintaining flexibility in delivering services to meet the unique needs of a variety of primary care patients (Mauksch & Fogarty, 2016). We similarly believe that flexibility in service delivery is a central component to providing integrated behavioral health services in rural settings, as each rural community may have specific needs and differing cultural and accessibility considerations. A flexible and community-focused approach to IPC requires awareness of the following practice domains and adjustments: provider ratio, sustainability of billing practices, generalist practice and ethical considerations, and flexible structure of behavioral health service delivery (see Figure 1).

Ratio of BHP to Medical Provider in Rural Practice

The balance of the number of medical and behavioral health providers is pertinent to the

Features of Urban-based Integrated Behavioral Health	Features of Rural Community-Focused Integrated Behavioral Health
• Model based (fixed) • Population based • Appointments are 30 minutes or less • Clinic patients only • High severity referred to specialty mental health • Collaboration primarily within clinic • 1 BHP to 3-4 PCPs • Treatment duration typically 1-6 visits • Bill Health and Behavior codes • Focus on health issues, health behavior change and mental health	• Need based (flexible) • Population and community based • Appointments determined by patient need and provider availability • May accept outside referrals • High severity may be treated by BHP • Collaboration within clinic and community • No standard ratio of BHPs and PCPs • Treatment duration based on patient need • Bill Health and Behavior and Psychotherapy codes • Focus on health issues, health behavior change, mental health, advocacy, disaster relief, crisis work and some case management

Figure 1. Summary of contrasting features of urban and rural integrated behavioral health services.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

success and sustainability of an IPC practice. In brief, IPC models the ratio of BHPs to medical providers is 1:3–4 (Robinson & Reiter, 2015). It is alleged that this ratio allows a BHP to remain productive with both warm-handoff introductions and follow-up appointments with existing clinic patients. Although some rural clinics may be able to sustain a relatively large number of medical providers, many rural clinics are staffed with fewer than 3–4 PCPs. This staffing scenario may result in a lower provider ratio between BHP and PCP, therefore the role and scope of the BHP is broadened to compensate for the smaller amount of referrals expected from a sole practitioner.

A rural BHP concerned about sustainability should consider augmenting their productivity by taking self-referred clients from the community who are only seeking mental health services and make a reverse referral to their medical provider colleague when that patient does not have an existing PCP. In this instance, a patient may initially establish care with a clinic for behavioral health service only, later becoming a primary care patient to access medical care. It is additionally recommended that rural BHPs consider adding more scheduled patients throughout their day to offset downtime when they are not consulting with the medical provider.

Sustainability of Integration

Sustainability remains a barrier for some primary care practices who wish to integrate behavioral health services but struggle with how to develop payment and reimbursement systems that cover the cost of nonmedical staff (Kathol, Butler, McAlpine, & Kane, 2010). This situation can be especially challenging for smaller practices with smaller budgets, where a BHP's salary significantly impacts the practice budget. We are familiar with some integrated practices who have chosen to primarily use health and behavior billing codes that provide reimbursement for behavioral health services under the medical portion of a patient's insurance plan. However, these codes yield relatively small reimbursements and are not uniformly reimbursed (Kessler, 2008), especially in small rural practices where the BHP may only see a few patients whose primary issues are appropriately represented by a health and behavior code. Psychotherapy codes reimburse at a higher rate comparatively. These codes may be considered for rural integrated practices where the demand for psychotherapy is present, where there are limited mental health services available, or when underutilization is a problem (Rost, Fortney, Fischer, & Smith, 2002).

Consideration of the payer mix for behavioral health reimbursement is important, as reimbursement varies state by state. A BHP may find that there are extra steps to access Medicaid reimbursement for psychotherapy, requiring billing consultation. Rural BHPs may expect more consistent reimbursement from Medicare and private insurances, and additionally, may need to consider negotiating a sliding scale for uninsured individuals in the community, or for patients who do not have mental health coverage. In our experience, BHPs can achieve sustainability with a community-focused approach by using a combination of strategic scheduling, using both types of billing codes, negotiating individual contracts of enhanced payment for integrated services through Medicaid, and serving as a training site for psychology, counseling, and social work students and interns.

Rural IPC clinics may be able to expand access to address some behavioral health needs through the inclusion of other helping professionals or trainees like medical family therapists and bachelors level health and wellness coaches (Jordan & Livingstone, 2013). However, psychologists and licensed clinical social workers are the only behavioral health providers approved for Medicare reimbursement, an insurance type held by many rural health care consumers. This population may go untreated if accessing services at sites struggling to hire those particular BHP types.

Generalist Practice and Ethical Considerations

The wide variety of behavioral health concerns treated in primary care requires that any successful BHP have solid generalist training, paralleling the generalist demands of PCP practice. Because of the diverse needs of underserved rural populations, we believe that BHPs in rural settings need to be able to provide generalist services, while also being capable of effectively delivering specialty mental health care in children, adults, and elderly populations

with conditions ranging from mild to severe. Although the rural and urban BHP may approach consultation and brief interventions similarly, the rural BHP may need to provide additional longer term services for a variety of populations who are unable to access more intensive care.

Along with treating a wide variety of patients with varying clinical presentations, BHPs in rural settings encounter unique ethical issues. Dual relationships, conflicting roles, and practicing at the limits of one's scope of competence are all issues commonly experienced by rural mental health providers (Roberts et al., 1999). According to Schank (1998), rural community expectations and standards may contribute to ethical dilemmas that conflict with professional codes and guidelines. Whereas urban BHPs can more readily consult specialists and refer traditional or intensive mental health cases to specialty mental health, rural BHPs may be faced with consulting and treating conditions with which they have limited experience, or face turning the patient away.

Because of the closeness of rural community members and the potential for dual relationships that occurs when community members are also clinic staff, navigating issues related to confidentiality and dual roles can lead to unique ethical conflicts in rural IPC. We believe that BHPs preparing for, or currently in, rural practice may not see their ethical issues adequately reflected in much of the literature about integrated care or in the general application of their professional ethics code. The American Psychological Association's Committee on Ethics and Committee on Rural Health are working toward more practice-based guidance for ethical decision making across practice settings and population diversity (including geographic location) that will ideally resolve this area of growth in our field. Rural BHPs are advised to routinely consult colleagues with expertise in ethics and rural practice to remain prepared to face the ethical issues regularly experienced in rural practice.

Technological Bridges to Specialty Care

Innovations in consultation and education including telehealth, Extension for Community Health Care Outcomes (Project ECHO), and the hub-and-spoke model have provided additional support and training to rural practitioners who may otherwise face professional and educational isolation. These programs can offer continued guidance to support PCPs and BHPs when treating cases that challenge their competency limits and generalist model. Telepsychiatry provides the opportunity to integrate specialty psychiatric treatment. The AIMS center at the University of Washington provides excellent examples of how telehealth can be used to provide effective and evidenced based treatments for chronic conditions, like the protocol driven Collaborative Care Model (Gilbody, Bower, Fletcher, Richards, & Sutton, 2006).

The Collaborative Care Model has demonstrated meaningful outcomes for the treatment of depression and anxiety (Archer et al., 2012) and should be considered along with other telehealth services in rural communities where access to psychiatry is often very limited (Hilty et al., 2006). BHPs may consult, facilitate, and engage in co-management during psychiatry telehealth, bridging the access gap to psychiatric treatment typically found in rural areas. Although the function of the BHP differs within a collaborative care model as opposed to a consultant model, both can be used in combination and tailored to meet the needs of a clinic population.

Frequency and Structure of Behavioral Health Services

BHPs in rural practice may consistently need to balance their range of services within the context of their community population, which includes special attention to session frequency. Some models of integration provide firm guidelines for the frequency of behavioral health visits (Robinson & Reiter, 2015). In our experience, flexibility in the length and range of behavioral health visits is congruent with the needs of rural communities and does not necessarily negatively influence the BHP's availability to provide integrated services and consultation to the primary care team. For example, recent data from one of our practice sites in rural Virginia demonstrated an average of 4.5 behavioral health visits among referred patients during 2015, with single visits removed from the data. However, the session range extended to 42 visits, demonstrating the BHP flexibility

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

for a small amount of patients requiring more intensive care. Another of our practice sites in rural Oregon produced similar data in 2016, with an average of 4 visits for each person seen in behavioral health. The behavioral health team in this clinic was able to see nearly 10% of the total clinic population, while not restricting the number of visits for patients needing longer term mental health services.

Just as BHPs in all practices must achieve a balance of consultation and direct patient care, each practice may employ differing strategies to increase BHP availability. Based on our collective experience, we have observed success in achieving behavioral health access by setting an intentional culture of flexibility for behavioral health services with both patients and primary care team colleagues. For example, BHPs working alone and who are dedicating some of their practice to psychotherapy may prepare their patients for the possibility of interruptions for urgent consultation needs. The BHP may carry a pager or use a messaging system based in the electronic health record to ensure easy and accessible communication with other providers. Each practice and individual BHP may adapt the range of services they provide to their community based upon need. For example, some patients may need advocacy around legal problems or help with case management and navigating social services systems. Some primary care psychologists may offer psychological testing when patients cannot receive those services in their community. In our experience, achieving and maintaining this level of flexibility in service delivery and structure requires intentional and ongoing evaluation of processes to monitor for needed changes and improvement, as well as constant communication with members of the primary care team.

Conclusion

The integration of behavioral health services into primary care settings promotes access to quality care for people of all communities and minimizes barriers to treatment. Cultural and contextual factors are necessary considerations in the design and implementation of integrated primary care delivery in rural settings. Mauksch and Fogarty (2016) described the importance of flexibility in meeting the needs of the range of patients that may present in primary care, which is amplified when considering patients living in rural communities. As a result of the unique practice implications inherent in rural health care settings, adjustments in the IPC model design are necessary to best meet the needs of these underserved communities.

Literature offering guidance on the implementation of alternative models or adjusting behavioral health care service in primary care models has been limited to date. It is recommended that IPC education and research initiatives further investigate and disseminate information and best practices in this area to promote competence in rural IPC practice. Such advancement in knowledge may promote recruitment and retention of behavioral health providers in rural IPC settings, minimize the risk of burnout, and lead to increased access to behavioral health services.

References

Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., . . . Coventry, P. (2012). Collaborative care for depression and anxiety problems. *Cochrane Database of Systematic Reviews, 10,* CD006525.

Bradley, J. M., Werth, J. L., Jr., Hastings, S. L., & Pierce, T. (2012). A qualitative study of rural mental health practitioners regarding the potential professional consequences of social justice advocacy. *Professional Psychology: Research and Practice, 43,* 356–363. http://dx.doi.org/10.1037/a0027744

Campbell, C. D., Kearns, L. A., & Patchin, S. (2006). Psychological needs and resources as perceived by rural and urban psychologists. *Professional Psychology: Research and Practice, 37,* 45–50. http://dx.doi.org/10.1037/0735-7028.37.1.45

Crosby, R. A., Wendel, M. L., Vanderpool, R. C., & Casey, B. R. (2012). *Rural populations and health*. San Francisco, CA: John Wiley & Sons Inc.

Gatchel, R. J., & Oordt, M. S. (2003). *Clinical health psychology and primary care: Practical advice and clinical guidance for successful collaboration*. Washington, DC: APA Books, American Psychological Association. http://dx.doi.org/10.1037/10592-000

Gilbody, S., Bower, P., Fletcher, J., Richards, D., & Sutton, A. J. (2006). Collaborative care for depression: A cumulative meta-analysis and review of longer-term outcomes. *Archives of Internal Medicine, 166,* 2314–2321. http://dx.doi.org/10.1001/archinte.166.21.2314

Helbok, C. M., Marinelli, R. P., & Walls, R. T. (2006). National survey of ethical practices across rural and urban communities. *Professional Psy-*

chology: Research and Practice, 37, 36–44. http://dx.doi.org/10.1037/0735-7028.37.1.36

Hilty, D. M., Yellowlees, P. M., Cobb, H. C., Bourgeois, J. A., Neufeld, J. D., & Nesbitt, T. S. (2006). Models of telepsychiatric consultation—Liaison service to rural primary care. *Psychosomatics: Journal of Consultation and Liaison Psychiatry, 47,* 152–157. http://dx.doi.org/10.1176/appi.psy.47.2.152

Hirsch, J. K., & Cukrowicz, K. C. (2014). Suicide in rural areas: An updated review of the literature. *Journal of Rural Mental Health, 38,* 65–78. http://dx.doi.org/10.1037/rmh0000018

Human, J., & Wasem, C. (1991). Rural mental health in America. *American Psychologist, 46,* 232–239. http://dx.doi.org/10.1037/0003-066X.46.3.232

Jordan, M., & Livingstone, J. B. (2013). Coaching vs psychotherapy in health and wellness: Overlap, dissimilarities, and the potential for collaboration. *Global Advances in Health and Medicine, 2,* 20–27. http://dx.doi.org/10.7453/gahmj.2013.036

Kathol, R. G., Butler, M., McAlpine, D. D., & Kane, R. L. (2010). Barriers to physical and mental condition integrated service delivery. *Psychosomatic Medicine, 72,* 511–518. http://dx.doi.org/10.1097/PSY.0b013e3181e2c4a0

Kessler, R. (2008). Integration of care is about money too: The health and behavior codes an element of a new financial paradigm. *Families, Systems, & Health, 26,* 207–216. http://dx.doi.org/10.1037/a0011918

Kwan, B. M., & Nease, D. E. (2013). The state of the evidence for integrated behavioral health in primary care. In M. R. Talen & A. B. Valeras (Eds.), *Integrated behavioral health in primary care: Evaluating the evidence, identifying the essentials*. New York, NY: Springer. http://dx.doi.org/10.1007/978-1-4614-6889-9_5

Lang, A. J. (2005). Mental health treatment preferences of primary care patients. *Journal of Behavioral Medicine, 28,* 581–586. http://dx.doi.org/10.1007/s10865-005-9019-2

Mauksch, L. B., & Fogarty, C. T. (2016). In search of a perennial philosophy for behavioral health integration in primary care. *Families, Systems, & Health, 34,* 79–82. http://dx.doi.org/10.1037/fsh0000196

Roberts, L. W., Battaglia, J., & Epstein, R. S. (1999). Frontier ethics: Mental health care needs and ethical dilemmas in rural communities. *Psychiatric Services, 50,* 497–503. http://dx.doi.org/10.1176/ps.50.4.497

Robinson, P., & Reiter, J. T. (2015). *Behavioral consultation and primary care: A guide to integrating services* (2nd ed.). Cham, Switzerland: Springer International Publishing.

Rosenblatt, R. A., & Hart, L. G. (2000). Physicians and rural America. *The Western Journal of Medicine, 173,* 348–351. http://dx.doi.org/10.1136/ewjm.173.5.348

Rost, K., Fortney, J., Fischer, E., & Smith, J. (2002). Use, quality, and outcomes of care for mental health: The rural perspective. *Medical Care Research and Review, 59,* 231–265. http://dx.doi.org/10.1177/1077558702059003001

Schank, J. A. (1998). Ethical issues in rural counseling practice. *Canadian Journal of Counselling, 32,* 270–283.

Schank, J. A., & Skovholt, T. M. (2006). *Ethical practice in small communities: Challenges and rewards for psychologists*. Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/11379-000

Slay, J. D., & McCleod, C. (1997). Evolving an integration model: The Healthcare partners experience. In N. A. Cummings, J. L. Cummings, & J. N. Johnson (Eds.), *Behavioral health in primary care: A guide for clinical integration* (pp. 103–120). Madison, CT: Psychological Press.

Smalley, K. B., Yancey, C. T., Warren, J. C., Naufel, K., Ryan, R., & Pugh, J. L. (2010). Rural mental health and psychological treatment: A review for practitioners. *Journal of Clinical Psychology, 66,* 479–489.

U.S. Department of Health and Human Services. (2005). *Mental health and rural America: 1994–2005*. Rockville, MD: Office of Rural Health Policy, Health Resources and Services Administration.

U.S. Department of Health and Human Services, Health Resources and Services Administration. (2012). *Designated health professional shortage areas (HPSA) Statistics*. Rockville, MD: Health Resources and Services Administration, Office of Shortage Designation.

Wagenfeld, M. O. (2003). A snapshot of rural and frontier America. In R. L. Stamm (Ed.), *Rural behavioral health care: An interdisciplinary guide* (pp. 33–40). Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/10489-002

Received October 16, 2017
Revision received February 3, 2018
Accepted February 7, 2018 ■

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.