CHAPTER 5

Standards on Competence

2. Competence

2.01 Boundaries of Competence

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.




Psychologists benefit those with whom they work and avoid harm through the application of knowledge and techniques gained through education, training, supervised experience, consultation, study, or professional experience in the field (Principle A: Beneficence and Nonmaleficence). Competence is the linchpin enabling psychologists to fulfill other ethical obligations required by the APA Ethics Code (APA, 2010b). Under Standard 2.01a, psychologists must refrain from providing services, teaching, or conducting research in areas in which they have not had the education, training, supervised experience, consultation, study, or professional experience recognized by the discipline as necessary to conduct their work competently.

- Psychologists with doctoral degrees from programs solely devoted to research should not provide therapy to individuals without obtaining additional education or training in practice fields of psychology.
- Graduates of counseling, clinical, or school psychology programs should not conduct neuropsychological assessments unless their programs, internships, or postdoctoral experiences provided specialized training in those techniques.
- Psychologists should not offer courses or professional workshops if their graduate education, training, or continued study is insufficient to provide students with fundamental knowledge and concepts of the topics or areas to be taught.

- Psychologists without applicable training in job-related counseling and assessment should not offer executive-coaching services (Anderson, Williams, & Kramer, 2012).
- Forensic psychologists should not offer opinions on children's ability to testify if they have not obtained requisite knowledge of developmental processes related to recollection of facts, susceptibility to leading questions, understanding of court procedures, and emotional and behavioral reactions to legal proceedings.
- Psychologists should not suggest to clients/patients that they alter their psychotropic medication regimen unless they have specialized training as a prescribing psychologist.

Specialties, Certifications, and Professional and Scientific Guidelines

Determinations of whether psychologists are engaged in activities outside the boundaries of their competence will vary with current and evolving criteria in the relevant field. For example, the Council of Specialties in Professional Psychology currently recognizes 13 "specialty areas" defined in terms of the education, training, and competencies required to provide distinctive configurations of services for specified problems and populations (http://cospp.org/specialties/).

As noted in the Introduction and Applicability section of the Ethics Code and discussed in Chapters 1 and 3 of this book, psychologists are encouraged to refer to materials and guidelines endorsed by scientific and professional psychological organizations to help identify competencies necessary for adherence to Standard 2.01a.

- According to the Specialty Guidelines for Forensic Psychology (APA, 2013e), when providing information about the legal process, forensic psychologists do not provide legal advice or opinions; rather they explain to parties that legal information is not the same as legal advice and encourage parties to consult with an attorney for guidance regarding relevant legal issues.
- According to the Guidelines for Child Custody Evaluation in Law Proceedings (APA, 2010), custody evaluation requires specialized knowledge of psychological assessments for children, adults, and families; child and family development and psychopathology; the impact of divorce on children; applicable legal standards; and, in some instances, expertise on child abuse and neglect, domestic violence, or parental mental or physical illness (see also Guidelines for the Practice of Parenting Coordination [APA, 2012e]).
- According to the Guidelines for the Evaluation of Dementia and Age-Related Cognitive Decline (APA, 2012d), psychologists who provide evaluations for dementia and age-related cognitive decline must have education, training, experience, or supervision in clinical interviews and neuropsychological testing and training in the areas of gerontology, neuropsychology, rehabilitation psychology, neuropathology, psychopharmacology, and psychopathology in older adults.

- The Guidelines for Ethical Conduct in the Care and Use of Animals (APA Committee on Animal Research and Ethics [CARE], 2012; http://www.apa.org/science/leadership/care/guidelines.aspx) state that psychologists conducting research with animals must be knowledgeable about the normal and species-specific behavior characteristics of their animal subjects and unusual behaviors that could forewarn of health problems.
- According to the task force on Ethical Practice in Organized Systems of Care, convened by the APA Committee for the Advancement of Professional Practice (CAPP), psychologists who are contracted providers for HMOs should only accept clients/patients whom they have the expertise to benefit (Acuff et al., 1999).
- The APA Guidelines for Education and Training at the Doctoral and Postdoctoral Levels in Consulting Psychology/Organizational Consulting Psychology (APA, 2007a) details three domains of competencies required for organizational consulting psychology: (1) individual (i.e., career and vocational planning, employee selection and promotion, employee job analysis, executive and employee coaching), (2) group (i.e., assessment and development of teams and functional and dysfunctional group behavior, work flow, technology, and stress management), and (3) organization/systemwide/intersystem (i.e., organizational assessment and diagnosis, corporate-wide job analysis, centralizing and decentralizing decision making, strategic planning).
- The American Statistical Association's (ASA) Ethical Guidelines for Statistical Practice (1999) warns that selecting one "significant" result from multiple analyses of the same data set poses a risk of incorrect conclusions and that failing to disclose the limits of conclusions drawn is highly misleading.
- According to the National Association of School Psychologists' ethical standards (NASP, 2010), school psychologists recognize conflicting loyalties that may emerge when their services involve multiple clients (i.e., students, teachers, administrators, and parents) and make known their priorities and commitments in advance to all parties to prevent misunderstandings (see also M. A. Fisher, 2014).

Digital Ethics: Competence in Basic Knowledge of Electronic Modalities

Psychologists utilizing the Internet, mobile phone, and other technologies for research, practice, consulting, and other activities need to obtain appropriate knowledge or training in the technical requirements necessary to ensure adequate provision of services, test administration, or data collection and analysis. This may require knowledge of the necessary screen size, speed of and bandwidth for Internet connections, storage capacity, and servers compatible with downloading programs, applications, or other materials. Basic competencies also include awareness of software options for conducting surveys and mobile applications for behavioral management and their related security protections.

Practitioners and researchers working with protected health information (PHI) need to ensure that encryption is consistent with HIPAA requirements; for example, not all video conferencing services meet government encryption standards (see American Telemedicine Association, 2014; Colbow, 2013).

(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.

Understanding the ways in which individual differences relate to psychological phenomena is essential to ensure the competent implementation of services and research. Insensitivity to factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status can result in underutilization of services, misdiagnosis, iatrogenic treatments, impairments in leadership effectiveness and member cohesion in group therapy, and methodologically unsound research designs (APA, 2000, 2003, 2012a, 2012c; Ridley, Liddle, Hill, & Li, 2001; Trimble & Fisher, 2006).

Standard 2.01b requires that psychologists have or obtain special understanding and skills when the scientific and professional knowledge of the discipline establishes that an understanding of factors associated with these individual differences is essential to competent work. According to this standard, the competencies required to work with such populations are determined by the knowledge and skills identified by the scientific and professional knowledge base—not by personal differences or similarities between psychologists and those to whom they provide services or involve in research.

Under Standard 2.01b, psychologists have three sequentially related obligations: (1) familiarity with professional and scientific knowledge, (2) appropriate skills, and (3) knowledge of when to refrain and refer.

Familiarity With Professional and Scientific Knowledge

For each activity in which they engage, psychologists must be sufficiently familiar with current scientific and professional knowledge to determine whether an understanding of factors associated with the individual characteristics listed above is necessary for effective implementation of their services or research.

- Research and professional guidelines suggest that familiarity with the concept of cultural paranoia and culturally equivalent norms on certain scales of psychopathology is required for competent clinical assessment of African

American clients/patients with presenting symptoms of subclinical paranoia (APA, 1993, 2003; Combs, Penn, & Fenigstein, 2002).

- Professional guidelines require knowledge of the mental health risks of social stigmatization and individual differences in the developmental trajectories of lesbian, gay, bisexual, and transgender (LGBT) youths, as well as cohort and age differences when treating LGBT clients/patients (APA, 2012c).
- Psychologists providing treatment must be alert to how religious ideals and internalized religious norms may positively or negatively influence clients'/patients' reactions to life events such as the death of a loved one or their attitudes and behaviors regarding sexual relationships, child rearing, and self-evaluation (APA, 2007d).
- There is growing awareness that research, assessment, and treatments involving girls and women need to be informed by biological, psychological, social, and political influences that may uniquely affect the development and well-being of this population. The APA *Guidelines for Psychological Practice With Girls and Women* (APA, 2007b) provides a historical overview as well as guidance for identifying and addressing areas in which a special understanding of factors associated with women's issues is required for competent provision of mental health services.

Appropriate Skills

If current knowledge in the field indicates that an understanding of one or more of the factors cited in Standard 2.01b is essential to conduct activities competently, psychologists must have or obtain the training, experience, consultation, or supervision necessary. The type of knowledge and training required depends on the extent to which the individual difference factor is central or peripheral to the service required as well as the psychologist's prior training or experience.

- ✓ A psychologist providing bereavement counseling to a recently widowed 70-year-old woman noticed that the client was reporting difficulties shopping for groceries and finding it frustrating to be among friends. While these difficulties might be attributed to depression following the loss of her husband, given the client's age, the psychologist advised the client to get a full medical checkup and sought additional consultation with a geropsychologist on changes associated with and techniques for enhancing functional capacities related to age-related declines in vision, hearing, and activities of daily living (APA, 2012d).
- ✓ A rehabilitation psychologist who began to receive referrals for work with hearing-impaired clients sought training in sign language and other appropriate communication techniques (Hanson & Kerkoff, 2011).
- ✓ A psychologist with prescribing authority was treating a woman for depression who was also under the care of a medical doctor for diabetes. The psychologist made sure he was up-to-date on research on potential interactions between insulin and antidepressants (APA, 2011a).

☒ A counseling psychologist working at a college counseling center typically provided either behavioral or interpersonal psychotherapy for non-Hispanic white students who met diagnostic criteria for anxiety disorder. However, he limited the treatment plan to behavioral therapy for students of Chinese and Korean heritage based on his erroneous assumption that members of this cultural group were not comfortable with treatments that involved insight-oriented techniques (Wang & Kim, 2010).

Need to Know: Critical Self-Reflection and Personal and Professional Bias

Familiarity with professional and psychological knowledge may also require critical self-reflection and the courage and vigilance to continually confront biases, prejudices, and privileges held by oneself, one's profession, and one's society (Allen, Cherry, & Palmore, 2009; Dovidio & Gaertner, 2004; Smith, Constantine, Graham, & Dize, 2008; Spanierman, Poteat, Wang, & Oh, 2008; Sue et al., 2007; Vasquez, 2009). This includes (a) acquiring the skills to identify and resist simplistic and monolithic stereotypes of clients/patients, research participants, and students in terms of their race, ethnicity, gender, social class, sexual orientation, or other socially constructed categories and (b) openness to see how an individual's strengths or vulnerabilities are or are not related to cultural issues (APA, 2012f; C. B. Fisher, 2014; Fisher, Busch-Rossnagel, Jopp, & Brown, 2012; Fisher et al., 2002; Hayes & Erkis, 2000; Hoop, DiPasquale, Hernandez, & Roberts, 2008; J. Johnson, 2009; Stuart, 2004; S. Sue, 1999).

Knowing When to Refrain and Refer

Under Standard 2.01b, psychologists who have not had or cannot obtain the knowledge or experience required must refrain from engaging in such activities and make referrals when appropriate, except in emergencies when such services are immediately needed but unavailable (Standard 2.02, Providing Services in Emergencies; see also Standard 2.01d).

✓ A psychologist trained only in adult assessment was asked to assess a child for learning difficulties. The psychologist referred the family to another psychologist with the specialized knowledge and experience necessary to conduct child assessments in general and developmental disabilities assessments in particular (APA, 2012a; Childs & Eyde, 2002).

☒ A counseling psychologist agreed to provide career services to a client with mild bilateral deafness. The psychologist had no education or training in

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career skills and opportunities available to people who are hearing impaired, employment-relevant disability law, hearing loss–appropriate counseling techniques, the use of American Sign Language and other modes of communication, and the appropriate use of interpreters (Leigh, 2010).

Need to Know: Guidelines for Psychological Practice With Transgender and Gender-Nonconforming People (TGNC)

There is growing recognition that gender identity is a nonbinary construct that is defined as a person's inherent sense of being a female, a male, a blend of male–female, or an alternative gender (Bethea & McCollum, 2013). Transgender and gender-nonconforming (TGNC) people are those who have a gender identity that is not fully aligned with their sex assignment at birth (APA, 2015b). A person's identification as TGNC is not inherently pathological; it can be healthy and self-affirming. It can also be associated with dysphoria due to discordance between one's gender identity and one's body or distress associated with societal stigma and discrimination (Coleman et al., 2012). Gender identity is theoretically and clinically distinct from sexual orientation, defined as a person's sexual and/or emotional attraction to other people.

The guidelines for psychological practice with TGNC people adopted by the American Psychological Association (2015b) were developed to assist psychologists in the provision of culturally competent, developmentally appropriate, and trans-affirmative practice. The guidelines provide recommendations helpful to ensure compliance with Standard 2.01b. For example, when TGNC people seek assistance from psychologists in addressing gender-related concerns or other mental health issues, practitioners must have the competencies required (a) to distinguish between mental health problems that may or may not be related to that person's gender identity; (b) to identify psychologically relevant direct and indirect effects of hormonal and other medical treatments for physical gender transitioning; and (c) to recognize how stigma, prejudice, and violence can affect clients' health and well-being.

Psychologists working with youth must also understand the different developmental needs of gender-questioning and TGNC children and adolescents. Research indicates that not all youth will continue in a TGNC identity into adulthood (Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013). Individual differences in developmental trajectories of children with gender identity concerns mean that psychologists must be familiar with current approaches to these children's care and have the necessary skills to work with parents in ways that provide optimal conditions for positive development (Tishelman et al., 2015). Psychologists working with clients of any age should never make assumptions about TGNC people's sexual orientation, desire for hormonal or medical treatments, or other aspects of their identity or transition

plans (http://www.apa.org/topics/lgbt/transgender.pdf). (See also the discussion of conversion therapy involving children and adolescents in Chapter 6 under Standard 3.04, Avoiding Harm and in the Hot Topic "Ethical Issues for the Integration of Religion and Spirituality in Therapy" in Chapter 13.)

(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

Standard 2.01c applies when psychologists wish to expand the scope of their practice, teaching, or research to populations, areas, techniques, or technologies for which they have not obtained the necessary qualifications established by the field.

- ✓ Prior to offering psychological rehabilitation services, a clinical psychologist without previous training in this area obtained knowledge and supervised experience with individuals with sensory impairments; burns; spinal cord, brain, and orthopedic injuries; catastrophic injury and illness; and chronically disabling conditions (Patterson & Hanson, 1995; Scherer, 2010).
- ✓ A psychologist trained solely in individual psychotherapy obtained appropriate advanced education and training prior to extending his practice to group and family therapy work (Stanton & Welsh, 2011; Wilcoxon, Remley, & Gladding, 2012).
- ✓ To deliver the short-term treatment required under the practice guidelines of the HMO for which she worked, a psychologist acquired additional supervised experience in the delivery of time-limited services (Haas & Cummings, 1991; Parry, Roth, & Kerr, 2005).
- ✓ A developmental psychologist who wished to test a theory of genetic and environmental influences on cognitive aging using an animal population obtained knowledge and supervised experience in animal models, animal care, and animal experimental techniques prior to conducting the research (APA CARE, 2012).
- ✓ Prior to implementing an executive coaching program in a South Asian country, a consulting psychologist obtained knowledge about the culture's orientation toward collective versus independent goals, receptivity to authoritative versus collegial coaching approaches, and preferences for launching quickly into a task versus spending time getting to know the coach personally (Peterson, 2007).
- ✓ A teaching psychologist who planned to offer an interactive Internet course consulted with a specialist to ensure the information would be presented accurately (e.g., Graham, 2001; Randsdell, 2002).

(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related

> prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.

Standard 2.01d applies to situations in which a psychologist without the appropriate training or experience is the only professional available to provide necessary mental health services. Such situations often arise in rural settings or small ethnocultural communities where a single psychologist serves a diverse-needs population (Werth, Hastings, & Riding-Malon, 2010). The standard reflects the balance, articulated in Principle A: Beneficence and Nonmaleficence, between the obligation to do good (to provide needed services) and the responsibility to do no harm (to avoid providing poor services as an unqualified professional). The standard also reflects the importance of providing fair access to services (Principle D: Justice).

Standard 2.01d stipulates two conditions in which psychologists may provide services for which they do not have the required education or experience: (1) Psychologists must have prior training or experience closely related to the service needed, and (2) having agreed to provide the service, psychologists must make reasonable efforts to obtain the knowledge and skills necessary to conduct their work effectively.

CASE EXAMPLE

Services to Under-Served Populations

A psychologist with expertise in culturally sensitive assessment of childhood personality and educational disorders was the only Spanish-speaking mental health professional with regularly scheduled appointments with individuals in a Mexican–migrant worker community. A social worker serving the community asked the psychologist to evaluate a Spanish-speaking 80-year-old man for evidence of depression. The nearest mental health clinic was 500 miles away, and the elder was too feeble to travel. The psychologist's expertise in multicultural assessment of mental disorders in children was related though not equivalent to the knowledge and expertise necessary for a culturally sensitive geropsychological diagnosis. The psychologist agreed to conduct the evaluation. Prior to evaluating the elder, she consulted by phone with a geropsychologist in another state. She also informed the elder, the elder's family, and the social worker that because she did not have sufficient training or experience in treating depression in elderly persons, if treatment was necessary, it would have to be obtained from another provider.

> (e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.

Standard 2.01e applies when psychologists wish to develop or implement new practice, teaching, or research techniques for which there are no generally agreed

upon scientific or professional training qualifications. The standard recognizes the value of innovative techniques as well as the added risks such innovations may pose for those with whom psychologists work.

Psychologists must take reasonable steps to ensure the competence and safety of their work in new areas. In using the term *competence*, the standard assumes that all work conducted by psychologists in their role as a psychologist draws upon established scientific or professional knowledge of the discipline (see Standard 2.04, Bases for Scientific and Professional Judgments). Adherence to this standard requires that psychologists have the foundational knowledge and skills in psychology necessary to construct or implement novel approaches and to evaluate their effectiveness.

- Psychologists planning to offer executive coaching services must demonstrate a knowledge and expertise in (a) techniques for fostering and measuring change within business, government, nonprofit, or educational organizations; (b) the nature of executive responsibility and leadership; (c) targeted goal setting within organizational cultures; (d) succession planning; and (e) relevant factors associated with executive challenges such as information technology and globalization (Brotman, Liberi, & Wasylyshyn, 1998; Diedrich, 2008; Kampa-Kokesch & Anderson, 2001).
- As states begin to grant psychologists prescriptive authority, psychologists proposing to practice in this area will need the education and training outlined in the evolving practice guidelines for this field (Fox et al., 2009). Psychologists who do not have prescription privileges but are knowledgeable about pharmacotherapy must continue to be cautious when discussing medications with clients/patients to ensure that they are not working outside evolving professional and legal boundaries of competence (Bennett et al., 2006; Sechrest & Coan, 2002).

Standard 2.01e also requires that psychologists working in emerging areas take reasonable steps to protect those with whom they work from harm, recognizing that novel approaches may require greater vigilance in consumer or research protections.

For example, the application of neurocognitive enhancement techniques to healthy individuals and those displaying no signs of neurocognitive degeneration or dysfunction is an emerging field. To date, there is little research documenting positive effects of neurocognitive pharmacological treatments, cognitive exercises, neuroimaging, neurosurgery, and noninvasive cerebral manipulation such as transcranial magnetic stimulation (Bush, 2006). Psychologists investigating these techniques and practitioners who wish to incorporate them into current modes of counseling or treatment must ensure they have the knowledge and skills to not only administer, assess, and monitor participant or patient reactions to these new methods but also remedy negative reactions if they arise (Standards 3.04, Avoiding Harm; 8.08, Debriefing). Psychologists must also inform prospective research participants and patients of the experimental nature of the techniques (see Standards 8.02b, Informed Consent to Research; 10.01b, Informed Consent to Therapy).

Digital Ethics: Competence in the Use of Telepsychology

Continuous advances in the use of electronic media present new opportunities and ethical challenges for psychologists. At present, there is a small but growing body of research suggesting equivalence of certain types of interactive telepsychological interventions (e.g., videoconferencing) to their in-person counterparts. However, traditional psychotherapy techniques based on oral and nonverbal cues may not transfer to audio, email, text message, or other forms of asynchronous communication, and there are no generally accepted theories or comprehensive models specific to telehealth psychological assessments or treatments (Backhaus et al., 2012; Colbow, 2013; Heinlen, Welfel, Richmond, & O'Donnell, 2003; Yuen, Goetter, Herbert, & Forman, 2012).

As with all new and emerging areas in which generally recognized standards for preparatory training do not yet exist, practicing psychologists using telepsychology must keep abreast of developing knowledge in the field and assume the responsibility of assessing and continuously evaluating whether they have sufficient knowledge or can obtain additional training or consultation necessary for competent practice (APA, 2013d; Standards 2.01e, Competence, 2.03, Maintaining Competence, 2.04 Bases for Scientific and Professional Judgments). Psychologists must also be attentive to harm that may be inflicted on clients/patients when the use of electronic media results in misdiagnosis, failure to identify suicidal or homicidal ideation, or inadvertent reinforcement of maladaptive behavior (e.g., social phobia). To ensure the competence of their work and to protect clients/patients from harm when using telehealth assessment or therapeutic services, psychologists should take the following recommended steps (APA, 2013d; Fried & Fisher, 2008; Maheu, 2001; Maheu, Pulier, Wilhelm, McMenamin, & Brown-Connolly, 2005; Shore & Lu, 2015):

- Stay abreast of advances in the field (Standard 2.03, Maintaining Competence).
- Identify professionals and health and social service agencies in the locality in which the client/patient lives who can be enlisted in crisis situations (Standard 3.04, Avoiding Harm).
- Provide clients with a clear written plan for what to do in an emergency (Standard 10.01, Informed Consent to Therapy).
- Document the rationale for selecting a specific telepsychology modality based on client/patient needs and current scientific and clinical knowledge of the field (Standard 2.04, Bases for Scientific and Professional Judgment).
- Consider termination and referral plans when telepsychology services are no longer needed, ineffective, or harmful (Standard 10.10, Terminating Therapy).

(f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.

According to the Specialty Guidelines for Forensic Psychology (APA, 2013e) psychologists assume forensic roles when they engage in activities intended to provide scientific, technical, or specialized knowledge of psychology to the legal system to assist in addressing legal, contractual, and administrative matters. Forensic roles include clinical forensic examiner, trial behavior consultant, psychologist working in a correctional system, researcher who provides expert testimony on the relevance of psychological data to a legal issue, practitioner who is called to appear before the court as a fact witness, and psychologist who otherwise consults with or testifies before judicial, legislative, or administrative agencies acting in an adjudicative capacity.

Need to Know: Expert and Fact Witnesses

Psychologists serving as *expert witnesses* are those who have, through education and experience, gained specialized knowledge in forensic psychology or other subjects relevant to the legal question at hand. The role of an expert witness is to educate the judge or jury on topics of which the average person is unlikely to have knowledge (Costanzo & Krauss, 2012). Sometimes the court calls on a psychologist who does not have specialized training in forensic psychology or the confluence of psychology and law to serve as a *fact witness,* whose role is to provide records or testify to knowledge of a patient's psychological functioning or treatment not originally obtained for legal purposes (Gottlieb & Coleman, 2012). For example, an independent practitioner seeing a client for anxiety-related disorders might be called as a fact witness in a workers' compensation case for mental distress involving the client. Under Standard 2.01f, even when psychologists have no advance knowledge that their work will be used in a legal or administrative setting, when called on to provide such a service, they are nonetheless responsible for becoming reasonably familiar with the rules governing their forensic role.

✓ A licensed practitioner was called to testify as a fact witness regarding the diagnosis, treatment, and treatment progress of a child he was seeing in group therapy. Prior to going to court, the psychologist obtained consultation on rules governing privileged communications for children and for patients in group therapy in the state in which the psychologist practiced (Glosoff, Herlihy, Herlihy, & Spence, 1997; Knapp & VandeCreek, 1997).

Familiarity With Law, Regulations, and Governing Authority

The provision of competent forensic services requires not only education and training in a psychologist's specific area of expertise but also knowledge of the judicial or administrative rules governing various forensic roles.

- Scientific psychologists serving as expert witnesses should be familiar with federal rules of evidence regarding case law and expert testimony (e.g., *Daubert v. Merrell Dow Pharmaceuticals, Inc.,* 1993; *Kumho Tire Co., Ltd. v. Carmichael,* 1999; see also the Hot Topic "The Use of Assessments in Expert Testimony: Implications of Case Law and the Federal Rules of Evidence" in Chapter 12).
- Psychologists offering trial consultation services to organizations may need to have an understanding of change in venue motions and sexual harassment or retaliation work policies and laws (Weiner & Bornstein, 2011).
- Psychologists conducting custody evaluations should have sufficient understanding of the hearsay rule and what the term *best interests of the child* means in legal proceedings. They should also understand the distinction between criminal and civil law. The purpose of criminal law is to determine a person's guilt or innocence as it relates to violation of law and to determine appropriate sanctions if the defendant is found guilty. On the other hand, the purpose of civil law is to determine the best interests of minors or others who are under guardianship (e.g., child custody disputes, adoption processes, capacity determinations), assign responsibility for claims of harm (e.g., workers' compensation, personal injury litigation), and provide legal remedies (Bush, Connell, & Denney, 2006).
- Psychologists administering psychological services in correctional facilities should be familiar with guidelines and regulations governing the minimum ratio of licensed mental health staff to adult and to juvenile inmates as well as regulations governing access to confidential information by nonpsychologist correctional staff (International Association for Correctional and Forensic Psychology, 2010).

Evolving Law and School Psychologists

School or educational psychologists who serve as expert witnesses in due process hearings for educational services need to be familiar with the legal foundations of special education law, such as *Brown v. Board of Education* (1954), and federal regulations, including Section 504 of the Rehabilitation Act of 1973 (1993), Education for All Handicapped Children Act of 1975, the Americans with Disabilities Act of 1990 (ADA), and the Individuals with Disabilities Education Improvement Act of 2004 (IDEA; Burns, Parker, & Jacob, 2013).

As district employees, school psychologists also have a legal duty to protect all students attending the school from reasonably foreseeable risk of harm, such as from student-on-student violence or harassment or student suicide (Marachi, Astor, & Benbenishty, 2007). When involved in school discipline decisions, they must also be familiar with the Gun-Free Schools Act (see No Child Left Behind Act, 2001), which requires every state that receives funding from the No Child Left Behind Act to have a law that expels any student who brings a firearm to school for no less than 1 year (Mayworm & Sharkey, 2014). The most common tort against school personnel is the claim of negligence in this duty. Jacob and Hartshorne (2007) identified four questions school psychologists may be called upon to address when testifying in a negligence suit: Was a wrong or damage done to the student's

person, rights, reputation, or property? Did the school owe a duty in law to the student? Did the school breach that duty? Was there a proximate cause (causal) relationship between the injury and the breach of duty?

Distinguishing Forensic From Clinical Assessments

Knowing the difference between clinical and forensic evaluations is also important. The clinician's goal is to help the client/patient adjust positively to life circumstances (Bush et al., 2006). The purpose of a forensic evaluation, on the other hand, is to assist the "trier of facts" (a judge, jury, or administrative hearing officer) with determining a legal question. While forensic evaluators must respect the legal rights and welfare of defendants or litigants whom they assess, techniques aimed at promoting the testee's mental health or therapeutic alliance, for example, are not necessary and, in fact, may be inappropriate (Greenberg & Shuman, 1997). In addition, legal definitions of mental disorders may differ from those ordinarily applied for diagnosis and treatment. For example, psychologists conducting competency assessments should know that the term *insanity* has different meanings in different jurisdictions (Denney, 2012). Readers may also wish to refer to the Hot Topic in Chapter 4 on forensic assessment of intellectual capacity in death penalty cases.

According to the Specialty Guidelines for Forensic Psychology (APA, 2013e), psychologists who conduct psychological evaluations of those accused of a crime must know how to acquire and report details about the defendant's intent, motivation, planning, thought processes, and general mental state at the time of the crime. When examinees divulge information not previously known by the court that could aid prosecutorial investigation, psychologists should carefully consider the extent to which the information is germane to assisting the triers of fact in understanding the defendant's mental condition. Psychologists should also be aware of ongoing debate regarding whether expert testimony should answer the "ultimate issue" under court consideration (e.g., Was the defendant sane at the time of the offense?) and consider using terms such as *clinical opinion* rather than *finding* to help triers of fact distinguish between legal conclusions and those based in psychological science and practice (Brodsky, 2013).

Need to Know: Treatment of Alleged Child Victims

Children who are alleged victims of child abuse may be referred for psychological treatment prior to trial. In such contexts, practitioners must become reasonably familiar with empirical data on how treatment may influence the children's testimony by intruding into or altering their memory of an event, whether or not they have been victimized. Branaman and Gottlieb (2013) provided the following guidance for psychologists conducting pretrial therapy with alleged child victims:

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- Carefully screen referrals to determine whether the child is actually exhibiting symptoms that require clinical care.
- Do not assume that the child's presenting symptoms are a consequence of the alleged abuse and avoid helping the patient "process through the trauma" when the child has not raised it as an issue.
- When therapeutic services are indicated, consider appropriate interventions that are symptom/solution focused and future oriented.
- Obtain skills necessary to avoid suggestive questioning or encouraging the child to recount alleged events when doing so is not clinically indicated.
- Be able to distinguish between your therapeutic role and that of a forensic interviewer or child advocate.
- Be aware that what the child tells you during therapy may be relayed to the court through the child's testimony or your testimony as a potential fact witness.

2.02 Providing Services in Emergencies

In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services are available.

Individual and public trauma following the Oklahoma City bombing; the September 11, 2001, attacks on the United States; the aftermath of Hurricane Katrina; and mass shootings such as at Sandy Hook Elementary School in Newtown, Connecticut, and the Inland Regional Center in San Bernardino, California, illustrate the important public role of psychological expertise during and after disasters. Standard 2.02 recognizes that when adequate mental health services are not available during emergencies, psychologists without training in therapeutic services or crisis intervention may still have knowledge and expertise that can benefit the public. The standard permits psychologists who do not have the necessary training to offer such services, but it requires that they limit services to the immediate time frame and to cease as soon as the emergency has passed or appropriate services become available. When a disaster erupts unexpectedly, psychologists wishing to offer their immediate services should have some knowledge of the efficacy of different intervention techniques to ensure that their services do not exacerbate psychological trauma.

✓ A family psychologist lived in a rural area that had just suffered a devastating tornado. Families were experiencing evacuation, loss of their homes, loss of a loved one, and other overwhelming changes in their normal role relationships

and responsibilities, family rules and processes, values they deem important, and family goals that provide the motivation for family member engagement (Myer et al., 2014). The psychologist realized that his family therapy training had not adequately prepared him to address these unique family systems needs. As the only family therapist in the area, he offered emergency services and at the same time contacted experts in the field of emergency family health to help him implement specific skills required for family crisis intervention.

✓ An Army psychologist was deployed for the first time to a country in which American soldiers were involved in active combat. The military health care setting she was assigned to was small, and she would be replacing the sole behavioral health practitioner. Although she had treated returning armed forces personnel in the United States, she had no experience treating patients who had just experienced a traumatic combat event requiring both immediate medical and behavioral health care. As soon as she knew the setting to which she was being deployed, she consulted with other military psychologists about her responsibilities while recognizing that such consultation was not a substitute for needed training. Once on site, so as not to deprive soldiers of emergency services, she provided treatment, exchanged emails with the prior provider to obtain additional information on effective treatment strategies, and continued to read training manuals and other materials to gain the competencies needed. (Adapted from Dobmeyer, 2013; see also Johnson et al., 2014).

Emergency Care and Suicidality

In rare instances, psychologists who do not have education or training related to suicidality assessment or intervention may come in contact with an individual who appears imminently suicidal and for whom no mental health or other health services are immediately available. Under Standard 2.02, psychologists without the necessary competencies would be permitted to try to reduce the immediate risk of suicide. However, the psychologist should call for emergency services or attempt to obtain appropriate services for the individual or refer the person to such services as soon as feasible. Unqualified psychologists should be wary of providing such services, recognizing the potentially harmful nature of uninformed interventions and the ethical inappropriateness of providing unqualified treatment if medical or other suicide crisis services are available (American Psychiatric Association, 2003).

✓ A second-year clinical psychology doctoral student was leaving her social services externship site when she received an emergency call from a guard who told her a member of the custodial staff was threatening to commit suicide. The student had never treated a suicidal patient but knew she was the only mental health provider still in the building. She immediately called her supervisor, who gave her instructions on how to provide limited support to the individual while the supervisor called the nearby hospital emergency services to send a treatment team to the building.

Need to Know: Provision of Emergency Services to Forensic Examinees

During a forensic examination, an examinee may manifest psychological symptoms or behaviors that require short-term emergency services to prevent imminent harm to the examinee or others. In such cases, forensic practitioners can provide such services. Once such services have been provided, psychologists must inform the retaining attorney or the examinee's legal representative and determine whether they can continue to provide a forensically valid assessment of the examinee and the appropriate limitations on the information about the emergency that should be disclosed to the court (APA, 2013e; see also Standards 2.01f, Competence; 3.04, Avoiding Harm; 3.05, Multiple Relationships; 4.01, Maintaining Confidentiality; 9.06 Interpreting Assessment Results).

Emergencies and Public Health Ethics

The ethical principles and standards guiding the work of psychologists trained to provide services for individuals and their families are concerned with the moral obligations of providers to the health of the specific individuals they serve. However, disasters often challenge core assumptions about these obligations because treatment relationships have not been formalized and providers must make difficult decisions about whom to treat among survivors with different and competing needs. In these situations, fairness requires that prioritizing whom to treat must be decided on evidence-based differences in the mental health needs of individuals (e.g., those most vulnerable or at greatest risk) or of particular groups essential to promoting the health of others (e.g., first responders). (See Principle A, Beneficence and Nonmaleficence; Principle D, Justice; Standard 3.01, Unfair Discrimination; Thoburn, Bentley, Ahmad, & Jones, 2012). To avoid conflicts between responsibilities to the public health and individual clients/patients, the Institute of Medicine (IOM, 2012) recommends that, whenever possible, those assigned to such triage responsibilities (assignment of treatment based on urgency) should be different from those providing direct delivery of services (Principle B: Fidelity and Responsibility; Standard 3.05, Multiple Relationships).

2.03 Maintaining Competence

Psychologists undertake ongoing efforts to develop and maintain their competence.

The scientific and professional knowledge base of psychology is continually evolving, spawning new research methodologies, assessment procedures, and forms of service delivery. Information and techniques constituting the core curricula of psychologists' doctoral education and training often become outdated and are replaced by new information and more effective practices as decades pass. Lifelong learning is fundamental to ensure that teaching, research, and practice

provide a positive effect for those with whom psychologists work. Standard 2.03 requires that psychologists undertake ongoing efforts to ensure continued competence. This standard is consistent with mandatory requirements for continuing education of many psychology licensing boards (Wise et al., 2010). The foundational competencies developed through graduate education and training (e.g., reflective practice/self-assessment, scientific knowledge/methods, ethical/legal standards, individual/cultural diversity) provide psychologists with the basic knowledge and skills to maintain and foster postgraduate developmental progressions in functional competence in specific work domains, for example, research evaluation, intervention, assessment, and consulting (Rodolfa et al., 2005). The requirements of this standard can be met through independent study, continuing education courses, supervision, consultation, or formal postdoctoral study.

- School psychologists are faced with a continuously evolving knowledge base and laws relevant to effective teacher and school consultation. They must be aware of requirements for statewide reading and mathematics tests and state and local board of education criteria pertaining to the attainment of academic proficiency for all students, availability of public school choice, supplemental tutoring, and criteria for evaluating teacher proficiencies (Jacob & Hartshorne, 2007). Psychologists must also understand the requirements of and fiscal implications for schools of federal laws such as the No Child Left Behind Act (2001) and keep abreast of future changes to the act (Dillon, 2010).
- Industrial–organizational psychologists developing personnel screening and employment practices must stay abreast of continually changing equal employment legislation (e.g., Title VII of the Civil Rights Act of 1964, Americans with Disabilities Act, Uniformed Services Employment and Reemployment Rights Act of 1994, Age Discrimination in Employment Amendments of 1996), administrative laws (e.g., Equal Employment Opportunity Act of 1972, Family and Medical Leave Act of 1993, Pregnancy Discrimination Act of 1978), executive orders (e.g., Executive Order No. 11246, 1964–1965), and court decisions (e.g., *Griggs v. Duke Power,* 1971; *Wards Cove Packing Company v. Antonio,* 1989; see also Cornell University Law School, 2007; Lowman, 2006; McAllister, 1991; Sireci & Parker, 2006).
- Forensic psychologists are often asked to assess the validity of an examinee's symptoms and presentation to determine whether the examinee is attempting to manage impressions of his or her psychological status. Impression management is highly variable both between and within individual examinees, and as a consequence, accepted measures and techniques for assessing symptom validity are continuously evolving. Failing to detect malingering or failing to recognize symptoms as indicators of a valid mental health disorder results in harm to all stakeholders in the legal process. Forensic psychologists need to keep abreast of evolving research on the assessment of facetious disorders (Larrabee, 2007; see also sections on malingering in Chapter 12).
- Investigators and statistical consultants should remain current in dynamically evolving statistical methodology and avoid the use of antiquated statistical methods (ASA, 1999; Panter & Sterba, 2011).

Competencies for Collaborative Group Practices and Primary and Integrated Care Settings

With the passing of the Affordable Care Act, psychologists will need to acquire competencies in collaborative practice. Collaborative practice in health care occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients and their families to deliver the highest quality of care. This can take place in small group practices or in primary care facilities and other integrated care organizational settings such as patient-centered medical homes (PCMH). The ability to deliver collaborative care requires psychologists to have a unique set of competencies, including (a) keeping up-to-date on the expectations and requirements of the systems of care in which they work, (b) remaining cognizant that psychologists have ethical and legal obligations as members of a distinct and autonomous profession, and (c) being prepared to clarify their distinct roles and services and how these relate to the roles and services of other health care professionals (APA, 2013c).

Working in a primary care context also requires the following (see also APA, 2013a, 2014; Johnson & Freeman, 2014; Nash et al., 2013):

- Knowledge of the psychological, behavioral, and social components of health and illness
- Knowledge of how families affect and are affected by a family member's health
- Ability to implement empirically supported preventive interventions for primary care and to develop collaborative treatment plans for patients with mental health and medical disorders
- Competencies in crisis management and the technique of brief interviewing for screening mental health problems in the undifferentiated medical populations seen in hospital exam rooms or emergency departments
- Awareness of quality improvement standards and the ability to effectively use information technology to track patient outcomes and provide a means for program evaluation

Consulting and Professional Competencies for Collaborative Care in Global Health

The World Health Organization's *Framework for Action on Interprofessional Education and Collaborative Practice* (WHO, 2010) recognizes education in interprofessional collaboration as important for meeting the urgent need to address worldwide crises in preventable infectious diseases and to provide coordinated responses to natural disasters and war. Psychologists working in international settings need to understand the large differences in health care and educational systems, water and food security, and exposure to violence that exist across countries

and regions (Jacob, Vijayakumar, & Jayakaran, 2008). Competency to provide services requires understanding cultural beliefs and misconceptions about disease and determinants of health, as well as governance structures that impede or facilitate health services. Collaborative care in international settings also requires culturally competent communication skills that help health care providers, policy makers, and civil leaders understand one another and work together to promote the development and evaluation of health policies and community education.

2.04 Bases for Scientific and Professional Judgments

Psychologists' work is based on established scientific and professional knowledge of the discipline (see also Standards 2.01e, Boundaries of Competence, and 10.01b, Informed Consent to Therapy).

Standard 2.04 requires psychologists to select methods and provide professional opinions firmly grounded in the knowledge base of scientific and professional psychology. *Scientific knowledge* refers to information generated according to accepted principles of research practice. *Professional knowledge* refers to widely accepted and reliable clinical reports, case studies, or observations. Standard 2.04 is firmly rooted in psychology's historic recognition of the importance of the reciprocal relationship between science and practice (APA, 1947). The current APA Competency Benchmarks (APA, 2012f) consider knowledge of the scientific, theoretical, and contextual bases of assessment and intervention core competencies for training in professional psychology.

Psychologists engaged in innovative activities who do not draw on established knowledge of the field may fail to anticipate or detect aspects of their work that could lead to substantial misrepresentation or harm. The standard permits the use of novel approaches, recognizing that new theories, concepts, and techniques are critical to the continued development of the field. It does, however, prohibit psychologists from applying idiosyncratic theories and techniques that are not grounded in either accepted principles or the field's cumulative knowledge of psychological research or practice.

☒ Several families who believed that their children had been the victims of sexual abuse in the day care center they attended retained the services of a clinical psychologist to evaluate and testify in court that the children had been abused. During her years in practice, the psychologist had created for her own use a set of criteria for determining abuse based on her clinical observations and the writings of two leading practitioners who observed what they determined were universal syndromes of child sexual abuse. The psychologist's testimony played an important role in convicting the day care staff members. On appeal, however, the conviction was overturned based

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on the appellate court's finding that the psychologist's evaluation methods were invalid, unreliable, and not probative of sexual abuse. For additional discussion of these issues, see Fisher (1995), Fisher and Whiting (1998), and Kuehnle and Sparta (2006).

☒ On the day of and immediately following the attacks on September 11, 2001, psychologists from across the country who were not trained in trauma treatment rushed to provide services to victims, rescuers, and their families. An immediate controversy arose regarding their application of the popular but unvalidated Critical Incident Stress Debriefing (CISD) technique. The CISD encourages individuals to discuss their emotional reactions to a traumatic event immediately following exposure; proponents claim that doing so reduces immediate distress, prevents later adverse psychological reactions, and helps screen for individuals who are at risk for developing more serious disorders (Everly, Flannery, & Mitchell, 2000). Critics claimed the debriefing treatment had no efficacy or was potentially harmful to victims of the terrorist attacks (van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002). By the second day, there was a public call to stop untrained "trauma tourists" from using the technique based on concerns they might have actually compounded the effects of trauma on those they "treated" (Bongar et al., 2002).

Psychologists trained in more traditional techniques also have a responsibility to keep up with evolving knowledge of the field to know under which conditions and for which disorders treatments do and do not work and which have iatrogenic risks (Pope & Vasquez, 2007; see also Standard 2.03, Maintaining Competence).

Evidence-Based Practice

The APA Presidential Task Force report on evidence-based practice in psychology (EBPP), which was adopted as policy in 2005 (see APA, 2006), emphasized both the importance of scientific knowledge to treatment decisions and the importance of clinical judgment to determining the applicability of research findings to individual cases. The task force defined EBPP as the integration of the best available research with clinical expertise in the context of client/patient characteristics, culture and preferences, and relevance to the client's/patient's treatment and assessment needs. *Clinical expertise* was defined as competence attained by psychologists through education, training, and experience resulting in effective practice and the ability to identify the best research evidence and integrate it with clinical data (e.g., patient information obtained over the course of treatment or assessment; see also APA, 2002a).

Other professional groups have endorsed the integration of research and practice knowledge as an ethical obligation.

- The National Association of School Psychologists' Principles for Professional Ethics (NASP, 2010) requires that "school psychologists use assessment

techniques, counseling and therapy procedures, consultation techniques, and other direct and indirect service methods that the profession considers to be responsible, research-based practice" (Standard II.3.2).

- The Specialty Guidelines for Forensic Psychology includes a provision that "forensic practitioners seek to provide opinions and testimony that are sufficiently based upon adequate scientific foundation, and reliable and valid principles and methods that have been applied appropriately to the facts of the case" (Guideline, 2.05, APA, 2013e).
- The *Journal of Clinical Psychology: In Session* recently published a series of articles describing the convergence of evidence-based practice (EBP) and multiculturalism with illustrations of EBP that have successfully addressed the clinical needs of cultural minority populations (Morales & Norcross, 2010).

Implicit in Standard 2.04 is the assumption that when patient characteristics and treatment context meet EBP criteria, psychologists implement the evidence-based treatments as designed, a practice known as "treatment integrity." This includes applying an evidence-based model to the assessment of psychological disorders to avoid incorrect diagnoses and subsequent treatment plans based on the idiosyncrasies of the clinicians and/or the setting in which the assessment is conducted (Barry, Golmaryami, Rivera-Hudson, & Frick, 2013; Standard 9.01, Bases for Assessments).

Digital Ethics: Navigating the Online Search for Evidence-Based Practices

The ability to use online searches to quickly identify evolving best practices may become an essential competency required by health insurance organizations (Standard 2.03, Maintaining Competence; Berke, Rozell, Hogan, Norcross, & Karpiak, 2011; Guyatt, Rennie, Meade, & Cook, 2008; Weinfeld & Finkelstein, 2005). New research on EBP for diverse disorders, populations, and treatment modalities is constantly emerging. Primary databases such as PubMed Clinical Queries (http://www.ncbi.nlm.nih.gov/pubmed/clinical/) and psycINFO (APA, 2010b) have begun to contain references to individual studies that clinicians must individually evaluate with respect to their validity and relevance to the current treatment question. Other EBP databases are designed to facilitate practitioner searches by including summaries of new empirical studies on clinical efficacy that have been evaluated for scientific validity and applicability (e.g., the National Registry of Evidence-Based Programs and Practices, http://www.nrepp.samhsa.gov; see also Hennessy & Green-Hennessy, 2011).

Falzon, Davidson, and Bruns (2010) have developed a formula to guide practitioner online searches for the EBP most applicable to a particular client/patient. Their PICO formula includes finding appropriate search terms for four components: (P) patient disorder, for example, depression with suicidal ideation; (I) type of intervention the clinician is considering, for example, dialectical behavior therapy (DBT); (C) the comparison intervention the clinician is considering, for

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example, cognitive–behavioral therapy; and (O) the outcome measure of interest, for example, reduction in symptoms or need for hospitalization. After identifying the research, psychologists need to draw on their scientific and professional training to critically evaluate which studies best meet criteria for ecological validity, relevance, and utility for the individual clinical case.

In many instances, the EBPs reviewed may not provide a perfect match to all aspects of the clinical question. Appropriate application of the EBP thus requires clinical judgment to determine how best to integrate or adapt the EBP in ways that are best fitted to the psychologist's clinical expertise, the treatment context, and the patient's clinically relevant needs and characteristics (see also Standard 2.04, Bases for Scientific and Professional Judgments). Final steps in the process include monitoring and evaluating the effectiveness of the EBP-informed treatment for the specific client, making clinically informed modifications, and, if needed, conducting a new database search (McGivern & Walter, 2014).

Implications of the Affordable Care Act (ACA)

Evidence-based health care is a major tenet of accountability within the ACA. To meet criteria for services coverage, psychologists working in group practices and primary care patient-centered health systems must be able to describe and utilize evidence-based practices that enhance the cost-effective quality of care. Practitioners will also need to be able to identify evolving evidence-based strategies for measuring and monitoring client progress within team-based care, including empirically derived signal–alarm systems to identify patients at risk for treatment failure (Lambert, 2013). In addition, the ACA focus on prevention and the integration of behavioral health into primary care will require the ability to identify evidence-based psychosocial practices involving brief interventions supported by self-management strategies, effective liaisons with specialty mental health providers such as those of substance abuse and obesity-related services, developmental assessments, and involvement of family members in brief episodes of care (Nash et al., 2013; Rozensky, Celano, & Kaslow, 2013). For adolescents, the law mandates that insurers cover screening for depression, assessments for substance use, sexual health counseling, and HIV screening (Tynan & Woods, 2013).

In addition, research psychologists with expertise in quality improvement and patient outcome research will become increasingly in demand and will need to develop research designs capable of assessing comparative clinical effectiveness and quality management. Psychologists will also need to develop new methods for continuous quality improvement research that conforms to the actual flow of patient care in a primary care setting and does not interfere with ongoing clinical practice while, at the same time, maintaining fidelity of recruitment and research procedures (Kanzler, Goodie, Hunter, Glotfelter, & Bodart, 2013a).