Kitchen Sink of Common Issues in a Joint Visit

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DISCLOSURE

- No disclosures to report

LEARNING OBJECTIVES

- Providers will grasp effective tools of gathering information about caregiver concern about psychotropic medications and ways to efficiently address concerns and explain risks and benefits.
- Providers will exhibit understanding of how to increase and enhance behavioral health treatment buy-in from the family system.
- Integrated Behavioral Health Clinicians will show ability to quickly assess presenting problem, underlying problem and effective interventions and deliver to the patient in a 20 minute joint visit.
- Providers and practices will have an increased grasp on the effectiveness of care coordination with patient stakeholders.

Common Themes

Parental concern regarding psychotropic medication impact

Increasing treatment buy-in from the whole system

Effective care coordination

Quick and effective interventions for BHC’s

Joint Visits

WORKFLOW

- Physician determines if a joint BH visit is appropriate
- BH joint visit is scheduled
- IBHC determines if patient is appropriate for co-located model or if a referral is needed
- If referred out, source is identified and referral is formally sent by practice

ALTITUDE'S APPROACH TO JOINT VISITS

- Scheduling:
  - IBHC's are scheduled in a staggered form in order to maximize availability per needed throughout day
    - 60 minute CLC visits and 20 minute joint visits
  - 1 full time BH director and one fellow seeing patients one day per week

(Review) INTERPERSONAL COMMUNICATION

Buy In

- INDIVIDUAL AND SYSTEMIC
- MAKING THE PATIENT AN ACTIVE PARTICIPANT IN THEIR HEALING
- THIS STARTS IN THE INITIAL VISIT

ENGAGE AND ACTIVATE PATIENTS IN THEIR CARE

BH providers engage patients in their care, helping them understand how their BH factors affect their health and illness, and how the BH aspects can be integrated in a team-based care plan.

What Does Buy-In Mean

acceptance of and willingness to actively support and **participate** in something

TABLE 1. SPECIFIC COMPETENCIES BY CATEGORY

I. INTERPERSONAL COMMUNICATION

The ability to establish rapport quickly and to communicate effectively with consumers of healthcare, their family members and other providers.

Examples include: active listening; conveying information in a jargon-free, non-judgmental manner; using terminology common to the setting in which care is delivered; and adapting to the preferred mode of communication of the consumers and families served.

II. COLLABORATION & TEAMWORK

The ability to function effectively as a member of an interprofessional team that includes behavioral health and primary care providers, consumers and family members.

Examples include: understanding and valuing the roles and responsibilities of other team members, expressing professional opinions and resolving differences of opinion quickly, providing and seeking consultation, and fostering shared decision-making.

III. SCREENING & ASSESSMENT

The ability to conduct brief, evidence-based and developmentally appropriate screening and to conduct or arrange for more detailed assessments when indicated.

Examples include screening and assessment for: risky, harmful or dependent use of substances; cognitive impairment; mental health problems; behaviors that compromise health; harm to self or others; and abuse, neglect, and domestic violence.

IV. CARE PLANNING & CARE COORDINATION

The ability to create and implement integrated care plans, ensuring access to an array of linked services, and the exchange of information among consumers, family members, and providers.

Examples include: assisting in the development of care plans, whole health, and wellness recovery plans; matching the type and intensity of services to consumers' needs; providing patient navigation services; and implementing disease management programs.

V. INTERVENTION

The ability to provide a range of brief, focused prevention, treatment and recovery services, as well as longer-term treatment and support for consumers with persistent illnesses.

Examples include: motivational interventions, health promotion and wellness services, health education, crisis intervention, brief treatments for mental health and substance use problems, and medication assisted treatments.

VI. CULTURAL COMPETENCE & ADAPTATION

The ability to provide services that are relevant to the culture of the consumer and their family.

Examples include: identifying and addressing disparities in healthcare access and quality, adapting services to language preferences and cultural norms, and promoting diversity among the providers working in interprofessional teams.

COMMUNICATING IN THE JOINT VISIT

- 1. Ability of a BH to be able to *rapidly* develop rapport with a wide range of individuals along with the PCP is crucial.
- 2. Listening actively and effectively is key to making the patient and family feel thoroughly heard and understood. Primary problems need to be grasped **quickly** and a framework begins to develop about patient needs, preferences which are then **reflected** back to the family.
- 3. Utilizing psychoeducation in a non-judgemental way that is tailored to the patient/family members in the room can be key in helping create a simple understanding of holistic and helpful concepts.
- 4. Explain to the patient/family the roles and responsibilities of each team member and how they will work together to provide services. This will include the PCP, the BH, referral sources, the case manager or other care roles within your office.

MAKING THE VISIT FLOW FROM START TO FINISH

BH scrubs schedules in a.m.

Maximizing BH availability.
Checking to see what joint appts are already scheduled and if there is a BH related appt that may not have been linked.

Check-in before appt

-BH looks at chart to gather context
-Daily Huddles - messaging/brief consult
-Preparing interventions

Beginning of visit

-PCP introduces IBHC as part of care team
-Briefly explains why the BH is in the room

JOINT VISITS

Case Conceptualization

Defined as a process and cognitive map for understanding/ explaining a patient's presenting issues and a guide for clinical direction. Provides IBHC with a clear plan for focusing treatment interventions, including the therapeutic rapport/alliance, to increase the likelihood of achieving treatment goals.

Method / clinical strategy for obtaining and organizing information about a patient, understanding and explaining the client's presenting problem and maladaptive patterns being exhibited, focusing treatment, anticipating challenges and roadblocks to tx. (Counseling Today, Sperry 2020)

Clinical Direction

BH determines along w/ the PCP what treatment direction fits the family map the best. (Referral, hot spotting, CLC, etc).

Review of Plan

Repeat the plan back to the patient/family to make sure everyone is on the same page and there is clear guidance for next steps.

NOTES

- Assertiveness is important in the room to make the visit as effective and efficient as possible.
- Pick 1-2 topics and have the family back if needed to address less acute concerns
- Present a united front: be attuned to and respect/ respond to the leadership displayed by other providers in or out of room - important to defer to others in clinical leadership on the particular case
- Be practical in your approaches and practice flexibility /adaptability if mid-intervention you realize it does not fit or meet the needs of the family. Be aware of an avoid rigidity.
- Connect the patient and family to others in the moment through the “warm hand off.”

CONT'D

- Avoid using terminology that is too clinical or confusing for the patient including acronyms or getting in the weeds.
- **BE BRIGHT, BE BRIEF, BE GONE**
- Use an interpreter wherever needed
- Adapt your language based on family capacities
- Provide visual/tangible resources/health/psycho- education materials that are appropriate for the family and give them something to bridge the information presented verbally.
- Recognize and manage personal biases related to healthcare consumers, families, health conditions and healthcare delivery.

UNWRITTEN RULES

Earning the right

Building a quick rapport
Making everyone in the room feel heard and understood
Giving quick summaries to streamline the visit

Reading the room

Sending parent out?
What does the family system look like?
Asessing readiness

Quick disciphering of direction

What is going to be most effective for this family in this momoment o t time?
This might be very different from what you would do in a trasditional visit or if theyfamiy was not under stress.

WARM HAND OFF

Creating a bridge between what is familiar and what is unfamiliar. Utilizing and leveraging the trust based relationship created in the medical home to connect to external referral sources.

QUICK WORD ON FAMILY SYSTEMS

- Internal versus external boundaries
- Ego strength analysis
- External family supports
- Congruent versus incongruent rules
- Level of participation

Transtheoretical Model of Change and Motivational Interviewing

DEVELOPED BY JAMES O. PROCHASKA AND CARLO DI CLEMENTE.

Pre-Contemplation

THE “BEFORE THINKING ABOUT IT” STAGE. “NOT YET READY TO TALK ABOUT IT” STAGE. THERE IS NO INTENTION OF CHANGING. LANGUAGE MAY INDICATES DEFENSIVENESS ABOUT THE ISSUE, LACK OF DESIRE FOR CHANGE, EXTERNALIZING BLAME , OR MINIMIZATION. SOME MIGHT CALL THIS STAGE “DENIAL”WITH A REFRAME OF ‘NOT YET READY.” PUSHING AWAY THOUGHTS/AVOIDANCE (MICENTERFORCHANGE.COM)

Contemplation

- THE “THINKING ABOUT IT” STAGE. CLIENTS IN THIS STAGE MAY TALK ABOUT THEIR AMBIVALENCE ABOUT CHANGE

- THEY KNOW WHAT THEY WANT TO CHANGE, BUT AREN’T YET READY TO DO IT.

- THEY EXPLORE PROS AND CONS AND ARGUE FOR BOTH.
- CAN BE DIFFICULT FOR AN IBH IN THE ROOM
- THEY CAN GO BACK AND FORTH AND MI WAS MADE TO WORK WITH THIS STAGE

. (MICENTERFORCHANGE.COM)

Preparation

- CLIENTS BEGIN ENVISIONING AND PLANNING CHANGE.
- THEY ARE READY/MAKING CHANGE AND THE STEPS INVOLVED A PRIORITY.
- EMPOWERING PATIENTS AT THIS STAGE IS CRUCIAL, GIVING THEM THE TOOLS AND INFORMATION THEY NEED TO SUCCEED.
- MAKE A SUPPORT TEAM FOR THE PATIENT
- SMART GOAL PLANNING IS KEY!

UTILIZING SMART GOALS IN JOINT VISIT

- Specific,
- Measurable,
- Achievable,
- Relevant,
- Time-Bound

Action

CHANGE IS IN FULL SWING.
THEY ARE HEADED TOWARD SECOND ORDER OF CHANGE AND INTEGRATED/GENERALIZING THE CHANGE INTO THEIR LIVES

Maintenance

SECOND ORDER OF CHANGE
HABITS HAVE BEEN FORMED
BENEFITS OF CHANGE EVIDENT

FOLLOW-UP

With the action and preparation phase, returning to the medical home for a follow up visit can create accountability, assess ongoing readiness and create opportunity for ongoing rapport.

Common Diagnostic Presentations

DIFFERENTIAL VERSUS CO MORBID DIAGNOSES

Differential Dx:
the process of differentiating between two or more conditions which share similar signs or symptoms.

Co-morbid Dx:
“Comorbidity refers to the occurrence of more than one disorder at the same time. It may refer to co-occurring mental disorders or co-occurring mental disorders and physical conditions.” (Australian Department of Health.)

RESOURCE

CoPPCap.com
Colorado Pediatric Psychiatry Consultation and Access Program-

direct consultation provided to pediatric care providers by licensed child & adolescent psychiatrists, psychologists, and specialized community resource navigators

Acronym	Name	Age	Completed By	English Version	Spanish Version	Dx Category
ADHD Rating Scale IV - Preschool Version	ADHD Rating Scale IV - Preschool Version	3 - 5	Caregiver	√		ADHD
Vanderbilt	NICHQ Vanderbilt Assessment Scale Diagnostic Rating Scale	6 - 12	Caregiver, Teacher	√	√	ADHD
SNAP-IV	Swanson, Nolan, and Pelham (SNAP) Questionnaire – IV	6 - 18	Caregiver, Teacher	√	√	ADHD
WURS	Wender Utah Rating Scale	18+	Self-Report	√		ADHD
MOAS	Modified Overt Aggression Scale	13+	Clinician; Caregiver	√		Aggression
GAD-7	Generalised Anxiety Disorder Assessment	13+	Self-Report	√	√	Anxiety
SCARED	Screen for Child Anxiety Related Disorders	8 - 18	Caregiver; Self-Report	√	√	Anxiety
SCAS	Spence Children's Anxiety Scale	preschool version 2.5 - 6.5; child version 8 -	Preschool; Child; Caregiver	√	√	Anxiety
M-CHAT-R	Modified Checklist for Autism in Toddlers, Revised	16 - 30 months	Caregiver	√	√	Autism
MDQ	Mood Disorder Questionnaire	11+	Caregiver; Self-Report	√	√	Bipolar
EPDS	Edinburgh Postnatal Depression Scale	18+	Self-Report	√	√	Depression
PHQ-9	Patient Health Questionnaire - 9 item	12+	Self-Report	√	√	Depression
PHQ-9A	Patient Health Questionnaire - 9A (modified for teens)	13 - 18	Self-Report	√	√	Depression
SMFQ	Short Mood and Feelings Questionnaire	6 - 18	Caregiver; Self-Report	√	√	Depression

EAT-26	Eating Attitudes Test	12 - 18+	Self-Report	√		Eating Disorders
Brief ECSA	Brief Early Childhood Screening Assessment	18 - 60 months	Caregiver	√		Social-Emotional Development
PSC-17	Pediatric Symptom Checklist - 17 item	4 - 18	Caregiver	√	√	Social-Emotional Development
PSC-Y-17	Pediatric Symptom Checklist - Youth - 17 item	11 - 18	Self-Report	√	√	Social-Emotional Development
PPSC	Preschool Pediatric Symptom Checklist	18 - 60 months	Caregiver	√	√	Social-Emotional Development
CRAFFT	CRAFFT	14 - 21	Self-Report	√	√	Substance Abuse
S2BI	Screening to Brief Intervention	12 - 17	Self-Report	√		Substance Abuse
ASQ	Ask Suicide Screening Questions	10 - 24	Self-Report	√	√	Suicide
C-SSRS	Columbia Suicide Severity Rating Scale	5+	Interview	√	√	Suicide
ACE-IQ	ACE International Questionnaire	18+	Self-Report	√	√	Trauma
CPSS	Child PTSD Symptom Scale	8 - 18	Self-Report	√		Trauma
PC-PTSD	Primary Care PTSD Screen	13+	Self-Report	√		Trauma
THS-Y	Trauma History Screener - Youth	3 - 18	Caregiver; Self-Report	√	√	Trauma
TESI-C	Traumatic Events Screening Inventory – Child	6 - 18	Self-Report	√		Trauma
YC-PTSD	Young Child PTSD Screen	3 - 6	Caregiver	√		Trauma

ADHD/executive functioning

- REFERRALS TO EXEC FUNCTIONING CLINIC/OT
- VANDERBILTS
- BASC/CONNERS
- DETERMINING IMPULSIVE, INATTENTIVE, HYPERACTIVE
- PSYCHOEDUCATION
- BREAKING UP TASKS
- VISUAL/TANGIBLE CUES
- SCHOOL SUPPORT/SCAFFOLDING
- CONTACTING OTHER STAKEHOLDERS

Depression

- USING SUD'S SCALE TO GET A MORE ACCURATE READ ON PATIENT'S PERSPECTIVE OF LEVELS
- GIVE TEENAGERS MOOD TRACKING APPS WITH ADAPTIVE COPING SKILLS AS THEIR PHONE IS THE EASIEST PLACE FOR THEM TO START
- TRAUMA ASSESSMENT
- ETIOLOGY ASSESSMENT

(FINCH, DAYLIO, CLARITY)

- SAFETY PLANNING WHERE NEEDED
- PHQ-9
- BECK DEPRESSION INVENTORY

Anxiety

- UTILIZING POLYVAGAL THEORY TO GO OVER NERVOUS SYSTEM STATES
- CO-REGULATION
- WINDOW OF TOLERANCE
- MINDFULNESS IN THE ROOM
- ASSESS FOR TRAUMA/ETIOLOGY
- COLLABORATE CARE WHERE NEEDED

ODD

- IS THERE A DIFFERENTIAL DX
- WHAT IS THE FUNCTION OF THE BX
- TRAUMA ASSESSMENT
- INCREASING STOP GAP BETWEEN STIMULUS AND RESPONSE
- SCAFFOLDING SCHOOL SUPPORTS

Developmental Delays

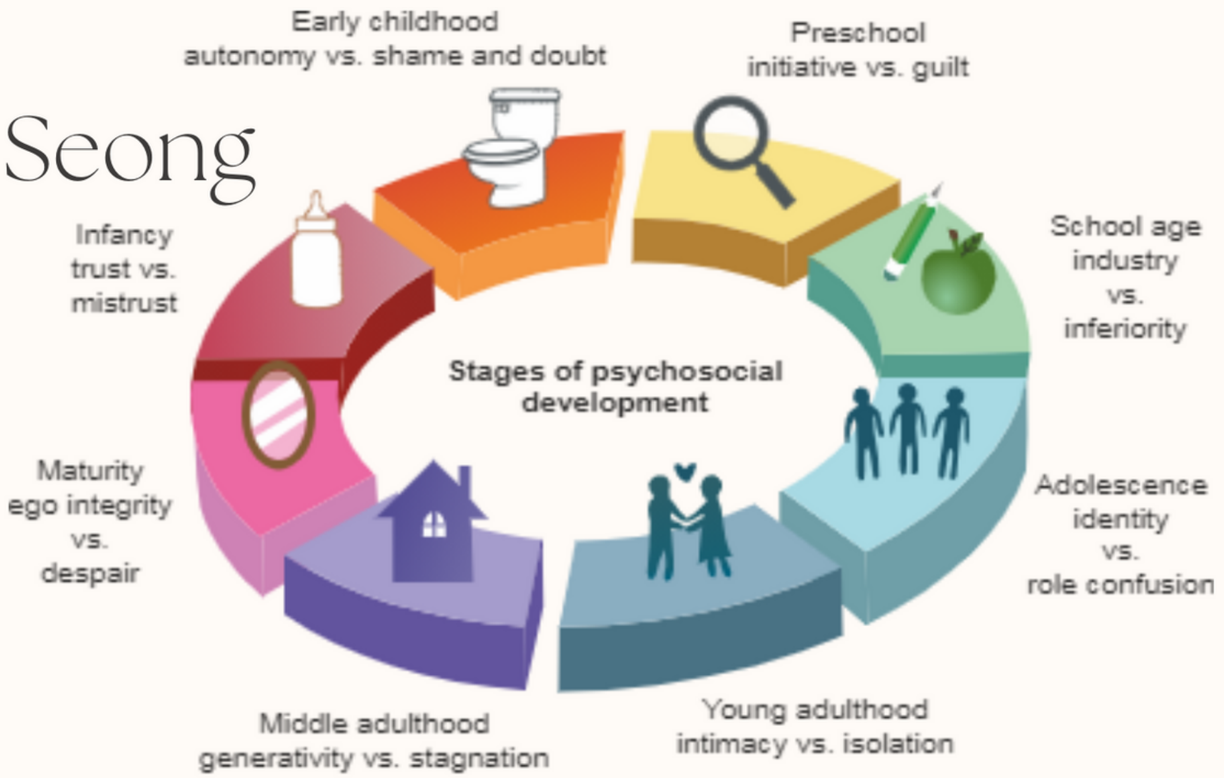
-FASD, COGNITIVE DEFICITS, BORDERLINE INTELLECTUAL FUNCTIONING, FUNCTIONS OF DAILY LIVING
-HAS CHILD BEEN TESTED
-IS CHILD RESOURCED IN ACADEMIC SETTING

Effective Interventions

BASED ON DEVELOPMENTAL STAGES

Verywell

Joshua Seong



Interventions

SAND TRAY

- ALLOWS CHILDREN TO SHOW THEIR EMOTIONS RATHER THAN ARTICULATE THEM
- ALLOWS CLINICIAN TO GATHER INFORMATION RE: COGNITIVE FUNCTIONING, PROCESSING
- SYSTEMIC INFORMATION
- EFFECTIVE IN TREATING TRAUMA
- EXPRESSION OF EMOTIONS WITHOUT THE DISTRESS OF VERBALIZING
- CLINICIAN CAN USE FOR PAST OR PRESENT CIRCUMSTANCES
- STUDY IN 2019 EVALUATED 33 STUDIES AND ALSO FOUND SIGNIFICANT IMPROVEMENTS IN BOTH KIDS AND ADULTS, ESPECIALLY THOSE WHO WERE EXPERIENCING TRAUMATIC STRESS OR WHO LIVED WITH DISABILITIES OR LANGUAGE ISSUES.

Addressing Medication

WAYS TO TALK WITH FAMILIES ABOUT COMMON CONCERNS

Psychosocial stages/interventions

- 2-6: PARENT TRAINING/SAND TRAY/EXPANSION OF EMOTIONAL VOCABULARY, TOKEN ECONOMY
- 6-11: EMOTION THERMOMETER, MIND/BODY CONNECTION, VISUAL/TANGIBLE REINFORCERS, BITLATERAL STIMULATION
- TWEEN/TEEN: POSITIVE IDENTITY BUILDING, SELF AWARENESS, MOOD TRACKING, PLANS OUTSIDE OF SESSION, POLYVAGAL, WINDOW OF TOLERANCE

FAMILY CONUNDRUMS WITH PSYCHIATRIC MEDICATION: AN INQUIRY INTO EXPERIENCES, BELIEFS, AND DESIRES(BENTLEY, THISSEN 2022)

Data from open-ended questions suggests families crave inclusion and wish providers would more radically embrace both collaboration and balance in their approach to medication maintenance. The hope of this research is to help mental health providers be more responsive and compassionate in their work with families of people with serious mental illness, especially as it relates to psychiatric medication.

COMMON CONCERNS

- Black Box Warning
- Family Hx of negative side effects or ineffectiveness
- Concern of addictive qualities
- Age
- Lack of effective information
- Lack of scaffolding/additional supports

EFFECTIVE STRATEGIES

- Simple explanations of brain function
- Explaining research behind including BOTH medication and psychotherapy as most effective for change
- Offering to pursue all other options in advance of this
- Explaining your practice’s approach to medication and medication management
- Talking through efficacy of therapeutic interventions when prefrontal cortex function is maximized
- Effective psychoeducation

Care Coordination

CREATING A NET

COMMUNICATE EFFECTIVELY WITH OTHER PROVIDERS, STAFF, AND PATIENTS (review)

BH providers in primary care communicate effectively with providers, patients, and the primary care team with a willingness to initiate patient or family contact outside routine face-to-face clinical work. BH providers communicate in ways that build patient understanding, satisfaction, and the ability to participate in care.

PROVIDE CULTURALLY RESPONSIVE, WHOLE-PERSON AND FAMILY-ORIENTED CARE

BH providers in primary care employ the biopsychosocial model – approaching healthcare from biological, psychological, social, spiritual, and cultural aspects of whole-person care, including patient and family beliefs, values, culture, and preferences.

EXPECTATIONS OF IBH COORDINATOR

-Being aware of additional funding sources including grants
-Staying up to date on latest billing practices, coding standards, changes in state ethic requirements
-Networking with knowledge of reliable referral sources who accept patient’s insurance and have reasonable availability
-Tracks CLC referrals of self and team members and gathers data on levels of completion
-Practice provides crisis resources and referrals as indicated

DAY IN THE LIFE

●9:00am: Check schedule and huddle with physicians for the day's patients.

●9:10am: Meet with Dr. Lopez for an IBH appt to follow up on an IEP meeting for a teenager with significant behavioral issues.

●9:25am: 60 minute therapy session with 3-year-old and her mother,who is beginning to exhibit Autism Spectrum behaviors. Make referrals to provide scaffolding for the family system.

●10:25am: Return messages about one middle schooler and one first grade both needing therapy; refer middle schooler for group and first grader to private practice clinician.

●10:35am: Called in by Dr. Murphy to see an 8th grader with suicidal thoughts. Spend 30 minutes assessing, the risk is acute enough to call the state hotline who sends mobile crisis. Coordinate care with provider and make patient comfortable until crisis arrives. Pt meets admission criteria.

●11:00am: 60 minute session with a recently graduated 19-year-old struggling with identity versus role confusion which has led to daily marijuana use. This patienthas stomach issues that have been medically ruled out with labs and exam and are largely deemed psychosomatic. Utilize EMDR to help with nervous system regulation and to help with marijuan cravings. Ask the physician to join the appointment to discuss adding a PRN anxiety medication in addition to her SSRI. Physician decides on Hydroxyzine. Collaborate with the physician to help the client utilize medication and coping skills in tandem.

●12:00pm: Warm hand off for a child who met ADHD criteria on Vanderbilts for executive functioning clinic.

DAY IN THE LIFE CONT'D

●1:00 pm: 60 minute family therapy session to help parents navigate behaviors of an adopted child who is exhibiting attachment issues. Discuss referral to a new group at Altitude that uses modality of Circles of Security to help with parent training, support, attachment analysis and a protocol to help orient family toward healing.

●2:00 pm: IBH appt with Dr. Willy to discuss a 6-year-old patient with sleep issues. Work on sleeping plan together and will follow up in 2 weeks.

●2:20pm: 60 minute session with 6th grader who is struggling with transition into middle school. Worked on adaptive coping techniques.

●3:20pm: IBH appt with Dr. Joy to follow up on Vanderbilts assessments for a complex 5th grader. Referred

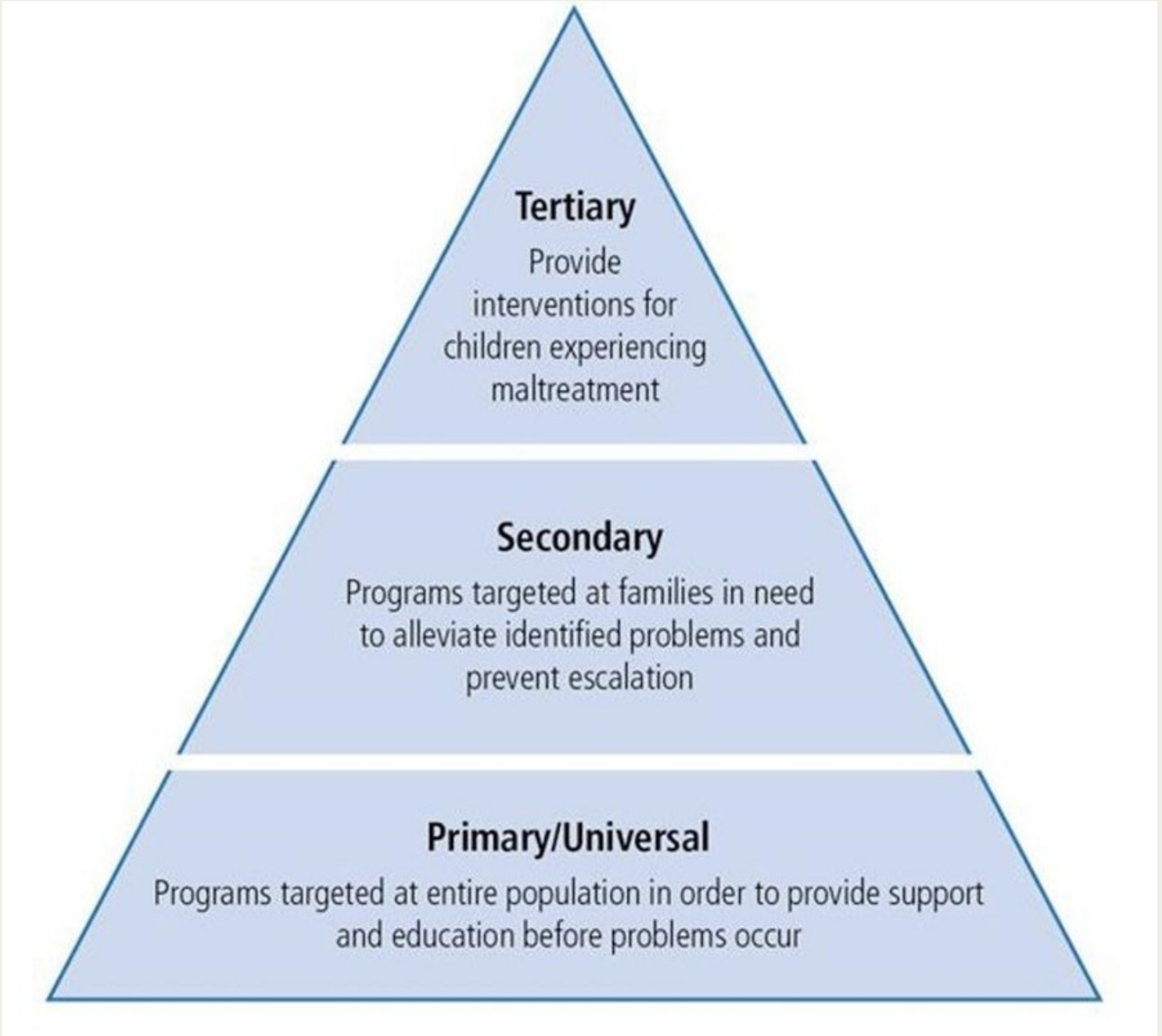
for further testing at Behavioral Health and Wellness to gather more information to inform treatment planning. ●3:40pm: 60 minute session with 5-year-old struggling with transition to and from parent's home who are recently divorced. Worked on utilizing transitional objects and helping parents understand inherent stressors of divorce.

●4:40 pm: Return phone calls from 2 parents following up on last session's content and help with

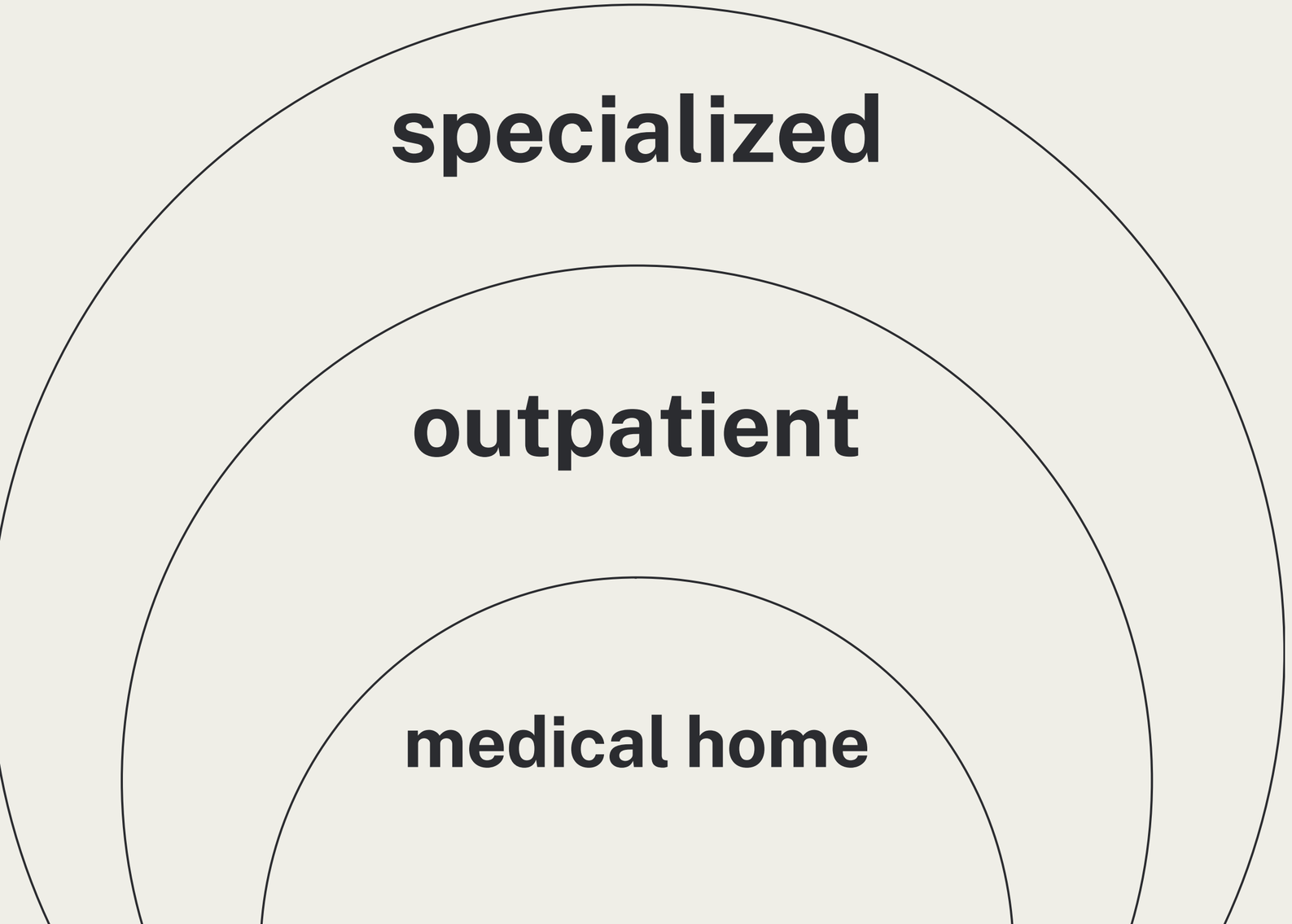
Prevention Model

FOR THOSE PATIENTS IDENTIFIED FOR 6 SESSIONS BRIEF MODEL, PREVENTION SYMPTOMS MAY BE TARGETED RATHER THAN A “TRAUMA DEEP-DIVE.”

APPROPRIATE USE OF SCREENERS, BASC, CONNERS, PHQ-9, SCARED, Y-BOCS ETC


Tertiary
Provide interventions for children experiencing maltreatment
Secondary
Programs targeted at families in need to alleviate identified problems and prevent escalation
Primary/Universal
Programs targeted at entire population in order to provide support and education before problems occur

REFERRALS TO MAXIMIZE CARE



Executive functioning resources

ABA

Neuropsychological testing

Evaluation for IEP, 504 plans
Medication management

Other specialized services not available in the CLC clinic

APA RESEARCH

PCBH improves the patient/family experience of care (satisfaction with care)

- Patient preference for PCBH services (Ogbeide et al., 2018)
- Improves access to mental health care (Hodgkinson et al., 2017; Pomerantz et al., 2010)
- Increases engagement and linkage to specialty mental health treatment when needed (Bohnert et al., 2016; Brawer et al., 2010; Wray et al., 2012; Zanjani et al., 2008)
- Increases antidepressant adherence (Szymanski et al., 2013)
- Reduces wait time for mental health services (Pomerantz et al., 2008; Pomerantz et al., 2010) and no-show rates (Pomerantz et al., 2010)
- Improves relationship between patient and provider (Corso et al., 2012)

PEDIATRIC IBH SPECIFICALLY

- Integrated behavioral health services in pediatric primary care offers a wide continuum of services ranging from prevention and health promotion activities (e.g., pregnancy-related depression, developmental and Healthy Steps consultations) to interventions around mental health concerns (e.g., mental health and psychopharmacology consultations; Talmi et al., 2016).
- Pediatric integrated care provides population-level care to more children, removes barriers to obtaining care and increases access to quality evidence-based treatments (Njoroge et al., 2016).
- PCBH services with pediatric patients are associated with savings in terms of medical cost-offset with one study finding a total monthly savings of $9,424 in reduced health care charges over the period after a behavioral health visit as compared to the period prior across patients who completed an episode of care (Dopp et al., 2018).

IMPROVING OUTCOMES

PCBH improves patient outcomes (improves population health; Reiter & Bauman, 2016)

- Increases provider adherence to treatment guidelines and appropriate antidepressant prescribing (Brawer et al., 2010; Serrano & Monden, 2011)
- Decreases in level of patient distress found two years post integrated primary care intervention (Cigrang et al., 2007)
- Improvements in outcomes regardless of presentation severity (Bryan et al., 2012; Cigrang et al., 2007)
- Targeted interventions associated with broad improvements in symptom reduction, functioning, and well-being (Bridges et al., 2014, 2015; Bryan et al., 2009, 2012; Cigrang et al., 2007, 2011; Corso et al., 2012; Davis et al., 2008; Gomez et al., 2014; Goodie et al., 2009; McFeature & Pierce, 2012; Ray-Sannerud et al., 2012; Sadock et al., 2014; Wilfong et al., 2021)

Thank you!

QUESTIONS?