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JUNE 2019

THE OPIOID CRISIS | NEW GUIDELINES FOR GIRLS AND WOMEN | THE POWER OF SOCIAL RELATIONSHIPS

monitor on psychology

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NEW SOLUTIONS FOR THE OPIOID CRISIS

Innovative research, interventions, assessment tools
and more are improving prevention and treatment

PAGE 32

How Social Relationships Protect Us

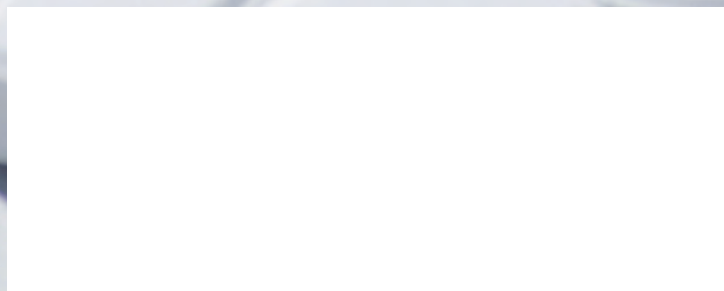
PAGE 68

New Guidelines for Practice With Girls and Women

PAGE 26

A Deep Dive Into Adolescent Development

PAGE 20



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COVER STORY

NEW SOLUTIONS FOR THE OPIOID CRISIS

Opioids remain a serious public health problem in the United States—in 2017, 1.7 million people had substance use disorders related to prescription opioids, and 652,000 had a heroin use disorder.

Now, psychologists are escalating their efforts to prevent and treat opioid use disorder through behavioral interventions, social supports, assessment tools, advocacy and more. *See page 32*



HOW PSYCHOLOGISTS IMPROVE CARE | 34

LIFE-SAVING SUPPORTS | 40

THE STIGMA THAT UNDERMINES CARE | 46

PREVENTION AS THE FIRST LINE OF DEFENSE | 50

WHO NEEDS OPIOIDS? | 56

TRAINING FRONT-LINE PSYCHOLOGISTS | 58

CHANGING OPIOID POLICIES AND PRACTICES | 60

RESOURCES FOR PSYCHOLOGISTS | 64

COVER: SOK ROM/GETTY IMAGES



The power of relationships. Page 68

- 6 PRESIDENT'S COLUMN
- 7 FEEDBACK
- 8 UPDATE FROM THE CEO
- 9 THE HOT LIST

RESEARCH

- 11 IN BRIEF
- 19 DATAPOINT
- 84 BY THE NUMBERS

NEWS

- 20 A DEEP DIVE INTO ADOLESCENT DEVELOPMENT
- 25 JUDICIAL NOTEBOOK

PEOPLE

- 23 5 QUESTIONS FOR RICHARD WIENER
- 81 PSYCHOLOGISTS IN THE NEWS

CAREER

- 68 LAB WORK
- 74 PSYCHOLOGISTS ON THE TEAM
- 78 HOW DID YOU GET THAT JOB?

EMPLOYMENT ADS

- 82 THE BEST JOBS IN PSYCHOLOGY

The magnetic brain. Page 13



CE CORNER

TREATING WOMEN AND GIRLS IN CONTEXT

APA's newly revised Guidelines for Psychological Practice With Girls and Women focus on intersectionality and global gender issues. They encourage practicing psychologists to understand the challenges that women of diverse identities face and to support the empowerment of their patients. *See page 26*



PSYCHOLOGISTS ON THE TEAM

“Buildings only perform well when they support the health, well-being and activities of the occupants in addition to being structurally sound, energy-efficient and fire safe.”

Jennifer Veitch, PhD, National Research Council of Canada. *See page 74*



The opioid epidemic: A brighter outlook through assessments

While prescriptions written for opioids are in a downward trend since their 2012 peak of 81.3 for every 100 Americans, it was still 58.5 for every 100 in 2017. Every year, more Americans are becoming addicted to opioids, an epidemic which has seemingly no end in sight.

How can you use assessments to help with the opioid epidemic?

- **Support**
 - Screen patients at intake and throughout treatment to identify mental health issues and track progress
 - Learn about past trauma, social history, physical and psychological concerns, and other factors that can contribute to addiction
- **Prevention**
 - Identify at-risk clients with chronic pain by looking at biopsychosocial factors
 - Use pain screeners to identify alternative treatments to avoid opioid usage

Learn more about using assessments to avoid, treat, and monitor opioid addiction at PearsonAssessments.com/HealthPsych.

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DIVERSITY MAKES US STRONGER

APA is enhancing psychology's ability to improve the human condition by actively seeking underrepresented voices

BY ROSIE PHILLIPS DAVIS, PhD, APA PRESIDENT

When I look around the room during APA's Council of Representatives meetings, I'm delighted to see we have made significant progress in the number of women representatives: This year, 105 of 180 council members are women. Unfortunately, the number of racial and ethnic minority representatives continues to be low, with nonwhite members constituting only 18 percent of the council.

I see a similar need for increased diversity in the field of health-service psychology. It's also clear that diversity is largely lacking in our research participant pools. While women earned three out of four psychology doctorates, people of color, individuals with disabilities, the LGBTQI+ community and other critical voices are still underrepresented.

Yet without more diversity, how can psychology truly bring its best to society? How can we ensure our research is strong, our leadership

representative and our policies fair unless we are training and including more diverse groups of people?

Addressing these concerns is one of APA's top priorities. In its new strategic plan, APA's vision is to create "a strong, diverse and unified psychology that enhances knowledge and improves the human condition." One of the plan's guiding principles is to "champion diversity and inclusion" by furthering "the understanding and appreciation of differences" and being "inclusive in everything we do" (www.apa.org/about/apa/strategic-plan/index).

To achieve these goals, APA has created an Equity, Diversity and Inclusion Framework that reflects APA's view that diversity, equity and inclusion are vital to our success and should be infused in all aspects of the association's work. The framework also provides a vision statement, guiding principles and a model for making an impact in the association, the field of psychology and the world. In addition, the framework identifies strengths and gaps in our current efforts, as well as opportunities for future progress.

As part of the effort to implement the new framework, APA just recently hired its first Chief Diversity Officer, who will lead the way in carrying out a transformational agenda to infuse equity, diversity and inclusion throughout APA, as well as communicate and promote the framework's broader goals.

To change our culture, we need to be intentional and place diversity at the forefront of everything we do. So, how can you help? Start wherever you are in the field of psychology, whether that's in a graduate or training program, research, applied work, practice and/or APA leadership. Don't just invite new people to the table. Ensure that they are heard, feel welcomed and have the same opportunities as everyone else to achieve success at every level. ■



APA President
Dr. Rosie Phillips Davis

WOMEN VS. WOMEN

In response to the April cover story “Renewing the Push for Equality,” I have to say after 20 years as a practicing psychologist, I have experienced the most harassment, bullying, discrimination and biases in the field of psychology by other women, not men. I have never been treated so badly, inappropriately or bullied as I have by women in my field, not



men. No one seems to be addressing the issue of women-to-women harassment. As an employee assistance program senior psychologist, I must say, anecdotally, that I hear more stories of women-on-women “workplace violence” than I do about men-on-women “violence.” From my perspective, rather than teaching and training men, we need to help, encourage, train and urge women to be respectful and kind to other women, rather than seeing each other as threats or easy targets of bullying. I am tired of people ignoring the mistreatment of women by other women. I have not once had a female mentor or even a woman who helped me advance in my own career. I have received more encouragement, support and mentoring by men in the field. Until we stop the women-on-women violence that continues to exist, only then can we get out of our own way, support each other and make the advancements that we are blaming men for keeping us from making.

Beth-Anne Blue, PhD
Gainesville, Florida

A NEED TO SEPARATE HEALTH AND WEIGHT

After reading the April article “Family-Based Interventions for Addressing Childhood Obesity,” I am disappointed that APA would support such guidelines: ■ Weight stigma is a more salient issue than weight itself. The medicalization

of “obesity” and such attempts to “treat” it pathologize those who naturally have larger bodies.

■ Attempts to control children’s weight contribute to difficulties with food, including chronic dieting, guilt and obsessiveness over food and weight, and eating disorders.

■ The article cites weight loss at 12-months as a “success.” Intentional weight loss is unlikely to be sustainable after 24 months and weight cycling is associated with increased risk for depression and other negative health outcomes.

■ The suggestion that families lack education on nutrition and exercise is paternalistic and shortsighted. Rather than intervening at the family level, systemic primary interventions are more likely to address barriers to health behaviors.

Culturally, we need to separate health and weight. In working from a HAES perspective, we can address systemic barriers to health, address weight stigma, and allow children to self-regulate with interoceptive cues.

Catharine Devlin, PsyD
Chicago

LOSING AN AUTISM DIAGNOSIS

As a clinical psychologist who focuses on the treatment and assessment of individuals with autism across the life span, I’d like to make two points regarding the news feature on “Losing an Autism Diagnosis” (April).

First, I believe that there is a substantial lack of training in the assessment of individuals with autism, particularly as they age into puberty and adulthood. I think that the lack of oversight at a broader health-care level explains some of the variations in having and then later losing an autism spectrum diagnosis. I would refer readers to Cathy Lord’s clinical research for a better understanding of the evidence base and training for autism assessment. Second, the consequences

of losing an autism diagnosis in adolescence or adulthood can be quite dire and drastic in terms of service eligibility and access. State offices for people with disabilities often require further substantiation of an autism diagnosis later in childhood, and a person losing their autism diagnosis can quite literally “flip the table” on what services a person and their family can access. I think there needs to be more cross-talk between health care and government systems to understand the consequences of losing an autism diagnosis.

Bryan R. Harrison, PhD
Pittsford, N.Y.



OUR FAVORITE TWEETS

Re: “Leading the Way” (April)

@LatinaRAS We spot two @LatinaRAS academic madrinas and members of our advisory council, Dra. Hortensia Amaro & Dra. Glorisa Canino Thank you @APA_Monitor for sharing all these trailblazer stories!

Re: “Renewing the Push for Equality” (April)

@STEPSPsych At the end of the day, we are humans first, psychologists second. So we have to become better humans! #EqualPay @APA @APA_Monitor

Re: “How to Mentor Ethically” (April)

@Russwarne Excellent article from @APA_Monitor about ethical mentoring in #psychology. @APA

Re: “Jogging Happy Memories” (March)

@jonsutton Who knew? The person leading the ‘Memories’ feature on @Facebook is a psychologist, Dr Artie Konrad. Fascinating @APA interview on being a ‘sensible steward of memories’ ■

● **We’d love your feedback.** Please send letters to *Monitor* Editor Sara Martin at smartin@apa.org.

PSYCHOLOGY'S UNIQUE ROLE IN REFRAMING THE OPIOID CRISIS

Our field is bringing fresh insights to a national challenge

BY ARTHUR C. EVANS JR., PhD

Every day in the United States, an average of 130 people die from an opioid overdose, whether through the use of heroin, synthetic opioids like fentanyl or prescription drugs. Since the start of the opioid epidemic in the 1990s, an estimated 300,000 Americans have died of opioid overdoses, and the problem is not expected to abate anytime soon.

This is a crisis that demands the knowledge and skills from the breadth of our field. As experts in human behavior, psychologists are uniquely equipped to address this epidemic. In this issue's special report on stopping the opioid crisis, we showcase the ways psychologists are:

■ **Improving treatment with behavioral interventions.** Working as part of treatment teams, psychologists are addressing the comorbid conditions that often accompany substance use, including pain, anxiety, depression and post-traumatic stress disorder.

■ **Creating programs informed by an ecological perspective.** Psychologists

are designing programs that take a more comprehensive look at the needs of people with opioid use disorder, helping to support them at work, with housing and in their relationships.

■ **Teaching people to manage pain without medication.** In their efforts to prevent opioid use disorder, clinical psychologists are employing cognitive-behavioral therapy and other evidence-based approaches to help patients cope with pain.

■ **Developing better screening tools.** Psychologists' assessments are helping to determine which patients experiencing chronic pain are at higher risk for opioid misuse and should not be prescribed opioids.

■ **Advocating for changes to opioid policies and practices.** Working at the federal, state and local levels, APA and individual psychologists are directly and indirectly impacting the opioid crisis through advocacy. Efforts include seeking greater funding for pain and opioid research, increasing the number of treatment providers by improving reimbursement rates, and changing prescribing practices, among other priorities.

I would like to take this opportunity to call attention to the outstanding work of an APA cross-divisional task force. Drawing upon expertise from multiple subfields of psychology, representatives from APA's Div. 12 (Society of Clinical Psychology), Div. 28 (Psychopharmacology and Substance Abuse) and Div. 50 (Society of Addiction Psychology) developed *The Opioid Guide: A Resource Guide for Practicing Psychologists*. Read an overview of the guide on page 64.

As this month's special report shows, psychologists are making unique and essential contributions to address the opioid epidemic, one of the greatest health challenges facing our nation. We are not content to sit on the sidelines. Please join us as we work to have a major impact on this critical societal issue. ■

APA CEO
Dr. Arthur C. Evans Jr.



SCOTT SUCHMAN

The Hot List

TOOLS TO FOSTER EARLY LEARNING

APA has updated its free **Early Learning Guidelines Educator Toolkit**, a collection of evidence-based strategies, lesson plans, activities, online learning tools and other resources that promote children's learning and development in their preschool years. The toolkit includes a state-by-state index of early learning standards and resources, as well as guidance for educators and the public on working with special populations of young children, including those with disabilities and immigrant children. Access the toolkit at <https://on.apa.org/ELG-Toolkit>.



HONORING COMPANIES FOR HEALTHY PRACTICES

APA presented its **Psychologically Healthy Workplace Awards** to eight organizations that excel in using psychological science to advance employee health and well-being while increasing performance and productivity. See the winners and nominate for 2020 at <https://on.apa.org/Healthy-Workplace>.

CANDIDATES FOR APA PRESIDENT

Starting this month, the candidates for APA's 2021 president are answering questions on important topics at <https://on.apa.org/2021-Election>. APA will send ballots to members on Sept. 16.

LEGAL HELP FOR PSYCHOLOGISTS

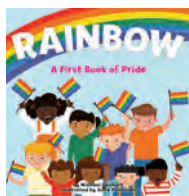
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RESEARCH TO IMPROVE SCHOOL SAFETY

A new policy brief, "**Reducing Weapons in Schools**," by APA's Div. 15 (Educational) summarizes psychological research, based on large-scale data in California, on the presence and impact of knives, guns and other weapons in schools and encourages policymakers to use psychological science-based solutions for reducing weapons and increasing school safety. Read it at <https://apadiv15.org/reducing-weapons-in-schools>.

LGBTQ+ PRIDE FOR NEW READERS



LGBTQ+ families and describes the meaning behind each colorful stripe of the pride flag. Go to <https://on.apa.org/Rainbow>.

APA's new Magination Press children's book, "**Rainbow: A First Book of Pride**," celebrates

DID YOU KNOW?

APA has a free app for those seeking to help patients **quit smoking** at <https://on.apa.org/SmokeScreen>.

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In Brief

THE LATEST PEER-REVIEWED STUDIES WITHIN PSYCHOLOGY AND RELATED FIELDS



Prison's Health Effects

People who have spent time in prison are more likely to suffer from chronic medical conditions, finds a study in *Health Psychology*. Researchers analyzed a nationally representative U.S. sample of more than 36,000 adults, 12.4 percent of whom reported a history of incarceration. Compared with people who had never been in prison, people who had been incarcerated were more likely to have

hypertension, myocardial infarction, minor heart conditions, stomach ulcers, arthritis, sleep problems, anemia and sexually transmitted diseases, among other serious conditions. The results held even after controlling for a history of childhood abuse and other adversity, recent stressful life experiences, sociodemographic characteristics, smoking status and past year alcohol use. DOI: 10.1037/hea0000720

THE DEFINITION OF DIVERSITY

Members of minority groups set a higher threshold for diversity when deciding whether they consider an organization to be “diverse,” finds a study in the *Journal of Personality and Social Psychology*. In a series of seven online experiments with more than 5,000 total participants in the United States, researchers asked participants to read descriptions of companies with different percentages of black, Latinx and female employees and then judge whether the organizations qualified as diverse. On average, to declare an

organization diverse, participants who were black, Latinx or female required it to have a higher percentage of minority employees than did white male participants. The difference was even larger when participants were asked to decide whether the organization was “diverse enough” rather than just “diverse.”

DOI: 10.1037/pspi0000182

ADHD-AMPHETAMINE RISK

Teenagers and young adults who take amphetamine-based stimulants to treat attention-deficit hyperactivity disorder (ADHD) are at increased risk for developing psychosis, finds a study

Is this group diverse? Your perspective might depend on your own gender and racial or ethnic identity.

in the *New England Journal of Medicine*. Researchers analyzed the health-insurance records of nearly 222,000 young people, ages 13 to 25, with ADHD. Half had been given prescriptions for an amphetamine, and half had been prescribed a different stimulant, methylphenidate, between 2004 and 2015. Among those prescribed an amphetamine, 0.21 percent developed psychosis, while among those who took methylphenidate, 0.10 percent developed psychosis. The researchers say that although the overall risk for developing psychosis is very low, the results suggest caution is warranted in

PEOPLE IMAGES/GETTY IMAGES



prescribing amphetamines to treat ADHD.

DOI: 10.1056/NEJMoa1813751

COMBAT STRESS, DECADES LATER

Combat veterans may experience more depression and anxiety as they age compared with military veterans who did not see combat, suggests a study in *Psychology and Aging*. Researchers examined survey data from more than 1,100 U.S. military veterans, collected between 1985 and 1991 when the men were ages 40 to 86 (average age 60). The researchers found that the veterans' anxiety and depression symptoms showed a common U-shaped curve over time—their symptoms decreased from their 40s to mid-60s, then increased again in their 70s and 80s. In their mid-60s, combat and non-combat veterans showed similar levels of depression and anxiety. However, the late-in-life rise in depression and anxiety symptoms was much steeper among the combat veterans than among those who did not see combat.

DOI: 10.1037/pag0000334

THE MAGNETIC BRAIN

Many species, such as migratory birds, have a geomagnetic sense that helps them navigate the world, but the same sense has never been reliably demonstrated in humans. Now, a study in *eNeuro* suggests that the human brain is also sensitive to Earth's magnetic field. Researchers used EEG to monitor the brain activity of 34 healthy adult participants in California as they sat inside a chamber in which the direction of the



magnetic field around them was manipulated. The researchers found that the brain activity in many of the participants showed sensitivity to changes in the horizontal direction of the magnetic field—but only when the vertical component of the field pointed downward, as it does in the Northern Hemisphere, where the participants resided. The researchers say that this indicates that the brain is attuned to Earth's local magnetic field. They further suggest that replicating the study in the

Combat veterans are more likely to suffer anxiety and depression late in life compared with noncombat veterans.

Southern Hemisphere, where the vertical component points upward, would strengthen this conclusion.

DOI: 10.1523/ENEURO.0483-18.2019

READING FACES

Teenagers are particularly sensitive to facial expressions of anger and fear and lose some of that sensitivity as they age, finds a study in the *Journal of Experimental Psychology: General*. Researchers tested more than 9,500 online participants, ages 10 to 85, on a task that measured sensitivity to emotion. Participants saw pairs of faces with carefully calibrated expressions and were asked to determine which member of each pair was happier, sadder or more fearful. On average, sensitivity to all facial expressions, but especially to anger, was highest among participants in early to mid-adolescence and was somewhat lower among those in early

The human brain may be sensitive to variations in Earth's magnetic field.



adulthood. Among older adult participants, sensitivity to anger and fear was even lower—but sensitivity to happiness was about the same as in younger adults.

DOI: 10.1037/xge0000559

CHIMPANZEE CULTURE

Human encroachment appears to be threatening chimpanzees' behavioral diversity, finds a study in *Science*. Previous research has found that chimpanzees pass on some behavioral traditions—such as using sticks to fish for algae or cracking nuts with stones—that differ from group to group. Researchers combed through new data and previously published studies that looked at 31 different chimpanzee behaviors in 144 communities. Compared with chimpanzees in areas relatively unaffected by humans, chimpanzees in areas with high human impact showed



an 88-percent reduced probability of using these culturally transmitted behaviors. The researchers posit that this finding may be related to population loss and habitat fragmentation, which reduce the chances for chimpanzees to learn behaviors from one another.

DOI: 10.1126/science.aau4532

FALLING DOWN

Older adults with depressive symptoms are more likely to

Older adults with depression are more likely to injure themselves in falls—and those who fall are more likely to become depressed.

injure themselves in falls—and those who fall are more likely to develop depression, finds a study in *The Gerontologist*. Researchers analyzed data on nearly 6,300 U.S. Medicare beneficiaries, age 65 and older, who lived in the community or in residential care (not nursing home) facilities. Participants were surveyed twice, a year apart, about their depressive symptoms and asked how often they had fallen in the past year. On average, those who reported more depressive symptoms on the first survey were more likely to fall over the next year. At the same time, participants who reported falls during the year between the two surveys showed more severe depression symptoms on the second survey, even after researchers controlled for the number of falls reported on the first survey, other health conditions and demographic variables.

DOI: 10.1093/geront/gny179



Human encroachment disrupts behavioral traditions passed from one chimp to another.

TOP: PEOPLE IMAGES/GETTY IMAGES; BOTTOM: GARY SANDY WALES/GETTY IMAGES



INHERITED MORALITY

Our characters are shaped by both our genes and our upbringings, suggests a longitudinal study in *Behavior Genetics*. Researchers examined 720 pairs of siblings with various degrees of genetic relatedness—including identical and fraternal twins, ordinary siblings, half-siblings and step-siblings. Using both self-report and parent report measures, the researchers assessed the siblings on the virtuous characteristics of responsibility and conscientiousness when they were young teenagers and again at ages 25 to 27. The parents also provided self-reports on positive parenting behaviors, such as responsiveness and praise, and negative parenting behaviors, such as yelling. The researchers found associations between positive parenting behaviors and children's virtuous characteristics,

Parents still sleep less even six years after a child's birth.

and found that these associations were determined by both genetic and environmental influences. They suggest that rather than children directly inheriting virtuous characteristics, a more complex mechanism may be at work: Children inherit other characteristics (e.g., difficult or anti-social behavior) that subsequently evoke particular types of behaviors in their parents, which in turn influence the children's development of virtuous characteristics.

DOI: 10.1007/s10519-018-09945-4

SLEEPLESS NIGHTS

Children disrupt their parents' sleep for up to six years after birth, finds a study in *Sleep*. Researchers surveyed 2,541 women and 2,118 men in Germany around the time of the birth of their first, second or third child, and then again yearly for six years, asking the parents

about sleep duration and sleep quality. On average, sleep duration and satisfaction with sleep quality declined sharply after childbirth and reached a nadir during the first three months of a child's life. Sleep for these parents did not fully recover even four to six years later. In that period, the mothers were still sleeping an average of 20 minutes less per night, and the fathers 15 minutes less per night, than they had been before their children were born.

DOI: 10.1093/sleep/zsz015

SUPPORTING SOLDIERS AT RISK

Compassionate text messages may help reduce suicide attempts among at-risk military personnel, suggests a study in *JAMA Psychiatry*. In the randomized clinical trial, researchers assigned 658 members of the U.S. Army and Marines who had

expressed suicidal thoughts to receive either standard care or standard care plus supportive text messages sent once a month for 11 months and on the participants' birthdays. Clinicians sent the text messages and then followed up if participants replied to them. Over the year, 9 percent of the participants who received the texts attempted suicide compared with 15 percent of those who received no texts. However, the study showed mixed or no effects for some other outcome measures (suicidal ideation and emergency room visits).

DOI: 10.1001/jamapsychiatry.2018.4530

WHEN VIOLENCE GOES VIRAL

About one in five Americans watched at least part of a graphic video of an ISIS beheading that "went viral" in 2014, according to a study in *American Psychologist* that explored people's motivations for watching it and



People who watched a graphic video of an ISIS beheading reported more symptoms of distress two years later.

Eating from a shared bowl may subtly encourage people to work together.

how viewers were affected. As part of a longitudinal study, the researchers followed a representative sample of almost 3,300 U.S. residents for three years and found that about 20 percent reported watching part of the video and 5 percent watched all of it. The most common reasons people gave for watching were "information seeking" and "curiosity." Men, unemployed individuals, Christians and people who had been exposed to more violence in their lifetimes or who reported a greater fear of terrorism were more likely to have watched it. The researchers also found that people who watched the video reported higher levels of fear of future

negative events and greater symptoms of distress two years later.

DOI: 10.1037/amp0000438

SHARED PLATES, SHARED GOALS

When people eat off shared plates, they are more likely to cooperate in negotiations, finds a study in *Psychological Science*. Researchers paired 200 strangers (students at a U.S. university) and asked each pair to negotiate an hourly wage for workers who were on strike, with one participant playing the role of management and the other playing the role of the labor union. Before the negotiation, participants ate a snack: tortilla chips and salsa, served from either one large shared bowl or two smaller separate bowls. On average, participant pairs who ate from a shared bowl settled on a wage more quickly—within four rounds of offers and counteroffers—than pairs who ate from separate bowls, who took nine rounds to agree on a wage. The researchers replicated the results in two more experiments, one with pairs of friends and another with pairs of acquaintances.

DOI: 10.1177/0956797619830633

NICOTINE AND ADHD

Babies born to mothers who smoke tobacco are at increased risk for attention-deficit hyperactivity disorder (ADHD), finds a study of Finnish mothers and infants published in *Pediatrics*. Researchers looked at 1,079 Finnish children born in 1998 and 1999 who were diagnosed with ADHD and 1,079 matched





controls without ADHD. The researchers measured the levels of cotinine—a biomarker of nicotine exposure—in the children's mothers during pregnancy, using serum samples stored in a Finnish biobank. On average, children of mothers with high levels of cotinine were more than twice as likely to develop ADHD than children born to mothers with low cotinine levels, even after the researchers controlled for maternal socioeconomic status, maternal age, maternal psychopathology, paternal age, paternal psychopathology and child's birth weight.

DOI: 10.1542/peds.2018-3144

GREEN SPACES AND MENTAL HEALTH

Living near parks and other green spaces as a child is associated with better mental health in adulthood, suggests a study in *PNAS*. Researchers analyzed geographic information systems data and data from the Danish Civil Registration System on more than 900,000 Danes born between 1985 and 2003. Even after controlling for socioeconomic status, parental mental health and other factors, the researchers found that growing up near green space was associated with a 15- to 55-percent reduction in the

Kids who grow up near parks and other green spaces are less likely to have a mental illness as adults.

incidence of mental illnesses and behavioral health disorders, including substance use, eating and mood disorders and others. The only disorders not significantly associated with childhood proximity to green space were intellectual disability and schizoaffective disorder.

DOI: 10.1073/pnas.1807504116

OLDER ADULTS' SCREEN TIME

Older adults who watch a lot of television perform worse on tests of verbal memory than those who watch less, finds a study in *Scientific Reports*. Researchers analyzed data from



Strong relationships with neighbors can provide meaningful support for people with serious mental illness.

a longitudinal study of about 3,600 British adults older than 50 (average age 67). Participants answered questions about their TV viewing habits, took a battery of verbal memory and word finding tests, and then repeated the same survey and tests six years later. Participants who watched more than 3.5 hours of TV per day scored lower on the verbal memory tests at baseline and saw a steeper decline in their abilities over the next six years. TV-watching was not associated with participants' scores on the word finding tests.

DOI: 10.1038/s41598-019-39354-4

SUPPORT IN THE NEIGHBORHOOD

Strong relationships with neighbors can ease loneliness and provide meaningful support for people with serious mental

illness (SMI), suggests a study in the *American Journal of Orthopsychiatry*. Researchers surveyed 232 people with SMI—including schizophrenia and major depressive disorder—who were receiving treatment at outpatient community mental health centers throughout the United States, as well as a comparison sample of 300 adults without SMI. On average, people

People who set attainable goals may end up happier than those with pie-in-the-sky aims.



with SMI reported weaker relationships with their neighbors, as well as more loneliness and fewer feelings of connection to their communities, compared with those without SMI. Among both those with and without SMI, however, those who had higher-quality relationships with their neighbors (such as being able to count on them for help or being treated by them as equals) reported less loneliness than those who had lower-quality relationships with their neighbors.

DOI: 10.1037/ort0000403

I CAN DO IT

Setting attainable goals now may set you up for happiness later, suggests a longitudinal study in the *European Journal of Personality*. Researchers interviewed 973 people, ages 18 to 92, living in Switzerland, and followed up with 637 of them two years later and 573 of them four years later. They asked about participants' well-being as well as about their life goals in 10 areas: health, community, personal growth, social relationships, fame, image, wealth, family, responsibility/care for younger generations and work. In particular, the researchers assessed how important those goals were to the participants and how attainable participants felt they were. On average, participants who felt their goals were more attainable at the beginning of the study reported greater well-being two and four years later. ■

DOI: 10.1002/per.2194

● For direct links to the research cited in this section, visit our digital edition at www.apa.org/monitor/digital.

Datapoint

NEWS ON PSYCHOLOGISTS' EDUCATION AND EMPLOYMENT FROM APA'S CENTER FOR WORKFORCE STUDIES

HOW SATISFIED ARE PSYCHOLOGY-DEGREE HOLDERS WITH THEIR JOBS?

Good news for those with psychology doctoral degrees: Compared with doctoral degree holders in all other fields, people with psychology doctorates were more likely to report satisfaction with their jobs overall, according to a 2017 national survey of the college-educated U.S. population.¹ That doesn't hold true for people with master's and bachelor's degrees in psychology: They reported lower overall job satisfaction than people with degrees in other fields.² Overall, the survey found that:

- People with doctoral degrees in psychology reported greater job satisfaction than doctoral degree

holders in other fields across almost all job aspects, except for benefits and job security.

- At the master's degree level, psychology degree holders were most satisfied with level of responsibility, intellectual challenge and job location relative to degree holders in other fields. They were least satisfied with salary, benefits and their contribution to society.

- Those with bachelor's degrees in psychology reported lower satisfaction for all job attributes compared with bachelor's degree holders in other fields, especially in relation to benefits and salary.

Degree of satisfaction 60% 70 80 90 100	Bachelor's		Master's		Doctoral	
	Psychology	All other fields	Psychology	All other fields	Psychology	All other fields
Job satisfaction overall	85%	88%	88%	90%	93%	91%
Salary	70%	77%	74%	78%	80%	80%
Benefits	71%	76%	71%	79%	73%	82%
Job security	84%	86%	83%	86%	83%	88%
Job location	88%	90%	91%	88%	90%	89%
Opportunities for advancement	63%	66%	64%	67%	75%	74%
Intellectual challenge	78%	80%	86%	84%	94%	92%
Level of responsibility	87%	88%	90%	88%	93%	93%
Degree of independence	90%	92%	92%	91%	96%	93%
Contribution to society	84%	85%	94%	98%	95%	93%

By Jessica Conroy, BA, Luona Lin, MPP, and Peggy Christidis, PhD

Want more information? See CWS's interactive data tools: <https://www.apa.org/workforce/data-tools/index> or contact cws@apa.org.

¹National Science Foundation (NSF), National Center for Science and Engineering Statistics. (2017). National Survey of College Graduates Public Use Microdata File and Codebook. Retrieved from <https://ncesdata.nsf.gov/datadownload>. Respondents were asked to rate their overall satisfaction with the principal job they held (job on which they spent the most hours during a typical workweek) as well as satisfaction with attributes of that job: very satisfied, somewhat satisfied, somewhat dissatisfied, and very dissatisfied. The percentages of those listed here as satisfied with their jobs or the jobs' attributes included those who responded either "very satisfied" or "somewhat satisfied." The use of NSF data does not imply NSF endorsement of the research, research methods or conclusions contained in this report.

²All findings discussed in the text are statistically significant ($p < 0.01$).

A DEEP DIVE INTO ADOLESCENT DEVELOPMENT

Spearheaded by psychologists, a new long-term study will produce mountains of open-access data on adolescents

BY KIRSTEN WEIR

In January, the National Institutes of Health (NIH) released the first complete baseline data set from the largest-ever study of adolescent health and development. The Adolescent Brain Cognitive Development (ABCD) Study will follow 11,874 children, starting at ages 9 and 10, for the next decade.

The ABCD Study will collect mountains of data: on neurological development, sociocultural and psychological factors, mental and physical health, environmental exposures, substance use, academic achievement and more. It's a huge undertaking, with huge implications for understanding children's development as they move through adolescence and into early adulthood.

"This is a massive effort, notable for both its scope and its depth," says Sandra Brown, PhD, vice chancellor for research and professor of psychology and psychiatry at the University of California, San Diego, and co-director of the ABCD Coordinating Center.

Because the project looks at so many different aspects of development, researchers will be

able to mine the data to understand problems such as substance use and the emergence of mental illness, as well as the normal course of healthy adolescent development, adds Sara Jo Nixon, PhD, a professor of psychology at the University of Florida and a principal investigator of the study. "Often, we're interested in what went wrong, and indeed we'll have data to speak to those problems. But we'll also have data to look at resiliency and the kinds of factors—whether biological, psychological, social or cultural—that really nurture healthy development," she says. "This study is the epitome of what any psychological scientist would love to do."

ABCD BASICS

Launched in 2016, the ABCD Study is coordinated by the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism, with support from numerous other NIH institutes and offices as well as the Centers for Disease Control and Prevention. To assist in recruitment, APA provided NIH with a statement encouraging families

to consider participating, and an APA staff member serves on the ABCD national liaison board.

The study encompasses 21 research sites across the country and will follow participants for 10 years. It's an interdisciplinary effort, but psychologists Brown and Terry Jernigan, PhD, also at the University of California, San Diego, sit at the helm of the Coordinating Center, and 26 of the 40 principal investigators are psychologists. The study was carefully planned from the start to include a diverse group





FATCAMEBA/GETTY IMAGES

of adolescents, Brown says. “We worked with high-quality epidemiologists, so the sample we’re bringing to the table is a good reflection of the socio-demographics of the United States,” she says.

To manage such a large project, the study’s designers included funding for a co-ordinating center and a data management center. There’s also a retention committee that works to ensure that as many of the participants as possible stick it out over the next decade—no

small feat, considering the time investment. The project involves neuroimaging, genetic testing and behavioral testing as well as numerous questionnaires for the children, their parents and teachers. Participants will wear sensors ’round-the-clock for several weeks, most likely once a year, to collect data about activity levels, heart rate and sleep patterns. Investigators will even collect hair samples and baby teeth to study exposures to environmental toxins. The study includes more than 2,000 twins and triplets,

The study has enormous implications for understanding children’s development as they move through adolescence and into early adulthood.

allowing researchers to begin to tease apart genetic susceptibility from environmental influences.

As the children move into their teenage years, researchers will be able to explore questions about substance use, physical activity, sports injuries, sleep, learning and the emergence of mental health problems—and that’s just for starters, says psychologist Susan Tapert, PhD, a professor at the University of California, San Diego, and an associate director of the ABCD Coordinating Center. “There’s really an infinite number of questions that can be addressed here.”

Principal investigators aren’t the only scientists who will be able to answer them. The study was developed with an open-access model, and the data collected are freely available to any qualified researcher who wants to tap into them via the National Institute of Mental Health Data Archive.

The open-science philosophy will drive the science forward faster, while the large sample size and methodologically rigorous study design will ensure that the data are trustworthy, says Raul Gonzalez, PhD, an ABCD principal investigator and professor of psychology at Florida International University. “There is a replication crisis in the sciences, and a lot of that crisis is partially due to small sample sizes and a bias to publish significant results,” he says. “With this study, there is an opportunity to assess a lot of questions that are controversial in our field.”

Another unique element of the open-access model: Lead investigators won’t have preferen-

tial access to data before they've been made available to the general public. Whether you're a principal investigator at one of the study sites or a grad student far from the action, you will have the same opportunity to access the same information at the same time through planned data releases. "That says a lot about the commitment of the leadership team to make sure transparency and reproducibility are addressed head-on," says Nixon.

EARLY FINDINGS

Investigators finished recruiting participants only last year, yet they have already begun drawing insights from the study. In one analysis of the baseline data, Aaron Blashill, PhD, and Jerel Calzo, PhD, of San Diego State University, explored differences in mood disorders and suicidality between 9- and 10-year-olds who identified as gay, lesbian or bisexual and those who identified as heterosexual. The rate of mood disorders was 22.5 percent for sexual minority children, compared with 6.9 percent for heterosexual children. Similarly, 19.1 percent of sexual minority children experienced suicidal thoughts, while just 4.6 percent of heterosexual children did (*Journal of Affective Disorders*, Vol. 246, No. 1, 2019).

Other groups have pulled from ABCD data to explore a pressing 21st-century problem: the effects of screen time. Jeremy Walsh, PhD, now at the University of British Columbia Okanagan, and colleagues explored physical activity, screen-time behavior and sleep among more than 4,500 of the

participants. They found that children who met recommended guidelines for these activities—at least 60 minutes of physical activity, no more than two hours of recreational screen time and 9 to 11 hours of sleep daily—had better cognition than those who did not, as measured by tests of attention, language abilities, episodic memory, working memory, executive function and processing speed. Unfortunately, though, only half of the children in the sample got the recommended amount of sleep, just 36 percent had fewer than two hours of screen time and a mere 17 percent engaged in the recommended amount of daily exercise, the researchers found (*The Lancet Child & Adolescent Health*, Vol. 2, No. 11, 2018).

Meanwhile, Tapert and colleagues found a link between screen time and a variety of complex structural brain changes, including cortical thickness, sulcal depth and gray matter volume. Different patterns of structural changes were related to downstream outcomes such as externalizing psychopathology and fluid and crystallized intelligence. But the changes differed depending on the type of screen media—and they weren't all bad (or all good) (*Neuroimage*, Vol. 185, No. 1, 2019). "Kids who frequently played video games tended to have poorer mental health profiles and more family conflict, for example, while kids who were engaged in social media tended to have slightly better social and mental health functioning," she says. "It's not just how much screen time a child gets, but what they're doing."

RESOURCES

The Structure of Cognition in 9 and 10 Year-Old Children and Associations With Problem Behaviors: Findings From the ABCD Study's Baseline Neurocognitive Battery

Thompson, W.K., et al.
Developmental Cognitive Neuroscience, 2018

A Description of the ABCD Organizational Structure and Communication Framework

Auchter, A.M., et al.
Developmental Cognitive Neuroscience, 2018

Adolescent Neurocognitive Development and Impacts of Substance Use: Overview of the Adolescent Brain Cognitive Development (ABCD) Baseline Neurocognition Battery

Luciana, M., et al.
Developmental Cognitive Neuroscience, 2018

With a single time point of data, it's too soon to make conclusions about the pros and cons of different screen media activities, Tapert notes. But as researchers follow the children in the years to come, they hope to be able to paint a more detailed picture of the effects of screen time on the brain.

A STUDY THAT EVOLVES

A lot can change in a decade. New social media platforms pop up almost overnight. Drug laws change, and the popularity of certain substances of abuse can wax and wane. New genetic tests and biomarkers may be discovered, new sensor technology could become available and neuroimaging techniques will be refined. The ABCD investigators have designed the study to accommodate such changes, so that new survey questions can be added and new technologies can be incorporated in future waves of data collection. "We have structures within ABCD that allow us to maintain enough continuity, so we can look at change in a systematic way and also augment the study using new methodologies," Brown says.

With its breadth, depth and flexible experimental design, the ABCD Study will serve as a model for other large-scale, long-term projects, investigators say. It also serves to showcase just how much psychology can do. "This is truly team science, led in large part by psychologists," Nixon says. "It speaks to the strength of our science, and the opportunity for psychologists to play a leading role in interdisciplinary research." ■

5 QUESTIONS FOR RICHARD WIENER

Drug courts have altered the criminal justice system and offered an alternative to a revolving door of incarceration, release and re-arrest. This psychologist and legal expert is working to expand similar programs to address other psychological and social issues.

BY STEPHANIE PAPPAS

The first drug court in the United States opened in Miami in 1989. This nontraditional approach dispenses with the usual sentencing-incarceration-release-rearrest cycle for low-level drug offenses. Instead, offenders are brought in front of a judge and given intensive supervision and substance use treatment, with the goal of getting them out of the criminal justice system altogether.

The model has proved so effective at reducing recidivism and lowering overall incarceration costs that today there are 3,000 drug courts nationwide, according to the National Institute of Justice. Now, criminal justice systems around the country are looking to push the drug court model further. Increasingly, specialized problem-solving courts are addressing mental health, veterans' needs or reintegration into society after incarceration.

As these courts become more common, there is increased interest in making sure they're effective, accountable and offering evidence-based services. Richard Wiener, PhD, the former director of the law and psychology program at the University of Nebraska–Lincoln, is among the experts finalizing the standards for new mental health courts in Nebraska. He spoke with the *Monitor* about the promise of problem-solving courts in improving people's lives and keep-

ing them out of the criminal justice system in the future.

What is the goal of problem-solving courts?

The notion rises out of therapeutic jurisprudence, the idea that the law can be used as a therapeutic agent to help people improve their psychological and social well-being. A number of people who have psychological and social problems plaguing them, such as untreated mental health disorders or substance use

disorders, wind up in the criminal justice system. The goal is to solve those psychological or social problems.

The problem we currently have is a revolving-door issue, where people will come in front of a judge, pick up a sentence, and then they are back in when the sentence is over with the same problems. The philosophy of problem-solving courts is to try to use the court as an agent to solve these problems so offenders won't return.

What issues are these problem-solving courts addressing, and what approach do they take?

Mental health courts, which are nowhere near as common as drug courts, have been in existence for 15 years or so. The more recent ones are veterans' courts and re-entry courts, for people who are on post-release supervision.

All these courts look at what services people need to keep them from re-offending. If they have psychological problems, the court will try to arrange for them to receive mental health services. If they have employment problems, the court will try to find them employment training or, ultimately, a job. The problem could be education issues, it could be family or legal issues. The vision is to not just treat the symptom, but to treat the whole person.

While drug courts typically have a set progression of supervision and treatment that everybody goes through, mental health courts are much more individualized. It's a matter of the team figuring



“These courts are an important avenue for people to get supervision and services that they need. There is real potential for helping people.”

out what, specifically, each person needs. The team can include attorneys, court officers, social workers and counselors. The optimal situation is to refer that person to quality, evidence-based mental health and social services. One of the advantages of the court being involved is that the court can also vet those services.

What role do psychologists play in these courts?

It's a very exciting area with lots of opportunities for researchers and policy psychologists and clinical psychologists. Psychologists are involved at all levels: in the organization and planning, in

evaluation and data collection, in data analysis and program evaluation. And psychologists are involved in direct services. Some do assessment, some do treatment, especially in the more difficult cases.

I'm on the strategic planning committee for Nebraska problem-solving courts, and we're in the process of writing standards for mental health courts. There is also a role for education. I teach students, future lawyers in law school, because they otherwise don't learn about this. You go to law school to learn to defend your client, so this is changing that legal mindset: “I'm not here only to

be the protector, I'm here to guard the best interests of my clients.”

How does the legal system decide who qualifies for problem-solving courts?

You want people who really have need and present risk. If a person's problems can be dealt with in less restrictive environments, or if they perhaps don't need much beyond the warning and embarrassment of being involved in the system, those are not the people who should be involved. It really should be people who have chronic problems, or more serious risk and higher needs, such as low-level offenders who continue to offend again and again.

In Nebraska, we're trying to make those decisions tied to objective assessments. We use the risk-need-responsivity principles developed by [Carleton University psychologist] Don Andrews and [clinical psychologist] James Bonta. This model matches the level of service to the risk of re-offending, assesses and targets the needs that can promote criminal behavior, and tailors the interventions to the individual.

What do you expect for the future of these courts?

One of the things happening now is increasing professionalization. There is now a big effort to develop standards and write professional guidelines for these problem-solving courts so there is a more systematic approach.

In an ideal environment, you wouldn't have people seeking mental health services through the courts, but in our realistic environment, these courts are an important avenue for people to get supervision and services that they need. There is real potential for helping people. ■

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BULLYING IS NOT JUST A PROBLEM FOR TEENS

A lawsuit brought by the resident of a senior living center raises the issue of bullying among older adults

BY BRITTANY WIEGAND, MA, AND JENNIFER K. ROBBENNOLT, JD, PhD, UNIVERSITY OF ILLINOIS COLLEGE OF LAW

In 2014, Marsha Wetzel, a 70-year-old lesbian, moved into the Glen Saint Andrew Living Community, a residential facility for older adults in Niles, Illinois. After her arrival, she spoke openly both to staff and other residents about her sexual orientation and was met with verbal and physical abuse. Residents called her vicious names, including “homosexual bitch.” Wetzel uses a motorized scooter, and at one point a fellow resident pushed her hard enough that she fell off a ramp. In another incident, an attacker yelled “homo” and struck her in the back of the head.

When Wetzel reported the abuse to Glen Saint Andrew’s staff, she was told that the behavior was accidental and that she was a liar. The management then retaliated against Wetzel for her complaints by barring her from some areas of the building. In response, Wetzel changed her daily routine. She ate meals in her room and stopped visiting certain areas to avoid one of her attackers. She did not use the laundry room at times when she might be alone. She stayed away from the common spaces from which she had been barred.

After 15 months, Wetzel filed a lawsuit alleging that Glen Saint Andrew had failed to ensure a nondiscriminatory living environment and had retaliated against her for complaining about sex-based harassment, each in violation of the Fair Housing Act (FHA). The district court dismissed the claims because there was no contention that Glen Saint Andrew acted with discriminatory animus. But the U.S. Court of Appeals for the 7th Circuit, in *Wetzel v. Glen St. Andrew Living Community* (2018), reinstated Wetzel’s case, holding that the FHA prohibition on discrimination in housing conditions encompasses the duty “to take reasonable steps within its control to stop” harassment between residents based on protected characteristics (like sex) of which it has “actual

notice.” The case is now pending in the district court.

Bullying is often thought to be a problem for adolescents. But Wetzel’s case is an instance of bullying among older adults and is similar to cases that arise in many senior living communities. Bullying behaviors often occur in small group settings with members who interact regularly, such as in schools. But senior living communities and senior centers also fit this description and provide opportunities for bullies to form cliques, cause social ostracism, and engage in verbal and even physical abuse. In older populations, bullying behaviors can emerge as individuals try to compensate for feelings of vulnerability resulting from a loss of independence, income or long-term relationships. And changes in abilities related to aging can make older adults vulnerable to bullying.

Instances of bullying among older adults are likely to increase in frequency as this population grows. But most state anti-bullying laws and education efforts to prevent bullying conceptualize bullying as a problem that primarily or only affects adolescents. This approach ignores the real issues faced by older adults like Wetzel. Civil rights laws such as the FHA don’t fully address the problem, as they provide remedies only in certain circumstances—for example, when harassment is based on a protected characteristic and the institution is aware of the harassment.

Research by psychologists on bullying among older adults can help address this problem by clarifying how this bullying is similar to and different from bullying among adolescents; shaping the reform of anti-bullying laws to effectively address the circumstances of older adult bullies and victims; and influencing the design of anti-bullying education that speaks to these issues and contexts. ■



**THE
VERDICT**
Psychologists’
research could
help inform
anti-bullying laws
to protect older
victims.

● “Judicial Notebook” is a project of APA Div. 9 (Society for the Psychological Study of Social Issues).



APA's newly revised Guidelines for Psychological Practice With Girls and Women focus on intersectionality and global gender issues.

CE

CONTINUING EDUCATION TREATING WOMEN AND GIRLS IN CONTEXT

BY STEPHANIE PAPPAS

In the decade-plus since APA released its first Guidelines for Psychological Practice With Girls and Women, the landscape of gender issues has shifted. The #MeToo movement has spotlighted the sexual assault and harassment endemic in many settings. The Women's March on Jan. 21, 2017, smashed records to become the largest single-day protest in U.S. history. And as transgender people have become more visible and politically active, they have spurred public conversation about the limits of the traditional binary view of gender.

These societal changes are reflected in APA's revised guidelines for girls and women, which encourage practicing psychologists to understand the challenges that women of diverse identities face and to support the

empowerment of their patients. The guidelines replace the previous set of guidelines, which were released in 2007 and recently expired.

"An emphasis on resilience is embedded throughout all of the guidelines," says Lillian Comas-Díaz, PhD, a clinical professor of psychiatry and behavioral sciences at the George Washington University School of Medicine and the executive director of the Transcultural Mental Health Institute, who co-chaired the working group that developed the revised guidelines.

The new guidelines include new research on girls and on trans-identified and gender-variant women and a focus on intersectionality and global gender issues.

UNDERSTANDING THE INTERSECTIONS

The effort to revise the guidelines began in 2013, and a diverse group of more than three dozen practitioners, scholars and graduate students contributed to the new document. The project was co-chaired by Comas-Díaz; Debra Mollen, PhD, a professor of counseling psychology at Texas Woman's University; and Sharon Lamb, EdD, PhD, a professor of counseling psychology at the University of Massachusetts, Boston.

The overarching theme of the new guidelines is the importance of understanding girls and women within their social contexts. The authors urge psychologists to

understand the way different aspects of identity such as gender, race, ethnicity, social class and age can inform a person's experience.

Overall, women and girls are diagnosed more often with certain disorders, particularly depression, anxiety disorders and eating disorders, than are men and boys. But the guidelines encourage a deeper understanding of the contribution of trauma to the development of many disorders affecting women and girls. For example, while United Nations data suggest that about 70 percent of women worldwide will experience some form of violence in their lives, trauma may be particularly pervasive among certain subgroups, including women and girls of color, refugees and transgender individuals.

Other gendered issues hit some groups of women harder than others. For example, pregnancy-related mortality in the United States is nearly four times higher for black women, with 40 maternal deaths per 100,000 live births, than for white women (Centers for Disease Control and Prevention, 2014). Similarly, the gender pay gap differs by race and ethnicity, with Hispanic women earning the least as of 2017 (Institute for Women's Policy Research, 2018). Scientific research often excludes nonwhite racial and ethnic groups, and discrimination against racial, ethnic or sexual minorities can negatively impact health-care

CE credits: 1

Learning objectives: After reading this article, CE candidates will be able to:

1. Discuss the research on the stressors that are more common in women.
2. Describe how the new guidelines for girls and women encourage psychologists to help women tap their strengths.
3. Discuss how the guidelines seek to raise awareness of how the intersectionality of different traits, including gender, race, class and age, can inform a woman's experience.

For more information on earning CE credit for this article, go to www.apa.org/ed/ce/resources/ce-corner.aspx.

access and treatment.

Girls of color or girls living in poverty may be particularly susceptible to having their mental health problems criminalized rather than treated. Epidemiological research suggests that two-thirds of girls incarcerated in the juvenile justice system meet the criteria for at least one psychiatric disorder (*Archives of General Psychiatry*, Vol. 59, No. 12, 2002).

Social class, education, age and other attributes can put particular pressures on girls and women. According to U.S. Census Bureau data, women experience poverty at higher rates than men across the life span (Census Report, 2017). Being poor is a disadvantage in and of itself, but it can also leave people vulnerable to implicit and explicit bias by health-care professionals (*BMC Medical Ethics*, Vol. 18, 2017).

Meanwhile, ageism is pervasive, research suggests. Older women are stereotyped as less competent than younger women (*Journal of Social Issues*, Vol. 61, No. 2, 2005). They're also vulnerable to structural disadvantages. For example, because of women's lower lifetime earnings, they receive lower annual Social Security benefits than men, on average, even though more women rely on Social Security as their nearly sole source of income (Social Security Administration, 2018). Thus, ageism can intersect with poverty for older women, and with race for women of color.

The guidelines attempt to combat a strict medical-model approach that puts the onus on individuals in struggling to cope with such challenges. Rather,

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Lamb says, psychologists should be aware of the systemic nature of these problems for girls and women.

The transition to parenthood is likewise a moment in which women may face unique pressures, both financial and psychological. Mollen's work has found a tension between the rose-colored discourse around the joys of parenting and the actual experience of parenting for many women. Multiple studies find, for example, that relationship satisfaction between partners declines across the transition to parenthood (*Analyses of Social Issues and Public Policy*, Vol. 14, No. 1, 2014).

Women of color, poor women and single mothers are particularly disadvantaged because of limited income, lack of federal paid parental leave and insufficient maternal and fetal health care. The question of access to reproductive choice is particularly important for women of color, says Comas-Díaz. Meanwhile, parenting expectations have become more intense, especially among middle- and upper-class white women, Mollen says.

"This pressure that some women feel, that they need to present as though motherhood is only joyful and only satisfying, puts tremendous pressure on women," Mollen says. "We need to continue to study the lived experiences of women as mothers."

SUPPORTING WOMEN'S STRENGTHS

While understanding the challenges girls and women face is key, a new guideline also urges

psychologists to recognize the strengths and resilience of girls and women and to honor and cultivate those strengths. Girls and women face many systemic challenges, Mollen says, from relationship violence to limits to reproductive freedom to unequal pay. But despite these challenges, girls and women can develop resources for coping.

For instance, many women are open to seeking support from friends or professionals when the going gets rough. Women are less socially isolated than men are in their older age, on average. Their increased social ties seem to contribute to their longevity advantage, according to research by University of North Carolina sociologist Yang Claire Yang (*Journal of Health and Social Behavior*, Vol. 54, No. 2, 2013).

Reminders to support these advantages are peppered throughout the guidelines, especially in the recommendation to foster a practice that promotes agency, consciousness and choice and to avoid overdiagnosing or pathologizing the problems of girls and women. In practice, this involves being aware of potential biases in scales or assessments, as well as considering the context of a client's distress. A patient who has experienced betrayal trauma such as child abuse, for example, can present with symptoms of borderline personality disorder (*Psychological Trauma: Research, Practice, and Policy*, Vol. 4, No. 4, 2012). However, understanding and addressing those traumatic experiences could be more fruitful than applying the "borderline" label.



The guidelines reflect a trend, both within psychology and beyond, to look at how people function in a globalized world.

Pathologizing can be a particularly tempting trap when women and girls present with sexual problems, the guidelines' authors write. A history of sexual trauma or exhaustion from juggling multiple roles (paid work, parenthood, domestic duties) can contribute to sexual issues that may be misattributed to medical or physical causes.

THINKING GLOBALLY

The guidelines also reflect a trend, both within psychology and without, to look at how people

function in a globalized world.

"Global approaches to psychological practice are needed as more transnational people, particularly girls and women, are leaving their countries," Comas-Díaz says. The guidelines urge practitioners to understand girls and women within their sociopolitical and geopolitical contexts.

In practice, the guidelines' authors say, this might mean understanding the stress put on immigrant families by uncertainty surrounding immigration laws and enforcement. It might

KEY POINTS

1

Women and girls face unique stressors, including high rates of sexual trauma and relationship violence.

2

The new APA Guidelines for Psychological Practice With Girls and Women urge psychologists to understand how factors such as race, ethnicity, disability, age, socioeconomic class and sexual minority status intersect to inform a girl's or woman's experience.

3

Psychologists should work to cultivate the strengths of girls and women to help them cope. For example, girls and women may be more willing to reach out to social support networks than men and boys, on average.

require stepping outside of the U.S. individualist mindset to understand why the daughter of a refugee family might prioritize earning money to help support her parents over schooling. For refugee patients in particular, practitioners should be well-versed in assessment and treatment of trauma. Post-traumatic stress disorder (PTSD) symptoms are increasing among women and girls globally, Comas-Díaz says, and refugee women in particular may have experienced sexual violence or the threat of sexual violence as they fled their countries of origin. Globally, rape, other sexual assault and stalking are the traumas that leave the highest proportions of PTSD in their aftermath (*European Journal of Psychotraumatology*, Vol. 8, 2017).

Given this global and intersectional understanding, psychologists should be aware that girls and women form their identities in the context of mixed and changing messages about what it means to be female. Tension can arise between norms expected by the dominant culture in the United States and the norms conveyed by minority sociocultural groups. Psychologists can help their patients explore these nuances and affirm their multifaceted identities. Meeting patients where they are is key to this process, Comas-Díaz says. A refugee mother who has risked everything to bring her children to a new country, for example, might need to be reminded of the importance of taking care of herself through the lens of her children's need for her to be strong and healthy.



Psychologists should work to empower their patients by fighting against systemic discrimination, the guidelines recommend.

"I try to use what they bring in as a way to connect," Comas-Díaz says. "Also, I need to be very culturally humble. Many times, we don't know it all."

Part of the process involves understanding the effects of discrimination and oppression, as well as reflecting on one's own internalized biases as a practitioner. It might also involve stretching oneself beyond the usual slate of therapies to consider the benefits of folk practices or alternative forms of healing. For example, Lamb visited a pueblo to supervise a student in training. There, she said, she observed indigenous healing practices combined with traditional cognitive-behavioral therapy.

"There are many things in the cultural backgrounds of our country that have histories of providing healing," Lamb says. "Therapists would be wise to work with those

practices and indigenous practitioners, and not against them."

A CALL FOR ACTION

Given the guidelines' focus on systemic issues facing women and girls, the recommendations also include inspiration to change the system. Part of this may involve supporting patients as they take on helping roles, Comas-Díaz says.

"Research has shown that once you go beyond yourself and start concentrating on others and contributing, that really helps the person with psychopathology," she says. "They feel like they're doing something."

This focus on action is exemplified in the final guideline in the new document, which recommends that psychologists work to change hostile environments and fight against systemic discrimination. This can mean many things,

FURTHER READING

APA Guidelines for Psychological Practice With Girls and Women

<http://www.apa.org/about/policy/psychological-practice-girls-women-guidelines.pdf>

Teaching Sizeism: Integrating Size Into Multicultural Education and Clinical Training

Bergen, M., & Mollen, D. *Women and Therapy*, 2019

Gender Issues in Psychological Testing of Personality and Abilities

Baker, N.L., & Mason, J.L. In J.C. Chrisler & D.R. McCreary (Eds.) *Handbook of Gender Research in Psychology: Vol 2. Gender Research in Social and Applied Psychology* Springer, 2010

Comas-Díaz says, from becoming politically active to expressing oneself through creative endeavors. For researchers, it could mean working collaboratively with study populations through the liberation-psychology approach of participatory action research, rather than dropping in, taking measurements and leaving. For an employee of a school system or another institution, it might mean nudging the administration to make services more available for marginalized groups, like people with disabilities. All of that, Comas-Díaz says, is social activism.

Ultimately, Lamb says, this kind of action is needed to make "empowerment" for patients more than a toothless term. "Empowerment is a tricky word in psychology," she says. Too often, it refers to internal processes, like self-confidence, rather than to the sort of resistance to oppression that can win real power, she says.

In psychological practice, empowering female-identified patients can mean more than providing transparency and informed consent; it can include giving patients data about the effectiveness of varying therapeutic approaches and collaborating with them to decide on treatment strategies. It can also include expressing empathy for the external barriers to empowerment that girls or women might face.

"A girl feeling empowered has so much to do with whether society is giving them power, whether there is a basis for them to take that power and whether they're punished for expressing that power," Lamb says. "Empowerment is more than just self-improvement." ■

● **APA has developed** several sets of guidelines for psychological practice with particular populations. All APA practice guidelines are developed by task forces of experts, reviewed by APA boards and committees, and shared with the public for comment before they are adopted. APA guidelines do not take precedence over a psychologist's informed professional judgment.

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SPECIAL REPORT

NEW SOLUTIONS FOR THE OPIOID CRISIS

IN 2017, 1.7 MILLION PEOPLE in the United States had substance use disorders related to prescription opioids, and 652,000 had a heroin use disorder, according to the National Institute on Drug Abuse. That year, more than 47,000 Americans died from opioid overdoses—six times as many as in 1999. Now, psychologists are implementing new solutions to overturn these grim statistics. Armed with fresh research, interventions, assessment tools, training and more, the field is escalating its efforts to prevent and treat opioid use disorder. Here's how.

HOW PSYCHOLOGISTS IMPROVE CARE

Medications have been the gold standard for treating opioid use disorder, but behavioral interventions can improve treatment for opioid addiction and address the comorbid conditions that go along with it

BY KIRSTEN WEIR

On an average day in the United States, 130 people die from an overdose of opioids, including prescription pain medications, heroin and synthetic opioids such as fentanyl. “The numbers are staggering,” says R. Kathryn McHugh, PhD, a psychologist who studies substance use at Harvard Medical School and McLean Hospital. “Opioids touch pretty much every part of society, and the scope of the problem requires an all-hands-on-deck approach from the health-care field.” ¶ Yet many health-care providers, including psychologists and other mental health professionals, don’t realize the role they could play in addressing the epidemic,

says Kathleen Carroll, PhD, a psychologist and principal investigator at the Center for Psychotherapy Development at Yale University School of Medicine, a National Institute on Drug Abuse (NIDA)-funded center devoted to studying behavioral therapies for addiction. “A lot of people don’t believe opioid use disorder is treatable, and it clearly is.”

Researchers are still determining how best to design and offer behavioral treatments for people with opioid use disorder, and there’s a lot of room for psychologists to contribute to that research. In the meantime, clinical psychologists can get involved by educating themselves and

their patients about opioid use disorder, supporting family members of those who are struggling with the disorder and getting comfortable asking patients about their drug use. (See “How You Can Make a Difference” on page 39.) “It’s rare that there’s a family in the United States that isn’t touched in some way by the opioid crisis,” Carroll says. “We must pay attention.”

THE CURRENT TREATMENT LANDSCAPE

A 2015 report in *Forbes* magazine valued the drug treatment industry at \$35 billion. As the opioid crisis has grown, so have inpatient treatment facilities for opioid use disorder. But critics

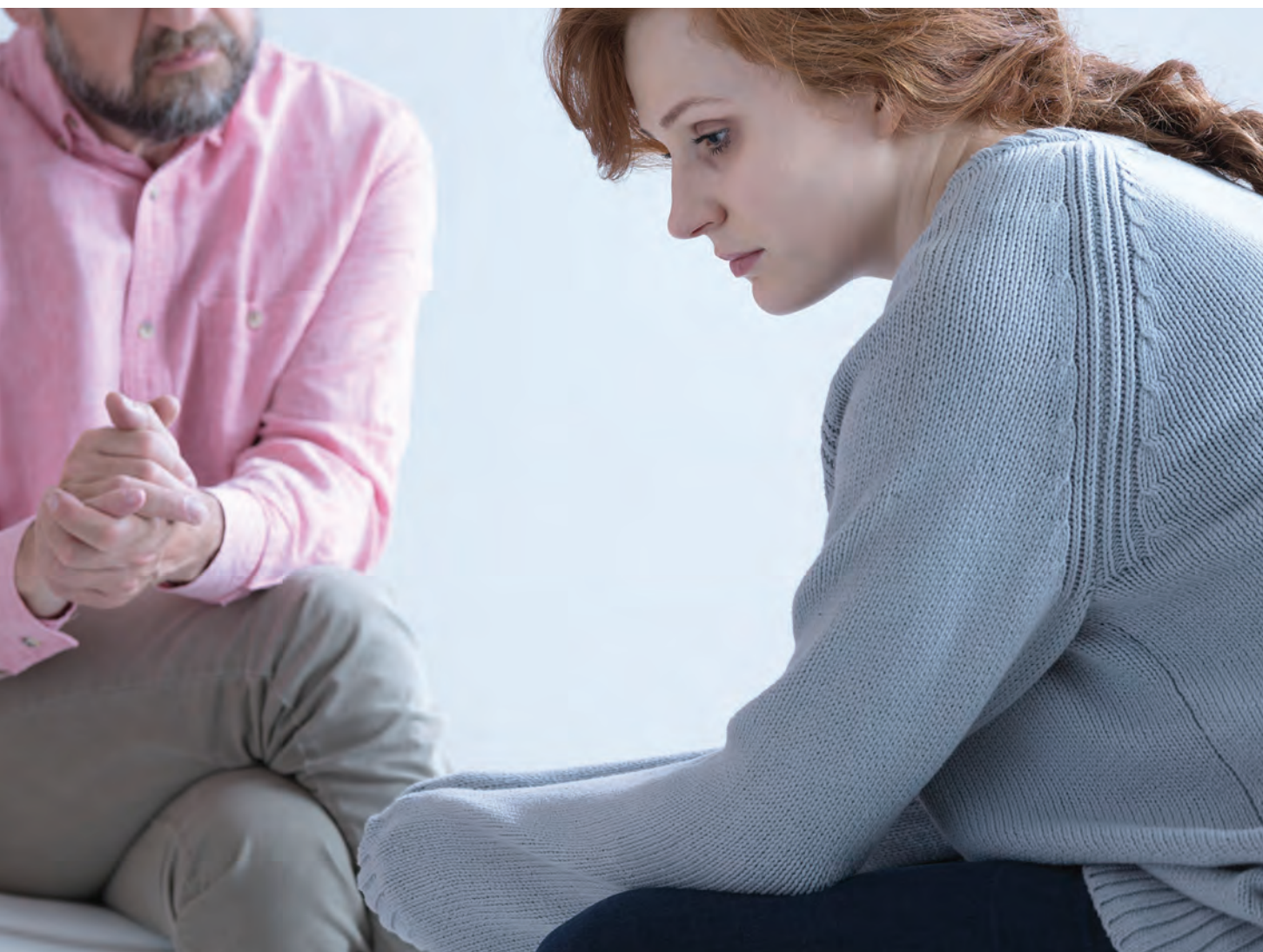
note that there are no federal standards for drug rehabilitation programs, and little regulatory oversight. The quality of care in those treatment programs varies widely. In some cases, patients are released after detoxification without ongoing care—putting them at increased risk of relapse and overdose. “The worst thing that can happen is for people to get detoxed and then released without medication. It’s heart-breaking,” Carroll says.

Indeed, the medication Carroll refers to is the backbone of treatment: methadone, buprenorphine and naltrexone. Those medications are prescribed to block the effects of other opioids and prevent cravings and withdrawal symptoms.

“There is strong evidence that these medications save lives, and that they’re effective across different ages, genders, ethnicities and social classes,” says Carroll.

But 80 percent of people in the United States who need them don’t get them, says Carroll, pointing to a new National Academies of Sciences, Engineering and Medicine report that she helped to write.





The report identifies several factors keeping these drugs from more widespread use, including inadequate training for professionals who work with people who use substances, the fragmentation of health care that often leaves people without the means to pay for treatment, and the misconception that substance use is a moral or purely behavioral problem.

“People totally misunderstand the nature of addiction, let alone its treatment,” says Alan Leshner, PhD, a psychologist and former director of NIDA, who chaired the committee that authored the report. “None of the barriers are new. It’s just that we haven’t made any real progress against

them.” (To read the full report, go to www.nationalacademies.org/ODTreatment.)

Regulations also impair access. Buprenorphine is a controlled substance, and physicians must complete extra training and receive a waiver from the Drug Enforcement Administration to prescribe it. Methadone, also a controlled substance, is available only through specially licensed clinics. While naltrexone can be prescribed by any physician, patients must complete a full detoxification before they can begin using it. On top of the prescribing difficulties, there’s a lack of knowledge—among physicians, insurers and society at large—about using medications

More psychologists are needed to provide addiction treatment services and conduct research on new behavioral approaches.

for substance use disorders, as well as a stigma attached to their use, McHugh says.

A study by Ramin Mojtabai, MD, of Johns Hopkins University, and colleagues found that just 36 percent of U.S. treatment centers offered at least one of the medications approved to treat opioid use disorder, and a mere 6 percent provided all three (*Health Affairs*, Vol. 38, No. 1, 2019).

Of course, medication is just one component of treatment. Often, treatment programs combine prescription medications with counseling or other behavioral therapies. But the quality of behavioral treatments varies considerably, says Tom

Horvath, PhD, ABPP, a clinical psychologist in San Diego who specializes in addiction treatment and recovery. “In some states, you can get a drug counseling certificate without a college degree,” he says. “Unfortunately, psychologists are highly underutilized in addiction treatment.”

One big reason: The health-care system is designed around fee-for-service, and reimbursement is an issue. Drug treatment programs often can’t afford (or aren’t willing to pay) psychologists or other professionals such as licensed social workers, he says. “The whole system would benefit from more psychologists, but it’s hard for them to work their way into the existing system.”

BEHAVIORAL THERAPIES FOR OPIOID USE DISORDER

That’s a missed opportunity, experts argue, since evidence-based behavioral treatments used in concert with medication have the potential to make a real difference in long-term recovery. “Substance use is not just about biology. When someone comes into treatment for opioid use disorder, there’s a lot of history that predates that, and a lot of things that happened when they were engaged in drug use,” says Sharon Walsh, PhD, a professor of behavioral science at the University of Kentucky College of Medicine who studies opioid use disorder and its treatment. “It’s critical for people to also have behavioral interventions as needed. You need to treat the whole person to get them well.”

While medications can help reduce cravings and decrease overdose risk, they do not reduce

people’s reactivity to stress, for example. And they don’t address comorbid conditions that often go hand-in-hand with opioid use disorder, such as anxiety, depression, post-traumatic stress disorder and chronic pain—all of which can lead people to relapse back into addiction despite medication. “We need to think about how we target everything that’s left over after treatment with medication,” McHugh says.

In a review of research on behavioral interventions with buprenorphine treatment, Carroll and Roger Weiss, MD, recommend a stepped-care model for buprenorphine treatment that focuses on what they describe as the “Five A’s” of successful treatment: adherence to medication, abstinence from illicit drugs, attendance at treatment appointments, alternative activities to drug use and accessing support. For patients who struggle with those efforts, Carroll and Weiss recommend more intensive behavioral interventions (*American Journal of Psychiatry*, Vol. 174, No. 8, 2017).

One behavioral strategy supported by some of the strongest data so far is contingency management. “One of the difficulties of substance use is that the benefits come immediately, but the costs come after a time lag,” McHugh notes. If someone uses opioids today, they satisfy a craving and prevent withdrawal symptoms. The costs—losing a job, alienating family—exist in a hazy, far-off future. Contingency management aims to flip the script.

“Contingency management moves the reinforcer for absti-

nence closer to the behavior,” McHugh explains. When a person provides an opioid-free urine test, attends scheduled therapy sessions or meets other behavioral goals, he or she receives a reward: a raffle ticket for an inexpensive prize, easing of behavioral restrictions (such as extending curfew for an adolescent being treated for opioid misuse) or a social reward (such as a special dinner).

In one review of the use of contingency management for treating various substance use disorders, Stephen Higgins, PhD, of the University of Vermont, and colleagues found that such programs are effective during treatment, though their effects weaken after treatment ends (*Preventive Medicine*, Vol. 92, No. 1, 2016).

Improving retention rates in treatment programs may be one of the most important targets for behavioral interventions. About half of people drop out of medication treatments by the six-month mark, putting them at increased risk of relapse and overdose. “Behavioral treatments could play a role in bringing up that response rate, and that’s a goal a lot of us are working toward,” McHugh says.

COGNITIVE-BEHAVIORAL TREATMENTS

To bring more evidence-based treatment to people with opioid use disorder, Carroll and her colleagues developed a computer-based training for cognitive-behavioral therapy (CBT4CBT). The self-guided web-based program teaches coping skills and is intended to

THE THREE WAVES OF THE OPIOID EPIDEMIC

An estimated 300,000 Americans have died during the crisis, which has been characterized by three waves:

1

The problem started in 1991 with a surge in opioid prescriptions for pain. At the time, prescribers thought there was a low risk for addiction.

2

By 2010, efforts to curb opioid prescriptions led people to use heroin, an inexpensive and widely available, albeit illegal, drug.

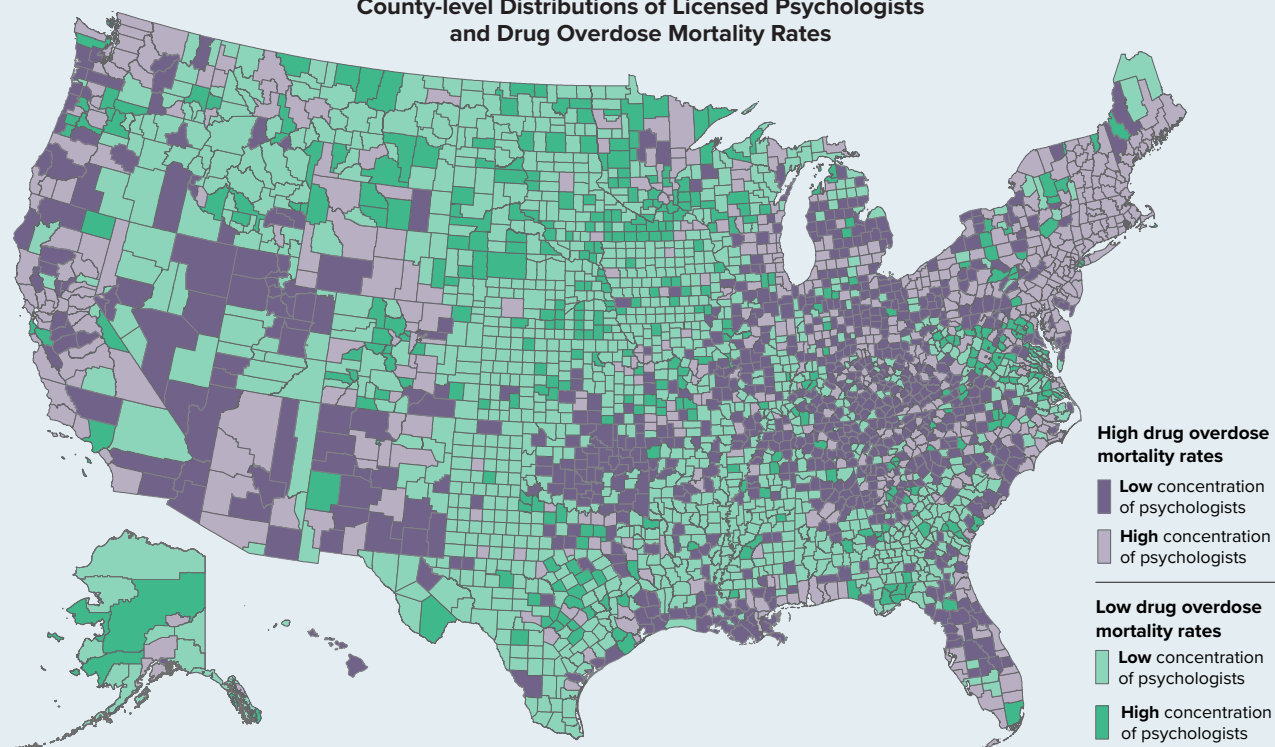
3

In 2013, an increase in the use of synthetic opioids, like fentanyl, led to an increase in deaths.

Where Are More Psychologists Needed to Address Overdose Deaths?

Data on the geographical distribution of psychologists and of overdose deaths can shed light on where more psychologists are needed and where training psychologists in substance use issues may have the greatest impact. When examined at the county level, the Southwest and parts of the Midwest, Southeast and Appalachian Mountain regions have higher drug overdose mortality rates and lower concentrations of licensed psychologists than average. The Northeast and parts of the West Coast and Rocky Mountain regions have higher drug overdose mortality rates and greater concentrations of licensed psychologists than average.

County-level Distributions of Licensed Psychologists and Drug Overdose Mortality Rates



By Karen Stamm, PhD, Luona Lin, MPP, Jessica Conroy, BA, and Peggy Christidis, PhD

For an interactive version of this map, visit <https://www.apa.org/workforce/data-tools/geographic-distribution>. Questions? Contact cws@apa.org.

Source: American Psychological Association. (2019). *Distribution of licensed psychologists and drug overdose mortality rates*. Washington, DC: Author.

Counties were classified by concentrations of licensed psychologists and drug overdose mortality rates higher or lower than the national mean at the county level.

be used as one piece of a comprehensive treatment program for people with alcohol and substance use disorders who are under the care of a qualified psychologist, physician or other trained health professional.

Several clinical trials have found that CBT4CBT is effective

for a variety of substance use disorders. In a 12-week randomized pilot study of the program tailored to patients receiving buprenorphine, 91 percent of patients in the CBT4CBT group had negative urine screens for opioids at the end of the trial, compared with only 64 percent

of the control group (*Substance Abuse*, online, 2019).

The program is now being used for alcohol and substance use disorders in 25 states and Canada but is available only through health-care providers, including psychologists and psychiatrists as well as primary care

physicians. “We want to make sure there’s a clinician who can assess the individual and make sure the level of care is appropriate,” Carroll says.

Horvath has also taken steps to reach more people with substance use disorder, using a mutual aid group model. Some 12-step programs, such as Narcotics Anonymous, promote total abstinence and may not welcome people taking medications for opioid use disorder, he says. To offer a more inclusive alternative, Horvath was a founding member in 1994 of Self-Management and Recovery Training (SMART Recovery), which now offers more than 2,500 local meetings worldwide for people with alcohol and substance use disorders. The evidence-based program is centered on CBT and motivational interviewing, and often addresses co-occurring problems such as depression and trauma (*Journal of Groups in Addiction and Recovery*, Vol. 7, No. 2–4, 2012). Importantly, he adds, it can be personalized to meet the needs of each participant.

INVESTING IN TREATMENT RESEARCH

Researchers—including many psychologists—are developing new treatments to help more people recover from opioid use disorder. The National Institutes of Health’s Helping to End Addiction Long-term (HEAL) initiative was launched in the spring of 2018 to address the opioid public health crisis. To date, much of the research funded through HEAL focuses on pharmacology, including efforts to develop vaccines to

prevent opioid use disorder, medications to treat it and new, safer drugs to treat pain. But the initiative is supporting some behavioral studies as well, including projects aimed at identifying patient characteristics associated with retention in treatment programs and efforts to explore cultural attitudes that can create barriers to taking medications for opioid use disorder.

The HEAL initiative is just one part of the effort by NIDA and other institutes within NIH to support opioid treatment research in a variety of areas, from basic science to clinical trials. For example, Mark Smith, PhD, a psychologist at Davidson College in North Carolina, has NIDA funding to study the behavioral effects of opioids in rodent models. Animal models naturally play an important role in the development of new medications and the identification of neurobiological mechanisms of drug dependence. But they also have a lot to tell us about behavioral interventions, he says. He’s found, for instance, that rats that get vigorous exercise self-administer significantly less heroin than their more sedentary counterparts, and also show changes in gene expression in the brain’s opioid and dopamine receptors (*Psychopharmacology*, Vol. 235, No. 4, 2018).

Many psychologists don’t realize how basic science research contributes to the field of substance use disorders, Smith says. “Psychologists are outstanding at developing animal models of pathological behavior. We can use those models to develop behavioral and nonbehavioral

interventions to both prevent and treat drug use.”

Of course, psychologists are also doing important work on the human end of the spectrum. NIDA’s Clinical Trials Network extends across 13 geographic “nodes,” with hundreds of affiliated clinical study sites nationwide to test new treatments in a variety of treatment settings. Carroll’s work on CBT4CBT, for example, was developed at the Clinical Trials Network site she oversees at Yale University. Through the network, she says, she hopes researchers will begin to answer some of the important open questions around opioid use disorder and its treatment: What is the optimal duration of treatment? What factors make people stick with it? How can interventions for co-occurring conditions such as depression and chronic pain be integrated into treatment for opioid use disorder? And what recovery support services can help sustain long-term remission of opioid use disorder? “There are more questions than answers,” Carroll says.

Those questions are also a call to action, adds McHugh. “The relative lack of behavior therapy studies for opioid use disorder further highlights how important it is for psychology to get more involved.”

A CALL FOR PSYCHOLOGY

The opioid crisis isn’t just a problem for researchers to solve. Experts in substance use disorders argue that clinical psychologists can do more in their everyday practices. For starters, they should get in the habit of

ADDITIONAL READING

Randomized Clinical Trial of Computerized and Clinician-Delivered CBT in Comparison With Standard Outpatient Treatment for Substance Use Disorders: Primary Within-Treatment and Follow-Up Outcomes

Kiluk, B.D., et al.
American Journal of Psychiatry, 2018

The Role of Behavioral Interventions in Buprenorphine Maintenance Treatment: A Review

Carroll, K.M., & Weiss, R.D.
American Journal of Psychiatry, 2017

The Opioid Guide: A Resource Guide for Practicing Psychologists

APA, 2018

APA Div. 50: Society of Addiction Psychology

<https://addictionpsychology.org/>



The SMART Recovery program—a mutual aid group model—offers more than 2,500 local meetings for people with substance use issues.

asking all patients about their substance use, McHugh says. If they're not comfortable treating such patients, they should make efforts to refer them to providers who are. "Substance use disorder is often separated from mental health care," she says. "But you

cannot be in the mental health field without running into substance misuse."

Unfortunately, too few psychologists get sufficient training to help people with addiction (see article on page 58). John Norcross, PhD, at the University

of Scranton, and colleagues surveyed clinical psychology doctoral programs between 1999 and 2017 and found that fewer than a third offered specialty training in addiction (*American Psychologist*, Vol. 72, No. 7, 2017). "We need to be doing a better job from graduate training through continuing education to make sure psychologists are getting the training that they need to work with folks with substance use disorders," McHugh adds.

"This is an incredibly complex public health problem," adds Walsh. "We need as many smart people as we can find to help solve it." ■

● **Interested in learning more** about how psychologists are reimbursed for their services related to opioid treatment? Look for an article in the summer issue of APA's *Good Practice* magazine at www.apaservices.org/practice/good-practice.

IMPROVING CARE

HOW YOU CAN MAKE A DIFFERENCE

Clinical psychologists who lack specific training and experience in treating substance use disorders often don't know how to get involved. Here are some places to start.

- **Educate yourself** on the basics and stay current as research opens up new avenues for treatment. Treatment for opioid use is evolving all the time.
- **Ask all patients** about their history of opioid and other substance use, no matter what they look like or why they are seeking treatment. Not sure how to ask? Ask them what substances they enjoy.

- **Provide patients** with information about safe medication storage and disposal, so that prescription opioids don't wind up in the hands of adolescents or others who might misuse them.
- **Reach out to physicians** who provide medical management for opioid use disorder to let them know you're available for referrals or willing to provide behavioral treatment as part of a team.
- **If you're not comfortable** treating opioid use disorder, connect with experts who are so you can refer patients as needed.
- **Help clients** with opioid use disorder and their family members understand

which treatments are evidence-based.

- **Learn about** how best to support family members of people with substance use disorder.
- **Encourage psychology students** and trainees to seek out experience in treating substance use disorders.
- **Get involved** in local or national advocacy efforts. (See page 60).
- **Take a deep breath**—and dive in. "To feel competent working with a new population, you have to get in there and do it," says substance use researcher R. Kathryn McHugh, PhD. "The earlier you can get started, the better."

LIFE-SAVING SUPPORTS

Psychologist-designed programs that include housing, work and family interventions for people with opioid use disorder show promise

BY STEPHANIE PAPPAS

Kevin Scott was in his early teens when he began using drugs and alcohol. Since that time, he's experienced homelessness and has struggled with chronic pain from back, neck and head injuries. ¶ Now 48, Scott has secured a stable footing in life, in part because he now has a home. He won't lose his apartment in Seattle's Plymouth Housing program if he does drugs; in fact, Scott is not entirely substance-free. But now that he is free from the stress and uncertainty of the streets, Scott has been able to reduce his use dramatically, participating in a combined behavioral and pharmacotherapy program through the Harm Reduction Research and Treat-

ment (HaRRT) Center and Harborview Medical Center. The program has helped him switch from hard drugs like heroin and methamphetamines to cannabis, and limit his alcohol use. He participates in vocational rehabilitation, has an emotional support dog and volunteers to cook community meals for others in his housing complex. "It's been my anchor," Scott says.

His case is just one example of how psychosocial supports can change lives. Opioid addiction is unique in that there are very effective medications that block opioid receptors to reduce cravings and even save lives in the event of overdose. But some people are reluctant to use med-

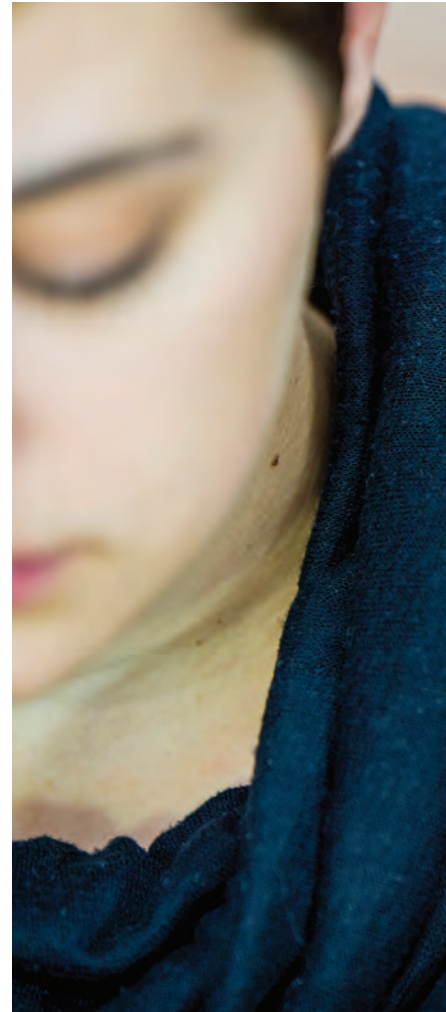
ications or are unable to stick to a medication plan because of instability in their lives. Others want to taper off medications over time or need to relearn how to be in the world without substances, says Katie Witkiewitz, PhD, a professor of psychology at the University of New Mexico Center on Alcoholism, Substance Abuse and Addictions. Psychosocial support programs focused on getting substance users into stable housing, bringing together their family members and loved ones, addressing their employment problems and dealing with legal problems stemming from their drug use can make sticking with a broader treatment plan possible.

KEY POINTS

1
Many people with opioid use disorder struggle to start or stay in treatment because of challenging life circumstances.

2
Getting individuals into safe housing and providing them family therapy or employment support can make treatment more effective and address issues that lead to substance use.

3
Effective evidence-based programs exist, but access to these programs lags behind need.



"A lot of the work focuses on the underlying issues that brought people to addiction in the first place," says Witkiewitz. For someone struggling with an opioid use disorder, these supports can make all the difference.

A SAFE HARBOR

Traditionally, housing programs have asked people with substance use disorders to "prove" themselves before receiving housing, says clinical psychologist Susan Collins, PhD, the co-director of the HaRRT Center at the



University of Washington School of Medicine in Seattle. They might have had to commit to substance use treatment programs or provide negative drug tests before they were considered “housing-ready.”

But that philosophy is amiss, Collins says. “What agencies were finding was that the most stable parts of the homeless community were getting housing. But the folks who were struggling the most—and were the most marginalized—were not,” she says.

Will Williams, a member of the community advisory board for the HaRRT Center, was once reluctant even to try to get permanent housing because he knew he would “screw it up” if he had to abide by rules like not smoking cigarettes or marijuana.

“You might be surprised how harmful being told that you can’t do something is to a person who already feels they’ve been pushed around, pushed around, pushed around,” Williams says.

In response, the philosophy of “housing first” was born. Hous-

ing First programs, the first of which was established in 1988, aim to get homeless people, whether they use substances or not, into housing with few strings attached.

“We know that housing forms the basic platform that folks need in order to even begin to think about how to heal,” says Karen DuBois-Walton, PhD, a clinical psychologist and president of the Elm City Communities/Housing Authority of New Haven, Connecticut.

Many cities across the United States now have Housing First programs, funded through a variety of federal subsidies, resident rent payments, grants and donations. The funding perpetually lags behind the need, DuBois-Walton says, especially because home prices and rents have risen faster than income over the past several decades, putting affordable housing in increasingly short supply.

For those who do gain a spot in them, Housing First communities provide an entryway into treatment, with services ranging from on-site case management to behavioral health treatments. Being late on the rent won’t trigger eviction proceedings. Rather, DuBois-Walton says, late rent is seen as a first sign that someone might be relapsing or otherwise in need of help. Many of these supportive housing communities that serve people with opioid use histories distribute naloxone (also known as Narcan) to residents and staff and hold trainings on how to use the kits in case a resident overdoses.

Research on using the Hous-

Psychosocial support programs can help substance users stick to an effective treatment plan.

ing First approach with opioid users is relatively sparse compared with research on its use with alcohol or polysubstance users. However, polysubstance use is the norm for people with opioid use disorder, Collins says, and the available evidence suggests the intervention works similarly across substance use disorders: People don't miraculously become abstinent as a result of getting housing, but they don't start using more, as some critics have worried. Overall, they appear to experience fewer negative health outcomes and have a better chance of getting treatment.

One study led by Philip Appel of the New York State Office of Alcoholism and Substance Abuse Services examined a Housing First program in New York and found that about half of homeless, mentally ill methadone patients who secured housing were adhering to their methadone treatment three years later, compared with just 20 percent of the same population who did not receive housing (*Journal of Addictive Diseases*, Vol. 31, No. 3, 2012).

Another study led by Sara Miller-Archie of the New York City Department of Health and Mental Hygiene found that among polysubstance users in the city, those placed in supportive housing were hospitalized less, used emergency departments less, and were more likely to initiate substance use treatment than those not given such housing (*Annals of Epidemiology*, in press).

However, a study of homeless adults receiving methadone

maintenance treatment in Vancouver, Canada, by Simon Fraser University clinical psychologist Julian Somers, PhD, and colleagues found that Housing First programs didn't increase methadone treatment adherence any more than treatment as usual, leading the authors to conclude that housing supports were not in themselves sufficient to improve treatment adherence (*International Journal of Drug Policy*, Vol. 56, 2018). That study did not examine other outcomes like hospitalizations.

HELP AT WORK

For many people who use opioids, struggles with stable work go hand-in-hand with housing struggles. But there are few direct workplace supports for people who use opioids, says Kenneth Silverman, PhD, a professor of psychiatry and behavioral services at The Johns Hopkins University School of Medicine. Silverman and his colleagues run a work program for people with substance use disorders who are chronically unemployed. The program takes a contingency-management approach: Participants are paid to do data entry, and to earn maximum pay, they must also submit substance-free urine samples regularly. The key to achieving abstinence seems to be a combination of workplace incentives and medication treatment, the team has found, an example of social support and medical treatment working in tandem (*Drug and Alcohol Dependence*, Vol. 197, 2019). Employees aren't fired for relapsing, as they might be in a typical workplace.

"Our people need more than a second chance," Silverman says.

Silverman says his program, which is funded by federal grants, would be hard to reproduce in most employment settings. At most companies, employees with substance use problems who aren't simply fired are likely to get treated through employee assistance programs, which are often limited to short-term counseling and referrals.

But some employers are getting interested in providing more support and second chances. Belden, a computer and telecommunications hardware company, has a "Pathways to Employment" program that lets job applicants who are rejected because of a failed drug screening participate in rehabilitation and try again. Contractors such as American Substance Abuse Professionals Inc. work with employers to develop treatments for employees who have failed drug screenings, particularly in jobs with high safety standards, such as transportation and nuclear energy.

Silverman and his team are in the midst of a study that recruits participants to work in their data-entry business for 90 days and then engage with an employment specialist for a year to find paid work outside the study. As long as they remain abstinent during this time, they receive a stipend.

"You need high-magnitude incentives, and you need to maintain those for long periods of time," Silverman says. "That's one of the motivations for using employment because employment can involve high-magnitude incentives, long-term."

FURTHER READING

Family Therapy and Systemic Interventions for Child-Focused Problems: The Current Evidence Base

Carr, A.
Journal of Family Therapy, 2018

Seattle's Law Enforcement Assisted Diversion (LEAD) Program: Within-Subjects Changes on Housing, Employment and Income/Benefits Outcomes and Associations With Recidivism

Clifasefi, S.L., et al.
Crime & Delinquency, 2017

Opioid Crisis: No Easy Fix to Its Social and Economic Determinants

Dasgupta, N., et al.
American Journal of Public Health, 2018



FAMILY THERAPY

Loved ones can also be a potent force in supporting the recovery of people with opioid use disorder. Family therapy can help families create a healthy environment around a member who is using drugs, help repair relationships fractured by drug use and help families support their loved one's recovery.

"Whether you're a teenager or a young adult or you're 40 years old, you have family, and the family can support recovery

or they can undermine it," says Gayle Dakof, PhD, a clinical psychologist and professor of public health at the University of Miami and director of MDFT International.

Often, patients come to treatment still enmeshed in relationships with other substance users, says Hortensia Amaro, PhD, a psychologist at Florida International University who founded a long-standing residential substance use treatment program for Latina

Housing First programs help substance users find stable housing without needing to first "prove themselves" by remaining entirely abstinent from substance use.

mothers, called *Entre Familia*, in Boston. Those patients have to reconstruct their social circles and find ways to navigate or disengage from toxic relationships, Amaro says.

Family involvement is especially important for adolescents who use substances, says Kimberly Kirby, PhD, a professor of psychology at Rowan University in New Jersey, and programs have been developed to help even when a loved one is resistant to treatment. Community Reinforcement and Family Training (CRAFT) is a program that teaches families to interact with a substance-using member by using positive reinforcement and improving communication and other relationship skills. This approach has been shown for decades to move more people with substance use problems into treatment than other family support options like Al-Anon and Nar-Anon or traditional interventions, according to research by Hendrick G. Roozen, PhD, of Erasmus University Medical Centre in Rotterdam (*Addiction*, Vol. 105, No. 10, 2010).

Kirby and her team have found that one particular aspect of CRAFT—treatment entry training, or training families to look for the fleeting moments when loved ones may be open to treatment and teaching them how to phrase their requests to get help—can be effective on its own in increasing treatment entry rates (*Psychology of Addictive Behaviors*, Vol. 31, No. 7, 2017).

Other effective family-oriented approaches include multisystemic therapy (MST)

"WE KNOW THAT HOUSING FORMS THE BASIC PLATFORM THAT FOLKS NEED IN ORDER TO EVEN BEGIN TO THINK ABOUT HOW TO HEAL," SAYS KAREN DUBOIS-WALTON, PhD.



and multidimensional family therapy (MDFT). Both programs differ from CRAFT in that they focus on directly treating substance use as well as building family relationships. There are differences between the programs. MST, for example, focuses on treating adolescents in their homes, schools and neighborhoods, and always includes parents in counseling sessions with youth. MDFT is implemented in community settings as well as inpatient facilities and prescribes solo counseling with youth as well as joint sessions with parents. But both ultimately focus on healing the family and enhancing positive social supports. MST has been shown to be one of the most effective interventions for teenagers who use substances and have conduct problems (*Substance Abuse:*

Research and Treatment, Vol. 6, 2012). MDFT, which is Dakof's treatment focus, is also highly rated for efficacy, as shown in a meta-analysis by Thimo van der Pol of Leiden University and colleagues (*Journal of Child Psychology and Psychiatry*, Vol. 53, No. 5, 2017). One particularly meaningful aspect of MDFT for opioid-using teens is the sessions in which they and their families meet to discuss an overdose prevention and safety plan.

"The idea is to stimulate an emotional conversation about drugs and about overdose and about death and life, and so on, to get people motivated to help each other," Dakof says.

These programs have high success rates, but a persistent problem is that they're not available everywhere and that families don't know about them, Kirby

Several forms of family therapy are successful in helping repair relationships fractured by drug use.

says. Access to these family-focused therapies for substance use is "really not great," she says.

SUPPORT, NOT PUNISHMENT

Instead of accessing effective treatments, people who use drugs often land in the criminal justice system. With the deepening of the opioid crisis, police, district attorneys and the courts are increasingly playing the role of lifeline rather than disciplinarian.

The problem is serious. Some 58 percent of state prisoners and 63 percent of sentenced jail inmates met the criteria for drug use or dependence, as of 2009 (Bureau of Justice Statistics, 2017). Jails and prisons aren't drug-free zones; a few years ago, Seattle's Scott says, he was jailed. He came out hooked on methamphetamines.

"Jail isn't a good place for addicts," he says.

For people with opioid use disorder in particular, imprisonment and its aftermath can be life-threatening. One meta-analysis found that among this population, overdose deaths increase three- to eightfold within the first four weeks of release from prison, because if they aren't using regularly while incarcerated, people with opioid use disorder lose their tolerance to heroin and other opioids (Merrall, E., et al., *Addiction*, Vol. 105, No. 9, 2010).

Another meta-analysis found that offering medications for addiction treatment may help—methadone, buprenorphine or naltrexone treatment during incarceration increase substance

use treatment entry, and methadone also reduces opioid use after release (Moore, K.E., et al., *Journal of Substance Abuse Treatment*, Vol. 99, 2019).

States are slowly taking notice: Rhode Island started screening every inmate for opioid use disorder and offering counseling and medication in 2016. California's Department of Health Care Services is funding the expansion of medication treatment for opioid addiction in the corrections system in 22 counties. The federal prison system is gradually coming around, too. In December, President Donald Trump signed the First Step Act, a criminal justice reform bill, into law. The law includes a mandate that the federal prison system expand evidence-based treatment for opioid dependence, including both medication and what the law calls "holistic" approaches.

A more well-established route is to usher people with substance use disorder out of the regular court system and into drug courts, where a judge supervises every aspect of treatment and recovery. These courts are popular because they reduce recidivism and cost less than the standard court-and-corrections process, Dakof says. The first drug court was established in Miami in 1989, and there are now more than 3,000 nationwide.

But drug courts don't always implement the best

evidence-based treatments, Dakof says. Very few, for example, implement MDFT or MST for juveniles, even though those approaches have some of the best evidence for the longest-lasting effects.

Because high-quality service is key to a successful drug court, psychologists can play important roles in them, and not just in treatment, says Richard Wiener, PhD, a professor of psychology at the University of Nebraska-Lincoln.

"It's getting to the point now where people are thinking about accountability issues and professionalization in drug courts. There is a major role for psychologists, and in fact, the organizational and research role may be the most prominent," Wiener says.

Wiener is now involved in drafting standards for Nebraska's mental health courts, an expansion of the drug-court model. Besides writing standards, he says, psychologists can help teach lawyers, who are trained to defend their clients, to instead think about the best way to get them treatment and services.

"There is an effort to look at things like education, housing, employment, social support, social security and insurance," Wiener says. "It's not just the substance use problem and mental health problems. It's a social service agenda of things people need in order to be successful." ■



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THE STIGMA THAT UNDERMINES CARE

Psychologists are working to tear down the stereotypes and biased language that foster discrimination against those with opioid and other substance use disorders

BY ZARA GREENBAUM

On paper, Robert Ashford, MSW, has a bright future: He's a doctoral student in health policy and a graduate research assistant at the Substance Use Disorders Institute at the University of the Sciences in Philadelphia. In reality, he has had to overcome many obstacles and continues to face many more. As a person in recovery from a substance use disorder since 2013, Ashford has faced housing discrimination and barriers to accessing and financing his education. ¶ "All of my research and advocacy work draws on my lived experience with a substance use disorder and the discrimination and bias I've faced over the last six years," he says.

These and other discriminatory practices are rooted in stereotypes of people with opioid use disorder. This population is often seen as criminals, poor employees and lacking a moral compass. Not only do such biased attitudes fuel unfair treatment toward people who use substances, they can also undermine health-seeking behaviors (Brenner, L., *Drug and Alcohol Review*, Vol. 29, No. 5, 2010).

"People who feel more stigmatized are less likely to seek treatment, even if they have the same level of addiction severity," says John Kelly, PhD, founder and director of the Recovery Research Institute at Massachusetts General Hospital in

Boston and associate professor of addiction medicine at Harvard Medical School. "They're also more likely to drop out of treatment if they feel stigmatized and ashamed."

As part of a broader effort to spread destigmatizing messages, psychologists are studying stigmas among various populations, getting involved with policy efforts and educating the public about addiction. "There are roughly 22 million people in recovery for substance use disorders in the United States, but you may not even know that your colleague or neighbor is one of them because of the high degree of stigma," Ashford says. "We shouldn't have to live in a

society where people can't disclose their history of addiction."

LANGUAGE, IDENTITY AND STIGMA

The stigma against substance use runs deep. It's embedded even in the language we use to describe it, which is often medically inaccurate and can do more harm than good (see sidebar on page 48).

For example, the commonly used terms "drug abuse" and "drug abuser" carry an implicit association with physical, sexual or emotional abuse.

"This gives rise to the idea that people with addiction are willfully and maliciously engaging in substance misuse, when in reality they have lost the choice of use," says David Eddie, PhD, clinical psychologist and research scientist at Massachusetts General Hospital's Recovery Research Institute.

In a study, Kelly found that physicians and clinical psychologists exposed to the term "substance abuser" in a vignette were more likely to blame a hypothetical patient for his or her condition than were those exposed to the phrase "having a substance use disorder." Clinicians

People who feel more stigmatized are less likely to seek treatment and also more likely to drop out of treatment, research finds.



in the first group were also more likely to say that punishment was required as opposed to treatment (*International Journal of Drug Policy*, Vol. 21, No. 3, 2010).

“Words matter—the words we use convey what’s normal and frame how clinicians, health professionals and society at large view a problem,” says Howard Koh, MD, MPH, a professor in Harvard’s T.H. Chan School of Public Health and former assistant secretary for health at the U.S. Department of Health and Human Services. “If we don’t choose our words carefully, we perpetuate bias, cloud understanding and end up distancing ourselves from the people we want to help.”

As a result of research by Kelly and others, Michael Botticelli, director of the White House Office of National Drug Control Policy during the Obama administration, initiated changes in language use at the federal level. In 2015, the International Society of Addiction Journal Editors also agreed to remove the terms “abuse” and “abuser” from addiction journals around the world, and in 2017, the Associated Press recommended that journalists use nonstigmatizing language when reporting on substance use disorders.

Other research has explored how stereotypes about addiction interact with racial, gender and other biases to affect different

groups in different ways. For example, Kimberly Goodyear, PhD, and colleagues conducted a nationwide survey of more than 2,600 people, using vignettes to measure stigmatizing attitudes, and found that males and individuals who started using opioids not prescribed by their doctors were rated more negatively (*Drug and Alcohol Dependence*, Vol. 185, 2018).

Stigma even exists within the recovery community. Compared with those in abstinence-based recovery programs, people who rely on safe injection sites or medications such as methadone and buprenorphine in their treatment are viewed by others in recovery as not being truly sober, says Kelly, even though such treatments significantly reduce overdoses and cravings and increase the chances of remission.

HOW PSYCHOLOGISTS CAN HELP

Studies also indicate that the public understanding of addiction, while not entirely accurate, may be more nuanced than previously thought. A survey of 1,300 community college students and administrators, conducted by Ashford and his colleagues, found that many Americans believe that addiction is both a disease and a moral failing (*Substance Use & Misuse*, in review). “We need to better understand how people conceptualize this problem so we can develop health messaging that can both reduce stigma and support evidence-based practices,” Ashford says.

Moving forward, psychologists can continue to

FURTHER READING

Changing the Language of Addiction

Botticelli, M.P., & Koh, H.K.
JAMA, 2016

The ADDICTIONary
Recovery Research Institute, 2016

study—and use—medically accurate language around opioid use disorder. They can also promote the use of nonstigmatizing language among health-care providers, politicians, journalists, law-enforcement officers and other groups involved with the opioid crisis.

More extensive education in medical schools and psychology doctoral programs around the genetic and neurobiological bases of addiction can also increase compassion, reduce blame and cut back on dis-

criminatory practices among health-care providers, Kelly says. For example, research shows that genetics account for roughly half of a person's addiction risk, while chronic exposure to opioids leads to measurable changes in brain activity and structure.

And perhaps most important, psychologists—especially those who work with people recovering from addiction—can help redefine what recovery looks like by providing what Kelly calls “personal witness” to addiction and recovery. This

may include inviting people in recovery to speak to faculty, staff or patients or partnering with a national anti-stigma effort such as Faces and Voices of Recovery, which uses online networking to strengthen the recovery community.

“To fight these stigmas, we first need to normalize the process of recovery, providing positive examples of what recovery looks like,” Kelly says. “When people see that up close, their stereotypes begin to break down.” ■

PREVENTING STIGMA

HOW TO TALK ABOUT ADDICTION

P sychologists who study stigmas around opioid use say that the scientific community can help dismantle unfair stereotypes by correcting language in clinical and research settings.

“Language that’s medically accurate will ultimately trickle down into mainstream media and popular culture,” says David Eddie, PhD, clinical psychologist and research scientist at the Recovery Research Institute at Massachusetts General Hospital in Boston.

Here are examples of stigmatizing language to avoid and alternative terms to use.

■ “Drug abuse” and “drug abuser”

Research by John Kelly, PhD, founder and director of the Recovery Research Institute, suggests that clinicians show increased bias toward patients described as “drug abusers.” Instead, Kelly recommends using the terms “substance use” and “person with a

substance use disorder.”

“We don’t speak this way about other health conditions, so we shouldn’t speak this way about addiction,” he says. For example, we refer to people with eating-related problems as having an eating disorder rather than being food abusers.

■ “Addict,” “alcoholic” and “user”

The terms “addict,” “alcoholic” and “user” define people solely by their behavior around substances, implying that other aspects of their identities are insignificant. Psychologists should avoid these words and instead use person-first language to describe patients or research participants. Terms such as “person with a substance use disorder” or “person in recovery” are less stigmatizing and more accurate.

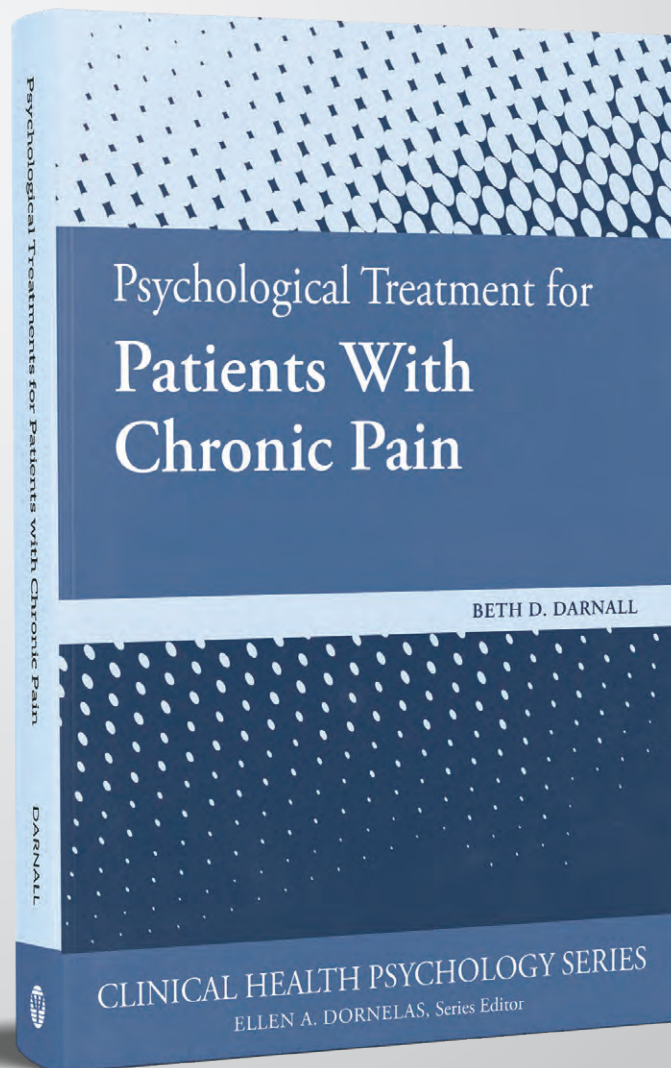
■ “Clean” and “dirty”

For decades, clinicians have used the words “clean” and “dirty” to describe both individuals and the results of their

drug screen tests. Howard Koh, MD, MPH, a professor in Harvard’s T.H. Chan School of Public Health, urges providers to forgo such language. Drug screens should be described as “positive” or “negative” and patients as “in recovery,” “abstinent” or “resuming use of a substance.”

■ “Medication-assisted treatment”

Even the term “medication-assisted treatment,” which describes rehabilitation involving medications such as methadone and buprenorphine, is often misinterpreted and can worsen stigmas around opioid use, says Kelly. The use of such language to describe treatment for addiction—but not for the thousands of other health conditions treated with medications—reinforces the misconception that those who rely on such treatments have simply developed a “replacement addiction.” A good alternative is to refer to these substances as “medications for addiction treatment.”



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PREVENTION AS THE FIRST LINE OF DEFENSE

By teaching people to manage pain without opioids, psychologists are helping to prevent those at risk from sliding into misuse

BY ZARA GREENBAUM

Americans make up less than 5 percent of the world's population but consume nearly one-third of the global opioid supply, according to an expert group affiliated with the United Nations, the International Narcotics Control Board. Much of that consumption is misuse: Data from the U.S. Substance Abuse and Mental Health Services Administration show that 11.8 million Americans currently misuse opioids. ¶ Often, that misuse stems from patients seeking to relieve physical pain by taking more medication than prescribed by their physicians, taking someone else's medication or purchasing substances on the black market, according

to the 2016 National Survey on Drug Use and Health. But physical pain alone does not predict opioid misuse—and other common reasons for misuse include using drugs to relieve tension, to feel good or to help with negative emotions, according to the survey.

"When we compare people who misuse opioids to people who take them as prescribed, there's no significant difference in their physical pain levels," says Eric Garland, PhD, LCSW, director of the Center on Mindfulness and Integrative Health Intervention Development at the University of Utah. "What does discriminate these patients is their emotional pain. That's what seems to be driving this problem."

In fact, the biggest predictors of opioid misuse are existing mental health issues, which is one reason the scientific literature has dubbed opioid use disorder a "disease of despair." People who have experienced trauma, received a depression or anxiety diagnosis, or have a personal or family history of substance use disorder are at greatest risk. Other predictors include being younger, heavy tobacco use and engaging in risk-taking behavior, according to research by Lynn R. Webster, MD (*Anesthesia & Analgesia*, Vol. 125, No. 5, 2017).

Those findings point to the essential role psychologists can play in preventing opioid misuse, not only by diagnosing and

treating mental health issues that precede what some providers call "chemical coping," but also by offering nonpharmacological strategies for treating physical pain. A growing body of research supports psychological interventions that are less expensive than, less risky than and often just as effective as opioids for treating pain.

Unless we embrace the prevention approach, the opioid crisis will persist, says Howard Koh, MD, MPH, a professor in Harvard's T.H. Chan School of Public Health and former assistant secretary for health at the U.S. Department of Health and Human Services. "Although we've seen more attention on the opioid epidemic in recent years, there's still very little focus on prevention," he says.

That's why psychologists are working to promote and expand their roles in the opioid crisis by developing, testing and administering pain management strategies that reduce reliance on opioids.

UNDERLYING ISSUES

Opioid use disorder (OUD), which affects 2.1 million Americans, involves chronic opioid

U.S. OPIOID USE BY THE NUMBERS

11.8 million
Number of Americans who misuse opioids

17
Percentage of the U.S. population that was prescribed an opioid in 2017

One-third
The amount of the world's opioid supply used by Americans, even though they make up only 5 percent of the global population



The greatest predictor
of opioid misuse is
mental health issues,
particularly among those
who have experienced
trauma, received a
depression or anxiety
diagnosis, or have
a personal or family
history of substance use
disorder.

misuse and is marked by physical tolerance of the drug, withdrawal symptoms when usage is stopped, and the disruption of daily life, according to the Diagnostic and Statistical Manual of Mental Disorders. OUD has two distinct etiologies, each with its own implications for prevention, according to research by Daniel Bruns, PsyD, a clinical health psychologist in Greeley, Colorado, who studied drug risk in more than 3,000 community members and patients in treatment for pain across 36 states (BHI 2 Medical Intervention Risk Report Manual, 2016).

One at-risk group follows what Bruns calls a more traditional pattern of substance use—they are more likely to have engaged in illegal behavior, show greater impulsivity and have a high likelihood of having experienced childhood trauma. These individuals are more likely to use illicit substances or to obtain prescription medications illegally. For this group, a key path to prevention requires psychologists to help patients address underlying mental and behavioral health issues before they begin to self-medicate with substances, says Bruns.

The second at-risk group Bruns identified is patients who have coped badly with a painful illness or injury. “In this case, the opioid use of these high-risk patients has been sanctioned by society,” he says. “These patients are often stunned when they become dependent on opioids after simply following the instructions of a physician.”

Preventing misuse and addiction among this second

COGNITIVE-BEHAVIORAL THERAPY IS BEING USED SUCCESSFULLY TO HELP PEOPLE MANAGE PAIN WITHOUT OPIOIDS AS WELL AS TO WEAN PEOPLE IN PAIN OFF OPIOIDS.

group—which Bruns says contributes a substantial portion to today’s opioid problem—requires a better understanding of which patients can benefit from opioids, which are at risk for misusing them and alternative methods for treating pain.

Opioids block pain signals, which is useful for treating acute pain, but the drugs become less effective over time as patients build up tolerance. With an estimated 50 million Americans living with chronic pain—defined as pain lasting more than three months—U.S. physicians have relied heavily on opioids, prescribing them to more than 17 percent of the U.S. population in 2017, according to the Centers for Disease Control and Prevention.

One of the ways psychologists are advancing prevention of opioid misuse is by creating and administering psychological assessments that predict which patients are at risk for misuse and addiction.

“There are huge individual differences in how people perceive, react to and handle pain, which is why it’s important to evaluate patients before we start prescribing opioids,” says Robert Jamison, PhD, professor of anesthesia and pain management at Harvard Medical School and

KEY POINTS

1
People who have experienced trauma, received a depression or anxiety diagnosis, or have a personal or family history of substance use disorder are at greatest risk for opioid use disorder. Other predictors include being younger, heavy tobacco use and risk-taking behavior.

2
One of the ways psychologists are advancing prevention of opioid misuse is by creating and administering psychological assessments that predict which patients are at risk for misuse and addiction.

3
Psychologists are deploying new outreach strategies and technologies to reach more people at risk of opioid misuse.

a pain psychologist at Brigham and Women’s Hospital’s Pain Management Center. He and his team have developed a series of validated risk assessment scales that are now widely used in studies and pain clinics around the country (see article on page 56 for more on these assessments).

Patients who “catastrophize” about pain, or ruminate on and magnify it, are particularly at risk because they may use opioids to manage their mood as well as the pain itself, says Jamison.

Psychologists can help by teaching people how to reduce that catastrophizing.

“If people are very fearful about pain, if they’re saying things to themselves like, ‘My life is over, I can’t do anything because of pain,’ that fear sets off alarm systems in the brain,” says Jeannie Sperry, PhD, a pain psychologist at the Mayo Clinic’s Pain Rehabilitation Center in Rochester, Minnesota.

To help reduce pain catastrophizing, Sperry provides psychoeducation about pain to patients who enter the clinic’s three-week intensive outpatient program. She teaches people with chronic pain from conditions such as fibromyalgia, amputations and Parkinson’s disease that their experience of pain does not correlate



with actual tissue damage.

Psychological interventions can help people treat pain without medication because of the way the brain processes pain signals: When a person is injured physically, sensory signals travel from the body to the thalamus and are then sent to several other brain areas associated with the subjective experience of pain. But the prefrontal cortex can modulate how the thalamus relays such signals, changing the way pain is perceived.

“By stimulating top-down control from the prefrontal cortex, psychological interventions can improve people’s ability to cope with pain,” says Garland. “When effective, these therapies can even decrease the pain itself.”

The most commonly used—and best studied—psychological

treatment for pain is cognitive-behavioral therapy (CBT), which practitioners like Bruns and Sperry use to help wean patients off opioids and prevent others from taking them in the first place. Cognitive therapy addresses how people think about their pain, for instance by teaching them to use non-catastrophizing language, while behavioral strategies help patients interrupt negative thought patterns and encourage them to resume activities they may previously have avoided, such as climbing stairs after a back injury.

Research shows that CBT improves mood and positive function, with numerous studies demonstrating its ability to reduce both pain and catastrophizing (*American Psychologist*,

Opioids treat pain by blocking pain signals, but the drugs become less effective over time as patients build up tolerance.

Vol. 69, No. 2, 2014). One study by David Seminowicz, PhD, and his colleagues at the University of Maryland, Baltimore’s Center to Advance Chronic Pain Research even indicated that CBT can lead to increases in the volume of the prefrontal cortex and other brain regions involved with modulating the experience of pain (*Journal of Pain*, Vol. 14, No. 12, 2013).

Other psychological interventions shown to be effective for pain management include acceptance and commitment therapy, a variation of CBT that incorporates acceptance of pain and commitment to behavior change; biofeedback, which helps patients gain a better understanding of their physical state; and hypnosis. Jamison is even starting to design interventions that employ virtual reality,

gamification and voice and facial recognition to better assess mood and teach patients to relax.

Psychologists are also increasingly using mindfulness therapies to treat chronic pain. Building on his research on emotional regulation deficits in people who misuse opioids, Garland developed Mindfulness-Oriented Recovery Enhancement (MORE), a series of eight two-hour sessions to help treat pain and reduce dependence on opioids.

“The labeling of OUD as a ‘disease of despair’ in the scientific literature isn’t just a metaphor,” Garland says. “Chronic pain patients who misuse opioids actually have abnormally high rates of anhedonia—their brains and bodies are blunted to the experience of natural pleasure, joy and meaning in life.”

MORE teaches patients coping strategies such as practicing three minutes of mindful breathing before each dose of opioids. The intervention has been shown to increase physiological responses to natural pleasure, including heart rate variability and electrophysiological response, which predict decreases in opioid cravings and misuse (*Journal of Behavioral Medicine*, Vol. 38, No. 2, 2015).

OUTREACH AS PREVENTION

Beyond administering psychological assessments and interventions in the clinic, psychologists are deploying new outreach strategies and technologies to reach more people at risk of opioid misuse.

“Tens of millions of Americans live in isolated areas without

access to pain psychologists,” says Robert Edwards, PhD, associate professor of anesthesia at Harvard Medical School and a pain psychologist at Brigham and Women’s Hospital’s Pain Management Center. “We can reach many more people if we make our assessment tools and interventions available via telepsychology and smartphone applications.”

Edwards and Jamison developed a five-question self-report scale, delivered daily to patients via a mobile application, that can identify people at risk for misusing opioids in just five days (see assessments article on page 56). The instrument helps fill a data gap on how patients are faring.

“Patients may see their provider periodically, but we often lack information about their moods and behaviors between visits,” Jamison says.

Cross-disciplinary collaboration among health-care providers is also key for effectively treating pain, says Sperry. The pain management program at the Mayo Clinic, for instance, is staffed with an addiction psychiatrist, a pain psychologist, a physical therapist, an occupational therapist, a nurse, a pharmacist and a chaplain. Patients practice Tai Chi, yoga and relaxation each day in addition to attending several hours of rehabilitation and pain management classes. This sort of integrative care helps pain patients learn long-term coping strategies and taper off high doses of opioids, and has been shown to reduce depression and pain catastrophizing (*Journal of Pain*, Vol. 19, No. 6, 2018).

Integrative chronic pain

management programs that include psychologists are not only more effective than solely medical approaches; they also save money. After Bruns helped develop and pass the Colorado Chronic Pain Guidelines, statewide regulations for treating pain in workers’ compensation cases, he measured the results of regularly replacing surgery with psychological interventions.

“Compared to certain spinal surgeries for pain, studies show that CBT is equally effective, while surgery is much riskier and costs about 168 times more,” Bruns says. Colorado’s annual medical costs for workers’ compensation dropped as much as \$859 million after the pain guidelines were implemented in 1992 (*Rehabilitation Psychology*, Vol. 57, No. 2, 2012). And an analysis of the Mayo Clinic’s pain rehabilitation program in Jacksonville, Florida, by Christopher D. Sletten, PhD, and colleagues, revealed a 90 percent drop in health-care costs 18 months post-treatment (*Pain Medicine*, Vol. 16, No. 5, 2015).

CULTURAL SHIFT

As helpful as psychological interventions are for preventing opioid misuse, experts say widespread adoption of such treatments requires a broader cultural shift toward a biopsychosocial treatment model.

“If you watch TV, it looks like there’s a pill for everything,” Sperry says. “Instead of promoting drugs to treat pain, unhappiness or sleep problems, we should be teaching people how their brains and bodies work together from a young age,”

ADDITIONAL READING

Psychological Treatment for Patients With Chronic Pain

Darnall, B.D.
APA Books, 2018

Neurobiologic Advances From the Brain Disease Model of Addiction

Volkow, N.D., et al.
New England Journal of Medicine, 2016

Contributions of Psychology to the Understanding and Treatment of Chronic Pain: Why It Matters to ALL Psychologists

Jensen, M.P., & Turk, D.C.
American Psychologist, 2014

Managing Chronic Pain: How Psychologists Can Help With Pain Management

APA, 2013



via teachers, pediatricians and parent education.

More extensive education is also needed for both psychologists and physicians, who currently receive no systematic training in pain management. In a national survey, more than half of psychology practitioners polled said they did not have adequate training to treat individuals experiencing pain (*Pain Medicine*, Vol. 17, No. 2, 2016).

“When therapists don’t feel competent in a certain area, they avoid it,” says Beth Darnall, PhD, clinical professor in the department of anesthesiology, perioperative and pain medicine at Stanford University and lead author of the study. “Psychologists aren’t going to ask people about their pain if they feel they have nothing to offer,” which is

problematic because a high percentage of patients seeking help for mental health issues are also experiencing pain.

To help train psychologists in pain management, APA published Darnall’s book “Psychological Treatment for Patients With Chronic Pain” and is developing an online continuing-education module in pain psychology. Darnall also created a single-session pain psychology class (*Journal of Pain Research*, Vol. 7, 2014) and offers certification workshops to clinicians who hope to gain foundational knowledge and training in the area.

As researchers continue to amass data on opioid misuse, pain and treatment approaches, psychologists and other health-care providers can develop tools

Integrative pain care is an important alternative to opioids. Patients at the Mayo Clinic, for instance, participate in Tai Chi, yoga and relaxation each day as well as rehabilitation and pain management classes.

to prescribe personalized interventions for managing pain.

“Using a combination of brain imaging, genetics and patient self-reports, we can begin to create algorithms that prescribe each patient the optimal combination of treatments as quickly as possible,” Edwards says, which may include medications, psychological treatments or a combination of both. Ultimately, this personalized, integrative approach can reduce dependence on opioids, especially in cases where they’re likely to be misused.

“When we know that pain is multidimensional and multidetermined, to only prescribe one modality is doomed to fail,” says Sperry. “Prescribing only medication for chronic pain is highly likely to be ineffective.” ■

WHO NEEDS OPIOIDS?

Psychologist-developed screening instruments help determine which pain patients should receive opioids and which are at risk for misuse

BY REBECCA A. CLAY

Just five days' worth of data collected via a new smartphone app is all it takes to identify people who "catastrophize" their pain and may thus be at risk for future opioid misuse, says Robert Jamison, PhD, chief psychologist at the Pain Management Center at Brigham and Women's Hospital (BWH). ¶ In a study conducted by Jamison and colleagues, participants used the BWH PainApp each day to rate their moods, the intensity of their pain, whether it interfered with activity or sleep, and whether their situations had improved, gotten worse or stayed the same over the past 24 hours (*Journal of Pain*, Vol. 20, No. 3, 2019). That last question is an extremely effective way to identify

people who indulge in recurrent worries about what might happen, says Jamison. "These people tend not to do well despite any attempts to help their pain," he says. But thanks to the app's two-way messaging feature, psychologists or other providers can intervene with relaxation exercises, cognitive-behavioral therapy or other approaches to pain management.

While the BWH PainApp is an example of a new tool psychologists have developed to assess risk of opioid misuse, psychologists are also using classic assessments in new ways to respond to the opioid epidemic. For example, the Minnesota Multiphasic Person-

ality Inventory-2-Restructured Form (MMPI-2-RF) and the Millon Behavioral Medicine Diagnostic (MBMD) can help assess whether patients are psychologically ready for potentially painful procedures, such as spinal or bariatric surgeries. In addition, Pearson's Battery for Health Improvement 2 (BHI-2) can identify factors that may impede recovery from pain.

"Depression, for example, can very much affect a person's recovery," says Paul Williams, PsyD, a health-care solutions analyst at Pearson Clinical Assessment. "If you're already depressed, go through a procedure and come out even more depressed because now you're

in pain, the symptoms of depression—pessimism, loss of interest and drive, low energy, low appetite—aren't good for recovery." Other issues that may warrant presurgical intervention by a psychologist include anxiety, a tendency to avoid problems, sedentariness that may prevent physical therapy and a lack of social support, he adds.

Another widely used assessment, the Screener and Opioid Assessment for Patients in Pain (SOAPP)—and an updated version called the SOAPP-R—helps physicians and psychologists determine whether opioid therapy is appropriate. Developed by psychologist Stephen Butler, PhD, Jamison and colleagues, the assessment evaluates patients' mood-related traits, such as mood swings, tension in the home and boredom, and looks at past behaviors that might hint at potential opioid misuse, such as running out of medications early or having had previous legal problems or arrests. A sister survey, the Current Opioid Misuse Measure (COMM), assesses risky behaviors over the past month, such as how often the patient struggled to control his or her anger.

Psychologists and physicians can use the SOAPP and the COMM, along with a patient's personal and family history of mental health issues, to determine when it is safe to prescribe opioids. These tools also help ensure that objective assessment data rather than physicians' own biases drive decision-making when it comes to treating patients in pain and deciding when, to whom and how to

SOME KEY ASSESSMENTS

Screener and Opioid Assessment for Patients in Pain

Helps determine whether opioid therapy is appropriate

Minnesota Multiphasic Personality Inventory-2-Restructured Form and Millon Behavioral Medicine Diagnostic

Help determine whether patients are psychologically ready for potentially painful procedures

Pearson's Battery for Health Improvement 2

Can identify factors that may impede recovery from pain



prescribe opioids, says Butler, now a consultant to Inflexxion, an integrated behavioral health company that offers free, web-based versions of the SOAPP and the COMM as part of a clinical evaluation system for pain patients. (The system is available at www.paincas.com/Account/RegisterFreeOrg.)

These often-unconscious biases can leave some populations undertreated for their pain, says pain specialist Beverly E. Thorn, PhD, ABPP, a professor emerita of psychology at the University of Alabama, who explains that physicians often “bump down” patients’ self-reported pain if they’ve had the pain for a long time or are members of certain groups. “For African Americans, the bias is they’re going to misuse medications or they’re going to sell their medications,” says Thorn.

“For women, the bias is that women are more hypochondriacal and more complaining. And people have said to my Hispanic patients, ‘You’re not going to be able to afford these medications, so I’m not going to prescribe them for you.’”

Once patients are prescribed opioids, Jamison’s Opioid Compliance Checklist can help clinicians monitor their patients’ adherence to their prescribed regimens and identify patients who may be misusing opioids or be at risk of misusing them in the future (*Journal of Pain*, Vol. 17, No. 4, 2016). The checklist asks whether patients have lost their medication, missed medical appointments or used illegal substances, for example.

Other assessment tools focus on patients who have already developed problems with opioid misuse, including

Too often, providers do not use any assessments, a problem psychologists are working to fix.

the Substance Abuse Subtle Screening Inventory (SASSI-4), which can identify even clients who are unable or unwilling to acknowledge that they have a problem. And Pearson’s Quality of Life Inventory (QOLI) can help clinicians and patients track progress in such areas as health, self-esteem, relationships and overall well-being. “It’s not looking for deficits like pain or anguish; it’s on the positive psychology side,” says Williams. “It’s very motivating.”

Unfortunately, many clinicians don’t use any assessments, says Butler. Whether the problem is clinicians’ reliance on their own instincts or a reluctance to change work flows, “we’ve found it can be really difficult to get doctors and their nurses to use these assessments,” he says. To help overcome that challenge, Butler and other psychologists are working to shorten and computerize assessments. A new version of the SOAPP developed by Butler, Jamison and other researchers, for instance, reduces the number of questions from the original 24 down to just eight without losing its effectiveness (*Pain Medicine*, Vol. 19, No. 10, 2018).

But there are still major gaps in the research on pain assessment, psychologists say. There’s no way to differentiate between someone whose pain is genuinely undertreated and someone who just wants drugs, for example. Another ongoing dilemma is how to measure outcomes when it comes to chronic pain. “Almost by definition, chronic pain is not expected to get better, so, what does a good outcome look like?” asks Butler. ■

TRAINING FRONT-LINE PSYCHOLOGISTS

Want to help address the opioid epidemic but need more expertise? Here's where to update and expand your skills.

BY REBECCA A. CLAY

When psychology interns and postdoctoral fellows show up to work with R. Kathryn McHugh, PhD, an associate psychologist in McLean Hospital's substance use disorders division, she's often surprised by how little preparation they've received to work with the patients they'll be seeing. ¶ "It's not unusual to see people who are done with most of their training but still haven't seen a single person with substance use disorder," says McHugh, who's also an assistant professor of psychology at Harvard Medical School. "That's not OK." ¶ For most psychologists, says McHugh, training on substance use disorders consists of a single lecture in an abnormal psychology class.

In programs where several faculty members focus on addiction, however, students typically get a good grounding in the topic as a routine part of their training. According to Katie Witkiewitz, PhD, a past president of APA's Div. 50 (Society of Addiction Psychology), schools offering top programs in this area include the University of New Mexico; the University of Missouri; Syracuse University; the University of California, San Diego; San Diego State University; the University of California, Berkeley; the University of Washington; Arizona State University; the University of California, Los Angeles; and

the University of Florida. Other excellent training programs include those at the University of California, San Francisco, and Johns Hopkins University, adds Nancy A. Piotrowski, PhD, Div. 50's federal advocacy coordinator.

While training for the next generation of psychologists is still catching up to the realities of the opioid epidemic, continuing education (CE) is an important avenue for bringing the existing workforce up to date. Div. 50 offers several CE options for psychologists who want to know the latest evidence-based practices as well as how to screen for problems, says Jessica L. Martin, PhD, who chairs the

division's Education & Training/CE committee.

To help those practitioners, Div. 50 typically offers CE courses at APA's Annual Convention, which will take place this year Aug. 8–11 in Chicago (go to <https://convention.apa.org>).

Div. 50 also holds its own annual meeting each spring: The Collaborative Perspectives on Addiction meeting offers CE programs on the latest clinical advances and scientific research across the addiction field (see www.addictionpsychology.org/cpa for more information).

In addition, the division offers clinical teleconferences on cognitive-behavioral approaches to opioid use disorders as well as other topics (see www.addictionpsychology.org/education-training/conference-calls).

APA offers its own CE options on opioid use and other addictions. Topics include treating opioid use disorders and preventing overdoses, identifying and managing patients with co-occurring chronic pain, and more general overviews of substance use disorders and treatment. (To



Psychologists can get CE on opioid prevention, screening and treatment through APA and Div. 50 (Society of Addiction Psychology.)



access them, go to www.apa.org/education/ce/topic and click on “addiction.”)

In addition, APA offers CE programs on non-opioid treatment of pain (go to www.apa.org/education/ce/topic and search for “pain”).

For psychologists who want to demonstrate that they already have proficiency in treating substance use disorders, NAADAC, the Association for Addiction Professionals, offers a master addiction counselor certification program. Designed to help psychologists and other practitioners position themselves as

specialists and thus boost their salaries and potential career advancement, the credential recognizes expertise gained via graduate-level coursework and supervised work experience. Among other requirements, the credential requires a minimum of 6,000 hours of supervised experience in substance use counseling, 500 hours of education and training on substance use disorders and a passing score on the National Certification Commission for Addiction Professionals exam or an equivalent. (See www.naadac.org/mac for details.) ■

ADDICTION TREATMENT

EDUCATING OTHER PROVIDERS

Psychologists are also helping to ensure that today’s nonpsychologist addiction workforce is up to date on evidence-based practices. Among them is Rachel Winograd, PhD, a research associate professor at the Missouri Institute of Mental Health, University of Missouri–St. Louis.

With a project called **Missouri Opioid-Heroin Overdose Prevention and Education**, Winograd is combating myths about naloxone, including the belief that it encourages opioid use. The curriculum Winograd and her team created for emergency responders, social service providers and the public replaces the traditional focus on abstinence with a focus on harm reduction.

In another project, Winograd is promoting a **Medication First** model that seeks to eliminate barriers to rapid access to medications for addiction treatment. Her team has already trained 15,000-plus counselors, social workers, case managers, peers, physicians, nurses and administrators and treated 4,000 individuals. According to preliminary data, clients served by such professionals are more likely to get medication and stay in treatment longer. Median monthly treatment costs are down 19 percent.

Other psychologists are investigating the best way to train the addiction workforce. As director of the Substance Abuse and Mental Health Services Administration–funded New England Addiction Technology Transfer Center, Sara Becker, PhD, trains psychologists, social workers, physicians and other addiction treatment providers with a model she calls the **Science to Service Laboratory**. This approach to training layers ongoing support—including leadership coaching and performance feedback—on top of didactic workshops.

Research by Becker and colleagues suggests that providers receiving this more comprehensive training are more likely to adopt evidence-based interventions than are those who receive workshops alone (*Substance Abuse*, Vol. 37, No. 1, 2016).

CHANGING OPIOID POLICIES AND PRACTICES

Advocacy by APA and individual psychologists is tackling the opioid epidemic at the federal, state and local levels

BY REBECCA A. CLAY

More funding for research on opioid addiction and improved prevention and treatment programs are among psychologists' advocacy priorities at the federal, state and local levels. ¶ At the federal level, advocates have won some major successes, including the launch of the National Institutes of Health's HEAL (Helping to End Addiction Long-term) initiative. The effort, which incorporates psychological approaches into its research plan, has nearly doubled funding for pain and opioid research, from \$600 million to \$1.1 billion, over two years. Advocates also secured expanded access to treatment, thanks to the enactment

of the SUPPORT (Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment) for Patients and Communities Act last fall. The SUPPORT Act requires state Medicaid programs to cover methadone and all other medications used to treat opioid use disorder beginning in 2020 and expands Medicare coverage to include telehealth services for substance use disorders. It also requires the Centers for Medicare and Medicaid Services to develop guidelines on non-opioid pain management for participating hospitals and state Medicaid programs. And it authorizes a demonstration project aimed at increasing

the number of substance use treatment providers through improved reimbursement rates and training.

Psychologists can play a key role in implementing the new law and making sure it fulfills its potential (see sidebar on page 62), says Nancy Piotrowski, PhD, federal advocacy coordinator for APA's Div. 50 (Society of Addiction Psychology). "There are lots of opportunities for psychologists to establish lines of funding for research, training and clinical services that address some of the systemic gaps that have existed in the health-care system," says Piotrowski. These new funding streams and programs also create opportunities

for psychologists to use their skills in translating research findings for use in real-life settings and in evaluating outcomes.

APA has also been successful in nominating psychologists to serve in advisory roles in federal groups addressing the opioid epidemic and related issues. Mary Meagher, PhD, of Texas A&M University is now a member of the federal Pain Management Best Practices Inter-agency Task Force, which will develop recommendations for better addressing acute and chronic pain, for example. APA also provided input to the President's Commission on Combating Drug Addiction and the Opioid Crisis.

Meanwhile, raising awareness of the issue of substance use disorders among members of Congress and their staffs is a key priority for researcher Sandra Comer, PhD, public policy officer for the College on Problems of Drug Dependence, an organization for scientists focused on understanding addictive disorders and finding new treatments for them.

"They often don't have a clear understanding of what substance

RECENT ACTION BY APA

1
Advocating to nearly double funding for pain and opioid research at the National Institutes of Health

2
Working to implement a new law that will expand treatment for opioid use disorder

3
Providing input to the President's Commission on Combating Drug Addiction and the Opioid Crisis



users face and what challenges they have,” says Comer, a research scientist at the New York State Psychiatric Institute and professor of neurobiology at Columbia University.

Another priority is convincing legislators to remove cumbersome barriers for researchers who study drugs of abuse. For example, last year the Drug Enforcement Agency changed the classification of illicit fentanyl analogues—which, unlike fentanyl itself, have no known medical use—to Schedule 1. While this action was appropriate for protecting public health, says Comer, it makes it more difficult for scientists to study these compounds.

“That’s a problem because it is critical that we understand the pharmacology of these drugs,” says Comer. “We’re trying to figure out more streamlined ways for scientists to do the research while at the same time ensuring proper controls on these substances.”

Research with nonhuman primates is also critical, Comer told policymakers and staff at a congressional briefing APA co-sponsored with the Supporting Truth About Animal Research Coalition in March. “The Food and Drug Administration would never in a million years allow me to give synthetic fentanyl to human research volunteers,” says Comer. “To

On the local level, psychologists are working with physicians to help ensure that only patients who truly need opioids get prescriptions for them.

understand how these drugs work, we have to rely on pre-clinical research.”

At another congressional briefing sponsored by the Patient-Centered Outcomes Research Institute, psychologist Beth Darnall, PhD, a clinical professor of anesthesiology, perioperative and pain medicine at Stanford University School of Medicine, focused on what she calls “the dual crises of pain and opioids in America.” Darnall described her research, which uses behavioral treatments to help pain patients taper their opioid use.

Other psychologists are advocating for change at the state level. In Connecticut, Traci Cipriano, JD, PhD, is taking several approaches in her advocacy. In addition to educating psychologists and physicians, she is working to ensure that the state’s workers’ compensation system follows its protocols for both medical and psychosocial treatments for chronic pain. Many physicians didn’t know the protocols existed, says Cipriano, a private practitioner and an assistant clinical professor of psychiatry at Yale University School of Medicine, who is an adviser to the state’s Workers’ Compensation Commission. “My work is trying to get the word out,” she says. In addition, Cipriano is working with policymakers, insurers and the Connecticut State Medical Society to explore policy options to improve interdisciplinary care for patients with opioid use disorder in ways that also reduce costs.

In Maryland, Carlo DiClemente, PhD, ABPP, a

professor emeritus of psychology at the University of Maryland, Baltimore County, is among those urging the governor's Opioid Operational Command Center to distribute naloxone for treating overdoses and incorporate other harm-reduction strategies, such as offering clean needles.

Collaborating with other health-care professionals at the state level is key, says Paul Korte, PhD, the Missouri Psychological Association's federal advocacy coordinator. The association is working with physician groups and others to urge legislators to enact a statewide prescription drug monitoring program to help reduce misuse of drugs. "Missouri is the only state in the union that still doesn't have one," says Korte, explaining that such programs help prevent "doctor-

shopping" by those seeking inappropriate access to drugs. "It's just one more tool to help control prescription opioids," says Korte.

Access to health care more broadly is another priority in the states. The Ohio Psychological Association, for example, is fighting to protect the state's Medicaid expansion, which now covers almost 630,000 of the state's most vulnerable residents, including those with substance use problems. "For many of them, it's the first time they've had coverage of any type," says Michael Ranney, the association's CEO.

At a more local level, Aaron Weiner, PhD, ABPP, is advocating for change within Linden Oaks Behavioral Health, part of Edward-Elmhurst Health, a large integrated health-care system in Illinois, where he is

director of addiction services. By tracking opioid prescriptions, he found that physicians were over-prescribing the drugs and that surgeons weren't customizing prescriptions. "I had one surgeon say, 'Whether it's a hip or a knee, a 110-pound woman or a 300-pound man, I give 160 tablets of narcotics post-operatively,'" says Weiner.

To ensure that physicians are writing prescriptions only for those who truly need opioids, Weiner worked with two dozen physicians to develop prescribing guidelines, drawing on those of the Centers for Disease Control and Prevention.

"A lot of what's going on with the epidemic right now focuses on the demand side for opioids," says Weiner. "From a health-care perspective, we need to take a hard look at the supply side." ■

CHANGING OPIOID POLICIES

HOW YOU CAN GET INVOLVED

Want to get involved in opioid-related advocacy? Scott Barstow, director of congressional affairs for APA Services Inc., recommends that psychologists:

- **Learn more** about what pain management and opioid treatment look like in your own community. Are there enough inpatient and outpatient treatment slots? Do patients have access to psychological services and the full range

of medications used for addiction treatment? Does Medicaid or private insurance cover such treatment?

- **Start calling** city council members, state legislators and other decision-makers after identifying gaps in treatment availability.

- **Contact** members of Congress to ask them to fund the programs established in last year's SUPPORT for Patients and Communities Act in this

year's appropriations bill. "Only about one in four Americans struggling with opioids gets decent treatment, and many experts believe new federal spending on the order of \$10 billion to \$20 billion per year for the next several years is needed to adequately ramp up treatment," says Barstow.

- **Act locally.** "A lot of the action is going to happen at the state level," says Barstow. State Medicaid agencies and substance use

disorder agencies will be the focus of much activity, including decision-making regarding the use of any increases in federal funding of treatment, prevention and recovery programs, Barstow predicts. Also, 14 states have yet to implement Medicaid expansion, which has increased access to opioid use treatment significantly in the states that have adopted it, he says.

For more information, visit www.apa.org/advocacy/substance-use.



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RESOURCES FOR PSYCHOLOGISTS

APA's cross-divisional resource guide offers practical advice to help psychologists respond to the opioid crisis

BY KIRSTEN WEIR

For clinicians who haven't trained in substance use disorders, it can seem overwhelming to figure out how to address the issue when it comes up with patients. In response, three APA divisions have developed a resource guide to help clinical psychologists respond to the opioid crisis. APA's "The Opioid Guide: A Resource Guide for Practicing Psychologists" was written by a cross-divisional task force of representatives from APA's Div. 12 (Society of Clinical Psychology), Div. 28 (Psychopharmacology and Substance Abuse) and Div. 50 (Society of Addiction Psychology). ¶ The guide is meant to be a practical handbook, says R. Kathryn McHugh, PhD, a psychologist

in the substance use disorders division at McLean Hospital, assistant professor of psychology at Harvard Medical School, and a co-author of the resource guide. "So many psychologists want to know, 'What do I do when...?'" she says. "We wanted to create a really practical primer to help psychologists as they work with this population."

The guide covers a lot of ground, from understanding different types of opioids and recognizing their misuse to identifying evidence-based treatments and resources for family members of those with opioid use disorder. Here are some key takeaways from the guide.

■ Recognizing overdose risk.

"Opioid use disorder is highly fatal," says Sharon Walsh, PhD, a professor of behavioral science at the University of Kentucky College of Medicine and a co-author of the guide. "People can come into care and be doing well, and just one slip can be fatal." Risk factors for overdose include decreased tolerance due to recent reductions in use, mixing drugs, a history of overdose, physical illness, using different opioids that vary in strength, switching to injecting opioids and using drugs alone. Naloxone is a medication that reverses opioid overdose. It has no abuse potential and few side effects. In some locations, a prescription is

required for the drug. Clinicians should consider formal training in the use of naloxone, and counsel family members of opioid users to get training themselves (see article on page 58).

■ **Identifying misuse.** Misuse of prescription opioids often leads to opioid use disorder. The earlier that opioid misuse is identified, the better the long-term prognosis. The guide's authors recommend that clinical psychologists ask all patients about opioid use with a simple screening question: "How many times in the past year have you used an illegal drug or a prescription medication for nonmedical reasons (for example, because of the experience or feeling it caused)?" Anyone who says they have done so even once should then be given a detailed screening to assess for problematic substance use.

■ **Evidence-based treatment programs.** Outpatient treatments that include the medications buprenorphine, methadone or naltrexone are the most effective for opioid use disorder. Behavioral treatments



At a minimum, clinical psychologists should be able to identify opioid use disorder and know where to send people for evidence-based treatment. "The Opioid Guide" can help.



such as contingency management and cognitive-behavioral therapy, used in addition to medication, may improve medication adherence and address problems not treated by medication, such as interpersonal difficulties and stress. Psychologists who identify opioid misuse should refer patients to a substance use disorder treatment specialist, who can help to determine the right level of care based on the patient's needs and the severity of the problem. Higher-quality treatment programs offer medication-assisted treatment, provide family support and are certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and accredited by the Joint Commission or the Commission

on Accreditation of Rehabilitation Facilities. The guide offers resources for locating and evaluating local providers and programs.

■ **Resources for families.**

Research shows that involving family members in treatment can be helpful for people with substance use disorders, but accessing family-based services can be a challenge. Whether or not a person with opioid use disorder seeks treatment, his or her family members can suffer greatly. Psychologists can help them manage difficulties such as guilt, anger, shame, fear, financial challenges and confusion about setting limits. Psychologists can also help family members connect with support groups.

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■ **Social support groups.** Mutual help groups may be useful for people with opioid use disorder. These groups can provide social support, reinforce recovery goals, teach skills that support recovery and provide structure and drug-free activities. However, some groups aren't welcoming to patients receiving medication-assisted therapy, since the use of the medications themselves is often stigmatized. By familiarizing themselves with support groups in their region, psychologists can help direct patients to groups that are most likely to be a good fit.

■ **Cultural competencies.**

Health-care disparities have implications for the assessment and treatment of opioid use

disorder. To address interactions among race, ethnicity, socioeconomic status, cultural context and geography, psychologists must first develop a working knowledge of possible treatment barriers among racial/ethnic minorities, with consideration of health-care system, provider and patient factors. Second, clinicians should assess patients' beliefs and expectancies regarding treatment for opioid use disorder. Finally, clinicians should deliver culturally appropriate care for opioid use disorder.

■ Misuse by adolescents.

Youth who misuse prescription opioids have a high risk

of transitioning to heroin use. The American Academy of Pediatrics recommends that all youth with a severe opioid use disorder be offered medication treatment in addition to behavioral therapy. Ideally, their families should be included in the treatment plan.

■ Managing chronic pain.

Millions of people are prescribed opioids for chronic pain. Several opioid risk assessment tools assess the risk of opioid misuse and dependence. These tools should be used with patients with chronic pain who are considering long-term opioid therapy. Nonpharmaco-

logical treatments are also recommended for people with chronic pain. The most widely studied and efficacious interventions for chronic pain include cognitive-behavioral therapy, acceptance and commitment therapy, exposure to feared movements, exercise, physical therapy and interdisciplinary rehabilitation.

■ Critical skills for clinicians.

Many clinical psychologists receive minimal training in substance use disorders, McHugh says, so it's not surprising that they may feel wary about treating people who are struggling with opioid misuse. Clinicians don't

need to be experts to make a difference, however. "It's unrealistic to think that the whole psychology workforce will specialize in this area or feel competent to offer these treatments themselves," she says.

But at a minimum, anyone working in mental health should be able to do two basic things, McHugh adds. "It's critical that people know how to identify opioid use disorder, and that they know where to send people for evidence-based treatments, if they can't manage it themselves. If we can check those two boxes, that would be a huge improvement over where we are now." ■

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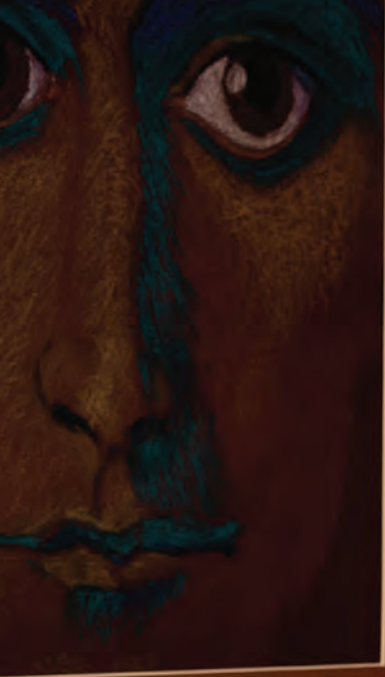


HOW ONE LAB STUDIES LOVE

PAGE 68

**A Psychologist Who Helps
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**Always On Call: Helping
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Dr. James Coan investigates the neurophysiology that underlies the link between social relationships and good health.

THE POWER OF LOVE

James Coan leads a University of Virginia lab that explores how social relationships protect us against stress and keep us healthy

BY CHRIS PALMER

A disagreement with your co-workers leaves you rattled, and on the way home you nearly have an accident. You walk into the house and realize you forgot to stop at the market to pick up dinner. As your frustration mounts, your partner comes through the door and with a hug and a few words lifts you up. You've found the strength to get through the end of a bad day.

Explaining this simple phenomenon—the power of human connection—has been a central focus of the Virginia Affective Neuroscience (VAN) Laboratory at the University of Virginia (UVA).

High-quality social relationships have long been known to reduce stress and to be associated with longer, happier and healthier lives. But the neurophysiology underlying these links has remained elusive. Over the past quarter century, James Coan, PhD, psychology professor at UVA and director of the VAN Lab, has been synthesizing and expanding upon what he's learned in the labs of world-class experts in the fields of brain plasticity, social relationships and functional brain imaging to better understand this mechanism.

"A baseline assumption your brain has is that you'll be around people and have social relationships," says VAN Lab graduate student Sara Medina-DeVilliers. "Anytime we don't have people to rely on and we're confronted with stress, our body and our brain have to use more resources to meet goals and confront various sources of stress. We're trying to figure out how that works."

One big clue has come from Coan's discovery that merely holding a loved one's hand offers protection against the stress of an impending electric shock. Coan and the members of the lab have gone on to demonstrate this hand-holding effect across a variety of social relationships, including romantic partners, close friends, and parents and their children.

Coan and the rest of the lab—including two graduate students, two undergraduate students and a lab coordinator—are now using EEG and fMRI to examine the neurophysiology of social relationships and their potential impact on health and well-being, with specific experiments directed at depression and immune system disorders such as lupus.

RESEARCH FOCI

The Virginia Affective Neuroscience Lab is exploring:

1
The power of close social relationships to mitigate stress and boost immune system health

2
The neural mechanisms that mediate these protective effects

3
The impact of early life experiences on the developing brain

"There's great power in social relationships," Coan says. "Interventions to support healthy, loving relationships have real potential to prevent and treat a wide variety of medical and psychological maladies."

Now, Coan is disseminating his findings by writing a book about his research on social relationships, hosting a podcast, and writing op-eds for *The Washington Post* and other outlets on the harm being done by the Trump administration's policy of separating children from their parents at the border. "This is something I feel very passionate about," he says.

EXTRA CREDIT

Before training with some of the leading researchers in psychology, Coan wasn't sure he would even go to college. Neither of his parents attended college, and he spent his early 20's installing and repairing roofs in his native Spokane, Washington.

But when he grew bored with that job, Coan enrolled in community college and soon transferred to the University of Washington (UW). In his first quarter there, he found himself in a class taught by cognitive psychologist Elizabeth Loftus,

PhD. At the time, in the early 1990s, Loftus was well known for her research on the misinformation effect, in which post-event information interferes with the memory of an original event, leading to inaccurate memories and in some cases even false memories of events that never took place. She would go on to provide contentious testimony in hundreds of criminal cases—including the O.J. Simpson, Ted Bundy and Oklahoma City bombing trials—about the malleability of eyewitness testimony.

As an extra-credit assignment for Loftus's course, Coan used a novel methodology of his own invention to implant false memories in his 14-year-old brother—convincing him that he had gotten lost in a shopping mall when he was 5 years old.

The research, later refined with Loftus and published in the book “Implicit Memory and Metacognition,” caused a sensation. By the summer of his first year at UW, Coan had been featured in *The New York Times* science section and *New York* magazine. “The experiment changed my life,” he says. “Everyone has imposter syndrome at some point, but I had imposter syndrome squared, because of my background. This study completely changed my whole view of myself and of what was possible.”

After graduating, Coan went to work as a lab coordinator for UW psychologist John Gottman, PhD, who ran the Newlywed Apartment Lab, which the media had dubbed the “Love Lab.”

“We brought in couples several times a week and goaded them into fighting with each other while videotaping them and recording EKG and galvanic skin response data,” Coan says. Using this data, Gottman and Coan built a model that predicted with greater than 80 percent accuracy which couples would divorce within the first five years of marriage (*Journal of Family Psychology*, Vol. 14, No. 1, 2000).

After three years running Gottman's lab, Coan entered a doctoral program at the University of Arizona with neuropsychologist John Allen, PhD. Coan and Allen demonstrated that different sides of the frontal cortex could be activated by asking subjects to make facial expressions associated with different emotions (*Psychophysiology*, Vol. 38, No. 6, 2001). Coan and Allen later found that differential activity in the right and left sides of the frontal cortex in the resting brain—referred to as frontal brain asymmetries—was associated with depression risk (*Journal of Abnormal Psychology*, Vol. 119, No. 3, 2010).

Coan's work on frontal brain asymmetries caught the attention of Richard Davidson, PhD, a psychologist at the University of Wisconsin–Madison who had been one of the first to describe the phenomenon years earlier. Davidson invited Coan and Allen to write a chapter for a volume summarizing the state of frontal brain asymmetry research. Impressed by the chapter, Davidson offered Coan a postdoctoral research position in his lab in 2003. At the time,

the lab was blossoming into one of the leading fMRI psychology labs as Davidson was just beginning a seminal collaboration with the Dalai Lama on studies of the neuroscience of meditation. “It was a very exciting time and was the start of a big change in my career,” Coan says.

LENDING A HAND

After getting up to speed on fMRI, Coan began thinking about how to deploy such a powerful tool. Inspired by the work on romantic relationships that he had done with Gottman years before, Coan designed his hand-holding study. “I only had enough money to run about 15 subjects, and I thought, ‘At the very least I better make sure that the effect is large,’” Coan says. “So, I selected a homogenous, all-white, middle-class sample of people in just absurdly happy relationships.” The effect he saw was striking—in women who held hands with their spouses there was a strong attenuation of specific brain structures that mediate behavioral threat responses, meaning that the women felt more secure with their partners. In addition, Coan found the effect varied as a function of self-reported marital quality (*Psychological Science*, Vol. 17, No. 12, 2006).

Soon after the hand-holding study was published, Coan joined the faculty at UVA and launched the VAN Lab, where he sought to replicate the study with a larger, more socioeconomically and racially diverse pool of participants. But because the UVA psychology department had no fMRI facilities, Coan had

FURTHER READING

Manufacturing False Memories Using Bits of Reality

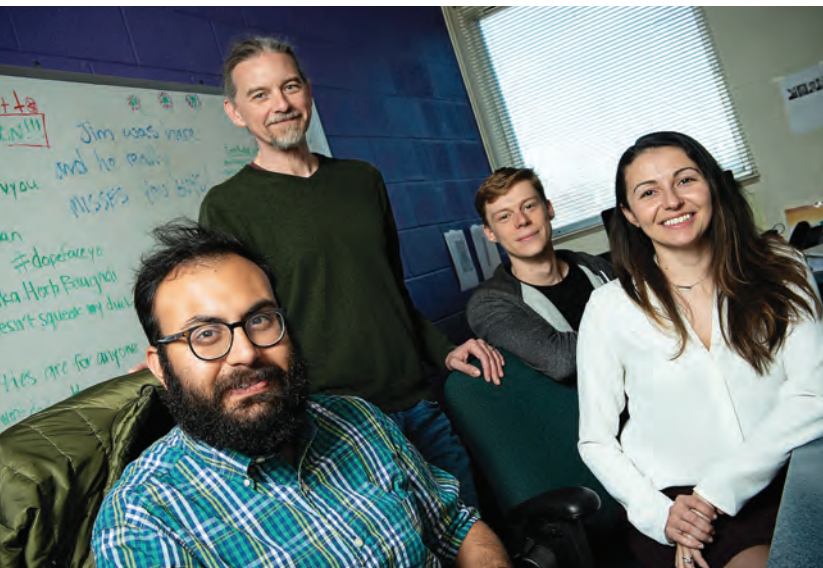
Loftus, E.F., et al.
In L. Reder (Ed.),
Implicit Memory and Metacognition,
Erlbaum, 2017

Subjective General Health and the Social Regulation of Hypothalamic Activity

Brown, C., et al.
Psychosomatic Health, 2017

Lower Neighborhood Quality in Adolescence Predicts Higher Mesolimbic Sensitivity to Reward Anticipation in Adulthood

Gonzalez, M.Z., et al.
Developmental Cognitive Neuroscience, 2016



Dr. James Coan
(second from left)
with lab members
(l-r) Nauder
Namaky, Finn
Roberts and Sara
Medina-DeVilliers.

to scrounge for time on fMRI scanners in other departments. “We have a fantastic facility and multiple faculty who do fMRI now, but at the time it was a pretty lonely situation,” Coan says. He found the hand-holding effect was just as strong in this diverse population, and his lab went on to document the effect in mother-child relationships as well (*PLOS ONE*, Vol. 7, No. 12, 2012).

A few years later, in a collaboration with Susan Johnson, the developer of emotionally focused therapy (EFT) for couples, Coan recruited 22 couples who were very unhappy in their relationships and found that hand-holding did not protect them against the threat of shock at all. But after roughly 20 weeks of EFT, a type of therapy that is strongly focused on repairing adult attachment bonds, a significant hand-holding effect emerged in those couples (*PLOS ONE*, Vol. 8, No. 11, 2013).

Coan and his students are

also using the hand-holding paradigm to explore the link between social relationships and physical health. In 2017, they showed that the degree to which their hand-holding manipulation decreased stress-related activity in the hypothalamus, as measured by fMRI, predicted subjects’ general health at a later time (*Psychosomatic Health*, Vol. 79, No. 6, 2017). “Of course, that was something that was speculated about for a long time by [psychologist] Janice Kiecolt-Glaser and others,” Coan says, referring to the proposed benefit of reducing hypothalamus activity to prevent it from dumping harmful levels of cortisol into the bloodstream. “Our study was the first time that anyone’s ever seen that happening *in vivo* in the brain.”

Perhaps influenced by his time in Davidson’s lab, Coan, with support from the Mind and Life Institute, a nonprofit organization in Charlottesville, Virginia, has begun to explore

the health benefits of the social aspects of group meditation. His team in the VAN Lab also recently secured a large grant from the Alliance for Lupus Research to use fMRI to investigate whether a popular mindfulness-based stress reduction method that emphasizes the maintenance and quality of social networks can limit the severity and frequency of lupus flare-ups.

While Coan’s previous work has shown the positive effects of receiving social support, graduate student Medina-DeVilliers’s doctoral research centers around EEG experiments with pairs of nurses and doctors exploring how giving support to the point of burnout can be harmful. Also riffing on the hand-holding paradigm was a project in which lab member Erin Maresh, PhD, now a postdoctoral researcher in Allen’s lab at the University of Arizona, showed that social anxiety and self-involvement interfere with the hand-holding effect.

Another interest of the VAN Lab is the effect of early social experiences on the developing brain. Former graduate student Marlen Gonzalez, PhD, now an assistant professor in human development at Cornell University, led an fMRI study that found people who grow up in distressed, high-crime neighborhoods tend to respond to potential rewards with increased activity in the nucleus

● **“Lab Work”** illuminates the work of psychologists in research labs. To read previous installments, go to www.apa.org/monitor/digital and search for “Lab Work.”

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Lab Work

accumbens and decreased activity in the prefrontal cortex (*Developmental Cognitive Neuroscience*, Vol. 22, No. 10, 2016). This result suggests the brains of people in this population have been shaped to seek potential resources more intensely than people who grew up with more resources.

SPEAKING UP

The media attention generated by Coan's discoveries led National Geographic television to ask him to serve as an expert on several episodes of the educational series "Brain Games" in 2014–15, in which he explained the psychology of concepts such as intuition and compassion.

Since then, Coan has branched out to other media. Since 2017, he has produced a roughly monthly podcast called "Circle of Willis," in which he interviews psychologists and other behavioral scientists studying a wide range of topics. The podcast originally grew out of his desire for a platform to discuss the replication crisis in psychology, but it quickly branched out. It took another turn last summer, when the Trump administration began separating children from their parents at the U.S. border.

Coan, shocked and wanting to do something, produced an episode of the podcast with experts who discussed what psychological research says about the effects of separating children from their parents. "It sort of went

viral," he says. "I was told members of Congress and people at the U.N. listened to it." Before long, *The Washington Post* asked Coan to write an op-ed on child separation. He went on to write more op-eds and blog posts and co-authored a lengthy amicus brief on the topic with other researchers and professional societies for the U.S. 4th Circuit Court of Appeals.

"My whole research program is about how our health and happiness depend on being embedded within trusting social networks, and there's nothing more representative of that than the relationship between a young child and their parent," he says.

Getting so deeply involved in fighting the Trump administration's child separation policies took a toll, Coan says. The stress of the situation may have contributed to his severe heart attack last September. "I was just working night after night, not taking care of myself at all," he says.

Coan has since slowed down. But he's keeping his mind on public outreach, refocusing his energy on writing a book summarizing his findings on social relationships and developing a new podcast series. "These past couple years have made me wake up to the reality that the work that I and my colleagues do really can make a difference in our social lives and our policy," Coan says. "We just have to put in the effort." ■

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GUIDING THE NEXT ERA OF ENERGY EFFICIENCY

Psychologist Jennifer Veitch works with a team of engineers, physicists and others to advance lighting and heating technology in ways that protect mental health and save energy

BY HEATHER STRINGER

Fluorescent lights that make faces look green or reflect in computer monitors may seem inconsequential, but poor illumination can affect people's moods, productivity, job satisfaction and overall well-being.

Understanding how lighting and other elements of the physical environment influence people requires the combined expertise of engineers, physicists and psychologists. These disparate disciplines have a rare opportunity to work together at the National Research Council (NRC) of Canada, the country's principal federal science and research organization in Ottawa. Jennifer Veitch, PhD, is one of three environmental psychologists among 120 other scientists in the NRC's Construction Research Centre, where she partners with researchers who seek to maximize energy efficiency in heating, lighting and ventilation while also valuing people's well-being.

Veitch's psychological knowledge is informing the development of lighting that enhances mood and saves energy by giving people more personalized control over their office environments and new options for lighting their homes.

Her work in the lab and office buildings is not only influencing building and renovation practices in Canada and internationally, but also changing the way that other scientists think.

CHANGING MINDS

One of those scientists is Chantal Arsenault, a physicist in the lighting and ventilation quality group at the NRC. "I come from a very technical, raw physics background, and I always thought that if you make the technology clever enough, people won't notice small changes in the indoor environment," she says. "But after working with Jennifer, I realized how much people detect minor environmental changes and how much they value their well-being."

When Veitch started working at the NRC 27 years ago, she sometimes encountered resistance from engineering researchers who were skeptical about results from human participant studies that included what seemed like too much variability. Scientists also worried that the requirement for approval from an ethics board for these studies would add extra administrative burdens and delays, which made such work less attractive to them.

"Engineers and psychologists do not speak the same language, but Jennifer took the time to reinforce a common language that each side could understand," says Guy Newsham, PhD, a physicist who has worked with Veitch for more than two decades. "Referring to psychology as a 'soft' science was common, but over time, we all came to realize that in fact it is often more quantitatively rigorous than what people traditionally think of as 'hard' sciences."

Now Veitch's knowledge of experimental methods, statistical analysis and ethics are well respected and even inspiring colleagues like Newsham to return to school to gain these skills.

"Often the publications in the construction field lack formal statistical analysis, and Jennifer taught me about the process of collecting data in a way that supported rigorous analysis, suitable statistical techniques and reliable conclusions," says Newsham, who completed a yearlong master's-level statistics course in the psychology department at Carleton University in Ottawa. "With this added dimension, we are in a superior position as we present research."



GREEN BUILDINGS PUT TO THE TEST

Veitch's interest in the effects of the physical environment on behavior took root when one of her undergraduate professors covered environmental psychology in an introductory psychology course.

That experience, coupled with lessons she gleaned from her father, a professor of interior

design, led her to enroll in a social ecology doctoral program at the University of California, Irvine, that offered an environmental psychology track. Her professors emphasized the importance of interdisciplinary work, and Veitch's classmates included sociologists, criminologists, urban planners and demographers, so she learned how to explain her work to

Dr. Jennifer Veitch is hopeful that the research she does as part of the team can increase the likelihood that consumers adopt more sustainable technologies.

people with different academic backgrounds. She then moved back to Canada and completed her PhD in environmental psychology at the University of Victoria, British Columbia.

Afterward, she applied for a postdoctoral fellowship in the NRC's lighting group, a role that would allow her to pursue her interest in interdisciplinary studies.

Three years later, the NRC gave her a full-time position. "The NRC hired me because the researchers saw that buildings only perform well when they support the health, well-being and activities of the occupants in addition to being structurally sound, energy-efficient and fire-safe," says Veitch.

In a series of experiments, for example, Veitch showed that people's lighting preferences vary significantly and that giving employees control over their local light levels contributes to better mood, higher environmental satisfaction, fewer physical and visual discomfort problems and higher job satisfaction. The studies also revealed that providing personalized control over local light levels can save about 10 percent in lighting energy compared with keeping light levels fixed (*Lighting Research & Technology*, Vol. 38, No. 4, 2006 and Vol. 40, No. 2, 2008).

Human behavior and energy efficiency are also intersecting as scientists explore whether green buildings—which must meet standards for energy efficiency, air quality, noise levels and multiple other factors—are beneficial not only for the environment but also for the people who work

in them. When Newsham and Veitch reviewed the literature on this topic, they discovered that there was scant research on the effects of green buildings on their occupants' behavior.

The duo teamed up with a large Canadian banking organization to study whether employees working in green buildings experienced more job satisfaction, earned higher performance reviews and showed increased commitment to the company compared with employees who worked in conventional buildings. After years of collaborating with Veitch, Newsham was well versed in carefully matching conditions. For example, he made sure to compare buildings of similar size, age and geographical location or climate, whose occupants had similar demographic profiles.

After analyzing the data, Veitch and Newsham discovered that organizational productivity indicators, including job satisfaction and employee performance evaluations, were better, on average, in green buildings (*Building Research & Information*, Vol. 46, No. 7, 2018). The green buildings could be boosting organizational productivity because the improved physical conditions—including better air quality, more comfortable temperatures and better ventilation—might lead to improved satisfaction and better conditions that support work, Veitch says. The study results provided evidence for the organizational benefits of adopting standards for greener buildings that leave a smaller carbon footprint than conventional buildings, says Newsham.

DEBUNKING LIGHTING MYTHS

Although Veitch's colleagues value her contribution to the team, the scientists have also taught her how physics, engineering and design elements interact to create the conditions that people experience. "If we want to understand people-environment relations, we need to deepen our understanding of the 'environment' side as much as the 'people' side," she says. Another reward of collaborating with physicists and engineers at NRC is the potential for immediate applications of her work to policies and standards that affect millions of people, says Veitch. That's why she's excited by a current project that could bring new lighting choices to consumers.

She's partnering with physicist Lorne Whitehead, PhD, to study "color rendering," or the ability of a light source to accurately reveal the colors of objects. "Some spectral power distributions with fluorescents make things look wrong, and people can find this quite sickening," says Whitehead, a professor at the University of British Columbia. "Some people are very sensitive to whether the environment feels normal, and if it looks abnormal, this can create a sense of worry and discomfort," he says.

Veitch and Whitehead set out to disprove the misconception that consumers had to forgo quality color rendering in favor of more energy-efficient alternatives. In one ongoing study, Veitch is testing lights designed by Whitehead that differ in the amount of light and the mix of

FURTHER READING

The Impact of Working in Green Certified Buildings on Cognitive Function and Health

MacNaughton, P., et al.
Building and Environment, 2017

The Oxford Handbook of Environmental and Conservation Psychology

Clayton, S.D. (Ed.)
Oxford University Press, 2012

How and Why to Assess Workplace Design: Facilities Management Supports Human Resources

Veitch, J.A.
Organizational Dynamics, 2018

colors they emit. The team is assessing mood and satisfaction as well as participants' ability to see well enough to complete tasks. They predict that people won't notice a small decrease in the amount of light—which means less energy consumed—but will be bothered by poor color (*Leukos*, Vol. 12, No. 1–2, 2016). "We aim to show that it is possible to have LEDs that provide high color quality while also saving energy," Veitch says.

The research could ultimately guide regulators who make decisions that affect which products are offered to consumers. Compact fluorescents—which were designed to save energy—never took off because they didn't provide the amount of light or color accuracy that people wanted and needed, explains Veitch. "So many people did not buy them in spite of financial incentives from utility companies," she says. "We hope this kind of research can change the likelihood that more sustainable technologies are adopted."

FIXING A POWER PROBLEM

While most of Veitch's work centers around participants who work in office buildings or laboratory settings, she recently applied her expertise to a collaborative project involving people at home. An electric utility company in New Brunswick, Canada, needed help solving a problem rooted in energy usage habits among their customers: In this province, the demand for electricity in the winter peaked around 7:30 a.m. when a large percentage of the local population woke up and turned



One study conducted by the team found that organizations benefit when they adopt standards for green buildings.

on lights, cranked up their thermostats and used power in other ways. While hydroelectric, nuclear, solar and wind sources could provide enough power for most electrical needs, the utility company was forced to turn to expensive fossil-fuel-based generation plants to meet the peak demand.

The company had an idea to solve the problem: installing smart thermostats in some homes to automatically pump up the heat at 5:30 a.m. and then decrease the temperature by one degree at 7:30 a.m. Ajit Pardasani, MSc, a mechanical engineer at the NRC, and Veitch partnered to study how this method to reduce the peak power demand would affect people. Together, they designed an intervention study, and Veitch created online surveys for more than 600 customers to assess whether they were feeling warm or cold at certain times and whether they had noticed any changes in their thermal comfort.

The findings from the study

revealed that people were comfortable with preheating their homes at 5:30 a.m. and then experiencing a slightly lower temperature set point for a couple of hours starting at 7:30 a.m. With the new system, the utility company could lower the peak demand for power because the heating was spread out over time.

When Pardasani and the electric utility company originally considered raising the temperature set point by more than 2 degrees Celsius—or 3.6 degrees Fahrenheit—at 5:30 a.m. to preheat the homes before the peak period, Veitch intervened. She explained that this would not pass muster in the ethics review because people might become uncomfortable.

“Jennifer’s role was crucial because this was an experiment on human beings, and I relied on her to navigate details like informed consent from the customers and designing questionnaires that would give us a good sense of how they

were feeling during the experiment,” says Pardasani.

Now the company is aiming to develop a winter season peak reduction program, which could include financial incentives in exchange for giving the company more control of the morning temperature settings. The technology could also be applied to reducing peak demands in other regions where electricity is used for heating, says Pardasani.

Before working with Veitch in the construction group, Pardasani spent many years at the NRC in manufacturing and information technology, but he had never collaborated with a psychologist. After partnering with her, he’s convinced that more psychologists should be included in engineering and physical science research. And building scientists like Newsham are starting to see other researchers drawn to this kind of collaboration.

“A lot of my colleagues see this interdisciplinary research with psychologists as the next frontier in energy efficiency,” says Newsham. Environmental scientists have historically focused on developing more energy-efficient equipment, but now they are starting to appreciate the importance of decisions people make with equipment, like whether to buy it in the first place and how to control it, he says. “The opportunity to get energy savings by influencing the behavior of individuals and organizations is growing.” ■

● **“Psychologists on the Team”** is a regular feature in which the *Monitor* explores the work of psychologists on interprofessional teams.

PSYCHOLOGICAL SUPPORT FOR FIREFIGHTERS

Houston Fire Department psychologist Jana Tran helps firefighters manage the intense stress of their jobs

BY JAMIE CHAMBERLIN

Like the firefighters she serves, Houston Fire Department psychologist Jana Tran, PhD, works whenever duty calls. As one of two psychologists in the department, Tran's main role is to serve as the mental health first responder to firefighters who may be in distress after responding to a lethal fire or a difficult 911 call, such as the death of a child. Tran meets firefighters wherever and whenever they need her—at their homes, at the hospital or fire station, or even on the scene as they are responding to a stressful event.

"The idea of a traditional clinic with office hours doesn't work with firefighters. To earn their respect, I must always be readily available," says Tran, who always keeps an extra uniform with her and drives a Houston Fire-issued emergency vehicle with lights and sirens, so she can answer calls quickly.

Tran is now in her fourth year at Houston Fire, which is one of only three fire departments in the country, along with those in Austin and Los Angeles, to have full-time psychologists on staff. The stress of firefighters' work goes far beyond battling fires: They spend about 85 percent of their time responding to emergency medical service calls that can involve suicides, abuse, shootings, car accidents and other distressing incidents that can take a toll on these men and women. Tran's research shows that many

Houston firefighters develop depression and post-traumatic stress from their work that puts them at an increased risk for suicide—a revelation that has led the city's fire department to focus more on this population's mental health.

The *Monitor* asked Tran about what it's like to work for the fire service, how she's addressing firefighters' mental health concerns and how she got her job.

What do you do for the fire department?

I am on call 24/7 along with my colleague, Dr. Sam Buser. The two main situations we respond to are firefighters in crisis, such as someone who is having suicidal thoughts, and critical incidents, the calls that firefighters respond to that are so stressful and traumatizing that they could potentially lead to post-traumatic stress disorder. For those, he and I work closely with a team of firefighters who are trained to do peer support. We meet with crews that have gone out on difficult calls, as well as offer one-on-one peer support that typically leads to a crisis assessment or a therapy referral.

I also consult daily with the department's command staff and fire chiefs who need advice on how to help a firefighter they are concerned about. Sam and I provide individual, family and couples therapy to firefighters, but we try to spend most of our time outside the therapy room. We supervise an advanced doctoral-level practicum, enabling our four trainees from the clinical and



Dr. Jana Tran is now in her fourth year at the Houston Fire Department, which is one of only three fire departments in the country, along with Austin and Los Angeles, to have full-time psychologists on staff.

counseling psychology programs at the University of Houston to provide most of the therapy services so that we can respond to emergencies and develop prevention programs. That enables us to be more visible to the other firefighters by, for example, attending academy graduations, promotion ceremonies, funerals and other important fire service events.

I also work closely with four faculty members at the University of Houston to conduct research on the mental health needs of the department.

MICHAEL BARLEY



How do you assist with a critical incident?

Typically, when I get word that a crew has been out on a difficult call, I wait until they are back at the fire station and have changed and showered and then I visit with them and work alongside the peer support team. Everyone clarifies their roles at the event and offers a short narrative on when they arrived at the scene and what happened next. When the firefighters hear others' experiences, it can be very therapeutic. A lot of what keeps people stuck after they experience

a trauma is not being able to fully process all the events, and that can lead to their questioning some of the actions they took. While the research on the use of this type of intervention is mixed, our approach is voluntary and includes robust professional oversight and individual follow-up. These meetings destigmatize asking for help, and through them, firefighters become much more willing to seek further care.

At the end, my role is to provide psychoeducation on the normal responses to stress and trauma. I tell them they

will likely have intrusive memories and disrupted sleep, and that they might be irritable with their spouse or partner. I also tell them there is no magic timeline for these symptoms to stop, but that if it has been a couple of weeks or a month or two and they still are thinking about that call, they should check in with me to see if they're OK.

What types of trauma are they experiencing?

The calls that affect firefighters the most are ones that involve kids. They often are

on the scene after children have drowned, and they see kids who have been physically or sexually abused on some of their 911 calls. They also respond to a lot of suicides; I worked with a firefighter who has seen more than 36 suicides. Deaths that involve an element of injustice or unfairness hit firefighters particularly hard, such as children who die in a motor vehicle accident. Many firefighters say that the most difficult calls involve transporting a critically injured patient who in one moment is conscious and talking with them, and then suddenly dies under their care. The natural outcome is for the firefighters to feel that as a rescuer, they have failed.

Most people don't realize firefighters also respond to shootings. They are often showing up to very dangerous scenes with no weapons or bulletproof vests, and those events can be very stressful. And then of course there's the danger of going into a fire. Firefighters also respond to natural disasters, like Hurricane Harvey. While rescuing victims all around Houston, many firefighters worried about the safety of their own families. Another type of incident that is difficult for them to process is a line-of-duty death of a fellow firefighter. Those deaths are few and far between, but they awaken the firefighters' own sense of mortality.

Our research shows that the primary concerns that firefighters can develop as a result are depression and PTSD and that these are also the highest predictors of suicide in our members.

How are you targeting those concerns?

We deliver a two-hour PTSD prevention program called Operation Lifeline to all 4,000 fire service members. The program includes a video that features some of our firefighters and health professionals describing the signs and symptoms of PTSD and discusses how they address the stigma associated with it. During that training, we speak to them about

“Deaths that involve an element of injustice or unfairness hit firefighters particularly hard, such as children who die in a motor vehicle accident.”

medication options, evidence-based treatments for PTSD and how to get connected with services. We also have a suicide prevention program called Courage in Despair; every crew learns about depression and suicide, and we have posters, magnets, brochures and other psychoeducational materials in every station that highlight the signs and symptoms of suicide and how to get help. We're currently collaborating with faculty from the University of Houston and Florida State University to develop a web-based program for suicide prevention based upon psychologist Thomas Joiner's interpersonal theory of suicide, and we've received two grants from the Criminal Justice Division of the Office of the Governor to train more peer support members and conduct another suicide and PTSD prevention program.

How did you get this job?

I was hired for my experience in trauma psychology and treating PTSD; I am trained in the gold-standard, evidence-based treatments for PTSD. I went to graduate school for counseling psychology at the University of Houston and did the majority of my practicum training at the Michael E. DeBakey VA Medical Center in Houston. That's where I fell in love with trauma work. I did rotations in the WISER program, an acute inpatient program targeting women with PTSD secondary to military sexual trauma, and the ROVER inpatient program for men with combat

trauma. I then went to the Bay Pines VA Healthcare System in Florida for internship in 2012, because they have a nationally recognized residential treatment program for military sexual trauma.

But trauma psychology hurts. It offers an amazing sense of meaning and purpose, but I also grieve with clients and have been vicariously traumatized by clients. So, once I had completed my trauma fellowship in 2014, I felt a little burnt out, and I went backpacking to Southeast Asia. My grandmother on my mother's side lives in Saigon, so I visited her and then used her home as base while I traveled alone for several months to Singapore, Thailand, Malaysia and Cambodia. It was one of the most empowering experiences I've ever had. When I came back to Houston in late 2014, I decided I would do something different from working for the VA. My mentor from the Houston VA saw the job opening for Houston Fire and told me I was the perfect person for that job. I interviewed with Sam and he offered me the job the next day.

What keeps you motivated?

One of my passions is being an advocate for female firefighters, and I am now developing a program to support them. There are only 150 women out of 4,000 firefighters in Houston—low numbers compared with the military and law enforcement. The fire service needs to do a better job of recruiting and retaining women, but the biggest hindrance to this is sexual harassment and gender discrimination. Some of the issues they face are specific to firefighting, such as having ill-fitting gear, but they also report not getting the same types of opportunities to prove themselves that men do. I don't know if I have the perfect solution yet, but I am in a position of power where I have a voice and can ask these women what they are going through and what we should do. ■



Aubuchon-Endsley



Bais



Davidson



Xiong



Hinton

PSYCHOLOGISTS IN THE NEWS

Idaho State University has presented a Distinguished Service Award to **Nicki Aubuchon-Endsley, PhD**, for her service to the university, community and the field of psychology. Aubuchon-Endsley is an assistant professor of psychology and director of the university's psychology clinic, where she has expanded access to psychological services for the local community. She has mentored students at the high school, undergraduate and graduate levels, and serves on numerous departmental and university-level committees and interdisciplinary teams.

Anjhula Mya Singh Bais, PhD, has earned a spot on the World Economic Forum's Young Global Leaders list of visionary leaders under age 40 for her public education efforts to destigmatize mental illness in Malaysia. She is the only psychologist named to the list. Born in India and now based in Kuala Lumpur, Bais specializes in trauma management and chairs the Board of Governance of Amnesty International in Malaysia.

Karina W. Davidson, PhD, has been named vice chair of the U.S. Preventive Services Task Force, an independent, volunteer panel of national experts in disease prevention and evidence-based medicine that works to improve

Americans' health by making evidence-based recommendations about preventive screenings, counseling services and medications. An expert in behavioral and cardiovascular health research, Davidson heads a new research center in Manhattan that is a part of Northwell Health's Feinstein Institutes for Medical Research and is senior vice president of research. She is also a professor of behavioral medicine at the Zucker School of Medicine at Hofstra/Northwell. She has served as a member of the task force since 2014.

The Bush Foundation has presented a \$100,000 Bush Fellow grant to psychologist **la Xiong, PhD**, of White Bear Lake, Minnesota. Bush Fellows are leaders selected for their potential to make a positive impact in their communities, from throughout Minnesota, North Dakota, South Dakota and the 23 Native American nations that share the same geography. The grants fund learning experiences over one to two years to help fellows enhance their work or build their leadership skills. Xiong will use her grant to travel to Laos to study ways of integrating traditional Hmong healing practices into modern mental health-care services in Minnesota, which has a large Hmong population.

The Association for Computing Machinery will present the 2018 Turing Award—an accolade often referred to as the Nobel Prize for computing—this month to cognitive psychologist and computer scientist **Geoffrey E. Hinton, PhD**, for his work to advance artificial intelligence technology. Hinton will share the award, which comes with a \$1 million prize from Google, with computer scientists Yann LeCun, PhD, of New York University, and Yoshua Bengio, PhD, of the University of Montreal, for their important work on deep learning and using neural networks to develop better artificial intelligence. Hinton is a computer science professor at the University of Toronto and an engineering fellow and a vice president at Google.

Georgia Southern University has presented this year's Black Heritage Award to **Johanna Workman, PsyD**, for excellence in mentorship and guidance of African-American students at the university. Workman is both the associate director and clinical services director of the university's counseling center and the creator and director of the Black Campus Forum, a weekly drop-in workshop where black students can connect and discuss their experiences at Georgia Southern. ■

ALARMING NEW DATA ON YOUNG ADULTS

Americans ages 18 to 25 report more psychological distress and depression than a decade ago

13.1%

The percentage of young adults who in 2017 said they had experienced symptoms of serious **psychological distress** in the past month—up from **7.7 percent** in 2009, according to an analysis of data from the National Survey on Drug Use and Health.

13.2%

The percentage of young adults who in 2017 reported an incidence of major **depression** in the past month—up from **8.1 percent** in 2009.

10.3%

The percentage of young adults who in 2017 reported **suicidal thoughts**, plans or attempts in the past year—up from **7 percent** in 2008. The researchers did not find the same rise in psychological distress, depression or suicidal ideation among older age groups.

Source: Twenge, J., et al. Age, Period, and Cohort Trends in Mood Disorder and Suicide-Related Outcomes in a Nationally Representative Dataset, 2005–17. *Journal of Abnormal Psychology*, 2019.



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"I'm not crazy for
feeling this way."

— Darryl

*Mental Health Advocate and Participant in
McLean's Deconstructing Stigma Campaign*



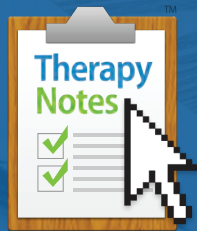
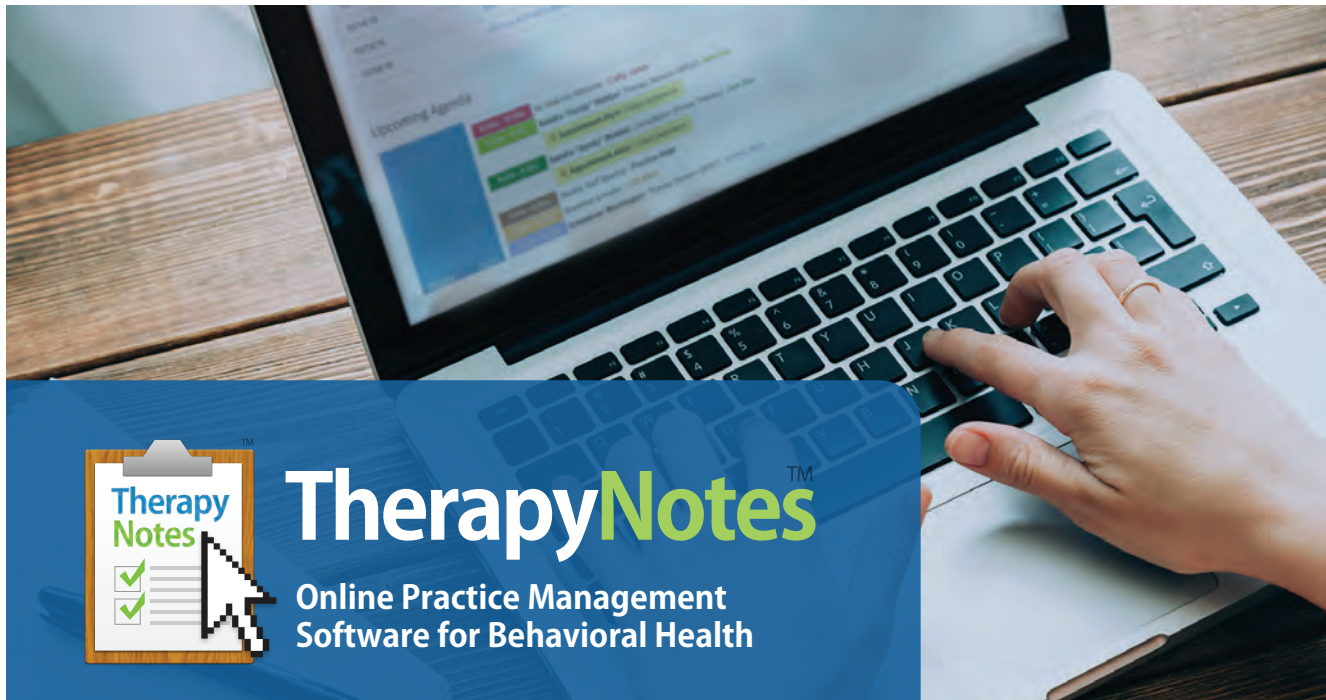
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Evaluation
Progress Note
Treatment Plan

Diagnosis: DSM-5 **anxiety**

Presenting Problem: F40.10 Social Anxiety Disorder
F41.0 Generalized Anxiety Disorder
F41.8 Other Specified Anxiety Disorder

Treatment Goals:

☒ Electronically Sign this Note

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☐ 12/9	\$75	90832

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Dr. Christina Zampitella, FT, Licensed Clinical Psychologist

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