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CONTENTS

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President Column

Donna LaPaglia, PsyD, ABPP

Greetings!

I am honored to serve as the President of the Society of Clinical Psychology (SCP). For those of you who do not know me, I am clinical psychologist and a faculty member at Yale University's School of Medicine. I came to academic medicine later in life after having worked in, and led, addiction treatment programs in the not-for-profit and the for-profit sector. My entire career has focused on the treatment of addictions and health service leadership. Addiction is a complex issue that knows no national boundaries, it does not discriminate – it cuts across race, class, and gender. It impacts individuals and the communities, and effects physical health, mental health, the health of families, and directly impacts the wellbeing of our society. My Division 12 involvement came through my membership in the Association for Psychologists in Academic Health Centers (APAHC), section 8 of division 12. Section 8 excels at mentorship, sponsorship, and leadership—and at its core it helps psychologists develop professional identities and professional self-esteem. I have benefited from the investment section 8 makes in its members and hope to carry that forward.

January—A Time of Reflection and Renewal

2023 was an extremely challenging year for so many people. The 'APA Stress in America Survey' listed global conflict, racism and racial injustice, inflation, and climate-related disasters as weighing heavy on the collective consciousness of Americans (APA Stress in America Survey; APA, 2023). As we enter a new year, the Society of Clinical Psychology (SCP) remains committed to easing human suffering through improvements in the field of clinical psychology. I believe we do our best work when we live our clinical values, open space for a multiplicity of perspectives and ideas, invite and empower our constituents' life-experience and contributions, and prepare

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the next generations psychologists for leadership. I am committed to working side by side with our membership through sections, and committees to accomplish great things—and to begin the work outlined in our strategic plan. In addition, here are my Presidential goals for the new year: 1) enhancing the SCP community with a focus on recruitment of diverse members and early career members 2) mentoring diverse and early career members for leadership positions through our leadership pipeline project, and 3), supporting the strategic mission of the society through integration of IDEAS (Inclusion, Diversity, Equity, Accessibility, and Sustainability) into the core identity and actions of SCP.

I will dedicate my year of service to carrying forth these initiatives which I see as interconnected with the health of our Division and important for invigorating the society and its work. We are about to pilot a leadership development project; led by our Education and Training committee co-chairs Allison M. LoPilato, Ph.D., Assistant Professor, Emory School of Medicine, and Misha Bogomaz, Psy.D., ABPP Director, UNF Counseling Center, in conjunction with other committees and section involvement, this project directly addresses mentorship, sponsorship, leadership identity formation, and succession planning. Stay tuned!

In addition to the above goals, I would like to see the society increase collaborations with colleagues in public health in the wake of the Covid -19 pandemic. Leveraging the collective clinical skill, insight, and acumen of our community, we have a unique and additive role to play in the development of innovative approaches to mitigate population health challenges through collaborative interprofessional work that addresses treating mental health concerns at the community level.

Looking Back…

As we begin this new year it is important to look back and carry forth the work done by our Past Presidents—we give our immense gratitude to our immediate past president-Dr. Kim Penberthy. Her drive and steadfastness to bring the Society through a strategic planning process, while also using her vast educational experience to champion a conference from the ground up with very talented committee co-chairs Drs. Lilly Brown, Assistant Professor, Perelman School of Medicine of UPenn and Richard Lebeau, Assistant Project Scientist, UCLA, and committee, have placed the Division on sound footing. And immense gratitude to Dr. Kalyani Gopal for laying the groundwork for our international agenda, and for our IDEAS implementation. In combination—these past achievements have laid a dynamic, integrated, and rich path forward. And as always, we at SCP are grateful for the exceptional skill of our executive director- Tara Craighead to help us realize our full potential. It is a full team effort at the Society for Clinical Psychology (APA Division 12)—Come join the team!

Donna LaPaglia, PsyD, ABPP

President, The Society of Clinical Psychology

Reference:

American Psychological Association. (2023, November 1). *Stress in America™ 2023: A nation grappling with psychological impacts of collective trauma* [Press release]. https://www.apa.org/news/press/releases/2023/11/psychological-impacts-collective-trauma

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The Future of Clinical Psychological Science

CONFERENCE SCHEDULE

Thursday, February 1, 2024: Pre-Conference Institutes

7:45 am – 8:45 am	**Breakfast in *Dining Room on Garden Level***
8:45 am – 9:00 am	**Welcome and Introduction – *Azalea Room*** Lucas Zullo, Ph.D. (Pre-Conference Institute Committee Chair); Kim Penberthy, Ph.D., ABPP (Immediate Past SCP President); Donna LaPaglia, Psy.D., ABPP (Current SCP President)
9:00 am – 10:30 am	**Mentor Panel – *Azalea Room***
10:30 am – 11:00 am	**Coffee with Mentors – *Oak Break Area***
11:00 am – 12:00 pm	**Institute Address 1 – *Azalea Room*** Lucas Zullo, Ph.D., Tori Knox-Rice, Ph.D.: “Navigating Self Care and Secondary Traumatic Stress When Working with Individuals at Risk for Suicide and During End-of-Life Care”
12:00 pm – 1:00 pm	**Lunch in *Dining Room on Garden Level***
1:00 pm – 2:30 pm	**Institute Address 2 – *Azalea Room*** Jennifer Wisdom, Ph.D., ABPP: “Leadership Skills for Clinical Psychologists”
2:30 pm – 4:00 pm	**Institute Address 3 – *Azalea Room*** Kristina Hallett, Ph.D., ABPP: “The Ethics of Self-Care”
4:00 pm – 4:15 pm	**Break – *Oak Break Area***
4:15 pm – 5:15 pm	**Pre-Conference CE Opportunity (Open to All Conference Registrants) – *Oak Amphitheater*** Lynn Bufka, Ph.D., ABPP: “Clinical Psychology: Changes and Opportunities”
5:30 pm – 6:30 pm	**Welcome Reception (Open to All Conference Registrants) – *Garden Overlook*** Beer and wine bar, hors d'oeuvres

Friday, February 2, 2024: Conference Day 1

7:30 am – 8:30 am	**Breakfast in *Dining Room on Garden Level***
8:30 am – 9:00 am	**Welcome – *Emory Amphitheater*** Lily A. Brown, Ph.D. (Conference Co-Chair); Richard T. LeBeau, Ph.D. (Conference Co-Chair); Kim Penberthy, Ph.D., ABPP (Immediate Past SCP President); Donna LaPaglia, Psy.D., ABPP (Current SCP President)
9:00 am – 10:00 am	**Keynote Address 1 – *Emory Amphitheater*** Michael Otto, Ph.D.: "Update on Exposure Therapy: Mediators, Moderators, and Mechanistic Science"
10:00 am – 10:15 am	**Break – *Oak Break Area***
10:15 am – 11:15 am	**Submitted Presentations Block 1** (Option 1 – Azalea Room) Advances in Approaches to Assessment and Case Conceptualization David McCord, Ph.D.: “A New Approach to Population-Level Mental Health Screening” – Azalea Room A. Jordan Wright, Ph.D., ABAP, ABPP, (President-Elect of SCP): “Integrating Culture and Context into Case Conceptualization” (Option 2 – Mountain Laurel Room) Panel Discussion: Anastasia Bullock, Psy.D. (Chair), Anastasia Bullock, Psy.D., Aimee Cruz, Psy.D., Lauren Bigham, Ph.D.: “Consultation-Liaison Psychology: Emerging Opportunities for Clinical Health Psychologists”
11:20 am - 12:20 pm	**Submitted Presentations Block 2** (Option 1 – Azalea Room) Panel Discussion: Brandon A. Gaudiano, Ph.D. (Chair), Marni E. Axelrad, Ph.D., ABPP, Lynn F. Bufka, Ph.D., ABPP, Rachel Hershenberg, Ph.D., ABPP, Michael W. Otto, Ph.D.: “Developing and Implementing APA's Clinical Practice Guidelines: What's Next?” (Option 2 – Mountain Laurel Room) Research Symposium: Sarah Meshberg-Cohen, Ph.D. (Chair), Courtney B. Worley, Ph.D., ABPP, Stefanie L. LoSavio, Ph.D., ABPP, Mary Katherine Howell, Ph.D.: “Written Exposure Therapy: Diverse Implementation Strategies for Equitable PTSD Treatment”
12:20 pm - 1:20 pm	**Lunch in *Dining Room on Garden Level***
1:20 pm - 2:20 pm	**Keynote Address 2 – *Emory Amphitheater*** Jennifer Tackett, Ph.D.: "The Future of Clinical Psychological Science is Diverse, Transparent, and Interdisciplinary"

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2:25 pm - 3:25 pm

Submitted Presentations Block 3

(Option 1 – Azalea Room) Lighting Talks on Mental Health Across the Lifespan and Ethical Considerations
1) Jacqueline Hatcher, L.C.S.W.: “Fostering Health Equity: Foster Parent Well-Being Is Essential to Foster Child Wellness” (15 min)
2) Nevita George, B.S.: “A Mixed Methods Systematic Review of Barriers and Facilitators Impacting the Utilization of Mental Health Services Among Asian American Youth” (15 min)
3) Jen Ying Zhen Ang, M.A.: “Age and Gender Effects on the Relationship between Expressive Flexibility and Wellbeing” (15 min)

(Option 2 – Mountain Laurel Room) Lightning Talks on Implementation Science and Ethics in Implementing Psychological Advances
1) Kari Eddington, Ph.D.: “Training and supervision of community health workers in a culturally adapted, empirically-based mental health intervention” (15 min)
2) Marina Weiss, Ph.D.: “From Global Strategy to Local Reality: Lessons in Implementation and Adaptation of Community-Based Mental Health Task Sharing Models to Promote Mental Health Equity” (15 min)
3) Amy Hyoeun Lee, Ph.D.: “If We Build It, Will They Come? Elucidating Caregiver-Reported Barriers to Mental Health Service Use for Asian American Youth” (15 min)

(Option 3 – Emory Amphitheater) Lightning Talks on Technology and Innovation in Psychological Science
1) Andrew Sherrill, Ph.D., and Christopher Wiese, Ph.D.: “Learning Psychotherapy with AI Teammates: Promises and Perils” (15 min)
2) Andrew Guzick, Ph.D.: “A randomized trial comparing email vs. telehealth-supported Internet-delivered cognitive behavioral therapy for autistic youth with anxiety-related disorders” (15 min)
3) Lorenzo Lorenzo-Luaces, Ph.D.: “Against innovation: The need for boring treatment research” (15 min)

3:25 pm - 4:00 pm

Poster Session and Coffee Break – *Hickory Room and Oak Break Area*

4:00 pm – 5:00 pm

Keynote 3 – *Emory Amphitheater*
Barbara Rothbaum, Ph.D. "Innovations in the Treatment of PTSD"

5:00 pm – 5:30 pm

Break – *Oak Break Area*

5:30 pm – 7:30 pm

Conference Reception – *Silverbell Pavilion*
Beer and wine bar, hors d'oeuvres, music

Saturday, February 3, 2024: Conference Day 2

7:00 am – 8:00 am

Breakfast in *Dining Room on Garden Level*

8:00 am – 8:30 am

Welcome and Awards Presentation – *Emory Amphitheater*
Lily A. Brown, Ph.D. (Conference Co-Chair); Richard T. LeBeau, Ph.D. (Conference Co-Chair); Kim Penberthy, Ph.D., ABPP (Immediate Past SCP President); Donna LaPaglia, Psy.D., ABPP (Current SCP President)

8:30 am – 9:30 am

Keynote 4 – *Emory Amphitheater*
Vonetta Dotson, Ph.D. “Advancing Brain Health Equity in an Aging and Increasingly Diverse Society”

9:30 am - 10:30 am

Submitted Presentations Block 4

(Option 1 – Azalea Room) Lightning Talks on Diversity, Equity, and Inclusion for Ethical Psychological Research and Practice
1) Nicolas Camacho, M.A., & Joseph Diehl, M.A.: “Converting Anti-Racist Principles into Sustained Action: Reflections from a Trainee-Led Movement” (15 min)
2) Laura Godfrey, B.S., and Nevita George, B.S.: “Graduate Student Perspectives: How to Support the Sustained Development of Culturally Responsive Clinicians” (15 min)
3) Sabreet Kaur Dhatt, B.S.: “Adapting Clinical Interventions for the Sikh Community: A Systematic Review of the Role of Religion and Culture in Promoting Resilience” (15 min)

(Option 2 – Mountain Laurel Room) Lightning Talks on Stress, Trauma, and Partner Violence
Danielle Shayani, B.S.: “Identifying in-session predictors of treatment outcome in IPV interventions: An examination of Fathers for Change and treatment as usual” (15 min)
1) Courtney Worley, Ph.D., ABPP, M.P.H: “Nightmares: A Universal Symptom?” (15 min)
2) Samuel Dreeben, Ph.D.: “Resilience Post-Conjugal Loss: Mindfulness and Identity” (15 min)

10:30 am - 10:45 am

Break – Oak Break Area

10:45 am - 11:45 am

Submitted Presentations Block 5

(Option 1 – Azalea Room) Research Symposium 3: Peter Hitchcock, Ph.D. (Chair), Michael Treadway, PhD & Vanessa Brown, PhD: “Translation from the Computational and Neural Decision Sciences to Improve Treatment”

(Option 2 – Mountain Laurel Room) Lightning Talks on Suicide, Depression, and Reward Processing
1) Leo Wilton, Ph.D.: “Understanding Suicide Prevention in Black Communities: The Role of Culturally Informed Systems of Care” (15 min)
2) Benjamin Rosenberg, Ph.D.: “Reward Processes in Extinction Learning and Applications to Exposure Therapy” (15 min)
3) Aliona Tsypes, Ph.D.: “Exploration/exploitation, behavioral adjustment, and suicidal behavior in borderline personality and depression” (15 min)

11:50am - 12:50 pm

Submitted Presentations Block 6

(Option 1 – Azalea Room) Panel Discussion 3: Jonathan Weinand, Ph.D. (Chair), Jonathan Weinand, Ph.D., Damion Grasso; Ph.D., Michael Otto, Ph.D., David Tolin, Ph.D.: “Defining Psychological Treatments: Regulatory, Research, and Clinical Issues”

(Option 2 – Mountain Laurel Room) Lightning Talks on Assessment and Ethical Considerations Holly Levin-Aspenson, Ph.D.: “HiTOP in Clinical Psychology Research and Practice: State of the Science and Future Directions” (15 min)
1) Andrea Bradford, Ph.D.: “Diagnostic Error in Mental Health” (15 min)
2) Millicent Phinizy, M.S., Ed.S, and Jakob Thorne, MS: “Pathologizing Poverty: A Critique of Diagnostic Practice and Treatment Accessibility in Low SES Populations” (15 min)

12:50 pm - 1:00 pm

Closing Remarks – *Azalea and Mountain Laurel Rooms*

1:00 pm - 2:00 pm

Lunch in *Dining Hall on Garden Level*

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Effects of Social and Clinical Characteristics on Alzheimer's disease stigma: A narrative review for clinicians talking with patients and families

Shana D. Stites, PsyD, MS, MA

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Introduction

Alzheimer's disease stigma refers to the negative perceptions, attitudes, emotions, and reactions related to Alzheimer's disease (Corner & Bond, 2004; Werner & Heinik, 2008). Alzheimer's stigma is a known barrier to early diagnosis, leading people to postpone seeking the care they need, and lowers the quality of life for persons living with the disease and their family members (Corner & Bond, 2004; Werner & Giveon, 2008). What drives stigma reactions? Is it the disease's symptoms, prognosis, diagnosis, or something else? The answers to these questions are clinically useful as they can aid in interpreting patient reported problems and guide clinical conversations that can improve wellbeing.

Alzheimer's disease stigma is multifaceted, pertaining to a wide range of negative consequences, such as worrying about structural discrimination, misattributing the severity of clinical symptoms, and antipathetic feelings (S. D. Stites, Milne, et al., 2018). Alzheimer's disease stigma depends on a signal, which marks a person as a potential target of negative reactions (Corrigan, 2006, 2007). According to the social-cognitive model of stigma, a signal is often a known or assumed hallmark of a disease, such as a symptom or diagnosis. The signal prompts others to apply negative stereotypes, which are cognitive frameworks that give meaning to signals. These stereotypes contribute to affective responses such as pity or fear, and behavioral reactions such as discrimination and social avoidance.

Shana D. Stites, PsyD, MS, MA

My colleagues and I are finding that there are multiple signals for Alzheimer's disease stigma. Each can lead to distinct experiences of stigma and require its own clinical conversation. Understanding what aspects of the disease experience signal higher stigma may help clinicians interpret patient symptoms and guide interventions to improve wellbeing. In this review, I describe a line of research that demonstrates how stigma varies with social and clinical characteristics. I discuss the results with attention to their implications for clinical conversations. It is essential to address stigma as it can discourage a person from seeking diagnosis, hinder a patient's quality of life, discourage participation in Alzheimer's disease research, and inhibit members of the public from adequately educating themselves (Alzheimer's Association, 2011; Alzheimer's Association & Centers for Disease Control and Prevention, 2013; Connell et al., 2001; Link et al., 1992).

General Framework for Alzheimer's Disease Stigma

As a condition, Alzheimer's disease exhibits the five interrelated components that Link and Phelan (2001) argue are important for claiming that a characteristic is stigmatized. Alzheimer's disease is a 1) human difference that 2) people associate with negative attributes such as poor hygiene and disruptiveness in social situations (S. D. Stites, Rubright, et al., 2018; Werner et al., 2010, 2011). These associations lead persons to 3) separate persons with and without Alzheimer's into "us" versus "them" categories. For instance, research into "anticipatory dementia" describes significant distress among some older adults that normal memory problems associated with aging are an indication of dementia (Cutler & Hodgson, 1996; French et al., 2012). This indicates that people make distinctions between "us"—older adults who sometimes face memory lapses—and "them"—those with a feared Alzheimer's diagnosis.

Link and Phelan's (2001) theory of stigma, modified labeling theory (Link et al., 1989), and the social-cognitive model of stigma (Corrigan, 2006, 2007) contain four assumptions that underpin the conceptual model of stigma. First, a signal, such as a diagnostic label, marks someone as a potential target of negative reactions. Second, the signal prompts others to apply negative stereotype. Third, the stereotypes evoke emotions such as pity or fear, which, lastly, can drive damaging behaviors, like discrimination, ostracism, and paternalism. Stigma can be understood as the over-attribution and misattribution of characteristics about the disease in ways that inaccurately and prejudicially impact on individuals with Alzheimer's disease. This interpretation builds from how stereotypes are understood to operate in the stigma experience (Corrigan, 2006, 2007) and from data on symptom attribution in Alzheimer's disease (Johnson et al., 2015; S. D. Stites et al., 2016; S. D. Stites, Rubright, et al., 2018). For example, due to stigma, a person with mild memory problems might be assumed to have severe memory problems. This has serious implications for all persons with Alzheimer's disease, including the newest group to be identified in research; persons with preclinical Alzheimer's disease, who have biomarkers of the disease but do not yet show symptoms. When symptoms begin to emerge, they could experience substantial stigma associated with moderate or severe stage disease.

Recently published scholarship on public stigma of Alzheimer's disease underscores its insidious nature as a cross-cultural phenomenon (Hagan & Campbell, 2021; Lee et al., 2021; Nguyen & Li, 2020; Rewerska-Juśko & Rejdak, 2020; Werner & Kim, 2021). Because stigma is influenced heavily by stereotypes, the public's expectations about how the disease affects individuals is an essential element of stigma. Mental illness, for instance, is similar to Alzheimer's disease insofar as both are expected to have cognitive, emotional, and mental impacts on individuals. Yet, stigma differs in terms of the specific qualities ascribed to these diagnoses; whereas mental illness evokes worries of danger and violence, these qualities are notably absent in Alzheimer's disease stigma (S. D. Stites, Rubright, et al., 2018).

The Changing Model of Alzheimer's Disease Care

The first goal of the U.S. National Plan to Address Alzheimer's Disease is to diagnosis persons with Alzheimer's disease before the onset of symptoms and then prevent or delay the onset of dementia (Alzheimer's Association National Plan Milestone Workgroup et al., 2014). To achieve this goal, there have been rapid advances in brain imaging and other biomarkers that can identify proteins associated with early disease in vivo and development of treatments that target those pathologies. Alzheimer's disease stigma can be a barrier to the success of this newly emerging model of care for Alzheimer's disease, which requires individuals seek diagnosis and treatment early (S. D. Stites, Milne, et al., 2018).

The emerging biomarker-based definition of Alzheimer's disease could also shift the character of the stigma associated with the disease, which could negatively affect individuals diagnosed early and their families (Ronchetto & Ronchetto, 2021; Rosin et al., 2020). This has been observed in cancer, where a preclinical diagnosis can be associated with stigma (Scherr et al., 2017) and receiving treatment for that diagnosis can also be stigmatizing (Kenen et al., 2007). Without being accompanied by disease-modifying treatment, Alzheimer's disease biomarkers convey a risk of developing debilitating cognitive and functional impairments without the ability to alter the disease course.

Jones (1984) highlights disease course as one of six underlying dimensions of stigma and defines it as the "pattern of change over time" persons associate with a condition (p. 24). Changing the course of Alzheimer's disease with new therapies that can slow the progression pathology may shift public understanding of Alzheimer's disease from a condition that is terminal to one that is chronic. This, in turn, may also alter the stigma associated with the disease. Advances in cancer research and care, for example, have transformed how the public understands some kinds of cancer. They are chronic rather than terminal conditions (Nakash et al., 2020).

Few studies have examined how stigma associated with an untreatable, terminal disease is affected by the advent of treatment (Chan et al., 2015; Dlamini et al., 2009; Mahajan et al., 2008; Treves-Kagan et al., 2016; Tsai et al., 2013). Treatment might alleviate stigma, or alternatively, negative attitudes about the disease, its causes, and the persons it affects might keep stigma societally entrenched. In HIV, studies have shown availability of treatments have changed but not ultimately eliminated stigma of that disease. One study showed that after 12 months on treatment, individuals' experiences of internalized stigma decreased by half, and they disclosed their HIV status to a significantly greater number of family members (i.e., from a median of two family members to a median of three at follow-up) (Pulerwitz et al., 2010). Another study focused on public stigma of HIV found that distribution of antiretroviral therapy in sub-Saharan Africa was associated with some features of stigma decreasing while others increased. For example, researchers found social distancing of persons living with HIV decreased after a treatment was available, but anticipated stigma due to increased social contact was heightened (Chan & Tsai, 2016).

The emerging model of prevention in Alzheimer's disease has raised a question about the contribution of clinical symptoms to stigma. Clinical symptoms have previously been considered an inherent and immutable part of Alzheimer's disease and the stigma that can accompany it. In the newly emerging model of care, optimally, Alzheimer's disease pathology will be identified prior to a person experiencing symptoms and then disease-modifying therapies will slow the progression of that pathology. The goal of the approach is to substantially delay onset of symptoms. Thus, it becomes vital to understand how stigma may affect individuals when clinical symptoms emerge; anticipatory worry about the onset of symptoms and the experience of symptoms could undercut the effectiveness of disease-modifying therapies.

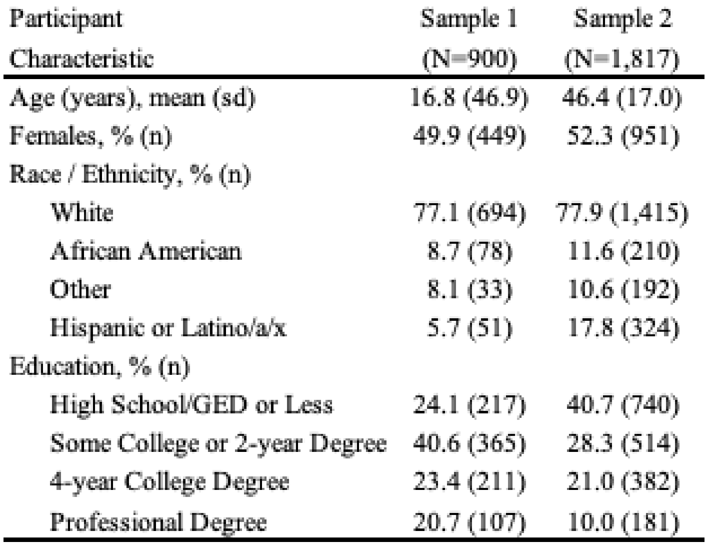
Studies of Public Stigma of Alzheimer's Disease

My colleagues and I have been conducting a line of research to understand the stigma of Alzheimer's disease and how advances in biomarker diagnosis and disease-modifying treatment may affect that stigma. To date, we have conducted multiple studies in one of two research samples.

Data collection for the first sample occurred between September 5, 2013 and September 13, 2013. The response rate was 57.4%. The completion rate was 87.3%. The sample had slightly higher educational attainment than the U.S. population, and likely undercounted participants who consider themselves Hispanic (Table 1). In this study, we used a vignette-based experiment that described a person seeking care for memory problems. We varied the person's diagnosis across three conditions: Alzheimer's disease, traumatic brain injury, and no diagnosis and prognosis across three conditions: improve, worsen, stay the same (Johnson et al., 2015).

Table 1.

Characteristics of Samples of General Adult Public



Participant Characteristic	Sample 1 (N=900)	Sample 2 (N=1,817)
Age (years), mean (sd)	16.8 (46.9)	46.4 (17.0)
Females, % (n)	49.9 (449)	52.3 (951)
Race / Ethnicity, % (n)		
White	77.1 (694)	77.9 (1,415)
African American	8.7 (78)	11.6 (210)
Other	8.1 (33)	10.6 (192)
Hispanic or Latino/a/x	5.7 (51)	17.8 (324)
Education, % (n)		
High School/GED or Less	24.1 (217)	40.7 (740)
Some College or 2-year Degree	40.6 (365)	28.3 (514)
4-year College Degree	23.4 (211)	21.0 (382)
Professional Degree	20.7 (107)	10.0 (181)

Note. Column percentages may not total 100 due to rounding. *sd* = standard deviation. n = frequency. GED = General Education Diploma.

Data collection for the second sample occurred between June 11 and July 3, 2019. The study flow from invitation through analysis is shown in Figure 1 in Stites et al. 2022. The response rate was 63%. The completion rate was 96%. Prior to randomization, participants were asked to complete a comprehension item. Participants read a paragraph about Alzheimer's biomarker testing and then answered a fact-based question. They were given two opportunities to answer correctly. Participants who failed the second attempt were excluded (n=272).

In this study sample, rather than diagnosis, we varied the fictional person's biomarker test result between positive and negative (S. D. Stites et al., 2022). We also varied clinical symptom stage across three levels defined by Clinical Dementia Rating (CDR) score of no symptoms (CDR 0), mild stage symptoms (CDR 1) and moderate stage symptoms (CDR 2), and treatment availability versus unavailability.

In the sample of 1,817, the mean age was 46 years (95% CI, 46 to 47), which is two years younger than the mean of the U.S. adult population. About half of participants were female (52.3% [95%CI, 50.0 to 54.6]), most self-identified as White (77.9% [95%CI, 75.9 to 79.7]), and most had beyond a high school education (59.3% [95%CI, 57.0 to 61.5]). These percentages are similar to the U.S. adult population (all p>0.05). All demographics were balanced across study conditions. In addition to the base sample, we also collected oversamples of individuals who identified as being 65 years of age or older and those who identified as African American or Black.

In both samples, participants completed the Family Stigma of Alzheimer's disease scale (FS-ADS), a validated scale that measures Alzheimer's disease stigma across a range of cognitive, emotional, and behavioral attributions (Werner et al., 2011a). Items on the original assessment were adapted for relevance to the vignettes (Johnson et al., 2015).

The modified FS-ADS is comprised of 41 items that load onto seven empirically derived domains. Items assessed the extent to which the participant believed that the person described in the vignette: (a) should worry about encountering discrimination by insurance companies or employers and being excluded from voting or medical decision making (Structural Discrimination); (b) would be expected to have certain symptoms like speaking repetitively or suffering incontinence (Negative Severity Attributions); (c) should be expected to have poor hygiene, neglected self-care, and appear in other ways that provoke negative judgments (Negative Aesthetic Attributions); (d) evoked feelings of disgust or repulsion (Antipathy); (e) would evoke feelings of concern, compassion, or willingness to help from others (Support); (f) would evoke feelings of sympathy, sadness, or pity from others (Pity); and (g) would be ignored or have social relationships limited by others (Social Distance). Responses were recorded on a 5-point Likert scale arranged on the screen horizontally from left to right, and analyzed by domain using established methods (Johnson et al., 2015), with higher scores indicating higher stigma.

Participants in both samples were asked "Do you, or have you, considered yourself the primary caregiver of a person with Alzheimer's?" They selected "yes" or "no". No definition of "primary caregiver" was provided. We focus on self-identification as it demarcates individuals who view that being an Alzheimer's disease caregiver is an aspect of their personal identity.

Features of the Emerging Alzheimer's Disease Model of Care

The model of care for Alzheimer's disease is changing (Sperling et al., 2014; S. D. Stites, Milne, et al., 2018). In 1906, Alzheimer's was first characterized based on a clinical symptoms (Yang et al., 2016). Today, Alzheimer's disease is moving toward a model of secondary prevention, where it is identified via imaging and fluid biomarkers and then treated. Caring for patients' psychological wellbeing in this model will be essential to reduce barriers to early diagnosis, assure treatment adherence, and optimize individuals' wellbeing.

Memory Center Setting

A new patient visit at a memory center is a key entry point into the healthcare system for early Alzheimer's disease diagnosis. Stigma is a barrier to accessing Alzheimer's disease care, including at a memory center. Stigma may differentially affect individuals who are at risk for experiencing disparities in accessing clinical care (Chin et al., 2011; Hatzenbuehler et al., 2013; Lines et al., 2014). To assess this, we compared reactions between self-identified Black (n=1,055) and White (n=1,451) adults who were randomized to a vignette of a fictional patient at a memory center (S. D. Stites et al., 2023). We found Black participants reported higher stigma than White participants on four of seven FS-ADS domains in multivariable models that adjusted for group differences in age, gender, Hispanic ethnicity, and educational attainment (S. D. Stites et al., 2023).

Black participants endorsed higher scores on Structural Discrimination (odds ratio (OR), 1.43, 95%CI 1.22 to 1.67), Negative Severity Attributions (OR, 2.00, 95%CI 1.70 to 2.33), Support (OR, 1.55, 95%CI 1.32 to 1.81), and Pity (OR, 1.48, 95%CI 1.35 to 1.85). Interventions may be needed outside memory centers to aid Black older adults and their family members in seeking out care they may need. In addition, our findings point to specific topics of concern such as worries about discrimination and over attribution or misattribution of symptoms. Opportunities to discuss these issues and identify support networks may help individuals in developing the resources needed to support a decision to seek professional care.

Alzheimer's Disease Diagnosis

In the sample of 900 U.S. adults, we found that prognosis, not diagnosis, caused higher stigma across all seven domains of the FS-ADS (Johnson et al., 2015). Yet, in the sample of 1,817 U.S. adults we found that a positive biomarker test result evoked stronger reactions on all but one FS-ADS domain (Negative Aesthetic Attributions) compared to a negative biomarker result (all $p<0.001$). The results of these studies are perplexing; why would a biomarker test result affect stigma but a diagnosis would not?

We hypothesize that the contradictory findings may be due to confidence in the biological etiology of the condition. We found in our studies that a positive biomarker result heightens stigma, it also increases confidence in a diagnosis (S. D. Stites et al., 2022, 2023). This is consistent with extant literature that shows attribution of a disease as being physical or biological has been shown to be associated with higher stigma (Weiner et al., 1988).

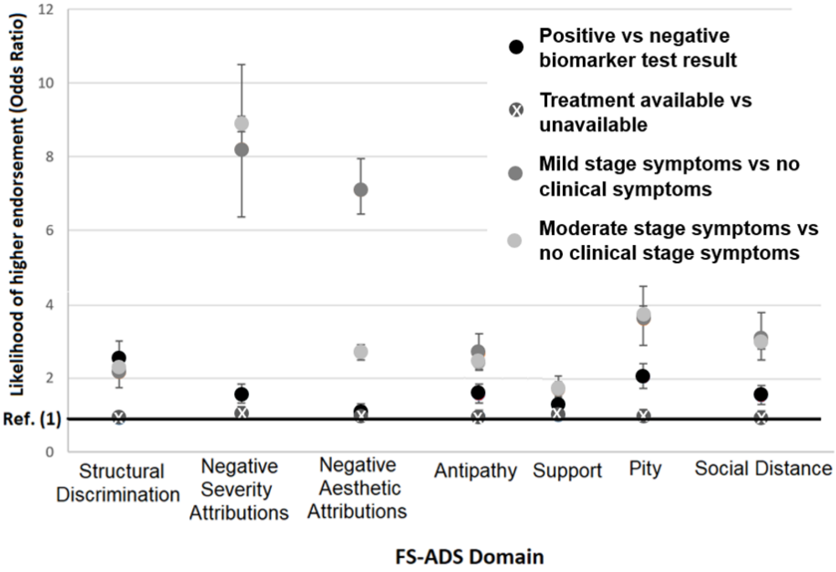
Our findings emphasize the need to talk with patients and their family members about a diagnosis of Alzheimer's disease and related testing in order to understand the meaning that individuals place on the information. Interpretation of Alzheimer's disease test results can be complicated, particularly for individuals who identify with sociocultural groups underrepresented in the research that develops those tests (S. Stites D. et al., 2022). While referral to experts in diagnosis and biomarker testing may be prudent, it is also worth considering whether individuals and their families may benefit from clinical conversations with psychologists that can lend support to identifying salient worries, questions, and cognitive errors.

It may be useful in these conversations to be attentive that stigma has both beneficial and negative consequences. Depictions of Alzheimer's disease that promote ageism, gerontophobia, and negative emotions (Joyce, 1994; Kirkman, 2006; Van Gorp et al., 2012; Van Gorp & Vercruysse, 2012) heighten stigma by emphasizing negative aspects of the condition (Van Gorp & Vercruysse, 2012). Simultaneously, they evoke attention-grabbing negative emotions that can be effective for motivating certain behaviors– like making financial donations (Van Gorp & Vercruysse, 2012) and risk reduction behaviors (Kessler et al., 2012).

Clinical Symptom Stage

In randomized comparisons we tested whether Alzheimer's disease stigma differed by clinical symptom stage: no clinical symptoms versus each mild stage symptoms and moderate stage symptoms. We found that participants in the condition describing mild stage symptoms worried about Structural Discrimination (OR, 2.3 [95%CI, 1.9 to 2.8]) and endorsed greater expectations of Social Distance (OR, 3.0 [95%CI, 2.4 to 3.7]) as compared to the condition depicting no clinical symptoms. More participants in the condition with mild stage dementia endorsed harsher judgements of symptoms (OR, 9.7 [95%CI, 7.7 to 12.2]), harsher aesthetic judgements (OR, 2.7 [95%CI, 2.0 to 3.5]), more Antipathy (OR, 2.6 [95%CI, 2.0 to 3.0]), more support (OR, 1.7 [95%CI, 1.4 to 2.1]), and more Pity (OR, 3.9 [95%CI, 3.2 to 4.8]) compared with the condition depicting no clinical symptoms.

Figure 1.
Results of Comparisons of Biomarker Test Result (Positive vs Negative), Treatment (Available vs Unavailable), and Clinical Symptom Stage (None vs each Mild and Moderate Stages) (N=1,817)



Note. FS-ADS = Family Stigma of Alzheimer's Disease Scale. Vertical error bars = 95% Confidence Interval

We found that comparisons of the condition with moderate stage symptoms to the condition depicting no clinical symptoms showed similar results. In other words, clinical symptoms – be those indicative of mild or moderate stage dementia – lead to similarly elevated levels of stigma (Figure 1). Our findings have a major implication for clinicians talking with patients and families.

While clinicians may differentiate stages of clinical symptoms, adults in the public appear to discern only between the presence versus absence of symptoms. This suggests rigid, black and white thinking that could benefit from education, interrogation, and mindfulness (Bacsu et al., 2022; Corrigan et al., 2012; World Health Organization & Alzheimer's Disease International, 2012). Intervention could help people identify functioning that they otherwise might overlook and challenge paternalizing beliefs that can lower wellbeing.

Availability of Disease-Modifying Treatments

Given that prognosis drives higher stigma reactions (Johnson et al., 2015), we designed a study to test whether availability of a treatment that slowed progression and thus altered the prognosis of the disease would mitigate stigma. In a sample of 1,817 adults, we randomized them to receive a vignette describing that either a disease modifying treatment was available or unavailable (S. D. Stites et al., 2022). We found that the availability of a treatment that would slow progression of the disease had no measurable influence on any of the seven domains of stigma on the FS-ADS (all p>0.05).

The lack of effect of disease-modifying therapies on Alzheimer's disease stigma was an initially unexpected and disappointing finding. If availability of a disease-modifying treatment cannot alleviate disease stigma, what opportunities are there for anti-stigma interventions? To date, anti-stigma campaigns show mixed effects (Angermeyer et al., 2011; Hanisch et al., 2016; Schomerus et al., 2012; Walsh & Foster, 2021), and better options are needed to mitigate the negative effects of Alzheimer's disease stigma.

Our findings about clinical symptoms (described in the prior section) might offer a clue to what would effectively reduce Alzheimer's disease stigma. Those findings suggest clinical symptoms are the most substantive contributor to Alzheimer's disease stigma (Figure 1) (S. D. Stites et al., 2022). If a treatment could not only slow disease progression but could prevent symptoms, it may aid in lowering stigma.

Findings from our studies also show memory problems are the most salient symptom among those contributing to Alzheimer's disease stigma (S. D. Stites, Rubright, et al., 2018); about three-quarters of participants (N=317) expected that a person with mild stage Alzheimer's disease dementia would not remember most recent events (73.8%, 95%CI 65.8 to 82.7). These problems and other clinical symptoms we found to be driving Alzheimer's stigma might be accurate in later stages of disease but are misattributions in early stages.

Moreover, among the top five most frequently reported aspects of stigma, four did not relate to clinical symptoms but rather related to worries about Structural Discrimination (S. D. Stites, Rubright, et al., 2018). Over half of participants expected a person with Alzheimer's disease dementia (that is, they show symptoms) would be discriminated against by employers (55.3%, 95%CI 47.0 to 65.2) and would be excluded from medical decision-making (55.3%, 95%CI 46.9 to 65.4). Similarly, high percentages expected the person would have his healthcare insurance limited due to data in the medical record (46.6%, 95%CI 38.0 to 57.2) or have his healthcare insurance limited due to a brain imaging result (45.6%, 95%CI 37.0 to 56.3).

Clinical conversations that encourage patients and family members to critically evaluate current functioning, without catastrophizing worries about problems that might arise later in the disease course, and challenge their fears about the disease may help give wellbeing back to patients living with Alzheimer's disease and their families. There are also other ways that clinicians can help patients reduce stigma through clinical conversations (S. D. Stites & Karlawish, 2018).

Alzheimer's Disease Caregiving

As a result of caring for a person with dementia, caregivers of persons with Alzheimer's disease may have distinct experiences with Alzheimer's stigma, whereby they witness individuals with Alzheimer's disease being discriminated against and socially mistreated. They may also experience stigma first-hand given their close association with a person living with Alzheimer's disease – called spillover stigma. To understand how caregivers' experiences might differ from others without these experiences, we conducted a study to compare self-identified caregivers (n=82) and non-caregivers' (n=828) expectations of public stigma experienced by persons living with dementia (S. D. Stites et al., 2021).

We found 9% (n=82) of participants self-identified as a current or former primary caregiver of a person with Alzheimer's disease, which is about the same as the national estimate of informal caregivers (8.8%). Compared to individuals without this experience, caregivers were more likely to report stronger reactions on all seven domains of the FS-ADS (all $p<0.05$). Their reactions were attenuated by AD knowledge and being female.

The finding that caregivers reported higher stigma is counter intuitive and raise doubts about current anti-stigma efforts. Common approaches to reducing Alzheimer's disease stigma, including close interpersonal contact and disease-oriented health education (Batsch & Mittelman, 2012; Goldman & Trommer, 2019; Harris & Caporella, 2014; Kim et al., 2019, 2021; Matsumoto et al., 2023; Tan et al., 2021), are grounded in the idea that greater familiarity with the stigmatized condition reduces the likelihood of stigmatizing individuals with that condition. Caregivers of persons with Alzheimer's disease are likely to have frequent face-to-face contact and higher than typical disease-oriented knowledge (Garcia-Ribas et al., 2020; Werner & Hess, 2016; World Health Organization & Alzheimer's Disease International, 2012).

Our findings underscore the importance of addressing Alzheimer's disease stigma with both individuals living with direct experience of the disease and their family members. The two-pronged approach is needed in order to address wellbeing in both groups. Addressing Alzheimer's stigma among caregivers is also needed specifically to mitigate harms that might be incurred by the cyclical effects of stigma transferring back and forth in the dyad of patients and caregivers, potentially with compounding ill effects.

Conclusion

Alzheimer's disease stigma affects millions of older adults and their families. It is essential for all clinicians, particularly psychologists, to understand Alzheimer's disease stigma and how it varies with lived experiences and clinical characteristics. The information can identify threats to patient and family wellbeing and guide clinical discussions, which may help individuals access care for Alzheimer's disease sooner and address social, psychological and physical threats to wellbeing. This review summarizes findings from a line of research that demonstrates how stigma varies with the emerging model of Alzheimer's disease prevention, and discusses the implications of the findings on clinical interactions aimed at addressing patient and family wellbeing.

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Winter 2024 Diversity Spotlight

Interviewee: Nadine A. Chang, PhD

Interviewer: Esther Lapite, M.A.

The current spotlight is centered on the contributions of Dr. Nadine A. Chang., a licensed clinical psychologist and advocate for Asian American mental health in the state of New York. Dr. Chang earned her B.A. in psychology at New York University, as well as her Ph.D. in clinical and school psychology at Hofstra University. As part of her graduate training, Dr. Chang completed her pre-doctoral internship at St. Barnabas Hospital in the Bronx, and a postdoctoral fellowship at the University of Pennsylvania School of Medicine. Following the acquisition of her doctoral degree, Dr. Chang dedicated herself to the pursuit of research, clinical work, and training.

Dr. Chang's primary research interests are centered around the implementation and dissemination of cognitive-behavioral interventions for suicide prevention, psychosis, and other severe and persistent mental illnesses, as well as Asian American mental health. To date, Dr. Chang has assisted in the publication of six published articles on these topic areas. These interests were fostered early in her career, as Dr. Chang was able to work alongside Dr. Aaron Beck during her postdoctoral fellowship and was a recipient of the NIH National Research Service Award for their work. Dr. Chang was later a recipient of a grant from the New York Community Trust, to fund research and outreach efforts to support Asian communities in NYC. In addition to being a scholar and a community activist, Dr. Chang is recognized as a competent clinician worthy of several esteemed positions.

Previously, Dr. Chang served as an attending psychologist at Mount Sinai Morningside and Mount Sinai West and later acquired the position of director for the Comprehensive Assessment Center. Currently, Dr. Chang holds a position as an Assistant Professor of Psychology in Clinical Psychiatry at Weill Cornell Medicine, as well as a role as an Assistant Attending Psychologist at NewYork-Presbyterian Hospital. In addition to these faculty appointments, Dr. Chang also serves as the senior psychologist and psychology training director at the inpatient psychiatric hospital, Gracie Square Hospital, and is chair of the Asian Psychiatry Program Committee. Dr. Chang's efforts mentioned thus far have demonstrated her commitments to addressing mental health issues at the individual, organizational, and systemic level. In light of these outstanding contributions, I received the honor of interviewing Dr. Chang with the following 4 questions. Her responses are indicated below:

Nadine A. Chang, PhD

1) What drove you to your current niche/specialty on cognitive-behavioral interventions, suicide prevention, SMI, and Asian American mental health? How would you encourage other students to find their niche/specialty areas?

The progression of my career has been atypical. I started as a research assistant as an undergrad, in a very different area of psychology. While I enjoyed the research process, the subject matter didn't captivate me. Seeking a change for my senior year of college, I joined Dr. Mark Serper's schizophrenia research lab at Bellevue Hospital Center, the oldest hospital in the country with a large psychiatry department. Schizophrenia had become my main areas of interest after volunteering at a Brooklyn day treatment program for serious mental illness. I ended up staying at Dr. Serper's lab at Bellevue for nine years, spanning undergrad through graduate school, conducting cognitive assessments and symptom ratings with inpatients with schizophrenia and comorbid substance use. My dissertation centered on Chinese inpatients with schizophrenia, investigating cultural aspects that factor into symptom presentation.

Bellevue Hospital's Asian American psychiatric unit allowed me to collect data for my dissertation, fueling my ongoing interest in serious mental illness and psychosis, particularly within the Asian American community. Post-doctorate, I joined a suicide research lab at the New York State Psychiatric Institute, gaining expertise in suicide assessment and treatments. I integrated my experiences in schizophrenia research, cultural considerations, and suicide assessment, shaping my current position. This journey reflects a transition from a broad research interest to a nuanced exploration of mental health intersections.

For students who are just starting out, finding mentors is crucial. Even if they don't align exactly with your specific niche, having mentors related to your interests is valuable. I was fortunate to have mentors who supported my interests in schizophrenia and Asian American mental health, and advocated on my behalf when it came to positions related to this topic. Additionally, I would also recommend having a community or team around you. You do not have to carry everything on your own. With a team and community of people to lean into, you can help cultivate interests, projects, and interests in ways that you could not have leveraged on your own. With a team, you are also able to cultivate a larger impact in your niche areas of interest.

2) How were you able to collaborate with the father of cognitive therapy and cognitive behavioral therapy, Dr. Aaron Beck? What lessons did you learn from your experience and what advice would you offer to students who aspire to work alongside such notable figures in the field?

I was fortunate and the timing aligned perfectly. When I spotted an opportunity for a postdoctoral fellowship focusing on schizophrenia with the chance to be a project director, it felt ideal. Having managed my graduate school research lab for years, I had the necessary skills, including assessment expertise. It was a great fit.

A colleague had seen the fellowship posting and forwarded it to me, knowing my research interests. Admittedly, many people applied for that position given it was with Dr. Beck. Fortunately, I had connections with individuals who had collaborated with him before, which worked in my favor, so networking played a significant role. Contacting leaders in the field can be quite beneficial and is something I recommend. We psychologists form a community, and I truly value our support for one another, such as sharing relevant opportunities like this with colleagues.

While I was lucky with the timing, I am grateful for everyone who contributed to me earning the position. Learning CBT for psychosis from Dr. Beck was invaluable. He supported my interest in inpatient work, granting me the opportunity to lead a pilot project at a local hospital. As a mentor, he encouraged creativity, a principle I uphold in my own training program. This experience also led me to other avenues and upward towards the positions I hold today.

For students who have similar aspirations, I want to further highlight the importance of networking and mentorship. Letting others know your interests, and not being afraid to contact leaders in the field, can help you cultivate a community-oriented journey for yourself.

3) Which of your accomplishments are you most proud of?

As you progress in your career, it changes over time. When I was a graduate student, when I had an article or book chapter published, that was the most amazing thing ever. When I was heading for a postdoc and was hired by Dr. Beck, that was the most amazing thing ever. When I received a grant to fund mental health outreach for Asian American communities a few years ago, that was also a definite highlight.

I think now at this point in my career, what I find most rewarding is training future generations of psychologists. This passion was formed during my postdoctoral fellowship where I was training and supervising research assistants on psychological and risk assessments, and training inpatient hospital staff on cognitive behavioral interventions. This experience has carried forward for me, as I now direct the psychology training program at Gracie Square Hospital. This experience has been incredibly rewarding, especially when supervising trainees who have never worked with people with serious mental illness or psychosis. It's a great feeling as well to introduce them to a field that I really love and to have the opportunity to be creative together with interventions and assessments. The ability to create an impact on them so early in their careers is the most rewarding part of all.

4) You have served as a researcher, professor, clinician, director, etc. What comes next for Dr. Chang?

That's always the question, what's next? Just recently, I became the director of the psychology service at our hospital. One of our goals is to continue to expand our clinical and academic services and collaborate with other hospital sites in doing so. We are affiliated with larger hospital systems, NewYork–Presbyterian and Weill Cornell Medicine, and our goal is to become more integrated and advance psychology services across the system.

I am thankful to be in this position as it has provided me with a lot of administrative and interdisciplinary support, all of which have allowed me to advocate well for our field of psychology as well as Asian American communities. It has been a lot of hard work and effort, but I am very grateful for these opportunities and the successes we have achieved.

In recognizing my journey that led to this position, there is an additional message I would like students to take away from this interview. When I first started my career, I was so certain that I was going to be in academia and never had a second thought about that. However, halfway through that journey, I experienced multiple shifts that have led me to become the training director and clinician that I am now. I make a point to acknowledge this with my trainees that one's career path does not have to be linear. Additionally, I also make it clear to my trainees that they don't have to make the decision about the remainder of their careers right now. They can always change paths and should welcome the opportunity for natural change to occur. After all, that is what happened to me.

Written by Esther Lapite, MA

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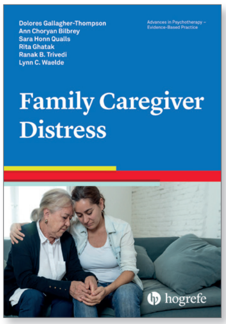

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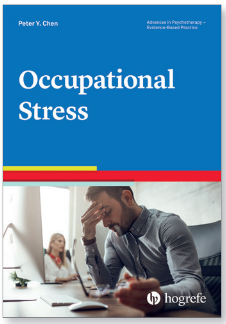

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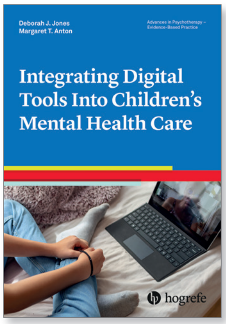

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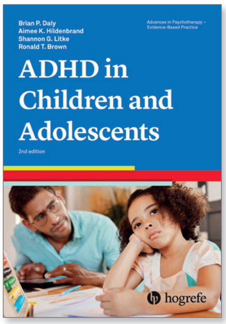

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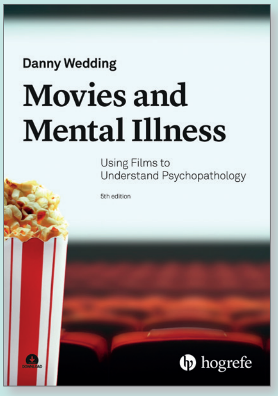

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