IMPLICIT BIAS AGAINST PEOPLE WITH SUBSTANCE USE DISORDER AMONG TRAINEES IN COUNSELING PSYCHOLOGY

by

STEPHANIE M. SHIFFLER

(Under the Direction of Brian Glaser)

ABSTRACT

Individuals with substance use disorder (SUD) face marginalization due to the historical othering of those who use substances. Despite the fact that SUD is a pervasive public health concern, gaps in mental health training and the perception of SUD treatment as specialized have contributed to this population being underserved (Martin et al., 2016). The present study was an adaptation of a study on language and stigma by Ashford, Brown, and Curtis (2018) and sought to explore the magnitude of negative automatic attitudes among trainees in counseling psychology towards stigmatizing terminology used to refer to individuals with SUD and to compare these to attitudes towards more progressive, humanizing terminology. The current study also collected information from trainees about clinical and educational experiences related to SUD. Results indicated the presence of negative automatic attitudes towards the "addict" category but not towards the "person with SUD" category. Significant differences were detected between the differences in attitudes across these categories.

Keywords: substance use disorder, language, stigma, bias, counseling psychology, training

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DEDICATION

This dissertation is dedicated to my partner, Owen, and my family and friends, whose love, support, and encouragement made the project possible. It is also dedicated to the memory of my cousin, John R. Shiffler, whose life may not have had to end if better resources for substance use disorder were available. May our field do better for this population going forward.

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I want to acknowledge the support I received from my colleagues and mentors throughout this process. I am especially grateful for the guidance of Dr. Brian Glaser, Dr. Edward Delgado-Romero, and Dr. Linda Campbell for encouraging me to pursue this project.

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CHAPTER 1

Introduction

The current state of the field of substance use disorder treatment is lacking at its best and systematically traumatizing at worst. This population is tragically underserved, with a minority of those afflicted receiving treatment (Hedden, 2015). Standard treatment for SUD involves the removal of the individual from their environment into a detox or rehabilitation center where their admittance is conditional upon their complete abstinence from psychotropic substances (Hedden, 2015). The requirement of abstinence for eligibility to participate in these recovery programs shuts out the majority of those dealing with a problematic relationship to a substance, while an inability to independently stop using is the defining diagnostic criteria for the disorder. What other system of treatment turns away an individual for displaying the very symptom that characterizes the disorder? This is just one instance of the ways in which clinical judgment is compromised in psychologists' attempts to case-conceptualize these clients.

Statement of the Problem

Despite the high comorbidity rate between substance use disorders and other psychological disorders, relatively few training programs in psychology prepare their students to work with presenting concerns relating to substance use and misuse (Martin, Burrow-Sanchez, Iwamoto, Glodden-Tracey, & Vaughn, 2016). Students often have to seek coursework on treating substance use disorders outside of their respective departments if it is not provided within and even if it is provided within, these courses are often optional (Martin et al., 2016). The reason behind the relative absence of psychologists in this field has yet to be known,

although a substantial body of literature has documented the existence of bias towards individuals with SUD in the general population as well as in the field of mental health treatment (Barry, McGinty, Pescosolido, & Goldman, 2014; Corrigan, Kuwabara, & O'Shaughnessy, 2009; van Boekel, Brouwers, van Weeghel, & Garretsen, 2015). Recent inquiry into implicit bias regarding certain recovery terminology found that individuals in the field demonstrated *more* bias than those who did not work in the field, which the authors explain is disconcerting; one would assume there would be more empathy and less bias among that group (Ashford, Brown, & Curtis, 2018).

The prevailing doctrine with regard to treatment of SUD has been that sobriety must first be obtained before meaningful therapeutic work can begin (Tatarsky, 2007). This set of assumptions effectively excludes a crucial subset of the population of those with SUD who want to change but are not yet prepared to stop using. The hypocrisy of these policies lies in that fact that for the majority of other presenting concerns, there exists no behavioral prerequisite to treatment; rather, treatment is typically the precursor to meaningful behavior change. Psychologists are effectively turning people away from treatment due to the nature of their presenting concern, which is in direct conflict with the ethical duty to serve those in need.

Due to the history of substance use being seen as either a moral flaw or progressive brain disease, misconceptions abound in the field of SUD treatment (Nathan, Conrad, & Skinstad, 2016). Despite a growing body of evidence supporting harm reduction interventions, the information provided on the website for the National Institute of Drug Abuse asserts that abstinence is a mandatory prerequisite for the initiation of treatment (NIDA, 2018; Tatarsky, 2007). By expanding the treatment eligibility requirements to include individuals seeking help

but who are not comfortable yet with total abstinence, those with SUDs seeking help will have the opportunity to receive care.

Integrating evidence-based SUD interventions into doctoral training in psychology is one way to assure that low-risk individuals with SUD can obtain psychotherapeutically-informed treatment. What has heretofore stood in the way of psychologists expanding their scope of competence to include these concerns? The comorbidity rate of these disorders suggests that those who are excluded from traditional outpatient psychotherapy due to reported substance misuse are left to handle their comorbid diagnosis on their own due to the 12-step principle that SUD must be treated discretely and prior to digging into other concerns or symptoms. Discussion of depression and trauma are often viewed as excuses or rationalization for substance misuse rather than integral components of a complex clinical picture. Psychologists have a unique opportunity to fill the gaps in this field and provide necessary services to individuals before the severity of their issues escalates.

Purpose of the Study

Considering the importance of both therapist and client expectations with regard to behavior change, it is critical that the deterministic narrative that pervades the world of SUD treatment be changed (Rosenzweig, 1936). In addition to these explicit conceptualizations of SUD, implicit biases fueled by negative SUD stereotypes are unavoidable in a society that has long neglected and dismissed the needs of this population. In order to adequately integrate SUD treatment into psychological training, it will be critical for trainees to engage in a transparent examination of the assumptions they hold about the population, as well as their own relationship to the issue of substance misuse.

The present study aims to assess for implicit bias against persons with SUD among counseling psychology students in doctoral training. Evidence of negative association patterns might be a first step toward exploring the types of attitudes, assumptions, and beliefs held by psychologists preparing to enter the field. In addition to measuring levels of bias among trainees, proposed study will assess the state of SUD training in the sample as well as the degree of exposure trainees have had to SUD in a clinical context. The proposed study will attempt to highlight and confront a glaring gap in the literature related to the treatment of SUDs by psychologists. No prior research to date has focused on trainees' attitudes toward this population; it is the hope of the researcher that this study will shed light on what first steps should be to address this complex issue.

Implications for Counseling Psychology

The values of counseling psychology involve a willingness to engage in ongoing self-examination, sharing power, giving voice, facilitating consciousness raising, building on strengths, and leaving clients the tools to work toward social change (Goodman et al., 2004). Students in training should be working to examine their biases and demonstrate lower levels of bias than general population as a result. Sue, Arredondo, and McDavis (1992), in trying to operationalize counseling psychology competencies, promoted the model of knowledge, skills, and awareness. Due to the paucity of doctoral training in SUD treatment, trainees are underprepared in all three of these domains (Martin et al., 2016). Regarding the state of SUD treatment, there are even more unmet needs in the Black and Latinx populations (Wells, Klap, Koike, & Sherbourne, 2001).

In a recent call to the profession published in the *Journal of Counseling Psychology*, Martin et al. (2016) identified the relative absence of SUD-related research and training from the

field of counseling psychology. One particularly alarming piece of information offered by Martin et al. was that a larger percentage of counseling psychology students report treating SUD than the percentage of students who reported receiving training in the area. The authors assert that counseling psychologists are particularly suited to attend to the needs of the population of those with SUD due to field's emphasis on social justice (Martin et al., 2016). Counseling psychologists have a legacy of initiating movements and maintaining a progressive lens with regard to areas in need of growth in the field (Delgado-Romero, Lau, & Shullman, 2012). If counseling psychology can develop an evidence-based, scientifically-informed approach to treatment that involves a rigorous exploration of one's biases and expectations, perhaps clarity can be gained regarding next steps in addressing what society continues to label a national crisis.

Definition of Terms

Substance Use Disorder: the label in the fifth edition of the Diagnostic and Statistical Manual (DSM) for the diagnostic construct of individuals who experience significant distress or impairment due to substance use (APA, 2013). The diagnosis includes eleven criteria that address physiological aspects of the disorder such as increased tolerance, cravings, and withdrawal symptoms, as well as behavioral components such as continued use in the face of negative social, occupational, or health-related consequences (APA 2013).

Substance Abuse and Substance Dependence: the label used in the third and fourth editions of the DSM for the diagnostic construct of individuals who experience distress or impairment due to substance use (APA, 1987; APA, 2000). The diagnosis was divided into Substance Abuse, the criteria for which outlined the negative consequences of use, and Substance Dependence, which described the physical components (APA, 2000).

Addiction: a commonly used term in society and the label used in the first and second editions of the DSM for the diagnostic construct of individuals who experience distress or impairment due to substance use (APA, 1952; APA, 1968).

Implicit Bias: a term born from research in the field of social cognition that describes the influence of automatic attitudes shaped by one's life experiences and societal context (Banaji & Greenwald, 1995).

Research Questions

Question 1: What proportion of psychology graduate students surveyed are required to undergo training in the treatment of substance use disorders?

Hypothesis 1: A minority of trainees surveyed will indicate that they are required to take coursework on treating substance use disorder.

Question 2: To what extent are trainees actively working with individuals with substance use disorders?

Hypothesis 2: The majority of trainees surveyed will report having worked with at least one individual presenting with substance misuse.

Question 3: To what extent do trainees exhibit negative associations with the term "addict" in isolation and when compared to "person with substance use disorder"?

Hypothesis 3: Participants will demonstrate stronger negative associations with the term "addict" than positive associations and will demonstrate significantly more negative associations with "addict" than with "person with substance use disorder".

CHAPTER 2

Review of Relevant Literature

Due to the fact that the corporate world of drug rehabilitation centers and the 12-step approach to recovery have dominated the narrative surrounding the nature of SUD and the most effective form of treatment, the literature on the topic is scattered across a variety of disciplines. In order to understand the sources of bias against individuals with SUD, it is essential to explore the history of SUD treatment, the sociopolitical context in which it is situated, and the role that language and perception play in the provision of these services.

History of SUD Treatment

The current SUD-related gap in psychology training can best be understood in light of the development of society's perception of SUD over the years. Before the emergence of the disease model of SUD that currently prevails in the recovery field and posits that SUD is a progressive brain disease for which abstinence is the only cure, the moral model prevailed, and any problems stemming from substance misuse was viewed as an innate failing of an individual's self-control (Hart, 2017; Nathan et al., 2016). Both of these conceptualizations fall short of capturing the complexity of SUD and both also have potentially harmful implications and carry permanent stigma.

The most widely utilized attempt to address SUD has been by Alcoholics Anonymous (AA) and other 12-step organizations that follow a strict program that involves aspects of both the moral and disease models (W., 1939). The fact that a self-help organization has become the primary means through which individuals receive help with SUD illustrates the reluctance of

mainstream mental health professionals and treatment researchers to tackle the daunting issue of "addiction." Although 12-step approaches to recovery have achieved striking success and proliferation without funding or centralized leadership, the narrative developed by AA's founders has woven itself into conceptualization of the disorder in the professional mental health context despite having no empirical or evidenced-based foundation.

The adoption of the disease model of SUD lends itself well to implementation in 12-step environments. The model's view of SUD as a chronic, progressive brain disease leads logically to the idea of a uniform treatment modality; however, variation in the etiology, progression, and remission of SUD is far from uniform (Hedden, 2015). As Hart (2017) points out, the trajectory of a disease can typically be predicted, as well as potential origins of the illness and likely manifestations of symptoms; however, a diagnosis of SUD provides no such information due to the innumerable differences between individuals' origins and patterns of use, otherwise, treatment success would be considerably higher.

The advent of the rehabilitation industrial complex combined the 12-step philosophy with a business model approach to treatment delivery (White & Miller, 2007). In the beginning of *The Big Book*, Wilson (1936) claims that if an individual does not successfully recover using the 12-step model, they have not adequately addressed their denial and character flaws. Thus, an industry was born that could attribute high relapse rates on the character strength, or lack thereof, of the individual patient.

The Drug War and the Criminalization of Substance Use

Perhaps more damaging than the ramifications of the moral and disease model are the lasting effects caused by the drug war on society's perception of substance use and misuse. Due to the criminalization of all use of illicit substances, even non-problematic use of these

substances is deemed deviant or pathological (Hart, 2017). The war on drugs, though framed as an attempt to mitigate the devastating effects of psychoactive substances, adopted an immovable focus on the substances themselves, rather than the sequelae underlying problematic use patterns (Hart, 2017). The consequences of this hardline approach to completely eradicate drugs from society have had a tragic effect on poor communities, particularly communities of color (Alexander, 2012). Rather than address harmful patterns of drug use, legal consequences of all substance use were expanded and rigidly applied (Alexander, 2012). These widespread arrests served to further associate substance users with dangerousness and criminality, bolstering existing stigma.

An additional barrier to addressing the stigma of SUD concerns the fact that the majority of current research on SUD is funded by a government aiming to associate drug use and negative outcomes to work toward the goal originally identified by the drug war: the creation of a drug-free society (Hart, 2017. The field of treatment could stand to benefit from an inclusion of all of the psychosocial factors involved the development and course of SUD. Directing attention towards alternative goals, such as moderating use or improving quality of life outside of substance use may provide valuable insights.

The public's perception of SUD tends to revolve around the specific substances towards which individuals gravitate. Media coverage of the "opioid epidemic" is one such example, in which intricacies about the social, political, and historical context of a substance's impact on a community are lost in the hyperfocus on the chemicals. Shifts towards understanding the biopsychosocial etiology of SUD, on both the clinical and research planes, may provide new avenues of exploration.

Perceptions of Substance Users

As a result of the aforementioned history of SUD, a number of stereotypes have emerged that, if left unaddressed, unexplained, and unexamined, have the potential to compromise the competency of any clinician working within the SUD treatment field. Studies employing self-report measures about bias have found that participants endorsed items characterizing users as dangerous as well as items that indicate a desire for social distance (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). A web-based national survey on participant attitudes, respondents endorsed significantly more negative views about individuals with SUD compared to individuals with "mental illness" (Barry et al., 2014). The same study found that participants were also more skeptical about positive treatment outcomes and more likely to support discriminatory policy against those with SUD (Barry et al., 2014). A separate study that also compared SUD and "mental illness" observed that those with SUD were seen as more blameworthy (Corrigan et al., 2009).

Although the American Psychological Association (2013) removed "abuse" from the DSM-5, the term persists in media, healthcare settings, and academic literature. Research into the language of SUD treatment found that participants consistently associated the word "substance abuser" with the need for punitive action (Kelly, Saitz, & Wakeman, 2016; Kelly & Westerhoff, 2010). Recent studies conducted by Ashford, Brown, and Curtis (2018) found evidence of respondents' implicit bias against the words addict, abuser, and alcoholic and therefore recommend that "person with substance use disorder" be implemented in the treatment settings, as well as in the literature. Considering the prevalence of these terms in clinical settings as well as in the general lexicon, it is possible that harm is being done simply by the language used to describe the population.

Psychology's Role in SUD Treatment

Although some psychologists do receive training and education about SUDs, the vast majority of treatment facilities operate from a model based on 12-step philosophy and most formal training for SUD treatment is compatible with the disease model (Hedden, 2014). SUD treatment is considered a specialized area within psychology despite the fact that prevalence rates rival that of both anxiety and depression (APA, 2013). Additionally, as Martin et al. (2016) found, many trainees, and presumably many clinicians, are currently treating this population anyway without having undergone training. In a meta-analysis of the literature about the providers in the field, van Boekel et al. (2015) found that health care providers who lacked education and training often demonstrated lower levels of empathy and engagement with patients with SUD and perceived violence, manipulation, and poor motivation as central barriers to recovery. Poor treatment outcomes were also associated with those who lacked adequate training (van Boekel et al., 2015).

As a result of the stigma and negative assumptions about substance use, clinicians have come to regard these clients with SUD as deceptive (van Boekel et al., 2015). Lack of trust in the validity of clients' self-report has the potential to threaten the integrity of the therapeutic relationship (Tatarsky, 2007). Even outside the SUD population, there is evidence that the perception of clients as deceptive elicits negative attitudes in clinicians, but that clinicians reported scientifically inaccurate beliefs about the behavioral indicators of deception (Curtis & Hart, 2015). Curtis and Hart (2015) went on to provide support for the idea that, even if a client is lying, an exploration of the lie's function could be beneficial and informative.

If clinicians, particularly those who have not undergone training, have not examined their automatic assumptions about this client population, it is possible that they will misattribute behavioral cues due to anticipating lies. Deception has also been assumed in cross-cultural

contexts due to the tendency to misinterpret violations of nonverbal social norms as attempts at deceit (Bond, Omar, Mahmoud, & Bonser, 1990; Bond et al., 1992). Considering the fact that the majority of psychologists-in-training are white, clients of color could be at even more of a disadvantage if they present for help with substance misuse.

CHAPTER 3

Research Method

The present study aimed to detect and measure implicit attitudes among psychologists-in-training about the word "addict" in isolation as well as compared with a preferable term, "person with an SUD." This study is an adaptation of Ashford, Brown, and Curtis' (2018) study examining bias among a sample of participants recruited from an SUD-related group on a social media platform. In light of the unexpected finding that greater bias was detected in the 40% of participants who worked in the behavioral health or medical field, this researcher decided to adapt the study to measure bias among psychologists-in-training (Ashford, Brown, & Curtis, 2018). Questions were also asked that pertained to trainees' clinical experience with SUD clients as well as their exposure to SUD-related courses.

Description of the Sample

Participants were recruited for this study through email listservs and individual emails to APA-accredited counseling psychology programs. In order to be eligible to participate, subjects had to be enrolled in an APA-accredited doctoral program in counseling psychology and have at least one year of clinical experience. With regard to gender identity, 11.76% of the sample (n = 4) identified as male and 88.24% (n = 30) identified as female. The majority of the sample (70.59%, n = 24) identified as White, 8.82% (n = 3) identified as Latina or Latinx, 5.89% (n = 2) identified as Asian or Asian-American, 2.94% (n = 1) identified as Hispanic, and 2.94% (n = 1) identified as Black and Pacific-Islander. With regard to degree type, 97.06% (n = 33) reported that they were in a Ph.D. program, while 2.94% reported pursuing a Psy.D (n = 1).

Design

This study employed a combined descriptive design using a survey and within-subjects experimental design using a behavioral task. The descriptive, survey-based component of the study was selected to collect information about trainees experiences and the within-subjects experimental design was implemented to measure automatic attitudes as it was in the study from which the present study was adapted (Ashford, Brown, & Curtis, 2018).

Instruments

Qualtrics Survey. From the study advertisement distributed via email, participants were directed to Qualtrics, where they signed an informed consent and answered a short survey about their demographic information, type of program, SUD-related academic coursework, and clinical experience.

Go/No-Go Association Task. Participants completed an online task using Inquisit Millesecond V.5, a program that allows you to administer web-based behavioral tasks remotely. Implicit bias was operationalized in this study using the Go/No Go Association Task (GNAT), which is similar to the Implicit Association Task (IAT) but provides researchers with the opportunity to examine participant bias against a category in isolation rather than comparison, which is the limit of the IAT's capability (Nosek & Banaji, 2001).

Participants completing the task were asked to put words in objective and evaluative categories; in addition to the accuracy of responses, the response time was also measured. In addition to the categories of good and bad, the GNAT contained the categories "addict" and "person with a substance use disorder." Each category contained a list of terms (See Appendix A) that were pulled from the Delphi study conducted by Ashford, Brown, and Curtis (2019) on SUD and linguistics.

Data Collection

Once recruited and screened for appropriateness, participants were provided with a link the Qualtrics website, which allowed them to participate in the study from their personal computer, and then asked to provide electronic informed consent and complete a short survey about basic demographic information, as well as their training and clinical experiences. After completing the Qualtrics survey, participants were redirected to the Inquisit website, where they were required to download the Inquisit program required to run the behavioral task. After completing the GNAT, participants were directed to a separate Qualtrics survey page, not linked to their experimental data, where they were asked to enter their email to participate in a drawing for three $50 gift cards to Amazon. Following data collection, this researcher drew three email addresses by assigning each participant email a number and using a random number generator, and the gift cards were distributed via email.

Statistical Treatment

For the survey data collected in Qualtrics, proportions were calculated to answer the first two research questions outlined in the introduction. Demographic data were also broken down to illustrate the demographic nature of the sample.

As in Ashford, Brown, and Curtis' (2018) study, analyses followed those initially conducted by the creators of the task in order to glean statistically meaningful information from the output provided by Inquisit Millesecond V.5 (Nosek and Banaji, 2001). Sensitivity is calculated using d', which involves translating the percent of accurate versus inaccurate scores into standardized scores and finding the mean difference (Green & Swets, 1966). For each test block, mean d' scores were calculated and paired t-test analyses were performed.

Limitations

Various limitations pertain to the current study and the results observed must be considered in the broader context of these limitations. The most prominent constraint of this study is the limited sample size (n = 34). Although the study from which the present one was adapted had a smaller same (n = 23), that study was intended to serve as a pilot for the use of this novel GNAT task to measure bias against linguistic representations of SUD (Ashford, Brown, & Curtis, 2018). This study aimed to measure these attitudes among a sample of counseling psychology trainees, which is a considerably smaller population than those studied previously by Ashford, Brown, and Curtis (2018).

Anecdotal data from study participants also indicated that the allotted time intervals to complete the final test block of the GNAT were exceedingly short and increased the difficulty of the task, which may have decreased the sensitivity of the GNAT to detect automatic attitudes. Though brief test blocks are necessary to measure automatic attitudes so that participants are not responding in a socially desirable way, it is possible that the complex nature of the stimuli may merit a small increase in the time allotted for test blocks.

The sampling method used in this study (distribution on student listservs for doctoral programs and student organizations) is an additional limitation that must be taken into account in the interpretation of the observed data. Future studies may benefit from employing a random sampling method in collecting this data in order to avoid possible selection bias.

Assumptions

The GNAT is based on signal detection theory, which posits that automatic attitudes may be measured by assessing participants' abilities to discriminate targets from distractors, or signals from noise (Green & Swets, 1966). Born from this research is the assumption that the standardized test statistic d-prime represents the magnitude of the automatic attitude observed

according to participants' task performance. Furthermore, following Nosek and Banaji's (1995) execution of the GNAT, this study follows the assumption that a negative difference in d-prime scores is indicative of a stronger negative than positive association and a positive difference in d-prime scores suggests a stronger positive than negative association with a target category.

Inherent to the hypotheses of this study is the assumption that automatic attitudes may have a predictive impact on human behavior, which is a contention that is debated, especially in absence of explicit attitude data to which the implicit attitude indexes may be compared (Blanton et al., 2009). Though this study does not examine implicit bias in the context of explicit bias, it aims to contribute to the existing body of data being created to determine whether these automatic attitudes may be detected in specific populations so that further research may be conducted that includes the investigation of the relationship of implicit attitudes to explicit ones, as well as to other pertinent variables, such as type and level of training experience.

Hypotheses

Question 1: What proportion of psychology graduate students surveyed are required to undergo training in the treatment of substance use disorders and what proportion has elected to obtain that training?

Hypothesis 1: A minority of trainees surveyed will indicate that they are required to undergo training and an even smaller minority will report having sought training independently.

Question 2: To what extent are trainees actively working with individuals with substance use disorders?

Hypothesis 2: The majority of trainees surveyed will report having worked with at least one individual presenting with substance misuse.

Question 3: To what extent do trainees exhibit negative associations with the term "addict" in isolation and when compared to "person with substance use disorder"?

Hypothesis 3: Participants will demonstrate stronger negative associations with the term "addict" than positive associations and will demonstrate significantly more negative associations with "addict" than with "person with substance use disorder".

CHAPTER 4

Results

With regard to the first research question, which sought to assess the proportion of students who were required to complete coursework related to the treatment of SUD, the hypothesis of this researcher was supported. Thirty-three out of thirty-four participants (97%) reported having no required coursework on this area.

The second research question aimed to measure the proportion of students who have worked with SUD as a presenting concern. This researcher's hypothesis was supported by the results of the survey, which indicated that 64.7%, or 22 out of 24, of the participants have encountered SUD in their clinical work.

The third and final research question pertained to the associations observed in participants' GNAT performance. The data supported the hypothesis that a significantly stronger negative association would be found between "addict + bad" (*d'* = .880) than "addict + good" (*d'* = .591, $t(33) = -3.344$, p = .002, $d = 0.621$).

Regarding the second component of the third research question, the association between Addict + Bad (*d'* = .864) was stronger than the association between "person with a substance use disorder" + "bad" (*d'* = .702), but the difference was not statistically significant ($t(33) = 1.590$, p = .121, $d = .296$). A statistically significant difference was observed, however, in the comparison of the mean differences between "addict + good" and "addict + bad" (*d'* = -.312) and "person with a substance use disorder + good" and "person with a substance use disorder + bad" (*d'* =

.291, MD = -.603, $t(33) = -4.421$, $p < .001$, $d = 1.222$). According to Nosek and Banaji (2001), a positive

While previous literature on this topic has consistently observed a stronger association with "person with a substance use disorder + bad", the results of the present study found that participants demonstrated a significantly stronger association with "person with a substance use disorder + good" (d' = .992) than "person with a substance use disorder + bad" (d' = .702, $t(33) = 3.886$, $p < .001$, $d = .611$). Possible explanations for this notable departure from the existing body of literature will be discussed in the limitations section.

Table 1

Differences in d-prime across target categories

	M	*SD*	*SE*	*t*	*df*	*p*
AA_dprime – AB_ dprime	-.312	.544	.093	-3.34	33	.002*
BA_dprime – BB_dprime	.291	.436	.075	3.886	33	.000***
AB_dprime - BB_dprime	.163	.597	.102	1.590	33	.121
dprime_diff_TargetA – dprime_diff_TargetB	-.603	.795	.136	-4.421	33	.000***

Note: * p < .01, *** p < .001
Note: AA = "addict" + good, AB = "addict" + bad, BA = "person with substance use disorder" + good, BB = "person with substance use disorder" + bad, Target A = addict, Target B = person with substance use disorder.

CHAPTER 5

Discussion

Summary of the Study

Individuals with SUD continue to be an underserved population in the United States and across other cultures (Hedden, 2015). Despite the need for more attention and resources in this area, as well as the well-documented comorbidity between SUD and other common mental health diagnoses, mental health professionals regard SUD as a separate, specialized area of treatment (Tatarsky, 2007). This perception has contributed to the development of a divide between those willing to treat SUD and those who consider it outside of their scope (Martin et al., 2016). Possible factors contributing to this divide include the medicalization of SUD, the historical criminalization of substance use and the consequent involvement of the criminal justice system, the absence of SUD-related curriculum in training programs, and the systemic marginalization of this population potentially as a result of stigma and bias (Hart, 2017; Martin et al., 2016; van Boekel et al., 2015).

The present study sought to collect data on the training experiences of counseling psychology students and use an experimental behavioral task to measure negative automatic attitudes towards frequently used stigmatizing language as well as more progressive terminology. This study was an adaptation of a pilot conducted by Ashford, Brown, and Curtis (2018), who aimed to test the use of the GNAT in detecting and measuring the magnitude of negative automatic attitudes in the general population towards derogatory SUD-related terminology.

Participants in this study were asked to complete a brief survey about demographic information and training experiences and to complete a behavioral task using an online experimental platform. This research hypothesized that a minority of participants would report being required to undergo SUD-focused training, a majority would endorse having worked with SUD, and that negative automatic attitudes would be detected towards stigmatizing terminology in isolation as well as in comparison to the terminology currently recommended in the field.

Conclusions

The present study set out to gain perspective on the training experiences of counseling psychology students in the area of SUD and to examine the nature of automatic attitudes among trainees about "addict" and related terms, as well as to compare these observed attitudes to participants' associations with "person with a substance use disorder." Consistent with previous research, the term "addict" elicited negative associations in isolation and significant differences were observed in the valence and magnitude of automatic attitudes towards "addict" and "person with a substance use disorder." Additionally, preliminary values were obtained from this sample that aligned with previous research on the lack of required SUD-related curriculum in counseling psychology programs, as well as a majority of students in this sample having contact with individuals from that clinical subpopulation.

Results observed in the present study were largely consistent with that of the previous research; however, a key difference was observed in relation to participants' automatic attitudes towards the category "person with a substance use disorder." While Ashford, Brown, and Curtis (2018) found a negative association that was smaller in magnitude to participants' negative association with "addict," the present study found that participants' positive association with "person with a substance use disorder" was stronger than the negative association.

Research Question #1. Consistent with the hypothesis put forth by this researcher, the overwhelming majority of participants reported that they were not required to undergo training or coursework specific to SUD. Although this is not a formal requirement for counseling psychology curricula, these results are surprising when taken in the context of the prevalence of SUD, particularly its comorbidity with other common presenting concerns, such as anxiety and depression.

Research Question #2. The hypothesis of this researcher was also supported by the survey results in that more than half of participants indicated that they had encountered SUD in their clinical work. Taken with the results from the first research question, this data is disconcerting; despite undergoing no formal training for working with SUD, the majority of the sample had provided services to this population.

Research Question #3. In line with the hypotheses set forth by this researcher, participants' performances on the behavioral task administered indicated a significant negative association with the category "addict." Though there was no statistically significant difference between participants' negative associations with "addict" and "person with a substance use disorder," the positive association found with "person with a substance use disorder" led to a statistically significant difference in positive versus negative associations in both categories.

These results support the previous body of research asserting that stigmatizing terminology such as "addict" should be systematically eliminated from clinical settings as it appears to elicit negative automatic attitudes. This language includes the term "addiction," which is still widely used in academic and clinical settings despite its removal from the fifth edition of the Diagnostic and Statistical Manual (APA, 2013). Support was also found for the substitution

of stigmatizing terminology with more humanizing language (eg: person with a substance use disorder, person who uses drugs, person who uses alcohol, etc.).

Implications

Research. The results of the present study suggest that implicit bias against individuals with SUD exists among trainees in the field of counseling psychology. In order to bolster these findings, future implicit bias research against individuals with SUD should compare implicit and explicit bias measures, such as measures of desire for social distance or vignette-based explicit bias methodology. Research into the existence of this bias could also be conducted in the context of comparing the attitudes of individuals who have received training versus those who have not. An examination of differences in attitudes across identities, program types, and experiences related to SUD may reveal patterns in the bias.

The survey responses collected in this study indicate that the current curricula on SUD in counseling psychology programs is lacking or altogether absent. These findings highlight the need for a more thorough investigation of the state of education related to SUD. Systematic research on the existence of SUD-related courses, the content of these courses, and whether students are encouraged or required to take them may paint a landscape of the state of counseling psychology curriculum and illuminate areas for growth and expansion.

Considering the finding that the majority of the sample in the present study have worked with SUD, it may also be helpful to further explore the types of interventions being used by these trainees, their basis for utilizing them, and outcomes observed.

The preliminary findings from this study also highlight the importance of an interrogation of the common practice of automatically referring clients with SUD-related presenting concerns to specialized services. Research into the rationale for this practice as well as psychologists' and

trainees' perspectives of the efficacy of specialized SUD treatment may reveal inaccurate assumptions about the level of expertise and positive outcomes in the SUD field.

To enrich the understanding of trainees' attitudes towards SUD, individuals with SUD, and treatment approaches, it may be useful to utilize methods of qualitative inquiry to paint a richer and more informative picture of trainees' perspectives. Qualitative research on trainees' personal experiences with substances, whether direct or indirect through exposure to familial SUD, may provide more insight into the basis for the automatic attitudes held by trainees against individuals with SUD.

Trainees' outlooks on SUD treatment may also be better understood through qualitative interviews about their professional experiences with individuals with SUD. Interviews designed to examine the felt experience of trainees in may point to common areas of difficulty, challenge, or frustration in the provision of these services. Useful information may also be gleaned from inquiring about trainees' perceptions of the therapeutic alliance, ruptures, and the establishment and achievement of treatment goals. Research into the experiences of trainees in supervision, as well as supervisors' perspectives, may also reveal common patterns and interpersonal mechanisms at play in the therapeutic treatment of SUD.

It may also be informative to collect information about trainees' understanding of SUD treatment approaches. In light of the prevailing disease model of SUD, which asserts that SUD is a progressive brain disease for which abstinence is the only viable "cure," trainees' may experience a hesitance or resistance to utilize alternative SUD treatment methods such as motivational interviewing or harm-reduction-based approaches for fear of contributing to disease progression. Without research tools that are sensitive to the subtle undercurrent of beliefs about this population, valuable observations could be lost.

An avenue of qualitative inquiry that will be crucial in working to reform and enhance the field of SUD treatment is the direct study of the experiences of individuals with SUD in therapy. Research that explores the lived experiences of this population are necessary to understanding the current shortcomings and improving the quality of services provided. Participatory Action Research (PAR), in particular, may provide a valuable opportunity for counseling psychologists to invite individuals with SUD into the engineering of treatment approaches and field reform (Brydon-Miller, 1997). In light of the results of the present study, special attention should be paid to clients' perceptions of treatment and the therapeutic relationship as well as experiences of stigma and discrimination in the context of psychotherapeutic treatment.

Training. Taken together, the results of these three research questions paint a concerning picture of the current state of clinical training for doctoral-level counseling psychology students. Students are providing services to individuals with SUD without formal training and significant negative associations have been observed with the outdated and stigmatizing terminology that continues to circulate in professional and lay settings.

Considering the negative attitudes observed, it is vital that programs prioritize the systematic elimination of these terms (eg: addict, addiction, substance abuse, substance dependence, etc.) from professional spaces. Curriculum should include an overview of research on the stigmatizing nature of SUD-related terminology as a basis for the adoption of terms that elicit less negative association. The findings of the present study suggest that positive associations outweigh the negative associations in the more progressive, person-oriented language (eg: person with a substance use disorder, person who uses alcohol, person in recovery, etc.).

SUD's impact is widespread and there are few in society who have not been affected personally or indirectly by SUD and the barriers to its treatment. There are many myths and assumptions about SUD, the characteristics of those with SUD, its course and prognosis, as well as what constitutes effective treatment (Tatarsky, 2007). Harmful stereotypes also exist, with "drug addict" often being used as a worst-case scenario in terms of life outcome. Disparaging attitudes towards individuals with SUD continue to be tolerated, if not encouraged in most areas of societal discourse, which may lead students to feel inner resistance to coursework that aims to untangle biases and promote the humanization of this population (Barry et al., 2014).

The present research findings suggest the presence of negative automatic attitudes among trainees towards stigmatizing language associated with SUD and the relative absence of formal SUD-focused training mandated in counseling psychology programs. These two findings, taken together, indicate that trainees' perceptions of SUD are shaped not by formal training, which includes the appropriate, updated terminology, but by the personal experiences and societal influences, the very forces that shaped the documented negative automatic attitudes. In other words, trainees are bringing a lay understanding of SUD, steeped in prejudice and unexamined negative bias, to their clinical encounters rather than an informed, scientifically-based understanding of the complex array of symptoms involved in SUD.

The ubiquitous nature of this subject matter will undoubtedly result in the surfacing of raw emotional material in the classroom environment. The content necessary to cover in related didactic and clinical training may elicit painful and traumatizing feelings in trainees, potentially rooted in their own relationship to substances or exposure to SUD in their families of origin. Personal experience with substance misuse may provoke shame, guilt, and unduly harsh criticism, as documented in studies of self-stigma related to SUD (Brown et al., 2015).

Experiences of SUD in the context of close relationships such as parents, siblings, friends, or partners, however, may trigger emotions associated with betrayal, deception, and hurt, such as rage, helplessness, resentment, and grief (Wangensteen, Bramness, & Halsa, 2019). These feelings may lead trainees to understandably avoid this aversive course material and be primed to respond with fear during conversations about SUD, which in turn may lead to an understandable and adaptive narrowing of emotional response, or shutting down entirely (Hayes & Monestès, 2018).

Prevailing societal messages, paired with the disease model of SUD, may lead trainees to perceive treatment for SUD as hopeless and positive outcomes as impossible. It follows that assumed negative outcomes might lead trainees to feel decreased self-efficacy in their provision of services to individuals with SUD, perhaps even before starting treatment. A similar effect can be observed in the common aversion many therapists have to working with clients with SUD and the pervasive tendency to immediately refer out any client presenting for help with these concerns. This behavior breeds an assumption that, just as those with SUD are subhuman, they are also a different class of clientele whose outcomes are reliably hopeless and who will intentionally deceive or manipulate unwitting clinicians.

Informed SUD-related education must provide information about alternative methods for treatment, particularly those outside the realm of abstinence-only treatment, so that trainees are prepared to meet clients where they are and foster the same autonomy they would in other therapeutic relationships. Through this training, it may be possible for trainees to re-conceptualize psychotherapy, applying their existing skillset to the SUD population, ideally de-specializing it and incorporating SUD into generalist training.

As it currently stands, there are few spaces in counseling psychology training in which trainees have the space and freedom to compassionately examine their biases against individuals with SUD. This absence may reflect a parallel process in which programs and their faculty are experiencing hopelessness about their ability to effectively train students to treat SUD. The silence on the matter of SUD, however, is still a form of communication; when programs omit SUD from their curriculum students may feel justified in their subsequent avoidance of the population (Kumashiro, 2000).

Going forward, it will be critical for training programs in counseling psychology to create opportunities and spaces for students to examine and address their automatic attitudes towards individuals with SUD. Experiential, group-based learning is often implemented in work to address bias and prejudice among trainees towards various identity groups and those responsible for students' training may do well to borrow from the tools developed in this field (Ruscio, 2010). Group process will be an indispensable piece of this didactic work, so that through normalization and recognition with others, the shame associated with the identification of prejudice may be attenuated.

Linguistics is central to the findings and training implications of the present study. An innovative framework that explores the impact of linguistic representations in the human experience, particularly with regard to one's understanding of the self, the other and the world, is relational frame theory (RFT) (Hayes, 1991). RFT posits that human language revolves around the relationship between concepts; this theory is central to the content of the present study in that trainees have come to relate certain terminology related to SUD with negative assumptions, manifested as automatic attitudes.

RFT is often linked with acceptance and commitment therapy (ACT), which highlights the importance of regarding one's thoughts and feelings with curiosity and nonjudgment, and learning to respond to inner and outer experiences in a way that is congruent with one's identified values (Hayes, Strosahl, & Wilson, 2009). ACT is relevant to the challenge of destigmatizing SUD in that trainees typically do not want to regard themselves as having bias or negative automatic attitudes towards certain groups, which may lead them to avoid SUD-related content altogether.

Acknowledging and unpacking negative automatic attitudes in a nonjudgmental, compassionate way, may allow counseling psychology trainees to face difficult feelings in service of their core values of being open-minded clinicians dedicated to equity and social justice (Miller & Sendrowitz, 2011). Although ACT is typically implemented in a clinical context, using these principles in the training environment may provide opportunities for trainees to thoughtfully examine and work through bias and model this compassionate approach for clients with SUD engaging in self-stigmatization.

Ideally, once biases are examined and the life experiences that influenced them are explored compassionately, students will feel safe and curious enough to entertain evidence and ideas that conflict with society's narrative. Impartiality or objectivity are not the goal in this scenario, but a mindful awareness of the emotions that surface in the discussion of SUD, which in turn may make space for more intentional responding. An attractive effect of remaining biased against those with SUD is the safety one feels when engaging in the devaluation of that population; in doing so, one may create social distance and feel protected from the possibility of being negatively impacted by a disorder they presume only afflicts inferior beings.

In doing this difficult but necessary work, it will be vital for those who participate in training to prepare themselves for the emotionally challenging nature of the subject matter, ideally consulting with fellow faculty and other colleagues in a vulnerable way so as not to unintentionally transmit bias through their own avoidance. Modeling humility and authenticity about this challenging and often painful material will set a tone for students who are apprehensive about engaging in the dialogue. Clinical supervision is an especially crucial space in which psychologists may have the opportunity to address provocative and painful issues, particularly if students have personal experiences with SUD that they find traumatic or shameful.

Implications for counseling psychology. In light of the longstanding history of the marginalization of individuals with SUD, it is evident that the unchecked bias and systematic exclusion of this population from general treatment settings is an issue of social injustice. The field of counseling psychology has a documented history of prescient and intentional action in promoting social justice and confronting oppression; addressing stigma and bias is a mission that is consistent with the field's dedication to the development of knowledge, skills, and awareness in trainees with regard to multicultural competence (Sue, Arredondo, & McDavis, 1992).

The paucity of psychotherapeutic resources that exist for individuals seeking help for SUD highlight the disparity in care experienced by this population. This gap in the quality and availability of treatment is even more pronounced when clients present to treatment with other intersecting marginalized identities as well as SUD, especially in light of the racially-charged messages rooted in the drug war (Flückiger et al., 2013). To operate in accordance with the values around the promotion of equity, counseling psychology programs must carefully examine the gaps in the training they provide to students, as these gaps will later contribute to the perpetuation of existing disparities (Buki & Selem, 2012).

Counseling psychology's focus on emphasizing strengths rather than deficits in addressing psychological distress is a central priority, which suggests that continuing to refer clients out to unregulated specialized treatment facilities and medicalizing SUD by endorsing it as a brain disease is in direct conflict with this stated value (Lopez & Edwards, 2008). Addressing prejudice against clients with SUD thoughtfully may allow students to look beyond substance use to conceptualize the client as a whole human being who exists in a complex context and environment.

The field of counseling psychology is particularly well positioned to assume a leading role in the deconstruction of oppressive ideologies surrounding SUD, with its historical emphasis on social justice and equity, as well as its tendency towards a strengths-based perspective and away from pathologization (Ratts et al., 2015). As a field that is ahead of its time in bringing challenging issues to the forefront of the mental health field, counseling psychology has a unique opportunity to pioneer social change through the incorporation of SUD-related course material into its curricula.

Though this study examined bias among trainees in the field of counseling psychology, the existing body of evidence suggests that these attitudes are prominent across contexts, which includes other areas of mental health. If counseling psychology embraces the challenge of thoughtfully educating its trainees and embracing the therapeutic treatment of this population, these changes could lead to life-saving resources being made available to a population that has been shut out for far too long.

Recommendations for Future Research

In future research pursuits aiming to explore automatic attitudes of trainees, measures of implicit bias should be paired with measures of explicit bias, as has been done in other work that

studies these attitudes in the general population. to join quantitative measures of bias with alternative sources of rich, contextual data. Additionally, considering the limited sample size gleaned with this research methodology, it will be essential to increase the compensation and compensate every participant rather than utilize a drawing method in order to gain more participants.

Future iterations of research on implicit bias against individuals with SUD may benefit from expanding the sample outside of counseling psychology trainees to all psychology trainees or mental health trainees. It may be helpful to explore attitudes across the various mental health training programs, including students training to become social workers, professional counselors, drug and alcohol counselors, as well as clinical psychologists. Further, more detailed inquiry into the curricula of these programs and their approaches to training students to work with SUD may reveal strengths and areas for growth across academic disciplines.

As was previously discussed, qualitative methods, such as interviews with participants, could be another way to explore bias in a deeper way. Research on students' understanding of SUD and experiences working with the SUD population may provide more in-depth information on trainee perspectives, both with regard to perspectives formed by life experiences as well as attitudes shaped by education and training.

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APPENDIX A

Survey Questionnaire

UNIVERSITY OF GEORGIA
CONSENT FORM
TRAINING EXPERIENCES OF COUNSELING PSYCHOLOGY STUDENTS

You are being asked to take part in a research study. The information in this form will help you decide if you want to be in the study. Please ask the researcher(s) below if there is anything that is not clear or if you need more information.

Principal Investigator: Brian Glaser, Ph.D.
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Human Development Services
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Co-Investigator: Stephanie Shiffler, M.A.
Department of Counseling &
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We are doing this research study to learn more about experiences of trainees in the counseling psychology field. You are being invited to be in this research study because you are subscribed to a listserv for counseling psychology students. **In order to participate in this study you must be a doctoral-level counseling psychology trainee with at least one year of practicum experience.**

For your participation, you will be entered into a drawing for a $50 gift card to Amazon. Three $50 gift cards will be distributed. You do not have to be in the study to enter the drawing. Send an email to stephanie.shiffler25@uga.edu to enter the drawing if you do not want to be in the

study. Your name will be provided to the investigator's departmental business office for tracking purposes if you win.

If you agree to participate in this study:

- We will collect information about your training experiences as well as basic demographics.
- You will be asked to fill out a survey, download and install a software program, and complete a word-association task using this program.
- The combined survey and task will take approximately 30 minutes in total.

Participation is voluntary. You can refuse to take part or stop at any time without penalty. Aspects of the task you will be asked to complete may make you uncomfortable and you may stop your participation at any time.

Your responses may help us understand how to enrich the training experiences of students in the field of counseling psychology. In order to make this study a valid one, some information about your participation or the study will be withheld until the completion of the study.

A response ID will be associated with your data and your responses will be anonymous. This research involves the transmission of data over the Internet. Every reasonable effort has been taken to ensure the effective use of available technology; however, confidentiality during online communication cannot be guaranteed. We will take steps to protect your privacy, but there is a small risk that your information could be accidentally disclosed to people not connected to the research. To reduce this risk we will not log any identifiable information such as name or IP address. At the conclusion of the study you will be asked to enter your email address, which will be collected separately from the other data you provide. We will only keep information that could identify you until compensation is provided to those eligible. Your information will not be used or distributed for future research.

Please feel free to ask questions about this research at any time. You can contact the Co-Investigator, Stephanie Shiffler, at (609) 675-4617 or stephanie.shiffler25@uga.edu. If you have any complaints or questions about your rights as a research volunteer, contact the IRB at 706-542-3199 or by email at IRB@uga.edu. If you agree to participate in this research study, please sign below.

Q1 Are you a doctoral-level trainee in counseling psychology?

○ Yes

○ No

Q2 Have you had at least one year of clinical experience working with adults?

- ○ Yes
- ○ No

Q3 What is your gender identity?

- ○ Male (1)
- ○ Female (2)
- ○ Transgender (3)
- ○ Nonbinary (4)
- ○ self-identify (5) _____

Q4 What is your race or ethnicity?

- ○ Black or African-American (1)
- ○ Asian-American (2)
- ○ American Indian/Alaska Native (3)
- ○ Native Hawaiian/Other Pacific Islander (4)
- ○ White (5)
- ○ Latinx
- ○ self-identify (6) _____

Q5 What is your program?

- ○ Psy.D. (1)
- ○ Ph.D. (2)
- ○ Other (3) _____

Q6 How many years have you been in your program?

- ○ 1 (1)
- ○ 2 (2)
- ○ 3 (3)
- ○ 4 (4)
- ○ 5 (5)
- ○ 6+ (6)

Q7 Please select the concerns you have addressed in your clinical work.

- [ ] Depression (1)
- [ ] Anxiety (2)
- [ ] Relationship Concerns (3)
- [ ] Trauma (4)
- [ ] Substance Use Disorder (5)
- [ ] Specific Phobia (6)
- [ ] Obsessive Compulsive Disorder (7)
- [ ] Personality Disorders (8)
- [ ] Grief/Loss (9)
- [ ] Anger Management (10)

Q8 Does your program require a course on treatment for PTSD?

- [ ] Yes (1)
- [ ] No (2)

Q9 Does your program require a course on Cognitive Behavioral Therapy?

- ○ Yes (1)
- ○ No (2)

Q10

Does your program require a course on Substance Use Disorder?

- ○ Yes (1)
- ○ No (2)

APPENDIX B

GNAT Word Lists

Target A: “addict”

/1 = "junkie"

/2 = "substance abuser"

/3 = "crackhead"

/4 = "dope fiend"

/5 = "drunk"

/6 = "wino"

/7 = "inebriate"

/8 = "boozer"

/9 = "addict"

/10 = "druggie"

/11 = "substance abuse"

/12 = "addiction"

/13 = "drunkard"

/14 = "drug injector"

/15 = "dirty"

/16 = "drug abuse"

/17 = "pill popper"

/18 = "alcohol abuse"

/19 = "stoner"

/20 = "relapse"

/21 = "recovering alcoholic"

/22 = "alcoholism"

/23 = "alcoholic"

/24 = "recovering addict"

Target B = "person with an SUD"

/1 = "substance use"

/2 = "substance user"

/3 = "substance misuse"

/4 = "person who uses substances"

/5 = "former drug user"

/6 = "recurrence of use"

/7 = "substance use disorder treatment"

/8 = "substance misuser"

/9 = "substance use disorder"

/10 = "substance use disorder recovery"

/11 = "person who uses alcohol"

/12 = "person who uses drugs"

/13 = "alcohol use"

/14 = "alcohol misuse"

/15 = "drug use"

/16 = "drug misuse"

/17 = "person with a substance use disorder"

/18 = "recovering person"

/19 = "drug user"

/20 = "alcohol use disorder"

/21 = "person with an alcohol use disorder"

/22 = "alcohol use disorder treatment"

/23 = "alcohol user"

/24 = "person who misuses substances"

Attribute A = “good”

/1 = "celebrating"

/2 = "pleasure"

/3 = "happy"

/4 = "friendly"

/5 = "joyful"

/6 = "loving"

/7 = "beautiful"

/8 = "smiling"

/9 = "glee"

/10 = "glad"

/11 = "glorious"

/12 = "excitement"

/13 = "wonderful"

/14 = "triumph"

/15 = "good"

/16 = "excellent"

/17 = "fabulous"

/18 = "superb"

/19 = "marvelous"

/20 = "splendid"

/21 = "laughing"

/22 = "cheerful"

/23 = "terrific"

/24 = "likable"

Attribute B = “bad”

/1 = "horrible"

/2 = "angry"

/3 = "terrible"

/4 = "noxious"

/5 = "tragic"

/6 = "unpleasant"

/7 = "hate"

/8 = "destroy"

/9 = "brutal"

/10 = "bad"

/11 = "evil"

/12 = "humiliate"

/13 = "disaster"

/14 = "nasty"

/15 = "gross"

/16 = "painful"

/17 = "yucky"

/18 = "ugly"

/19 = "dirty"

/20 = "dislike"

/21 = "awful"

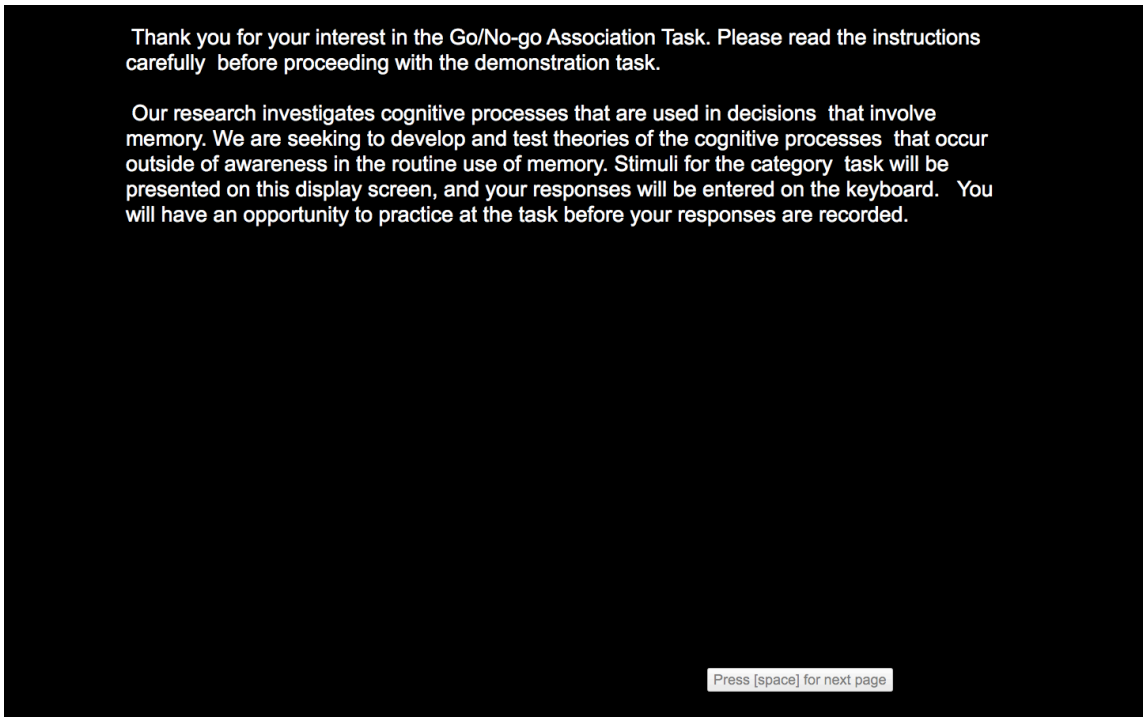
/22 = "disgusting"

/23 = "revolting"

/24 = "sickening"

APPENDIX C

GNAT



This work assumes that you can read English fluently, and that your vision is normal or corrected to normal.

The tasks that you will be doing in this experiment involve category judgment. For instance, in one condition your task may be to search for all the words that represent the categories 'good.' (e.g., celebrating, pleasure) or the category 'addict' (e.g., junkie, substance abuser).

All categorizations will be made with the SPACEBAR key. When you see a word that belongs to either one of the two categories (e.g., 'good' or 'addict') hit the spacebar key as fast as possible. Ignore words that do not belong to either category.

Press [⌫] for previous page

Press [space] for next page

The words you will be looking for will be from the 4 groups listed below.

person with a substance use disorder (blue letters): substance use,substance user, substance misuse, person who uses substances, former drug user, ...
addict (blue letters): junkie,substance abuser, crackhead, dope fiend, drunk, ...

good (white letters): celebrating,pleasure, happy, friendly, joyful, ...
bad (white letters): horrible,angry, terrible, noxious, tragic, ...

All 'good' and 'bad' items are descriptive (adjectives or adverbs), while 'person with a substance use disorder' and 'addict' are all objects (nouns). The color coding of the words is there to help distinguish between the evaluative (good and bad) words and the object categories.

Press [⌫] for previous page

Press [space] for next page

The task will get faster and harder as you get further along. In fact, you may at times find it very difficult to correctly classify ANY of the trials. Do not despair. This task is designed to be difficult and no one is expected to perform it perfectly. Please persevere and just try to catch as many words as possible.

You will have an opportunity to practice each new set before the task begins.

Hit the spacebar key when you are ready to begin.

Press [⌫] for previous page

Press [space] to continue

addict

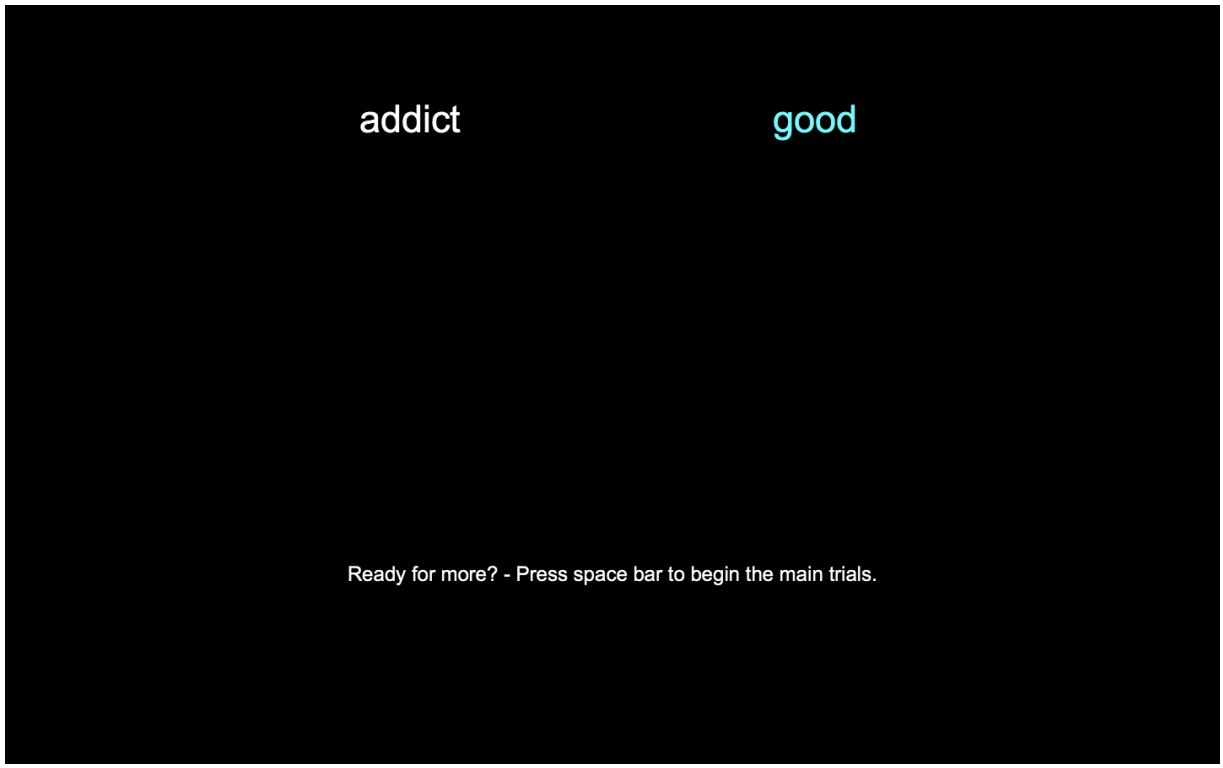
Words will appear in the center of the screen, one by one, at high speed. These words may or may not belong to the category you see printed at the top.

Press the space bar as fast as you can if the word belongs to the category you see at the top. If they do not belong to the category, don't do anything. Just wait for the next word.

If you made an error, a red X appears below the word. Otherwise, you will see a green 'O'.

Press the space bar to start.


person with an SUD
bad
New categories - Press the space bar for practice trials


addict
good
Ready for more? - Press space bar to begin the main trials.