DISTINGUISHED PROFESSIONAL CONTRIBUTIONS

The 2015 recipients of the APA Professional Contributions Awards were selected by the 2014 Board of Professional Affairs (BPA). Members of the 2014 BPA were Stewart E. Cooper, PhD, ABPP; Karen S. Budd, PhD; A. J. Franklin, PhD; Patricia Arredondo, EdD; Helen L. Coons, PhD, ABPP; Vickie M. Mays, PhD, MSPH; Linda A. Reddy, PhD; Celiane M. Rey-Casserly, PhD; and Antonette M. Zeiss, PhD.

AWARD FOR DISTINGUISHED PROFESSIONAL CONTRIBUTIONS TO APPLIED RESEARCH

This award is given to a psychologist whose research has led to important discoveries or developments in the field of applied psychology. To be eligible, this research should have led to innovative applications in an area of psychological practice, including but not limited to assessment, consultation, instruction, or intervention (either direct or indirect). Research involving the original development of procedures, methodologies, or technical skills that significantly improve the application of psychological knowledge and provide direct and immediate solutions to practical problem areas will be considered, as will research that has informed psychologists on how better to observe, define, predict, or control behavior. Original integration of existing theories or knowledge is also eligible for consideration. In previous years, this award was called the Award for Distinguished Professional Contributions to Knowledge. The name was changed in 2003 to better describe this award.

1979 Sol L. Garfield
1980 Leonard D. Eron
1981 Carl Eisdorfer
1982 Roy Schafer
1983 Neal E. Miller
1984 Norman Frederiksen
1985 Albert Ellis
1986 Edward Zigler
1987 Mary D. S. Ainsworth
1988 Herman Feifel
1989 Allen E. Bergin
1990 Manfred J. Meier
1991 W. Grant Dahlstrom
1992 Leopold Bellak
1993 Paul E. Meehl
1994 John L. Holland
1995 Kenneth I. Howard
1996 Paul Satz
1997 John E. Exner Jr.
1998/ Samuel M. Turner
1999 Peter E. Nathan
2000 Simon H. Budman
2001 Marvin R. Goldfried
2002 John D. Krumboltz
2003 Theodore Millon
2004 Robert J. Gatchel
2005 Gail S. Goodman
2006 Stephen M. Weiss
2007 Bruce E. Wampold
2008 Richard Rogers
2009 Luciano L’Abate
2010 Catherine E. Lord
2011 Ronald F. Levant
2012 Leslie Samuel Greenberg
2013 Richard M. Foxx
2014 Thomas Grisso
2015 Leonard A. Jason

http://dx.doi.org/10.1037/a0039618
Leonard A. Jason

Award for Distinguished Professional Contributions to Applied Research

Citation

“Leonard A. Jason is among the most prolific community psychology researchers whose work has had measurable and significant real-world impact. His work is characterized by a continuing desire to apply knowledge to major social problems. His research is methodologically sound and creative, collaborative, and participatory, thereby increasing stakeholders’ support for proposed changes. Guided by his persistence and knowledge of the legislative process, his work has provoked change in policies related to the use of child-safety restraints in cars, smoking cessation, chronic fatigue syndrome, and recovery from drug and alcohol addiction. He is a champion of social justice through research.”

Biography

Leonard A. Jason received his doctorate in clinical psychology from the University of Rochester in 1975. He is currently a professor of psychology at DePaul University and the director of the Center for Community Research. This year is Jason’s 41st year as a faculty member at DePaul University. He is a past director of clinical training for the clinical psychology doctoral program, past faculty sponsor of Psi Chi, and was one of the faculty members responsible for the creation of the human services concentration and community concentration within the psychology graduate program. He also was one of the faculty members that helped create the doctoral program in community psychology. Jason has served on 83 thesis committees (of which he chaired 57), and 70 dissertation committees (of which he chaired 36).

Jason is a former president of the Division of Community Psychology of the American Psychological Association (APA) and a past editor of The Community Psychologist. Jason has served as the vice president of the International Association for Chronic Fatigue Syndrome/Myalgic Encephalomyelitis. He also served as the chairperson of the Research Subcommittee of the U.S. Chronic Fatigue Syndrome Advisory Committee, which makes recommendations to the Secretary of Health and Human Services. Jason has edited or written 27 books and he has published over 690 articles and 90 book chapters on chronic fatigue syndrome (CFS) and myalgic encephalomyelitis (ME); Oxford House (OH) recovery homes; the prevention of alcohol, tobacco, and other drug abuse; media interventions; and program evaluation. He has served on the editorial boards of 10 psychological journals. Jason has served on review committees of the National Institutes of Health (NIH), and he has received over $36,900,000 in federal research grants. He has received three media awards from the APA and is frequently asked to comment on policy issues for numerous media outlets.

He received the 1997 Distinguished Contributions to Theory and Research Award by Division 27 of the APA. He was presented the 1997 Chronic Fatigue Syndrome Immune Dysfunction Syndrome Support Network Champion Award by the Chronic Fatigue Immune Dysfunction Syndrome Association of America in appreciation of research and educational efforts on behalf of persons with CFS and ME. He was also given the Dutch ME Foundation International ME Award for 2003 for outstanding work in the field of CFS. In addition, he was presented in 2007 with a Special Contribution to Public Policy Award by the Society for Research and Action. And, he was awarded the 2011 Perpich Award for distinguished service to the International Association for Chronic Fatigue Syndrome/Myalgic Encephalomyelitis. In 2011, he was presented with the Tom Fellows Award by the Oxford House Organization for his 20 years of research documenting the process of long term recovery from addiction. In 2013, he was presented with the DePaul University’s College of Science and Health’s Excellence in Research Award. In 2015, he was presented the American Psychological Association’s award for Distinguished Professional Contributions to Applied Research.

Jason has a longstanding interest in preventive interventions and, in the 1980s and early 1990s, had a series of NIH grants to implement a preventive interventions for school transfer students (Jason et al., 1992). For a 20-year period of time, he also investigated interventions to prevent youth from obtaining tobacco from merchants (Jason, Pokorny,
Adams, & Hunt, 2008). As another example, he worked with an antigang organization called Broader Urban Involvement and Leadership Development, which focused on community-building efforts to discourage adolescents from joining gangs (Thompson & Jason, 1988). Jason has also been involved in developing a comprehensive universal (or primary) prevention program was implemented to decrease the incidence of new smokers among African American adolescents in Chicago, Illinois (Kaufman, Jason, Sawliski, & Halpert, 1994). Jason has developed cognitive–behavioral interventions for high school students to prevent speech anxiety (Craddock, Cotler, & Jason, 1978) and has also been involved in developing cognitive–behavioral transition training interventions for youths graduating from high school (Jason & Burrows, 1986). Most recently, he has been working with Dr. LaVone Robinson on the development and evaluation of a NIH-funded violence prevention program for ninth-grade African American youth. These studies indicate a commitment to school-based prevention programs that began in the mid-1970s and continue to the present.

Jason has made many of his contributions in the ME and CFS area dealing with epidemiologic methods (Jason, Porter & Rademaker, 2012). In the first generation of adult ME and CFS prevalence studies, Reyes et al. (1997) published epidemiologic research that portrayed ME and CFS as being relatively rare, affecting about 20,000 adults, and further characterized patients as being European American and middle- to upper-class women. These findings supported the myth of ME and CFS as a “YUPPIE flu” disease. This Centers for Disease Control and Prevention epidemiologic study was based on a method that relied on physician referral of patients with ME and CFS (Reyes et al., 1997). However, if the physicians did not believe the illness existed, or if patients did not have a physician, many people with ME and CFS would not be referred to researchers or counted in prevalence surveys. Jason’s work in this area involved a randomly selected group of individuals being telephoned and screened for symptoms of ME and CFS (Jason et al., 1999). Those who were identified in the telephone screen as having several ME and CFS symptoms were then provided a complete medical and psychiatric examination to determine whether they actually had ME and CFS. This study estimated that over 800,000 people had ME and CFS, and this illness was found to be more prevalent among people of color. This study (Jason et al., 1999) and others (Reyes et al., 2003), by using community-based samples, differed from the methods used in the earlier Centers for Disease Control and Prevention study (Reyes et al., 1997) whereby physicians determined who was referred as a possible ME and CFS case. Jason subsequently conducted longitudinal prospective studies with this community-based sample. He has also helped developed a pediatric CFS case definition, and is now conducting a similar NIH-funded, community-based CFS and ME epidemiologic study of youth.

Jason’s group has completed several studies that have investigated the OH model of substance use recovery. For example, Jason completed a National Institute on Drug Abuse grant-funded study that examined abstinence-specific support and abstention from substance use in a national sample of OH residents. His group found that only 18.5% of the participants reported any substance use over 1 year (Jason, Davis, Joseph, Ferrari, & Anderson, 2007). Additionally, over the course of the study, the proportion of abstainers in individuals’ personal social networks increased. Finally, less support for substance use by significant others and time in OH predicted change in cumulative abstinence over the course of the study. Those with other OH residents as part of their social network were more likely to stay in OH for at least 6 months and were less likely to relapse (Jason, Stevens, Ferrari, Thompson, & Legler, 2012). In addition, a National Institute on Alcohol Abuse and Alcoholism grant-supported study successfully recruited 150 individuals who completed treatment at alcohol and drug abuse facilities in the Chicago metropolitan area. Half of the participants were randomly assigned to live in an OH, while the other half received community-based aftercare services (Usual Care). They were able to track over 89% of the OH and 86% of the Usual Care participants throughout the 2-year follow-up. Results from this randomized study indicated significantly lower relapse for OH (31.6%) than Usual Care participants (64.8%) at 24 months postdischarge from residential treatment (Jason, Olson, Ferrari, & LoSasso, 2006). Further, OH residents were more likely to be employed (76.1% vs. 48.6%) and less likely to report engagement in illegal activities (0.9% vs. 1.8%). Taken together, these studies demonstrate significant progress in documenting the effectiveness of the recovery home residence (e.g., lower relapse, better employment) and in understanding what mediates these outcomes (e.g., higher abstinence self-efficacy, minimum 6-month stay, more recovery-supportive personal associates outside the house, and a more cohesive house social ecology). Also, in a series of studies, they have found that among family members and friends, only children have a positive effect on helping OH residents with their substance use. Jason is now conducting follow-up research interviewing a sample of children who are living in OHs.

Selected Bibliography


Ethical and Diversity Challenges in Ecologically Sensitive Systems-Oriented Interventions

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This article discusses ethical and diversity challenges involved in implementing ecologically sensitive, systems-oriented research. These issues are considered with reference to a series of community-based interventions dealing with stigma and chronic illness, recovery from substance-use disorders, and prevention of tobacco use. Each of these ecological interventions incorporates a systems approach, which allows an understanding of how individuals affect and are influenced by their social environments. In addition, issues of diversity with respect to underrepresented and marginalized groups are considered, including overcoming obstacles to gaining access to resources and promoting increased opportunities and empowerment. Throughout, the central importance of developing relationships with key gatekeepers and stakeholders, as well as timely and effective communications with various coalition members, is highlighted. By bringing into the research and policy process diverse citizen/participant suggestions and input regarding the need for, or design and implementation of ecologically and systems-based interventions, researchers can build collaborative relationships that fuel trust and partnerships, leading to more ethically responsible research.

Editor’s note. Leonard A. Jason received the Award for Distinguished Professional Contributions to Applied Research. Award winners are invited to deliver an award address at the APA’s annual convention. This article is based on the award address presented at the 123rd annual meeting, held August 6–9, 2015, in Toronto, Ontario, Canada. Articles based on award addresses are reviewed, but they differ from unsolicited articles in that they are expressions of the winners’ reflections on their work and their views of the field.

Author’s note. I express my thanks to David Glenwick, John Light, Daphna Ram, and Diana O’hanian for their editorial help in writing this article. I also thank the many collaborators both from academia and the community who have collaborated with me over the years on the studies reviewed in this article. I appreciate National Institutes of Health funding from the National Institute on Alcohol Abuse and Alcoholism (Grant R01AA022763), the Eunice Kennedy Shriver National Institute of Child Health and Human Development (Grant R01HD072208), and the National Institute of Allergy and Infectious Diseases (Grant R01AI105781).

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Ecological analyses seek to understand behavior in the context of individual, family, peer, and community influences (Kelly, 2006). As noted by Revenson and Seidman (2002), the field of community psychology has focused on the transactions between people and community-based structures, or, in other words, individuals’ and groups’ behavior within their social contexts, with a focus on prevention and intervention. Consonant with this perspective, this article provides examples of ethical challenges in implementing community assessments and interventions. Within such analyses, issues of diversity are considered, including understanding barriers and obstacles to gaining access to resources and opportunities for underrepresented and marginalized groups.

Efforts to study ecological exchanges between individuals and their social environments have been limited in number and scope (Jason & Glenwick, 2012). When the effect of environment on behavior has been studied, it has rarely been extended to the effects of behavior on environment broadly (e.g., Todd, Allen, & Javdani, 2012). Systems-oriented ecological approaches, however, provide a foundation for thinking about and describing two-way transactional dynamics, as they center on how microlevel mechanisms (i.e., how we both influence and are influenced by others) aggregate to the macrosystem level and then feed back to the microlevel in an ongoing causal loop. To better understand lack of access to economic and education opportunities and the experiences of marginalized persons, one must apply a systems framework. As we shall discuss, failure to account for these types of system dynamics carries certain ethical risks in both conceptualizing and implementing social service and community-based programs.

Some of our more person-focused interventions have been piecemeal, expensive, and ineffective, particularly when failing to address the social environments surrounding and encompassing the interventions, and this is particularly salient in the case of marginalized populations (Jason, 2013). Consequently, ethical issues arise regarding the delivery of interventions that bring about only superficial change and, at best, short-term solutions to those most in need of services. In particular, people may be powerless to overcome oppression when interventions fail to address or take into account such macrosystemic processes as poverty, racism, and neighborhood disintegration (Moritsugu, Vera, Wong, & Duffy, 2013).

In contrast, a preventive systems perspective moves beyond attempts to treat each affected individual. Understanding social problems from this perspective highlights the bidirectional interchange between individuals and their social environments and in this way promotes consideration of contextual influences, challenging thinking of problems as resting solely within individuals (Ryan, 1971). Ethically responsible interventions do not blame the victims or succumb to the influence of destructive macrolevel forces such as harm-promoting businesses, narrowly focused governmental bodies, and/or countervailing media messages.

In this article, I will give examples of how marginalized groups and communities can be empowered. I will also redefine the term *diversity* in a broader way than usual, comprising the voices of all unempowered community members and including but not limited to more traditional criteria like race and gender. I will discuss the delivery of ecological programs and the distribution of resources in a dynamic systems framework, focusing on diversity issues in the way several community-based social change efforts are formulated and implemented. Finally, I will offer several illustrations of ecologically sensitive systems-based research grounded in diverse citizen/participant suggestions during both need identification and design phases. This approach that can ultimately contribute to more ethically responsible interventions.

**Stigma Regarding Chronic Health Conditions**

Over the past 30 years, while persons with chronic fatigue syndrome (CFS) have described their illness as serious and physically disabling, many within the medical profession have remained skeptical of the legitimacy of this diagnosis (Friedberg & Jason, 1998). Patients have been characterized as predominantly having a “yuppie flu” disease, affecting middle-class, relatively affluent women (Jason, Richman, et al., 1997). The social construction of this disorder as a psychogenic illness of neurotic women, similar to early depictions of multiple sclerosis (MS), likely contributed to the negative attitudes that health care providers have toward those with this syndrome (Richman & Jason, 2001). Investigators have found that 95% of individuals seeking medical treatment for CFS reported feelings of being misunderstood because of the illness or the treatment (Green, Romei, & Natelson, 1999).

Initially, prevalence estimates from the Centers for Disease Control and Prevention (CDC) suggested that there were fewer than 20,000 patients with this illness in the United States (Gunn, Connell, & Randall, 1993). However, these estimates were based on statistically unrepresentative, incomplete, and inaccurate methods. CDC researchers had used case ascertainment methods where physicians identified patients who presented with unexplained fatigue-related symptoms and then referred those patients for a medical examination to determine whether they met criteria for CFS. This methodology had several flaws. Many low-income individuals lacked access to medical settings and thus may not have been included in the prevalence studies. Moreover, many physicians doubted the existence of CFS, and may not have made referrals to CFS epidemiologic research studies. When research designs have these types of flaws, and the findings...
are widely disseminated, they may unwittingly victimize and stigmatize patients. As a consequence, researchers have an ethical obligation to attempt to counter the negative effects of such problematic investigations.

If medical personnel believe that CFS is a relatively rare disorder, and one that can be attributed to psychiatric-related factors, the physicians might minimize or misinterpret the physical complaints of patients with CFS, thereby leading to the mistrust and lack of communication that has been reported between patients and medical personnel. In line with a diversity perspective, our research group explored whether there might be voices or information representing a different point of view regarding the characterization of patients. For example, we learned that the CDC was receiving thousands of phone calls each month from patients with severe fatigue (McCluskey, 1993), thus suggesting that the illness might not be nearly as rare as stated by the CDC. In addition, the largest patient advocacy organization had thousands of members, suggesting higher prevalence numbers. By attending to non-traditional sources of data, we came to believe that the CDC estimate of fewer than 20,000 in the United States with CFS was probably an underestimate and that the characterization of CFS as being a “yuppie flu” disease may also be incorrect.

Judy Richman and I next formed a research team in Chicago, Illinois, which included professionals from diverse areas, including epidemiology, psychology, psychiatry, medicine, immunology, sociology, and biostatistics, as well as patient representatives. We believed that ethically responsible research required the engagement of multiple perspectives, including those of patients, right from the start of the research endeavor. We hoped that by doing so, we would overcome some of the design flaws in prior epidemiological studies. We wrote a National Institutes of Health (NIH) grant that proposed conducting an epidemiology study that involved contacting a random community sample, rather than generating the sample through physician referral. However, the NIH review group members were very critical of our grant application, indicating that because the CDC prevalence study had found so few people with CFS, in our proposed study of a random community sample of 28,000 individuals, we would find very few if any patients with this illness.

In an effort to refute this criticism, we received financial support from the national patient CFS self-help organization to conduct a pilot community-based CFS prevalence study. At the onset of this pilot research, we again attended to diversity issues and deliberately brought in multiple points of view. For example, by partnering and building a relationship with the largest patient organization, we benefitted from their clinical expertise, and we had a forum for ultimately publicizing the findings of our study as well as advocating for social change (Kroll-Smith & Gunter, 2000).

Our group actively involved patient perspectives in this pilot study, and one of the first issues we had to deal with was finding a way to identify and contact patients without having a referral from a treatment setting or physician. To accomplish this, we first talked to members of the local Chicago Chronic Fatigue Syndrome Association, who suggested that patients with CFS could be contacted using the telephone. Prior CFS epidemiology studies had not used this method to identify patients. The local CFS organization maintained a list of symptomatic individuals, and they thought that this list could be considered a valid source. We then used this list of telephone numbers to try to telephone the patients with CFS, and we were able to successfully contact about 90% of the sample (Jason, Fitzgibbon, Taylor, Johnson, & Salina, 1993), thus suggesting that telephone calling was an excellent way of reaching patients. Our team now had a strategy to successfully contact people from the community with this illness, without using a biased physician case ascertainment method. We were able to identify patients without doctor referrals by collaborating with people who were affected by the illness, and they provided us with helpful tips to overcome this first barrier.

In order to eliminate bias, even within our own participant recruitment, and to ensure diversity, we needed to think through how we might best identify minority groups and promote their participation in our study. This was especially important as at the time, CFS was believed to rarely occur among minorities. Yet this belief was likely a result of flawed implementation methods used to reach those from underrepresented groups. To remedy this, we again talked to patients from our local CFS support group who suggested the inclusion of Spanish-speaking telephone interviewers so that we could contact the many Spanish-speaking individuals who lived in our area. In addition, the patients suggested that to increase participation rates after we identified individuals in the telephone screen as having CFS symptoms, we should provide transportation to those we brought in for complete medical and psychiatric examinations and provide babysitting money for those who would need someone to look after their children. All of these recommendations and suggestions were incorporated into our plans to conduct a community-based CFS prevalence study. These diversity strategies and considerations regarding ways to access this population as well as ways to increase the demographic representativeness of our participants involved conversations with patients and professionals.

Our pilot study consisted of interviewing a random community-based sample of approximately 1,000 adults. Individuals who self-reported having CFS or many of the symptoms of CFS were examined by a physician and interviewed by a psychiatrist in order to determine whether they met case criteria for CFS. Our research team’s rate of diagnosis was considerably higher than that reported by the CDC (Jason et al., 1995). With this pilot data, we approached program officials at NIH with the intention of resubmitting our CFS prevalence grant. We were surprised when they informed us...
that they were not interested in a CFS epidemiology grant application. Perhaps these officials were skeptical of the legitimacy of this illness.

Although in science, we often believe that there is a linear progression of new discoveries and knowledge, each building on the other to incrementally support a particular theory, in the policy arena, data are only one source of information for setting the agenda or for developing and implementing policies (Jason, Beasley, & Hunter, 2015). There is rarely a simple cause and effect relationship (e.g., pilot data indicating the need for a larger study), and it is helpful to think in terms of complex dynamic systems that involve a variety of officials and gatekeepers, each having different motives and needs, and all exerting influence on the decision regarding which research projects to encourage and which to discourage. Just as there were numerous obstacles to gaining interest in our ecologically sensitive, community-based study, we also had many community partners who continued to encourage us regarding the importance of our proposed epidemiological study, reminding us that even the initial decisions can be altered with feedback.

When a revised grant was submitted, and there was not an epidemiologist on the NIH review committee, we challenged the review, and an epidemiologist was then added to the review committee. When a new CFS case definition was being developed by the CDC, our internal contacts provided the criteria to us, so that we could test it out to see how well it could identify patients as a screening tool (Jason, Ropacki, et., 1997) before resubmitting the grant. There were multiple actors and coalitions that emerged to help us ultimately secure NIH funding for our study, with each group influencing and being influenced by a variety of transactions and decisions over time. A dynamic systems perspective is helpful for explaining this process and outcome that challenged the logical and simplistic way in which science is typically portrayed in our journals and texts (e.g., Willard, 1996). Additionally, as this example illustrates, in our efforts to obtain funding and secure valid data, ethical rules of research conduct may need to be refined to take into account these types of complexities in our relationships and communications with community partners and colleagues.

Our group was finally successful in obtaining NIH funding for a study that involved screening a socioeconomically and ethnically diverse community-based random sample for CFS symptomatology and then providing comprehensive medical and psychiatric examinations for those that screened positive during the telephone interview for self-reported CFS symptoms. Rather than 20,000 people with this illness, our study found the CFS prevalence rate to be closer to 800,000 to one million (Jason et al., 1999). Moreover, about 90% of people identified as having CFS in our sample had not been previously diagnosed by a physician prior to participation in the study.

In addition, from a diversity perspective, our efforts to promote participation from minorities and marginalized populations were also successful, as we found that women, Latinos, middle-aged individuals, and persons of middle to lower socioeconomic status were at higher risk for this illness. These findings directly contradicted the perception that middle- to upper-class White women were most at risk for this illness. Our close relationship with the largest self-help group provided a natural outlet for our findings. This group was already highly motivated to correct public misperceptions about CFS, and subsequently helped publicize our evidence that ethnic minorities had higher CFS rates than Whites and that CFS rates were not greater among those with higher incomes. Qualitative methods (Anderson, Jason, & Hlavaty, 2014) provided us with a deeper understanding of the interaction of the multiple systems involved in the experiences of the patients, and allowed us to link the connection of illness to the distribution of power and privilege within the medical community (e.g., many patients mentioned that they experienced negative attitudes such as physician minimization of their illness). Thus, our work illustrates how ecologically oriented, systems research can achieve positive ethical and diversity outcomes by reducing stigma and debunking the myth that CFS was a rare “yuppie flu” illness.

Over the next 10 years, the debate over prevalence rates continued, with the CDC expanding the case definition and estimates of prevalence (Reeves et al., 2007), and others providing data indicating that this expansion might have brought into the case definition those with a primary affective disorder (Jason et al., 2009). Jason (2012) suggested that the erroneous inclusion of people with primary psychiatric conditions in CFS samples would have detrimental consequences for the interpretation of epidemiologic, etiologic and treatment efficacy findings. In this dynamic process, one research finding would often influence another in often unexpected ways. This CFS prevalence history has all the elements of a complex system, represented by various key scientists and patient organizations, often with contrasting opinions and research methods, and all seeking to win the allegiance and norms of the greater scientific community.

Moreover, the names chosen to characterize an illness can contribute to stigma and hinder research and advocacy endeavors. For example, MS was at one time believed to be caused by stress linked to oedipal fixations (Richman & Jason, 2001). When the name of the disorder was changed from hysterical paralysis (which had discredited the legitimate medical complaints of predominantly female patients) to MS, stigma was reduced for patients with this illness (Richman & Jason, 2001). With respect to CFS, the CDC had coined the name “chronic fatigue syndrome” in the late 1980s, even though the syndrome previously had been referred to as myalgic encephalomyelitis (ME). Patients disliked the CFS name, feeling that the CDC had trivialized their illness, as fatigue was part of many illnesses and was not the
primary problem faced by patients with this disorder. They preferred a medical name that was less stigmatizing. In the late 1990s, a patient contacted me and asked if I would conduct a study that might provide evidence that the “CFS” name could have detrimental attributions.

With input from this patient (who had been a researcher herself prior to becoming ill), we implemented a research design that involved giving a sample of medical interns a case study of a patient having all the symptoms of CFS. The interns were randomly assigned to several groups; one group was told that the patient had CFS, and another group was told that the patient had been diagnosed with a more medical name, ME. The labels did indeed influence attributions, with those interns who were told that the patient had ME evaluating the illness as being more disabling than those told that the patient had CFS (Jason, Taylor, Plioplys, Stepanek, & Shlaes, 2002). In conducting this study, we attended to the voice of a patient who helped lead us to important findings. In other words, by listening to the patient, we were able to appreciate how much we could gain from the important insights of people who live with this illness. Our ecologically sensitive research confirmed and supported the belief that negative attributions were caused by the CFS label.

These findings were disseminated widely by the patient community, which, in addition to bolstering public education, further continued the process of building strong relationships with this critical group of gatekeepers. Many patient groups worldwide have renamed their organizations to include terms such as ME. Moreover, a major scientific organization also changed their name to the International Association of CFS/ME. This effort to change the name has actively continued over the past decade (Jason & Glenwick, 2012). In 2010, an Advisory Committee of Health and Human Services recommended to rename CFS with the term ME/CFS, and in 2015, the Institute of Medicine released a report also suggesting a new name.

From a social capital/social power perspective (Bourdieu, 1977; Bourdieu & Wacquant, 1992), it is clear that there are often powerful vested interests that are major players in decisions about (a) the methods adopted to study its prevalence, (b) the federal support and approval of grants to study it, and (c) the terminology used to label the illness. There are constant transactional processes occurring, many of which have ethical implications. For example, inaccurate prevalence estimates, incorrect characterizations of patients, and inappropriate illness names can result in stigma and affect access to treatments and resources, particularly for those who are marginalized or underrepresented. By attending to diversity issues and patients’ suggestions and input, we can develop collaborative relationships that increase trust and legitimization, which can help set the policy agenda by fostering more ecologically sensitive and ethically sound research.

**Community Building and Substance-Abuse Recovery**

Drug abuse and addiction are among the costliest of health problems, totaling approximately $428 billion annually (National Drug Intelligence Center, 2011). An estimated 23.9 million Americans aged 12 or older use illicit drugs (Substance Abuse Mental Health Services Administration [SAMHSA], 2012b), which represents 9.2% of the population. Increasingly, substance abuse treatment programs are providing briefer formal programs followed by aftercare, which is often merely a referral to Alcoholics Anonymous or Narcotics Anonymous and an expectation to refrain from subsequent substance use.

Vaillant (1983) noted that environmental factors, including the amount and type of support one receives, may be key contributors as to whether or not individuals maintain abstinence after treatment. Individuals who participate in aftercare services sustain abstinence for a longer period of time (Laughter, Becker, & White, 2009). Unfortunately, many individuals who complete substance abuse treatment are released back into the community without the types of environmental supports needed to solidify their abstinence. Though community-based support groups such as Alcoholics Anonymous do offer immediate psychological and/or spiritual support, they usually do not provide needed housing, employment, or reliable sober-living environments.

The Oxford House (OH) network represents one model for helping reintegrate people in recovery back into communities (Jason, Olson, & Foli, 2008). OHs provide affordable and safe housing for people recovering from substance-use disorders. Residents are rented, single-family homes with a gender-segregated capacity for six to 12 individuals. They are completely self-governed with no professional staff. Residents can stay as long as they want as long as they pay their rent and abstain from drugs or alcohol. The organization has grown from one house in 1975 to over 1,900 OHs now operating within 48 states. During the last year it served over 25,000 people, making it the largest residential recovery network in the country. In the current cost-conscious environment, OHs represent an inexpensive setting promoting abstinence.

In 1991, I saw Paul Molloy (one of the creators of OH) on CBS’s 60 Minutes talking about this model. After viewing the broadcast, I telephoned him, saying that I was a community psychologist and was wondering if anyone had conducted any evaluations of OHs. Out of that initial conversation grew a long-term collaborative partnership between a university-based research team and a grassroots, community-based organization. OH representatives in Illinois and my research team spent a year getting to know each other; our group sent research assistants to attend their OH meetings, and OH sent a representative to our weekly research meetings to tape record our deliberations and then these recordings.
were shared with the other OH members in Illinois. During our early work, using qualitative methods, we heard the voice of the historically silenced OH members, whom had previously been homeless and disempowered (Jason, Ferrari, Dvorchak, et al., 1997), but had found fellowship, support, and hope in their new residential settings (Jason, Ferrari, Smith et al., 1997). OH members helped us to develop and modify our interview questions for our pilot work. Thus, over the course of a year, we were engaged in a dynamic process that involved building a relationship, developing avenues for communication, learning each other’s norms and values, and beginning to develop ecologically sensitive research methods. Some scientists might not understand the need for the development of these types of community-based collaborations, or the importance of compromises that must be made when studying real-world situations, but in the following paragraphs, I will try to show that these partnerships were critical in overcoming the many challenges in implementing this systems-level research.

After collecting pilot data, we spent several years submitting and resubmitting NIH grant proposals in the hope of receiving funds to more intensively study the effectiveness of OHs. The NIH grant committee reviewers repeatedly recommended that we needed to first conduct a randomized study, to assess whether the OH model actually worked, but our research group felt that this was not possible, as each OH votes on whether to allow new individuals to live in its OH. After 7 years of not being successful in securing a grant, we mentioned to Paul Molloy that we probably would not be able to secure the NIH funding, because we could not implement a randomized study; Paul then said that he would work with us to make it happen. What I didn’t know is that before I met Paul, another research group that had wanted to do a randomized study with OH. He had declined their offer as he had not built up a supportive relationship of trust with them. In contrast, our group had worked for 7 years getting to know Paul and his organization before we began this discussion of using a randomized design to evaluate OH.

With the support of Paul and the Illinois OH chapter to conduct a randomized study, we did finally receive NIH funding for a study, for which we recruited 150 people who were finishing addiction treatment at alcohol and other drug use treatment facilities. Half were randomly assigned to live in an OH, while the other half were randomly assigned to receive standard, traditional aftercare services. We interviewed each participant every 6 months over 2 years. Our results indicated that those who were provided an opportunity to live in an OH were twice as likely to remain abstinent over the 2 years, with significantly higher incomes and significantly lower incarceration rates (Jason, Olson, Ferrari, & Lo Sasso, 2006). Besides contributing to the empirical literature, these findings benefitted our OH collaborators in legitimizing the OH model, as our study was critical in having the federal government list OHs within the National Registry of Evidence-Based Programs and Practices (SAMHSA, 2011).

Our study was made possible by years of developing a partnership with the OH organization, and, by listening to the voices of our partners, as we were engaged in a dynamic process of systematic collaboration that allowed each party to learn from the other. For example, at the end of one of my presentations at an OH annual convention, an OH resident approached me and suggested that we include the issue of tolerance in our future research. He mentioned that prior to living in an OH, he was very prejudiced against people who were different from him, and he then pointed to a woman, who was his girlfriend, noting she was HIV positive. Before living in an OH, he said, he would never even have talked to her, as he was so intolerant and narrow minded, and discriminated against people who were infected with HIV. He then mentioned that it was just as important to measure changes in values and prejudices among residents as it was to assess abstinence. From a diversity perspective, this was a voice our group had not been aware of, so I took this feedback to our team, and we later began a study on the development of tolerance among OH members. We found that, over time, OH residents showed significantly greater increases in tolerance than those not provided with the OH experience (Olson, Jason, Davidson, & Ferrari, 2009). These results helped set a new research agenda for our group, with a focus on opportunities for personal development within OHs (Jason & Olson, 2011), exploring the experiences of transgendered individuals and those of different sexual orientations in OHs (Yang, Beasley, Chernyavsky, Jason, & Ferrari, 2011), helping establish Spanish speaking bilingual and bicultural OHs (Jason et al., 2013), assessing how affective experiences influence engagement and disengagement (Beasley & Jason, 2015), and exploring how relationship dynamics depend not only on individual characteristics, needs, and preferences, but also on the state of the network and individuals’ positions within it (Jason, Light, & Callahan, 2016). For example, we are beginning to understand the system dynamic pathway to a successful OH residence experience, with the formation of “high-trust” relationships being positively related to time in residence, and high trust is necessary to the formation of confidant relationships. In other words, successfully finding a confidant or mentor may be a key element for continued sobriety.

There are many advantages to seeking input from community members to guide research efforts; yet, there are often contrasting opinions from communities on these important policy issues, and therefore underlying ethical and diversity issues must be addressed. Though individuals living in OH and those that support them see the benefits of these houses, some communities are threatened by a house of individuals in recovery, fearing a lowering of property values or disruptive behavior. Some of these communities then passed laws or regulations that could further isolate or stigmatize vulnerable
and marginalized segments of our society. For example, some towns have passed laws that make it illegal for more than five unrelated people to live in a house; this deliberately targets OH, which usually needs six to 10 house members to make rent affordable for all house members.

Because I had worked for many years on evaluation studies of OH, I was contacted by a lawyer who asked if our research group could help him with a legal dispute involving a town trying to close down the local OH, by passing an ordinance forbidding more than five unrelated individuals from living in one home. We quickly examined a national OH data set and investigated how the number of residents in OH affected individual residents’ likelihood of recovery. We found that house sizes of eight to 10 residents corresponded with less criminal and aggressive behavior (Jason et al., 2008). These findings were entered into the court case, and I was later told that they were critical in the judge ruling in favor of the OH. Since then, I have testified with this data in a number of other high-profile court cases, and in each one, the findings of our study helped convince the judges to allow the OHs to remain in the communities.

When community members do have more contact with these recovery homes, they have more positive attitudes toward the people in recovery living in those houses (Jason, Roberts, & Olson, 2005). This type research provides glimpses of system transactions, which provide ideas for intervening with respect to both the microlevel (e.g., how OHs influence their neighbors as well as are influenced by them) and macrolevel (e.g., judicial decisions allowing OHs to remain in communities), as well as feedback the data obtained and the knowledge gained to the OH community members and others in an ongoing dynamic loop. In addition, social contexts affect people’s perceptions of “reality,” that is, the sociology-of-knowledge recognition that reality is to a large extent socially constructed, for that reason, subject to change by social processes (Strauss, 1997).

A few years later, an official from the Substance Abuse Mental Health Services Administration (SAMHSA) studied the OH movement with an effort to expand the number of houses by thousands. The official at SAMHSA concluded that because the organization of OH has a highly decentralized governance model, OH itself would not be able to oversee this degree of expansion. The person who was writing this report had studied my work with the OH organization and concluded that I was in the best position to oversee the expansion of this network. This official approached me, offering to provide my team with considerable funding to take over this expansion. I declined. He apparently did not understand that a primary strength of the OH movement was its decentralized, democratic governance model. This model may not have appeared to be efficient from a traditional hierarchical organization perspective, but our research had quite clearly demonstrated that the model was consistently good at creating recovery-friendly environments for its residents. A top-down governance model would, in other words, probably destroy what it was intended to promote.

From a systems perspective, contradictions are to be expected, as when one part of a federal agency such as SAMHSA can be providing legitimacy to an organization by listing it in the National Registry of Evidenced-Based Programs, whereas another official at the agency is inadvertently undermining it with financial offers to take over its expansion. There are potential differences between the needs of different institutional players; SAMHSA needs to feel like they can deal with responsible individuals to promulgate a recovery model, but those involved in recovery need a personal, localized environment, because that is how the mutually supportive recovery culture develops within a house. Another genuinely systems-oriented observation is that we tend to be used to managing social change (i.e., some person is in charge of it, etc.). But a more natural and perhaps sophisticated view is that once a social process is set in motion, it can be self-sustaining and this is far more likely when adherents feel empowered, because they are empowered (i.e., control where it’s all going). By recognizing, attending to, and appreciating these contradictions of dynamic systems within settings, we are better able to intervene to create and maintain trusting relationships with our community partners and intervene in an ethically and ecologically sensitive way.

**Prevention of Tobacco Use**

Over the past 50 years, a new normative landscape regarding tobacco use has developed in the United States, with changed attitudes toward tobacco, fewer smokers, and more restrictions on where tobacco use can occur. Community organizations, aided by a variety of psychologists and other social scientists, have made many important contributions to this process. Still, each day nearly 4,000 youths try cigarettes for the first time, and nearly 400,000 become daily smokers each year (CDC, 2014). It is estimated that one out every three youth who become regular smokers will die prematurely from tobacco-related illnesses. Smoking continues to be the leading preventable cause of death in the United States, killing over 400,000 people each year, which is more people than die each year of AIDS, homicide, suicide, automobile accidents, illegal drug use, and fires combined.

In the late 1970s and early 1980s, my research team was working with schools in implementing cognitive behaviorally based smoking prevention programs (Jason, 1979). In the process of implementing our interventions, we were informed by the students that merchants were openly selling them cigarettes, and these students pointed out the contradiction between our tobacco prevention messages and community merchants who openly sold cigarettes. Person-centered approaches such as ours were being compromised by a broader social ecology that included merchants illegally selling to-
bacco to underage youth as well as tobacco companies tacitly supporting these harmful practices.

With this qualitative student input as a guide, in 1988, our group decided to assess illegal commercial sales of tobacco. When we sent youth into stores to purchase cigarettes, we confirmed the student observations by finding that about 80% of merchants sold cigarettes to minors. After the local Chicago media widely publicized our study’s findings, Officer Talbot from the suburban town of Woodridge, Illinois, contacted me saying that his town had solved this problem by sending merchants a letter saying that it was illegal to sell minors tobacco. I explained to Officer Talbot that this might not deter the merchants from selling the minors tobacco, for it was unlikely that the merchant would be caught selling to minors as a police officer would have to be in the store watching the transaction when the merchant sold the cigarettes. This again highlights the real world versus science world frameworks; Officer Talbot thought he had solved this problem, but our team realized that something different needed to be done to address this issue.

We next jointly decided to launch a study that involved sending minors into the 28 stores in Woodridge to see whether merchants would sell them cigarettes. Using behavioral time series methods, we found that the majority of the stores did indeed sell the minors tobacco. This is an example of an iterative, dynamic process, in which mainstream (lay) opinions about the effectiveness of one intervention (sending letters to merchants) are taken seriously, but scientifically tested and scrutinized. These transactions occurring within a context of a developing relationship between our research team and the community collaborators, which positioned us to conceptualize how these microlevel data could be used by the police department, legislative and executive town officials, to consider marcosystem change that might ultimately impact the microlevel illegal merchant sales behavior. By involving the police in our work, moreover, we were able to avoid the often common resistance to new knowledge when it is perceived as being imposed from “outsiders.”

Using these data as a catalyst for change, our research team collaborated with Officer Talbot and the Woodridge police to help pass legislation in which fines would be given to vendors caught illegally selling tobacco. Officer Talbot and I reasoned that compliance checks (i.e., regularly sending in minors to stores to purchase cigarettes and fining those that illegally sold tobacco to minors) could reduce illegal merchant sales to minors. However, Officer Talbot also felt that it would be important to reduce minors’ public smoking by fining minors for possession of tobacco. I had some misgivings about this latter provision, as it might lead to a criminal record for youth. However, as youth were given only a parking-like fine, which would not lead to criminalization, and my community partner was invested in this approach, I lent my support for this two-part intervention. This is another example of the importance of compromise when working with community partners. Two years after implementing the legislation, rates of merchant cigarette sales to minors decreased from an average of 70% to less than 5%, and adolescent smoking decreased over 50% percent in a Woodridge junior high school (Jason, Ji, Anes, & Birkhead, 1991).

Word of our experiment spread throughout the United States even before our publication on the outcome. People across the country were fascinated with our successful effort to reduce youth access to tobacco. After passage of the Woodridge legislation, Officer Talbot was contacted by dozens of communities interested in initiating similar campaigns. Additionally, Officer Talbot presented our study during hearings at the 1990 national legislative initiative to reduce cigarette sales to minors, called the Synar Amendment. Woodridge research was a critical piece of the information that was used in the passage of this Amendment in 1992. All states are now bound by Synar federal regulations to reduce illegal sales of tobacco to minors and are required to provide a yearly report to the federal government that they are in compliance with Synar by regularly sending minors into stores to determine whether youth are being sold cigarettes.

When I sent my findings on the study conducted in Woodridge to the Journal of the American Medical Association for publication, the reviewers initially rejected the article. Around that time, Officer Talbot received an invitation from the journal’s editor to review an article on educational approaches to reduce illegal merchant sales. Officer Talbot immediately called me asking me what he should do, as he was someone outside of the research field. I responded by telling him that he was now considered an expert in this area, and I encouraged him write a review of the article. In Officer Talbot’s review, unbeknownst to me, he stated that the education-only approach that was used in the article he was reviewing would never be successful in reducing illegal tobacco sales, but that researchers at DePaul University had found that compliance checks and fining did work to reduce illegal commercial sales of tobacco to minors. A week later, I was contacted by the editor of that journal and asked if I would be willing to resubmit my manuscript. I did, and it was later accepted (Jason et al., 1991). This was clearly an unexpected benefit I received from my collaboration with Officer Talbot. This is also an example of social change occurring through a process of “legitimization.” My paper might have been initially rejected for a number of reasons ultimately related to the reviewers’ own beliefs, but as other individuals and institutions began to take our views and findings seriously, this changed. In fact, sometimes a new perspective can reach a “tipping point” of legitimacy relatively quickly, requiring only a few participating institutions to certify the perspective as worthwhile.

From a systems perspective, obtaining success in this youth access to tobacco area of research led to unexpected second-order opportunities in the policy arena as I was invited to testify at the House Commerce Committee, Subcom-
committee on Health and Environment during the tobacco settlement hearings of the 1990s. My testimony focused on adolescent tobacco prevention research that would best encourage progress in the antitobacco movement (Jason, & Fricano, 1999). In November 1998, the tobacco industry settled with the Attorneys General of 46 States for $206 billion dollars (four states had already made separate settlements). My example is a type of “systems” perspective, in recognizing that scientific knowledge emerges within a particular social context, and that this context will affect how (and even if) it is accepted and acted upon. The sociology-of-knowledge literature provides a natural framework for discussing such issues (Berger, 1977; Merton, 1968).

When our group began work in this area in the late 1980s, over 80% of merchants sold minors tobacco illegally, but by 2012, because of the Synar Amendment, the national average rate of tobacco sales to minors for the 50 States was 9.1% (SAMHSA, 2012a). In addition, a study by DiFranza, Savageau, and Fletcher (2009) found that because of the Synar Amendment and state efforts to reduce youth access to tobacco, there has been a 21% decrease in the odds of tenth graders becoming daily smokers. There is now a global consensus that sales to minors should be prevented. This is illustrated by the Framework Convention on Tobacco Control, which was unanimously adopted by the World Health Assembly and has since attracted more than 172 member states, representing almost 90% of the world’s population. Officer Talbot was instrumental not only in the passage of the Synar federal amendment but also in working with grassroots organizations throughout the United States in disseminating this successful innovation.

Our group has worked for over two decades on documenting the effectiveness of efforts to reduce illegal sales of tobacco to minors, as well as other related areas, such as examining the effects on youth of the density of tobacco retailers around schools (Adams, Jason, Pokorny, & Hunt, 2013). In addition, we have found that potent interventions that successfully modify specific behaviors may produce beneficial system effects within the community. For example, in comparing two communities with and without enforcement of strong tobacco vendor sales laws and youth fines for possession of tobacco, we found that adolescents in the enforcement condition had used less marijuana and were less often approached by someone trying to give or sell them illegal drugs than adolescents in the no-enforcement condition (Jason, Berk, Schnopp-Wyatt, & Talbot, 1999). In a larger randomized study, the likelihood of a child currently using drugs or illicit drug offers was lower in the towns with merchant enforcements plus fines for tobacco possession (Jason et al., 2010). From a system’s perspective, it is possible that these ripple effects result from indirect messages conveyed by the specific tobacco access intervention at the macrosystem level (i.e., the school system, the police and the media) and that certain illegal activities at the micrcoevel are not permissible within the community, promoting further macrolevel changes.

Although a consensus has emerged on the public health benefits of not smoking cigarettes, ways to achieve this goal continue to be debated. Some researchers suggest that youth access to tobacco efforts should be abandoned, as they waste antismoking resources (Glantz, 2002), and other social scientists oppose efforts to provide fines to minors who smoke in public, even though this policy continues to be broadly endorsed at the community level. When seen through the lens of dynamic systems, it should not be surprising that the policy arena is fraught with these types of conflicting points of views, and we, as social scientists, need to realize that there might be varying opinions about which interventions are ecologically sensitive.

The impetus for the youth access to tobacco interventions was precipitated by listening to students, who pointed out the contradiction of being provided a tobacco prevention program while merchants in the community openly sold them cigarettes. By bringing into the research process new voices, we broadened the contextual targets for intervention to include the community as well as youth, which confirmed the benefits of this diversity perspective. Equally important, when we fail to incorporate these types of contextual issues into our community-based interventions, and maintain our focus on exclusively person centered approaches, our change efforts might be ecologically insensitive and ethically irresponsible.

Discussion

In this article, I have argued for the importance of context and ecologically sensitive analyses of social problems—analyses that are systems oriented and that take an affirmative diversity approach. I provided examples of complex system-oriented barriers and obstacles involving ecological factors that compromised assessments or implemented community interventions. My team became aware of these environmental issues by being receptive and open to feedback and comments from patients who felt stigmatized by misrepresentations of their illness, from individuals who were alienated after being discharged from substance abuse treatment facilities into environments with dilapidated and inadequate housing, and, from schoolchildren who informed us they were being provided tobacco by merchants. A theme that occurs among these case studies is that researchers and public policy officials often have an idealistic view of how things should be and think that their way is “right,” but it is not until we work together, which often involves compromise and changing some of our original assumptions that we actually better understand and have the capacity to effectively make system-level change.

It is clear that many psychologists avoid approaching these types of more macrolevel factors, which involve multifaceted issues dealing with executive level decisions (to
change a stigmatizing name), economics (e.g., housing and poverty) or the political process (e.g., legislation to curtail the easy availability of tobacco to youth), because they feel inadequately trained or lacking the resources or knowledge to deal with these system-level complexities. For example, APA indicates that competence is an ethical issue, and psychologists should only practice within their competence bounds (Koocher & Keith-Spiegel, 2008). Yet, to develop ecologically sensitive interventions, and to intervene in ethically responsible ways, it might be incumbent upon social scientists to attempt to either include such factors in their assessments, seek advice or partner with other professionals with expertise in these areas, solicit consultants with training in specialized areas, and/or collaborate with community partners and organizations who have access to needed resources to bring about change.

Examples of this latter type of collaboration were provided, and they featured the building of mutually reinforcing relationships that helped patients, citizen groups, organizations, and students find solutions to their problems in an active way (Freire, 1970). In the case studies presented, effective communications were essential for building supportive, trusting collaborations with a variety of partners and organizations. In systems terms, these long-term relationships and commitments were essential to being able to leverage the resources and power to effect meaningful, second-order social change. But from a dynamic systems perspective, there are almost always multiple community voices or perspectives on social issues, and ultimately, one’s values might determine which groups or organizations to collaborate with (as was evident with the community opposition to locating OHS in their neighborhoods or with merchants providing minors tobacco). However, our efforts should be data driven, with our studies or the extant research used to justify our support of a particular policy or the development of culturally appropriate and ecologically sensitive interventions.

In this article, I discussed the idea of dynamic systems in several ways. I initially proposed the idea that in the communities we study, social ecologies are both constructed by individuals, and also act to constrain their behavior. In addition, the effect of ongoing findings on new studies is a sort of dynamic system. Alternatively, a more social-capital/social power/sociology-of-knowledge approach (Berger, 1977; Merton, 1968) deals explicitly with the power biases in social institutions—of which science is certainly one important example, and I gave examples of others including the police, SAMHSA, and so forth. The sociology-of-knowledge framework is of importance when considering the dissemination and practical use of research findings, such as translating such findings from scientific studies to the real world. A large part of what is being addressed in this article involves how to organize research in a way that maximizes its real world impact. This can be thought of from a systems point of view, and sociology-of-knowledge researchers have employed such a perspective regarding issues such as the social definition of reality, social change, and the role of social institutions (Berger, 1977; Merton, 1968).

Diversity is often considered to involve race, ethnicity, gender, disability, sexual orientation, and intellectual perspectives (Robinson, Brown, Beasley, & Jason, 2015), but in this article, I have broadened the term to include the voices and perspectives of unempowered community members and students. As evident in this article and elsewhere (Moritsugu et al., 2013), inclusion of such points of view can lead to better decision making for solving community problems. However, the power structure has and probably will be resistant to hearing many of these voices for change (Hall, 2006), particularly when they are from marginalized populations who encounter macrolevel barriers to full participation in decisions and access to resources.

Often, social inequalities are caused or exacerbated by an underlying abuse of power. Such power is frequently used to control resources, restrict channels for participation in community decisions, and shape the definition of a public issue. When ethical responsibilities conflict with laws, regulations, or other governing legal authority, psychologists are required to take action in order to protect or defend human rights (Fisher, 2013). What I have suggested in this article is that these types of power inequities can be challenged by psychologists’ collaborating on ecologically sensitive interventions with multiple stakeholders, including patient advocates, community organizations, and government groups, who can bring about change at the legislative, executive, or judicial levels.

This type work can be conducted at four primary phases of the policy cycle, and they include policy agenda setting (i.e., policy items to be considered), policy formulation and adoption (generation and passage of legislation/laws), policy implementation, and policy evaluation and revision, and policy-related activities. Examples were provided of several of these areas such as policy agenda setting by helping to legitimize the seriousness of the ME illness, and by policy implementation with the efforts to reduce illegal sales of tobacco with the Synar Amendment. There are many roles for community psychologists in working with advocacy organizations and the government, and some include legitimation, translating science into clear policy-relevant language, community organizing, policy analysis and strategy development, and public/political communication (Maton, Humphreys, Jason, & Shinn, 2015).

One of the lessons from the three case studies is that engaging in applied, community research is both challenging and important, but there are sometimes trade-offs between what is traditionally thought of as more scientific controlled experiments (i.e., experimental studies in a lab) and the challenges of doing controlled experiments in the real world. In addition, being willing to make compromises when building relationships is often critical in building the capacity to implement these types of community based interventions.
These themes were evident in the ME and CFS area, where initial CDC data gathering methods didn’t realize the importance of seeking patients’ opinions; in the OH area, where NIH reviewers requested a randomized study whereas we initially thought this would not be possible because of the nature of OHs; and with the tobacco studies, where our person-centered approach initially prevented us from recognizing the influence of system-level factors. We were able to deal with these and other challenges through building strong, flexible and collaborative relationships with our community partners.

This article considered the ethical issue of participant representation in research. Such representation is not only beneficial for participants in giving them a voice, a sense of personal efficacy, and legitimacy as part of the ongoing discussion, but also it is also beneficial for science in terms of providing ideas as to what is important to examine. In addition, the community members can become a natural supportive constituency for whatever is found because the findings are in a sense jointly created, rather than just created by researchers and then disseminated to the study population. I suggest that such partnerships in effect legitimize both the science and the at-risk population—they legitimize each other, and create a far more potent force for social change than either could manage alone.

Diversity also can be addressed in our research methods to enhance the ecological validity of our assessments and interventions. For example, methodological pluralism (the use of varied methodologies in research, typically the integration of quantitative and qualitative approaches) is especially suitable for research in the pursuit of social justice for marginalized populations because it is more sensitive to context and more likely to uncover power differentials and give voice to participants (Ponterotto, Mathew, & Raughley, 2013). We can employ these methods to chronicle and document the type of intervention, the community, the researchers and then disseminated to the study population. I suggest that such partnerships in effect legitimize both the science and the at-risk population—they legitimize each other, and create a far more potent force for social change than either could manage alone.

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