The Addictions Newsletter

The American Psychological Association, Division 50

Autumn, 1995 **Vol. 3, No. 1**

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President's Column

Mark S. Goldman
University of South Florida

Thank you for allowing me to serve as president of Division 50 this year. I am honored to have been elected and look forward to working with all of you. Before making any other comments, let me first take this opportunity to urge you to cast as many votes as you possibly can for Division 50 on the APA apportionment ballot you should be receiving about now. As you know, the role and influence of a Division is dependent on the number of votes apportioned to it. Division 50 is in great need of an increase in apportioned votes to be able to effectively press our case within APA. Without your support we could find ourselves without even our one current representative to APA Council.

As I consider the issues impacting the Division, I am once again struck by a sense of irony that has continued with me since I first entered the addictions field. The consequences of addictive behavior loom large both for the individual who suffers from these disorders and for society. And yet systems built to counteract these problems so often are relative newcomers that are forced to "run uphill" against already pressing events. Health professionals, and then mental health professionals, were late to attend to these problems and now have to justify their place among already active lay groups. Unlike many conditions with less impact on society, research on the devastating disorders of alcohol and drug abuse has had the support of independent national

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Editor's Corner

Bruce S. Liese
University of Kansas Medical Center

Once again I feel like a proud father. This issue of *The Addictions Newsletter* is edited, printed, and mailed; its articles deal with important matters in a constructive and sometimes humorous manner, and; most important, you are reading your copy!

With this issue we have entered our third year of publication. Recently, a student asked me my motivation for editing *TAN*. At first I was surprised. I thought the answer was self-evident. But, alas, I guess it is not. For the record, here is my answer. First, I cannot think of a ***topic*** more interesting than the psychology of addictions. As I stated in my last Editorial, there are so many important questions and so few definitive answers in our field. Second, I cannot think of a group of ***people*** more interesting and diverse than addicted people: individuals whose common thread is that they have difficulty controlling their use of nicotine, alcohol, illicit drugs, prescribed medications, food, sex... Have I excluded out? And third, I cannot think of a finer group of ***colleagues*** than those I have met working with addicted people (talk about a diverse group of individuals!). As the Editor of *TAN*, it seems as if I am at the confluence of it all. Where else do so many bright professionals meet to discuss the extraordinarily complex problems of so many millions of people? We are at the proverbial cutting edge!

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In This Issue

APA '96 Convention Reminder!

December 1, 1995 is the deadline for submitting proposals for the 104th Annual Convention of the American Psychological Association, which will be held in beautiful Toronto on August 9-13, 1996. Proposal information and application materials were included in the September issue of the *APA Monitor.*

Division 50 encourages submissions representing the full range of addictive behaviors, including smoking, eating, gambling, and sex, as well as the more traditional alcohol and illicit drug use. We are also interested in increasing the visibility of the Division by sponsoring symposia that will attract nonmembers. For example, such symposia might include presenters or discussants who are most well-known in clinical psychology, health psychology, neuropsychology, physiological psychology, or experimental psychology, but whose work has implications for the study and treatment of addictions.

The Division 50 Program Chair, **Tom Brandon, Ph.D.**, also asks that researchers who are willing to serve as reviewers of proposals in December please call him at (607)777-4171 or drop him an e-mail at:

brandon@bingvmb.cc.binghamton.edu

Please state your area of expertise in the message.

APA Council is important to the future of our Division. The more seats we have on the Council, the greater our voice. Please assign your votes to Division 50 when you receive your ballot from APA!

Pathological Pluripolar Mitosis
Or, APA Needs Another Division

John Grabowski
Past President of Division 28
Health Sciences Center
University of Texas-Houston

Thanks to your Editor for inviting me to carry on a tradition of forthright commentary established while I was president of Division 28 (Psychopharmacology and Substance Abuse). I offer my apologies in advance, since this piece deviates somewhat from what was originally expected. Broadly, the task was to comment on overlapping Divisions in APA, with special attention to Division 28 and 50. I dwell on the general, but from this the specifics should be apparent. Thanks to those who seriously consider the issues raised and see the forest for the trees. Make of it what you will. My basic assertion is that there should be no Division 50 independent of 28 or 12 (depending on the defined mission of Division 50). What? Should there be Divisions of Bipolar Disorders? Schizophrenia? Tricotillimania? Probably not; most would agree. Prior to pathological pluripolar mitosis there were a few Divisions: General, History, Physiological, Experimental, Statistics, Clinical, Developmental. Interestingly, psychology had little interest in geriatrics in its early years, but this is true of most of us.

Branching began. Some of the branches capitulated to the pressures of membership loss and died out. No longer do the numbers 4 and 11 have meaning in the APA. "Their jerseys were retired" (Division 47, Exercise and Sports Psychology). Not only cells are successful at apoptosis.

There were early portends of things to come (e.g. Division 10, Psychology and the Arts). I support the arts, and I am so far left of Jesse Helms and Newt Gingrich, that I could not see them over the horizon but for their "Contract on America" in which they have proclaimed the world flat. Why would a large multi-cultural and multi-faceted discipline have as an early branch, Psychology and the Arts? Where were the proponents of metaphorical, mystical, or botanical psychology? (Admittedly they came later.)

Some newly formed but redundant Divisions emphasized setting (or was it population?), e.g. Educational Psychology (15), distinct from Teaching of Psychology (2); Military Psychology (19) presumably preparing for down-sizing but distinct from Public Service (18) which, by the way, includes VA psychologists; Child, Youth and Family Services (37); Independent Practice Psychology (42) and Family Psychology (43). Others emphasized perceived distinct activities, e.g. Organizational (but also) Industrial (14), and Consulting (13).

Eventually, there were enough old psychologists to assure that Adult Development and Aging became a special interest, but unfortunately it also became a Division (20). Is it heretical to ask why the Developmental Division (7) was not reformulated to have 3 Sections, e.g. Early, Middle, and Late. And, taking into account that not all development is perfect, the activities of Mental Retardation and Developmental Disabilities (33) could be considered complimentary to, rather than separate from, the presumed normal development that is the object of Divisions 7 and 20.

As special anomalies there emerged a Division of Theoretical and Philosophical Psychology (24) independent of the original Divisions. Why was it not joined by the Psychology of Religion (36) which truly represents a theoretical premise and untestable hypothesis?

The special interests multiplied, including Divisions based on "therapy types" e.g. Psychological Hypnosis (30), Psychoanalysis (39), and Counseling (17), a form of low octane therapy, somehow distinct from clinical. There is a Division based on "N", rather than therapy type *per se*: Group Psychology and Group Psychotherapy (49) simply reflects a common failure to distinguish between setting and content of activity in that setting. The "really big N" Division, Population and Environmental Psychology (34), is an amalgamated enigma. The Experimental Analysis of Behavior (25) Division claims to study the "real" subject matter of psychology--i.e. behavior. Similar is the claim from Applied Experimental and Engineering (21), members of which believe they are the source of application of data (opposed to those who are appliers of insights?).

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The Addictions Newsletter
is the official Newsletter of Division 50
of the American Psychological Association

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NIDA Multisite Collaborative Treatment of Cocaine Abuse

Lisa M. Najavits
Harvard Medical School
Project Director, NIDA Collaborative Cocaine Study
McLean Hospital and Massachusetts General Hospital

A major psychotherapy study is currently underway that may be of interest -- as well as a potential resource -- for addictions psychologists. Five hospitals around the country currently offer 6 months of free, high-quality psychotherapy to outpatients with cocaine dependence, as part of a National Institute on Drug Abuse (NIDA) study. Entitled the NIDA **Multisite Collaborative Treatment of Cocaine Abuse** study, it is the largest research project ever conducted on the psychotherapy of cocaine addiction, at a cost of 14 million dollars over seven years. It is also one of a very few large-scale collaborative psychotherapy studies: five hospitals across the country are simultaneously carrying out the project, under the direction of experts in the psychotherapy of substance abuse. A description of the study's design, the questions it addresses, and benefits are provided below.

Study design and goals. The main goal of the study is to compare four modalities of treatment: individual cognitive psychotherapy (Beck, Wright, Newman & Liese, 1993), individual supportive-expressive psychotherapy (Mark & Luborsky, 1992), individual 12-step drug counseling (Mercer, Carpenter, Daley, Patterson, & Volpicelli, 1994), and group 12-step drug counseling (Mercer & Woody, 1992). All subjects receiving individual treatments are also offered 12-step group drug counseling (GDC), since GDC is standard treatment, typically offered in most addiction settings. Subjects will be randomly assigned to one of these four treatments, until 480 individuals have been enrolled in the study. The central question of the study is whether treatment modality (cognitive, supportive-expressive, or 12-step), and format of treatment (individual versus group) relate to patient outcome. "Outcome" in this study is defined primarily as substance use, measured by self-report and urinalysis, with additional outcomes in such diverse areas as co-occurring psychiatric disorders, social and occupational functioning, HIV risk behaviors, and service utilization. Several process variables are also included, such as attendance at treatment, therapeutic alliance, and clinicians' emotional responses to subjects.

The coordinating center of this study is at the University of Pennsylvania, under the direction of Paul Crits-Christoph, Ph.D., Principal Investigator. The sites participating in the project (and their principal investigators) are: Brookside Hospital in Nashua, New Hampshire (Arlene Frank, Ph.D.); Massachusetts General Hospital in Boston and McLean Hospital in Belmont, Massachusetts (Roger Weiss, M.D.); University of Pennsylvania (Lester Luborsky, Ph.D.); and University of Pittsburgh (Michael Thase, M.D.).

The methodological rigor of this study reflects state-of-the-art psychotherapy research. All treatments follow a treatment manual specifically designed for this population; all therapists are carefully selected for experience, training, and clinical skill. Throughout the project, therapists receive biweekly individual supervision, based on audiotape recordings of their sessions. Adherence ratings, completed by clinicians' supervisors, are conducted on a regular basis to ensure that clinicians are following treatment manuals. All subjects are evaluated by trained diagnosticians for eligibility for the study using the Structured Clinical Interview for DSM-III-R (SCID). Interrater reliability is established on all major assessment measures used. The study has undergone a three-year pilot phase to train therapists, establish procedures, and refine methodology.

What do patients receive? Patients in the individual treatments are provided 36 individual counseling sessions plus 24 group counseling sessions over six months. Patients in the group drug counseling-alone condition only receive 24 sessions of group counseling. Subjects in all four conditions are additionally encouraged to attend self-help groups in their community (e.g., Alcoholics Anonymous, Cocaine Anonymous, Rational Recovery). All treatments and diagnostic interviews are free and subjects are paid for completing research assessments, conducted at intake, monthly for the first six months of treatment, and then at 9, 12, 15, and 18 months.

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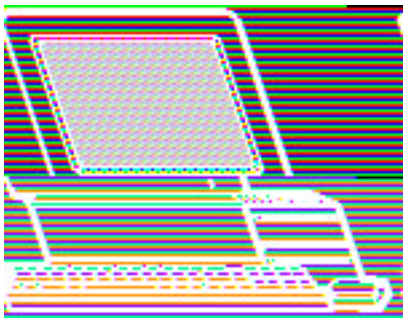
The Division 50 e-mail listserver is alive and well!



With over 100 members, the APA Division 50 Forum (APADiv50-Forum) has begun to serve an active role in aiding communication between Division members and others interested in addictive behaviors. Issues addressed on our listserver range from the status of Project Match to locating addiction treatment resources in another city.

If you have not subscribed as yet and would like to do so, send a message to:

listserv@csd.uwm.edu

The message should consist only of the following:

subscribe APADiv50-Forum [yourfullname]

Please do not include any other information or corrspondence when signing up for the list (it will not be understood by the listserver).

Your message will result in a returned welcome message with a full description of the APADiv50-Forum and additional instructions about using the list. Professionals who are not members of Division 50 and others may contact Vince Adesso, Ph.D. by e-mail about joining the list:

vince@alpha2.csd.uwm.edu

Once again, we look forward to hearing from you and having you contribute to some lively discussions.

Misconceptions for Sale

Eric F. Wagner
Brown University
Providence, RI

I opened my copy of the Summer, 1995 issue of *The Addictions Newsletter* in the hope of spending a pleasant moment or two catching up on the activities of Division 50 members. I was especially looking forward to reading the articles about Alcoholics Anonymous (AA) and Rational Recovery (RR), two approaches to addressing addictive behavior that, in my opinion, get too little attention in the scientific literature. I started with Charles Clark's piece about common misconceptions about AA. Indeed, there are many misconceptions about "the program," and such misconceptions have impeded attempts to understand why and for whom AA is effective (see Kassel & Wagner, 1993; McCrady & Miller, 1993). Unfortunately, as I read Clark's article, my pleasant moment or two became increasingly less pleasant. While I was sympathetic to Clark's speculations as to why AA might appear less effective today than in times past because of legally-mandated participation in recovery programs, I was less enthusiastic about his opinions concerning the subject of the recovery status of addiction professionals. Specifically, Clark claimed the following:

"Unfortunately, many professional who research, develop, and implement treatment programs are not recovering people themselves. These professionals can be compared with male obstetricians who graduate from prestigious medical schools with honors, who have decades of experience. They themselves have never been pregnant or given birth (of course). These experts do not really know what a mother FEELS while she is giving birth to HER baby. They don't know the hundreds of thousands of thoughts that go through her mind. How can these experts possibly KNOW what is going on inside each mother emotionally, spiritually, and intellectually. Similarly, how can a professional who has never been an addict or alcoholic understand EXACTLY what is going on inside someone struggling desperately to overcome an addiction?" (p. 22)

My decreased enthusiasm could be attributed to three things: (1) I'm one of those "professionals who research, develop, and implement treatment programs who are not recovering people themselves," and I'd like to think that it's fortunate (not unfortunate) that I

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Integrating Psychotherapy and 12-Step Programs

Marilyn Freimuth
New York, NY

Psychologists can expect to treat an increasing number of patients involved in some type of addiction recovery program. In AA alone, 60% of its membership seek some "treatment or counseling" (AA World Services, 1990). This paper considers some benefits and roadblocks to integrating psychotherapy and 12-step work. While the focus is on 12-step programs many of the issues are relevant to patients in other recovery programs.

Some psychotherapists view patients' 12-step involvement with neutrality or negativity. The latter has been true for those psychoanalytic clinicians who believe that addiction, as a symptom, will resolve only as dynamic issues are addressed (Berger, 1991).

Recently a number of addiction specialists have suggested that simultaneous involvement in psychotherapy and a 12-step program can be beneficial. These authors follow what can be called an adjunct model (e.g., Rosen, 1981; Zweben, 1987). By helping the patient cease substance abuse, 12-step involvement becomes a supportive adjunct to psychotherapy. A patient who actively works his/her program has a place to go and people to call whenever addiction related issues arise. This extra-therapeutic support frees the therapist to address emotionally difficult issues with some comfort that the resulting stress will not lead to substance abuse. Likewise, psychotherapy is an important adjunct to the 12-step work. Therapy becomes a place to process complex and changing feelings about the 12-step experience (e.g., relationship to a sponsor). Thus, therapy supports continued program involvement and enhances benefits to the patient (Zweben, 1987).

The collaborative model of integration incorporates the adjunct model but is distinguished by the belief that the benefits of 12-step work extend beyond cessation of substance abuse to include therapeutic-like emotional growth. Flores (1988) illustrates this idea with reference to alcoholism: "The first step of the AA program is the only step that addresses drinking. The rest of the eleven steps of the 12-step program are dedicated exclusively to what AA calls 'the removal of character defects.' AA is commonly referred to by its members as a 'program for living'" (p. 213).

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Report on the APA Council Meeting

Herbert J. Freudenberger
APA Division 50 Council Representative
New York, NY

As your sole APA Council Representative, I would like to report on matters that came up on the APA Council Agenda when we met in New York City in August, 1995. The purpose of the APA Council is to monitor APA's course and introduce changes that are often relevant to Division 50's interests. There are approximately 120 Council Representatives representing Divisions and State Associations. The following is a list of issues discussed at the meeting:

1. Divisions will remain autonomous. It was decided that each may develop local chapters and issue annual reports.
2. APA members who are at least 65-years-old who have belonged to APA for at least 25 years are eligible to become exempt from dues.
3. Regarding managed care, a 6-member task force will be formed to advise and make recommendations to the Committee for the Advancement of Professional Practice (CAPP). If you have any input please contact me in writing.
4. California and other states are preparing for a legislative battle for prescription privileges. The Council (and I as your Representative) supported the resolution.
5. Our Division received approval for nine Fellows: David B. Abrams, Raymond F. Hanbury, Jr., John P. Allen, Ronald M. Kadden, Sandra A. Brown, Alan R. Lang, Gerard J. Connors, Elizabeth C. Penick, D. Dwayne Simpson. Congratulations to all who received this honor!
6. A major discussion evolved regarding outcome measures. Given the complexity of this project, CAPP authorized staff to retain Coopers and Lybrand to research existing entities in order to evolve specific proposals for a practice research network. There are many unsolved and complex problems regarding this project.
7. We were informed about the progress of a $1.5 million public education project. As your Council Representative, I objected to the lack of input sought from Divisions and relevant committees regarding this project. As a consequence a task force was established and I was nominated to be a member of this task force.

Please contact me and share your thoughts and concerns, so that I may appropriately represent you.

Editors Needed!

The Publications and Communications (P&C) Board has opened nominations for the editorships of the *Journal of Experimental Psychology: Animal Behavior Processes*, the Personality Processes and Individual Differences section of the *Journal of Personality and Social Psychology*, the *Journal of Family Psychology*, *Psychological Assessment*, and *Psychology and Aging* for the years 1998-2003. Stewart H. Hulse, Ph.D., Russell G. Geen, Ph.D., Ronald F. Levant, Ed.D., James N. Butcher, Ph.D., and Timothy A. Salthouse, Ph.D., respectively, are the incumbent editors.

Candidates should be members of APA and should be available to start receiving manuscripts in early 1997 to prepare for issues published in 1998. Please note that the P&C Board encourages participation by members of underrepresented groups in the publication process and would particularly welcome such nominees.

To nominate candidates, prepare a statement of one page or less in support of each candidate and send to the attention of the chair of the appropriate search committee. Search committee chairs are:

- Joe L. Martinez, Ph.D., for *JEP: Animal Behavior Processes*;
- David L. Rosenhan, Ph.D., for the "Personality Processes and Individual Differences" section of the *Journal of Personality and Social Psychology*
- Carl E. Thoresen, Ph.D., for the *Journal of Family Psychology*;
- Hans H. Strupp, Ph.D., for *Psychological Assessment*; t
- Lyle E. Bourne, Ph.D., for *Psychology and Aging*

Address all nominations to the appropriate search committee at the following address:

Lee Cron
P&C Board Search Liaison
Room 2004
American Psychological Association
750 First Street, NE
Washington DC 20002-4242.

First review of nominations will begin December 11, 1995.

Removing Barriers
Integrating Outreach and Standard Addiction Services

Robert Westermeyer
San Diego, CA
HabitSmart Web site at
http://www.cts.com/~habtsmrt/

The vast majority of individuals grappling with addictive behaviors are not connected with addiction services (NIDA, 1991, Regier et al, 1993). Those adhering to the disease model might contend that the principal reason these individuals do not access treatment or support groups is because their disease has not progressed to the extent that they have "hit bottom." Those of a "non-disease" orientation might argue that these individuals do not access services because they find the 12-step model and associated dichotomous treatment mandates unattractive.

Though I am more inclined to agree with the latter as a major obstacle, I do not believe it is the principal one. Would throngs of addicted individuals, who would not have otherwise accessed treatment, suddenly flock to existing treatment agencies if the treatment philosophy changed? I think it is highly unlikely.

I believe that the "standard" model of treatment provision (i.e., professionals waiting in an office or agency for patients to show up for appointments) is the chief barrier to connecting with these "out of touch" individuals. In this article I will discuss outreach as a model of addiction service provision successful in making connections with this hard to reach group. It is a model from which we, as psychologists, can learn a great deal.

The standard model of addiction treatment is sort of like fishing in the harbor. All you need is a pole, some bait and a seat on the wharf and you're set! A few zealous fish might even venture into the harbor, but the vast majority aren't going to go near it. If you want to catch these fish, you have to use completely different gear, and it requires leaving the harbor, venturing into turbulent waters. The addicts who show up for their appointments at agencies or psychologists' offices represent the motivated elite. They have already "tipped the scale" of ambivalence (Miller, 1995). This is a monumental achievement! These fortunate few are already on the road to change.

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PRESIDENT'S COLUMN *continued from page 1*

institutions such as the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA), for less than 25 years. Other disorders represented by members of our Division, such as eating disorders and gambling, do not have any dedicated support system. I do not have to tell members of our Division why this may be so; we are only too familiar with the mixed sentiments that society, and sometimes professional groups, have toward these disorders.

Our Division is now coping with a very immediate example of these circumstances. As a formal Division of APA, Division 50 is a "newborn." But the ordinary tasks of getting up and running as a Division could not take precedence. We were already facing the rapid creation by APA of the new College of Professional Psychology and its efforts to develop a certificate system for psychologists working in the field of substance abuse treatment. If we, as experts on addictions, could not play a central role in this process, the importance of our Division would be undermined just as it was born.

Although the final product of the College process is not yet certain, I am pleased to report that our Division has had, and will likely continue to have, an impact on the development of the test that will be used to credential psychologists in the substance abuse field. I believe representatives from our Division also have had an influence on how the College itself will function in the future with respect to how expert consultation is obtained from the larger membership of APA. Rather than functioning as a totally independent entity, I am hopeful that the College will continue to seek expertise from the Divisions of APA for appropriate experts. Because the process is still ongoing, we need to remain vigilant in this respect, however. Many individuals are responsible for our progress in this arena, but Sandy Brown should receive special credit for her efforts. As head of the Education and Training Committee of our Division, she has been tireless in making sure we have been well represented at college meetings. Barbara McCrady also should receive our thanks for her efforts as Chair of the group within the Education and Training Committee that developed the knowledge-based curriculum for the Division. Our efforts have been well-coordinated with Division 28, in large part thanks to Maxine Stitzer. Considerable thanks go as well to Jalie Tucker, who as president initiated much of this activity, and to Ray Hanbury, who followed it up.

We now are presented with the opportunity to avoid another ironic instance of having much to offer but arriving too late. I refer to the current "hot button" issue of empirically-validated treatments. Yes--there are dangers in putting on paper what might appear to be an exclusionary list of those treatments that "should" be practiced in the field. And I agree that some lists are being put forward with a naive disregard for some of the realities faced by those in the service delivery trenches. Nevertheless, the call for accountability is now too pervasive to ignore. The leadership of the Practice and Science Directorates is calling for this information, in part, to provide them with ammunition to better represent us within the national forums that are deciding things such as who gets to offer services and which services will be reimbursed. If we do not address these issues, someone will do it for us. Within Division 50, we can bring to bear expertise from both the service delivery and research communities, and in a fashion that recognizes the value of addictions treatment. Contrast the guideline development process that could take place within Division 50 with one that might derive from managed care providers or from another professional group. In fact, there have already been lists of empirically-validated treatments compiled within various APA groups that do not include much of the work already carried out within the addictions field. Omitted are both treatments of addictions themselves, as well as the appropriate methods for evaluating these treatments (see Hester & Miller, 1995, as just one example). The latter point is especially significant; only those working within this field are truly equipped to establish some of the essential ingredients of evaluation, such as the criteria for treatment success in relation to these very difficult-to-treat disorders.

Fortunately, a thorough and dispassionate examination of the full range of criteria necessary to establish empirical validation of a treatment can lessen the concerns both of those who provide services and those who wish to apply research strategies to demonstrate the effectiveness of these treatments for consumers (these are, of course, often the same people). For example, I recently had the good fortune of participating on a committee put together by APA's Board of Professional Affairs, Board of Scientific Affairs, and Committee for the Advancement of Professional Practice, for the purpose of constructing a set of rules and procedures (a template) for developing guidelines for treatment of specified disorders.

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The committee consisted of individuals from the practice and science communities (Dan Abrahamson, David Barlow, Sol Garfield, myself, Steve Hollon, Sue Mineka, Elizabeth Robinson, and George Striker) to insure attention to both applied and research issues in the development of practice guidelines. A review of these issues by this balanced committee revealed less inherent conflict than may have at first been anticipated. The product of the committee's deliberations was approved as an official APA document by the APA Council of Representatives (February, 1995) entitled *Template for Developing Guidelines: Interventions for Mental Disorders and Psychosocial Aspects of Physical Disorders*. This document is available upon request from the Practice Directorate (Fax requests to 202-336-5797, attention Steve Rentner). It is anticipated that this template will become the standard against which all guidelines must be evaluated, including those constructed by government agencies, third party payers, and even other professional groups.

While this 30-page document cannot be described at length here, two unique features are important. First, and most important, in addition to the usual specification of the need for a methodologically rigorous system for validating treatments (referred to in the document as the treatment efficacy axis), the template includes separate criteria for validating treatment utility (how well a treatment works in real-world applications). Among the considerations here are generalizability of the intervention for various patients and in various settings, the feasibility of carrying out the intervention across patients and settings, and the various costs and benefits associated with a particular intervention. Second, even the efficacy axis includes a place for clinical judgment by experts in the field, recognizing that not all treatments have reached the phase of their development at which they have been subjected to the full range of rigorous clinical trials. The template does, however, systematically urge that treatments be subjected to increasingly stringent evaluation.

To my knowledge, no psychologically-based treatment of any disorder, has been validated across all criteria recommended in the template. In the addictions field, the template will show some treatments to have more support than others, and all current treatments will require considerable further validation. I believe our Division can take the lead in this process. During my tenure as president, I will explore the possibility of forming a Divisional working group, consisting of service providers and researchers, to begin this process. I invite written recommendations for participants on this working group. Ideally, recommendations will include CV's.

On a related note: I am told that the first findings from Project MATCH, a large scale alcoholism treatment consortium study funded by the NIAAA, will be released this Fall. In Project MATCH, Twelve-Step Facilitation Therapy is compared with Cognitive-Behavioral Coping Skills Therapy and Motivational Enhancement Therapy in both outpatient and inpatient follow-up settings, and with special attention to outcomes that may be influenced by "matches" between patients and treatments (see Donovan & Mattson, 1994). Bruce Liese informs me that a similar NIDA-funded study is in progress. (*Editor's note: please see the article by Najavits in this issue of* TAN.) Hence, the material for assessing treatments along the treatment efficacy axis is becoming increasingly available in the addictions field. (I apologize for the heavy use of alcohol references--this is the area I know best. I would be pleased to hear of developments in other addictive problems.)

In closing, the need to provide service, develop new assessment and treatment modalities, and validate these, once again underscores the utility of the scientist-practitioner model with which so many of us identify. This model now has considerable practical, economic, and philosophical bases. As currently structured (in the form of separate Directorates), APA has no formal mechanism for supporting this model. Divisions such as our own, which include interests ranging across this continuum, need to have APA mechanisms for recognizing and supporting this diversity. We should look for ways to encourage the development of such mechanisms. At the very least, this process may assist individuals falling at various places along the science-practice continuum to find common ground. Hopefully, Division 50 can serve as a model for this sort of interaction.

REFERENCES

American Psychological Association. (1995). *Template for developing guidelines: Interventions for mental disorders and psychosocial aspects of physical disorders*. Unpublished document.

Hester R.K., & Miller, W.R. (Eds.). (1995). *Handbook of alcoholism treatment approaches: Effective alternatives* (2nd ed.). Boston: Allyn & Bacon.

Donovan, D.M., & Mattson, M.E. (1994). Alcoholism treatment matching research: Methodological and clinical issues. *Journal of Studies on Alcohol*, (Supplement No. 12), 5-14.

NIAAA Gives Priority to Health Services Research

Robert B. Huebner
National Institute on Alcohol Abuse
and Alcoholism (NIAAA)

Health services research, an integral and emerging area within the alcohol field, focuses on understanding how alcohol treatment and prevention services are organized, managed and financed, and how these factors influence the availability, quality, utilization, and effectiveness of these services. The National Institute of Alcohol Abuse and Alcoholism (NIAAA) has established a Health Services Research Program, headed by Robert B. Huebner, Ph.D. to develop a diverse and well-rounded knowledge base to improve the quality, accessibility, and outcomes of alcohol services. The program is part of the Institute's Division of Clinical and Prevention Research.

NIAAA has organized its health services research portfolio into four areas: financing and reimbursement of services, service utilization and cost, effectiveness of services and client/patient outcomes, and delivery system organization and management. Each of these categories contains numerous research opportunities that encompass a broad range of issues and scientific disciplines. Presented below are highlights of the many challenging topics within these categories that, through further exploration, will provide a wealth of information that will be critical to improving alcohol-related prevention and treatment outcomes.

Financing and Reimbursement. Assessing the impact of alternative financing arrangements on the cost, availability, utilization, effectiveness and efficiency of alcohol-related health services is another important part of the Institute's agenda. For example, both public and private sources provide substantial funding for alcohol treatment services. Significant differences have been noted between publicly and privately funded treatment in terms of clientele served, nature of services provided, average length of stay, and other variables of interest.

In addition, private innovations in financing and reimbursement arrangements, such as the trends toward managed care and capitated insurance arrangements, may have critical implications for the availability, quality and efficiency of services. Although there have been few alcohol-related studies in these areas, research on financing and reimbursement issues are a high priority under the health services research program.

Utilization and Cost. These studies measure and analyze the use and costs of various alcohol- related groups in different settings and geographic locations. Particular issues that warrant exploration include the psychological, financial and physical barriers that may limit access to care, and the availability, supply and distribution of prevention and treatment programs.

The Institute continues to support studies that examine whether the costs of prevention and treatment services are balanced by subsequent reductions in health care expenses. A recent study compared assessments of outpatient and inpatient approaches in studies dealing with detoxification and intensive day treatment for alcoholism. This study found that most patients can be treated effectively in less costly outpatient settings (including a range from short clinic visits at intervals to full-day hospital stays). However, more research is needed to evaluate the cost-effectiveness of different population, beginning with improvements in measuring the costs of alcoholism treatment.

Effectiveness and Client/Patient Outcomes. Alcohol-related health services research conducted in this area focuses on three fundamental questions: how effective are carefully researched alcohol treatment and prevention interventions when implemented in real world settings, what are the long term effects of alcohol treatment and prevention interventions, and what aspects of service delivery (i.e. how service delivery is organized, financed and managed) improve prevention and treatment outcomes? Although evaluations of individual treatment and prevention programs are numerous, a project Matching Alcohol Treatments to Client Heterogeneity (MATCH) is collecting utilization data at nine sites and cost data at three. Near completion is a comprehensive meta-analysis of treatment outcome studies that will provide valuable information about patterns of outcome in various types of alcohol-related treatment settings. Such studies can point the way to multi-site investigations that can further elucidate the impacts of treatment content, process and level of care on outcomes.

Delivery System Organization and Management. There have been several important shifts in the organization and management of alcohol treatment and prevention services over the past 20 years, and initiatives in both the public and private sectors indicate that further changes can be expected.

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Report of the Membership Chair

Janice G. Williams
Clemson University
Clemson, SC

Since July, Division 50 has received dues payments from seven new Members, two Associates, and six Student Affiliates. Eighty-six members have resigned from the Division. Total membership in the Division is currently 986.

The Membership Chair's office has mailed information packets to 125 individuals who indicated interest in Division 50 to APA, as well as 240 psychologists on the Federal Register who listed an interest in addictions. Tom Horvath has also obtained addresses for members of the American Society of Addictions Medicine. I will be sending out information packets to those approximately 400 individuals, as well.

The Regional Membership Representatives have been active, distributing membership brochures in their regions. Of particular note is **Carol Butler's** work in the **Northeast** region. She has recruited some enthusiastic new members from the New York State Psychological Association, who are helping her to disseminate information about the Division. Carol will also be presenting an inservice training program at the Montrose VA Medical Center at the end of the month, where she will also talk about the role of Division 50 in facilitating professional communication about sexual addictions. In the **Southeastern** region, **Pat Flynn**, the newest regional representative, has been busy recruiting new members. He will be attending a conference at the end of the month, where he will distribute membership information.

Current membership issues facing the Division on Addictions include the following:

New members. We need to continue reaching psychologists who have not heard about the Division. Dr. Sorensen mailed out almost 1,000 recruitment packages last year, and I will be continuing that work. Mass mailings must be followed up by more personalized contacts and particular efforts to make new members feel welcome in the Division.

Retention of new members. We have just learned of 86 psychologists who have dropped their membership in the Division. Most of these individuals retained their membership in the American Psychological Association. The most frequent complaint received by the Membership Chair has been that the journal and newsletter are slow in coming to new members. Because these are important benefits of belonging to the Division, we need to make an effort to get new members on the mailing list as quickly as possible. The Membership Chair and the Secretary-Treasurer will be working on this problem. Additionally, the Membership Chair will coordinate efforts with the Regional Representatives to encourage former members to rejoin.

International affiliates. There is interest in developing a more formal role for psychologists in other countries. Currently they can be enrolled as "Professional Affiliates" of the Division, but this status may not nearly match their status in their homelands, and there is no mechanism to give members the authority to organize other members or to sponsor events. Former Executive Committee members Miles Cox and Alan Marlatt worked on this issue last year. A change in status will probably require an amendment to the Division 50 bylaws.

Call for Papers

Psychosocial and Behavioral Factors in Women's Health

Research, Prevention, Treatment, and Service Delivery in Clinical and Community Settings

The American Psychological Association will sponsor a National Conference on *Psychosocial and Behavioral Factors in Women's Health: Research, Prevention, Treatment, and Service Delivery in Clinical and Community Settings* at the Renaissance Hotel - Downtown, Washington, DC.

Conference dates: September 19-21, 1996
CE Workshops: September 18, 1996

Conference Objectives:

- To identify factors that result in effective clinical and community-based interventions and facilitate accurate risk perception, early detection, and the adoption and maintenance of health-promoting behaviors among diverse populations of women;
- To critically examine the current systems and structures for health care services in women's health and to identify effective models of health care delivery;
- To present research findings and successful models that highlight features that improve service delivery and behavior change interventions in women's health care;
- To develop and promote strategies for information transfer among women's health researchers, clinical and community health care providers, health educators, community outreach workers, and health administrators;
- To identify effective psychological and behavioral interventions in women's health care which reduce psychological distress, improve quality of life and disease outcomes;
- To create a guide for developing effective health promotion/disease prevention programs, state-of-the-art community-based interventions, and programs for service delivery in women's health.

Content Areas:

- Sociocultural Influences on Health
- Health Promotion and Disease Prevention
- Psychosocial and Emotional Issues
- Information transfer
- Systems and Structures for Women's Health Care
- Health Services Delivery

All proposals must be received by February 5, 1996.

For additional information and submission materials contact: Women's Health Conference, American Psychological Association, Women's Programs Office, 750 First Street, NE, Washington, DC 20002-4242; Phone: 202-336-6070; Fax: 202-336-6117; e-mail: **whc.apa@email.apa.org**

Johns Hopkins Postdoctoral Positions in Substance Abuse Research

Postdoctoral human research positions are available in a stimulating and productive environment with excellent clinical and research resources.

Applied Research in Behavioral Treatment of Substance Abuse. Develop and evaluate treatment interventions for opioid and cocaine pregnancy clinics.

Human Laboratory Behavioral Pharmacology. Design and implement controlled laboratory research on the behavioral, subjective, and physiological effects of psychoactive drugs for abuse liability testing and medication development. Drug classes under study include: opioids, cocaine, anxioloytics, caffeine, nicotine.

Research background and experience required. Minorities encouraged. USPHS stipend levels based on experience.

Send vita, letter of interest, names and phones of 3 references to George E. Bigelow, Ph.D. or Maxine L Stitzer, Ph.D.; BPRU, Behavioral Biology Research Center, 5510 Nathan Shock Drive; Johns' Hopkins Bayview Campus, Baltimore, Maryland 21224-6823. (410) 550-0042.

EDITOR'S CORNER - continued from page 1

I know you will like this issue of *TAN*. It includes a very informative article written by our new President, **Mark Goldman**. In his article, Dr. Goldman discusses important issues, including the apportionment vote, the challenges we face as a Division, empirical validation of treatment, and the MATCH study. **Tom Brandon** reminds us that the deadline for submitting proposals for the APA '96 convention is just around the corner. **John Grabowski**, past President of Division 28, provides a vivid description of his aversion to APA's divisional structure. Dr. Grabowski's article is so entertaining that one is almost able to overlook his opposition to Division 50's existence, as well as the incomprehensible title of his article! **Lisa Najavits** reports on a NIDA-funded cocaine treatment study that should be of interest to Division 50 members. This study, which provides almost a year of free psychotherapy to cocaine-addicted individuals, is still taking referrals at its five sites. **Vince Adesso** reminds us that the Division 50 listserver is "alive and well." (If you have an e-mail address, sign up!) **Eric Wagner**, in his article entitled "Misconceptions for Sale," eloquently argues against the widely held belief that previously addicted clinicians are more effective than those who have never been addicted. **Marilyn Freimuth** strongly encourages psychologists to pay attention to, and collaborate with, 12-step programs. **Robert Huebner** describes the new Health Services Research Program at the National Institute on Alcohol Abuse and Alcoholism (NIAAA). As head of this program, Dr. Huebner provides valuable information about current NIAAA interests and funding opportunities. And in each of their reports, **Herb Freudenberger** (Council Representative) and **Jan Williams** (Membership Chair) discuss their important activities as representatives of Division 50.

In closing, APA elections held this past summer were tabulated in July. On behalf of the membership of Division 50 I would like to express gratitude to the three Executive Officers who just left office: Ray Hanbury (Past President), Dan Kivlahan (Secretary-Treasurer), and Alan Marlatt (Member-at-Large). Each contributed substantially to the growth of our fledgling Division. And congratulations to our incoming Executive Officers: Mark Goldman (President), George De Leon (President-elect), Tom Horvath (Secretary-Treasurer), and Jerome Platt (Member-at-Large). In my limited contacts with these individuals, I have already found them to be very committed to the future of our Division. I wish them (and you in the New Year, 1996)***Mazel Tov!***

Psychology Pursues Large-Scale Outcome Measurement Project

APA Practice Directorate

Demands for accountability within the American health care system have created a new trend: the drive toward systematic use of outcomes data. If handled appropriately, the use of outcomes data could evolve into tools for assuring the cost-effective delivery of quality care. On the other hand, if outcome data systems are misused solely in the service of cost containment, as has been observed in the trend toward industrialized health care, providers and their patients stand to suffer the adverse consequences.

Working to exert a significant influence on the way outcome measurement data are applied to psychological services, organized psychology must take great care to assure that the fine line is maintained in utilizing outcomes measurement to inform treatment but not rigidly control it. On one side of that line, said Russ Newman, Ph.D., J.D., APA's executive director for professional practice, there are health care policy makers promoting a reductionistic model of outcomes. This is a simplistic "cookbook" approach, said Dr. Newman, one that results in an overly standardized approach to treatment. On the other side of the line is an absence of any accountability to third party payors or consumers that resources are being used wisely.

Psychologists need to apply their expertise in research methodology to the use of outcome measurement, said Dr. Newman. "If we don't assume a leadership role, others with less expertise and different motives will do so," he said.

As a result, the Committee for the Advancement of Professional Practice (CAPP), the Board of Professional Affairs and the APA Practice Directorate recently proposed a "practice research network (PRN)" to be designed and developed by the APA and practice community representatives. This network is envisioned generally as a national information system infrastructure that would enable large-scale outcome data collection using an array of measures and instruments. The result would be a data base which could be utilized by practitioners to

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OUTCOME PROJECTS *continued from page 13*

compare their treatment outcomes to a national sample in order to inform the treatment process or to help demonstrate the quality and cost-effectiveness of their treatment to third party payors. It could even be used to do research related to the development of new outcome measurement instruments and treatment approaches.

Given the potential size of the PRN project and the need for timeliness, the directorate staff along with representatives of the APA governance groups involved with the project have enlisted the help of Coopers & Lybrand, a nationally-known health care consulting firm, in seeking appropriate outside entities to help build the necessary management information system which would provide the infrastructure for data collection and analysis. Coopers & Lybrand officials are performing a "due diligence" analysis on interested organizations to determine which organizations have the financial, technical and managerial resources to work with the APA in developing the PRN.

The PRN project would entail developing a data base system that is readily accessible and useful to practitioners of differing therapeutic orientations. "It's crucial that this system be able to accommodate outcome instruments that apply to the wide variety of psychological interventions and settings," said George Taylor, Ph.D., chair of CAPP. According to Dr. Taylor, the data will be risk-adjusted to allow for considering the differential difficulty of dealing with various clinical problems and groups of clients. Dr. Newman added that a broad range of practitioners will be involved with considering the important question of what outcome measurements to incorporate into the data system.

Once operational, the PRN might be utilized in several ways by practicing psychologists. For example, it would give practitioners and the organizations that represente them a tool to advocate for the inclusion of psychological services in health benefits plans based on the cost-effectiveness of psychological care. On a more individual level, providers could use their treatment outcomes data to help them market their practices. By demonstrating their treatment outcomes relative to a national sample, practicing psychologists could use the PRN data base to help support the claim that an employer or other purchaser of health care should use their professional services. From the standpoint of research, one example of the PRN's potential use would involve norming tests for certain groups of patients.

Further, the PRN is being designed to help inform the treatment process through the use of sound empirical data. According to Dr. Newman, such empirical data could be quite valuable in facilitating the clinical decision making process. "The data to be available through the PRN will give practitioners a basis for making any necessary 'mid-course' corrections to maximize the overall effectiveness of the treatment," he said.

In summing up the PRN, Dr. Taylor characterized it as an important strategy in APA's initiatives to strengthen psychology's position and influence in the readily evolving health care marketplace. "We know from past experience with utilization review that mechanisms designed to hold down health care costs can be applied in inappropriate and even abusive ways," said Dr. Taylor. "Psychology's expertise in research and measurement should serve as a very helpful tactic in combating the use of arbitrary, cost-driven treatment decision making in the outcomes arena."

PLURIPOLAR MITOSIS *eontinued from page 3*

There are two Sex/Gender Divisions. Alas, they are not the two that would flow smoothly off the tongue of the above average well-educated lay person. "Hello, I am conducting a survey for the APA on behalf of the Division of Evaluation and Measurement -- I have one question I would like to ask you -- "What are the names and focus of the two special Divisions (like a chapter, or sub-organization) devoted to Sex/Gender differences?" [Respondent] "Is this a trick question? No? OK. Hmmmmm-let me see, the Division of Women Studies and the Division of Men Studies? -- What do you mean that's not the right answer?"

So we have the Division of the Society for the Psychological Study of Lesbian and Gay Issues (44) and Psychology of Women (35). Should not the activities of these Divisions fall within the other Divisions, e.g. experimental, physiological, developmental, personality, social issues, etc.? Alternatively, if we must have a sex/gender (note there is a distinction no longer understood by many) Division, why not one that addresses biological, behavioral, social aspects, and their interplay. Within it would be sections concerning women, men, and gender roles, gays and lesbians, and all the possible interrelations. This may be mindless pandering to logic but it is as reasonable as the two, or is it three?, sexual enclaves now recognized by the APA, i.e. gays, lesbians, and women. We can be sensitive to the issues without being divisive and generating administrative chaos. Further, I absolutely do not believe we need a Division on Psychology of Men.

There are some other Divisions, each of which had and has a basis for argument, though one would hope that sunset might eventually ensue. These include the American Psychology-Law Society (41), Society for Psychological Study of Ethnic Minority Issues (45), Clinical Neuropsychology (40), and of course who could war with the wisdom of a Division of Peace Psychology (48)? the historical basis of which was only a counterpoint to the military psychology Division. With respect to those Divisions that are independent societies, one might argue that affiliated groups should not be given Divisional status.

Aside from a very special kind of special interest, the need for a Division of Media Psychology (46), is far from clear, though it sheds light on a puzzlement I have had of late. Have you noticed that everyone blames the media (not people) for society's ills? So there really aren't any people behind those talking electronic heads (MAX HEADROOM is alive and well)? Does Division 46 represent the study of Sensation and Perception in the '90s? Or is it an advanced electronic update of the Society for the Psychological Study of Social Issues (9). Or should the APA have other special Divisions for major human organizations and activities, e.g. Death and Undertaking Psychology?

Health Psychology (38) is an example of interdisciplinary activity, a behavioral medicine Division within the APA. Aside from the original Divisions, it is the only step towards integration among Divisions in the last several decades. However, do its activities require a special Division?

I, or anyone with an intellect greater than an acorn, can argue for differentiation and specialization, more mail boxes, and idiosyncratic niches. Is psychology so intellectually sophisticated, measurement so refined, and administrative need so great, that all of these Divisions are required? Or, has the discipline taken a back seat to special interests.

Seeking commonalties and solutions across problems is the more difficult, though more interesting task. Do all of these Divisions represent a Wundtian Figure-Ground problem? Incidentally, and in addition, the state organizations are represented even though many of their members do not belong to APA. The result is over 100 entities represented on the APA governance council and tremendous cost of bringing the assembled masses together--so that they can bicker over new Divisions.

Now, with this context, why is there a Division of Addictions, independent of Substance Abuse and Psychopharmacology? Or independent of Clinical Psychology? Were we unable to see that the behavioral processes that characterize persistent behaviors so commonly called addictions are fundamentally similar to behavioral processes already represented by other Divisions. Further, why would one want to name a Division with a word that is based in invincible and unscientific folklore (see Jaffe in *Pharmacological Basis of Therapeutics*, Goodman & Gilman, 1995)?

My most recent encounter with the word "addiction" was a newscast that included interviews with the Women Harley Davidson Riders of Houston. They claim to have an addiction; an addiction to their Harleys, riding "bikes", and all that is associated with this activity. Riding a motorcycle may be pathological, nigh to the point of causing one to do so without a helmet, but it is far from any clinical diagnostic sub-category with which I am familiar in

continued on next page

PLURIPOLAR MITOSIS *eontinued from page 15*

DSM-IV. Is there a picture emerging here? If one is interested in alcohol and other drug dependence, Division 28 would be a good home. If one has a special penchant for clinical activity with people engaged in stereotypic behaviors (e.g. gambling), Division 12 is appropriate. And, if one is more experimental-biological, Division 6 would seem a compatible environment.

So, whyfore do we call people addictionologists? Where are the depressionologists? or the triochotillomanists? When will divvying up the behavioral, psychosocial pie end for the American Psychological Association? We all have special needs and know that ours is the most important part of the elephant as defined by the three blind people (men). Unfortunately, we now have a fragmented and nonsensical organization. By the way, what about Division 28? Might not the study of drugs and behavior, writ large, have resided in physiological and clinical psychology, or for the behavioral types, at least in Division 25?

Consider too that with lack of forethought, the Addictions Division itself is so narrow that it misses a critical opportunity. Some so-called addictions, can be construed as beneficial. Establishing stereotypic and consistent medication taking (i.e. compliance) is an essential feature of many therapeutic regimens. The absence of this behavior is a serious problem in most therapeutic fora. It would be magnificent if we could establish the same level of stereotypy in diabetics, hypertensives, and depressives. We have here the basis of a new Division--The Study of Positive Addictions.

When Division 50 was proposed, I argued that the better course was to broaden the base of Division 28 which frankly had been exclusionary to the interests of some of those now affiliated with Division 50. The case was for inclusiveness though others encouraged the separatist philosophy. This may come to haunt important aspects of research and clinical practice. Divergence will emerge although there have been notable positive examples of collaboration between the Divisions. Division 50 will likely develop a program of education, clinical recommendations, and research as strong as that of Division 28 over the next 20 years. However, without heroic efforts of the leaders of the two Divisions, it is likely that east and west will rarely meet. This will be to the detriment of both, and the field as a whole. Gradually, the two Divisions will make contrary statements about the same subject matter. Recall that the APA, in support of one Division, once filed an amicus brief against the use of antipsychotic medications without seeking the expertise of those in Division 28. And so goes communication and cooperation between Divisions.

It is time to have a major overhaul of the APA Divisional structure. Planning is needed in place of the haphazard and piecemeal emergence of Divisions. A decision should be made regarding the primary underlying premise of Divisions (setting, theory, technology, or other topographical feature). Divisions should be encouraged to have sections catering to special issues (ala Division 12), but speak for the whole. This must be resolved to preclude further proliferation of ill-conceived Divisional factions diluting and separating effective relationships in the APA.

Ultimately, if we go on with the same enthusiasm for new Divisions, we might rename the entire organization, Psychology In the Special Self-Serving Interest. This would reflect the level of divisiveness and self-aggrandizement that is rampant. Appropriately enough, the acronym could be descriptive of internecine warfare and intersibling rivalry; it would be really PISSSI. Make of it what you will.

Editor's note: Dr. Grabowski, the past president of Division 28, is the Director of the Substance Abuse Research Center and Professor of the Department of Psychiatry and Behavioral Sciences at the Health Sciences Center, University of Texas-Houston. He provides the following phone and e-mail numbers: (713)792-7925 - office; (713) 794-1479 - fax; and

jgrabows.utmsimail@msi66.msi.uth.tmc.edu

He explains that letters without return addresses will remain unopened. However, he does look forward to other responses.

On behalf of all
Division 50 members,
The Addictions Newsletter
wishes to congratulate the
following new APA fellows:

David B. Abrams
John P. Allen
Sandra A. Brown
Gerard J. Connors
Raymond F. Hanbury, Jr.
Ronald M. Kadden
Alan R. Lang
Elizabeth C. Penick
D. Dwayne Simpson

NIDA -*continued from page 4*

Inclusion and exclusion criteria. To be enrolled in this study individuals must meet criteria for cocaine dependence and they must use cocaine in the month prior to entering the study. They must not be receiving other treatments, have a history of schizophrenia or bipolar disorder, and they must not be opioid-dependent. They must have stable mailing addresses, they cannot be mandated to treatment and women cannot be more than 3 months pregnant. Potential subjects are screened rapidly by telephone to determine whether they are eligible. Potential subjects can call the following screening numbers directly:

- **Brookside Hospital**--Nashua, New Hampshire (800-866-9006)
- **Massachusetts General Hospital**--Boston, Massachusetts (617-726-8163)
- **McLean Hospital**--Belmont, Massachusetts (617-855-3206)
- **University of Pennsylvania**-Philadelphia, Pennsylvania (215-662-2848)
- **University of Pittsburgh**--Pittsburgh, Pennsylvania (412-383-1222)

These sites will continue to enroll subjects for approximately six more months.

Additional research goals. In addition to the central research questions described above, a variety of subsidiary questions are of interest. For example, the relationship between "external coping style" (a defensive tendency to act out, avoid, and compartmentalize) and ability to benefit from treatments will be evaluated. Previous research would suggest that subjects with predominantly external coping styles might benefit more from structured treatments (such as cognitive therapy), while patients with predominantly internal coping styles might benefit more from traditional verbal therapies (such as supportive-expressive therapy). This question has not yet been addressed with this population. Another important question is the extent to which degree of psychiatric severity will affect outcome. Will patients who have, for example, major depression, do as well in 12-step treatment as in psychotherapy, where presumably therapists are more familiar with psychiatric illnesses? Additional topics of interest include the identification of predictors of good outcome (e.g., patient motivation level, subjects' and clinicians' abilities to establish alliance, selected sociodemographic variables, and clinicians' professional background characteristics); and trying to understand the impact of what subjects learn in their particular treatment (e.g., do patients in supportive-expressive learn more about relationships, while patients in 12-step groups learn more about substance abuse relapse?).

Initial results. Initial results from the pilot phase of the study are presently being analyzed and reviewed for publication. Topics include: the incidence of posttraumatic stress disorder (PTSD) in the sample and a clinical profile of PTSD versus non-PTSD patients; the relationship between initial motivation for substance abuse treatment and actual outcomes; assessment of subjects' craving for cocaine in relation to their ability to initiate abstinence; subjects' attendance at 12-step self-help groups as a predictor of outcomes; and characteristics of subjects who have dropped out of treatment.

REFERENCES

Beck, A.T., Wright, F.D., Newman, C.F., & Liese, B.S. (1993). *Cognitive therapy of substance abuse*. New York: Guilford.

Mark, D., & Luborsky, L. (1992). *A manual for the use of supportive-expressive psychotherapy in the treatment of cocaine abuse*. University of Pennsylvania: Unpublished manuscript.

Mercer, D., Carpenter, G., Daley, D., Patterson, C., & Volpicelli, J. (1994). *Group drug counseling manual*, Unpublished manuscript. Philadelphia: University of Pennsylvania.

Mercer, D., & Woody, G. (1992). *Addiction counseling*. Philadelphia: University of Pennsylvania & Philadelphia VAMC Center for Studies of Addiction.

Don't forget to vote. By now you should have received the apportionment ballot from APA. Please give all ten of your votes to our Division. Doing so will give us a strong voice in important APA matters.

MISCONCEPTIONS *continued from page 5*

do the work I do; (2) my mother's obstetrician was male, and despite his inability to give birth she found him to be an extremely sensitive and competent physician; and (here's where my enthusiasm really evaporated!), (3) the research literature indicates that addiction treatment providers in recovery are no more effective than those not recovering from anything.

For example, Blum and Roman (1985) compared job performances of recovered alcoholics and nonalcoholics in alcoholism-related occupations. These researchers found the two groups to be equivalent in their performance at work. Johnson and Prentice (1990) investigated the effects of counselor drinking status on mandated clients' perceptions of counselor trustworthiness, expertness and attractiveness, and confidence in the counselor. Results revealed no differences between clients' ratings of recovering alcoholic, nonalcoholic, or no-statement counselors on any of the dependent measures. Machell (1991) examined the impact of counselor drinking status on recidivist inpatient alcoholics' treatment outcome and perceived belongingness. Results indicate counselors' treatment status was not associated with length of stay, relapse rate, or perceptions of belongingness. In essence, these three recent studies (and other older studies not cited here for the sake of brevity) demonstrate that counselors' substance abuse histories are unrelated to treatment effectiveness.

So I turned to Jack Trimpey's RR article, which was a response to Barbara McCrady's comments in an earlier issue of *The Addictions Newsletter*. RR, as most Division 50 members are aware, is a self-help movement that was developed in part out of a desire to provide an alternative to AA, and Trimpey's piece was devoted to clarifying RR by answering frequently asked questions about the approach. I read with interest Trimpey's article but soon found myself experiencing an altogether unpleasant episode of *deja vu*, which was precipitated by the following:

"Never addicted professionals, in my experience, are quite limited in their understanding of addiction, just as men are of childbirth, and seriously impaired in grasping the intuitive aspects of AVRT, just as a virginal sex therapist might be. For their own lack of first-hand knowledge, they substitute their own perceptions of what it must like to be addicted, build elaborate theories around their misperceptions, and then sell the misguidance to others in the form of addiction treatment." (p. 23)

Talk about a loss of enthusiasm! According to Trimpey, a never addicted professional like me is limited, seriously impaired, and a merchant of misguidance. I take offense at such accusations. More importantly, other than Trimpey's personal experience, there is no reason to believe that once-addicted professionals are more effective than never addicted professionals. The research literature simply doesn't support such a claim.

While very different in many regards, Clark's description of AA and Trimpey's description of RR share in common the notion that a substance abuse history is essential for an addiction treatment professional to perform effectively. Members of Division 50 should not take such a claim lightly, as research has tested this supposition and found it to be false. If either Clark or Trimpey have data to support their claim, I'd like to see them. Otherwise, I suggest that they take greater care when making statements concerning the recovery status of addiction treatment professionals, lest either of them be accused of marketing misconceptions.

REFERENCES

Blum, T.C., & Roman, P.M. (1985). The social transformation of alcoholism intervention: Comparisons of job attitudes and performance of recovered alcoholics and non-alcoholics. *Journal of Health and Social Behavior, 26*, 365-378.

Johnson, M.E., & Prentice, D.G. (1990). Effects of counselor gender and drinking status on the perceptions of the counselor. *Journal of Alcohol and Drug Education, 35*, 38-44.

Kassel, J.D., & Wagner, E.F. (1993). Processes of change in Alcoholics Anonymous: A review of possible mechanisms. *Psychotherapy, 30*, 222-234.

Machell, D.F. (1991). Counselor substance abuse history, client fellowship, and alcoholism treatment outcome: A brief report. *Journal of Alcohol and Drug Education, 37*,25-30.

McCrady, B.S., & Miller, W.R. (1993). *Research on Alcoholics Anonymous: Opportunities and Alternatives*. New Brunswick, NJ:Rutgers Center of Alcohol Studies.

Important Notice:

The staff of *The Addictions Newsletter* cannot process address changes or subscription orders!

If you have changed your address, please contact APA directly at (202) 336-5500. If you are **not** a member of Division 50 and you wish to receive *TAN*, contact Jan Williams, Ph.D. at (803) 6564755 to become a Division 50 Affiliate. Thank you!

12-STEP -*continued from page 6*

Numerous articles address the growth promoting effects of 12-step work (e.g. Bean, 1975; Brown, 1985; Dodes, 1988; Flores, 1988; Matano and Yalom, 1991; Tiebout, 1944). However, only a few authors (Brown, 1985; Freimuth, in press; Levin, 1985) emphasize that the 12-step experience can benefit the patient's progress in therapy. For example, a psychotherapist who seeks collaboration values a patient's intense attachment to a sponsor or home group for two reasons: (a) it serves to support abstinence and (b) it may diffuse the patient's relationship to the therapist which, if too intimate, might provoke premature termination (Dodes, 1988). Those who do not value collaboration may view these intense attachments solely in terms of undue dependence.

While the benefits of collaborating with a 12-step program are recognized (Brown, 1985; Levin, 1985), existing literature fails to provide a model for putting this relationship into practice. Conjoint therapy provides such a model. Conjoint treatment "refers to the concurrent treatment of a patient in two different settings by two different analysts [therapists]. The analysts [therapists] work separately to resolve the patient's resistance, one in a group setting and the other in a individual setting" (Ormont & Ormont, 1986, p. 424). Typical conjoint therapy combines individual and group treatment. However, these authors note that a conjoint relationship can develop between a psychotherapist and any outside agent (p. 435).

Anyone who has worked conjointly knows there are distinct challenges to a successful alliance. Just as two psychotherapists working conjointly may not have the same theoretical orientation, so it is that values of a 12-step program and psychotherapy can conflict. The sources of conflict may arise from the therapist's personal experiences with such programs and addiction. Other differences will be conceptual in origin (Flores, 1988; Matano & Yalom, 1991). Is the goal abstinence or controlled drinking? Is a person always an addict even if he/she has been "sober" a long time? Can a patient have a strong attachment to a 12-step program without this being a substitute addiction? Still other differences arise from uncritical acceptance of certain "stereotypes": (a) *12-step programs are religious*. The spiritual dimension of 12-step philosophy (i.e., belief in a higher power as conceptualized by the individual) is mistakenly equated as religious (Humphreys, 1993). (b) *12-step philosophy is against therapy and medication*. Bill W., AA's founder, sought therapy twice after becoming sober (Levin, 1985). AA World Services publishes pamphlets which discuss the value of medication and psychotherapy. (c) *12-step philosophy encourages people to abdicate responsibility*. Rational Recovery is quite critical of AA on this point. Early recovery does emphasize the addict's "powerlessness" over addictive substances. This fits the program's position that addicts are not responsible for addiction (which is considered a disease). However, addicts are responsible for their recovery by attending meetings and following the steps such as four and eight where the addict is responsible to make a "searching and fearless moral inventory" and become "willing to make amends" (Matano & Yalom, 1991). (d) *Strong negative emotions such as anger are discouraged* (Bean, 1975; Levin, 1985). While members' anger toward the program is not accepted in meetings, there is no unilateral discouragement of negative affect. Only when anger threatens sobriety is it considered necessary to circumvent negative feelings. See Freimuth (1944) for further discussion of common misconceptions of 12-step philosophy.

The therapist who follows a conjoint model must become familiar with relevant recovery literature and attend open meetings. While conceptual differences will remain, as long as the therapist respects the program's position for the patient (e.g., abstinence over controlled drinking), a collaborative relationship can develop.

A second challenge to collaboration comes from the patient's resistances and the therapist's reactions to them. For example, an alcoholic with a year's sobriety begins psychotherapy by expressing disgruntlement with AA and praising the therapist's helpfulness. Kinney and Montgomery (1979) caution against being seduced by the patient's appeal to one's narcissism which can mask doubts about maintaining abstinence or fears about how to manage allegiances to both a 12-step group and therapy.

Other times, psychotherapy will be viewed as "less than." When a patient speaks enthusiastically about the insights gained from talking with a sponsor or listening at meetings, the therapist can feel jealous ("Why didn't I come up with that observation?") or annoyed that similar reactions offered in therapy have been ignored. In light of these feelings, the program's value for the patient may not be recognized and the patient's enthusiasm interpreted merely as a veiled criticism of the therapy.

The therapist who uses a conjoint model values the benefits which arise from having multiple input from multiple settings. In traditional conjoint treatment, where multiple input involves group and

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individual therapy, each modality is seen to serve a different function. Through careful treatment planning, resistance is accepted in one setting and analyzed in another or feelings aroused in one setting are worked through in the other (Ormont & Ormont, 1986).

This allotment of responsibility seems impossible when collaborating with a leaderless 12-step group. However, like typical conjoint treatment, the patient develops distinct ways of relating to the psychotherapy and 12-step experiences. The differences is that responsibility for the treatment plan rests solely with the psychotherapist who must understand the psychic role played by the 12-step program and then provide the patient with the complementary experience. For example, a patient's resistance to exploring the defensive functions of grandiosity is accepted knowing that the psychological dimensions of steps one, two and eleven will help the patient address this issue. Similarly an idealized transference to a 12-step program is recognized as meeting a need and helping support abstinence while, at the same time, the therapy setting is used to help the patient express anger and begin to integrate positive and negative feelings.

In sum, collaboration is based on a mutual respect for the processes of 12-step groups and psychotherapy and a recognition that both have a role to play in facilitating abstinence and emotional growth. Psychotherapy patients involved in a 12-step program who sense that the therapist values collaboration will feel safe to make both modalities a significant part of ongoing recovery.

REFERENCES

AA World Services. (1990). *Alcoholics Anonymous 1989 membership survey*. New York: AA General Services.

Bean, M. (1975). Alcoholic Anonymous: Chapter I, II. *Psychiatric Annals, 5,* 7-61, 7-19.

Berger, L.S. (1991). *Substance abuse as symptom*. Hillsdale, N.J.: The Analytic Press.

Brown, S. (1985). *Treating the alcoholic: A developmental model of recovery*. New York: John Wiley.

Dodes, K.M. (1988). The psychology of combining dynamic therapy with AA. *Bulletin of the Menninger Clinic, 52,* 283-293.

Flores, P.J. (1988). *Group psychotherapy with addicted populations*. New York: Haworth Press.

Freimuth, M. (1994). Psychotherapy and twelve-step programs: A commentary on Humphreys. *Psychotherapy, 31,* 551-553.

Freimuth, M. (in press). The conjoint model for working with psychotherapy patients in 12-step groups. *Modern Group*

Humphreys, K (1993). Psychotherapy and the twelve step approach for substance abusers: The limits of integration. *Psychotherapy, 30,* 207-213.

Kinney, J., & Montgomery, M. (1979). Psychotherapy and the member of Alcoholics Anonymous. *Currents in Alcoholism, 6,* 79-85.

Levin, J.D. (1985). *Treatment of alcoholism and other addictions* Northvale, N.J.: Jason Aronson.

Matano, R.A., & Yalom, I.D. (1991). Approaches to chemical dependency: Chemical dependency and interactive group therapy--a synthesis. *International Journal of Group Psychotherapy, 41,* 269-293.

Ormont, M.J., & Ormont, L.R. (1986). Conjoint therapy, In A. Wolf & I. Jutash (Eds.), (pp. 424-235). *Conjoint therapy casebook* San Francisco: Jossey Boss.

Rosen, A. (1981). Psychotherapy and Alcoholics Anonymous. *Bulletin of the Menninger Clinic, 45,* 229-246.

Zweben, J.E. (1987). Recovery-oriented psychotherapy: Facilitating the use of 12-step programs. *Journal of Substance Abuse Treatment, 19,* 243-251.

EuroCAD/96
Reykjavik, Iceland

The Third Annual European Conference on Addictive Disease (EuroCAD/96) is scheduled for April 10-13, 1996 in Reykjavic, Iceland.

Co-sponsors of the conference include: The International Council on Alcohol and Addictions (ICAA), The National Association of Alcoholism and Drug Abuse Counselors (NAADAC), and The Consolidated Association of Nurses in Substance Abuse (CANSA).

For more information:

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BARRIERS -*continued from page 7*

The majority of individuals in the throes of addiction are far from the sort of motivation which drives them to weekly sessions. Why? A convincing case has not been made that sobriety will render them better off. For many, the use of substances is a primary means of coping. It is all but maladaptive to refuse to give up a mechanism of survival without a fight. Many people experiencing ambivalence do not come into treatment agencies because they do not want their ambivalence attacked. Moreover, some people have no intention of giving up their addictive habits. As Snow, Prochaska and Rossi (1992) have pointed out, the vast majority of people with addiction problems are "precontemplative."

Outreach workers understand and respect the addict's ambivalence or unwillingness to change. They recognize that not everybody is ready to completely relinquish tried and true methods of coping. Outreach workers believe, however, that intervention is possible. They recognize that unbiased connection with these individuals in imperative if harm reduction or lifestyle enhancement is to occur.

Therefore, in contrast to this standard model of treatment provision, outreach workers attempt to make a connection in the addict's environment and on the addict's terms. This is done either by placing an agency in a convenient and unthreatening location with hours which are conducive to the addict or by leaving the shelter of the agency altogether --going to where the addicts dwell.

Outreach workers respect that the therapist-client dichotomy is different "out there." "What can I do to help you?" is asked (rather than, "Here is what you must do."). Sometimes the answer is, "Nothing, get lost." Other times needs are expressed -- often having nothing to do with the reduction of substance use. Respecting these agendas is vital as it initiates a relationship with individuals who haven't even considered entering treatment. This connection makes further aid more likely because trust has been established.

Does outreach work? Using needle exchange programs as examples, studies have suggested that well-designed programs are associated with eventual entrance into drug treatment programs, reductions or cessation of high risk behaviors, increases in behaviors that minimize the harm to active users (Centers for Disease Control, 1990, Frisher and Lawrence, 1993) and a leveling off of HIV and Hepatitis B seroprevalence curves (Waters et al., 1990; Moss et al., 1990). Countries in which outreach is widely utilized and supported appear to have much larger contact rates than those which do not. Consider Marlatt and Tapert's (1993) citation that Dutch authorities report 60-80% of the addicted population are registered in some program. Most of us are well-aware of the prevalence of harm reduction interventions and wide acceptance of harm reduction philosophy and outreach in The Netherlands.

To offer an example of successful outreach, I'll summarize an anecdote presented by Edith Springer (New York Peer AIDS Education Coalition) at the Harm Reduction Conference last year in Seattle. Her program was concerned with the growing problem of HIV infection in prostitutes and the difficulty in gaining access to this group. Outreach workers approaching prostitutes with AIDS information were met with abrupt responses like, "Get the hell out of here!" This response makes sense, as these women had a great deal to lose if their employers witnessed them talking to "recovery people." They were on the job, trying to make a living. The way these women were "hooked" by outreach workers was really quite ingenious: they were offered their usual fee to meet for a designated amount of time. They were gathered in a hotel room and all were asked what was most difficult about their jobs. Many complained of foot pain caused by wearing high heeled shoes for extended periods. In response to this complaint, workers offered free foot massages, provided by students of a nearby massage school. They were also offered makeup application classes! After taking part in these services, the outreach workers were asked, "Since we know you didn't bring us here to talk about our feet, what do you really want?" The women were asked if they worried about AIDS. Unanimously they answered in the affirmative. At that point they were open to discussing methods for reducing high-risk behavior, open to accepting bleach and other needle-cleaning supplies, open to hearing about needle exchange and condom distribution, open to spreading the word. This contact, which probably will save lives, represented a "foot in the door" for further intervention, which would have been impossible had the women not been respected for their time and priorities.

Am I suggesting that psychologists abandon lucrative practices and become outreach workers? Hardly. Rather, psychologists specializing in addiction can integrate the harm reduction/outreach model into their practices and access a great many more individuals. Many already do and have for some time. The "stepped-care prevention" on-campus program for heavy drinking college students outlined by Marlatt and his colleagues (1992) is an

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example. My insights are largely based on the work of such ground breaking psychologists.

What can psychologists do specifically? Here are some ideas:

- Psychologists specializing in empirically-driven models of addiction assessment and treatment (e.g., motivational interviewing) can use their knowledge and experience to help train outreach workers.

- Psychologists could devote a day, or even an afternoon, to working alongside outreach workers, venturing into the inner city and making connections with precontemplators who are miles away from visiting a psychologist's office, a treatment agency, or even a meeting.

- Psychologists can orchestrate inner-city harm reduction support groups for active users with the only suggestion that they show up and listen.

- Psychologists can aid in the targeting of hard-to-reach patients, such as the schizophrenic amphetamine user who is repeatedly hospitalized but ineligible for partial hospitalization upon discharge.

- Psychologists can disseminate bibliotherapy materials and provide self-scoring assessment materials to agencies involved in outreach.

- Psychologists can deviate from "regulation" therapy by integrating outreach into their care regimes. The idea of orchestrating transportation or even making a home visit to the individual who repeatedly "misses" that initial session is not unheard of from an outreach perspective. When the Harm Reduction philosophy becomes a mind set, the sky's the limit in terms of creative interventions!

Integration of the outreach model requires a great deal of flexibility with regard to how "success" is defined. Optimal change will be defined differently and will require different pathways depending on the unique attributes of each individual. Treatment providers embracing the harm reduction/outreach philosophy are flexible about goals and about the manner in which "treatment" is rendered. First and foremost is the connection which, if successful, is in and of itself a move toward enhanced well being.

I have been involved in the development of an inner-city, non-profit venture (i.e., "HabitSmart") devoted to addiction assessment, triage, education, and outreach. (I am also the author of *Lasting Change*, to be published by Nova Science in 1996.) I invite you to learn more about my program by visiting the HabitSmart Web site at:

http://www.cts.com/~habtsmrt/

REFERENCES

Centers for Disease Control (1990). Update: Reducing HIV transmission in intravenous drug users not in treatment--United States. *Morbidity and Mortality Weekly Report, 39*, 529-530/535-538.

Marlatt, G.A., Larimer, M.E., Baer, J.S. & Quigley, L.A. (1993). Harm reduction for alcohol problems: moving beyond the controlled drinking controversy. *Behavior Therapy, 24*, 461-503.

Marlatt, G.A. & Tapert, S.F. (1993) Harm Reduction: Reducing the Risks of Addictive Behaviors. In J.S. Baer, G.A. Marlatt, & R.J. McMahon (Eds.), *Addictive Behaviors Across the Lifespan: Prevention, Treatment and Policy Issues*. Sage Publications: Newbury Park.

Miller, W.R.(1995). Increasing Motivation For Change. In R. K. Hester & W. R. Miller (Eds.), *Handbook of Alcoholism Treatment Approaches: Effective Alternatives*. Allyn and Bacon: Boston.

Miller, W.R. & Rollnick, S. (1991). *Motivational Interviewing: Preparing People to Change Addictive Behavior*. Guilford: New York.

Moss, A.R., Vranizan, K., Bacchetti, P., Gorter, PR., Osmond, D., and Brondie, B. (1990, June). Seroconversion for HIV in intravenous drug users in treatment. Paper presented at the Sixth International Conference on AIDS. San Francisco, CA.

National Institute on Drug Abuse. (1991). *National household survey on drug abuse: Main findings 1990*. (DHHS Pub. No. [ADM]91-1788). Washington, DC: Government Printing Office.

Regier, D.A., Narrow, W.E., Rae, D.S., Manderscheid, R.W., Locke, B.Z. & Goodwin, F.K. (1993). The de facto US mental and addictive disorders service system. *Archives of General Psychiatry, 50*, 85-94.

Springer, E. (1995, January) Drug Treatment, Harm Reduction Style: Substance Use Management. Symposium presented at the Harm Reduction Conference. Seattle, WA.

Snow, M.G., Prochaska, J.O., & Rossi, J.S. (1992). Stages of change for smoking cessation among former problem drinkers: A cross-sectional analysis. *Journal of Substance Abuse, 4*, 107-116.

Watters, J.K., Cheng, Y., Segal, M., Lorvick, J., Case, P., & Carlson, I. (1990, June). Epidemiology and prevention of HIV in intravenous drug users who are not in drug treatment. Paper presented at the Sixth International Conference on AIDS. San Francisco, CA.

NIAAA RESEARCH *continued from page 10*

Among the most obvious changes is the move toward treatment in settings other than state-run psychiatric hospitals; the expanded role of addiction counselors in the provision of treatment services; the "medicalization" of alcoholism treatment and the growing attention it receives from primary care providers; the role of employers and Employee Assistance Programs in initiating prevention and treatment interventions; the trend toward combined treatment settings and protocols for "substance abuse" rather than distinct facilities and specialists for alcohol and other drugs; the increase in court-mandated treatment; and the tremendous growth in managed care arrangements for the delivery of treatment services.

The effects of these innovations on the availability, quality and efficiency of services are not well understood. NIAAA is taking the lead to encourage research on these and other changes in organization and management arrangements. The findings will be useful to employers, insurers, the courts, and treatment providers in their quest for more effective and economical ways to prevent and treat alcohol problems.

A key issue for both researchers and clinicians that crosscuts the four issue areas outlined above is the effect of managed care on health services. Accordingly, the Institute has launched a Managed Care Initiative to stimulate research on the impact of managed care on the delivery of alcohol services. This initiative consists of a variety of activities discussed below:

Request for Application on Health Services Research. An important feature of this Request for Application (RFA) was a focus on financing and organization issues including managed care. Approximately one-third of the 57 applications addressed research questions on the financing and organization of alcohol health services. In August 1995, these applications were reviewed by a special review committee (SRC) comprised of researchers with expertise in health services research. Awards relating to this RFA will be made in fiscal years 1995 and 1996.

Meeting on Managed Care. NIAAA, along with the National Institute on Drug Abuse and the Center for Substance Abuse Treatment, co-sponsored a meeting on July 17-18, on managed care and alcohol and drug abuse. The mission of the meeting was to develop an agenda for future research on managed care. A total of 30 participants representing a wide range of perspectives attended the meeting. Conference proceedings are being prepared and will be available in late fall, 1995.

Special Studies. Over the next fiscal year, NIAAA expects to fund several small contract awards on selected topics in managed care. These contract awards are designed to supplement the growth of research project grants on managed care in the Institute's Health Services Research portfolio.

Request for Applications on Managed Care. The Institute is currently developing an RFA specifically devoted to managed care. The RFA will request applications that address one or more features of managed care arrangements to ensure access, quality and outcomes of alcohol-related services. Both secondary analyses of extant databases and prospective studies of managed care arrangements will be encouraged.

Paralleling the research supported by NIAAA, the Institute's National Advisory Council is developing a National Plan for Health Services Research in the alcohol field. The NIAAA National Advisory Council's Subcommittee on Health Services Research and its three working panels (Financial and Organization, Effectiveness and Outcome, and Utilization and Cost) are producing background reports that will serve as the building blocks for the national plan. Each report will assess current research activities on alcohol-related health services within an issue area, identify research gaps, and make recommendations for future work. A total of 20 background papers have been commissioned across the three panels to address these issues. Plans are being made to publish the commissioned papers as a separate, research-oriented volume.

For more information on funding opportunities in the health services area at NIAAA, please contact Robert B. Huebner, Ph.D. at (301) 443-0786 or by e-mail: **bhuebner@willco.niaaa.nih.gov**

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