The Addictions Newsletter

The American Psychological Association, Division 50

Special Issue: Project MATCH

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Project MATCH delivered what it was paid to do, and

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President's Column

Research, Practice, and Change in the Structure of Professional Psychology

Robert A. Zucker
University of Michigan

In my Fall column I discussed the potential interplay between research and practice and the potential tension between them (at least historically) because they involve different universes of discourse. I also wrote about the advantages for psychologists in the marketplace because of our special skills in assessment and evaluation. In this issue of *TAN*, which focuses on Project MATCH, our Editor Bruce Liese asked me to comment on the MATCH study findings. I have a few observations to make, but I thought it would be even more useful to focus on this project as an indicator of changes in our profession.

Project MATCH and the scientific method. Good researchers know that a scientific study involves the development of a relationship between the researcher and the data. In exchange for rigorous hypothesis formulation, experimental design, and study execution, the work gives an answer back to the investigator (more often a series of answers) that could not be known without doing the work. Then comes the courageous and most difficult part: the investigator commits to changing what he or she thinks, based on the findings obtained. If the study has any practical relevance, then subsequent investigator behaviors are also changed. Neither persuasiveness or charisma are relevant, and the investigator commits to this change process ahead of time.

Editor's Corner

Bruce S. Liese
University of Kansas Medical Center

Welcome to our special issue on Project MATCH.

For approximately eight years the largest randomized clinical trial of psychotherapy has been underway. This trial has been important to Division 50 members because it has involved the treatment of 1,726 persons with alcohol problems. Known as Project MATCH, the main purpose of this study has been to test whether matching clients to various types of alcohol treatment improves outcome. (MATCH is an acronym for Matching Alcoholism Treatments to Client Heterogeneity.)

Like many psychologists, I have considered the matching of patients to treatments to be an intriguing idea. So I was surprised last year when I discovered a heated debate taking place on our Division 50 listserver (Addict-L). On one side, certain individuals were describing Project MATCH quite favorably, while on the other side some were arguing that it was a colossal waste of money. As I watched this scenario unfold I became convinced that Division 50 members needed to learn more about this historic study and the surrounding controversy.

I approached some of the key players in this debate, who generously agreed to submit their viewpoints for publication in this special issue of *TAN*. Undoubtedly, these contributors deserve our gratitude for taking the time to participate in this undertaking. Gerard Connors and Dick Longabaugh are productive researchers and members of the Project MATCH Research Group, well-qualified to discuss the study. Stanton Peele is best known for his passionate opposition to the

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Letters to the Editor

Editor's Note: These two letters respond to "Can You Help Me With This Ethics Case?" in the Fall, 1997 edition of TAN.

Dear Editor: The case of "Kathy" involves a woman who enters a hospital substance abuse treatment group and subsequently becomes a hospital employee. As an employee, her position is supervised by psychiatric residents who (for training purposes) also observe the treatment group. After two weeks on the job, she expresses (in the group) her discomfort about this situation but is relieved when assured by one resident that she is doing "a great job." Nevertheless, after that group session, the leader reiterates his concern that "her involvement in the group while an employee of the hospital might not be in her best interest." She responds, "I don't want to have to choose between the group and my new job. This is the only group that has ever helped me!"

The questions raised include: What ethical issues are involved? What should the group leader do?

I propose that two crucial issues here are the right to choose treatment and informed consent. The leader could make clear to this woman exactly how information she reveals or has revealed in the group could impact her employment (this might not be a simple task!). She then has the option of not revealing selected information or seeking other treatment. It would be arbitrary to exclude her from a helpful service simply because a problem *might* arise, especially when she has substantial control over what to reveal (not to mention control over whether to use). Being able to stay in the group, and on the job, presumably would become significant factors in her personal cost-benefit analysis of whether to slip or relapse, and with luck, tend to enhance continued maintenance of change.

Virtually all treatment relationships involve some degree of dual relationship, even if it is only payer/payee as well as client/provider. The goal is not to avoid all dual relationships but to avoid unnecessary ones and exploitative ones. The proper management of this particular case would appear to involve adequate informed consent, not arbitrarily discharging someone who has apparently made a significant effort to find personally acceptable services.

Tom Horvath, Ph.D.

Dear Editor: Regarding the case of "Kathy," I see three ethical issues: appropriate treatment, informed consent, and dual relationships. First, it is not clear from the vignette whether or not Dr. Smith assessed Kathy's depressive symptoms and determined if additional treatment beyond the group experience would be recommended.

Second, the informed consent procedure may have been inadequate. Informed consent requires more than having the patient acknowledge that there may be breaches of confidentiality. It behooves the psychologist to discuss with the patient in sufficient depth the specific kinds of problems that might arise. After such a discussion, even if the patient consents, the psychologist still has to assert professional judgment that the conditions of treatment are not likely to be harmful to the patient. In this case, continuing in the group was critical to Kathy's treatment. (It is unlikely that Kathy, given how much she valued the group, would search for potential problems with her dual relationship as employee and patient.) Unless Kathy's job prospects were severely restricted, Dr. Smith should have advised her to seek employment elsewhere. If that were not feasible, the informed consent discussion needed to include the possible dual relationship of a job supervisor also observing her therapy, a situation that would be unnecessarily distressing and untenable. (Despite what Kathy or the residents say, Kathy's case of speaking freely in the group and the residents' objectivity as supervisors are compromised.)

Third, the policy of accepting hospital employees as patients is problematic because of the risk of such detrimental duel relationships, not only between present and future therapists or observers, but also between members of the group who may develop unbalanced power relationships as employees in the future. In this case, the decision resulted in two residents being placed unknowingly into a dual relationship with a patient.

The dual relationships between the patient and the residents should be ended as soon as possible. The commitment to the patient takes precedence over the commitment to the psychiatric residents for this particular training experience or even their position as supervisors. (The residents' observation of this group is not as critical to their welfare as participating in the group is for the patient, and even their temporary role as supervisors is not as critical to them as the job is to the patient.) The residents should no longer be allowed to observe, and, preferably, they should no longer be her supervisors. (If I were the patient, I would wonder if my supervisors would resent losing this training experience and retaliate against me.) By reviewing these ethical and clinical issues with the residents, Dr. Smith would be providing a valuable educational experience. He could also help arrange for them to observe another group.

Finally, if the practice of accepting hospital employees as patients is continued, then a more thorough informed consent procedure should be instituted. Trainee-observers should also be informed that in the event a group member poses a dual relationship for them they will be excluded as observers or may have to excuse themselves as supervisors. Hindsight is 20/20.

Lou Moffett, Ph.D.
Manager, Outpatient Addiction Treatment Services

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The Case of "Kathy"

A Stimulus for Teaching Ethics

Geri Miller, LaSharion Henderson, and Wayne Hogwood
Appalachian State University

We have written this paper in response to the Fall, 1997 *TAN* article, "Can You Help Me With This Ethics Case?". The first author, Dr. Miller, is a member of Division 50 and the instructor of a Masters' level course entitled, "Counseling the Addicted Client." The second and third authors are students in Dr. Miller's class.

Upon reading the article by Dr. Liese, Dr. Miller decided to use the case of "Kathy" to stimulate a class discussion on "Ethical Issues in Treating Addictive Behaviors." The case in *TAN* was chosen because it was interesting, complex, based on a real life situation, and well-written. The results of the class discussions are reported here because this teaching methodology proved to be stimulating and educational for the entire class. In addition, students related some interesting ethical concerns regarding the case.

All 16 students in Dr. Miller's class were provided with the case and a copy of the North Carolina Substance Abuse Professional Certification Board's ethical standards. Students were evenly divided into four groups where they were instructed to discuss the case, utilizing the ethical standards provided by the instructor. Each group appointed one member to report their conclusions to the entire class. Students were given approximately 30 minutes for small group discussion and 45 minutes for large group discussion.

As students discussed the case, five ethical issues seemed important: (a) competence of the therapist, (b) sufficiency of informed consent, (c) client access to hospital drugs, (d) ramifications of client relapse, and (e) client overdependency on the group. These issues are addressed in the following sections.

Competence of the therapist. Competence of the therapist was defined as the therapist acting within his area of expertise (i.e., in a manner considered common practice by other professionals in the addictions field). Most students questioned the therapist's competence. They doubted that his behavior was "common practice." They believed that he might be enabling continued drug use by allowing Kathy to remain in the group despite her drug use. Concerned students viewed Kathy as caught in a cycle of addiction, and they saw the therapist and group as enabling her addiction because there were no negative consequences for her drug use. Also, with regard to common practice in the addictions field, students were concerned that the therapist was sending a positive message about drug use to all group members. This client could not have been the first to

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Overview of Project MATCH

Gerard J. Connors
on behalf of the Project MATCH Research Group

At the Eighth International Conference on the Treatment of Addictive Behaviors (ICTAB-8), Bruce Liese and I had occasion to discuss the debate on Project MATCH* then being prepared for this issue of *TAN*. We agreed that it would be helpful to provide an overview of Project MATCH before invited commentaries, along with citations of some articles that have emerged from the study. In this regard, I agreed to develop such an overview on behalf of the Project MATCH Research Group.

Background. Project MATCH is a multisite study of patients' responses to different treatment approaches for alcohol use disorders. This nationwide clinical trial, which involved 1,726 patients, was funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Project MATCH represents the largest randomized trial of psychotherapies ever undertaken. The study is described in detail by the Project MATCH Research Group (1993).

The study. Listed below are some of the major features of the study.

Three 12-week treatments were offered that differ widely in philosophy and practice: a 12-session Twelve-Step Facilitation Therapy (TSF) designed to help patients become engaged in the fellowship of Alcoholics Anonymous and to work the first few of the Twelve Steps; a 12-session Cognitive-Behavioral Therapy (CBT) designed to teach patients coping skills to prevent relapse to drinking; and a Motivational Enhancement Therapy (MET) designed to increase motivation for and commitment to change, consisting of four sessions spread over 12 weeks.

The three treatments were tested in parallel studies in two types of settings: outpatient and aftercare. There were 952 outpatients and 774 patients in aftercare following inpatient or intensive day hospital treatment.

Based upon prior research, specific predictions were made about which individuals would respond best to the different treatments. Patient characteristics evaluated as primary matching hypotheses were: severity of alcohol involvement, cognitive impairment, conceptual level, gender, meaning-seeking, motivational readiness for change, psychiatric severity, social support for drinking, sociopathy, and typology. In addition, 11 secondary matching variables were assessed, including anger, prior engagement in Alcoholics Anonymous, severity of dependence, self-efficacy, and social functioning. The primary and secondary matching variables, along with the specific hypotheses associated with each, are detailed elsewhere (Project MATCH Research Group, 1997a, 1997b).

Primary outcome data were obtained throughout a 12-month posttreatment follow-up period.

Study quality. The Project MATCH study was carefully designed and successfully implemented. For example, patients' participation in treatment was excellent (patients attended, on average, over two-thirds of their scheduled treatment sessions). Over 90% of patients provided data for each follow-up point (3, 6, 9, 12, and 15 months after entry to the study). The content of treatments was carefully controlled, and analyses show that the three treatments as delivered were, in fact, very different from each other in expected ways (see Carroll et al., in press). Finally, blood tests as well as interviews with patients' family and friends confirmed patient self-reports of drinking.

Overall outcomes. Patients in all three treatment conditions showed major improvement not only on drinking measures, but in many other areas as well, over the 12-month follow-up period. There are several examples: (1) Before treatment, Project MATCH patients averaged about 25 drinking days per month. This decreased fourfold to fewer than 6 drinking days per month after treatment. (2) Volume of drinking also decreased dramatically. Before treatment, Project MATCH patients averaged about 15 drinks per day when drinking. This decreased fivefold to about 3 drinks on an average drinking day. (3) Project MATCH patients showed significant decreases in the use of other drugs, depression, and alcohol-related problems, as well as improvement in liver function.

Differences among treatments. The largest effects seen in Project MATCH were in the substantial improvement in drinking by all three treatment groups. Although Project MATCH was intended to study patient-treatment interactions, the design did permit comparisons across treatments. Overall, there were few clinically significant outcome differences among the three treatments in either the outpatient or aftercare arm of the study. One exception is that outpatients who received TSF were more likely to remain completely abstinent (24%) during the year after treatment than outpatients in the other two groups (14% and 15%). Another exception is that outpatients assigned to MET had a lower success rate during the active treatment phase on a composite outcome variable, compared to outpatients assigned to CBT or TSF (see Project MATCH Research Group, in press).

Patient-treatment matching. Of the 10 primary matching variables, only one *a priori* prediction was supported. Outpatients with few or no psychological problems had more abstinent days during the year following treatment when given

* **M**atching **A**lcoholism **T**reatment to **C**lient **H**eterogeneity

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TSF treatment than when given CBT. Among the secondary matching variables, two hypotheses were supported. First, outpatients high on anger had better posttreatment drinking outcomes when treated in MET than when treated in CBT. Second, aftercare patients high in alcohol dependence had better posttreatment outcomes in TSF, while low dependence aftercare patients did better in CBT. A full description of these results is provided elsewhere (Project MATCH Research Group, 1997a, 1997b).

It must be noted that the findings of Project MATCH do not rule out the possibility that other patient-treatment matching effects may be clinically important. For example, Project MATCH data cannot speak at all to possible matches to different treatment settings, therapists, pharmacotherapies, family or group therapy, or psychological treatments other than those studied.

General summary. It is difficult to isolate a few "most important" outcomes of a study of this scope. These are the broadest conclusions reached by the Project MATCH Research Group, based on analyses completed to date. Additional analyses will continue during the years ahead, which may amend this list.

The overall outcomes of patients receiving all three of the treatments studied in Project MATCH were quite favorable. Project MATCH patients remained in treatment, many achieved sustained abstinence, others showed reduced consumption when drinking, and there was substantial improvement on a broad range of measures.

Matching (or mismatching) of patients to treatments on the basis of their personal characteristics contributed surprisingly little to the overall effectiveness of treatment. The strongest effects observed in the context of the 12-month posttreatment period were for psychiatric severity and anger among outpatients and for severity of dependence among aftercare patients.

There were relatively few outcome differences among the three treatments designed to differ dramatically in philosophy and procedures.

Although MET was less successful among outpatients during the treatment phase, there were only a few outcome differences after treatment between the 4-session MET and the two 12-session treatments. Further, no relationship was found between severity of alcohol problems and response to MET versus other treatment.

Work in progress. While the initial, published findings from Project MATCH focus mostly on the 12-month follow-up period, a number of important new analyses and publications are in progress and/or in press. Among the topics the Project MATCH Research Group will report on in the future are overall outcomes and matching effects within the treatment period (Project MATCH Research Group, in press); status of outpatients at a 39-month follow-up (manuscript under review); detailed process analyses, including studies of the dynamics of the treatment process and examination of the mechanisms of action postulated for interactions between patient characteristics and treatment modalities; detailed analysis of compliance, including measurement approaches, predictors, and relationship to outcome (Mattson et al., in press); practical strategies to enhance compliance to research protocols (Zweben et al., in press); and implications of the Project MATCH findings for clinical practice.

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Letters to the Editor (continued from page 2)

Dear Editor: I thought I'd offer an update on my attempts to get some smoking cessation/nicotine addiction interest going. In an effort to set up a forum where practitioners can share thoughts about this topic, I've set up a smoking cessation web page at **http://www.customforum.com/stopsmoking**. My hope is that those of us who are doing some clinical practice in this area can share clinical and practice ideas quickly and easily. The issues can range from "what methods work best in helping smokers quit" to "how can I get reimbursed for this service" to "how can I best market this service." Drop by and share a few thoughts.

Ted Jones, Ph.D.
University of Tennessee Medical Center, Knoxville

Ten Radical Things NIAAA Research Shows about Alcoholism

Stanton Peele
Fellow, The Lindesmith Center, New York

The National Institute on Alcohol Abuse and Alcoholism's (NIAAA) Project MATCH is the most elaborate clinical trial of psychotherapy ever conducted -- in its ninth year, it has cost 30 million dollars and has involved most of this country's prominent clinical alcohol researchers. MATCH tested the hypothesis that alcohol treatment outcomes could be significantly improved by matching alcoholics on relevant dimensions with appropriate treatments. MATCH did not actually match alcoholics with treatments, but conducted a multivariate analysis on outcomes as predicted by a variety of traits in interaction with undergoing one of three types of treatment: Twelve-Step Facilitation (TSF), Cognitive-Behavioral Coping Skills Therapy (CBT), and Motivational Enhancement Therapy (MET).

MATCH results were reported in a long article by the collective Project MATCH Research Group (1997). None of the three treatments produced better outcomes overall, nor did any treatment produce better results for alcoholics with any given profile. Nearly all subjects were DSM-III-R alcohol dependent. Treatment was 12 weeks on an outpatient basis (for a purely outpatient group and a hospital treatment aftercare group), and patients were followed up for a year. Ten primary client characteristics were reported (e.g., motivation, psychiatric severity, gender). Outcomes were measured as days abstinent and drinks per drinking day. Among 64 tested interactions -- 16 proposed patient/treatment interactions by outpatient versus aftercare treatment by 2 outcome measures -- one proved significant: in the outpatient group only, less psychiatrically severe subjects had four more abstinent days per month on average in TSF than in CBT treatment.

The idea of patient-treatment matching has for some time been regarded as the cutting edge in alcoholism treatment. The failure of MATCH's primary analysis to confirm the matching hypothesis revealed more than methodological oversights or the need for further analysis. It, along with other NIAAA and alcoholism research, shows that American conceptions of alcoholism and treatment policy are fundamentally wrong.

(1) *The objectivist medical approach to alcoholism treatment does not work.* Although psychologists were the primary movers in MATCH, MATCH typifies the modern medical approach to alcoholism which NIAAA director Enoch Gordis has promoted. In its aftermath, Gordis concluded, "Treatment matches may become apparent when we get to the core of the physiological and brain mechanisms underlying addiction and alcoholism." The idea underlying matching is often appropriate in medical treatment, but the failure to find benefit from matching contravenes the value of matching alcoholics to treatment based on their objective traits and symptoms. An alternate psychological approach is to allow alcoholics to select treatment types and goals based on their values and beliefs. Research by psychologists like Heather, Winton, and Rollnick (1982), Heather, Rollnick, and Winton (1983), Orford and Keddie (1986), Elal-Lawrence, Slade, and Dewey (1986), and Booth, Dale, Slade, and Dewey (1992), none American, has shown the superiority of subjective over objective matching, although this approach is not part of American alcoholism treatment.

(2) *Individual and situational variables are more important for alcoholism outcomes than treatment variables*. MATCH uncovered significant individual and setting factors including motivation and the drinking behavior of cohorts. In other words, MATCH found that outcomes of alcoholism were the results of who people are, what they want, where they reside, and who they spend time with. Alcoholism cannot productively be addressed like medical illnesses by relying on a strict diagnostic-treatment protocol.

This phenomenon is apparent in the overall results of MATCH. In several public presentations, MATCH researchers highlighted the overall improvement of patients, noting that subjects on average reduced drinking from 25 to 6 days per month and drank less on these days. However, this improvement occurred with alcoholics who were not typical of alcoholism patients in the United States. To start with, prospective subjects with simultaneous diagnosable drug problems were eliminated although, according to SAMHSA's (1997, February) national treatment admissions census (TEDS), "combined alcohol and drug abuse. . . [is] the most frequent problem at admission to substance abuse treatment."

Many additional filters were introduced by both the subjects and the researchers. Of 4,481 potential subjects identified, fewer than 1,800 ultimately participated in MATCH. MATCH participants were volunteers, which places them at odds with the many coerced treatment referrals by the courts, employers, and social agencies. The MATCH team also eliminated potential subjects for reasons like "residential instability, legal or probation problems." Another 459 potential subjects declined to participate because of the "inconvenience" of treatment. Subjects who actually participated in MATCH were more motivated, stable, noncriminal, and free of drug problems -- all of which indicate greater likelihood of success. Thus overall MATCH results, like the MATCH analysis itself, illustrate that patients and their lives outside of treatment are more critical to alcoholism treatment results than the nature of their therapy.

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MATCH: Looking Inside Out

Richard Longabaugh
Brown University Center for Alcohol and Addiction Studies

As one of the 10 principal investigators, it is my pleasure to have been asked to join the *TAN* discussion of Project MATCH. For the past 15 years I have been captivated with the idea that matching treatments to patient characteristics could improve outcomes. Consequently, I was thrilled that the National Institute on Alcohol Abuse and Alcoholism (NIAAA) was allocating significant resources to conduct a multi-site, multi-center study of this question. At the time of MATCH's development, over 30 studies had reported evidence of matching in alcohol research (Mattson et al. (1994). Additionally, the Institute of Medicine's (1990) *Broadening the Base of Treatment for Alcohol Problems* had recommended matching as high priority research. Moreover an influential book on alcohol treatment (Lindstrom, 1992) recommended pursuit of this question with research strategies comparable to the ones we ultimately chose. Thus, as Dr. Peele indicates, patient-treatment matching has been at the cutting edge of the research agenda. MATCH was undertaken as a vehicle for addressing this question.

This response is undertaken with considerable apprehension as it has been my impression over the years that offering a view at variance with Dr. Peele's is rarely "a day at the beach." By way of "freeing up the innocent," I emphasize that these comments are solely my own. They should not be seen as representative of any of the other 22 scientists comprising the Project MATCH Senior Research Group.

Many of Dr. Peele's comments address issues falling outside the purview of Project MATCH. What follows is my own critique of the study, its pluses and minuses. In doing so, I will respond to much of Dr. Peele's critique of MATCH.

As an aside, while Dr. Peele spends considerable time comparing drinking data of treated and untreated community samples, MATCH was not designed to address this question. Our patients were limited to alcohol-dependent people who, for whatever reasons, were seeking treatment. Many came, perhaps, because they believed that treatment was what they needed, irrespective of how non-treatment seekers dealt with their own drinking problems. (Dr. Peele's critique appears to suggest the need for a study where a community sample of problem drinking treatment seekers and non-treatment seekers are randomly assigned to treatment vs. no treatment. A worthy study, though I would imagine very difficult to implement and have approved by Institutional Review Boards [IRBs]. Nevertheless, Stan, go for it!)

It is difficult for research to deny treatment to alcohol-dependent people who seek it, and it is often judged unethical to do so by local IRBs. We considered a no treatment condition, but concluded that it would be neither ethically defensible nor practical because of the large number of IRBs necessary to approve the protocol. Because ours was a matching study to find which patients responded best to which treatments, we realized that it was not critical to the study to determine whether the average patient benefited from any of the treatments.

The aims of MATCH were twofold: (1) to provide clinicians with information that would enable them to improve the outcomes achieved by matching patients to treatment, and (2) to contribute to the knowledge base concerning treatment effectiveness.

Largely, we have been unsuccessful in achieving the first aim. We found that these three treatments are not significantly differentially effective on most dimensions of outcome across most client characteristics assessed. Even where matching effects were found, increments in drinking outcomes were very small. Consequently, clinicians have gained little information about matching that will help to significantly enhance the outcomes of most patients. This is clearly a disappointment to the research group.

The absence of robust matching effects was a major surprise to most of us. I believe that in the long run such surprises are often of greater benefit to the knowledge base than confirmations of highly likely *a priori* hypotheses. Trying to fathom why the expected did not occur can yield important leads ultimately valuable in developing more effective treatments.

The major unanswered question of the study is why the three MATCH treatments, clearly discriminable from one another (Carroll et al., in press) did not have differential effects on outcomes of clients with differing characteristics. Given the magnitude of our effort to develop the most likely *a priori* matching hypotheses (Longabaugh & Wirtz, 1998), our results are especially surprising. Three kinds of explanations are likely: (1) matching is not an important ingredient in improving client outcomes; (2) design issues diminished potential matching effects; and (3) matching theory as presently developed is under-specified (Project MATCH Research Group, 1997).

Matching is not an important ingredient in improving client outcomes. Perhaps therapists and clients adjusted to different treatment-client fits, neutralizing potential barriers to successful treatment. Certainly therapists are trained to deal with people with problems, and clients come to treatment with expectations that they will be expected to change. Initial matches may be of little import in this dynamic process,

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Horsing Around at Sobriety Downs

A Parable Based on Project MATCH

G. Alan Marlatt
University of Washington

Once upon a long time ago in the Kingdom of Oz, a great horse race took place. This was no ordinary horse race. For one thing, all the jockeys were intoxicated prior to beginning the race. For another, only three breeds of horses (known in Oz as the Red, White, and Blue breeds) were allowed to run in the race. Another unique feature was the length of the race: after the initial jockey training period, the race itself lasted a full year. Once past the opening gate at Sobriety Downs, all jockeys and their mounts began a series of twelve month-long laps around the course. Another strange feature of the race was the sheer number of entries: over 1,700 horses and riders began the marathon race together.

How did this race come to be, and what were the results? To begin, we must first describe the controversy that eventually led to the race. At the time of our story, the Kingdom of Oz was plagued with chronic drunkenness, particularly among its male citizens. For many generations, there was no known cure for this malady, a problem dating back to the early royal visit of King Dionysus when he and his followers planted the now famous Garden of Grapes on Oz's western mountain slopes. Following the harvest fermentation ceremonies (*bacchanalias*), many citizens continued to consume large quantities of wine, if the truth be told (*in vino veritas*).

As the years went by, it was discovered that some drunken Ozzies were able to overcome their addiction to wine after learning to ride a horse. Of course, this was a time long before planes, trains, or automobiles; a time when the horse was the only known vehicle of travel. At first, no one could explain why some intoxicated riders achieved sobriety. The Wizard of Oz claimed that the successful cases of sobriety could all be explained by a simple observation. Since drunken riders continued to fall off their horses, only sober riders were able to stay in the saddle long enough to get from one place to another. The Wizard therefore predicted that only those riders who were motivated to move on (or go anywhere, for that matter) would benefit from horse therapy. Still the controversy continued. Even when the horse was hitched to a wagon (in order to provide greater stability), large numbers of riders continued to fall off the wagon. In response to the controversy, the king convened a consensus conference at the National Institute of Intoxication.

After listening to research reports from experts around the kingdom about what kind of riders were most likely to succeed or fail in horse therapy, a leading addictionologist rose to her feet to pose the obvious question: Maybe it's not the *rider* that makes the difference, but the breed of *horse* that is the vehicle of change. The conference audience listened attentively as she reviewed the emerging data. In some regions of Oz, the highest sober rider rates were obtained with the red horse breed, whereas in other areas, white horses showed the best results. In still other parts of the kingdom, the blue-blood breed had the best track record. What was not clear was why some intoxicated riders did better on one breed, while others did better on another. Perhaps, said the Minister of Diagnosis, we should be *matching riders* to the best type of horse!

The breed familiar to most citizens was the White horse breed, also known as the "Twelve-Stepper." Riders taught to ride the White horse are told (First Step) to accept their helplessness over their use of fermented grapes and (Second Step) to turn their reins over to a Divine Horsepower, affectionately known as the "High Horse." It was also noted that High Horse riders tended to stick together in anonymous groups and that this might be an important factor in their success.

The Red horse breed was also known as the "Lazy Horse" or "Amotivational" breed. Prospective riders of Red horses are told that all they need to bring for the ride is a carrot and a stick. If the horse refuses to move, jockeys are taught to dangle the carrot out of reach just ahead of the hungry horse's nose. If the horse still refuses to budge, the stick can be used to prod it into movement. Breeders of Amotivational horses assume that potential riders already possess the skills to ride but that what they are missing (as with the horse itself) is the motivation to get moving.

Considered a dark horse in the race, the Blue-Blood breed, was first known as the "Skillful Means" horse. Prospective riders are instructed that the best way to ride is to take over the reins and learn skills on how to best manage the horse over long journeys. Riders learn navigational skills and are trained how to avoid high-risk situations for potential falls.

One the last day of the conference, the Director of the National Institute of Intoxication announced that the Institute would fund a large national study to settle the question once and for all: Which breed of horse is best for which type of rider? Results from this study would be used by the Minister of Diagnosis to assign future riders to the best horse to carry them to Sobriety. Rather than first matching riders to one of the three breeds and observing their progress compared to a non-matched control group, it was decided by a majority vote that all riders would be randomly assigned to one of the three horse breeds

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prior to the race. Every rider would be carefully assessed for prospective matching criteria prior to the race, in order to determine (by future hindsight) which rider characteristics were associated with reaching Sobriety and which were not.

It was a bright sunny January 1 at Sobriety Downs as the shot of the starting gun was heard ringing through the cold winter air. Crowds of onlookers strained to catch a glimpse of hundreds of intoxicated jockeys as they attempted to mount their horses as the race began. (Some jockeys took considerably longer than others, and several seemed unable to mount at all.) Crowds cheered and children waved as more than 1,700 chronically intoxicated jockeys mounted their fleet of Red, White, and Blue horses and headed off in a cloud of dust. And this was just the first day of a 365 day race. The Wizard of Oz commented as the race began, "You can lead a horse to water, but you can't make him drink, so hopefully the same will be true of the jockeys."

From the first day on, the Big Race was a constant source of community gossip throughout Oz. Although periodic official observations were made during the course of the race (every 90 days), the results were kept secret from the public. Excitement mounted as the months progressed, reaching a peak at the time of the final lap in late December.

On the final day of the Big Race, a large crowd gathered at the finish line at Sobriety Downs. The whole kingdom waited anxiously as the first horses began to appear. People shouted and leapt to their feet, craning their necks to get a glimpse of the action in the final lap. Three horses appeared way ahead of the pack, galloping together in a tight trio as they approached the final ribbon. Onlookers gasped and screamed as the three leading horses charged forward, nose-to-nose in a cloud of dust.

At first it was difficult to determine the winner. The crowd waited restlessly while the three jockeys were administered breathalyzer tests by race officials. After a few minutes of agonizing delay, the following announcement was made: "**Photo finish! Results show a three-way tie!**" flashed the giant sign on the tote board. Although all three jockeys were found to be sober, the photos of the finish line revealed no clear winner!

Amazingly, as the day progressed and hundreds of the horses (many without jockeys) finally arrived at the finish line, those same overall results were obtained: There were no significant differences (statistically speaking) among the three breeds. All the Red, White, and Blue horses seemed to do equally well, in terms of the number of sober jockeys who reached the finish line, as well as the percentage who fell off during the race itself. "Everyone has won, and all must have prizes!" exclaimed the Dodo Bird, who had come all the way from a distant underground kingdom to witness the race.

The Director of the Institute of Intoxication addressed the crowded press conference in time for the 6 p.m. national news on New Year's Eve. The first question asked was the one everyone had on their minds: "Can you please tell us, Sir, what the results mean?" After a long pause, the Director replied: "Well, the good news is that horse therapy works in getting riders sober. At this point it doesn't seem to make any difference which horse you use in therapy -- they all seem to do equally well. None of our prior hypotheses about which type of rider would do best on which breed of horse panned out."

Just then, a commotion broke out at the back of the room. After a few moments of bustling confusion, the Director was handed a note by his Chief of Security. After glancing it over, he shook his head in disbelief before stepping to the microphone. "I have an important announcement to make!" the Director exclaimed, as a hush fell over the crowd of reporters. "Strange things are going on outside right now at the finish line," he said. "Apparently, at first there were just a few people, then there were more, and now there seem to be literally *hundreds* of people arriving at the finish line completely sober!! And *none* of them are riding horses!! We seem to have an outbreak of what can only be called spontaneous remission!!"

Whatever you want to call it, spontaneous remission or just plain old willpower, the bottom line at the finish line was this: More winos eventually ended up at the finish line without horses than those who stayed on their original horses or even those who changed horses in mid-stream. Actually, the number of jockeys who remained totally on their horses, without a slip from start to finish, turned out to be relatively small (only about one out of four jockeys were sober for the entire race). Of the horseless riders who successfully made it over the line, some were jockeys who had experienced a fall from their horses at some point during the race but were then somehow able to get back on their feet and make it to the finish line (although their track time was significantly longer since they arrived on foot).

Others seemed to complete the entire race on foot, without any horse to carry them through. These so-called "horseless wonders" were later interviewed as to the source of their success. Most attributed the positive outcomes to having read the diagnostic assessment questions about addiction to wine administered to all potential jockeys before the race began. "Reading the assessment questions made me think about my problem in a different light," reported one ex-wino who ran the entire race without a horse. "Because I couldn't afford a horse of my own, I thought I would try to walk the walk on my own," he said proudly.

Others who made it without equestrian assistance reported a variety of helpful resources, some from friends and family, still others from reading self-help manuals. It was even reported that one or two former winos who made it over the finish line were carrying large frozen poultry (later dubbed the "cold turkey"

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APA Division 50
Executive Committee Meeting

Minutes from Mid-Winter Meeting
Washington, DC -- February 9, 1998

Tom Horvath
Secretary-Treasurer

Members present: Barrett (Member-at-Large), Brown (President-Elect), De Leon (Past President), Horvath (Secretary-Treasurer), Leonard (Member-at-Large), Platt (Member-at-Large), Tucker (APA Council Representative), Zucker (President).

No members absent.

Also present: Kim Fromme (1998 Convention Chair), Bruce Liese (*TAN* Editor), Rob Thompson (Continuing Education Co-Chair).

Selected Motions (all unanimous):

To increase Fellows, Members and Associates dues from $33 to $35 for calendar year 1999 (Horvath, De Leon).

To authorize the Treasurer to invest surplus funds in short-term secured investments (Horvath, Tucker).

To accept a 1998 budget of $55,270 (Horvath, Leonard).

To solicit contributions from organizations which support research, to be used for support of the Convention Social Hour or other Convention activities, provided these contributions are accepted in accordance with APA guidelines (Horvath, Brown).

To acknowledge the extensive and very high quality work of Kim Fromme, the 1998 Program Chair (Brown, Horvath).

To match funds (up to a $1500 match, for a $3000 total expense) for the purchase of a computer suitable for desktop publishing for Bruce Liese, to be paid for out of expected *TAN* advertising revenues (Horvath, Brown).

To appoint an editorial search committee (to include Leonard, Brown, Zucker, Tucker, and Platt) for the editorship of *Psychology of Addictive Behaviors (PAB)*, to report back in August, 1998, with a nominee.

To nominate Kim Fromme to run for Member-at-Large in the upcoming election.

To nominate [candidate later declined invitation] to run for Member-at-Large in the upcoming election.

To permit nominees to submit to *TAN* a campaign statement, including biographical material, maximum 300 words.

To defer holding the Pre-Convention Institute until next year, when it will be organized by the Continuing Education Committee, with focused planning to take place at the August, 1998 meeting (Horvath, Brown).

To appoint Susan Tate, University of California, San Diego, as the Graduate Student Representative.

Marlatt (continued from previous page)

group). Not all made it to the finish line, however. It was later reported that many who never finished the race were living comfortably in Moderation Meadows, where they eventually produced some of the finest gourmet wines in Oz.

About a month after the end of the Big Race, a huge wooden horse appeared (as if by magic) one morning at Sobriety Downs. It was tied up with a large black ribbon. Not knowing its origin, the Minister of Police and his assistants approached the giant horse with trepidation. The Minister moved a stepladder in position so that he could climb up to the horse's head. Peering inside the horse's open jaws, he yelled inside: "'Hello!! Is anyone inside??"' Suddenly, the ribbon broke and the sides of the huge horse fell apart without warning. A debauched group of 100 intoxicated jockeys streamed out, yelling and shouting in glee, pouring wine over each other in joyous abandon. "You'll never get us to stop drinking!" they jeered in unison to the gathering crowds. Watching the wild bacchanalia, the Wizard of Oz was heard to say: "Wow! It's those sneaky Trojans again! Just as I always said: Never look a gift horse in the mouth!"

APA Certification for Addictions

Janet Ciuccio
APA College of Professional Psychology

Merit Behavioral Care (MBC) now accepts the American Psychological Association's College of Professional Psychology's Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders as a stand-alone criterion for a verified specialty in addictions. This means that if you have met MBC's basic credentialing standards and hold this certification, you need not meet any other criteria to be considered a verified addictions specialist. Providers with verified specialties may receive referral preference when it is determined that a specialist is needed.

If you hold this certification and you have not already reported your addictions specialty by returning an affidavit and addictions checklist from MBC's Specialty Verification packet, you may call Provider Relations at (800) 999-9772, extension 2992, to request a Specialty Verification packet and attain this verified specialist status.

Come to the 1998 APA Convention!

Lisa Najevits

Kim Fromme
1998 APA Convention Program Chair

The 1998 APA convention will be held in San Francisco, August 14-18; the Division 50 theme is "The Spectrum of Addictive Behaviors and Their Consequences." Programming of interest to our membership is enhanced this year because of a collaborative effort between Divisions 50 (Addictions) and 28 (Substance Abuse and Psychopharmacology), as well as a miniconvention in conjunction with NIAAA (see next article). Division 50 addresses will be given by our President, **Robert Zucker** (Spectrum of Alcohol and Drug Use Disorders: A National Agenda for Focused Change), **Marc Schuckit** (Relationship Among Genetic, Environmental, and Psychological Variables in Predicting Alcoholism), **Stewart Agras** (Treatment of Bulimia Nervosa), **Sharon Hall** (Depression, Dysphoria, and Smoking Cessation), and the Director of NIAAA, **Enoch Gordis** (Alcohol and Addiction Research: Achievements and Promise in Behavioral Science). Twelve symposia will be featured on substance and non-substance addictions (e.g., alcohol and illicit drug use, gambling, and eating disorders), forensic issues, and basic research. Two poster sessions will address "Alcohol Use and Abuse, Smoking, and Gambling" and "Eating Disorders and Treatment of Drug Abuse." Programming will be complimented by a workshop on "Treatment of Dually Diagnosed Patients Using Relapse Prevention" and a discussion hour on "Psychotherapy and 12 Step Programs." Division 28 is also sponsoring a number of exciting speakers, symposia, posters, and paper sessions on basic and applied topics in the addictions.

With 121 conference submissions, there was enthusiastic response to our Call for Proposals. An 80% acceptance rate yielded extremely high quality presentations. Consistent with the composition of Division 50 membership, both science and practice concerns will be well represented. It is safe to say there is "something for everyone" in the Division 50 program this year. A detailed listing of presentations, days, times, and locations will be included in the summer issue of *TAN*. As Program Chair, I welcome your comments and suggestions. I would also like to extend my sincere thanks to the Program Committee, Mac Horton, Tom Brandon, and Michael Sayette (1999 Program Chair) as well as this year's reviewers (see below) for their hard work and valuable assistance in creating, what I hope you will agree, an outstanding 1998 program.

Vince Adesso
Curtis Barrett
Marsha Bates
Ken Carpenter
Tony Cellucci
Peter Giancola
Gloria Miele
Woods Miller
Mark Myers
Roger Peters
Alan Reifman
Laurie Roehrich
Mariella Shirley
Mark Sobell
Eric Stice
Maria Testa
Peter Vik
Rudy Vuchinich

Miniconvention on Alcohol and Addiction Research

Geoffrey Laredo
APA Office of Policy Analysis

APA Divisions 50 (Addictions) and 28 (Substance Abuse and Psychopharmacology), in cooperation with other APA Divisions and with the assistance of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) of the National Institutes of Health (NIH), are sponsoring a miniconvention at this year's APA convention in San Francisco, CA. The miniconvention, titled "Alcohol and Addiction Research: Achievements and Promise in Behavioral Science," will highlight alcohol (and connected other drug-related) research, prevention, and treatment activity, and will call attention to the potential of the Institute as a sponsor of new work in a number of areas. Programming will provide a way of highlighting how alcohol and other drug use connects with a wide variety of behavioral research realms of interest to APA members (e.g. basic research, prevention, neuroscience, the integration of behavioral and pharmacological treatment methods, epidemiology, managed care, etc.). Experts from across the field will participate as faculty, and NIAAA Director Enoch Gordis, M.D. will also speak. APA will present Dr. Gordis with a National Recognition Award for Contributions to Behavioral Science Research.

For more information on the miniconvention, please visit NIAAA on the World Wide Web at http:\\www.niaaa.nih.gov. For specific questions, contact the Division program chairs, Kim Fromme, Ph.D. (Division 50, [512] 471-0039, fromme@psy.utexas.edu) or Nancy Piotrowski, Ph.D., (Division 28, [510] 642-5208, npiotrowski@arg.org). For NIAAA information, please contact Geoffrey Laredo at (301) 443-6371; glaredo@willco.niaaa.nih.gov.

The Journal of Division 50

Psychology of Addictive Behaviors

Support our journal by sending us your manuscripts. Our journal is recognized as one of the fastest growing peer-reviewed addictions journals. We also welcome guest-edited special issues on relevant topics. Complete author instructions are printed in each issue.

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For more information contact: Susan J. Curry, *PAB* Editor, Center for Health Studies, Group Health Cooperative, 1730 Minor Avenue, Suite 1600, Seattle, WA 98101. Phone: (206) 287-2873; e-mail: currys@mpe.ghc.org

Vote for Division 50 Officers
Report of the Nomination Process

Lisa Najavits
Elections Supervisor

The elections process for Division 50 is moving along very smoothly. We are honored to have two people running for the position of President: Arthur "Mac" Horton, Ed.D. and Arthur "Tom" Horvath, Ph.D. (No, it was not a criterion to be named Arthur to run!) For Secretary-Treasurer, Gregory T. Smith, Ph.D. is on the slate; and for Member-at-Large, Kim Fromme, Ph.D. is running. For the latter two positions, no one else joined the ballot. The number of nominations received for the President position was high: over 95, suggesting a strong nominations process. Kim Fromme, Ph.D. was approved to run at the Board meeting in February, after no nominations had been received for the Member-at-Large position. Division 50 members may want to think about running in future years for office (which are always announced in *TAN* in the fall). May the best win!

Candidate Biographies

Candidates for Division 50 President

Q & A with **"Mac" Horton**

Q. How did you become interested in addictive behaviors?

A. I had an uncle who was an alcoholic and he was very kind to me when I was a boy. I tend to think of him when I treat alcoholic patients.

Q. What was your most important experience in working with addictive behaviors?

A. The eight years, I was the Coordinator of the Alcoholism Section of Medical Service of the Baltimore, VA Medical Center. It was both a 20 bed inpatient detox unit and 600 monthly visit outpatient treatment program. I coordinated a large multidisciplinary staff and also ran a weekly outpatient psychotherapy group.

Q. What have you done for Division 50?

A. I have been a reviewer for the Division's Program Committee for several years and was the Program Committee Chairperson last year in Chicago. I thought I did a good job as the 1997 Division 50 Program Chairperson and demonstrated my knowledge of the field and my management and diplomacy skills. My impression is both scientist and practitioner members of Division 50 felt the program committee decisions were fair, and that is easier to say than to do.

Q. What will you do for Division 50 if elected President?

A. The most pressing problem facing the Division is the fact the national substance abuse treatment system has dramatically deteriorated in the last ten years. Part of this has been due to managed care but part has been due to a lack of commitment to provide sufficient resources. I think the Division needs to address the challenges presented by managed care and to also lobby for more public funding of substance abuse research and services.

Arthur "Tom" Horvath is in independent practice at the Center for Cognitive Therapy, La Jolla (San Diego), CA, specializing since 1985 in the empirically supported treatment of addictive behavior and comorbid disorders. He earned his B.A. in Liberal Arts from St. John's College, Annapolis, MD, in 1975. He earned his Ph.D. from the California School of Professional Psychology at San Diego in 1981, and then served three years as a psychologist in the United States Navy. He is a Diplomate in Clinical Psychology (ABPP), a Past President of the San Diego Psychological Association, and since 1995 the President of S.M.A.R.T. Recovery, a non-profit corporation offering free support groups and other services to individuals desiring to abstain from any type of addictive behavior. He has published several articles and chapters on motivation for treatment, treatment of comorbidity, and alternative support groups, and has written a self-help manual for individuals desiring to moderate or abstain from addictive behavior. He has been active in the Division since the signature drive that created the Division out of SPAB, and has served on the Membership and Education and Training Committees. He is currently completing his term as Secretary-Treasurer.

He believes that one of the Division's fundamental assets is the good relationship between its researchers and its clinicians. He believes that the Division's primary goals should include maintaining and enhancing this relationship and disseminating scientific knowledge about the prevention and treatment of addictive behavior to professionals and the public. As President he would also focus on (1) increasing the awareness of all psychologists about addictive behavior, (2) increasing the standing of the Division as a necessary participant in the development of guidelines and standards regarding prevention and treatment, and (3) positioning the Division as a necessary consultant on research funding and public policy.

Candidate for Division 50 Secretary-Treasurer

Gregory T. Smith. I received my Ph.D. from Wayne State University in Detroit in 1986. From 1986 until 1989, I worked two full-time jobs: one as a clinician and one as an academic in Detroit. Clinically, I worked at a community mental health center and directed Wayne State's psychological clinic. I did a significant amount of outpatient addictions treatment at that time. Academically, I worked as principle investigator on an NIAAA grant studying risk factors for adolescent drinking. In 1989, I moved to the University of

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Biographies (continued from previous page)

Kentucky, where I have now worked for nine years.

I have research interests in two kinds of addiction: alcoholism and eating disorders. Regarding alcoholism, I have worked on several studies investigating psychosocial learning risk factors for early adolescent problem drinking. My newest work involves integrating personality and learning risk factors. More recently, I have begun studying eating disorders, again with the aim of identifying learning and modeling factors that place some girls at greater risk for eating disorders.

I would like to serve the Division as its Treasurer primarily because of all the ways in which I have benefited from the activities of the Division. My own career has benefited greatly both from personal, mentoring relationships with Division members and from Divisional support of research in the addictions. A student of mine once won the Divisional award for outstanding graduate student research; the award furthered her own interest in our field. I found my work as Divisional APA program chair in 1995 very rewarding -- and enlightening about all the great work being done by Division members. To serve you as Treasurer would simply be my way of giving something back. We need a strong Division now more than ever, and I would like to help bring that about.

Candidate for Division 50 Member-at-Large

Kim Fromme is Associate Professor (effective 9/1/98) in the Department of Psychology at The University of Texas at Austin, having previously held a faculty position at the University of Delaware (1988-93). She received her Ph.D. in Clinical Psychology from the University of Washington in 1988, under the mentorship of G. Alan Marlatt. Consistent with the Scientist/Practitioner model, Dr. Fromme has been actively involved in research, teaching, and clinical supervision throughout her career. Her speciality area is alcohol use and abuse; focusing on the effects of alcohol intoxication and the development of brief, empirically-based prevention programs for adolescents and young adults.

A member of APA since 1991, Dr. Fromme has been a member of Division 50 since it was formed and SPAB prior to that. She has served as Associate Editor (1994-96) and Consulting Editor (1993) for *Psychology of Addictive Behaviors*. She co-chaired the Division 50 convention program for 1997 and is currently Program Chair for the 1998 convention in San Francisco.

Candidate's statement. This is an exciting time for our Division. Membership is growing, the field of addictive behaviors is increasingly recognized among the larger membership of APA, and we've made tremendous progress towards our objective of linking science and practice. As Member-at-Large, I would continue these efforts and strive to effectively represent our membership on the Division 50 Executive Committee.

As 1998 Program Chair, I have tried to build bridges between our Division and others in APA (e.g., 7, 12, 38), particularly Division 28 (Psychopharmacology and Substance Abuse). We have much to gain from cross-division dialogue and interdisciplinary approaches to addictive behaviors. This has been a theme across my leadership in other professional organizations, and I would carry this into my role as Member-at-Large for Division 50. It would be my privilege to represent you in Divisional activities.

Congratulations!!!

Thanks to your support, Division 50 retained a seat on the APA Council of Representatives for 1998!!!

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 Joy M. Schmitz, Ph.D. at (713) 500-2867 to become a Division 50 Member or Affiliate. Thank you!

Addictions Abstracts

Typically in this section Division 50 members contribute abstracts of their own work. However, in this special issue we have selected abstracts of three important Project MATCH studies. Please continue to send abstracts for future issues of *TAN*. One abstract may be submitted per person, per issue. The maximum length of each abstract is 150 words. Only papers published within the past year (articles, books, chapters) are acceptable. Please include the full citation (not included in 150-word limit). We will accept abstracts on a first-come, first-served basis. Please send abstracts by mail, or preferably by e-mail, to **bliese@kumc.edu**. Thanks!

Project MATCH: Rationale and Methods for a Multisite Clinical Trial Matching Patients to Alcoholism Treatment

Project MATCH Research Group. (1993). Project MATCH: Rationale and methods for a multisite clinical trial matching patients to alcoholism treatment. *Alcoholism: Clinical and Experimental Research*, *17*, 1130-1145.

No single treatment approach is effective for all persons with alcohol problems. A more promising strategy involves assigning patients to alternative treatments based on specific needs and characteristics of patients. Project MATCH is a multisite clinical trial designed to test a series of *a priori* hypotheses on how patient-treatment interactions relate to outcome. Two independent but parallel matching studies are being conducted, one with clients recruited from outpatient settings, the other with patients receiving aftercare treatment following inpatient care. Patients are randomly assigned to Twelve-Step Facilitation, Cognitive-Behavioral Coping Skills, or Motivational Enhancement Therapy. Subjects are followed at 3-month intervals for 1 year following completion of the 12-week treatment period and evaluated for changes in drinking patterns, functional status/quality of life, and treatment services utilization, interaction effects with selected patient characteristics will be studied. Project MATCH will provide a rigorous test of the utility of patient-treatment matching in general and, depending on the specific *a priori* hypotheses validated, will have important implications for clinical practice.

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Matching Alcoholism Treatments To Client Heterogeneity: Project MATCH Posttreatment Drinking Outcomes

Project Match Research Group. (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol*, *58*, 7-29.

Objective: To assess the benefits of matching alcohol dependent clients to three different treatments with reference to a variety of client attributes. ***Method:*** Two parallel but independent randomized clinical trials were conducted, one with alcohol dependent clients receiving outpatient therapy (*N*=952; 72% male) and one with clients receiving aftercare therapy following inpatient or day hospital treatment (*N*=774; 80% male). Clients were randomly assigned to one of three 12-week, manual-guided, individually delivered treatments: Cognitive Behavioral Coping Skills Therapy, Motivational Enhancement Therapy or Twelve-Step Facilitation Therapy. Clients were then monitored over a 1-year posttreatment period. Individual differences in response to treatment were modeled as a latent growth process and evaluated for 10 primary matching variables and 16 contrasts specified *a priori*. The primary outcome measures were percent days abstinent and drinks per drinking day during the 1-year posttreatment period. ***Results:*** Clients attended on average two-thirds of treatment sessions offered, indicating that substantial amounts of treatment were delivered, and research follow-up rates exceeded 90% of living subjects interviewed at the 1-year posttreatment assessment. Significant and sustained improvements in drinking outcomes were achieved from baseline to 1-year posttreatment by the clients

assigned to each of these well-defined and individually delivered psychosocial treatments. There was little difference in

outcomes by type of treatment. Only one attribute, psychiatric severity, demonstrated a significant attribute by treatment interaction: In the outpatient study, clients low in psychiatric severity had more abstinent days after 12-step facilitation treatment than after cognitive-behavioral therapy. Neither treatment was clearly superior for clients with higher levels of psychiatric severity. Two other attributes showed time-dependent matching effects: motivation among outpatients and meaning-seeking among aftercare clients. Client attributes of motivational readiness, network support for drinking, alcohol involvement, gender, psychiatric severity and sociopathy were prognostic of drinking outcomes over time. ***Conclusions****:* The findings suggest the psychiatric severity should be considered when assigning clients to outpatient therapies. The lack of other robust matching effects suggests that, aside from psychiatric severity, providers need not take these client characteristics into account when triaging clients to one or the other of these three individually delivered treatment approaches, despite their different treatment philosophies.

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Project MATCH Secondary A Priori Hypotheses

Project MATCH Research Group. (1997). Project MATCH secondary *a priori* hypotheses. *Addiction, 92,* 1655-1682.

Aims: (1) To assess the benefits of matching alcohol dependent clients to three treatments, based upon *a priori* hypotheses involving 11 client attributes; (2) to discuss the implications of these findings and of matching hypotheses previously reported from Project MATCH. ***Setting and participants*****:** (1) Clients receiving outpatient therapy (*N*=952; 72% male); (2) clients receiving aftercare therapy following inpatient or day hospital treatment (*N*=774; 80% male). ***Intervention***: Clients were randomly assigned to one of three 12-week, manual-guided, individual treatments: Cognitive Behavioral Coping Skills Therapy (CBT), Motivational Enhancement Therapy (MET) or Twelve-Step Facilitation Therapy (TSF). ***Design***: Two parallel but independent randomized clinical trials were conducted, one with outpatients, one with aftercare clients. Participants were monitored over 15 months including a 1-year posttreatment period. Individual differences in response to treatment were modeled at a latent growth process and evaluated for 17 contrasts specified *a priori*. Outcome measures were percentage of days abstinent and drinks per drinking day. ***Findings***: Two *a priori* contrasts demonstrated significant posttreatment attribute by treatment interactions: (1) outpatients high in anger and treated in MET had better posttreatment drinking than in CBT; (2) aftercare clients high in alcohol dependence had better posttreatment outcomes in TSF; low dependence clients did better in CBT. Other matching effects varied over time, while still other interactions were opposite than predicted. ***Conclusions***: (1) Anger and dependence should be considered when assigning clients to these three treatments; (2) considered together with the results of the primary hypotheses, matching effects contrasting these psychotherapies are not robust. Possible explanations include: (a) among the client variables and treatments tasted, matching may not be an important factor in determining client outcomes; (b) design issues limited the robustness of effects; and (c) a more fully specified theory of matching is necessary to account for the complexity of the results.

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Miller (continued from page 3)

relapse in the group. Therefore, students wondered about group norms regarding relapse and whether Kathy was receiving special treatment.

In attempting to determine the therapist's competency, the class felt limited by an obvious lack of information about him. They wondered about the timing and circumstances of his entry into the group, whether he had the power or credibility to change group norms (particularly regarding abstinence and relapse), and what his relationship was with the hospital administration (e.g., was he required to lead a group where he was not allowed to screen members for exclusion?). At the same time, class consensus was that the therapist needed to consistently take a stand against group members' drug use.

Sufficiency of informed consent. Sufficiency of informed consent was defined as the client being provided with all pertinent information about the therapeutic process prior to beginning therapy. The class became increasingly concerned about informed consent after Kathy's role-shift, when she became an employee and group member. There was no indication that informed consent was reviewed after Kathy became an employee. The main concerns of the class related to her protection and well-being. Because of her dual roles, students thought the following questions needed to be addressed by the therapist (privately and conjointly) with Kathy:

(1) How could she be assured of confidentiality?
(2) How would she know who would be observing her in the group each week?
(3) Even if observers did not violate her confidentiality, how might self-disclosure impact their view of her as an employee?
(4) Does she know the possible ramifications of being both a client and an employee within the hospital (or should the counselor, who would be better versed in the possible consequences, set the boundaries on her roles)?

Client access to hospital drugs. Access to hospital drugs was a concern, since the class assumed that Kathy would have increased access to them as an employee. This concern was exacerbated by the fact that there were no apparent negative consequences in the group for drug use (from either the therapist or the group). In view of the therapist's and group's potential enabling behavior, students believed that drug access could result in eventual abuse of prescription drugs. Also, they believed that there was an increase in the liability of the therapist and the hospital if her supervisors were not warned of her current drug use and the danger of having drugs available through her job.

Ramifications of client relapse. Client relapse in this case would involve Kathy's return to her usual amount of drug use following any reduction of use resulting from treatment. Concerns about relapse were linked to her possible access to drugs on the job. The students also expressed concern about any possible harm she might cause hospital patients in the event of a relapse. The students' concern was that even if she were able to maintain some abstinence, the entire situation would put her at high risk for relapse. Once again, the students viewed the hospital and the therapist as having increased liability in this situation.

Overdependency on the group. Overdependency was defined as Kathy's excessive reliance on the group for daily support and functioning. Students believed that her dependency was becoming apparent from three observations: continued drug use, lack of separation between her personal and professional lives, and childlike interactions with her therapist. Because she was unable to remain abstinent, the students believed that she had developed a group dependency that fused with her addiction: the leader and group were enabling and rationalizing her drug use, and therefore she had no reason to achieve abstinence. Second, students stated that because she was also an employee, the group was too powerful in her life (because it linked her personal life with her professional life). Finally, her approach with the therapist seemed to involve a childlike dependency where the therapist was given responsibility for her inclusion in the group rather than her taking responsibility for her own drug use and her choice to obtain a job with the hospital.

In summary, the class did not fully resolve the ethical dilemmas raised by this case. Nonetheless, the number of questions left unanswered gave the class a feeling that something was definitely wrong with Kathy's circumstances. There was consensus that the therapist needed to resolve the dilemma(s) with great attention paid to the best interests of the client. They believed a part of their struggle with this case resulted from a lack of information about the patient, group, hospital, and therapist. And they developed the following list of questions whose answers might contribute to the resolution of these ethical dilemmas:

(1) What is Kathy's job at the hospital, especially as it relates to patient welfare?
(2) Is there an Employee Assistance Program available to Kathy?
(3) What have been past group rules about abstinence and group membership?
(4) Although it appears that the group is helping Kathy (by her own self-report), is it *really* in her best interest to remain in the group if she is still using?

Because the original article published in *TAN* asked for feedback, the class requested that the instructor summarize their concerns and send them to the Editor of *TAN*. As it turned out, there were significant benefits to teaching ethics based on this actual client situation. First, this case helped students see that there are not necessarily clear-cut answers regarding ethical dilemmas but that additional information and consultation with colleagues are essential to their resolution. Second, the classroom discussion also underscored that even professionals may disagree about complex ethical situations and issues.

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Miller et al. (continued from previous page)

Finally, students are likely to find theoretical discussions of ethics to be dry or boring, but when presented with an actual case, discussions can became lively and enthusiastic, ultimately contributing to the learning of ethics. At the end of the class, an ethical decision-making model was provided to students, with emphasis placed on the importance of documenting consultation (to both assure client's welfare and protect the therapist legally). Providing real cases and practicing ethical decision-making with actual cases makes the information to be learned by students more pertinent.

Peele (continued from page 6)

(3) *The characteristics of therapists and of interactions between patients and therapists are more important than type of treatment in alcoholism outcomes*. While treatment type was not significant in MATCH, treatment site and site by treatment type effects were. In other words, the way particular therapists interacted with alcoholics had a substantial impact on patient outcomes whereas the label of the therapy they practiced did not.

(4) *Alcoholism treatment in the United States is not notable for its success*. Gordis's fundamental summary of MATCH was that while its findings "challenge the notion that patient-treatment matching is necessary for alcoholism treatment, *the good news is that treatment works*" (emphasis added; Bower, 1997). But MATCH could make no categorical statements about the impact of treatment since it had no untreated control comparison. Moreover, so much about the MATCH clinical trial was unique that there is little reason to assume its results generalize to alcoholism treatment at large in the United States. On the other hand, the NIAAA *has* conducted a thorough assessment of treated and untreated remission rates as experienced in the general population -- the National Longitudinal Alcohol Epidemiologic Survey (NLAES) -- based on face-to-face interviews about drug and alcohol use and treatment and concurrent emotional problems.

The NIAAA's Deborah Dawson (1996) analyzed over 4,500 NLAES subjects whose drinking at some point in their lives qualified for a diagnosis for alcohol dependence (DSM-IV). Treated alcoholics were more heavily alcohol dependent on average than untreated alcoholics and, according to the NIAAA's Bridget Grant (1996) in the same journal volume, to also have a drug problem (thereby distinguishing these from MATCH subjects). NLAES found that a third of treated (and 26% of untreated) subjects were abusing or dependent on alcohol in the past year. Of those whose alcohol dependence appeared within the last five years, 70% who received treatment were drinking alcoholically in the past year. Although population differences color comparisons between treated and untreated outcomes in NLAES, the results nonetheless show that alcoholics undergoing treatment in the United States do not experience the reliable improvement rosily reported by NIAAA/MATCH officials (see Table).

Table
National Longitudinal Alcohol Epidemiologic Survey Data on Alcohol Dependent Subjects

Drinking over prior year (*n*)	Treated (1,233)	Untreated (3,309)	Total (4,585)
Total population			
% drinking with abuse/dependence	33	26	28
% abstinent	39	16	22
% drinking w/o abuse/dependence	28	58	50
Less than 5 years since onset of dependence			
% drinking with abuse/dependence	70	53	57
% abstinent	11	5	7
% drinking w/o abuse/dependence	19	41	36

Note. From "Correlates of past-year status among treated and untreated persons with former alcohol dependence: United States, 1992," by D. A. Dawson, 1996, *Alcoholism: Clinical and Experimental Research, 20*, p. 773. Adapted with permission.

(5) *American twelve-step treatment is of limited usefulness*. Any documented success of twelve-step treatment would reflect well on American alcoholism treatment, since Roman and Blum (1997), in their National Treatment Center Study, found that 93% of drug and alcohol programs follow the twelve-step program. Margaret Mattson (1997, March), a principal NIAAA MATCH coordinator, declared: "The results indicate that the Twelve Step model, . . . the most widely practiced . . . in the U[nited] S[tates], is beneficial." But this conclusion is not consistent with a meta-analysis of all available controlled alcoholism treatment studies reported by Miller et al. (1995). Unlike MATCH, Miller et al. found that alcoholism treatments were clearly differentiated in terms of their demonstrated effectiveness, with brief interventions ranked first, followed by social skills training and motivational enhancement. Ranked at the low end were confrontation and general alcoholism therapy. The two tests of Alcoholics Anonymous (AA) found it inferior to other treatments or even no treatment but were not sufficient to rank AA reliably.

Remarkably, Miller et al. (1995) noted a strong inverse correlation between the popularity of treatments practiced in the United States and the evidence that these treatments work, with the typical program comprising "a spiritual twelve-step (AA) philosophy . . . and . . . general alcoholism counseling, often of a confrontational nature," usually administered by former substance abusers. That this conventional treatment is not effective is consistent with NLAES results, although not with

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Peele (continued from previous page)

the impression created by MATCH.

(6) *TSF in MATCH differed from standard twelve-step treatment, which is overly directive and otherwise poorly delivered*. Treatment in MATCH was not the same as treatment in the field. Manuals were developed and counselors carefully selected and trained, each treatment session was videotaped, and the tapes were monitored by supervisors. Jon Morgenstern, as part of a Rutgers research project which has observed standard treatment providers, has noted that they offer very poor quality therapy. One way in which usual twelve-step therapy might differ from its MATCH version is that it is often highly directive (to the point of being abusive).

(7) *The most cost-effective therapy for any severity alcohol problem is brief interventions/motivational interviewing -- that is, short-term, nondirective treatment*. In both brief interventions and motivational interviewing, therapies found most effective by Miller et al. (1995), patients and counselors jointly discuss the patient's drinking habits and consequences in a nonjudgmental way that focuses the patient on the value of reducing or quitting drinking. Meanwhile, MET would be the recommended treatment based on MATCH because it produced equal results at far lower cost. TSF and CBT were designed to be 12 weekly sessions while MET was designed to be only 4 sessions. However, MATCH patients on average attended only two-thirds of their sessions, so that MET in MATCH approached brief interventions. **That the briefest treatment in MATCH worked as well as more extensive treatments challenges conventional wisdom that brief interventions are inappropriate for alcohol-dependent patients.**

(8) *Elaborate alcoholism treatment is not necessary for recovery; most alcoholics in the United States recover without treatment.* MATCH indicated that people who seek to overcome alcoholism and have a supportive social environment can well do so with brief therapeutic interactions that focus their motivation and resources on improving their lives. The NLAES analysis of untreated alcoholics shows (a) that most alcoholics do not seek treatment and (b) that most of these stop abusing alcohol (Dawson, 1996).

(9) *Nonabstinent remission is standard for American alcoholics*. Not only do most alcoholics improve significantly without treatment, but they typically do so without quitting drinking. **According to NLAES, from five years following a dependence diagnosis on, a majority of ever-alcohol-dependent people in the United States are drinking without manifesting alcohol abuse/ dependence.** Untreated alcoholics are more likely to be in remission than treated alcoholics at all points since dependence onset because, although they are less likely to abstain, they are far more likely to drink without diagnosable problems.

On September 8, 1997, *U.S. News & World Report* ran a cover story on controlled drinking. Gordis responded in the magazine that "current evidence supports abstinence as the appropriate goal for person with the medical disorder 'alcohol dependence' (alcoholism)" (Shute, 1997, September 8). Yet Gordis touted MATCH's excellent outcomes consisting of a reduction in the frequency and intensity of drinking by alcoholics! NIAAA's MATCH and NLAES results defy the irrational claims this agency (and American alcoholism treatment) makes about abstinence as the desired -- if largely unobtainable -- goal for all alcoholics.

(10) *The clinical tool used for the medical diagnosis of alcoholism confounds those who most strongly endorse the medical treatment of alcoholism.* Possible resolutions of Gordis's views on abstinence with NIAAA research are (a) that those diagnosed alcohol dependent by DSM (both III-R and IV) are not really alcohol dependent and/or (b) that those categorized in remission are not. Untreated alcoholics in NLAES have less severe drinking problems than treated alcoholics. Perhaps they are not fully alcoholic. But what then is the significance of a DSM-IV alcohol dependence diagnosis on which so many treatment decisions are made?

At the other end of the spectrum, the criticism might be that DSM-IV too readily finds drinkers are not categorizable as alcohol abusers/dependent. Many formerly dependent alcoholics in NLAES who now drink without abuse or dependence would not qualify for standard outcome definitions of moderate/social drinking. This is because American alcoholism researchers have become extremely cautious, not to say paranoid, about claiming that former alcoholics are drinking moderately. Yet, as indicated by the results MATCH proudly proclaimed, such reductions are clinically important. The pubic health term for this clinical improvement without full remission is "harm reduction."

Summary. NIAAA research shows that a medicalized conception of alcoholism and treatment is not suited to the nature and course of drinking problems. Project MATCH represents a massive effort to shoehorn a large amorphous peg into a small square hole. That it fails in this impossible task does not bother the health care industry, however. This is because, whether or not it accounts for the behavior of alcoholics, the medicalization of alcoholism succeeds in justifying the mission and policies of government and treatment agencies and professionals.

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Cast your ballot!
Vote in Division 50's elections!

Liese (continued from page 1)

disease model of addictions. He has written a number of popular books on this topic, including: *The Truth about Addiction and Recovery*, *Love and Addiction*, and *The Diseasing of America*, to name just a few. Alan Marlatt has been one of the most influential psychologists in the field of addictions with his work in the areas of relapse prevention and (more recently) harm reduction.

In the first article of our series, Gerard Connors (page 4) provides a concise overview of project MATCH, including the study's background, methods, results, and additional work in progress. In the second article, Stanton Peele (page 6) sharply criticizes Project MATCH. He states in no uncertain terms that "It, along with other NIAAA and alcoholism research, shows that American conceptions of alcoholism and treatment policy are wrong." In the third article, Dick Longabaugh (page 7) responds to Peele's charges by providing important details about the research design and various possible interpretations of the results. And finally, Alan Marlatt's commentary (page 8) provides a rare opportunity to savor his creative writing skills. In his parable, "Horsing Around at Sobriety Downs," he compares Project MATCH to a horse race that took place "Once upon a long time ago in the Kingdom of Oz" where "all the jockeys were intoxicated prior to beginning the race."

In addition to the commentaries themselves, numerous references are cited and our "Addictions Abstracts" section contains detailed abstracts of three major articles on Project MATCH. Furthermore, Bob Zucker in his "President's Column" was kind enough (per my request) to address some of the issues raised by Project MATCH.

I believe that you will find this series on Project MATCH informative and thought-provoking. Please give the articles your thoughtful attention and consider sending your reactions to us (bliese@kumc.edu) so we can publish them in the next issue of *TAN*.

Division 50 elections. Another important feature of this issue of *TAN* is the elections section (pages 12-13). All candidates are invited by the Elections Supervisor to submit their biographies (maximum 300 words) which are printed just as we receive them, without stylistic changes (except for typographical and spelling errors). This issue of *TAN* is mailed prior to the mailing of APA election ballots, so members can read candidates' biographies and make informed decisions prior to voting. (Lisa Najavits deserves our thanks for serving as Elections Supervisor this year.)

This year we have two candidates for Division 50 President, Arthur "Mac" Horton and Arthur "Tom" Horvath. While their names sound similar, they are *different* people who possess *different* strengths so please be sure to read their biographies.

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Longabaugh (continued from page 7)

suggesting that efforts to match individually administered psychosocial therapies to single pre-treatment characteristics are of little use (Project MATCH Research Group, 1997).

Limitations in research design. Our efforts to maximize internal validity may have resulted in diminution of the potential for external validity (a substantial concern to Dr. Peele). Had we to do it over again, we might sacrifice some of the former for more of the latter. I should point out that some of these limitations in external validity are not nearly as severe as suggested by Dr. Peele.

MATCH included polydrug abusers (Peele comment #4). Prior to MATCH treatment, 44% of outpatients and 32% of aftercare patients had used illicit drugs. However, Dr. Peele is correct that those diagnosed as dependent on another drug (other than marijuana) in the six months prior to treatment were excluded from the study.

MATCH did eliminate some patients unable to provide indication that we would be able to follow them after treatment completion (Peele comment #2), i.e., we excluded patients who did not have a stable address and could not provide a locator who would know where they could be found. However, few patients were excluded for this combination of reasons.

We did exclude a few patients who were court ordered to participate in a specified treatment precluding random assignment to MATCH (Peele comment #2), but we included many others who may be regarded as "coerced treatment referrals" when it was still possible to randomize them to MATCH treatment.

We took great pains to make each of the three therapies as uniform as feasible through manuals, therapist training, and on-going supervision. Nevertheless we found that therapists affected outcomes within each of the three treatments (Peele comment #3). However, we could identify no single therapist characteristic useful in forecasting differential outcomes across treatments. In each instance, the bulk of the variance was attributable to a single therapist found to be at odds with the more uniform results of the rest of the group (Project MATCH Research Group, in press, a). At our present level of understanding, this finding is not especially useful for informing clinical practice.

While the Twelve Step Facilitation (TSF) manual (Nowinski, Baker, & Carroll, 1992) was developed specifically for the MATCH study, it was written by Minnesota Model proponents and reviewed for content by a highly regarded institution using the Minnesota Model, which concluded that the manual was consistent with Twelve Step treatment principles and practices. The effectiveness of TSF, when compared with that of well-researched CBT, indicates that under the conditions in which it was delivered in MATCH, it is at least as effective as CBT (Peele, comment #5). The juxtaposition of this finding with the meta-analysis of Miller et al. (1995) is not as incompatible as Dr. Peele asserts. Twelve Step treatment had not been subjected to randomized clinical trials in prior studies with enough frequency to judge its comparative effectiveness. While assignment to Alcoholics Anonymous (AA) had fared poorly as a stand alone intervention (see Walsh et al., 1991), it had not been tested as an adjunct to TSF delivered by a professionally trained and guided individual therapist. Thus, the MATCH finding is of considerable potential importance to the treatment field and is consistent with meta-analyses conducted which conclude that AA participation in conjunction with treatment enhances outcomes (Emrich, Tonigan, Montgomery, & Little, 1993; Tonigan, Toscova, & Miller, 1996). The MATCH finding is also consistent with that of Ouimette, Finney, and Moos (1997) who find Twelve Step and CBT based programs to be comparable in outcomes. Thus, if Twelve Step counselors learn to use TSF as it was delivered in MATCH, (Peele, comment #6), it is likely they can achieve drinking outcomes comparable to those obtained in MATCH.

While MET fared as well post treatment as TSF and CBT, it cannot be concluded that brief intervention/motivational interviewing is the most cost effective therapy for any severity alcohol problem (Peele, comment #7). Most obviously, such a conclusion needs to be based on measures of treatment cost as well as effectiveness. While number of sessions appears to be a plausible proxy measure of treatment cost, sessions and costs are not the same thing. On-going research with MATCH data is undertaking a thorough analysis of the cost-effectiveness question, factoring in the costs of subsequent treatments that may be differentially associated with the three treatments (Holder, 1993-97). Preliminary findings suggest that while MET may be more cost-effective for some clients, it may be less cost-effective than TSF for others. The jury is still out on this one. (In passing it is worthwhile to note that MET was not as effective as either CBT or TSF in reducing drinking during the period of treatment [Project MATCH Research Group, in press, b] especially for those low in self-efficacy [Project MATCH Research Group, 1997]. Thus, although prior research has shown that posttreatment outcomes may be more influenced by extra-treatment factors than treatment [Moos, Finney, & Cronkite, 1990; Peele, comment #2], MET is the least effective of the three treatments studied, at least while treatment is on-going).

Still another methodological question, unaddressed by Dr. Peele, is whether the frequent and intensive pre- and posttreatment patient assessments obliterated potential treatment differences. As has been noted elsewhere (Project MATCH Research Group, 1997), the number of assessment hours was actually greater than the time devoted to MET treatment. We do not know how MET would have fared in the absence of this extensive assessment.

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Matching theory is under-specified. The inconsistency of observed matching effects across time and the two arms of the study suggests that the sufficient conditions for matching were not identified. Examination of the causal chains providing the rationale for the hypothesized matching effects indicates that for the most part the three treatments did not have the anticipated differential proximal effects (Longabaugh & Wirtz, 1998). This suggests that even though the treatments were distinctive, they were not affecting clients differentially. DiClemente, Morrell, Carbonari, and Velasquez (1997, June) have reported that successful clients use the same processes of change irrespective of treatment assignment. The implication is that matching that depends upon putative processes occurring solely within the treatment hour is unlikely to be a robust factor in treatment outcome. One of the most surprising matching findings in MATCH supports this assumption. We have recently discovered that outpatients with networks supportive of drinking before treatment have drinking outcomes substantially better three years after treatment when treated in TSF versus MET, but not in the first year of follow-up. In contrast, those with low network support for drinking do not show this incremental benefit with TSF (Project MATCH Research Group, in press, c). Analysis of the active ingredients for this matching effect suggests that participation in AA is a contributing factor. Those with networks supportive of drinking assigned to TSF are more likely to participate in AA. Those who participate in AA are more likely to have better drinking outcomes (Longabaugh, Wirtz, Zweben, & Stout, in press). The rationale underlying this matching hypothesis depended upon factors outside the patient and the treatment hour: network support for drinking and AA participation. This suggests that matching hypotheses not building on such pre- and posttreatment environmental factors will be weak determinants of outcomes.

There were other unexpected findings. Among them, outpatients with poor social functioning had best outcomes with TSF and worst with CBT (Project MATCH Research Group, 1997); clients with more severe alcohol dysfunction had better, rather than worse outcomes (Project MATCH Research Group, in press, c); that results in the two arms of study were as different as they were (Project MATCH Research Group, 1997); that three-year outcomes were so good (Project MATCH Research Group, in press, c). These findings and others have been reported in 77 publications and 174 presentations. Other indicators of the study's value are apparent in methodological contributions and findings. A host of new instruments were developed and tested: Form 90 (Miller & Del Boca, 1994), DrInC (Miller, Tonigan, & Longabaugh, 1995), Global Outcome (Zweben & Cisler, 1997), and many more published in *Psychology of Addictive Behaviors* (1996). The value of urn balancing in assigning patients to treatment (Stout, Wirtz, Carbonari, & Del Boca, 1994) was also established.

Perhaps the finding with the most profound implication for treatment research pertains to the essential strategy of the multi-site study. Despite our efforts to make the research protocol as uniform as possible across treatment sites, we found that the site in which the treatment was delivered interacted with treatment condition to effect drinking outcomes. While TSF may have been more effective at one treatment site, MET was more effective in another. Thus, findings arising from single site studies cannot be assumed to generalize to other sites. The implication is that a knowledge base regarding treatment effectiveness cannot be aggregated without cross-treatment site replication. This conclusion has enormous negative cost implications for future treatment research. Nevertheless, this finding should markedly temper the tendency to apply new research findings prematurely. By doing so, it will also enhance the credibility of the resultant research knowledge base. Just by itself, (re)learning this lesson justifies the study effort.

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Apply for a Grant to Study *Adolescent Substance Abuse*

A Request for Applications (RFA) on adolescent alcohol abuse and alcoholism research was published in the National Institutes of Health (NIH) Guide on Friday, March 13. Applications will be conjointly funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the Center for Substance Abuse Treatment; up to $3.9 million in set aside funds should be available. The due date for applications is June 12, 1998.

A copy of the RFA can be accessed through the NIH home page (http:\www.nih.gov) by the following route: Grants and Contracts, NIH Guide for Grants and Contracts, Request for Applications, AA98003. Those who cannot access the Internet can obtain a hard copy from: Cherry Lowman, NIH NIAAA, Division of Clinical and Prevention Research/Treatment, Research Branch, 6000 Willco Bldg., Suite 505 (MSC 7003), Bethesda, MD 20892-7003. For express mail, use Rockville, MD 20852. Phone: (301) 443-0637; FAX: (301) 443-8774; e-mail: clowman@willco.niaaa.nih.gov

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showed a number of interesting findings. From my perspective, the three most important were: (a) that all three brief interventions made a substantial difference in drinking and in a number of relevant nonalcohol-specific variables; (b) that Twelve-Step Facilitation was more effective at producing abstinence at follow-up among patients lower in psychiatric severity; and (c) that treatment interactions relating to a fair number of highly plausible patient matching characteristics were far fewer than many researchers and clinicians had expected. I do not believe that anyone attempting to "armchair" this unique set of findings would have been able to do so. This is the contribution of empirical work. Once research is carried out, the challenge becomes how to integrate the results into our beliefs about what we regard as facts.

Empirical validation of professional practice: An expectable activity in the new millennium. There will be much more to come from this project as this large data base continues to be carefully scrutinized, as additional follow-up data become analyzed, and as the parameters of generalizability of this work become more carefully delineated. What is less obvious, but needs to be clearly articulated, is that this work is simply the most visible sign of a process that is already upon us and that will increasingly guide professional practice in the generation ahead. This process involves the careful, empirical scrutiny of clinical work and the formation of empirically based conclusions about what works and what does not. Nathan and Gorman's (l997) new book, *A Guide to Treatments that Work*, is another example of this process. Psychologists can either join in or fight a delaying battle, but ultimately such a battle will be lost because there are too many forces pushing us in this direction.

One such force comes with the advent of managed care, with its heavy emphasis upon cost containment and demonstrated efficacy. A related force is the degree to which the population is covered in one or another capitated health practice plan. Even when such plans are "point-of-service," cost/benefit analysis will continue to play a role in the choice menu, and demonstrations of proven effectiveness are part of this process. A third factor is the increasing sophistication of diagnostic/nosological description, which began with the advent of DSM-III and is strongly in place today. Still another is the burgeoning of an evaluation technology that has its roots in epidemiology, community psychology, and most recently in health services policy studies.

There are several other factors that drive these changes that are less obvious but equally important. One is a very reasonable question asked of a field with a proliferation of treatments. What works? Psychology has not had its Flexner Commission, but the question of what is the most efficacious intervention for a given problem is an appropriate one. It is one that every competent practitioner should be able to answer and should monitor as the field evolves and the answers change. Proficiency licensure is an effort to move in that direction; continuing practitioner education is a second. But even more to the point is the systematic scrutiny of the existing armamentarium of practice and the establishment of a set of standards for best practice that has an empirical base, for which the gold standard is ultimately the randomized clinical trial. Clearly there are a number of intermediary levels of acceptable practice that depend upon summarization of existing studies and sometimes the utilization of trials that, for good reasons, are not fully randomized or are only single-blinded. But the more general point is that the field has moved to a place where the availability of empirically grounded demonstrations of efficacy are reasonable to expect and where an increasingly informed set of consumers is asking for them.

Who is managing the store? Professional psychology has had major role in providing what these days is called "behavioral health care." The special understanding that behavioral science can give to problems of addictive behavior is still better understood within the profession than outside. It is fitting that the American Psychological Association (APA) and the National Institutes of Health (NIH) are now contemplating a celebration of "The Decade of Behavior" as a counterpoint to "The Decade of the Brain." At the same time, it is increasingly clear that major issues about funding and management of mental health/substance abuse services are being carried on by managed care systems that are either free standing or hospital-based and that are more focused upon physical health than mental health needs of their clienteles. Interestingly, within this framework, there has been an emerging attention to behavioral regimens for prevention of poor health practices. Brief intervention techniques aimed at a variety of addictive behaviors and the encouragement of broad-based population screening as a way of providing early detection for high cost illnesses are two examples of this current focus. Unfortunately, my distinct sense is that professional psychology, despite its origins and history, has been a notably low end participant in this activity.

Who will be managing the store? We have already moved into a new health care arena. It is one that is heavily interdisciplinary and that makes use of all that information technology has to offer. It offers the potential for more precise information gathering and treatment monitoring than ever before, and it likewise offers easier access to an immense array of new findings that are capable of being disseminated at the touch of a computer key stroke. There are, of course some parallel threats. Individual activity is capable of being more closely monitored and specified than was true in an era where such information gathering techniques did not exist. There also is a steady pressure to update one's knowledge base, which again did not exist in an era before information was so readily accessible. This is the new tension that all treatment providers must live with. As is true of most other income producing ventures of this generation, this arena is under sustained pressure for accountability and cost containment. This is a reality of the operating climate for provision of services for addictive behaviors for the foreseeable future. It has always been possible

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for a select and small group of providers to access a network of clients who are sufficiently well-off so that providers may operate outside the constraints of a larger managed care system. But aside from that select few, the change is upon us.

We have the opportunity to be system designers, as well as participants in this new health care environment. In order to do so, the problem needs to be reframed as a multidisciplinary puzzle in which behavioral science has a major, but not the only role to play. At the point of first professional contact, addictive problems need to be viewed as not just clinical problems but also as problems of populations, who to a degree embrace a spectrum of addictive behaviors, in some instances avoid them, in other instances hold them off, and in still others, succumb to a greater or lesser degree. Likewise, addictive problems need to be understood as both neurobiological and behavioral in operating structure and process. And last, addictive problems need to be understood as individual problems of purposive human beings who are struggling to make sense out of ongoing life course issues. This is too large a territory to travel without a good road map. The development of an empirical base for knowing (a) what part of the territory you are in, and (b) how to negotiate your way through it is an essential part of the design of new health care systems. Without the participation of professional psychology, which has ties to more of these areas than any other mental health discipline, what is created will fall short. The challenge is present; the payoff is major.

Update on the 1998 APA Miniconvention -- Alcohol and Addiction Research: Achievements and Promise in Behavioral Science. In this issue of *TAN* there is the formal announcement that planning for a miniconvention (organized in conjunction with the National Institute on Alcohol Abuse and Alcoholism [NIAAA]) on alcohol and addiction research for the San Francisco meeting did go forward successfully (see page 11). As a result of the heavy involvement of the Division 50 Program Chair, Kim Fromme, and her counterpart in Division 28, Nancy Pietrowski, an exceptional program has been put together. The program runs across the entire length of the meeting, but the primary programming will be on Saturday and Sunday (August 15-16). The weekend activity is capped with an address by Enoch Gordis, Director of NIAAA, immediately followed by a reception sponsored by the two Divisions. We hope you will join us. An invitation has also been extended to Congresswoman Nancy Pelosi, and we are cautiously optimistic that she will be able to appear. The miniconvention will provide another opportunity for the Division's work to become more visible to our APA colleagues and to a broader national audience.

References

Nathan, P.E., & Gorman, J.M. (l997). *A guide to treatments that work.* New York: Oxford University Press.

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We also have one candidate each for the positions of Secretary-Treasurer (Greg Smith) and Member-at-Large (Kim Fromme). All four of these individuals have made significant contributions to the Division, so please show your support by voting when you receive your ballot.

The ethics case of "Kathy". In our last *TAN*, I described an actual case that raised difficult ethics issues and I invited comments on this case from Division 50 members. The number and variety of responses I received was gratifying. One member of Division 50, Geri Miller, even used the case as a stimulus for discussion in her class on counseling addicted clients. She and two of her students (LaSharion Henderson and Wayne Hogwood) submitted an article (page 3) describing the issues raised in the case and the class' experience discussing the case. Please consider writing about ethics cases of interest to you, so this column ("Can you Help Me with This Ethics Case?") can become a regular feature of *TAN*.

Apportionment. For those unfamiliar with the APA governance structure, representation on APA Council is partly determined by Division members' votes. Ballots are mailed to all APA members, who are instructed to distribute their ten votes to any Division(s). The good news is that we have secured our Council seat again this year, thanks to your generous votes. Please remember Division 50 again next year!

The Executive Committee Meeting. In February we had our Executive Committee meeting in Washington, DC (see Tom Horvath's report on page 10) and I again had the opportunity to observe our dedicated officers hard at work. Tom Horvath prepared us well for the meeting (with itineraries, reservations, travel, and lodging accommodations) and Bob Zucker, Sandy Brown, Jalie Tucker, Curtis Barrett, George De Leon, Jerome Platt, and Ken Leonard all gave their valuable time and effort to carefully review the Division's activities over the past year and make important decisions for next year.

Division 50 Members run for AABT office. Numerous APA members are also members of the Association for the Advancement of Behavior Therapy (AABT). It is noteworthy that two of our Division members, Barbara McCrady and Kate Carey are both running for AABT offices (President and Representative-at-Large, respectively). If you haven't already voted, there's still time for you to support these Division 50 members with your votes. Ballots must be postmarked by April 30, 1998.

The APA Convention is quickly approaching! The 1998 APA Convention will be held in San Francisco from August 14-18. Thanks to Kim Fromme, her committee, and the many applicants, we have an excellent program planned, as well as an exciting miniconvention sponsored by the National Institute on Alcohol Abuse and Alcoholism (see page 11). San Francisco is a great place to visit and this should prove to be another great meeting, so please join us there!

Announcements

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. **Human Laboratory Studies** related to the clinical and behavioral pharmacology of abused drugs, abuse liability testing, and anti-drug-abuse medication development. Opioids, cocaine, anxiolytics, caffeine, and nicotine. **Clinical Trials of Substance Abuse Treatments** -- pharmacotherapies and behavior therapies and their interaction. Opioids, cocaine, nicotine, mixed/other dependence. Minorities encouraged. USPHS stipend levels based on experience. U.S. citizens, permanent residents only. Contact: George E. Bigelow, Ph.D., Roland R. Griffiths, Ph.D., or Maxine L. Stitzer, Ph.D., BPRU, Behavioral Biology Research Center, 5510 Nathan Shock Drive, Johns Hopkins Bayview Campus, Baltimore, MD 21224-6823, (410) 550-0035.

Postdoctoral Research Associate Palo Alto VAMC

Dr. Theodore Jacob, Career Scientist at the Palo Alto V.A. Medical Center, is seeking a Ph.D.-level research scientist for a new, 4-year study regarding the genetic/environmental basis of alcoholism. The position will involve three primary functions: project coordination, data analysis, and scientific report writing. The ideal candidate would have a strong background in behavioral genetics, alcoholism, and quantitative methods, as well as experience in working with large data sets, collaborating with other scientists, and integrating behavioral genetics and psychosocial research perspectives. Salary Range: $32,000 -- $35,000 per year. Send curriculum vitae and letter of interest to Dr. Theodore Jacob, Palo Alto V.A. Health Care System, 3801 Miranda Avenue, Mail Code 151J, Palo Alto, CA 94304. Phone: (650) 617-2755; FAX: (650) 617-2756; e-mail: tjacob@odd.stanford.edu

Senior Research Scientist and Post-Doctoral Research Positions at Research Institute on Addictions

The Research Institute on Addictions (RIA) is recruiting for four State of New York permanent Senior Research Scientist positions (starting in 1998) and two Postdoctoral Research Associates (temporary positions, Foundation funding). Candidates must have Ph.D. in criminal justice, epidemiology, health sciences, psychology, sociology, or other relevant field. For the Senior Research Scientist positions, experience as Principal Investigator on externally-funded research projects or prior grant funding (preferably from NIAAA and/or NIDA) highly desired; preference will be given to candidates with current funding. For the junior positions, evidence of strong likelihood of future funding required. All successful candidates are expected to obtain funding in areas of addiction research which answer important scientific questions, account for previously unexplained phenomena, and open significant new avenues for further study. Applications welcome from individuals at all levels of experience beyond the doctorate. Permanent

positions are subject to New York State Civil Service regulations. Salary and fringe benefits are competitive. Secondary faculty appointments at SUNY-Buffalo available. Applications from minority candidates particularly welcome. Visit the RIA website at http://www.ria.org. Send cover letter outlining research experience and future plans, curriculum vitae, and three letters of support to: Mark Ruda, Personnel, Research Institute on Addictions, 1021 Main Street, Buffalo, NY 14203. Application review will begin February 1, 1998. AA/EOE

Announcements(con't)

Postdoctoral Research Associate in Alcoholism at Palo Alto VAMC

Dr. Theodore Jacob, Career Scientist at the Palo Alto V.A. Medical Center, is seeking a Ph.D.-level research scientist to work on one of several projects concerned with the etiology and course of alcoholism. Common to these efforts has been a focus on the developmental nature of alcoholism; the role of multi-level influences in understanding alcoholism etiology with a particular interest in family factors; the assessment of mediators and moderators of risk; interest in the development and expression of alcoholism from adolescence into early adulthood; and the use of various data-analytic strategies for examining the complexity of topics under study. It would be hoped that candidates would have considerable familiarity with theoretical and empirical literatures in the alcoholism area; competence in multivariate statistical approaches such as multiple regression and hierarchical level modeling, and structural equation modeling; and notable strength in the preparation of scientific manuscripts. Salary Range: $32,000 -- $35,000 per year. Send curriculum vitae and letter of interest to Dr. Theodore Jacob, Palo Alto V.A. Health Care System, 3801 Miranda Avenue, Mail Code 151J, Palo Alto, CA 94304. Phone: (650) 617-2755; FAX: (650) 617-2756; e-mail: tjacob@odd.stanford.edu

Post-Doc Fellowships in Substance Abuse at University of Vermont

Two postdoctoral research positions are available in a stimulating productive lab at the University of Vermont. Applicants must have completed doctoral training in psychology or pharmacology and have research experience. Minorities are encouraged to apply. Competitive stipends. Fellowships begin June-September, 1998, and last two to three years. Applicants must be United States citizens. For more information, call (802) 660-3060; FAX: (802) 660-3064.

Position #1: Responsibilities are in the behavioral economics of drug self-administration and studies of self-control (delay discounting) in drug dependent populations. Send letters of interest, vita, and letters of reference to Warren K. Bickel, Ph.D., Human Behavioral Pharmacology Laboratory, Department of Psychiatry, 38 Fletcher Place, Burlington, VT 05401-1419. e-mail: warren.bickel@uvm.edu

Position #2: Responsibilities are in studies on reduced smoking and Eclipse plus pharmaceutical company trials of new cessation aids. Those interested should contact: John R. Hughes, M.D., Department of Psychiatry, University of Vermont, 38 Fletcher Place, Burlington, VT 05401-1419. e-mail: john.hughes@uvm.edu

SUNY Brockport Assistant Professor Alcohol and Substance Abuse Program

Assistant Professor, Alcohol and Substance Abuse Studies Program (ASAP)/Health Science: State University of New York at Brockport invites applications for a tenure-track position, beginning Fall semester 1998, to teach a variety of courses in ASAP, advise students, develop and supervise internships, participate in curriculum development, and perform scholarly, service, programmatic and departmental activities as needed. Required qualifications include a doctorate in counseling, counselor education, social work, clinical/counseling psychology, health education, or related area; teaching or counseling experience in alcohol and substance abuse; a commitment to preparing entry-level counselors; and an ability to work with a culturally diverse population. Preferred qualifications include evidence of scholarly activity related to substance abuse, grant writing experience, and a substance abuse counseling credential. Applications including a vita, three letters of reference, and supporting materials should be sent to: Mr. Richard Meade, Faculty/Staff Recruitment Office, SUNY College at Brockport, 350 New Campus Drive, Brockport, NY 14420-2929. EO/AAE. Review of applicants will begin on 4/3/98.

Post-Doc in Alcohol Problems University of Michigan

The University of Michigan currently houses 20 projects addressing issues of etiology, course, and clinical manifestations of alcoholism and alcohol problems. The Center invites applications for its NIAAA funded post-doctoral research training program. An interdisciplinary faculty provides research opportunities that emphasize developmental aspects of alcohol involvement with a lifespan focus. Fellowships provide the opportunity to develop an integrated research program in preparation for an academic/research career. Fellows must be United States citizens or permanent residents with an already completed degree. Appointments typically are for two years and salaries are commensurate with NRSA regulations. Applications are currently being accepted for appointments starting on or about July 1, 1998. Send a curriculum vitae, three letters of reference, and a cover letter describing your research interests and career goals to:

Robert A. Zucker, Ph.D.
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400 E. Eisenhower Parkway, Suite 2A
Ann Arbor, MI 48108-3318
Phone: (734) 998-7952; e-mail: zuckerra@umich.edu

Announcements(con't)

Post-Doctoral Fellowships in Adolescent Drug Abuse Research

The Center for Family Studies offers an unique, two-year NIH/NIDA-funded postdoctoral research training program to develop research competencies in the area of family-based interventions for adolescent drug abuse. Throughout the program, fellows take part of a seminar on intervention science research in adolescent drug abuse and also take courses in areas that will enhance their current research and clinical knowledge. Fellows will become actively involved in existing clinical research studies on outcome and process of drug abuse treatments with culturally diverse populations, will participate in the project/application conceptualization and writing, and receive training in the responsible conduct of prevention and intervention science. Applicants must hold a Ph.D. or M.D. and have demonstrated research skills and a strong interest in intervention science.

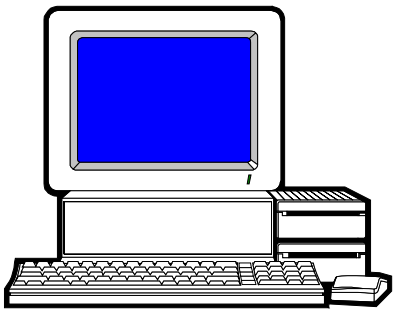
For more information contact Dr. Howard Liddle, Professor of Psychiatry and Behavioral Sciences, Center for Family Studies, University of Miami, 1425 NW 10th Ave., 3rd Floor, Miami, FL 33136. e-mail: hliddle@mednet.med.miami.edu

Don't forget to register for the 1998 APA Convention in San Francisco!

Registration and housing materials
can be found in the March, 1998 issue of the
American Psychologist

The Division 50 Listserver

gives you instant access to hundreds of addiction psychologists!



There are now more than 250 subscribers to the Division 50 listserver. This means you can have instant access to the minds of over 250 addiction psychologists!

To subscribe, 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 correspondence when signing up for the list (it will not be understood by the listserver). Your e-mail address will be registered automatically from the initial e-mail you send. After you sign up you will receive a 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**

Are you a member or affiliate of Division 50?

If you answered "no," here's your chance to join.
If you answered "yes," how about recruiting a new member today?

Join other psychologists interested in addictions by becoming a member of Division 50. If you are already a member or affiliate, recruit a friend with an interest in addictions. Members receive the two Division 50 publications, *Psychology of Addictive Behaviors (PAB)* and *The Addictions Newsletter (TAN)*. Those who recruit new members get a toaster oven for each new member they recruit. (Just kidding -- I wanna see if anyone ever reads these ads!) To become a Division 50 Member or Affiliate, contact:

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