The Addictions Newsletter

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President's Column

The Heterogeneity of Substance Abusing Populations: Relevance to Clinical Practice

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In this, my last column, I return to a theme I briefly mentioned last fall, concerning the importance of understanding subpopulation characteristics and the limits on generalizability for all the addictive phenomena we encounter. The importance of this issue repeatedly strikes me as I consult with younger clinicians and when I present overview talks on substance abuse to professional practice groups who are not specialists in this area. The issue is frequently not a part of our everyday practice base, even though most of us are aware of the importance of "special populations." I will confine my remarks here to addictive phenomena related to substance use, but much of what is addressed is also relevant to other arenas of addictive behavior.

Why are subpopulation characteristics so important? One of the first pieces of the clinical encounter is formulating some initial understanding of the nature of the problem, which allows one to map it onto the larger envelope of similar problems. Establishing a diagnosis is only part of that process. The diagnosis typically characterizes the substance abuse but not the surrounding matrix of relationships and environmental stressors that may sustain it. Formulations about relative treatment difficulty, level of motivation for change, social support structure, and even Axis V ratings are all efforts to broaden the envelope of descriptors that are useful in estimating prognosis and course.

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Editor's Corner

Project MATCH and the Issue of Psychotherapy Talent

Bruce S. Liese
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The last issue of *The Addictions Newsletter* (*TAN;* Spring, 1998) focused on Project MATCH.* The primary goal for that issue was to stimulate constructive discussion about the project. Based on most of the discussions I have observed and feedback I have received, that goal has largely been achieved. I am grateful to those who contributed to the special issue, as well as those who continue to participate in discussions about Project MATCH. I have found most of these exchanges to be thoughtful and informative.

My attraction to Project MATCH is related to my strong interests in both alcoholism and psychotherapy research. In the years since Eysenck (1952) challenged the efficacy of psychotherapy, researchers have made substantial progress towards understanding not only ***that*** psychotherapy works (i.e., it is effective and efficacious), but also ***how*** psychotherapy works. What we have ***not*** learned is that any single "brand" of psychotherapy is *best* for all problems.

As early as 1936, Rosenzweig compared diverse approaches to psychotherapy and concluded, "Everyone has won, and *all* must have prizes." This well-known phrase is commonly referred to as the "Dodo Bird verdict" (named after the character in

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*__M__atching __A__lcoholism __T__reatment to __C__lient __H__eterogeneity

Letters to the Editor

Editor's note: *In Spring, 1998, we featured a special issue of* The Addictions Newsletter (TAN) *on Project MATCH*, one of the largest randomized clinical trials of psychotherapy ever conducted. The primary purpose of this study was to test the hypothesis that alcohol treatment outcomes would be improved by matching patients to various types of treatment. This study, perhaps due to its size, cost, and results, has been controversial. Hence the special issue was published.*

Since publication of the special issue, I have invited members of Division 50 (Addictions) to comment on Project MATCH, and they have done so. In fact, one person posted a very strongly worded response on the Division 50 Listserver (Addict-L), resulting in a flood of responses. With permission from respondents, some of these postings are published in this "Letters to the Editor" section of TAN. *(For those who have not yet signed up for our listserver, I recommend that you do so. It is an excellent opportunity to participate in such important discussions as this one about Project MATCH. For more information regarding our listserver, see page 7, column 2.)*

It is my hope that these letters will stimulate more thought about Project MATCH and about clinical research on addictions generally. I want to emphasize that these letters do not necessarily reflect the opinions of Division 50 or its newsletter staff.
(B.S.L.)

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As a spectator who has followed Project MATCH with keen interest for six years, I certainly got my money's worth. The study has influenced both the clinician and the researcher in me in several ways, all well. First is a sense of gratitude to MATCH, both for advancing the field beyond a one-team-wins-all perspective and for providing years of anticipation and interesting reading, with more to come. It's been like watching a long, well-fought extra-inning baseball game played by the best-coached teams, under fair umpires, and to a near draw.

Although I've been trained to appreciate the importance of investigating matching hypotheses, I confess I was still curious to learn if any team had won the game. No resounding overall victories for any of the three treatments, I'm afraid. But as an advocate of Motivational Enhancement Therapy (MET), I was pleased to see that it at least held its own, given that the MET clients received only about three hours of "treatment" because they attended 100% of the four MET sessions.

The rigor of MATCH's methods was inspiring (don't say "matchless"), such as the standardization of counselor training

and the purity of the interventions delivered. The follow-up preponderance of null findings for the hypothesized matches is unsettling. The few significant matches had effect sizes that were a bit anemic. Fewer than half the matching hypotheses were supported. My epistemological confidence hasn't been this rattled since I learned that Santa doesn't and can't fly. What, now, are we to make of the substantial body of prior literature that MATCH culled and reviewed to help generate their matching hypotheses? Does it contain so much type I and type II error that an extensive scholarly review cannot generate verifiable hypotheses from it even half of the time? Perhaps most of these prior studies did not specifically or intentionally test these matches, in which case MATCH's hypotheses were mostly extrapolated from this prior literature? If so, then please, may I return to the relative comfort of having a reasonable level of trust in most substance abuse studies to at least point me in the best clinical directions? After all, I sometimes criticize my chemical dependency (CD) counselor colleagues for scoffing at addiction treatment outcome literature, so I badly wish to regain my confidence in it.

If the follow-up rates of MATCH were enviable, the sheer effect sizes for sobriety rates, reduced drinking days per week, and drinks per drinking day are daunting--even if there was no control group for comparison. Despite the fact that participants were probably highly ready for change by virtue of their volunteering for the study, that homeless people with low social support were excluded, and that the frequent follow-ups probably stirred a Hawthorne effect, despite all that, the outcome numbers from MATCH were *big*. And the treatment contact hours were small. By contrast, in the state of Washington, almost all clients with the severity level of MATCH clients would wind up in "intensive outpatient," and many of them would have done inpatient treatment first. This outpatient program would require 111 hours in the first 34 weeks of the program, plus another 112 hours of required Alcoholics Anonymous (AA) or community support meetings, for a total of 223 contact hours, not counting their intake assessment and their one-on-one hours of counselor contact. That's 223 hours versus only about 24 hours (12 for Cognitive-Behavioral Coping Skills Therapy/Twelve-Step Facilitation or 4 for MET plus the numerous follow-up sessions). I think we need to rethink our mainstream program lengths in Washington. We should also consider adding follow-up outcome assessments as part of treatment. Wouldn't it be great to make outcome assessment standard equipment on all CD treatment?

Could the MATCH outcomes mean that the "purity" of all three interventions boosted their effectiveness, and therefore purity should become another "nonspecific" variable in outcomes? It might be that MATCH clients did so well with

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

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The Defeat of the McCain Bill

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Background of the "McCain Bill." Senator McCain's historic tobacco bill was defeated on the Senate floor on June 17, 1998. It would have cost the tobacco companies $516 billion over 25 years and would have funded a variety of public health programs. The aims of the bill were to decrease teen smoking by 1) allowing FDA regulation of tobacco, 2) imposing penalties on tobacco companies if smoking rates did not decrease to targeted levels within 10 years, 3) limiting cigarette advertising and marketing, and 4) raising the price of cigarettes by $1.10 per pack. This article provides a brief history of the bill, a description of its evolution and defeat, and a discussion for concerned addiction specialists.

The tobacco bill initially featured strong public health provisions. It incorporated the recognition that behavioral and social factors are instrumental in the prevention and treatment of addiction to tobacco. In fact, early in the life of the bill, there were allowances for the allocation of one third of the new tobacco money to be targeted to National Institute of Health (NIH) behavioral and social sciences research on tobacco. At the end, however, all specific research funds had been dropped in favor of less germane items, including tax cuts for low to mid-income married couples, and illegal drug interdiction programs.

The coalitions in Congress around this legislation often went across traditional Republican and Democrat lines. Some Democrats, for example, were rooting for more money for attorneys involved in tobacco legislation, and some Republicans found themselves championing "big government" public health initiatives, such as government-mandated reductions in teen smoking. In the end, however, party lines were re-drawn, and the posturing returned to typical "Big Taxes/Money vs. Public Health."

The author of the bill, Commerce Chairman John McCain (R-Arizona), is an outspoken proponent of reducing teen smoking through the various measures he was advocating. Another Republican, Don Nickels (R-Oklahoma), was a frank opponent of McCain's bill. John Ashcroft (R-Missouri) and Phil Gramm (R-Texas) led vocal opposition to the bill with the support and influence of Senate Majority Leader Trent Lott (R-Mississippi). Industry opposition was particularly strong to giving the FDA regulatory power over the manufacture of cigarettes.

Conservative House Speaker Newt Gingrich was also vocal regarding his opposition to this or any other similar bills, stating that he would only support a tobacco legislation bill that

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In This Issue

The Addictions Newsletter

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Harm Reduction in Clinical Practice with Active Substance Users

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Over the years there have been a number of important conceptual developments that have dramatically advanced the field of addictions. The "disease concept," the "self-medication hypothesis," and "relapse prevention," among others, have been ideas that have made powerful contributions to our effectiveness at helping people with substance use problems. I believe that ***harm reduction*** is the most recent of these great ideas. In this paper, I will discuss a variety of ways in which the harm reduction paradigm has relevance for our work with the full spectrum of substance-using clients.

The Context in Which Harm Reduction Emerged. I have specialized in the field of substance use treatment since 1982. Over the early years of my career, I developed an integrative treatment approach that has blended psychodynamic, cognitive-behavioral and biological interventions that target drug-using behavior as well as the biological, psychological and social issues that factor into why people use and misuse drugs. I have used this approach in several outpatient programs that I have supervised and directed and in my private practice for many years. And, I have experienced satisfaction in participating in many of my patients' successful work toward achieving stable long-term sobriety from drugs and alcohol. I am still in contact with some clients that I worked many years ago who now have more than ten years in recovery.

Despite many successes along the way, I began to become increasingly concerned about a serious problem that I have observed in my work and one that I believe characterizes the field as a whole. Namely, the overwhelming majority of substance users never effectively become engaged in treatment, "fail" out of treatment before successful completion, or are denied treatment at the start.

These poor outcomes are generally attributed to the "lack of motivation" of substance users or the difficulties inherent is treating people with substance use problems. Many popularly blame this poor success rate on the "cunning and baffling nature of the disease of addiction." In my own work, I began to feel uneasy and unsatisfied with these explanations. The idea that people needed to "hit bottom" became increasingly unacceptable to me. It seemed as if our field was putting the responsibility for our failure on our clients rather than sharing responsibility for the problem.

If we look at the basic assumptions which characterize traditional substance use treatment, what generally cuts across differing theoretical approaches is what I call the "abstinence-only" philosophy. According to this philosophy, people with substance use problems cannot benefit from psychotherapy while they are using, must accept abstinence as a goal of substance use treatment to be in treatment, and must achieve and maintain abstinence in order be allowed to remain in treatment. The complete abstinence from all drugs and alcohol, even those for which the client did not seek treatment (i.e., "zero-tolerance"), is generally required. Abstinence is the criterion of success for the user and the program. It is also the prerequisite to anything else being addressed. If clients claim that other issues are more important and should be addressed first, they are routinely told they are in denial about the central, primary nature of their "disease" and that these other issues must be put on the shelf while the substance use is tackled. Most programs generally have what has been called "high threshold" access, meaning that there are many requirements to which clients must agree in order to gain access to treatment (e.g., attending AA meetings every day, breaking contact with all other substance users, agreeing to urine testing, etc.). Clients unable to live up to these requirements are often referred for more intensive treatment while unwilling clients are routinely discharged from treatment with the statement that they should come back when they are ready.

Substance users are a broadly diverse group of people who cannot all be effectively treated in the same way. Unfortunately, this one-size-fits-all point of view is institutionalized in the field and expressed in the popularly used expression that "addicts suffer from the disease of terminal uniqueness." Substance users differ on many variables that suggest the need for a flexible, comprehensive model for treating this broad spectrum of people: severity of substance use, personal goals regarding use, motivational stage of change, emotional and personality strengths and difficulties, psychosocial supports, and so forth Many of these people want help for their substance use or other personal issues, but because they are unwilling or unable to accept abstinence as a goal for themselves, they are denied treatment.

There is also a more subtle way in which the abstinence-only assumption can have a negative impact on treatment. Some clinicians will agree to treat actively using clients while not believing that anything useful can take place in the context of active use. This stance, taken by many clinicians who may or may not verbalize it to their clients, has a potentially crippling impact on the therapeutic encounter. How might a client who is experiencing problems with using feel about attempting to modify his use in a positive direction or addressing other personal issues when the professional being consulted for help believes that what he is trying to do is impossible? Or worse, what if the clinician believes that the client is not capable of being honest or is not emotionally available for treatment because "active users can't tell the truth"?

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The clinical implication of the abstinence-only assumption is to first convince the client to accept abstinence as the necessary starting point of treatment, often by any means. Any other focus is considered colluding with denial, being pulled into the client's wish to avoid what is most problematic, the substance use. When the client does not agree with this assessment, client and clinician are immediately polarized and the possibility of a working alliance in the treatment is sabotaged. This may explain a large part of the failure of many treatments to proceed to successful outcomes.

The Relevance of Harm Reduction. While abstinence-oriented approaches effectively meet those clients who recognize the need to stop using, the harm reduction paradigm challenges us to find new ways to extend the reach of treatment to that large population of substance users who are not ready, willing, or able to stop. Harm reduction pragmatically accepts the fact that these people exist and must be met on their own terms. Harm reduction turns the abstinence-only assumption on its head by starting with no assumptions about the nature of the substance use or the value of abstinence for a given individual. This simple shift in assumptions has implications for the assessment and engagement phases of treatment, goal setting, attention to issues presented by the client other than substance use, and the direction of focus on modifying use (whether toward moderation or abstinence).

This shift is consistent with basic psychotherapy principles that have not generally been applied to the treatment of substance users. The cornerstone of all effective treatment is the alliance between client and clinician around shared goals. An alliance is necessary for engaging clients in treatment and always grows from the client's experience of being recognized and offered something by the clinician that addresses his or her subjective concerns. So, the initial focus must be on the client's definition of the problem and goals. In a harm reduction approach, the goal is to engage people in a relationship that will support them in clarifying the problematic aspects of their substance use and working toward addressing these problems with goals and strategies that are consistent with who they are as individuals. If the clinician has an overt or covert agenda at odds with the client's, this is likely to be experienced by the client as a failure to adequately understand and will sabotage the alliance from the beginning. The clinical ambition of harm reduction is to *really* begin where the client is. By starting with an attempt to understand the client's reason for coming without preconceptions about substance use, an alliance can form around a mutual exploration of the client's concerns and how, if at all, the substance use impacts on them.

I believe that psychotherapy can be conducted with many, if not most, active substance users. The degree to which the use of substances interferes varies in the same way that it does with other potentially defensive or self-destructive behaviors. In fact, whether or how it interferes can be best identified in the context of the therapeutic situation, and this process can help the client gain greater insight into the problematic nature of the use more generally.

Abstinence-oriented approaches target clients that are motivated to stop using and, by definition, do not address a whole host of issues that may need to be resolved before the substance use can be directly addressed. These may be concrete reality concerns such as housing, money, health, and so forth, or a variety of emotional issues. For many users, substances serve important psychological functions or express powerful wishes and needs. These issues must be identified and alternative, more effective solutions envisioned before many people are likely to consider modifying their use of substances. This motivational focus and goal setting can only take place in a clinical context that accepts continued substance use. With this approach, the clinician is less likely to be experienced as wanting to take something vital away from the client or as failing to empathize and is more likely to be seen as an ally in support of discovering better solutions. The harm reduction context can also reduce feelings of isolation, shame, and hopelessness by offering relationships that accept and respect the user regardless of substance use status.

Many users also question whether they can moderate their substance use rather than stop altogether. When substance use continues to have some positive value for the user, many are likely to need this question answered before becoming willing to attempt to stop. It is important to support people in clarifying for themselves what they are interested in working toward as they set goals. Whatever we believe is realistic for them is less important than what the client is ready to work toward. I feel free to share my opinion about how realistic I think their goal is for them based on my experience with other people but admit that I cannot know whether they can achieve their goal. I suggest working toward goals with an experimental attitude that we can join around. Goals and strategies can be revised as an difficulties are encountered along the way. Within a harm reduction context, what is realistic is not assumed but instead emerges from the client's experience of working toward moderation or the resolution of other issues with the support of the clinician. Harm reduction accepts that many positive changes in use are possible short of abstinence. The negative consequences of use can be gradually "stepped down" in a number of ways (e.g., by adopting safer techniques for using drugs or reducing amount and frequency of use). These small positive changes can increase the client's sense of competence, thereby increasing hope and motivation for taking on larger challenges such as an attempt at abstinence. Issues related to substance use can be identified and addressed when they arise as obstacles to achieving the goals the client is working toward. As these issues become clarified, it becomes possible to work toward developing more effective ways of managing or expressing them. This last aspect involves getting to know oneself better, learning to listen to and accept oneself more deeply, and discovering more effective ways of caring for oneself. This approach supports the user in a self-generated process of change in which the client is in charge of his or her own growth and change.

Secular and Spiritual Forgiveness Interventions for Recovering Alcoholics in Alcoholics Anonymous

A Patient-Treatment Matching Study

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One of the many lessons that alcohol researchers have learned from the Project MATCH findings is that interventions designed to promote greater involvement in Alcoholics Anonymous (AA) can yield *very* respectable treatment benefits. This finding has had the "knock-on" effect of bestowing greater legitimacy to studies that seek to examine the process and outcome of treatments that involve participation in AA and has no doubt fuelled greater interest among Division 50 members in Britain to conduct research on AA. Project MATCH findings have also shown that anger is an important client variable that interacts with treatment to predict outcome.

It is in this historical context that The John Templeton Foundation (JTF; see http://www.templeton.org) has awarded us a grant in support of a three-year controlled clinical trial to test the efficacy of two interventions designed to help recovering alcoholics in AA let go of harmful angers, resentments, and the desire for revenge. The study, which has not yet begun, is to be conducted in the north of London, England, and is entitled, "*Secular and Spiritual Forgiveness Interventions for Recovering Alcoholics in AA: A Patient-Treatment Matching Study.*" Thus, the investigation seeks to compare and contrast the potential benefits of a psychological approach and a psychospiritual approach to promoting forgiveness among AA members who suffer from high levels of interpersonal anger.

12-Step Facilitation aimed at AA's Steps 8 and 9. One of the two treatments that we will be examining consists of a (Project MATCH style) "Focused 12-Step Facilitation" aimed specifically at promoting greater involvement in Steps 8 and 9 of AA. Step 8 reads "Made a list of all persons we had harmed, and became willing to make amends to them all," and Step 9 reads, "Made direct amends to such people wherever possible, except when to do so would injure them or others." We call this condition the Spiritual Forgiveness Treatment by way of contrast to the second intervention, which is strictly "secular" (read "psychological"). Our spiritual condition places very heavy emphasis on encouraging clients to become aware that Steps 8 and 9 of AA actually represent a transformative "*spiritual practice.*" Consistent with conference-approved AA literature (i.e., AA's "Big Book"), clients will be given the rationale that the main purpose of "doing" Steps 8 and 9 is to be in a better position to carry out the Third Step decision, which involves a willingness to let "God" (or some "Higher Power") direct one's thoughts and behaviors. According to AA literature, anger, resentment, guilt, and shame all serve to block the AA member from successfully "turning it over" to this "Spiritual Force." Moreover, because of the overlap in the Forth and Eighth Step lists, clients who make amends during Step 9 will be doing so to people with whom they were (formerly) angry. We expect that the process of participation in this "spiritual practice" will cultivate a measure of humility and forgiveness. We also expect that completing the amends process (i.e., seeking forgiveness from others) will help dissolve guilt, shame and remorse (unforgiveness of self), as well as anger toward others and the desire for revenge (unforgiveness of others). According to AA literature, diminishing these "character flaws" permits the AA member to enjoy a richer experience in awareness and fuller expression in behavior of "Divine Grace." As documented in AA literature, such a "spiritual awakening" is the overarching goal of AA involvement.

Secular (Psychological) Forgiveness Treatment. For our second treatment condition, we will be adapting a psychologically based therapeutic approach developed by Dr. Robert Enright at the University of Wisconsin. Enright is perhaps the world's leading authority on research-based forgiveness therapies, and his approach to treatment makes no explicit mention of "God" or "spiritual growth." Rather, it suggests to clients who have been "victimized" that negative emotions and harsh judgment toward an offender can be attenuated by viewing the perpetrator with compassion and benevolence. According to theory and research published by Enright (1996), compassion can be cultivated through the growth of moral reasoning skills that are specifically designed to foster improved ability to empathize with an offender's imperfections, predicaments and human frailties. Thus, according to the Enright model, as clients progress up Kohlberg's stages of moral reasoning, they will experience improved ability to value and accept their offender(s) as a flawed and imperfect human being. Depending on the amount of client progress, forgiveness can be bestowed and resentments let go in greater or lesser amounts, in full realization that the offender's actions may not merit such benevolence. In summary, the Enright model implicitly adopts the view of "self-as-victim" while the Step 8 and 9 model accepts the tacit assumption of "self-as-perpetrator." For this reason, participants exposed to the Enright intervention will seek to bestow or "give" forgiveness to others (who have harmed them), while participants exposed to the Steps 8 and 9 intervention will attempt to seek forgiveness from others and make restitution for the suffering they (the AA members) have caused.

Matching hypotheses. Our study seeks to identify which types of clients benefit most, from which type of

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treatment, in what kind of way. It is expected that the magnitude of all of incremental therapeutic benefits associated (uniquely) with participation in the Secular Treatment will be especially pronounced for individuals who initially show high levels of dispositional empathy. Thus, empathy will moderate the impact of Secular Treatment on beliefs in the value of forgiving others (i.e., attitudes toward forgiveness) and on interpersonal anger. However, level of pre-treatment empathy will not moderate the efficacy of Spiritual Intervention on any of the outcomes. Next, we expect the degree of therapeutic benefit derived from participation in the Spiritual Treatment will be especially noticeable for people with a positive attitude toward spirituality. Thus, attitude toward spirituality (favorable-unfavorable) will moderate the impact of the Spiritual Treatment on self-forgiveness, forgiveness-from-God, forgiveness-from-others, shame/guilt/self-esteem, and spiritual growth. However, attitude toward spirituality will not moderate the impact of the Secular Treatment on any outcomes. While drinking outcomes will also be assessed, we have not developed *a priori* hypotheses.

Methodology. Clients will consist of 96 members of Alcoholics Anonymous residing in London, England who have a history of at least six months of regular attendance in AA and who are suffering from unresolved angers and resentments. One of the inclusion criteria is that clients will score above the mean on a measure that taps "desire for revenge" (i.e., unforgiveness). One of the exclusion criteria is full completion of Steps 8 & 9. Using a randomized block design, these clients will be matched on empathy and attitude toward spirituality and then assigned to a treatment condition. Professional addiction therapists are currently developing standardized therapist and client manuals for the two treatment conditions. Using a "group-session" format, counselors who are trained in the use of the manuals will deliver the sessions on a fortnightly basis for a period of five months. Clients will undergo a rigorous screening process, and those who pass through will complete batteries of questionnaire measures at pre-treatment. They will also complete "process" measures and will be followed up four times during the one-year post-treatment period.

Significance. We expect that theoretical benefits will come by showing specific effects of both interventions and by identifying "what works best for whom." In the latter connection, results should have practical implications for treatment providers involved in the treatment of alcohol abuse and alcoholism and who work with angry and resentful clients. In particular, the findings from this study may assist these health care providers in deciding which type of forgiveness therapy is best suited for their client.

Feedback. This study has just been funded; thus, we are only in the very early steps of manual development. For this reason, we welcome any feedback from readers of *TAN*. Our expectation is that knowledge of this feedback will result in a stronger study and greater benefit for the AA members involved. Please send e-mails to KH at kenh@psychology.leeds.ac.uk.

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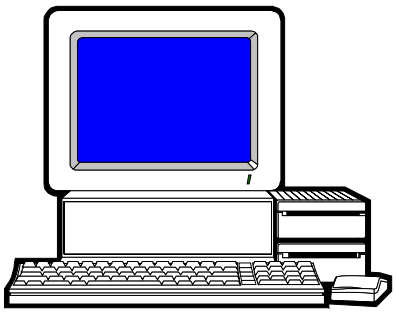

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For Therapists

Double Jeopardy: Treating Juvenile Victims and Perpetrators for the Dual Disorder of Sexual Abuse and Substance Abuse

by Chris Frey, MSW, LCSW

Therapists know all too well that **sexual abuse and substance abuse** are flip sides of the same coin for many young people. Yet, there are next to no resources that help therapists deal simultaneously with this **dual disorder**. For this reason, Chris Frey developed *Double Jeopardy*, a practical manual that gives therapists concrete tools--**program designs, activities and worksheets**--for structuring sound treatment programs for preteens, adolescents, and young adults.

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by Sally and David B.

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The Toad Within: How to Control Eating Choices

by James Weldon Worth, Ph.D.

This book is **not about diets**, calories, and fat grams. It is about self-awareness, self-mastery, and self-expression. The Toad is that mischievous creature, lurking inside, that tempts people to make unwise, unhealthy eating choices. Dr. Worth shows your clients **how to** own their Toad and **accept responsibility** for its actions and responses. According to Dr. Worth, once a Toad has been visualized, it can also be confronted, captured, and controlled. This book is humorous, insightful, and filled with **practical strategies** for taming the toad within.

(Soft cover, 6 x 9, 92 pages, $12.95)

"Persons with any addictive or impulsive tendencies would derive benefit from this volume. . . .a book to keep and return to throughout life." **--David Pierce in *The Journal of Contemporary Psychotherapy***

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McIntosh et al. (continued from page 3)

did not include cigarette price increases. Both the public health community and the White House, however, backed price increases as the "single most important step" in reducing teen smoking. Research, in fact, indicates that raising the price of cigarettes has significantly more of an effect on reducing teen smoking than other single variables (Institute of Medicine, 1998).

President Clinton was, throughout, one of the strongest supporters of a comprehensive bill. He stated, "I don't see how any senator can now stand in the way of a bill that fights drugs, cuts taxes and protects young people from a habit that kills." The president had factored the settlement of 1997 into his budget, and had counted on it for billions of dollars to help fund not just anti-tobacco programs, but also child care and education plans.

How the bill died. One thing both Democrats and Republicans agreed upon is that the bill was ultimately drowned by the weight of the amendments added to it. Tobacco lobbyists had apparently succeeded in positioning the legislation as a tax measure geared to penalize U.S. citizens. Two late amendments to the legislation (the reduction in "marriage tax" and funding for the war on drugs) had taken $0.9 billion and $1.9 billion respectively away from the public health provisions originally in the bill. And, although many Republicans voted for these provisions for use of the funds generated from the legislation, they also used these reasons for ultimately opposing the bills' passage. In a series of failed cloture votes, the Senate was 3 votes short of the 60 vote majority required to end debate (cloture), thus killing the bill by blocking it before it could come to a vote on the Senate floor.

While the White House quickly moved to portray this as an election issue, the effect of the bill's defeat on Senators' future job security is unknown. However, in an election year, the House of Representatives' reluctance to take on this legislation was heightened. The House GOP leadership reportedly appealed to Senator Lott to keep the bill from passing the Senate, so that it would be harder for Democrats to use the tobacco issue as a weapon against House Republicans in the fall (CNN News, 1998).

Regarding the lobbying efforts, The American Cancer Society noted that public health advocates "were outspent by the tobacco industry 50-to-1." By spending upwards of $50 million, tobacco companies were able to frame the debate to their advantage by portraying the measure as a tax increase. Interestingly, Senators who voted against the bill received, on average, more than four times the tobacco industry political action committee (PAC) contributions during the last three election cycles compared to those who voted to move the bill forward (Common Cause, 1998).

Among the main players supportive of the bill and involved in educating Congress were the American Psychological Association, the American Psychological Society, the American Academy of Pediatrics, the Society for Public Health Education, the Society for Research on Nicotine and Tobacco, and the Society for Behavioral Medicine. Also, the ENACT coalition of 50 leading public health organizations, including the Campaign for Tobacco Free Kids and numerous other organizations, worked to support the McCain bill and its behavioral provisions.

What's next. Within a week of the defeat of the McCain Bill, other members of both the Senate and House were beginning work on new bills. At the time of this writing, Senate Judiciary Chairman Orin Hatch (R-Utah) and Senator Dianne Feinstein (D-California) have proposed legislation that would charge tobacco companies $428 billion over 25 years, but which would not require an increase in cigarette prices. Reps. James Hansen (R-Utah) and Martin Meehan (D-Massachusetts) proposed a House bill similar to McCain's bill that would use any money paid the government by the tobacco companies to pay down the national debt. The Hansen-Meehan bill includes a $1.50 per-pack cigarette tax increase, full authority for the FDA, and other tobacco control measures.

Most public health funds in the McCain tobacco bill were subsequently reassigned to non-tobacco programs. But in regards to any future legislation, how should acquired funds be spent? It's one thing for a bill to pass on its obvious benefit to the public health of U.S. citizens but another to define what programs would best serve that end. Successful legislation will need to clearly define spending goals along bipartisan lines, as will the matter of how much to penalize the tobacco companies, and other details.

It may have been a "win-win" situation for proponents of the McCain Bill. If the bill had progressed and passed, it would have been a major step in the war against smoking. But, even though it was defeated, it has raised awareness of the public health issues to the point that some form of legislation will be back soon and will likely eventually pass. The bill's defeat will surely provide this fall's campaigns with a hot issue for debate.

As addiction specialists, we should strongly advocate the provision of funds for research in whatever form the next tobacco legislation takes. The literature to date is replete with evidence that smoking is addictive, but these findings seem to fall by the wayside when "Big Politics" are involved. Support for research efforts needs to be boosted in both the tobacco use prevention and the tobacco use treatment arenas. Whatever legislation eventually succeeds (and it seems inevitable that it will pass in some form), not supporting prevention and treatment research would send a conflicting message. If smoking is one of the most significant health problems of our era, we must be willing to provide for state-of-the-science countermeasures.

"It's now up to our public health allies in the states and local trenches to raise their voices that this legislation is about

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McIntosh et al. (continued from previous page)

kids, not tobacco politics or PACs," said Elaine Auld, Executive Director of the Society for Public Health Education. "We must put our community empowerment strategies to work to ensure that consumers who do want effective national anti-tobacco legislation are heard loud and clear."

It is unfortunate that comprehensive tobacco legislation was not passed, as tobacco use has been increasing among adolescents. Currently, 3,000 adolescents in the United States begin smoking each day. Those willing to take action can write, call, or e-mail legislators to encourage support for comprehensive tobacco legislation, and for increased smoking prevention and tobacco control research through the NIH.

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Liese (continued from page 1)

Alice in Wonderland who originally declared it). Over the years, there have been numerous studies and reviews (e.g., Lambert & Bergin, 1994; Luborsky, Singer, & Luborsky, 1975; Wampold, Mondin, Moody, Stich, Benson, & Ahn, 1997) that have concluded that "bona fide psychotherapies are roughly equivalent" (Wampold et al., 1997; p.203). Project MATCH is likely to go down in history as further evidence for the Dodo Bird verdict, despite the fact that it was not designed to be yet another psychotherapy "horse race."

For me the most intriguing question in psychotherapy research (and Project MATCH) regards clinician ***talent***. In fact I recently attended the 29th Annual Meeting of the *Society for Psychotherapy Research* where I moderated a panel entitled: "Psychotherapy talent: What is it? Where does it come from? And what can we do when therapists don't have it?"

For approximately 10 years I have been involved in developing and researching psychotherapeutic treatments for addictive behaviors. Over that time I have had numerous opportunities to supervise mostly advanced clinicians involved in the delivery of addiction treatment. In contrast to my initial expectations, I have found experienced therapists to vary dramatically in their clinical abilities. Time after time I have noticed that certain therapists have extraordinary talent, while others seemed to have little talent. At times I have found myself inspired by the work of talented therapists, while at other times I have felt repulsed by the pain inflicted by untalented therapists.

Webster's Ninth New Collegiate Dictionary (Merriam-Webster, 1986) defines talent as, "a special, often creative or artistic aptitude; ability; gift; involving mental or intellectual power" (p.1203) This definition raises some difficult questions. For example, if talent is an "aptitude" or "gift," can it be learned? If so, does the learning of talent occur early in life? If talent is learned early life or if it is innate, can it also be taught in graduate school? If talent cannot be taught in graduate school, what do we do when students enter graduate programs without substantial talent? Or what do we do when clinicians we supervise do not appear to have talent?

There are numerous descriptions of psychotherapy "skillfulness" in the psychotherapy literature (the term "talent" is rarely used). I am particularly intrigued by some of the older descriptions. For example, consider the description by Egan (1975; paraphrased to eliminate gender-biased language):

> Helpers are committed to their own growth: physical, intellectual, social-emotional, spiritual. They realize that they must model behaviors that they wish others to achieve. They know that they can help only if, in the root sense of the term, they are 'potent' human beings, people with the will and the resources to act. Even more important, they have good common sense and good social intelligence. They are at home in the social-emotional world, both their own and that of others. They have developed extensive social-emotional skills that enable them to respond spontaneously and effectively to a wide range of human needs. These skills are second nature to them.

In this passage Egan describes the essence of psychotherapy talent**.** His descriptions are similar to those of other humanistic psychologists of his time. For example, in his classic paper on "The necessary and sufficient conditions of therapeutic personality change," Rogers (1957), states that "the therapist should be, within the confines of this relationship, a congruent, genuine, integrated person. It means that within the relationship he is freely and deeply himself, with his actual experience accurately represented by his awareness of himself" (p.97).

Strupp, as early as 1960, recognized that talent alone is not likely to be sufficient for effective positive therapy outcome. He (and others) have argued:

> It is the duality of therapists' contributions--technical and personal aspects--that goes to make up therapeutic success. We need to know much more about each. But this I believe: The greatest technical skill can offer no substitute for nor will it obviate the preeminent need for integrity, honesty, and dedication on the part of the therapist. Unless

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(1) If one examines the major epidemiological surveys of the past decade (e.g., Regier et al, 1990; Helzer et al, 1991; Kessler et al, 1996; Warner et al., 1995), it is evident that one of the major differentiators of types of abuse/dependence is the presence or absence of other mental disorder along with the substance use disorder. This distinguishing characteristic is different in men and women (women are more likely to have a comorbid diagnosis), course is different (those with comorbidity are more likely to have persistent substance use disorder), and comorbidity is more often found in populations where the substance abuse is more severe (e.g., treatment populations) and where there are other major life difficulties (e.g., prison populations).

(2) If one looks within the comorbid subpopulation, it is also clear that the diagnosis most disproportionately over-represented is antisocial personality disorder (APD). This diagnosis is not always the most prevalent co-diagnosis because of base rate differences in occurrence of other comorbid disorders (e.g., anxiety and depression are more common in both the substance abusing and non-substance abusing populations), but it has the strongest co-association with alcohol/other drug involvement. Those with alcohol/other drug abuse/dependence and APD are a clinically challenging subpopulation, marked by a large number of troubles and risk factors including other psychiatric comorbidity besides the ASP, a denser family history of substance abuse, earlier onset of disorder, greater likelihood of spousal violence, higher chance of childhood abuse, and so forth. This is not at all the same substance use disorder as the one with no comorbidity and with adult onset.

(3) This subpopulation is also of special interest because evidence is now compelling that some of its origins are diagnosable before these youngsters even reach kindergarten (Zucker, in press). Clearly, with so much trouble going on and starting so early, a different strategy for intervention is called for than substance use disorder that begins in adulthood and that is of much shorter course.

(4) If one turns just to alcohol abuse/dependence, some other, clinically interesting epidemiological facts suggest the importance of paying attention to subpopulation differences. Programs like Drinkwise have capitalized on the fact that persons with shorter and less severe histories of drinking problems, who do not have a positive family history that is indicative of potentially greater genetic diathesis, and who, by way of their life circumstances have more motivation to attend to their ongoing difficulties, are more likely to benefit from harm reduction strategies. This is not the same subpopulation that is described in (2) and (3) above.

(5) Another fact about alcohol problems that tends to be lost in clinical practice, and ignored in prevention programming is that a very large chunk of the difficulty is confined to a fairly small proportion of the population: The top 5 percent of drinkers accounts for approximately 40 percent of the total self-reported alcohol consumption of the nation; the next 15 percent accounts for another 45 percent of the total (Greenfield & Rogers, in press). Put another way, one-fifth of the population accounts for more than four-fifths of the use and one-twentieth accounts for close to half of it! A very reasonable hypothesis, not systematically tested, would be that the thirsty 5 percent will need different intervention regimens than the rest of the population of problem users.

(6) There is an interesting attribute of all substance use disorders that makes this behavior domain different from most other forms of psychopathology*: the deviant behavior occurs in relation to an external object, the drug*. Drug availability and ongoing patterns of use in the immediate peer structure directly affect likelihood of (1) onset, (2) sustained use, and (3) the likelihood of relapse after cessation of use. Subpopulations (and cultures) that have heavier use rates are more likely to create risk for earlier use. They are also more likely to produce higher levels of abuse and dependence in their members than do subpopulations with lower levels of use (object presence). This point is well appreciated by clinicians and researchers, by members of Alcoholics Anonymous, and by the therapeutic community movement. One simple part of the effect is the arousal of the craving structure for drug use brought on by stimulus cueing. Involvement in a peer structure where use is not present invokes the obverse: out of sight, out of mind.

(7) What is less well appreciated is that because the pathological behavior occurs in relation to an object external to the self, a network of control structures relating to decision making is also an integral part of the behavioral sequence. Sustained use requires a matrix of decisions about whether or not to seek out the object, consort with peers who use it, decide to continue (or desist from) use after problem signs occurs. So the decision making is a part of the causal structure for use. On these grounds, impulsivity, poor capacity to delay, deficits in problem solving, have been posited at the neuropsychological level as vulnerability indicators for substance abuse. The more general point is that these control structure deficits have nothing specifically to do with the psychopathology (i.e., the appetitive, sensitivity, or reinforcement structures of drug involvement). They are nondrug specific (see Zucker et al., in press). At the same time, subpopulations where there are greater control deficits are also subpopulations where drug involvement is greater (see points [2] and [3] above).

These issues are receiving increasing attention in diagnostic and treatment circles, as we move to a health care system where early detection, disease management, and prevention programming are being emphasized. This is a clinically challenging time, because much of our evaluation and intervention activity is outside the scope of prior practice. It also is a time of opportunity, that encourages the development of subpopulation-specific treatment menus. With the new

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resources of information technology, it is now possible to closely and rapidly evaluate treatment effectiveness, build in feedback systems that allow change when old procedures do not work, and provide information dissemination of the ones that do. These new pressures also provide the impetus for more truly preventive activity than has existed since the community mental health movement of the Sixties proposed this idea.

A brief addendum about Division activities and San Francisco: In a number of places in this issue of *TAN*, you will find reference to the NIAAA Miniconvention jointly being sponsored by Divisions 50 and 28. There are many special aspects of this "meeting within a meeting," but one in particular speaks to a change in the Division's modus operandi. I refer to the close working relationship between us and Division 28. This has involved an intense, sustained, and highly effective collaboration of the two Program Chairs (our own Kim Fromme, Ph.D., and Division 28's Nancy Piotrowski, Ph.D.) that has resulted in a wonderful Miniconvention program. The Annual Meeting also, for the first time, includes a joint reception/social hour by the two Divisions, scheduled for 5 p.m. on Saturday, August 15th, immediately following the Division 50 Business Meeting. The collaboration also has involved our cosponsoring a reception for Enoch Gordis, M.D., Director of NIAAA, on Sunday, August 16th at 6 p.m. (following the remarks of Congresswoman Pelosi, an APA Special Recognition Award presented by Dr. Seligman to Dr. Gordis, and Dr. Gordis' invited address). Another activity during the past several months has involved the two Divisions' collaboration in a joint project for development of the specifications for a psychopharmacology proficiency. This activity, spearheaded by Marlyne Kilbey, Ph.D., under Division 28 auspices, and involving Rudy Vuchinich, Ph.D., our liaison to Division 28, has received a small grant from APA to facilitate the work. All of these activities speak to a joint recognition by both Divisions that although our constituencies are somewhat different, there are many areas where joining forces can enhance the activities of all of us.

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Highlights of the 1998 APA Convention

1998 APA Convention Events!

Kim Fromme
1998 APA Convention Program Chair

The 1998 APA convention will be held in San Francisco, CA, August 14-18, and the Division 50 theme this year is **"The Spectrum of Addictive Behaviors and Their Consequences."** In conjunction with Division 28 (Substance Abuse and Psychopharmacology) and NIAAA, Division 50 is also sponsoring a **"Miniconvention on Alcohol and Addiction Research: Achievements and Promise in Behavioral Science."** There is no special registration for the Miniconvention other than the regular APA Convention registration (see related article in the next column). All sessions for Divisions 50 and 28, as well as the Miniconvention, will be held in the San Francisco Marriott Hotel and the Moscone Center--South Building (very near the Marriott). Thus it should be much more convenient to attend all Division 50 and 28 presentations this year than it has been in the past.

A listing of times and places for all Division 50 presentations is provided in a special pullout section of this newsletter. Briefly, the program includes addresses by **Robert Zucker**, **Marc Schuckit**, **Stewart Agras**, **Sharon Hall**, and the Director of NIAAA, **Enoch Gordis**; two poster sessions (40 posters in each) on **"Alcohol Use and Abuse, Smoking, and Gambling"** and **"Eating Disorders and Treatment of Drug Abuse;"** a workshop on the **"Treatment of Dually Diagnosed Patients Using Relapse Prevention;"** and a discussion hour on **"Psychotherapy and 12-Step Programs."** Social events include a joint **Social Hour** with Division 28 on Saturday, 5-6 p.m. and a catered **Reception** honoring Dr. Gordis on Sunday 6-7 p.m. These events offer an excellent opportunity for meeting other Division members.

Ten symposia will be featured, with the content covering both substance and nonsubstance-related addictions. The Chairs of these sessions are listed in the pullout program and the presenters, their paper titles, and discussants for each symposia are listed on the page 16.

I would 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 (listed in the Spring *TAN*) for their valuable assistance in creating an interesting and informative program for 1998. I hope to see everyone in San Francisco! It should be a perfect time of year to visit the Bay area, with average temperatures in the 60's to 80's. For those of you who are unable to attend the conference this year, you might consider contacting the presenters for copies of their conference papers.

APA Miniconvention on Alcohol and Addiction Research

Robert Huebner and Geoff Laredo
National Institute on Alcohol Abuse and Alcoholism

A major highlight of the upcoming APA convention will be a "miniconvention" devoted to the contributions of behavioral and biomedical science to alcohol and other addiction disorders. The miniconvention--entitled Alcohol and Addiction Research: Achievements and Promise in Behavioral Science--is co-sponsored by Division 50 (Addictions), Division 28 (Psychopharmacology and Substance Abuse) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

The miniconvention will provide psychologists both inside and outside the addiction field with a unique opportunity to learn about recent behavioral and neurobiological research on the causes, consequences, treatment, and prevention of alcohol and addiction disorders. Workshops, paper sessions, symposia, and poster sessions will explore such topics as: the interplay of genetic, environmental, and psychological variables in predicting alcoholism; alcohol use and abuse in adolescence and young adulthood; contributions of cognitive psychology to understanding alcohol intake; prevention of driving while intoxicated; the behavioral economics of alcohol abuse; brain imaging and alcoholism; compliance and treatment outcomes; and co-occurring disorders and relapse prevention. In addition to presentations on specific topics, there will be a number of invited addresses that take a broad perspective on what is known about alcoholism and other addictions, and how we might best direct our efforts in the future. You will be receiving a miniconvention program in the mail within the next few weeks.

Please mark your calendar for the miniconvention's keynote address, which will be delivered by Dr. Enoch Gordis, Director of NIAAA on Sunday, August 16th at 5:00 p.m. (Room 302, Moscone Center, South). APA President Martin Seligman, Ph.D., will be on hand to present Dr. Gordis with the APA Presidential Award. Representative Nancy Pelosi (D-Calif.) is scheduled to attend this session and share her thoughts on alcohol and addiction research. All Division 50 members are invited to attend a reception immediately following Dr. Gordis' presentation. The reception will be held at 6:00 p.m. in the Golden Gate Room (Salon 2) at the San Francisco Marriott.

This is an exciting time in the alcohol research field. The miniconvention planning committee (Bob Zucker, Kim Fromme, Nancy Piotrowski, Stephen Long, Geoff Laredo, and Bob Huebner) has assembled a first rate group of researchers and clinicians to present their latest findings. Division 50 members are encouraged to find time in their busy convention schedules to attend as many sessions possible.

Division 50 Events at the 1998 APA Convention*

	FRIDAY	SATURDAY	SUNDAY
8:00 AM	**Symposium:** Addictions & Family Law Chairs: *Eric Y. Drogin, Curtis L. Barrett* MC 224	**Conversation Hour:** Psychotherapy & 12-Step Programs as Resistances to Each Other *James M. McMahon* MC 250	
9:00 AM			**Poster Session:** Alcohol Use & Abuse, Smoking, and Gambling Chairs: *Laurie Roehrich, Michael Sayette* MC Exhibit Hall B
10:00 AM	**Invited Address:** Treatment of Bulimia Nervosa Past, Present & Future *Stewart Agras* MC 212		**Symposium:** Disentangling Alcohol & Drug Use From Abuse Chair: *Eric Stice* MC 222
11:00 AM			*Symposium Continues*
12:00 PM			
1:00 PM	**Invited Address:** Depression, Dysphoria & Smoking Cessation *Sharon M. Hall* MC 236	**Symposium:** Alcohol & Drug Use Consequences in Adolescence & Young Adulthood Chairs: *Thomas A. Willis, James M. Sandy* MC 232/234	
2:00 PM		*Symposium Continues*	**Invited Address:** Relationship Among Genetic, Environmental, & Psychological Variables in Predicting Alcoholism *Marc Schuckit* MC 222
3:00 PM		**Presidential Address:** Spectrum of Alcohol & Drug Use Disorders: A National Agenda for Focused Change *Robert A. Zucker* MC 274/276	
4:00 PM		**Business Meeting:** Chair: *Robert A. Zucker* MC 309	
5:00 PM		**Joint Division 28/50 Social Hour:** *Kim Fromme, Nancy A. Piotrowski* at San Francisco Marriott, Yerba Buena Salons 4/5	**Invited Address:** Alcohol & Addiction Research: Achievements & Promise in Behavioral Science *Enoch Gordis* MC 302
6:00 PM			**Reception for Dr. Gordis:** *Kim Fromme, Nancy A. Piotrowski* at San Francisco Marriott, Golden Gate Salon C2

MC = Moscone Center--South Building

***Note:** Detailed descriptions of Division 50 symposia are on page 16.

Division 50 Events at the 1998 APA Convention*

	MONDAY	TUESDAY
8:00 AM	**Executive Committee Meeting:** Chair: *Robert A. Zucker* San Francisco Marriott, Pacific Conference Suite F	**Workshop:** Treatment of Dually Diagnosed Patients Using Relapse Prevention *Patricia M. Averill* MC 272
9:00 AM	*Executive Committee Meeting continues*	*Workshop Continues*
10:00 AM	*Executive Committee Meeting continues*	**Symposium:** Craving & Cognition in the Addictions--Marriage, Separation, or Divorce? Chairs: *Edward G. Singleton,* *Jack E. Henningfield* MC 272
11:00 AM	**Symposium:** Eating Disorders--New Perspectives on Development & Treatment *Dorothy L. Espelage* MC 222	*Symposium continues*
12:00 PM	*Symposium Continues*	
1:00 PM	**Symposium:** Addictive Behavior in Women, Ethnic Minorities & Other Under-served Populations Chair: *Laurie Roehrich* MC 250	**Symposium:** Youth Gambling--Prevalence, Risk Factors, Clinical Issues & Social Policy Chair: *Jeffrey L. Derevensky* MC 232/234
2:00 PM	*Symposium Continues*	*Symposium continues*
3:00 PM	**Symposium:** Innovative Services for Treating Refractory Alcohol & Drug Abusing Patients Chair: *Carl Isenhart* MC 250	**Symposium:** Psychiatric Comorbidity Among Adolescents With a Substance Use Disorder Chair: *Elizabeth Rahdert* MC 232/234
4:00 PM	**Poster Session:** Eating Disorders & Treatment of Drug Abuse Chairs: *Arthur M. Horton, Jr.,* *Mariella Shirley* MC Exhibit Hall B	**Symposium:** Using Drug Courts for Substance Abuse Treatment Chair: *Merith Cosden* MC 232/234

MC = Moscone Center--South Building

***Note:** Detailed descriptions of Division 50 symposia are on page 16.

The 20th Anniversary APA 5K Race and Walk

The annual APA 5K Race and Walk will be held on Sunday morning, August 16th, at 7 a.m. at the Embarcadero, a site within walking distance of the major hotels.

In order to encourage as many early registrations as possible, early registrations are again being discounted. Preregistration will run until August 6th. Preregistrations save us loads of effort at the convention and on the day of the race. THE ENTRY FEE FOR PREREGISTERED RUNNERS IS $17.00, which includes the annual dues to Running Psychologists. CONVENTION AND DAY-OF-RACE REGISTRATION FEE IS $20.00. Special reduced fees for APA Student Affiliates, including APAGS members, will be $7.00 (preregistered) and $10.00 (day of race).

If you are not running but would like to volunteer to help out, please call, e-mail, or send a note. Thanks.

Race Contact: Frank Webbe, School of Psychology, Florida Institute of Technology, 150 W. University Blvd., Melbourne, FL 32901-6988. Phone: (407) 674-8104; FAX: (407) 768-6113; e-mail: webbe@fit.edu

Addiction Symposia at the 1998 APA Convention

Addictions and Family Law: William Foote (Discussant)
Eric Droggin "Addictions and Family Law: Legal Perspectives"
Curtis Barrett "Addictions and Family Law: Clinical and Forensic Perspectives"

Alcohol and Drug Use Consequences in Adolescence and Young Adulthood: Michael Newcomb (Discussant)
Laurie Chassin "The Relationship Between Adolescent Substance Use and Young Adult Psychopathology"
Lynne Cooper "Motivational Pathways to Alcohol Involvement Among Black and White Drinkers"
Gregory Smith "Expectancies and Differential Prediction of Alcohol Use and Alcohol Consequences"
Thomas Wills "Novelty Seeking and Self-control Predict Adolescent Substance Use Consequences"

Disentangling Alcohol and Drug Use from Abuse: Ken Sher (Discussant)
Eric Stice "Differential Prediction of Onset of Alcohol Use versus Problem Use"
Lynne Cooper "Motivational Pathways to Alcohol Use and Abuse"
Stan Sadava "Structural and Therapeutic Implications"
Michael Newcomb "Influence of Adolescent Drug Use on Adult Drug Problems in Women"

Eating Disorders: New Perspectives on Development and Treatment: Joel Killen (Discussant)
Suzanne Mazzeo "The Challenge of Body Image Assessment: Research and Treatment Implications"
Kris Gowen "Social Victimization, Teasing and Weight Concerns in Young Adolescents"
Melissa Holt "Social Competence and Relationship Quality: Associations with Disordered Eating Behaviors"
Dorothy Espelage "Treatment Outcome in Eating Disorders: A One Year Follow-up"

Addictive Behavior: Women, Ethnic Minorities, and Other Under-served Populations:
Ken Sher and Richard Wilsnack (Discussants)
Laurie Roehrich "Inconvenience Sampling: Creative Methods for Special Populations"
Sharon Wilsnack "Surveying Women's Drinking: 20 Years of Learning How"
Westley Clark "Legal and Ethical Aspects of Substance Abuse Research"
Lisa Onken "The NIDA Treatment Initiative: Moving 'Special Populations' into Mainstream Research"

Innovative Services for Treating Refractory Alcohol and Drug Abusing Patients:
Carl Isenhart "Development and Rationale for Expanded Alcohol and Drug Abuse Services"
Douglas Olson "Integrated Outpatient Treatment for Medically Ill Alcoholic Men"
Marci Mylan "A Treatment Model for Substance Dependent Patients with Psychiatric Comorbidities"

Craving and Cognition in the Addictions: Marriage, Separation, or Divorce?: Maxine Stitzer (Discussant)
Stephen Heisman "Tobacco Craving in a Polydrug-Abusing Population"
David Newlin "Craving for Alcohol on 42,862 Subjects: A DSM-V Criterion"
Edward Singleton "Craving, Coping, and Drug Use"
Steven Grant "Brain Imaging of Cue-elicited Craving with PET"

Youth Gambling, Prevalence, Risk Factors, Clinical Issues, and Social Policy: Jeffrey Derevensky (Discussant)
Randy Stinchfield "Youth Gambling: Prevalence and Trends"
Durand Jacobs "Youth Gambling and Dissociative Behaviors: Predicting Addictive Behaviors"
Rina Gupta "Youth Gambling: Some Risk Factors Predicting Probable Pathological Gambling Behavior"
Harold Wynne "Youth Gambling: An Important Social Policy Issue"

Psychiatric Comorbidity Among Adolescents with a Substance Use Disorder: Arthur Horton (Discussant)
Mark Myers "Coping Among Substance Abusing Adolescents with Concomitant Conduct Disorder"
Gayle Dakof "Gender Differences in Comorbidity Among Adolescents Referred for Drug Treatment"
John Curry "Treating Comorbid Depression and Substance Abuse in Adolescents"
William Latimer "Relapse Odds Associated with ADHD Among Adolescents in Drug Treatment"

Using "Drug Courts" for Substance Abuse Treatment:
Merith Cosden "What are Drug Courts?"
Craig Parks "Providing Substance Abuse Treatment Through A Drug Court"
Stacey Peerson "Psychological Characteristics and Outcomes for Clients in a Drug Court"
Linda Crothers "Outcomes for Male and Female Clients in a Drug Court"

APA Office of Substance Abuse and "TIP's"

Gil Hill
Director, Office of Substance Abuse
Practice Directorate

The mission of the APA Office of Substance Abuse (OSA; in the Practice Directorate) is to serve as representative and policy advocate for psychologists in matters related to substance abuse. The office has a liaison with APA Division 28 (Psychopharmacology and Substance Abuse) and Division 50 (Addictions). OSA communicates with other divisions, state psychological associations, and various federal agencies in Washington with interests in substance abuse. As Director of OSA, I have been asked by the Center for Substance Abuse Treatment (CSAT) to serve on their Editorial Advisory Board, for the Treatment Improvement Protocols (TIP's) they produce.

Treatment Improvement Protocols (TIP's) are prepared by CSAT to facilitate the transfer of state-of-the-art protocols and guidelines for the treatment of alcohol and other drug abuse from acknowledged clinical, research, and administrative experts to the nations' substance abuse providers and organizations. They are developed by panels of non-federal experts who meet in Washington for five days to make recommendations, define protocols, and arrive at agreement on the protocols. The members of the panel are multidisciplinary. One of the functions of OSA is to suggest the names of psychologists with treatment, research, and policy expertise on the topics selected for TIP's. I am happy to report that many psychologists have served on the panels for the 25 TIP's that have been published to date. Surprisingly, I find that the knowledge of the TIP's existence on the part of psychologists in general is minimal and that is the reason for this article.

TIP's have the potential of informing psychologists involved in substance abuse prevention, treatment, and rehabilitation fields of the latest consensus on various treatment modalities. A partial list of the TIP's that are available includes:

- Pregnant Substance Abusing Women
- Screening and Assessment of Alcohol and Other Drug Abuse in Adolescents
- Guidelines for the Treatment of Alcohol and Other Drug Abusing Adolescents
- Intensive Outpatient Treatment for Alcohol and Other Drug Abuse
- Assessment and Treatment of Patients with Coexisting Mental Illness and Other Drug Abuse

The most recent TIP undertaken by CSAT is on Enhancing Motivation for Change. I am currently seeking the names of psychologists to serve on the Consensus Panel for the TIP and will provide additional input to the TIP by serving on the Resource Panel that helps CSAT plan the TIP. CSAT has already selected the Chair of the Consensus Panel. He is William Miller, Ph.D., a psychologist on the faculty of the University of New Mexico, well known for his work in this area. For information on the other TIP's that are available and to obtain free copies of all TIP's, contact the National Clearinghouse for Alcohol and Drug Information at (800) 729-6686. The mission of the Editorial Advisory Board is to suggest topics for new TIP's and to identify TIP's in need of update. In my role as a member of the Board, I draw on the expertise of Divisions 28 and 50 as well as the suggestions of individual APA members. I am always interested in receiving suggestions and can be reached on e-mail (jgh.apa@email.apa.org) or by phone at (202) 336-5857.

Liese (continued from page 10)

> these are at the core of therapists' personalities, they will not be successful in helping patients to develop within themselves (pp. 230-231).

In a classic and often cited study, Crits-Christoph and Mintz (1991) argued that "therapist" should be included as a random design factor in psychotherapy research. Since the publication of their paper, many others have come to similar conclusions (e.g., Beutler, Machado, & Neufeldt, 1994; Garfield, 1997; Lambert & Bergin, 1994; Lambert & Okiishi, 1997; Luborsky, McLellan, Diguer, Woody, & Seligman; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; Najavits & Weiss, 1994). Actually, this should not come as a surprise, given that many of the world's prominent psychotherapists and psychotherapy researchers have argued that the "person of the psychotherapist" (McConnaughy, 1987) is a critical variable in the therapy process.

In 1993, Bill Miller and his colleagues reported one of their original studies on motivational interviewing. In their paper the authors acknowledged the important role of therapist effects in the design and implementation of their services. They made the point that the "better way" for clinicians to deliver addiction services is in a "reasoned, respectful, and individualized" fashion, maximizing empathy and minimizing advice and disagreement. An important and relevant finding of the Miller et al. study was that, independent of experimental condition, "a single therapist behavior was predictive of 1-year outcome such that the more the therapist confronted, the more the client drank" (p.455).

Of particular interest to me in Project MATCH is whether significant therapist differences were nested within treatment groups in the study. Were there some extraordinarily *talented* clinicians in the three treatment conditions? Were there some extraordinarily *untalented* clinicians? If so, what can we learn from these clinicians? How was their talent (or lack thereof) manifested? How did talent relate to treatment adherence (as measured by standardized adherence scales used in the study)? How were *talented* and *untalented* clinicians similar to or different from each other? Did their talents (or lack thereof)

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Addictions Abstracts

In this section, Division 50 members share their work. 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!

Medication Take-Home Doses and Contingency Management

Schmitz, J.M., Rhoades, H.M., Elk, R., Creson, D., Hussein, I., & Grabowski, J. (1998). Medication take-home doses and contingency management. *Journal of Experimental and Clinical Psychopharmacology, 6*, 162-168.

Two studies examined contingent take-home medication doses during treatment of opiate or cocaine dependence. Study 1: Methadone maintenance patients were randomly assigned to one of two 8 week baseline take-home (TH) conditions differing in frequency of clinic visits/week. This was followed by a 12-week contingency management (CM) procedure in which frequent THs resulted from drug-free urines. Subjects receiving more frequent take homes during baseline had lower illicit drug use during the first six weeks of CM. Study 2: Fluoxetine (0, 20, 40-mg) TH doses were similarly contingent in treatment of cocaine dependence. The 40-mg group used less cocaine during contingency than did other groups. The combination of fluoxetine and environmental contingencies may produce benefit where neither alone, is sufficient.

Relationship Between Self-Efficacy Perceptions and In-Treatment Drug Use Among Regular Cocaine Users

Rounds-Bryant, J.L., Flynn, P.M., & Craighead, L.W. (1997). Relationship between self-efficacy perceptions and in-treatment drug use among regular cocaine users. *American Journal of Drug and Alcohol Abuse, 23*, 383-395.

Perceived ability to engage in situation-specific behaviors (self-efficacy) has been predictive of the actual ability to engage in such behaviors. Behavior change during treatment and maintenance of the change after treatment has been related to self-efficacy. Relationships between self- efficacy and drug use were investigated in a subsample of the National Institute on Drug Abuse's (NIDA's) Drug Abuse Treatment Outcome Study (DATOS) participants who were regular cocaine users (n = 294) and who remained in outpatient drug-free treatment at least 3 months. Results showed that as self-efficacy increased, frequency of drug use during treatment decreased. This relationship also strengthened with increased time in treatment. Findings support the importance of self-efficacy enhancements as important treatment interventions.

Behavioral Self-Control Program for Windows: Results of a Controlled Clinical Trial

Hester, R.K. & Delaney, H.D. (1997). Behavioral self-control program for Windows: Results of a controlled clinical trial. *Journal of Consulting and Clinical Psychology, 65,* 686-693.

Forty nonalcoholic heavy drinkers were randomly assigned to receive a computer-based version of behavioral self-control training either immediately after pretreatment assessment or after a 10-week waiting period. Results at each of three follow-ups strongly support the study hypotheses. Participants in the Immediate treatment group significantly reduced their drinking relative to their pretreatment levels and relative to those in the Delayed treatment condition at the initial follow-up, 10 weeks after the pretreatment assessment. The Delayed group did not change their drinking behaviors during this period of time. However, they significantly reduced their drinking by the second follow-up conducted after they received training. At the 12 month follow-up participants maintained the gains they had achieved during treatment. There were no interactions involving participant ethnicity or gender. While use of other drugs was not specifically addressed, such use did not increase and there was some evidence of a decline.

Integrating Substance Abuse Treatment for the Seriously Mentally Ill into Inpatient Psychiatric Treatment

Bradizza, C.M. & Stasiewicz, P.R. (1997). Integrating substance abuse treatment for the seriously mentally ill into inpatient psychiatric treatment. *Journal of Substance Abuse Treatment, 14,* 103-111.

This paper offers guidelines for the assessment and treatment of substance abuse problems in seriously mentally ill persons admitted into inpatient psychiatric treatment. This approach may be most useful in settings where a specialized dual-diagnosis treatment program is not feasible. The first step consists of identifying potential substance abusers using several sources of information including the patient's record, a brief patient interview, and an interview with the patient's family and caseworker. Patients who have a confirmed or suspected substance abuse problem undergo a substance abuse assessment designed to evaluate consumption patterns, negative consequences of substance use, and high-risk situations for use. Patients are presented with individualized feedback in a non-coercive manner intended to increase their motivation to change. Treatment consists of a structured coping skills group. The content of each group session is described along with guidelines for conducting coping skills group treatment with the seriously mentally ill.

Training in Cognitive, Supportive-Expressive, and Drug Counseling Therapies for Cocaine Dependence

Crits-Christoph, P., Siqueland, L., Chittams, J., Barber, J.P., Beck, A.T., Frank, A., Liese, B., Luborsky, L., Mark, D., Mercer, D., Onken, L.S., Najavits, L.M., Thase, M.E., & Woody, G. (1998). Training in cognitive, supportive-expressive, and drug counseling therapies for cocaine dependence. *Journal of Consulting and Clinical Psychology, 66,* 484-492.

This study assessed the effects of training on the performance of 65 therapists in delivering manual-guided therapies to 202 cocaine-dependent patients. Changes in ratings of therapists' adherence and competence was assessed in three treatment modalities: supportive-expressive dynamic therapy (SE), cognitive therapy (CT), and individual drug counseling. Effects of manual-guided training on the therapeutic alliance were also assessed. Training effects were examined through a hierarchical linear modeling approach that examined changes both within cases and across training cases. A large effect across cases was detected for training in CT. Supportive-expressive therapists and individual drug counselors demonstrated statistically significant learning trends over sessions but not over training cases. Training in SE and CT did not have a negative impact on the therapeutic alliance, although alliance scores for trainees in drug counseling initially decreased but then rebounded to initial levels.

An Empirical Typology of Drinking Partnerships and Their Relationship to Marital Functioning and Drinking Consequences

Roberts, L.J. & Leonard, K.E. (1998). An empirical typology of drinking partnerships and their relationship to marital functioning and drinking consequences. *Journal of Marriage and the Family, 60,* 515-526.

Cluster analysis was used to identify a natural typology of "drinking partnerships" in early marriage. Couples (n = 296) were entering their second year of marriage. Six variables reflecting husband and wife drinking behavior were used to identify the couple profiles: husband and wife drinking frequencies, husband and wife typical quantities, percent of couple's total drinking done in each other's presence, and percentage of couples' drinking done at home. An interpretable five cluster solution was found that evidenced significant and meaningful relationships with both marital functioning and drinking consequences. Clusters characterized by high levels of consumption were not uniformly associated with lower marital quality. Moreover, significant relationships between the drinking partnerships and marital functioning and alcohol consequences held after statistically controlling for husband and wife monthly volume measures, suggesting that the multidimensional notion of a "drinking partnership" may be useful in future efforts to understand the implications of alcohol use for marriage and family life.

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Letters to the Editor *(con't)*

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these treatments for the very reason that they were "non-eclectic." Maybe the "everything-but-the-kitchen-sink" approach in mainstream treatment is confusing for some clients. For example, imagine how it might be for you as a newly-sober client in an intensive outpatient program to be exposed to the following treatment experiences in a single week: on Monday night, you are challenged to grapple with the metaphorical meaning of powerlessness and loss of control during a "First Step Group;" on Wednesday night, you practice exerting your willpower during a drink-refusal role play in Relapse Prevention Group; and in Friday's Communications Group you disclose the painful details of your broken marriage, only to learn that, according to the definition of verbal abuse, "you is one." All of this is coming from different therapists, while you fight off the sleep you are told you must get to live a balanced life and stay sober, even though you've had a hard day at work and the kids will need your attention once you drag yourself home from treatment. Don't worry, tomorrow morning you'll attend one of your two required weekly 12-Step meetings, where if you're lucky, you will find solace in the promise that your higher power will take care of anything that you can't handle. . . . I think some people are finding our mainstream programs overwhelming.

MATCH treatments were very unlike many mainstream programs that often contain a little bit of everything. Maybe the MATCH clients were better able to dance with their therapists because they had only one step to learn. Bill Miller has suggested that maybe people do best in treatment when they just stay engaged, doing something. Because as Bem would say, if they see themselves doing something, they conclude that they must be committed because they see themselves acting as if they were committed, and so they then continue to act committed by remaining engaged in treatment. And how better to remain engaged in treatment than to feel that you can grasp what that treatment is, how it works, and where it's going? After all, who wants to dance if they can't learn the steps?

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The Challenge of the Precontemplator:
Rethinking Motivational Readiness in Project MATCH

Although the matching hypothesis of Project MATCH was not supported, there are still several important findings contained in this study. One hypothesis that was partially supported was that subjects who were less motivated at baseline (precontemplators or contemplators) would do better in Motivational Enhancement Therapy (MET) than Cognitive-Behavioral Coping Skills Therapy (CBT). This result is significant at the 15-month timepoint. It is not at all surprising that it took 15 months for this MET group to exhibit effects because those low in motivation are less likely to move quickly into action (Project MATCH Research Group, 1997).

Research on smoking and other problem behaviors has shown that smokers who move just one stage (e.g., precontemplation to contemplation) are twice as likely to quit in the near future than those who stay in action (Prochaska & DiClemente, 1992). This is what MET is most likely to accomplish. Also results from other smoking studies designed to increase motivation to quit only begin to show substantial effects about 12 months following the end of treatment (Prochaska, DiClemente, Velicer, & Rossi, 1993; Prochaska et al., 1998a; 1998b; Velicer et al., in press). This is expected, especially in studies enrolling a large proportion of individuals in the precontemplation stage, since it takes time to move through the stages. The proportion of individuals taking action should therefore increase with time. We would predict these effects for individuals with low motivation at baseline in MET should increase at subsequent follow-ups.

Consistent with this matching hypothesis, Heather, Rollnick, Bell, and Richmond (1996) found that hospital patients who were not motivationally ready were more likely to benefit from motivational interviewing (which, like MET, is designed for those who are not ready to change) than from behavioral skills training (which is more appropriate for those preparing to make a change). This finding corroborates other research that has found stage of change to be an important predictor of reduction in alcohol abuse (DiClemente & Hughes, 1991; Heather, Rollnick, & Bell, 1993). As Peele (1998) pointed out, Project MATCH did not actually match individuals with treatments, but rather conducted multivariate analyses on outcomes across three treatment modalities as predicted by individual variables (Miller & Rollnick, 1991). Although the results indicated that all of the treatments were similarly effective, they did not affect clients differentially. This does not rule out the possibility that matching treatments at the individual level by stage of motivational readiness would not prove to be a superior approach. This is suggested by the ancillary finding that successful clients used the same processes of change regardless of treatment assignment (DiClemente, Morell, Carbonari, & Velasquez, 1997). Similarly, motivational readiness was found to be a significant predictor among outpatients, but not among those in aftercare, suggesting that motivational readiness may be an influential factor, especially among drinkers who score lower on measures of alcohol dependence. These results indicate that matching

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treatment messages to individual characteristics has important potential for providing insights into alcohol problem prevention research. This approach, however, would be tested best in randomized and controlled efficacy trials.

Unfortunately, Project MATCH was not set up to test this hypothesis explicitly. Future research should recruit samples proactively, so that precontemplators are not excluded. A sample recruited in this manner representing drinkers in all stages of motivational preparedness would mirror the actual alcohol population and provide more generalizability to the results. Action oriented programs, such as CBT and Twelve-Step Facilitation (TSF) have not been effective in recruiting early stage people, whereas proactive recruitment rates for studies tailoring on motivational readiness have faired quite well in this respect (e.g., Prochaska, DiClemente, & Norcross, 1992; Prochaska et al., 1993; Velicer et al., 1998). The data for Project MATCH indicate that MET should be a superior treatment for early stage people due to its tailoring to motivational readiness, while TSF and CBT might be more effective for later stage people due to their action orientation and intensity of sessions. Future studies should include matching on individual characteristics, such as stage, and a long enough period of follow-up to detect effects of movement through stages of motivational readiness. Also, intermediate outcomes such as stage transitions, changes in self-efficacy, and other predictors of treatment success should be included to assess treatment effects, especially prior to 12 months post follow-up.

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I believe Project MATCH tells us more about the alcoholism and addiction treatment industry than it does about treatment effectiveness. It does this indirectly through the deficiencies in its design and the way outcomes are interpreted.

The first deficiency is the lack of a control group. MATCH gives us no information whatsoever on whether *any* of the treatment conditions are more effective than natural history or placebo treatment. This is a serious failing. It is now *routine* to perform alcohol studies without control groups, despite historical evidence of the importance of subjecting any form of treatment to a clinical trial. Alcoholism is considered by MATCH investigators to be so serious that it would have been unethical not to offer all subjects treatment. I believe this untrue given the lack of previous trials.

It would be feasible to run only 10% of subjects in the control condition, so that 90% of subjects would have still received immediate treatment. The control condition in studies of psychotherapy is usually a wait list whereby the subject is offered therapy after the trial has finished. Even the 10% in the

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control condition would still receive treatment if they wished--the sole penalty would be having to wait. This might be considered unethical, but only if one has evidence that *at least* one of the treatment conditions was definitely effective. There is such a shortage of controlled studies that in my opinion this view is wrong.

Estimates of the number of sufferers from alcohol problems are estimated to be in the millions in the United States alone. The 1,700 subjects used in MATCH are only a handful of these individuals. By failing to provide a controlled study, the interests of these millions have been compromised badly. So important is the need for controlled studies that I consider it unethical *not* to use a control condition in MATCH, and to use MATCH to claim a demonstration of effectiveness for treatments when it does not provide it. Claims are made that MATCH demonstrates that Alcoholics Anonymous (AA) is effective. AA was *not a treatment condition* in MATCH. What was studied was Twelve-Step Facilitation (TSF), which is not the same thing. MATCH might show some indirect support for AA but not the direct support claimed.

It is claimed that MATCH shows TSF to be more effective than the other conditions. However, there was no statistically significant difference between the three conditions in overall performance. Given the strong statistical power of the study, if any difference did exist it was very likely to be found, unless its effect size was very small and of no practical significance.

Two interactions claimed are that outpatients in the TSF condition were more likely to be completely abstinent in the following year than those in the other conditions, and that those with low psychiatric severity who had TSF had more abstinent days than those who had Cognitive-Behavioral Therapy (CBT). However, 64 interactions were tested, which means that if the usual 5% significance level is employed, on average 3 such interactions would be found by sheer chance.

All treatments apparently performed at levels way above that seen in clinical practice. The explanation offered is that MATCH's treatment was of a particularly high quality--above that found in the field. However, there were several prognosticators of recovery that may have led to greater success rates. For example, individuals with coexisting drug problems were excluded, as were those with insecure housing.

The Motivational Enhancement Therapy (MET) condition provided just *four* sessions, and on average, clients attended only three. Could superior quality of MET *really* explain the greater success rate? In the other conditions, clients were offered 12 sessions. The improved quality would have to effect all conditions equally, although not equally intensive. Is that likely?

CBT critics of TSF suggest that it includes components that are completely contradictory to the central tenets of CBT. These are primarily: Belief that one is powerless over alcohol (Step 1), Surrender to God/Higher Power (Step 3), and Moral Inventory (Steps 4, 8, and 10). These contradict the objectives of CBT which emphasize personal self-efficacy, internal locus of control, and avoidance of negative self-assessments.

TSF supporters may claim the contradiction is illusory and the two approaches can be combined, but they certainly *appear* contradictory to someone new to them. It is hard to see how *both* these approaches could be *equally* effective. The more the quality of treatment improves, the *greater* one would expect the disparity of the more effective over the less effective to be. Yet one sees very high quality treatment of both kinds producing the same effectiveness. (The success rate is not so high that a ceiling effect is likely.)

Many TSF patients attended AA. TSF is *intended* as an introduction to AA; TSF clients likely heard the same thing in AA they heard in their TSF sessions. Other clients heard something completely different, and in CBT, apparently contradictory. Are they as likely to benefit from AA attendance as much as those in the TSF condition? Isn't it more likely that hearing the 12-Step program in AA is likely to *undermine* their therapy, if it has any effect at all? If the non-TSF clients had attended a treatment-neutral support group (such as Secular Organizations for Sobriety: Save Our Selves [SOS]) or a CBT-friendly support group (such as S.M.A.R.T. Recovery), they might have performed even better. Since no attempt was made to test this, we cannot know.

The simplest explanation for the high success rates is the improved patient prognosticators alone. Since clients were randomly assigned across all groups, these are the *only* variables that are likely to affect each condition equally.

In some ways, any two conditions act as a kind of placebo for the third. The equal effectiveness is possibly suggestive that *none* of the treatments would outperform control. The remarkable uniformity of performance of alcohol treatments found previously by Hester and Miller already hints at this, and MATCH is consistent with their findings.

People assume that AA is effective because many thousands of people attribute recovery to it. Forgotten is the placebo effect and the self-selection principle. People who go to AA choose to go. These are more likely to be motivated to get well. Those more motivated are more likely to get well anyway. One can show an association between AA attendance and recovery--showing causality is more difficult. The association could be through a third factor (such as motivation) or there may even be some causality in the reverse direction--people actively drinking feel may they have to stop in order to attend a meeting.

Hester and Miller found better outcomes when patients *chose* their type of treatment. This was not examined in Project MATCH. Patients are more likely to comply with a therapy

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they have chosen themselves. They are likely to choose in accordance with their existing beliefs, and both compliance and behavioral change are more likely to occur. MATCH could have randomly assigned only half the clients, the others allowed to choose their treatment condition. Failing that, the patients could still have been asked their preference--and correlating with attendance and outcome. If treatments are equally effective, the one preferred is where patients most attend. People might prefer MET because it only "required" four sessions--others might think that CBT or TSF gave them three times as much value (this is more significant when clients are paying for treatment). Some people preferred to sit in jail rather than comply with court orders to attend AA. This suggests that the 12-Steps are definitively aversive to some people. There is good reason to believe that patients will have treatment preferences and may benefit from being granted that wish. It is important to know if this is true and find out what the levels of preference are.

MATCH would have been greatly improved by including a controlled drinking program. Someone in a controlled drinking program may choose not to drink at all anyway. In various studies, when offered a choice, approximately 55% to 85% of patients choose abstinence anyway. It's possible that a controlled drinking program might even prove better on abstinence criteria, or on non-drinking days, as well as reduced severity of actual drinking.

MATCH is a flawed study. So what? The "so what" is the reason those flaws are there. I believe an apparently sincere attempt to provide hard evidence of use to the treatment of alcoholism left out components vital to that purpose. Not for ethical reasons or poor science, but because the researchers were actually afraid of what might be found: (1) Abstinence-based alcohol treatment may have little effectiveness over natural history, and less than placebo treatment with social facilitation (such as support group SOS); (2) The benefits of AA are from social support, rather the 12-Steps, and it is only effective for a small proportion of self-selecting individuals; (3) Offering patients the *choice* of controlled drinking would improve recovery rates.

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Finalist B.Sc. Psychology
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Bravo Peter--you have nailed us! The Emperor indeed is naked. The politics of this field have conspired to make fools of us all! And don't think that managed care doesn't know it!!! Oh how we all long for an honest dialogue on this score. You do credit to the field of psychology. Finish your studies and join the fray.

Steven J. Levy, Ph.D.

Peter, you make a lot of assumptions--most of which are incorrect. For example, Project MATCH didn't "presume" effectiveness--the treatments were selected on several bases, only one of which was that there was good evidence of efficacy for that treatment (this was the primary reason for including the CBT condition--that there was already extensive research evidence of its efficacy). Perhaps you should re-read the two major MATCH reports--the initial one in the *Journal of Studies on Alcohol*, as well as the one recently published in *Addiction*.

Also, participants in MATCH were most certainly not presumed to be passive recipients of treatment, nor "objectified" as you imply. Instead, on the basis of extensive literature reviews conducted prior to the final designing of the MATCH studies, certain restrictions were imposed (i.e., no moderate drinking goals, regular follow-up assessments, no encouragement of folks in the Cognitive-Behavioral Therapy [CBT] or Motivational Enhancement Therapy [MET] conditions to attend Alcoholics Anonymous [AA], etc.). Nonetheless, if you read the reports carefully you will see that participants did, in fact, act very much as their own agents. So, some did resume drinking, but moderately. Some in the CBT and MET conditions did attend AA meetings (although fewer than in the Twelve-Step Facilitation [TSF] condition, etc.).

I think before you level criticisms, you should be thoroughly familiar with what the MATCH researchers actually did!

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Withholding treatment in a controlled trial is not unethical when the patients have given informed consent that included consent to possible inclusion in a control group. It is done all the time. I can not only imagine a human subjects committee approving placebos for schizophrenics but have been involved in conducting such studies in the past.

Studies which compare a new treatment to a standard of care which has already been proven effective are a useful (though less desirable) alternative to the use of placebo controls. The problem with applying this procedure to studies such as Project MATCH is that no treatment for alcoholism has had its effectiveness demonstrated to the satisfaction of skeptical researchers like myself. There is no known effective treatment to compare the others to; only treatments of unknown value and dubious theoretical basis.

The best case for a proven therapy would have to be for cognitive-behavioral treatment, but the evidence for it is not

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strong enough to convince many of the most outspoken "doubters" in the field.

While I argued often with some of the Project MATCH investigators for the inclusion of a control group, it is important to remember that they never presented Project MATCH as a test of the hypothesis that treatment works. This was never one of the aims of the study. The question of comparative effectiveness of the three treatments was, I believe, a secondary hypothesis. The purpose of Project MATCH was, as reflected in its name, to test the matching hypothesis--that some types of patients do better in one type of treatment than another. This hypothesis virtually took for granted that treatment works, an assumption which was also at the root of objections to placebo controls. There is no ethical issue raised by withholding an ineffective treatment. It is unfortunate that this assumption was made, since we would know a great deal more today if MATCH had included controls, but it was implicitly made, and the National Institute on Alcohol Abuse and Alcoholism review process accepted it that way.

David F. Duncan, Dr.P.H., C.A.S.

Liese (continued from page 17)

effect outcome? Or even more relevant to the original goals of the study, did certain therapist *talents* interact with certain patient characteristics to predict outcome?

I hope that my comments and questions spark further interest and discussion among Division 50 members. Again I sincerely seek answers to the questions listed earlier: "What is psychotherapy talent? Where does it come from? And what can we do to help therapists that don't have it?"

Before closing, I want to congratulate our newly elected Division 50 officers: ***Tom Horvath*** (President-elect), ***Greg Smith*** (Secretary-Treasurer), and ***Kim Fromme*** (Member-At-Large). All three have worked hard for the Division and I am quite sure that they will continue to serve well as Division 50 officers.

And one final note: This issue of *TAN* contains information about the upcoming APA convention in San Francisco. It is important to note that the schedule of events in this issue (pp. 14-15) does not contain all events offered as part of the *Miniconvention on Alcohol and Addiction Research*. Be sure to consult all three sources (the official APA program, the miniconvention brochure, and *TAN*) as you plan your time at the convention. I hope to see many of you in San Francisco!

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Announcements

Boston Postdoctoral Fellowship
Clinical Addiction Research

The Boston University Medical School and Boston VA Medical Center and Outpatient Clinic are recruiting a psychologist for a two-year postdoctoral position to start in September, 1998 or before. Applicant will work collaboratively on several funded research projects concerned with the development of new treatments for alcohol and drug disorders. Applicant should have clinical experience in the field of addictive behaviors, strong research skills, and an interest in working on multi-site research trials funded by NIAAA and NIDA. Applicants must have an APA accredited Ph.D. in clinical psychology and must have completed an APA-accredited predoctoral clinical internship. Stipend is approximately $32,000 for 12 months with benefits. Applications will be accepted until the position is filled.

Please send letter of interest, vita, and three letters of recommendation to:

Joseph S. LoCastro, Ph.D., Associate Chief
Psychology Service (116B)
Boston VA Medical Center
150 South Huntington Avenue
Boston, MA 02130
FAX: (617) 278-4408

e-mail: locastro.joseph@boston.va.gov

Boston University is an Equal Opportunity/Affirmative Action Employer.

Call for Nominations

Psychology of Addictive Behaviors

APA's Division on Addictions (Division 50) is soliciting nominations for Editor of the *Psychology of Addictive Behaviors*. This journal invites contributions on psychological aspects of all addictive behaviors, including alcohol and other drug use and abuse/dependence, eating disorders, smoking and nicotine addiction, and other compulsive behaviors.

Candidates must be members of APA and the Division, and should be available to start receiving manuscripts in the middle of fall 1998. Note that the Division 50 Board encourages more participation by underrepresented groups in the publication process and would particularly welcome such nominees. To nominate a candidate (including self-nominations) send a supporting statement of one page or less, along with a current curriculum vita. Submit nominations to:

Robert A. Zucker, Chair
Search Committee: *Psychology of Addictive Behaviors*
University of Michigan Alcohol Research Center
400 East Eisenhower Parkway, Suite 2A
Ann Arbor, MI 48108-3318

Other members of the Search Committee are Sandra A. Brown, Kenneth E. Leonard, Jerome J. Platt, and Jalie A. Tucker. First review of nominations began June 1, l998.

Announcements (con't)

Call for Nominations
Fellows of Division 50

The Fellows and Awards Committee extends an invitation to those wishing to nominate candidates for new Fellow status in Division 50. Self-nominations are also welcome. In addition, those members who are already Fellows in other Divisions who wish to be considered as Fellows in Division 50 should also contact the committee. Correspondence and requests for applications and forms should be addressed to the chair:

James L. Sorensen, Ph.D.
UCSF General Hospital Dept. of Psychiatry, Ward 21
1001 Potrero Avenue
San Francisco, CA 94110
Phone: (415) 206-3969

The deadline for receipt of completed applications is **December 15, 1998**, for consideration by the APA Board at the 1997 meeting. Applications received after December 15 will be deferred for consideration until the 1999-00 cycle.

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. To become a Division 50 Member or Affiliate, contact:

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NIAAA Offers Free Bulletin
Alcohol Alert

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) periodically publishes the *Alcohol Alert*, a brief bulletin that summarizes research findings for health care workers and other professionals.

Alcohol Alert No. 41: Alcohol and Sleep explores

- The disruptive effects of alcohol consumption on sleep patterns
- Breathing disorders during sleep
- The role of sleep disturbances in relapse among abstinent alcoholics

For more details, see http://silk.nih.gov/silk/niaaa1/publication/aa41.htm. To learn more about NIAAA visit: http://www.niaaa.nih.gov/.

To order single copies of any *Alcohol Alert* or to place yourself on the *free* mailing list, fill out the on-line order form: http://silk.nih.gov/silk/niaaa1/publication/alalerts.htm#online_request.

Bulk quantities of this publication are available at no charge by writing to: NIAAA Publication Distribution Center, P.O. Box 10686, Rockville, MD 20849-0686.

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