The Addictions Newsletter

Spring 2007 The American Psychological Association, Division 50 Volume 14, No. 1

Contents

President's Column

You Answered (and Asked)

Kim Fromme

In my first column titled "Division 50 Wants You!" I addressed possible reasons for the relatively low participation of members in Division 50 activities. Several of you responded with offers of your service, while others posed questions about members' opportunities to become more involved. In response to those requests, I would like to describe the activities of the various Division 50 committees here and provide brief examples of recent reports for which Division 50 has provided response.

Kim Fromme

Division 50 has six standing committees (Membership, Fellows and Awards, Nominations and Elections, Education and Training, Bylaws, and Science Advisory) and three ad hoc committees (Finance, Advocacy, and Evidence-Based Practices). The standing committees are derived from our bylaws, whereas the President and Board form the ad hoc committees in response to recognized needs in the division.

The *Membership Committee* (Chair: Keith Morgen; Co-Chair Michael Madson) serves to foster the development of member and student resources and engage members and students in division activities (e.g., leadership, convention, publications). Current projects of the membership committee include: (a) organizing student and early career professional (ECP) focused convention programming; (b) developing student and ECP-specific resources, (c) enhancing member communication, and (d) broadening our membership ranks to include masters-level addictions counselors and professionals.

The *Fellows and Awards Committee* (Chair: Kathleen Carroll) coordinates and provides documentation for Division 50 Fellow nominations. After gathering nomination materials, the Committee seeks endorsement by the Division 50 Board and then sends approved Fellow nominees on to the APA Council for final vote. The Committee also coordinates nominations for a number of annual Division 50 awards, including Distinguished Contributions by early career and senior members (see "Call for 2007 Award Nominations" in this issue).

The *Nominations and Elections Committee* (Chair: Ron Kadden) solicits nominations for the Division 50 offices to be filled each year, tallies the nominations, and makes periodic announcements on the Division 50 listserv of those who have received nominations and whether they have enough endorsement (2.5% of membership) to be declared candidates. The list of nominees is submitted to the Division 50 Board for ratification and then to APA for printing the ballots. Votes in the actual election are tallied by APA and sent to the Chair, who informs the division President and publishes the results in *TAN*.

The *Education and Training Committee* (ETC; Co-Chairs: Chris Martin and Cynthia Glidden-Tracey) works to optimize

(Continued on page 2)

President's Column

(Continued from page 1)

communication and collaboration between the Division 50 membership, APA Education Directorate and other psychology education organizations. In particular, the ETC delineates and implements the roles of Division 50 in predoctoral training, postdoctoral continuing education, certification and licensure for psychologists regarding interests and specializations in addictions treatment.

The *Bylaws Committee* is in need of revitalization. This committee serves to maintain the policies and procedures of Division 50 and helps to ensure that we are in compliance with the bylaws and regulations of APA. The Board is especially interested in having an active Bylaws Committee that provides "institutional memory" for our Division—thereby helping to avoid the potential of reinventing the wheel with each new President and Board. Volunteers for this committee are welcome!

The *Science Advisory Committee* (Chair: Mark Wood) is designed to enhance the visibility, quality, and relevance of scientific activities within Division 50. Activities include: (a) responding to science-related initiatives, task forces, and position papers generated by the APA Science Directorate and other entities; (b) strengthening existing relationships with other science-based addictions organizations, such as the Research Society on Alcoholism and the College of Problems on Drug Dependence; and (c) working with Division 50 leadership to provide educational forums regarding the conduct of research and translational work as it might be applied within the Division.

The *Finance Committee* (Chair: Marsha Bates) facilitates the Division's goals by regularly reviewing the status of division finances and making recommendations to the Board regarding investments and expenditures. The committee provides plans to maximize the value of current assets through long-term investments and to balance potential future gains with expenditures intended to encourage and maintain member involvement and benefit, such as support of special divisional events at the annual convention.

The *Public Policy and Advocacy Committee* (Chair: Brad Olson; Federal Advocacy Coordinator: Rebecca Kayo) strengthens the ability of the division and its members to effect positive policy changes through frequent communication with APA and efforts to educate and support members in effective advocacy practices within the division. Specifically, the committee targets new initiatives, monitors those policies already in place, and generally increases our members' awareness of addiction-related policy issues.

The *Committee on Evidence-Based Practice (EBP) in Addiction* (Chair: Nancy Piotrowski, Co-Chair: Harry Wexler) currently serves four primary functions for the division: (a) review of document on EBPs and related topics for providing feedback, public comments, etc., as needed; (b) proactive monitoring of issues related to EBPs in addiction; (c) proactive communication on EBPs in addiction for the division, framed mostly as development of symposia on EBPs for the annual convention, posting to the listserv, and developing articles on EBPs for *TAN*; (d) developing other projects related to the first three purposes as needed.

In addition, as part of their ongoing activities, Division 50 committees (and members who are invited based of their particular expertise) provide commentary and recommendations for a variety of reports. For example, Nancy Piotrowski and Brad Olson recently spearheaded a Division 50 response to the National Drug Control Strategy document (White House, February 2006). In response to our comments, Division 50 was invited to send a representative to a stakeholders meeting at the Office of National Drug Control Policy (October 24, 2006), and Brad Olson represented us at this meeting. Also, the Education and Training Committee recently responded to an APA Board of Educational Affairs report of the *Task Force on Quality Assurance of Education and Training for Recognized Proficiencies of Professional Psychology*. Following a briefing to the Board, the committee prepared a response to the report, which was forwarded to APA.

The activities of Division 50 are varied, dynamic, and offer many opportunities for you to utilize your talents and abilities to further the agenda of practice, research, and public policy in the addictions. Most of the work is handled via email and periodic telephone contacts, with activities and reports discussed at the annual convention. I hope you will continue to find time in your busy professional schedules to help enrich our division.

Call for Awards Nominations

Division 50 (Addictions) seeks nominations for its 2007 awards, which will be announced at APA's 2007 Annual Convention. Awards for 2007 include: (a) Distinguished Scientific Early Career Contributions, (b) Distinguished Scientific Contributions, and (c) Distinguished Career Contributions to Education and Training, and (d) Outstanding Contributions to Advancing the Understanding of Addictions. Information on award qualifications and nominations can be found on Division 50's web site at http://www.apa.org/about/division/div50.html. The deadline for receipt of all award nominations and relevant materials is May 1, 2007.

Nominations and related materials (CV and detailed letter describing how the nominee meets the criteria for the award) should be sent to the Fellows and Awards Committee at the following address: Fellows and Awards Committee, c/o Kathleen M. Carroll, Chair, Yale University School of Medicine, Division of Substance Abuse, 950 Campbell Avenue (151D), West Haven CT 06516.

For further information, please contact Kathleen Carroll at kathleen.carroll@yale.edu

Editor's Corner

Editorial Ethics in Action

Nancy A. Haug

During the preparation for this issue, my editorial assistant and I were working on an original article submitted by a member. I was initially excited about the piece, when suddenly the writing style and content changed dramatically towards the end of the article. Superscript characters and a paragraph in a different font also raised our suspicions. To our dismay, a quick internet search revealed sources from which entire sentences and paragraphs were lifted intact. With regret, I informed the author that the submission was rejected on the grounds of plagiarism. The author was taken aback and claimed ignorance of citation standards. While this issue ultimately ended in understanding, I chose to devote my column to restating the gravity of this incident. As a scientific community, unauthorized use of copyrighted material jeopardizes our institutional integrity. During this transition time my *TAN* Editorial successor, Liz D'Amico, and I would like to remind future contributors that it is your responsibility—whether you are a clinician or researcher—to be informed and familiar with the APA guidelines for citations and referencing. The *Publication Manual of the American Psychological Association* is an informative place to start. In addition, the February, 2002 *Monitor on Psychology* (Vol. 33, No. 2) has several excellent articles on plagiarism and the Internet. For example, Siri Carpenter discusses the notion of "inadvertent plagiarism" or "cryptomnesia." Bridget Murray states that plagiarism rates are rising in university settings, and she offers ways to give students more guidance.

I read an article recently about college students caught plagiarizing from Wikipedia (an online encyclopedia) when several mentioned the same incorrect information in a paper. Now that reference sources are widely available online, there is an even higher risk of taking short-cuts in our writing. It is important to be as vigilant in our writing as we are with our clients. Clearly, with *TAN*, there is a need to strike a balance as we have a limited amount of space in which to publish original articles. You need not reference every single mention of a certain topic; the most seminal or current papers will usually suffice. If you have questions while working on your piece, please feel free to contact us at *TAN*.Editor@gmail.com. Although we are not a peer-reviewed journal, *TAN* is a national publication with a readership of over 1200 members. We carefully read through and consider each submission and its potential interest to our readership. I see *TAN* as a forum for members to express their ideas, communicate with the addictions community, and share research findings. We do not want contributors to be intimidated by this process or feel the need to bring in outside material to come across as more scientific. In fact, there need not be any references if you are submitting, for example, a discussion paper, case study or other practice-oriented experience—as long as it is your own work.

That said, we have fabulous original articles as well as our regularly featured columns and reports. Although I predicted Spring *TAN* was going to be a "light" issue, we wound up with more submissions than we were able to publish. I believe this is an exciting time for our Division 50 newsletter. During the past 3 years, this division has put *TAN* back on the map. Interestingly, *TAN*'s growth seems to parallel my own process as I have also experienced many personal and professional changes during this time. I am grateful for the editorship opportunity, and I will comment on my experience in Summer *TAN* 2007, which will be my last issue as Editor. The due date for this issue is ***May 18, 2007***, and I will send reminders to the listserv. Thank you for your contributions—whether they make it into *TAN* or not—it is significant that so many of you are considering *TAN* as an outlet for your work.

TAN POLL

We are conducting a poll on the Division 50 *TAN* web page in response to feedback from our readers regarding mailed versus electronic distribution of *TAN*: <http://www.apa.org/divisions/div50/newsletter.htm>. Please take the time to participate, as your input is important in shaping the future of *TAN*.

APA Council Report: Winter 2007

Jalie A. Tucker
Division 50 Council Representative

APA's governing body, the Council of Representatives, convened on February 15-18 in Washington, D.C. for its annual Winter meeting and was chaired by incoming APA President Sharon Brehm. I returned to the Council after a 3-year hiatus during which Sandra A. Brown skillfully represented Division 50 and added another contribution to her longstanding service to the division. Sandy, we thank you. I was joined at the meeting by Division 50 Fellows and new Council members Linda C. Sobell, representing Division 12 *Society of Clinical Psychology*, and Kenneth J. Sher, representing Division 28 *Psychopharmacology and Substance Abuse*. The presence of the addiction community continues to grow at APA.

The agenda for the meeting had several task reports and resolutions presented to Council for approval as APA policy:

- Task Force Report on the Sexualization of Girls. The task force reviewed published research on the content and effects of media, advertising campaigns, and merchandising of products aimed at girls. The report calls on parents, school officials, and all health professionals to be alert for the potential negative impact of sexualization on girls and young women. Text and tips on "What Parents Can Do" are available at: http://www.apa.org/pi/wpo/sexualization.html

(Continued on page 4)

Council Report

(Continued from page 3)

- Task Force Report on Military Deployment Services for Youth, Families & Service Members. The task force examined research on the effects of military deployments on service members and their families, barriers to receiving mental health care, and availability and effectiveness of current programs. More than 30% of all soldiers met the criteria for a mental disorder, but less than half of those affected sought help. The report offers recommendations to improve the delivery of mental health services to deployed personnel, those returning from a combat zone, and military families. Text available at: http://www.apa.org/releases/MilitaryDeploymentTaskForceReport.pdf

- Resolution Rejecting Intelligent Design as Scientific and Reaffirming Support for Evolutionary Theory. Submitted by the APA Committee on Animal Research and Ethics (CARE), this resolution reaffirms earlier APA resolutions and joins other scholarly organizations, including the American Association for the Advancement of Science, American Astronomical Society, American Society of Agronomy, Federation of American Societies of Experimental Biology, and the National Association of Biology Teachers, in opposing the teaching of Intelligent Design as a scientific theory. Check http://www.apa.org/releases/ for website links (unavailable as of 2/26/07).

As these agenda items illustrate, for better or worse APA is increasingly in the public eye and concerned with its media presence, including on its website. Rhea Farberman continues to serve as Executive Director of Public and Member Communications, and Tony Habash was recently hired as APA's Chief Information Officer after serving in that role for AARP. Habash will lead the Association's Information Technology strategy and operations, including all core business systems development and use of technology to provide member services. To that end, the APA website is now undergoing a major overhaul.

In other action, Council reviewed and approved a Board of Directors proposal for the establishment of a strategic planning process for the Association. Although the APA Policy and Planning Board has a mandate to prepare a review of the structure and functions of the Association every five years, the process is not ongoing on an annual basis. APA Chief Executive Officer Norman B. Anderson spoke persuasively about the need for a process that can be revised frequently and tied to the annual budget. Happily, the APA budget, real estate, and other financial holdings are in sound shape this year under the continuing masterful direction of APA Chief Financial Officer Charles L. "Jack" McKay. Let me give you a sense of the esteem in which Jack is held by ending with a Haiku composed by Paul L. Craig, current Vice-Chair of the APA Finance Committee, as recited during the Council Plenary Session when Paul declared his candidacy for APA Treasurer:

Grow strong, APA
Cornucopia of wealth
Thanks – to Jack McKay

An Update on NQF from the Committee on Evidence-Based Practices in Addiction

Nancy A. Piotrowski
Chair, Division 50 Committee on Evidence Based Practice in Addictions

The National Quality Forum Substance Use Disorders Project (NQF-SUDP)* is identifying practices to improve substance use treatment and assist in setting a foundation for establishing performance measures. Seven general areas of practice focus are screenings, brief interventions, comprehensive prescriptions for all services a client might need, psychosocial interventions, pharmacotherapy, treatment engagement and retention strategies, and coordinated longer term monitoring and management. Over 300 stakeholder organizations are members in the effort. The Committee has monitored the project and submitted comments on documents made available for review. In January and February of this year, a draft set of recommendations were available for comment. The Committee and Board worked hard to supply a thorough and thoughtful set of comments. These comments are available for review on the NQF site, as well as those submitted by other organizations choosing to provide reviews. We hope to have contributed useful adjustments to the recommendations and invite division members to examine the overall project and watch it for future developments.

We expect to circulate requests for information to you in the coming months regarding our ongoing collaboration with Division 56 (Trauma Psychology) to expand the informational resources available to practitioners and trainers on specific needs arising from the combination of addiction and trauma. Please watch your email and future issues of *TAN* for more information on this effort.

Finally, we will have a symposium at the annual convention in San Francisco. The presentation focus is on "Practical Challenges Integrating Evidence-Based Practices into Addiction Treatment Programs," and will feature work by Joan Zweben, Harry Wexler, Michael Levy, and Greg Brigham. Harold Perl and Dan Kivlahan will serve as discussants, and we will hold a Q & A session with the audience. This Friday morning symposium is in consideration for CE credit, and we hope you will attend.

As always, if any of this is of interest, please send an email to napiotrowski@yahoo.com. Many opportunities to assist with ongoing and new projects exist, and we would enjoy learning about your interests.

*see http://www.qualityforum.org/projects/ongoing/sud.asp

Visit the "City by the Bay" this Summer: 2007 APA Convention in San Francisco, CA

Clayton Neighbors and Tammy Chung, 2007 APA Convention Program Co-Chairs

The 2007 APA convention will be held in beautiful San Francisco, California, August 17–20. We would like to thank all of you who submitted program proposals. As a result of the large number of high quality submissions, we had to be very selective in choosing which symposia submissions to accept for this year's conference. The net result is that we will have an extremely strong program.

This year's program features events of broad interest to Division 50 members: clinicians, researchers, students, and early career investigators. Division sponsored symposia and poster presentations cover a broad range of addictive behaviors including problematic use of alcohol, marijuana, nicotine, and other drugs, as well as disorders involving gambling, eating, and sexual behavior.

City view photographed by TAN Editor

Division 50 is sponsoring or co-sponsoring 17 symposia representing basic and applied research in the addictions. A primary feature of this year's programming is an emphasis on supporting student and early career members. Several symposia will feature a balance of established and widely-known senior members with promising and talented more junior presenters. These include symposia focusing on college student drinking, prevention and treatment of marijuana abuse, and adolescent decision making. In addition, as in previous years, Division 50 and Division 28, with generous support from NIAAA and NIDA, will co-sponsor an Early Career Poster Session and Social Hour, during which early career members will have the opportunity to present their work. Our Divisions are fortunate to receive substantial federal funding for invited speakers and travel awards from NIAAA and NIDA.

A second feature of this year's program is a concerted effort to collaborate with other divisions on issues central to Division 50 but also relevant to a broader audience of APA members. In collaboration with Division 20 (Adult Development and Aging) and Division 8 (Social Psychology), Division 50 will co-sponsor an interdivisional Cross-Cutting Program focusing on self-regulation. Marsha Bates (past Division 50 president) will represent our division in discussing alcohol, emotion regulation, and heart rate variability. Other collaborative programs sponsored by Division 50 will include a symposium on understanding and treatment of steroid use and abuse (co-sponsored by Division 47: Exercise and Sport Psychology) and a symposium focused on creating an environmental context for sustained alcohol and drug recovery (co-sponsored by Division 27: Community Psychology). Division 50 has again partnered with Division 28 to co-sponsor a number of events and symposia, including: practical challenges in integrating evidence-based practices into addiction treatment programs; harm reduction therapy for substance users: an emerging evidence-based approach; assessing, moderating and modifying implicit cognitive processes in alcohol and drug misuse; HIV/AIDS related research in the NIDA clinical trials network; and women's issues and substance abuse treatment. Division 28 symposia co-sponsored by Division 50 include: HIV and Hepatitis C Virus (HCV) transmission risks in non-injecting drug users; psilocybin and experimental mysticism; and extinction learning application to drug addiction.

In addition to the Early Career Poster Session and Social Hour, Division 50 and Division 28, along with NIAAA and NIDA, are co-sponsoring symposia regarding contemporary perspectives on mechanisms of behavior change in alcohol treatment (NIAAA) and treatment of drug-use disorders in dual-diagnosis patients (NIDA). We will also be co-sponsoring a pre-conference NIDA/NIAAA workshop on grant-writing chaired by Harold Perl from NIDA, which we sincerely believe will be worth traveling to San Francisco a day early.

As our Division 50 invited address, President, Kim Fromme, will discuss "The Challenges of Alcohol and Behavioral Risks Among Emerging Adults."

We would like to thank members of the program committee, whose timely and thoughtful reviews helped us make difficult decisions as we developed this outstanding program. **Committee Members:** Josefina Alvarez, John Baer, Nancy Barnett, Marsha Bates, Clara Bradizza, Tammy Chung, Ronda Dearing, Christine Grella, Jason Kilmer, Christine Lee, Ken Leonard, Melissa Lewis, Matt Martens, Cynthia Mohr, Mark Muraven, Dan Neal, Clayton Neighbors, Jennifer Read, Frederick Rotgers, Jeff Simons, and Denise Walker. **Assistant to the Program Chair:** Nicole Fossos.

Candidates for Division 50 Officers

Nominations for Division Officers closed on January 31. The following slate of candidates was confirmed by the Division 50 Board of Directors:

President-Elect: Tom Brandon and Harry Wexler
Member-at-Large of the Executive Committee: Todd Campbell and John Kelly

The Member-at-Large position to be filled is for the Practice Directorate liaison. This person will serve a liaison function between Division 50, other practice oriented divisions, and APA's Practice Directorate.

The candidates have provided personal statements, which follow. Please review them and cast your ballot when you receive it from APA in mid-April.

Thanks to all who participated in the nominations process, both as candidates and as voters. Division 50 provides a "home" for psychologists working in the addictions field, and represents our interests to APA. As such, it is of considerable value to clinicians and researchers alike. I therefore urge all division members to vote in the upcoming election, and to consider participating in Division affairs.

Ron Kadden
Division 50 Nominations and Elections Chair

Candidates for President-Elect

Thomas H. Brandon, PhD

I am honored to be nominated by my colleagues for the position of president-elect of Division 50, and I am very pleased to accept the nomination. I received my bachelor's from UC-Berkeley, and my master's and doctorate from UW-Madison. Following internship at the Indiana University Medical Center, I was on the faculty at SUNY-Binghamton for 7 years. In 1997, I moved to the University of South Florida, where I am currently Professor of Psychology and Interdisciplinary Oncology. I also direct the Tobacco Research and Intervention Program at the H. Lee Moffitt Cancer Center. My research focuses on understanding and treating tobacco dependence, with an emphasis on relapse-prevention.


Thomas H. Brandon, PhD

I have been an affiliate or member of APA since my undergraduate days, and a member of Division 50 since its inception. My involvement with the division began in 1993 with my appointment to the editorial board of our journal, *Psychology of Addictive Behaviors* (*PAB*). I served as associate editor of *PAB* (1995–1999), and then editor (2000–2004), culminating in the advancement of *PAB* from divisional status to a full-fledged "All-APA" journal. I also served as our program chair for the 1996 APA convention. Division 50 has truly been my "home" at APA, and I feel fortunate to have had the opportunity to contribute.

I would like to share three guiding principles that I would bring to the division:

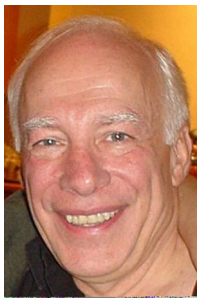
1. Although the addiction field in general has been characterized by an unfortunate chasm between science and practice, I believe that psychology offers the greatest promise for bridging the two, as epitomized by Division 50. APA classifies us as a practice division, but we are in fact a hybrid division, both across and within members. We must continue to take the lead in integrating research and application.

2. The contributions of psychologists to the treatment of addictions have traditionally been under-recognized and under-utilized within and outside psychology, for reasons described by Miller & Brown (1997). Increasing the visibility and stature of addiction psychology was my primary motivation for pushing *PAB* toward all-APA status. It must also remain a focus of Division 50.

3. Finally, for the first two principles to be achieved and maintained, we must nurture future generations of psychologists who share our passion for work in addictions. As it was for me, Division 50 should be a welcoming home for developing psychologists including undergraduates, graduate students, and early career psychologists, and we need to draw upon internal and external resources to assist their professional development.

The success of Division 50 during its relatively short history can be traced to the dedication of its members. It would be a privilege to serve you and help continue the phenomenal development of our division.

Harry K. Wexler, PhD


Harry K. Wexler, PhD

I am honored to accept the Division 50 presidential nomination and eager to serve for a number of reasons. First, I firmly believe that we need to be more proactive in providing relevant activities and services for psychologists

and others in the addictions. For example, the growing interest in evidence-based practices (EBP) and access to relevant information needs to be a Division priority. I have had the good fortune to serve as co-chair to the EBP subcommittee for the last three years and recently worked with colleagues to provide an EBP update in *TAN* (Fall/Winter 2006). Additionally, our EBP committee has recently submitted a proposal to APA for support to develop an interactive EBP website. Throughout my 40-year research career I have been engaged in federally funded work focused on developing and evaluating substance use disorder treatments that has been recognized as influential in the field.

A second major reason I seek your support is my long-standing and active relationship with APA and Division 50. My involvement ranges from being one of the division founders to several terms as a Member-at-Large, regular conference presentations, and advancing interdisciplinary dialogue. In December 2006, I served as the co-chair of an interdisciplinary addiction and criminal justice EBP conference including practitioners, researchers, and policymakers. Conference evaluations showed that the goal to promote and support dialogue (e.g., balanced speaking and listening) among the groups was accomplished. Overall, I believe that my extensive experience as a researcher, clinician, and teacher provides the experience to appreciate multiple perspectives.

The third reason I would like to serve is that I believe my approach to project leadership will be inspiring and enjoyable for those who volunteer to work for the division. Participating should be exciting and valuable for current members and this should be communicated to prospective members, especially in a voluntary organization. As president I plan to bring this kind of energy and commitment to the division.

As such, I believe my experience, effectiveness, and interests will combine to make an inspiring and productive presidential term. I would sincerely appreciate your support and to be able to give my time to the division in these ways.

Candidates for Member-at-Large (Practice Directorate)

Todd C. Campbell, PhD

I am honored to be nominated for Member-at-Large Division 50 and I accept this nomination. I have been involved with APA and Division 50 since 1993. I served on the Evidence-Based Practice Task Force for Division 50 and, over the years, have presented at Division 50 events at APA's annual meeting. From my perspective, the role of the Member-at-Large is to grasp the various constituencies within Division 50 and to represent these constituencies in a fair and balanced manner. Given this perspective, my professional experiences in research, practice, and education are relevant to this position.

Since 1984, I worked in a variety of treatment settings including community mental health centers, hospitals, residential treatment, and private practice. I am a Licensed Psychologist (WI), a Certified Alcohol/Drug Counselor III and Certified Clinical Supervisor II (CCS II) in Wisconsin. Currently, I am an Associate Professor and Chair of the Department of Counseling and Educational Psychology at Marquette University. Our department offers several graduate degrees including an APA-accredited doctoral program in Counseling Psychology. I serve as a Center Scientist for the Center for Addiction and Behavioral Health Research and also for our Integrative Neuroscience Research Center. My primary areas of research and practice are co-occurring disorders, homelessness, stress and relapse prevention, and motivational therapies. I am currently a member of the State of Wisconsin Department of Regulation and Licensing *Substance Abuse Counselors Advisory Committee.* In addition, I served on the Evidence-Based Practice Task Force—Division 50 *Addictions* of the American Psychological Association. I am also a member of the AODA Work group—*Healthiest Wisconsin 2010.* I volunteer with the American Red Cross Disaster Response Mental Health Team. I also founded and direct the 7Cs Clinic—a partnership between our university and a local homeless shelter. This clinic provides mental health-addiction treatment services to people who are homeless and is a training site for graduate students and post-doctoral fellows.

Todd C. Campbell, PhD

I firmly believe that psychologists have unique skill sets and perspectives to address the understanding and treatment of addiction. Division 50 is the collective of these skills and perspectives and I am honored to represent Division 50.

John F. Kelly, PhD

I am very happy to receive the nomination to serve our Division as Member-at-Large for the Practice Directorate. I believe I can bring the necessary level of enthusiasm, dedication, and experience as a scientist, practitioner, consultant, and teacher, in our field to represent our Division membership's broad views and interests to the Board of Directors. Thus, I gladly accept the nomination.

I have been a member of our division for many years and serve as the Division 50 contact within the institutions where I work. I have contributed to our division through direct efforts, such as submitting clinical and policy-relevant articles to *TAN*, and by supporting and participating in division activities at our national convention whenever possible.

I feel very fortunate to have trained and worked over the past 15 years with some of the most talented and creative individuals in our field. These experiences have inspired me and contributed greatly to my own professional growth. I work currently as the Associate Director of the Massachusetts General Hospital (MGH)/Harvard Addiction Research Program and I am an Assistant Professor in Psychiatry at Harvard Medical School. In addition to conducting clinical research, I teach students, interns, and residents about addiction, and provide direct clinical service and consultation to a broad array of patients and families with substance use disorders and other addictive behaviors. I am the recipient of two grant awards from the National Institute of Alcohol Abuse and Alcoholism (NIAAA). I also serve as a scientific reviewer for the NIAAA and as an Associate Editor for the Journal of Substance Abuse Treatment (JSAT), which keeps me at the cutting edge of policy and practice-relevant findings in our field. This mix of activities keeps me sensitized to the day to day struggles of patients suffering from addiction, the broader issues affecting clinical programs, and keenly aware of the need for science-based policy and approaches to improve the efficiency and effectiveness of our clinical efforts. I value the opportunity to bring my experience and commitment to serve our division and I ask for your vote to enable me to do so. Thank you for your consideration!

John E. Kelly, PhD

Student and Trainee Perspectives

Making the Most of Clinical Supervision

Amee B. Patel and Alicia Wendler
Graduate Student Representatives

An experience common to many students and trainees is that of clinical supervision. Regardless of whether we are seeking our bachelor's, master's, or doctoral degree or whether we plan to have a career in counseling, academia, research, or policy, most of us have had supervised clinical experiences. Moreover, psychology interns and postdocs are required to obtain many hours of supervised clinical experience. In this issue of *TAN*, we decided to address supervision, as it is an area about which we receive virtually no formal education or direction. As well, we share some thoughts about supervision specifically in addictions.

As therapists-in-training, our experience with supervision is both objective and subjective. As with academic courses, there is information to be learned in a teacher-student modality; however, there is a unique element of apprenticeship in the supervisor-supervisee relationship. It is through this process of apprenticeship and "hands-on" training that students develop abilities in active listening, diagnosis and treatment planning, decision-making, and ethical and practical boundaries. The ability to conceptualize cases through the use of a specific theoretical orientation is also a major component of the supervision hour. Perhaps most importantly, the trusted supervisor helps the trainee gain self-efficacy in their abilities as a therapist.

The development of a quality supervisory relationship depends on both the supervisor and supervisee. As students, we expect the supervisor to guide us in a nonjudgmental, noncompetitive manner. We expect supervisors to be supportive, accessible, reliable, and willing to help us grow as individuals. But what can we, as students, do to ensure a quality relationship?

1. **Be open to feedback.** We know; we know. Everyone tells us to be open to feedback and learn to take constructive criticism, but it can sometimes be difficult to have your performance critiqued. Keep in mind that supervisors have the responsibility of making certain that we adequately understand and can execute specific techniques, despite the fact that good therapy can take many forms.

2. **Don't let fears about your own competency prevent you from seeking opportunities.** As students, we are expected to not know how to do therapy and to need training. This is the reason we are in school and in supervision.

3. **Even if it is not required, try to use a video or audio tape.** It is uncomfortable to hear your own voice or, worse (at least to us!), to watch yourself. But some of the most effective supervision comes from evaluating and discussing both the large and small moments in a session.

4. **The one thing that you don't want to talk about in supervision is the one thing you *have* to talk about.** Even more discomfort! We have all made mistakes and are afraid or unwilling to bring them up; however, avoiding discussion of the mistake often leads to it happening again.

5. **It is okay to disagree with your supervisor.** It can be tricky to balance this with #1, but your perspectives are important. We each bring something unique to the table and not saying something may prevent you from providing the best care to your client. If it seems like you and your supervisor are not a good match, it is also fine to request a new supervisor or an additional supervisor.

Finding supervisors who specialize in addiction treatment may present special challenges for trainees. Among doctoral students, a common problem is that supervision can only be given from a licensed psychologist. As many addiction treatment certifications and licensures can be obtained at the associate's, bachelor's or master's level, there may simply be a limited number of placements or experiences for the doctoral student. One way to get experience in this scenario is to have two supervisors, one who specializes in addictions and the other who has the degree requirement. Great places to gain experience with an addicted population include community mental health centers, state hospitals, and Veterans Administration hospitals.

An issue specific to addiction treatment is the controversy about whether the counselor must be in recovery themselves or not. Students and supervisors may find themselves on opposite sides of this issue. It is important for students to try to be sympathetic to and try to compromise with the other side; however, having opposing views should not prevent you from receiving good supervision. Students who find themselves in this position should try to focus the supervision on providing the best care for the client and using collective opinions to create a sensitive and theoretically-sound treatment plan.

In addition to making the most of your supervision experiences, another monumental training task that may arise is *providing* clinical supervision to your peers. Relatively little attention is paid to the process of becoming an effective supervisor; beginning supervisors are expected to simply learn "on the job." Based on our own experiences as supervisors of fellow student trainees, new supervisors usually attempt to emulate the qualities of their own favorite supervisors, keeping in mind what it was about that environment that enabled us to become better clinicians. It

is also useful to take advantage of organized courses, symposia, or workshops on supervision or asking your supervisors for specific literature and research that was helpful for them. Licensed psychologists who supervise are actually required to take 6 hours of continuing education credit on supervision and these courses are widely available to trainees at all levels. Finally, not enough can be stated about the importance of receiving supervision of supervision.

Before we conclude this article, we wish to provide special congratulations to our colleagues who recently matched for predoctoral internships. You survived internship interviewing season and hopefully all of you landed the internship of your choice. Some of the information provided in this article may prove useful as you find yourselves in several new supervisory relationships in the coming months.

Federal Update

Special Issue of *The Prison Journal* Highlights NIDA's Criminal Justice Drug Abuse Studies

For the first time, *The Prison Journal* will highlight the Criminal Justice Drug Abuse Treatment Studies (CJ-DATS), a cooperative research effort funded by the National Institute on Drug Abuse (NIDA), a component of the NIH. This special issue of *The Prison Journal*, edited by Harry K. Wexler, Michael Prendergast and Gerald Melnick, is the first collection of articles to provide preliminary findings from a number of the CJ-DATS studies focusing on substance abuse for offenders. Each of the projects described are part of an effort to improve the assessment and treatment of drug-abusing offenders who must negotiate the difficult transition process from institutional to community life.

NIDA created the CJ-DATS national research network in 2002, in partnership with researchers, criminal justice professionals, and drug abuse treatment practitioners. These studies are concerned with drug-involved offenders (juveniles and adults) who have received drug treatment while incarcerated or who are referred to community treatment services as a condition of their release.

"While we know drug abuse treatment works for offenders and ex-offenders, we do not yet know which interventions work best. These studies help us to understand how to provide better drug treatment services for criminal justice offenders to alter their drug use and criminal behavior," said Nora D. Volkow, NIDA Director.

One of the highlighted studies focuses on screening for co-occurring mental disorders and substance abuse, given the high prevalence of such disorders in offenders. A brief instrument to identify offenders likely to have mental health problems could be an important tool for correctional health care administrators, allowing them to more accurately determine who should get comprehensive mental health assessments. The data reported here describes a pilot test that resulted in the development of a six-item screener for mental disorder and a three-item screener for severe mental disorder.

Two of the studies address interventions to reduce HIV and hepatitis infections. Rates of HIV in prison populations are 8 to 10 times higher than those in the general population. These higher rates are largely attributed to risky drug use and sexual behaviors prior to incarceration. One study describes the development of separate gender-and race/ethnically-sensitive DVDs designed to help individuals avoid behaviors that increase the risk of HIV infection, particularly during the period of risk immediately following release to parole. Another study describes findings from a series of focus groups used to inform the development of a gender-specific HIV intervention for female offenders. The authors used those findings, along with principles from the relational model of women's psychosocial development, to develop an intervention to help women change their thinking patterns and make healthier decisions about drug use and sexual behavior.

The connection between drug use and crime is well known. The number of adults involved in the criminal justice system has soared to 6.9 million, and 68% of jail inmates report regular drug use. According to the National Institute of Justice, drug use is involved in 50% of violent crimes and 60-80 percent of cases of child abuse and neglect. Drug abuse treatment is one of the most effective means of helping such individuals avoid a return to the criminal justice system. Treatment that begins in prison and continues in the community after release reduces drug use and criminal behavior, and research also indicates that continuing treatment can sustain these gains.

"NIDA has provided ongoing support for research on prison and reentry programming for drug abusers, and that has led to an increased use of evidence-based interventions throughout the country," said senior principal investigator Harry K. Wexler of National Development and Research Institutes, Inc. "This is especially important because of the increases of substance abusing populations in prisons over the past decade, longer sentences for drug-related crimes, as well as a general decrease in community social services."

The Prison Journal features studies, ideas, and discussions of adult and juvenile confinement, treatment interventions, and alternative sanctions, and explores broad themes of punishment and correctional intervention, and advances theory, research, policy and practice. The journal also enhances the knowledge of correctional-systems practitioners and scholars by providing descriptive and evaluative accounts of innovative programs and policies, state-of the-art surveys and reviews, and legal and historical analysis. Distinguished experts discuss emerging trends, innovations and developments in the rapidly changing world of corrections and alternative sentencing.

For more information about CJ-DATS and NIDA, go to: www.cjdats.org and www.drugabuse.gov

Report from the Committee for the Advancement of Professional Psychology (CAPP)

Frederick Rotgers
Division 50 Observer to CAPP

A lot has happened with CAPP since my last report in *TAN*. I want to first thank Ray Hanbury who ably filled in for me at a CAPP meeting last year. As many of you know, Division 50's influence with CAPP has grown dramatically over the last year. In November, I was elected Chair of the CAPP Integration Workgroup (IG), the committee that serves as the direct conduit to CAPP from the constituencies that comprise the APA Practice Organization (organizations with at least 50% of members paying the APA Practice Assessment). My term as Chair is two years. The IG is an important advisory group to CAPP, and is a way for you to make your voice heard in Washington by both the APA and through the Practice Directorate's activities.

The last CAPP and IG meetings were held February 2–3, 2007. At that meeting, the reports of the APA Practice Organization staff to CAPP and to the IG detailed significant strides that the Practice Organization has made in advancing the practice agenda. Russ Newman, the Director of the Practice Organization, also provided valuable insight into the extreme complexity of much of what the Practice Organization is doing on Capitol Hill. In this column, I will briefly cover some of the highlights of this last meeting, describe some of the important issues that CAPP and the APA Practice Organization continue to address, and point out how I think Division 50 has had an impact.

Mental Health and Substance Abuse Parity

After many years of effort, there are strong parity bills in both the U.S. House of Representatives and the Senate. This past year, APA has finally talked directly to the major opponents of parity (employers and insurance carriers) in an effort to overcome objections to full parity for both mental health and substance abuse treatment. Those efforts appear to be paying off! Both of the parity bills currently moving through Congress provide for *full* parity for mental health and substance abuse treatment under all insurance coverage provided in the private sector to companies with more than 50 employees. The number of Americans who will be covered by this bill is 113 million. A major aspect of both bills in the Congress is that they override existing state parity laws to the extent that those laws failed to provide a comparable level of parity to the Federal law. This is a major step forward. While I have no hard evidence to support this, I believe that the inclusion of substance abuse in APA's parity-focused efforts resulted, at least in part, from Division 50, bringing this issue to the forefront via the IG and CAPP. Your APA advocates on Capitol Hill are optimistic that the parity bills will both pass. While there are still some differences between the House and Senate versions of the bills to be resolved in committee, it seems likely that a major parity bill will be sent to the President this year for his signature.

Medicare Reimbursement

Medicare providers are already aware of the cuts in reimbursement that are automatically scheduled each year and that can happen as a result of revisions to how the billing codes are used. This year an automatic 5% cut was defeated through the efforts of the APA Practice Organization. However, an additional 9% cut has been implemented. This cut came about because of an attempt by the Centers for Medicare and Medicaid Services (CMS; the agency that oversees Medicare billing and reimbursement regulations) to open up additional avenues for physicians to bill using what are called Evaluation and Management (E&M) codes. The goal was to encourage physicians to spend more time interacting with patients. CMS increased reimbursement for E&M codes. Unfortunately, this resulted in an across-the-board negative impact on reimbursement for all non-physician providers, as the E&M codes are only available to physicians. The law requires that shifts in reimbursement practices be budget neutral, that is, that money paid out in one area must be compensated by reduced payments in another. Hence, the 9% increase physicians received for E&M codes became a decrease in reimbursement for non-physicians who cannot use those codes.

At the IG meeting, Russ Newman provided a fascinating look into the process that APA must go through in order to overturn the 9% cut in reimbursement that resulted from this CMS action. APA has often been able to turn to Congress in similar situations to override CMS decisions. In this case, however, the law prevents Congress from acting until CMS has actually refused to redress the grievances brought by psychologists and other non-physician Medicare Providers. CMS has not yet refused to address this issue, but it is clearly not moving quickly. Russ asked for patience on the part of Practice Organization members. APA is working diligently on this problem, and it is hoped that any settlement would be retroactive to January 1, 2007 when the 9% cut in reimbursement took effect.

The cuts in Medicare reimbursement have a significant impact on Division 50 members who treat Medicare clients. The Practice Organization would like to hear from you about how the cuts have affected your practice. *Have you decided to leave Medicare? Have you reduced the number of Medicare clients you accept into your practice?* If you or your colleagues were negatively affected by these cuts, please contact me with details so I can pass them on to the Practice Organization staff working on this issue.

Pay for Performance

One aspect of the growing movement called consumer driven healthcare is the notion of pay for performance (P4P). That is, clinicians are reimbursed by insurance carriers according to a formula that factors in not only the actual provision of treatment to patients, but any of a variety of aspects of how that treatment is delivered and what outcomes are achieved. Under P4P, at least a portion of reimbursement is contingent upon the clinician's meeting certain performance criteria (eg. seeing the patient for a specified number of visits, a high degree of patient adherence to treatment procedures, whether or not the clini-

cian could document abstinence, etc.) The American Medical Association has already accepted, in principle, some form of P4P and is working with the insurance industry to establish P4P criteria and guidelines for medical treatments and services. P4P is likely on the horizon for psychologists, as well. We have all encountered insurance companies who ask us to verify that a client is attending AA or NA as a part of certifying additional sessions with that client. That practice is only a small step away from P4P.

Needless to say, not all physicians are happy with the idea of P4P, and it clearly presents many of the same potentials for abuse that have begun to surface in other aspects of practice regulation such as mandating the use of particular empirically-supported treatments for clients carrying specific diagnoses. In a recent survey of physicians, when asked how they would respond if an insurance company withheld reimbursement for non-adherent patients, 25% indicated that they would discharge such patients from their practices to avoid penalties to their bottom line!

So what does this mean for psychologists? P4P represents both a potential set of difficulties, as well as an opportunity for psychologists. The potential difficulties come in the form of uncertainty as to how criteria for P4P will be established and applied to psychological treatment services. The potential opportunity is already here—in the form of increased need on the part of physicians treating patients covered by P4P insurance to access the expertise of psychologists. This is all a very new and growing issue.

The work of the IG and CAPP continues. How can you help? Contact me or the Division 50 Advocacy Committee about issues that arise in your state or locality that pertain to practice. The only way we can bring such issues to APA is if you tell us about them. Feel free to contact me by phone at 215-871-6457 or e-mail: fredro@pcom.edu.

Information from the 2007 Division Leadership Conference

Nancy A. Piotrowski
Division 50 President-Elect

The Division Leadership Conference (DLC) is an annual event hosted by the Committee of Division–APA Relations (CODAPAR). The event for this year was from January 19–21 in Washington, DC. Division President-Elects and other leadership attended. A chief focus of the meeting is to orient President-Elects to what lies ahead in their presidential year. More generally, the meeting helps attendees identify resources within APA, develop leadership skills and strategies, cultivate interdivisional collaborations, foster long-range planning within their division, and participate effectively at an organizational level in APA.

Three highlights were addresses provided by the current APA President, the President-Elect, and CEO Norman Anderson. President Sharon Stephens Brehm discussed her presidential initiatives. These included a focus on integrative health care issues for an aging population, math and science education enhancement, and issues of importance for Institutional Review Boards in psychological science. The overall thrust of these initiatives was that each had the potential to affect policy and provided psychologists with good opportunities to have an impact locally and nationally. President-Elect Alan E. Kazdin presented on his developing interests for the coming year, underscoring his desire to help divisions work on their goals. He joined with CEO Anderson in suggesting that communications issues would be an important priority for coming years, such as working to improve the APA website.

The meeting also featured discussion on the issue of membership. A general trend noted was that our APA organization as a whole is getting older. With this trend come life transitions to retirement and a changing of the guard with respect to leadership. The implication is that it is vital for us all to bring in new members to keep the organization as a whole and our divisions vibrant. Another implication is that it is important that divisions stay informed about what their members need, want, and would like to see. This is where you come in! Take some time to talk to your students and colleagues about the organization as a whole and about Division 50 in particular. We welcome new members and want to cultivate and encourage new psychologists in the field of addiction. It also is important for you to let the division leadership know how we may best serve you and the field. We are very much interested in your ideas and goals for the future – so please do not hesitate to communicate with us. We are also happy to take any concerns you have to APA more generally.

In sum, the DLC event was a very productive experience. The meeting was also a wonderful opportunity to informally network with the leadership of other divisions. I heartily encourage future division President-Elects to participate in this event when the opportunity presents.

Division 50 Listserv

The Division 50 listserv is now web-based and members of the listserv can manage their own subscription by going to: http://listserv.uwm.edu/mailman/listinfo/apadiv50-forum

You will need to enter your email address, name, and create a password. Vince Adesso will verify new subscribers.

To send messages to the forum, subscribers just use the same address as always: apadiv50-forum@uwm.edu

Developing an Effective Treatment for Prescription Opioid Abuse

Stacey C. Sigmon, Kelly E. Dunn, and Todd L. McKerchar
University of Vermont

The non-medical use of prescription opioids is increasing at an alarming rate (SAMSHA, 2003). Abuse of prescription opioids, such as oxycodone (e.g., OxyContin®, Percodan®), hydrocodone (e.g., Vicodin®), and hydromorphone (Dilaudid®), increased by more than 400% from 1990 to 2000 (SAMSHA, 2003). The Monitoring the Future survey reports a similar increase among adolescents as well, with past 30-day non-medical use of prescription opioids increasing by 173% among 12th graders since 1991 (Johnston, O'Malley, & Bachman, 2002). This increase in prescription opioid abuse is also evident in data from the Drug Abuse Warning Network, which reported a 408% increase in emergency department visits with specific mentions of prescription opioids between 1994 and 2002 (DAWN, 2003). Not surprisingly, the rise in prescription opioid abuse is associated with increases in the number of individuals seeking treatment for this problem. A recent report from the Treatment Episode Data Set indicates the number of yearly admissions for primary prescription opioid abuse increased by 350% between 1992 and 2002 (TEDS, 2004).

Characterizing the Prescription Opioid Abuser

Despite this escalation in prescription opioid abuse, the demographic and drug use characteristics of prescription opioid abusers remain largely unknown. A recent position paper from the College of Problems on Drug Dependence highlighted the urgent need for both an improved understanding of prescription opioid abusers as well as the development of effective treatments for this form of drug abuse (Zacny et al., 2003). One emerging theme is that primary prescription opioid abusers may have a less severe dependence on opioids than primary heroin users, and thus, they may exhibit several characteristics suggesting a more favorable treatment outcome. First, prescription opioid abusers often report using a less severe route of drug administration than primary heroin abusers (Brands, Blake, Sproule, Gourlay, & Busto, 2004; Sigmon, 2006; TEDS, 2004). Second, some early data suggests that prescription opioid abusers may use smaller amounts and/or less frequently than primary heroin abusers (Sigmon, 2006; TEDS, 2004). Third, prescription opioid users may initiate opioid use at an older age than primary heroin users (Brands et al., 2004; TEDS, 2004). Finally, prescription opioid users report less other-drug-use compared to heroin users (Brands et al., 2004; TEDS, 2004).

Developing an Effective Intervention for Prescription Opioid Abuse

We have recently commenced a large-scale, NIDA-funded study aimed at developing an efficacious treatment for prescription opioid abuse. We believe that for a treatment to have efficacy and broad acceptability in this population, a combination of behavioral and pharmacological therapies is needed. The Community Reinforcement Approach (CRA) serves as our behavioral therapy. CRA is an efficacious treatment for drug abuse that was originally developed as a treatment for alcohol dependence (Hunt & Azrin, 1973) and subsequently demonstrated to be effective with cocaine-dependent (Higgins et al., 2003) and opioid-dependent (Abbott, Weller, Delaney, & Moore, 1998; Bickel et al., 1997) outpatients.

In terms of the pharmacotherapy, we are not convinced that the existing information automatically supports the need for long-term use of agonist therapy with prescription opioid abusers. As was noted above, the extant data on characteristics of prescription opioid abusers suggest they may be less severely dependent than primary heroin abusers and have a number of characteristics that would predict better treatment response. Towards this end, we believe that an initial effort at a relatively brief opioid detoxification in combination with antagonist and behavioral therapies may be a more prudent course to pursue, at least initially. Many prescription opioid abusers are likely to shun agonist maintenance programs due to the stigma associated with them (Zacny et al., 2003), and maintenance treatments are also highly restricted by federal regulation (SAMHSA, 2001) such that patients with less severe or brief opioid histories like those noted above may be ineligible for treatment. Finally, opioid maintenance programs can be difficult for patients to access, especially those residing in rural areas (O'Connor et al., 1997).

Considering these factors, the pharmacological therapies in the current project include an opioid detoxification followed by a regimen of antagonist therapy. The partial opioid agonist, buprenorphine, is used as the detoxification agent. Buprenorphine has a pharmacological profile that makes it an excellent candidate for opioid detoxification with this population (see Walsh & Eissenberg, 2003 for recent review). Naltrexone is a long-acting competitive opioid antagonist that, when taken regularly in sufficient doses, can block the reinforcing effects of opioids and markedly diminish or eliminate opioid self-administration and subjective effects (Gonzalez & Brogden, 1988; Martin, Jasinski, & Mansky, 1973). Detoxification and naltrexone can be particularly effective with individuals who are more socially stable or motivated (e.g., Ling & Wesson, 1984; Washton, Gold, & Pottash, 1984). Given that prescription opioid abusers tend to have less severe opioid abuse histories, use a less risky route of administration, and may be more socially stable that heroin abusers, it is reasonable to explore whether this approach maybe efficacious with them as well.

Summary

The overall aim of this project is to systematically and empirically develop a manualized, efficacious treatment for prescription opioid abuse. Our current randomized clinical trial seeks to determine an appropriate duration of opioid detoxification. This first step is critical to developing an effective medication-assisted detoxification protocol that prevents the poor retention and high relapse rates that can plague detoxification programs (Amass et al., 1994; Bickel et al., 1988). Perhaps extended or maintenance therapies will be necessary, but that should be determined empirically rather than assumed. Following completion of this study,

we will conduct a second randomized clinical trial to identify the duration of subsequent naltrexone therapy most effective in sustaining opioid abstinence. Results from these studies will contribute important new scientific and clinical knowledge critical to the development of effective interventions for prescription opioid abuse.

References

Abbott, P. J., Weller, S. B., Delaney, H. D., & Moore, B. A. (1998). Community reinforcement approach in the treatment of opiate addicts. *American Journal of Drug and Alcohol Abuse, 24*, 17–30.

Amass, L., Bickel, W. K., Higgins, S. T., & Hughes, J. R. (1994). A preliminary investigation of outcome following gradual rapid buprenorphine detoxification. *Journal of Addictive Diseases, 13*, 35–47.

Bickel, W. K., Amass, L., Higgins, S. T., Badger, G. J., & Esch, R. A. (1997). Effects of adding behavioral treatment to opioid detoxification with buprenorphine. *Journal of Consulting and Clinical Psychology, 65,* 803–810.

Bickel, W. K., Stitzer, M. L., Bigelow, G. E., Liebson, I. A., Jasinski, D. R., & Johnson, R. E. (1988). A clinical trial of buprenorphine: Comparison with methadone in the detoxification of heroin addicts. *Clinical Pharmacology and Therapeutics, 43*, 72–78.

Brands, B., Blake, J., Sproule, B., Gourlay, D., & Busto, U. (2004). Prescription opioid abuse in patients presenting for methadone maintenance treatment. *Drug and Alcohol Dependence, 73,* 199–207.

Drug Abuse Warning Network (DAWN). (2003). *Trends in drug-related emergency department visits: 1994–2002 at a glance.* The DAWN Report, November 2003. Rockville, MD: Office of Applied Studies, SAMSHA.

Gonzalez, J. P., & Brogden, R. N. (1988). Naltrexone: A review of the pharmacodynamic and pharmacokinetic properties and therapeutic efficacy in the management of opioid dependence. *Drugs, 35,* 192–213.

Higgins, S. T., Sigmon, S. C., Wong, C. J., Heil, S. H., Badger, G. J., Donham, R., et al. (2003). Community reinforcement therapy for cocaine-dependent outpatients. *Archives of General Psychiatry, 60,* 1043–1052.

Hunt, G. M., & Azrin, N. H. (1973). A community-reinforcement approach to alcoholism. *Behaviour Research and Therapy, 11*, 91–104.

Johnston, L. D., O'Malley, P. M., & Bachman, J. G. (2002). *Monitoring the Future National Results on Adolescent Drug Use: Overview of key findings, 2001* (NIH Publication No. 02-5105). National Institute on Drug Abuse, Bethesda, MD.

Ling, W., & Wesson, D. R. (1984). Naltrexone treatment for addicted health-care professionals: A collaborative private practice experience. *Journal of Clinical Psychiatry, 45*, 46-48.

Martin, W. R., Jasinksi, D. R., & Manksy, P. A. (1973). Naltrexone, an antagonist for the treatment of heroin dependence. *Archives of General Psychiatry, 28*, 784–791.

O'Connor, P. G., Carroll, K. M., Shi, J. M., Schottenfeld, R. S., Kosten, T. R., & Rounsaville, B. J. (1997). Three methods of opioid detoxification in a primary care setting. *Annals of Internal Medicine, 127*, 526–530.

Sigmon, S. C. (2006). Characterizing the emerging population of prescription opioid abusers. *American Journal on Addictions, 15*(3), 208–212.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2001). Federal Register: Opioid Drugs in Maintenance and Detoxification Treatment of Opiate Addiction, Final Rule. *21 CFR Part 29, 142 CFR Part 8.* Department of Health and Human Services, Rockville, MD.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2003). Office of Applied Studies, Results from the 2002 National Survey on Drug Use and Health: National Findings. *NHSDA Series H-22, DHHS Publication No. (SMA) 03–3836*, Rockville, MD

Treatment Episode Data Set (TEDS). (2004). National Admissions to Substance Abuse Treatment Services: 1992-2002. *DASIS Series: S-23, DHHS Publication No. (SMA) 04-3965*, Rockville, MD.

Walsh, S. L., & Eissenberg, T. (2003). The clinical pharmacology of buprenorphine: Extrapolating from the laboratory to the clinic. *Drug and Alcohol Dependence, 72,* S13–S27.

Washton, A. M., Gold, M. S., & Pottash, A. C. (1984). Successful use of naltrexone in addicted physicians and business executives. *Advances in Alcohol and Substance Abuse, 4*, 89–96.

Zacny, J., Bigelow, G., Compton, P., Foley, K., Iguchi, M., & Sannerud, C. (2003). College on Problems of Drug Dependence taskforce on prescription opioid non-medical use and abuse: Position statement. *Drug and Alcohol Dependence, 69,* 215–232.

Routine Screenings: Expanding Psychologists' Role in Preventing Substance Use Disorders

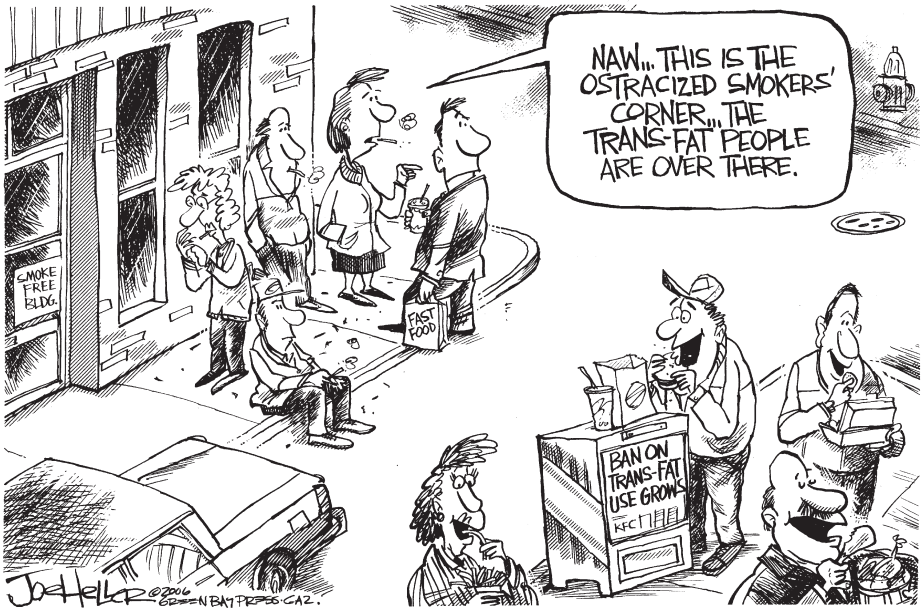
Marilyn Freimuth
Fielding Graduate University

Primary prevention programs for substance-use disorders (SUD), such as grade school courses about the nature and dangers of addictive substances, attempt to head off a problem by addressing the conditions that precipitate it. Secondary prevention strategies are designed to detect disorders before symptoms fulfill diagnostic criteria (U.S. Preventative Services Task Force, 1996). Addiction psychologists' role as providers of tertiary prevention is well recognized. Tertiary prevention focuses on accurate diagnosis and treatment of SUD's with the goal of reducing negative consequences and preventing the emergence of more severe problems.

While a great deal of research has examined the reliability and validity of diagnostic tools and best treatment strategies for the 30% of mental health patients with co-occurring addictive disorders (Kessler et al. 1997), relatively little attention has been given to psychologists' potential contribution to secondary prevention. A primary example of a secondary prevention strategy is routine screening for alcohol use. Routine screening can identify "at risk" populations and/or substance use problems in a preclinical stage. If psychotherapy patients are similar to those who make physician visits—where 50% have one or more signs of alcohol misuse (McQuade et al., 2000), there are ample opportunities to identify substance use problems before they meet diagnostic criteria. Early recognition of SUD's followed by brief interventions has the potential to confine the enormous emotional, interpersonal and financial costs of such problems (Grant et al., 2004).

To effectively provide secondary prevention, health care providers must do routine screenings and/or be able to recognize an emerging SUD amidst the patient's array of presenting symptoms. Research in the medical field reveals that screenings are rare and that even fully developed SUD's frequently are overlooked or misdiagnosed. For example, less than one third of physicians do routine alcohol screens, and 94% of primary care physicians failed to diagnose alcohol abuse in a vignette containing numerous symptoms consistent with this diagnosis (National Center on Addiction and Substance Abuse, 2000).

Relatively little is known about psychologists screening practices and ability to identify the early signs of SUD. In one study (Weisner & Matzger, 2003), 65% of mental health professionals asked their patients about their drinking. This figure is deceptive however. A closer examination revealed that those most likely to be asked had an identified history of addiction. For patients without history of an SUD, the screening rate was closer to the one third level observed with physicians. If mental health providers do not routinely assess for substance-related disorders, then they must be adept at identifying signs of a problem as they emerge in an interview. Among college counselors, who you might expect would be attuned to addiction issues, half of the intake reports failed to mention alcohol problems even though a student's self-reported level of use merited concern (Matthews, Schmid, Conclaves, & Bursley, 1998).



Given the benefits of early identification of substance use problems, how can we understand the relatively low rate of screenings and recognition of such problems? Research designed to better understand why physicians do not screen for or recognize addictions provides some clues that merit research to determine if they apply to psychologists and other mental health providers.

- Mistaken Beliefs: Physicians report not doing screenings because patients will not tell the truth. While true for those in the more advanced stages of alcoholism, many patients with substance use problems do not even know they have a problem and thus, have no reason to lie or distort their drinking level (Substance Abuse and Mental Health Services Administration, 2002). Another belief that may affect screening practices is that compared to other mental health issues, addiction treatment is believed to be less effective. Why do screening if help for the problem is likely to fail? Stereotypes about who is most likely to be addicted and how an addicted person behaves may be another factor that gets in the way of addiction recognition (Freimuth, 2005).

- Self-Disguising Nature of Addictions: Health care providers do not realize that the addictive process can mask its

own identification (Freimuth, 2005). The adverse effects of alcohol use mimic physical disorders such as irritable bowel. Even moderate alcohol use can alter sleep patterns and create lowered mood that will be misdiagnosed as a depressive disorder.

- The Stigma of Alcoholism: Health care providers are uncomfortable asking patients if they have a problem that society at large stigmatizes and finds shameful. Practitioners seem to worry that patients will experience an addiction screening as a questioning their integrity, or it might frighten or anger the patient (The Recovery Institute, 1998; To, 2006).

- Interviews with physicians reveal that they have a difficult time knowing what risky drinking looks like (Thom & Tellez, 1986). While doctors had a clear conception of alcoholism, they felt problematic drinking and alcohol misuse were poorly defined. An understanding of the early signs of potential SUD's is necessary in order to implement secondary prevention strategies and intervene before a diagnosable condition develops. If *DSM-V* moves in the direction of viewing addictions as a continuous rather than dichotomous variable (Saunders & Schuckit, 2006), this should help to facilitate early recognition of problematic substance use.

The medical field is far ahead of the mental health field in trying to improve its providers' secondary prevention skills. It is time that psychology and mental health providers join in this quest to lessen the enormous personal, interpersonal, and emotional costs of addictions by exploring ways to make substance use screenings routine and improving their ability to identify substance problems before severe consequences emerge.

References

Freimuth, M. (2005). *Hidden addictions: Assessment practices for psychotherapists, counselors, and health care providers*. New York: Jason Aronson.

Grant, B. F., Dawson, D. A., Stinson, F. S. Chou, S. P., Dufour, M. C., & Pickering, R. (2004). The 12-month prevalence and trends in *DSM-IV* alcohol abuse and dependence: United States, 1991-1992 and 2001-2002. *Drug and Alcohol Dependence, 74*, 223.

Kessler, R. C., Crum, R. M. Warner, L .A., Nelson, C .B., Schulenberg, J., & Anthony, J.C. (1997). Lifetime co-occurrence of *DSM-III-R* alcohol abuse and dependence with other psychiatric disorders in the National Comorbidity Study. *Archives of General Psychiatry, 54*, 313–321.

Matthews, C. R., Schmid, L. A. Conclaves, A. A., & Bursley, K. H. (1998). Assessing problem drinking in college students: Are counseling centers doing enough? *Journal of College Counseling, 12*, 3–9.

McQuade, W. H., Levy, S. M., Yanek, L. R., Davis, S. W., & Liepman, M. R. (2000) Detecting symptoms of alcohol abuse in primary care settings *Archives of Family Medicine, 9*, 814–821.

National Center on Addiction and Substance Abuse at Columbia University. (2000). *Missed opportunity: National survey of primary care physicians and patients on substance abuse.* New York: Author.

The Recovery Institute (1998). *The road to recovery: A landmark national study on social attitudes toward alcoholism*. San Francisco: Author.

Saunders, J. B., & Schuckit, M. A. (Eds.). (2006). Diagnostic issues in substance use disorders: Refining the research agenda. *Addiction, 101*(Suppl. 1).

Substance Abuse and Mental Health Services Administration. (2002). *Results from the 2001 National Household Survey on Drug Abuse: Volume 1*. Summary of National Findings. Office of Applied Studies, NHSDA Series H-17, DHHS Publication No. SMA02-3758. Rockville, MD: U.S. Department of Health and Human Services.

Thom, B., & Tellez, C. (1985). A difficult business: Detecting and managing alcohol problems in general practice. *British Journal of Addiction, 81,* 405–418.

To, S. E. (2006). Alcoholism and pathways to recovery: New survey of results on views and treatment options. *Medscape General Medicine, 8*. Retrieved January 9, 2007, from http://www.medscape.com/viewarticle/518483

U.S. Preventative Services Task Force. (1996). *Guide to clinical preventative services* (2nd ed.). Baltimore: Williams & Wilkins.

Weisner, C., & Matzger, H. (2003). Missed opportunities in addressing drinking behavior in medical and mental health settings. *Alcoholism: Clinical and Experimental Research, 27,* 1132–1141.

Advocates Alcove

We Need Equality!

Rebecca Kayo
Division 50 Federal Advocacy Coordinator

The APA practice organization and advocacy coordinators across the country continue to work hard for mental health and addiction treatment improvements that will have a direct effect on our profession and our clients. Recent focus and passion have moved us closer to the passage of Mental Health and Addiction Equity health plans. Congressmen Patrick J. Kennedy (D-RI) and Jim Ramstad (R-MN) launched a nationwide campaign with forums in major cities across the country. These forums, along with insightful testimonies, will hopefully add momentum to our pursuit of a comprehensive law to end insurance discrimination against those who need mental health and addiction treatment. Very soon the Congressmen expect to introduce legislation with renewed encouragement from new House Leaders, who promise to bring their bill, the Paul Wellstone Mental Health and Addiction Equity Act, up for a vote. With encouragement from House leaders and now with the inclusion of addiction, along with mental health, there is every reason for Division 50 members and addiction professionals to rise up and rally. We hope that each and every psychologist, mental health professional, will take the time to let your congressperson know you support this bill. In addition, please lend support or attend one of the forums that may be near you. For the latest updates on confirmed hearings and locations please check the Campaign website: www.equitycampaign.net.

A Person-Centered Perspective to Understanding Variation in Alcohol Expectancies Among Teenage Drinkers

Sabrina E. Des Rosiers, Jonathan G. Tubman, and Eric F. Wagner
Florida International University

Current research suggests that adolescents' alcohol and other drug (AOD) use patterns are associated with multiple risk factors (e.g., Flory et al., 2004; Johnson, O'Malley, Bachman, & Schulenberg, 2005). Furthermore, empirical research has documented substantial heterogeneity in multivariate patterns of risk associated with AOD use and related problems among adolescents. The application of person-centered approaches to the analysis of AOD use data is effective for depicting heterogeneity in the levels and co-occurrence of multiple risk factors associated with AOD use problems among adolescents (see von Eye, Bogat, & Rhodes, 2006).

This brief report describes an application of a person-centered analytic strategy (i.e., cluster analysis) to the study of alcohol expectancies in a treatment sample of adolescents. Specifically, the current report provides evidence that the utilization of cluster analysis: (a) facilitates identification of homogeneous subgroups in patterns of alcohol expectancy ratings (i.e. heterogeneity), and (b) highlights the clinical utility of person-centered analytic strategies via documentation of between-group differences in psychosocial adjustment outcomes for an alcohol expectancy typology.

Alcohol Expectancies and Relations with AOD Use and AOD-Related Problems

An expanding body of research supports the position that alcohol expectancies are associated with the initiation and persistence of AOD use and AOD-related problems (Christiansen, Smith, Roehling, & Goldman, 1989; Fromme & D'Amico, 2000; Rohsenow, Colby, Martin, & Monti, 2005). In particular, positive alcohol expectancies have been found to be strong predictors and correlates of maladaptive patterns of AOD use (e.g., Goldman, Darkes, & Del Boca 1999). Furthermore, they act as putative risk factors for AOD use and related outcomes (Walton, Blow, Bingham, & Chermack, 2003). Specifically, variation in endorsement patterns of alcohol expectancies among high-risk and low-risk adolescents may show divergent expectancy trajectories (Smith, Goldman, Greenbaum, & Christiansen, 1995), influencing multivariate patterns of psychosocial adjustment outcomes.

Application of a Person-Centered Approach to the Study of Alcohol Expectancies

Most expectancy research has used traditional variable-centered approaches that provide aggregate-level descriptions of differences in expectancy scores and their relations to AOD use outcomes. However, von Eye et al., (2006) emphasize the use of variable-centered approaches (e.g., regression analysis) to examine complex patterns of risk associated with AOD use do not validly describe meaningful patterns of risk "unique to the individual." Therefore, the description of distinct and meaningful patterns of expectancy endorsements can not be fully captured by comparing mean level differences in specific alcohol expectancy domains. The study of alcohol expectancy endorsement patterns via person-centered analyses accounts for both diversity and variation (i.e., heterogeneity) in expectancy patterns. Such variation may produce differential amenability to treatment among subgroups of adolescents with alcohol or drug use problems (Gil, Wagner & Tubman, 2004).

Alcohol Expectancy Profiles

Our example is drawn from a randomized clinical trial, the Teen Intervention Project (TIP; R01 AA10246; PI: Wagner). Alcohol expectancy profiles defined by adolescents' self-reported scores on the Alcohol Expectancy Questionnaire-Adolescent Version (AEQ-A; Christiansen, Goldman & Inn, 1982) were empirically derived using cluster analysis. High risk drinkers tend to form expectancy concepts related to the positive social and arousing effects of alcohol while lower risk drinkers form concepts that emphasize less positive, more negative and sedating effects of alcohol (e.g., Reich & Goldman, 2005). TIP data confirmed that higher risk expectancy profiles included elevated AEQ-A scores for positive alcohol expectancies of social facilitation, global positive transformation, sexual enhancement, increased arousal and cognitive enhancement. Lower risk alcohol expectancy profiles included lower mean scores for global positive effects, social facilitation and cognitive enhancement expectancies.

Differences in AOD Use and AOD-Related Problems by Alcohol Expectancy Profile

Validation of the alcohol expectancy typology was demonstrated by subgroup differences on specific key psychosocial adjustment variables, AOD use and AOD-related problems (Figure 1). The application of person-centered analyses to alcohol expectancies helped to depict significant within-group differences in alcohol expectancy patterns associated with AOD use in this treatment sample of adolescents. Adolescents reporting more AOD use and AOD-related problems were overrepresented in higher risk expectancy profiles (i.e., *positive sedating*, *high positive sedating*, *positive social, extreme positive arousing and enhancing* subtypes). Furthermore, this methodology has documented that adolescents endorsed alcohol expectancies that included both positive/arousing and negative/sedating characteristics. However, heterogeneity in endorsement patterns of positive arousing expectancies is far more reflective of patterns of risk, and is associated with systematic variations in adjustment outcomes. Consequently, these data add meaningfully to our understanding of relations among alcohol expectancies, AOD use and broader patterns of psychosocial adjustment.

Clinical Implications of Person-Centered Data Analysis Strategies

Isolation of meaningful and distinct homogeneous subgroups helps to identify youth at risk for the development of AOD-related problems (e.g., Bergman & Magnusson, 1997). Differences in psychosocial adjustment by expectancy typology membership provide practice-relevant information useful for AOD use prevention and intervention programs. While the TIP sample consisted of high risk adolescents, alcohol expectancy profiles did not reflect uniform patterns of risk. Alcohol expectancy profiles charac-

terized by endorsement of *extreme positive arousing and enhancing* expectancies were associated with more involvement with AOD use and AOD-related problems, suggesting greater subsequent risk for poor adjustment outcomes. Significant associations between heterogeneous patterns of expectancy endorsements and psychosocial adjustment ratings highlight important sources of within-group variability among adolescents receiving treatment services. The use of person-centered methods not only documented relations between an expectancy typology and group differences in adjustment outcomes, but demonstrated that alcohol expectancies, in addition to being predictors of AOD use behaviors (i.e., from a variable-centered framework) may be amenable to treatment factors that could be addressed to improve the effectiveness of treatment services for adolescents.

ACKNOWLEDGEMENT: Data collection for this report was supported by NIAAA R01 AA10246.

References

Bergman, L. R., & Magnusson, D. (1997). A person-oriented approach in research on developmental psychopathology. *Development and Psychopathology*, *9*, 291–319.

Christiansen, B. A., Goldman, M. S., & Inn, A. (1982). Development of alcohol-related expectancies in adolescents: Separating pharmacological from social-learning influences. *Journal of Consulting and Clinical Psychology*, *50*, 336–344.

Christiansen, B. A., Smith, G. T., Roehling, P. V., & Goldman, M. S. (1989). Using alcohol expectancies to predict adolescent drinking behavior after one year. *Journal of Consulting and Clinical Psychology*, *57*, 93–99.

Flory, K., Lynam, D., Milich, R., Leukefeld, C., & Clayton, R. (2004). Early adolescent through young adult alcohol and marijuana use trajectories: Early predictors, young adult outcomes, and predictive utility. *Development and Psychopathology*, *16*, 93–213.

Fromme, K., & D'Amico, E. J. (2000). Measuring adolescent alcohol outcome expectancies. *Psychology of Addictive Behaviors*, *2*, 206–212.

Gil, A. G., Wagner, E. F, & Tubman, J. G. (2004). Culturally sensitive substance abuse intervention for Hispanic and African American adolescents: empirical examples from the Alcohol Treatment Targeting Adolescents in Need (ATTAIN) Project. *Addiction*, *2*, 140–150.

Goldman, M. S., Darkes, J., & Del Boca, F. K. (1999). Expectancy mediation for Biopsychosocial risk for alcohol use and alcoholism. In I. Kirsh (Ed.), *How expectancies shape experience* (pp. 41–63). Washington, DC: APA Books.

Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2005). *Monitoring the Future national results on adolescent drug use: Overview of key findings, 2004*. (NIH Publication No. 05-5726). Bethesda, MD: National Institute on Drug Abuse.

Reich, R. R., & Goldman, M. S. (2005). Exploring the alcohol expectancy memory network: the utility of free associates. *Psychology of Addictive Behaviors*, *19*, 317–325.

Rohsenow, D. J., Colby, S. M., Martin, R. A., & Monti, P. M. (2005). Nicotine and other substance interaction expectancies questionnaire: relationship of expectancies to substance use. *Addictive Behaviors*, *4*, 629–641.

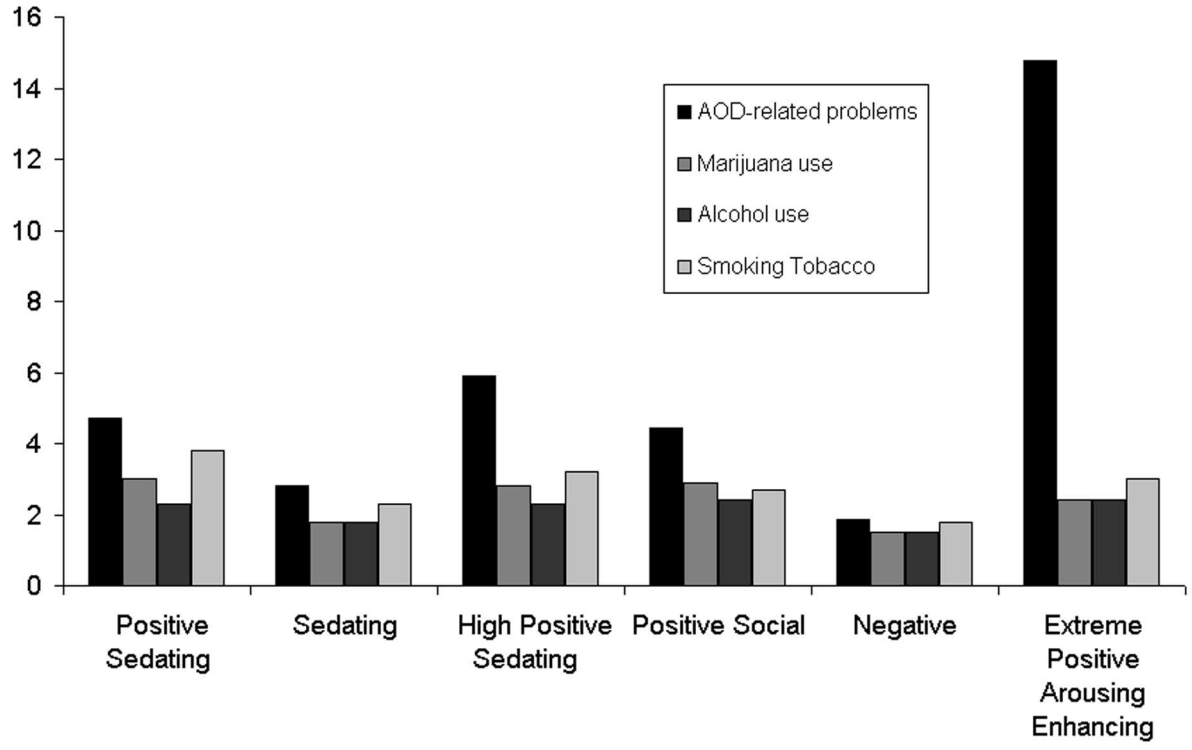
Smith, G. T., Goldman, M. S., Greenbaum P. E., & Christiansen, B. A. (1995). Expectancy for social facilitation from drinking: the divergent paths of high-expectancy and low-expectancy adolescents. *Journal of Abnormal Psychology*, *1*, 32–40.

Stacy, A.L., Newcomb, M.D., & Bentler, P.M. (1991). Cognitive Motivation and Drug Use: A 9-Year Longitudinal Study. *Journal of Abnormal Psychology*, *4*, 502–515.

von Eye, A., Bogat, G. A., & Rhodes, J. E. (2006).Variable-oriented and person-oriented perspectives of analysis: The example of alcohol consumption in adolescence. *Journal of Adolescence*, *6*, 981–1004.

Walton M. A., Blow F. C., Bingham C. R., & Chermack, S. T. (2003). Individual and social/environmental predictors of alcohol and drug use 2 years following substance abuse treatment. *Addictive Behaviors*, *4*, 627–642.

Figure 1. AOD Use and AOD-related Problems by Alcohol Expectancy Profile



Abstracts

Burrow-Sanchez, J. J. & Lundberg, K. J. (2007). Readiness to change in adults waiting for publicly funded substance abuse treatment. ***Addictive Behaviors, 32,*** **199–204.**

The primary objective of this study was to evaluate the factor structure of a modified version of the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) for a sample of indigent adults with alcohol and other drug problems. A community sample of 338 adults on waiting lists for entrance into publicly funded substance abuse treatment completed a 19-item modified version of the SOCRATES. Confirmatory factor analyses were conducted on two structural models of the SOCRATES based on prior literature. The results indicated that a two-factor model of the SOCRATES provided the best fit for the data in this study. Suggestions for future research using a modified version of this measure are discussed.

LaBrie, J. W., Pedersen, E. R., & Tawalbeh, S. (2007). Classifying risky-drinking college students: another look at the two-week drinker-type categorization. ***Journal of Studies on Alcohol and Drugs, 68,*** **86–90.**

OBJECTIVE: The present study examined the effectiveness of the 2-week period currently used in the categorization of heavy episodic drinking among college students. Two-week drinker-type labels included the following: nonbinge drinker, binge drinker, and frequent binge drinker. METHOD: Three samples of college student drinkers (104 volunteers, 283 adjudicated students, and 238 freshmen male students) completed the 3-month Timeline Followback assessment of drinking. Drinking behavior during the last 2 weeks of the month before the study was compared with drinking behavior during the first 2 weeks of the same month to compare behavior and resulting labels during both 2- week periods. RESULTS: Inconsistencies existed in drinker-type labels during the first 2 weeks of the month and the last 2 weeks of the month for all three samples. Between 40% and 50% of participants in the three samples were classified as a different drinker type across the month. Nonbinge drinkers experienced a wide range of alcohol-related problems, and much variation existed among the frequent-binge-drinker label. CONCLUSIONS: The results suggest that the current definition needs to be modified to accurately identify risky-drinking college students. Expanding the assessment window past 2 weeks of behavior, as well as developing different classification schemes, might categorize risky drinkers more accurately.

Stern, S. A, Meredith, L. S., Gholson, J., Gore, P., & D'Amico, E. J. (2007). Project CHAT: A brief motivational substance abuse intervention for teens in primary care. ***Journal of Substance Abuse Treatment, 32,*** **153–165.**

Many adolescents use alcohol and drugs (AOD); however, most do not seek help because of stigma or confidentiality concerns. Providing services in settings that teens frequent may decrease barriers. We examined the feasibility of adapting a brief motivational intervention (MI) for high-risk adolescents (age 13–18) in a primary care (PC) setting by conducting small feedback sessions with adolescents, parents, and clinic staff, and pilot testing the MI with adolescents. Findings from feedback sessions indicated that clinic staff thought teens would not talk about AOD use. In contrast, adolescents reported that they would talk about their AOD use; however, they were afraid of being judged. Parents were also concerned that the PC provider might be judgmental. Feedback from the MI pilot indicated that teens were willing to talk about their AOD use and indicated readiness to change. Findings suggest that providing a brief MI in a PC setting is a viable approach for working with high-risk youth.

Priester, P. E., Speight, S., Vera, E. & Azen, R. (in press). The impact of counselor recovery status similarity on perceptions of attractiveness with members of Alcoholics Anonymous: An exception to the Repulsion Hypothesis. ***Rehabilitation Counseling Bulletin.***

This study explores the impact of counselor alcoholism recovery status on perceptions of recovering alcoholics who are active members of Alcoholic Anonymous. The participants (n=116) were given a description of an analogue counselor and rated this counselor using the Counselor Rating Form-Short. There were three forms of the analogue counselor description: similarly perceived recovering, dissimilarly perceived non-recovering and control. The similarly perceived recovering counselor was viewed more positively than the control. No statistically significant differences between the dissimilarity and control conditions were found. These results are discussed in terms of support for Rosenbaum's Repulsion Hypothesis of interpersonal relationship development.

NOTE: A call for abstract submissions to *TAN* was posted on the Division 50 listserv. The purpose of publishing abstracts in *TAN* is to highlight and share the research of our members. The guidelines for abstract publication are as follows: (a) early career division members (less than 7 years post-doctoral) and graduate students; (b) peer-reviewed articles in press or published in the past year; (c) highly innovative research in areas of addiction where research is lacking; (d) research published in journals other than *Psychology of Addictive Behavior* (since members already receive this journal); and (e) one submission per author. Please send abstract submissions to: TAN.Editor@gmail.com.

Announcements

Call for Nominations: Master Lecturers and Distinguished Scientist Lecturers

The American Psychological Association's (APA) Board of Scientific Affairs (BSA) is soliciting nominations for speakers for the 2008 Master Lecture Program and the 2008 Distinguished Scientist Lecture Program. These annual programs spotlight experts in psychological science and are sponsored by the APA's Science Directorate.

Selected speakers receive an honorarium of $1,000 and reimbursement for travel expenses, up to $1,000. All nominees should be excellent public speakers. BSA will review all nominations at its 2007 spring meeting and begin to contact potential speakers for these programs. Nominations may be for either the Distinguished Lecture Program or the Master Lecture Program (or both).

The **Master Lecture Program**, developed by BSA, supports up to five (5) psychological scientists to speak at the APA Annual Convention. A list of previously selected speakers can be found on-line at http://www.apa.org/science/masterlecturers.html. BSA has organized the lectures into ten core areas that reflect the field. Each year, *five* of these areas are addressed by Master Lecturers. Speakers for the 2008 Convention, to be held in Boston, MA, August 14–17, 2008, will be chosen to have expertise in each of the following areas:

- developmental psychology
- learning, behavior and action
- methodology
- psychopathology
- social and cultural psychology

The **Distinguished Scientist Lecture Program**, developed by BSA, supports up to three (3) psychological scientists to speak at Regional Psychological Association meetings to be held in 2008. Speakers must be actively engaged in research, with expertise in any area. A list of previously selected speakers and their topics can be found on-line at http://www.apa.org/science/distsci-lecturer.html.

Please send in the name of your nominee(s) by e-mail or fax to Suzanne Wandersman, APA Science Directorate, 750 First Street, NE, Washington, DC. 20002-4242 (e-mail: swandersman@apa.org; fax 202-336-5953). **Nominations must be received by February 20, 2007.**

National Alcohol Screening Day

National Alcohol Screening Day is set for April 5, 2007. For those interested in marking the day with community screenings for alcohol problems, screening kits are available for $50. They include 50 AUDIT screening forms; publicity templates (news releases, PSAs etc.); posters; videos; educational materials and giveaways. For $150, local organizers can obtain web-based materials, including screening instruments for unlimited community use. Sponsoring organizations can customize their welcome page and referral message, and generate reports and graphs of screening results, community demographics, and utilization. The kits can be ordered and additional information obtained from program coordinator Liz Sisto at National Alcohol Screening Day, One Washington Street, Suite 304, Wellesley, MA 02481, by phone at (781) 239-0071, Ext.108, or by email at esisto@mentalhealthscreening.org.

Harm Reduction Conference

The Association for Harm Reduction Therapy (AHRT) Presents: Harm Reduction Therapy in the Real World, the 2nd National Harm Reduction Therapy Conference on November 2–4, 2007 at the Philadelphia College of Osteopathic Medicine. Individual workshops by pioneers of harm reduction therapy (HRT) will focus on how to do HRT in real world settings. Speakers will include: Patt Denning, Jeannie Little, G. Alan Marlatt, George Parks, Frederick Rotgers, and Andrew Tatarsky. For further information contact Frederick Rotgers at fredro@pcom.edu

Postdoctoral Position

Postdoctoral Research Fellow in Clinical Psychology—Yale University: Applicants are invited for a postdoctoral position to engage in NIDA-funded studies of the efficacy and neural mechanisms of behavioral and pharmacologic treatments for substance abuse. These studies integrate fMRI measures into clinical trials to investigate brain function pre- and post-treatment. Research is multidisciplinary and employs clinical, neurocognitive, neuroimaging, and genetic components. Candidates should have a PhD in neuroscience, clinical psychology or a related discipline. The annual salary will range from $36,996 to $51,036 per NIH guidelines. For further information contact: Kathleen Carroll, PhD, tel.: 203-937-3486, ext. 7403, fax: 203-937-3472, kathleen.carroll@yale.edu. Yale University is an Equal Opportunity/Affirmative Action Employer.

Anticipated Postdoctoral Opening

Private Practice, specializing in forensic and substance abuse issues. Evaluation and Treatment. Fast paced. Send resume/CV to: Stephen Bloomfield, EdD, Clinical and Forensic Psychology, 3725 DuPont St. Ct S., Jacksonville, FL 32217.

Call for Papers and Op-Eds

The *Journal of Opioid Management* is soliciting papers and op-eds. The next deadline is 4/2/07. The journal comes out six times a year, is peer-reviewed, and is in MEDLINE. We have a distinguished Editorial Board headed by Dr. Robert Enck. *Journal of Opioid Management* addresses all aspects of the use and safe management of opioids. It provides guidance to physicians and healthcare professionals on how to safely prescribe and responsibly manage these drugs. Our website at www.opioidmanagement.com has advice for authors and subscription information.

Division 50 Executive Officers

The Addictions Newsletter
Nancy A. Haug, Editor
Division 50 Central Office
750 First Street, NE
Washington, DC 20002-4242

Please Recycle

First Class Mail
U.S. Postage
PAID
Washington, DC
Permit No. 6348