The Addictions Newsletter

The American Psychological Association, Division 50

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Contents

President's Column

The Promise and Perils of Empirically Supported Treatments

Lisa Najavits

The evidence-based practice committee of Division 50 is currently developing a peer-reviewed list of empirically supported treatments (ESTs) in the addictions for inclusion on the Division 12 website (www.psychology.sunysb.edu/eklonsky-/division12). Division 50 has sponsored panels on the topic of ESTs at the APA convention for five years, headed by Greg Brigham, Harry Wexler and Nancy Piotrowski. I am currently heading this committee, with Greg, Harry and Nancy all serving as co-chairs. We welcome your nominations of ESTs and your feedback on the process (see the notice in this issue).

Lisa Najavits

Such projects lead to a lot of reflection on the role of ESTs in the addiction field. The term "double edged sword" comes to mind—the EST movement encompasses both great promise and perils. It represents a dialogue within the field between the worlds of clinical, research and policy perspectives, and also between our field and outside entities such as government agencies and insurance companies. There are continual balancing acts and tensions between these perspectives and the stakes are high in terms of what clinicians learn, what clients receive, where funding goes and which treatments are ultimately embraced or ignored. This dialogue is now several decades old and although much has been accomplished, there is still a humbling amount to be done. It is also worth remembering the era before ESTs, which relied, more than today, on the cult of personality, word-of-mouth, fads, politics and impressionistic judgments. These have not disappeared, but are tempered by the goal of verifying clinical innovations with rigorous data.

However, the perils of ESTs are also clear. To name a few:

The "funhouse mirror" phenomenon. There are many criteria sets, including the National Registry of Evidence-Based Programs and Practices, the 1998 Chambless and Hollon criteria (which Division 12 requires), the Cochrane Reports, the Institute of Medicine reports and lists by various professional societies such as the Association for Behavioral and Cognitive Therapies and the International Society for Traumatic Stress Studies. Thus, a model may be defined as an EST in one criteria set, yet may not be defined as an EST in another set. The effect can be a confusing experience, especially for stakeholders who are not trained in research methods.

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President's Column

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Once an EST always an EST? In many criteria sets there are a minimum set of standards, but once a model meets those standards it may not get removed, even if subsequent evidence is mixed.

Iatrogenesis. Assessment of iatrogenic effects is not typically part of criteria sets. If the treatment works on average, it may nonetheless have some serious clinical failings as well as successes. The "first do no harm" principle should likely be at the top of any list and the rate and severity of negative outcomes (not just averages) should be part of the picture. The rate of dropouts may also be an important indicator.

EST as marketing strategy. The term "EST" and its cousins, "effective," "efficacious," and "evidence-based" are now widely used and often misused (whether intentionally or not). These terms have no consistent meaning, and thus it is up to reviewers, journal editors, the public and others to determine when the terms are accurate. It is a Tower of Babel and thus vulnerable for marketing goals to overtake science.

Science and "science." Although journal reports typically appear as finely polished works where all went according to plan, the reality is often murkier. Indeed, there are treatment studies in which clients were paid to attend treatments (not just travel reimbursement) or where the experimental treatment was scheduled for a more convenient time of day than the control to promote attendance. Even the best reports typically lack assessment of the amount and types of external treatments clients received outside of the study treatments.

"Apples and oranges." It is easier to attain good results for a treatment that is tested on healthier clients than a population that is chronic, comorbid, complex, or severe. People often look to effect sizes for the amount of change a treatment produces, but unless two treatments are compared in the same study, setting and population, there is usually no way to conclude that one is better than the other. Moreover, lists of ESTs are not set up to identify such "pre-existing characteristics" that might affect outcomes. This is especially relevant in the addictions where challenging clients are the norm.

The price tag. Buying anything is usually a weighing of quality plus cost—not quality alone. With therapies, a public health perspective suggests that a therapy that works well but at high cost may be less useful in some contexts than a therapy that works somewhat less well but at lower cost. Or a therapy that is powerful but applicable to a narrow range of clinicians and clients may be less useful than other treatments. These are quantifiable questions that need to be addressed in the next generation of studies. Moreover, "cost" means the full array of real costs, which are rarely identified in outcome trials (e.g., clinician training and monitoring). This may be especially relevant for addiction settings that have limited resources and clinicians without advanced degrees.

The "little secret." In addiction treatment, and also more broadly, active treatment, comparisons typically find no difference between models (see, for example, Imel, Wampold, Miller & Fleming, 2008). Sometimes this reflects a lack of adequate statistical power, but can also occur in well-powered studies. Thus, a broader framework is likely needed beyond the proverbial horse-race comparison. This does not mean, however, that just therapeutic alliance or nonspecific factors are sufficient. Indeed, active treatments generally outperform treatment-as-usual, suggesting that there is something in well-crafted manuals that really does work.

Beyond the frame. Many of the most important issues related to treatment are beyond the scope of ESTs: resource allocation, workforce issues such as staff turnover, the culture of treatment programs (promoting respect for both clinicians and clients), clinician differences (those conducting the same EST may have very different outcomes), and clinician self-care and empowerment.

A Wish List

In light of some of the challenges of ESTs, below is a wish-list for the future.

- Open access to data from outcome trials to promote transparency
- A redefinition of "EST" to encompass both efficacy and effectiveness
- A uniform list of descriptors to cover when writing outcome articles (comparable to the CONSORT statement; Moher, Schulz, & Altman, 2001); the list would be broadened to include contextual factors such as costs of interventions, client severity, external treatments, etc.
- A way to pair researchers and clinical innovators to encourage their collaboration
- More frequent updating of EST lists
- Greater understanding of how much fidelity is actually needed to attain positive outcomes
- Assessment of interrater reliability on whether particular models meet EST criteria
- A toolkit of resources so that clinicians and programs can more easily collect valid outcome data (a repository of measures they could use, typical study designs, etc.)
- More focus on decision rules to help clinicians evaluate when an EST may be helpful
- Greater exploration of adoption and adaptation—how clinicians make use of models in real-world settings

Continuing the Dialogue

I hope you will engage with Division 50 in its efforts to identify ESTs in the addictions. Our goal is to represent the wide-ranging interests and expertise of our members. We are currently accepting nominations for treatments

and soon will be extending an invitation for peer reviewers. We invite your participation. Please also feel free to email me directly with comments, which will be incorporated into our ongoing work (Lnajavits@hms.harvard.edu). As someone who works in both the research and clinical realms, I greatly value all perspectives in this endeavor.

References

Imel, Z., Wampold, B., Miller, S., & Fleming, R. (2008). Distinctions without a difference: Direct comparisons of psychotherapies for alcohol use disorders. *Psychology of Addictive Behaviors, 22*, 533-543.

Moher D., Schulz K. F., Altman D. G. (2001). The CONSORT statement: Revised recommendations for improving the quality of reports of parallel-group randomized trials. *Annals of Internal Medicine*, *134*, 657-662. ψ

Editor's Corner

Nonstante la pioggia e neve, il TAN *è qui per voi (Despite rain and snow, TAN is here for you)*

Elizabeth J. D'Amico

Well, no matter which coast you call home or even if you live somewhere in the middle, it's been an adventure these past few weeks as we say "*Arriverderci*!" to winter and head into spring. I know I had LOTS of fun pumping the water *out* of my pool so it would not overflow—in the pouring rain, as my children, Seth and Veronica, cheerleaded for me from inside the warm and dry house: *"Go, mom, go!"* Despite the season's record-breaking rain, sleet and snow, members loyally sent in their columns, abstracts, and article submissions. I am happy to report that we have another packed issue.

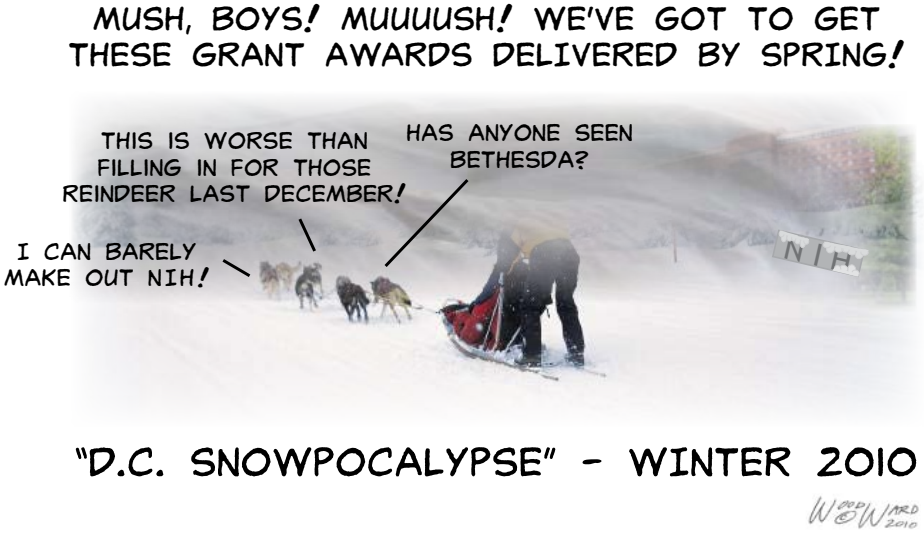
First off, it's that time again. Yes, time to get to know your candidates and cast your vote for President and Member-at-Large. Please take the time to read the candidate statements and think about which Division 50 member will best represent our interests in that particular position. And, as often is the case, there is something for everyone in this issue of *TAN*! We received some very interesting articles that I encourage you to read. John Kelly discusses the effect that terminology may have on how clients are perceived by treatment providers; and Steven Proctor and his colleagues present findings on the importance of screening for substance use disorders in county jail inmates. In the *Bridging the Gap* column, Nancy Piotrowski and Lynda Hemann interview Kathleen Carroll about computer-based training for cognitive behavior therapy—very cutting-edge. Erika Litvin, our student representative, provides an excellent synopsis of the internship process; and Cindi Glidden-Tracey summarizes her recent experience at the 2009 APA leadership conference in Washington, DC. We also have the benefit of Kris Anderson's expertise on the recent health care reform issues that have been taking center stage in Congress.

Last issue, our President, Lisa Najavits, outlined some of the themes she felt were important to move our Division forward, for example, mentorship across the career span and how new technologies can be used to enhance Division 50. In this issue, she provides us with an update on how these themes are progressing.

Thanks again to everyone for your submissions. As always, I enjoy hearing from you. Soon, I will be turning over *TAN* to a new editor. It's hard to believe that this summer's issue will be my last one—my three-year tenure is coming to a close…but more on that in the next issue.

If you would like to submit an idea for a new column, article, abstract, or announcement for the summer edition, please send them to taneditor@rand.org by **Tuesday, June 1, 2010**. I hope to hear from you.

Ciao for now and stay warm! ψ



Update on Presidential Themes

I am delighted to announce an update on the themes described in the Fall/Winter 2009 *TAN*:

1. ***Webinar series***. Our first webinar will be presented by John Kelly of Harvard Medical School on *Detecting and Managing Substance use Problems in Practice: Screening, Brief Intervention, and Referral to Treatment*. It will be free to Division 50 members and will provide continuing education credits for psychologists. Date and details to be announced soon.
2. ***One Hour Mentor***. Forty-one Division 50 members graciously offered to serve as mentors and we are currently accepting sign-ups. Any member can sign up—the goal is mentorship by and across the career span. For more information, email Ty Schepis (schepis@txstate.edu).
3. ***The "Amazing Race" for new members***. This is underway and the prize will be awarded at the APA conference in August. See the Division 50 website, Fall/Winter 2009 *TAN* for details (www.apa.org/divisions/div50/).
4. ***Web repository for Division 50***. The repository is now underway and the Archive Workgroup is starting to upload both current and historical documents onto a password-protected site. Workgroup members are Erin Deneke, Kathy Parks, Amee Patel, Nancy Piotrowski and myself.
5. ***Special interest groups / social networking***. Members Joshua Wexler, Jessica Martin, and Harry Wexler are leading the development of a social networking site for Division 50. More details soon.
6. ***TAN goes green***. As of 1/1/10 *TAN* is now electronic, with paper copies only to those who signed up for that option.
7. ***Increasing membership***. See the "*New Member Spotlight*" article in this issue of *TAN*. Also, encourage your colleagues to join—membership is free this year to new members (past-president Tom Brandon's initiative) and does not require one to join APA.

As always, email me anytime with your ideas and comments (Lnajavits@hms.harvard.edu).

Best wishes, Lisa

Special Issue of the *Journal of Clinical Psychology: In Session*

Andrew Tatarsky and G. Alan Marlatt have co-edited a special issue of the *Journal of Clinical Psychology: In Session* on harm reduction psychotherapy (HRP). This is the first significant coverage of harm reduction psychotherapy in a major psychology journal. This issue explores HRP from many vantage points to give practitioners evidence-based applications of HRP in a variety of clinical settings and with different populations. Below is a list of the articles in this issue:

Tatarsky and Marlatt - State of the art in harm reduction psychotherapy: An emerging treatment for substance misuse

Tatarsky and Kellogg - Integrative harm reduction psychotherapy: A case of substance use, multiple trauma, and suicidality

Rothschild - Partners in treatment: Relational psychoanalysis and harm reduction therapy

Larimer - Brief motivational feedback for college students and adolescents: A harm reduction approach

Denning - Harm reduction therapy with families and friends of people with drug problems

Franskoviak and Little - So glad you came! Harm reduction therapy in community settings

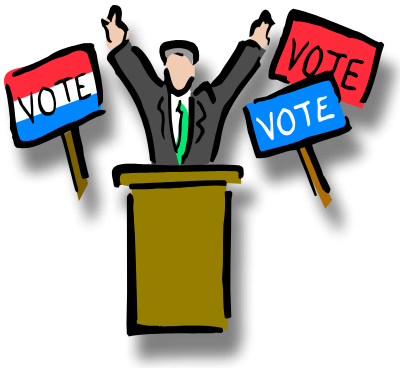
Blume and Lovato - Empowering the disempowered: Harm reduction with racial/ethnic minority clients

Logan and Marlatt - Harm reduction therapy: A practice-friendly review of research

Candidates for Division 50

Announcing Candidates for Division 50 Offices

William Zywiak
Chair, Division 50 Nominations and Elections Committee



This year we have three candidates running for two offices. Warren Bickel is running for President-Elect, and Mark Schenker and John Kelly are running for Member-at-Large (Practice). Collectively, this group of candidates has pushed the field forward with their publications. For instance, Warren Bickel co-authored an interesting chapter with Mark Potenza in 2006 on addiction as a self-organized system in the Miller and Carroll text, *Rethinking Substance Abuse*. Mark Schenker has written a book entitled *A Clinician's Guide to 12-Step Recovery* published in 2009 and John Kelly and Barbara McCrady have written a chapter on 12-Step Facilitation in non-specialty settings for the Galanter and Kaskutas text, *Alcoholics Anonymous and Spirituality in Addiction Recovery*, published in 2008. Please review the statements by all the candidates and cast your ballot in April/May when you receive it in the mail. Lastly, I would like to thank those who emailed me their nominations regarding these three candidates during the past four weeks.

Candidate for President-Elect

Warren Bickel

I am very honored to be nominated for the office of President-Elect of Division 50. Below I briefly review the experiences that I believe prepare me for that role and I discuss my goals if I were elected.

Administrative Experience: Currently, I am the Director of the Center for Addiction Research (CAR) in the College of Medicine and Director of the Center for Tobacco Research at the College of Public Health at the University of Arkansas for Medical Sciences (UAMS). Prior to coming to UAMS, I was at the University of Vermont where I served as Interim-Chair of the Department of Psychiatry for a period of three years. I have been elected President of the College on Problems of Drug Dependence and President of the Division of Psychopharmacology and Substance Abuse of the APA. I have served on NIDA's Council of Scientific Advisors for the past three years. I currently serve on the Drug Abuse Subcommittee in the Center for Drug Evaluation and Research at the Food and Drug Administration. I also collaborated in establishing the first methadone treatment program in the state of Vermont and was the founding Director of that program. I have served a term as Editor-in-Chief of the journal, *Experimental and Clinical Psychopharmacology*.

Research Experience: Over my career I have conducted research on the development of buprenorphine as a treatment for opioid dependence, was instrumental in the initial applications of behavioral economics to drug dependence, adapted numerous procedures from more basic preparation for clinical use with addicted humans and have been involved in the development of novel treatments including the utilization of information technologies to deliver treatment. I have been continuously funded as PI with multiple concurrent NIH grants since 1988, including a MERIT award. I have published over 265 papers and chapters and have co-edited five books.

Goals: During my term, I would like to focus on translational research and practice as a means to facilitate effective interaction of scientists and clinicians, to promote the framing of novel science questions and to assist in the adoption of new research innovations. I would also like to focus on training the next generation of psychologists. In particular, I would support efforts to train students to become the translational researchers and clinicians of tomorrow. I would seek to cooperate with other like-minded divisions to push for our agenda.

(Candidate statements continued on page 6)

Candidates for Member-at-Large—Practice

John F. Kelly

I am delighted to receive and gladly accept the nomination to continue to serve our Division on Addictions as Member-at-Large for the Practice Directorate. I believe I can bring the essential 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.

During the past 15 years I have had the good fortune to have trained and collaborated 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 Center for Addiction Medicine and as the Director of the Addiction Recovery Management Service. I am an Associate Professor of Psychology at Harvard Medical School, where, in addition to conducting clinical research, I teach students, interns and residents about addiction and provide clinical services and consultation to a broad array of patients with addiction problems. I am the recipient of several grant awards from the National Institute on Alcohol Abuse and Alcoholism (NIAAA). I also serve as a scientific reviewer for the NIAAA and Substance Abuse and Mental Health Services Administration (SAMHSA) and as an Associate Editor for *Addiction* and the *Journal of Substance Abuse Treatment*. 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 makes me keenly aware of the need for science-based policy and approaches to improve the efficiency and effectiveness of our clinical efforts. I would value greatly the opportunity to bring my experience and commitment to continue to serve Division 50 and I ask for your vote to enable me to do so. Thank you for your consideration and for your dedication to our field!

Mark Schenker

I am pleased to be considered for Member-at-Large of Division 50 and I respectfully ask for your vote. I'd like to introduce myself.

As a card-carrying member of the 1960s, I came to Clinical Psychology with the idealistic goal of utilizing scientific knowledge to ease human suffering. As an undergraduate, I attended Brandeis University, and sat under prominent instructors like Abe Maslow and Morry Schwartz. Working as a Psych Tech at McLean Hospital in the 1970s, I encountered Yalom's text on Group Therapy and understood the relevance of research in informing clinical practice. I went to graduate school at Temple University and Jay Efran and Tom Shipley were influential mentors during my time there.

My formal education on addictions consisted of one class in a psychopathology survey course. When I got a job in a drug clinic in the 1980s I largely taught myself, aided by patient and generous clients. Early on, I was struck by the absence of training opportunities in this area and took on a small personal goal of helping to train my colleagues in treating the pervasive problem of addiction. My recent book (Schenker, 2009) is a clinical primer on the 12-Step program and was written in the spirit of training others to work with this population.

I currently work at the Caron Foundation where I oversee adult psychological services and supervise psychologists and psychiatric residents. In my private practice, Recovery Options Associates, I take a more eclectic approach, using motivational and transtheoretical perspectives in addition to the 12-Step model. I am guided by research demonstrating the importance of the therapeutic relationship in effecting clinical change.

I feel that Division 50 should reflect the needs of practitioners as well as researchers and that we should balance evidence-based rigor with clinical insight and humanistic values. I see a primary role of the Division as one of raising awareness of the prevalence of addictive disorders and serving as a resource for clinicians of all backgrounds. Division 50 should actively advocate for a healthy level of funding for both clinical and research endeavors. Finally, I'd like to see an integration of the activities and interests of Division 50 into the overall goals and mission of the American Psychological Association. So much of what we have to offer has relevance beyond our Division. ψ

New Member Spotlight: *Justin Enggasser*

Division 50 president, Lisa Najavits, has launched a new feature in *TAN*: the *New Member Spotlight*. The goal is to explore some of the many reasons for joining Division 50. For this issue, Lisa interviewed Justin Enggasser, staff psychologist at the VA Boston Healthcare System, Acting Director of the Substance Abuse Residential Rehabilitation Program (Brockton Division) and Instructor at Harvard Medical School. He received his PhD in 2005 from the Illinois Institute of Technology.

Justin Enggasser

LN: What motivated you to join Division 50?

JE: I have been working primarily in the field of addictions during my early career. I view this as a great way to make further contacts with other psychologists in this area of work, as well as to learn more about the successes and challenges that people experience in other settings.

LN: How did you did hear about Division 50?

JE: There was a recent flier sent to addictions psychologists in the VA. I had heard about Division 50 before but this reminded me of it and led to my joining.

LN: What prompted you to get into the addictions field?

JE: My background was originally in mood and anxiety disorders, but as I gained more clinical experience, it became increasingly clear how often substance use disorders emerged as a comorbid diagnosis. There is a real need for clinicians who can work effectively to provide treatment for people with substance use disorders. I became fascinated with how substances serve so many different functions for people. This specialty also allows me to practice widely as clients with substance use disorders can have a wide range of comorbidities—certainly mood and anxiety disorders, but also psychotic disorders, personality disorders, and so on. This always keeps the work interesting and it feels very rewarding to help these clients.

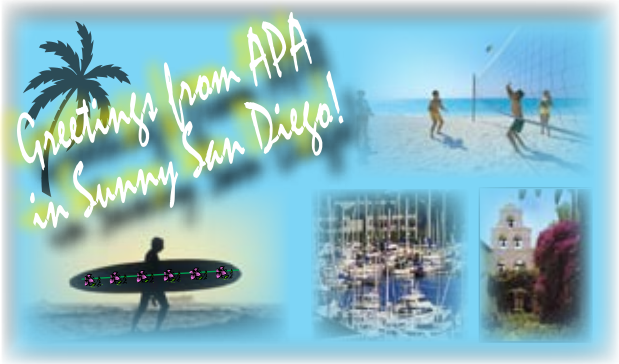
LN: How might Division 50 help you develop your career in the addictions?

JE: I want to maintain active involvement in direct clinical care and also in developing my line of research. Division 50 provides a way to network with others who are engaged in cutting-edge therapies, which can help improve my clinical care and generate new ideas for research. It also may help me stay abreast of educational information to keep current in the field. ψ

Surf's Up! Come to the 2010 APA Convention in San Diego

Amy Rubin and Sherry McKee
2010 APA Convention Program Co-Chairs

The 2010 APA Convention will be held in sunny San Diego, California, August 12-15. Attractions (besides the convention) include the world famous San Diego Zoo; Balboa Park, with its museums and other cultural institutions; Old Town, the first Spanish settlement in California; and, of course, surfing, boating, and other water-based activities.



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APA is featuring substance abuse issues in the convention-wide plenary sessions this year—watch for announcements about these special speakers. They tentatively include (1) Nora Volkow, Director of the National Institute on Drug Abuse, who pioneered the use of brain imaging to investigate the toxic effects of drugs and their addictive properties; (2) Alan Marlatt, Professor of Psychology, University of Washington; and Director, Addictive Behaviors Research Center. Marlatt is best known for his Relapse Prevention program, as well as his research on harm reduction; and (3) George Vaillant, Professor of Psychiatry, Harvard Medical School, who researches adult development and addiction processes.

This year's program features events of broad interest to Division 50 clinicians, researchers, students, and early career investigators. Division-sponsored symposia and poster presentations cover a range of addictive behaviors including alcohol, marijuana, nicotine and other drug problems, as well as disordered gambling and eating behaviors. Work with adolescent, college, and minority populations are well represented.

Division 50, in close collaboration with Division 28 (Psychopharmacology and Substance Abuse) is sponsoring or cosponsoring 17 symposia and 2 poster

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2010 Convention

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sessions on cutting-edge developments in basic and applied research as well as dissemination of evidence based practices. Comorbidity issues are highlighted this year. In addition to two symposia on treatment of people with comorbid substance and other problems, our President, Lisa Najavits, is giving an invited address on "*Trauma and Addiction.*" Work will also be presented on the effectiveness of new technologies for use in treatment. Examples include using text messaging for support and the use of virtual reality. Both divisions have many sessions that may be of interest to members. Details will be published in Summer *TAN* and in the Convention Program.

Division 50 is proud to support student and early career investigators. As in previous years, Divisions 50 and 28, with generous support from NIAAA and NIDA, will co-sponsor an Early Career Social Hour and Poster Session, during which early career members will have the opportunity to present their work and meet other Division members.

Our Divisions are fortunate to receive substantial federal funding for invited speakers and travel awards from NIAAA and NIDA. Divisions 50 and 28 have collaborated with NIDA and NIAAA to co-sponsor two pre-convention workshops that we anticipate will be of significant interest to Division members: *"Helping Patients Who Drink Too Much- Using The NIAAA Clinician's Guide"* (NIAAA), and our *"Grant Writing Workshop"* (NIDA) require pre-registration. Please e-mail division50apa@gmail.com to register.

We would like to thank members of the program committee whose thoughtful reviews provided important guidance in making difficult decisions as we developed this outstanding program.

Committee Members: Nancy Barnett, Christopher Barrick, Clara Bradizza, Scott Coffey, Suzanne Colby, Susan Collins, Lorraine Collins, Gerard Connors, Rina Eiden, Kerry Grohman, Joel Grube, Suzy Gulliver, Larry Hawk, David Hodgins, Greg Homish, Rebecca Houston, John Hustad, Kristina Jackson, Carl Lejuez, Steve Maisto, Sherry McKee, Jen Read, Damaris Rohsenow, Julie Schumacher, Paul Stasiewicz, Matthew Tull, Ken Weingardt. **Assistant to the Program Chair:** Erin Cunniff.

We hope to see you at the convention. Please look for additional information on upcoming events in the summer issue of *TAN*. ψ

2010 Convention Special Events

Supported in part by R13AA017170

Division 50 is sponsoring several informal venues to promote the exchange between the clinical practice and research communities to **advance the dissemination and implementation of evidence-based clinical practices** related to the early detection, intervention, and treatment of alcohol-related problems.

Preconvention Workshops (free CE credits)

"Helping Clients Who Drink Too Much: Using the NIAAA Clinician's Guide"

"Unlock the Mysteries of NIH Research Funding: Improve Your Grant Application & Improve Your Chance at Success"

Attendance at these workshops is limited to allow individualized attention and maximize exchange between front line clinicians and clinical researchers.

Early Career Psychologist Poster Session & Social Hour

Join us at this informal event to build your professional network with clinically- and research-oriented peers, prominent addictions researchers/clinicians, and individuals from the NIH community.

Conversation Hours

Hosted by renowned addiction experts, these informal sessions offer researchers and clinicians the opportunity to discuss major obstacles to disseminating and implementing evidence-based practices.

NEW! Clinician's Panel Discussion

Hear prominent clinicians talk about their unique experiences implementing evidence-based practices and join in the dialog with other clinicians and treatment researchers.

Check the Division 50 website for updated information about these events at **www.apa.org/divisions/div50/.**

Bridging the Gap

Chatting With Kathleen Carroll

Nancy A. Piotrowski
Capella University

Lynda K. Hemann
Concepts for Change, Inc.

A highly cited researcher and author of over 240 journal articles, chapters, and books, Kathleen Carroll is a Professor of Psychiatry at the Yale University School of Medicine, Scientific Director of the National Institute on Drug Abuse (NIDA) -supported Center for Psychotherapy Development at Yale and Principal Investigator of the New England Node of the NIDA Clinical Trials Network (CTN). Her professional interests are in the area of developing, specifying and evaluating evidence-based treatments for substance use disorders. She also is a Past President of Division 50 and received the Division 50 Distinguished Scientific Contributions to Education and Training Award. For this column, we focus on her work related to computer based training for (CBT4) cognitive-behavioral therapy (CBT) for substance use disorders.

NAP: What was most persuasive in your decision to concentrate your recent work on CBT4CBT (Carroll et al., 2008; 2009)?

KC: CBT has always seemed like a big challenge for dissemination. It is a complex, demanding treatment for both clinician and patient, and with multiple demands on clinicians' time, seems difficult for them to squeeze in to their activities. Even in our clinical trials, we found patients not getting as much of a 'dose' of CBT as we would like. In our CTN trials, we also found that even though a lot of the community-based clinicians said they used CBT, it was virtually undetectable in sessions we monitored (Santa Ana et al., 2008) and clinicians overestimated time spent on evidence-based interventions (Martino et al., 2009a). So, when NIDA issued an RFA on making evidence-based treatment more community friendly, it seemed like a natural extension of our work. The other important feature of a computer-based intervention is the level of standardization it allows—it can be revolutionary in psychotherapy research because we can control delivery of treatments.

LKH: In your 2008 article, you mentioned a need for comparisons of CBT4CBT to clinician-delivered CBT. Are studies like this underway now?

Kathleen Carroll

KC: We have only evaluated CBT4CBT as an adjunct to treatment. We are evaluating CBT4CBT as a tool to extend treatment and free clinician time in settings like VA outpatient programs, methadone programs, and so on. It will be some time before we know enough to think about stand-alone therapies. I also think it is very important that we evaluate computer-assisted therapies with the rigor we require for traditional clinician-delivered therapies. We are doing that with CBT4CBT, particularly with regard to whether it retains the features of clinician-delivered CBT and for understanding the mechanisms of action (i.e., does it teach the targeted skills and does that drive outcome). Computer-assisted therapies have great promise, but the quality of studies evaluating some of them is uneven. The quality of the research really needs to be shored up and some basic questions thought through very carefully (e.g., control groups, independent assessment of outcome, etc.).

LKH: In such studies, how can one control for the effect of characteristics inherent to individual clinicians on delivery of CBT?

KC: Clearly, in a 'man versus machine' type trial, it would be crucial to have the treatment delivered by talented, well-trained and highly skilled clinicians. That's the interesting thing about this question and type of research; however, as delivery of CBT4CBT would be relatively consistent, there could be a lot of variability in the clinician-delivered CBT, which we'd try to minimize as much as possible in an efficacy trial. In the real world though, I'd expect that CBT4CBT could be more effective than poorly-delivered CBT, but not quite as good as when done by a first rate therapist.

LKH: How do counselors bill for these services? Do you think the healthcare system is ready for CBT4CBT and similar interventions, such as Griest (2008) describes?

KC: The billing question is interesting; but the first issue is simply to understand basic questions about computer-assisted therapies. We're at the stage of beginning to address the "what type of computer-assisted therapy, for what type of individual, at what time" type of issues. There are many interesting questions: For whom will these therapies be appropriate and sufficient? What kind of individuals will require or have better outcomes with traditional clinician administered therapies? Will these therapies enable us to reach the 90% of those with substance-related problems who never seek treatment?

NAP: Since the publication of your 2007 article with Bruce Rounsaville, where you ask the question, "Whither or wither evidence-based practice (EBPs) in addictions?" and in light of the upcoming 10th anniversary of the Clinical Trials Network (CTN), where

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Bridging the Gap

(Continued from page 9)

do you think the greatest strides have been made on implementation of EBPs?

KC: I think the most important gain is that the focus has shifted to the best ways of getting EBPs into practice and the people who can benefit from them, and away from questioning their validity. There's been remarkable change in acceptance of treatments like contingency management and medications by the clinical community. A problem we face, however, is the availability of high quality supervision in EBPs. A key point often overlooked is that one of the methodological requirements for determining that a treatment is evidence-based is that it is evaluated in trials where the therapists are closely supervised and fidelity is evaluated. Supervision with fidelity monitoring and feedback (as we do in the CTN) may be crucial to the effective delivery of EBPs (and the suppression of 'chat'; cf. Martino et al., 2009b), but it is not widely available or recognized as critical. Steve Martino is currently conducting what we think is the first randomized trial evaluating the value of supervision and monitoring/feedback in the delivery of EBPs and I look forward to seeing how that turns out.

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Federal Update

Kristen G. Anderson
Member-at-Large, Public Interest
Chair, Policy and Advocacy Committee

Reform of our nation's health care system continues on a rocky course. Since the *TAN* Fall/Winter 2009 issue, substantial headway was made in passing healthcare reform legislation in the House and Senate. However, the outcome of the special election in Massachusetts on January 19, 2010, substantially changed the tenor of discussions around the legislative process. Below is a summary of progress to date as it pertains to issues for mental health and addiction services at the national level.

Healthcare Reform

The House passed the *Affordable Health Care for America Act* (H.R. 3962) in November, followed by the Senate bill, the *Patient Protection and Affordable Care Act* (H.R. 3590) on December 24, 2009. APA advocated for a number of actions pertaining to mental health services and addiction in these bills, including: treatment parity, Medicaid coverage for tobacco cessation programs for pregnant women, integrated health care initiatives, increased comparative effectiveness research and support for prevention and wellness programs. Both reform bills changed Medicare payment provisions to extend the 5% psychotherapy payment restoration, increasing access to mental health services. An amendment to the Senate bill established minority health offices in the Centers for Disease Control, Substance Abuse and Mental Health Services Administration and the Centers for Medicare and Medicaid services.

Supreme Court (Photo: Public Domain)

Given the loss of the 60-vote majority in the Senate, the Democratic leadership is now considering the next step for healthcare reform legislation. Options include passing the Senate legislation in the House, precluding the inclusion of amendments, or using a fast track budgetary procedure to pass the legislation. While the second option would prevent a Republican filibuster, reconciliation requires the bill to only address healthcare reform issues that impact the federal budget. For a more comprehensive view of this process and the implications for reform, I would suggest reviewing the Kaiser Family Foundation website (http://healthreform.kff.org/).

Medicare Access

In November 2009, the House passed the *Medicare Physician Payment*

Reform Act (H.R. 3961), replacing the Sustainable Growth Rate (SGR) formula with inflation-based adjustments for Medicare payments in the future. Senate action on this issue was included in the healthcare reform bill (H.R. 3590). Had the overall healthcare reform bill passed, these measures would have halted the 21.2% cuts to Medicare provider payments set to take effect on January 1, 2010. As a stopgap measure, an amendment to a defense appropriations bill in December 2009 postponed the rate cuts until February 28, 2010. It is hoped that movement on healthcare reform will prevent these cuts and allow for increases in payments from 0.5–1.0% for providers for 2010.

Mental Health Parity

The *Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* was released for comment in late January 2010. The rules outlined by the legislation are under review in preparation for the July 1, 2010 enactment. Interested parties can download this document from the U.S. Department of Labor website (www.dol.gov/federalregister/PdfDisplay.aspx?DocId=23511) and provide comment before the end of April. Congratulations to our members who worked to make this a reality! ψ

Report on the February 2010 Meeting of the APA Council of Representatives

Jalie A. Tucker
Raymond F. Hanbury
Division 50 Council Representatives

The Council of Representatives, APA's governing body, met on February 19-21 for the first of its two meetings a year in Washington, D.C. APA President Carol Goodheart chaired the meeting, which covered an agenda of 25 action items. Council also participated in a diversity education session that focused on "intersectionality," or how socially constructed categories (e.g., race/ethnicity, gender, disability) interact to contribute to social inequality. The following items are of general interest or are directly relevant to the activities of Division 50.

Ethics. Revisions to the APA Ethics Code were approved that clarified that Ethical Standards 1.02 and 1.03 concerning conflict resolution between psychologists, organizations, and laws can never be interpreted to justify or defend violating basic human rights. Psychologists are further required to "...take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code."

Revision of APA's Model Act for State Licensure of Psychologists. APA's Model Licensing Act (MLA) serves as a prototype for drafting state legislation regulating the practice of psychology and was last revised in 1987. In the culmination of work of the 2006 Task Force charged with revision of the 1987 MLA, Council approved a new act that, among many updates and changes, incorporated prescriptive authority for psychologists into state licensing laws, removed the 1987 exemption from licensure for industrial/organizational consulting and practice and continued to allow limited use of the term "psychologist" by masters level psychologists who work in public school settings governed by state education boards (rather than psychology licensing boards). The independent practice of psychology is restricted to the doctoral level.

Development of Treatment Guidelines by APA. In a reversal of prior policy against guidelines development, Council approved a motion for key APA groups, including the Committee for the Advancement of Professional Psychology, Board of Professional Affairs and Board of Scientific Affairs to collaborate in developing evidence-based treatment guidelines. A Steering Committee and Guidelines Development Panel will assist in this endeavor. Consistent with prior policy, guidelines will remain aspirational, not prescriptive; documents to guide practice and existing guidelines that satisfy APA criteria for evaluating guidelines will be approved regardless of the originator or author.

APA's Strategic Plan: Core Values. Council approved the following core values statement as part of APA's strategic plan: "the continued pursuit of excellence, science-based knowledge and application, outstanding service to its members and to society, social justice, diversity, and inclusion, and acting ethically in all that we do."

Public Education Campaign (PEC). Council reauthorized funding for the PEC for three more years to broaden its messages and reach and to be consistent with APA's Strategic Plan.

Council voted to move its August 2010 meeting out of the San Diego Manchester Hyatt Hotel. Hotel owner, Doug Manchester, donated to the California Proposition 8 "Marriage Protection Act" campaign that voided the state constitutional right of same-sex couples to marry. Numerous APA divisions and members have voiced concerns about APA's use of the hotel during its annual meeting. Council suspended the rules to discuss and voted positively on a motion to move its meeting out of the Manchester Hyatt, at an estimated maximum cost of $100K, per APA Treasurer Paul Craig. APA is not calling for a general boycott of the hotel. President Goodheart said: "T[his] decision allows Council to make an important statement that it stands in solidarity with the LGBT community ...Council will now not be faced with having to choose between their responsibilities as members of Council and their wish to express their opposition to Mr. Manchester's action by not entering his hotel."

In other business, President Goodheart described her presidential initiatives and convention activities, including a task force and initiatives aimed at integrating the practice of psychology in health care. Former First Lady and longtime mental health advocate Rosalynn Carter is scheduled to be the keynote speaker at the opening convention ceremony. Ψ

Student and Trainee Perspectives

Pre-Doctoral Internships for Students Interested in Careers in Addictions

Erika Litvin

Greetings! As a 5th year clinical psychology graduate student, I recently completed my pre-doctoral internship applications and interviews. By the time this article is published, I will know whether and where I have matched. Graduate school is a long marathon and I am very much looking forward to the next phase of my career. Given the great anxiety associated with the internship match process for many students, in this issue I will share my experience and offer some advice tailored to students interested in careers in addictions. Here are some factors to consider that may help you to select sites and ensure an optimal result on Match Day.

Career Goals

Are you primarily research-oriented, aiming for an academic career? Mostly interested in clinical work? A mix of the two? Although you will spend most of your time doing clinical work at all internships, there is wide variation in programs' attitude toward research. Some sites do not protect any time for research and discourage interns from getting involved in research with the exception of finishing their dissertations. Other sites don't protect time, but encourage involvement outside of the standard workweek. Still other sites protect a limited number of hours within the standard workweek, perhaps 2 to 8, and strongly recommend or even require interns to complete a research project. Finally, a few programs offer a specialty track designed specifically for students interested in academic careers focusing on addictions research. In these tracks, interns serve as therapists for randomized clinical trials of addictions treatments and become integrated into the research team.

The Elusive "Fit"

"Fit" is an overused word during the application and interview process. Be prepared to make a strong argument for why a site is the right fit for you. Ultimately I decided that the best fit for me was an internship that would offer advanced training in addictions treatment but would also provide general training in areas I had less exposure to during graduate school. Students interested in addictions-related rotations are fortunate because there is a great wealth of opportunities available in a variety of internship settings. Given the high prevalence of addictive disorders in veteran populations, most internships in Veterans Affairs (VA) hospitals in particular offer at least one addictions rotation, with many offering multiple rotations in both inpatient and outpatient settings.

Program Structure

Internships vary greatly in the number and length of training experiences offered. Some sites offer a standard curriculum completed by all interns, whereas other sites offer numerous rotations from which to choose. Some sites divide the training year into 2 to 4 full-time rotation periods. Other sites offer quarter or half-time rotations that run for the entire year, so that interns complete multiple rotations at the same time.

Size of Intern Class and Program Coherence

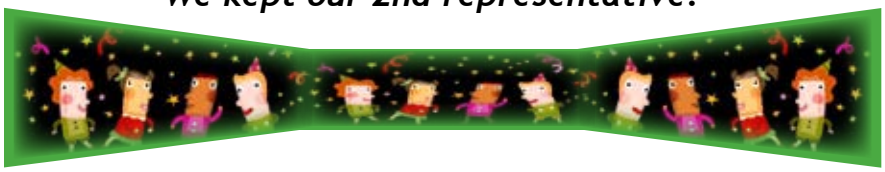
Internships also vary widely in class size and coherence. For example, some sites have a small intern class but many rotation choices across a large geographical area, so it is possible you may rarely see your fellow interns. Other sites are just the opposite and you may work closely with fellow interns in a single clinic.

Post-Internship Opportunities

One of the most important things I learned during the interview process was that I needed to think beyond just the internship year. I realized that at many sites, I was not just choosing an internship but perhaps a post-doctoral fellowship as well and even my first "real" job. Several sites emphasized that many of their faculty had completed internship and/or post-doc at the site. Consider the faculty at the site and whether you could imagine yourself working with them for a post-doctoral fellowship. Once again, I think that students interested in addictions are fortunate because many internship sites have great opportunities for addictions-related post-doctoral fellowships and beyond, especially academic medical centers and VAs.

Good luck! And remember that, despite everything I have said, it is important to keep internship in perspective as simply one component of your full clinical and research training plan. It is, after all, only one year. Ψ

We kept our 2nd representative!



Thanks to all Division 50 members for voting!

Report on the 2009 APA Education Leadership Conference

Cynthia Glidden-Tracey, Co-Chair Division 50 Education and Training Committee

This past year the APA Education Leadership Conference (ELC) was held the first weekend in October in Washington, DC. I was glad to have the opportunity to attend as the Division 50 representative for the third time in the past four years. There is much to learn about the purpose and function of the ELC. Attending repeatedly allows an ELC participant to build on what has been learned in previous years. The shared forum and advocacy efforts to promote psychology education through the ELC involves representatives of numerous APA Divisions, APA Governance Groups, Psychology Education and Training Organizations and other interested parties and invited guests.

This year's ELC theme was entitled *Preparing Tomorrow's Health Workforce*. The conference opened Sunday, October 4th with a series of plenary sessions on the roles of academic health centers and community colleges and on biomedical informatics and their convergence with cognitive psychology. I was particularly interested in the emphasis on comprehensive health care workforce reform as necessary for health system reform to be successful. A legislative overview was presented next and focused on federal funding of the Graduate Psychology Education (GPE) Program in fiscal year 2010. This session emphasized several training programs that have received GPE funding. During the afternoon, ELC participants broke into discussion groups that addressed: (1) the teaching of psychology to undergraduates, (2) doctoral training programs, (3) internship programs, (4) postdoctoral programs and (5) professional development and continuing education.

On Monday, October 5th, morning sessions focused on interprofessionalism and promising practices in the education and training of the nation's future health workforce. This was followed by an afternoon session about the US Health Resources and Services Administration (HRSA) advisory committee, which provides advice and recommendations to Congress and supports funding for research and education for several professional groups, including psychology. More information about the GPE grant program was provided in preparation for the Tuesday visits to Capitol Hill, which would address increased funding for the GPE program to expand the number of psychology training grants available, thus helping to increase and improve the participation of psychologists in the health workforce of the future. The remainder of Monday's presentations focused on what to expect and how to convey our legislative requests at the Tuesday Hill visits. ELC participants grouped into clusters of psychologists from individual States and developed pitches tailored to their own Congresspersons after role-playing visits with Congresspersons. APA Federal Education Advocacy Coordinators (FEDACS) played the roles of Senators and Representatives asking us questions and providing "push-back" in response to our appropriations request, so that we would be better prepared to make a compelling case for increased GPE funding in the next fiscal year.

Monday evening, an ELC reception was held in honor of Congressman Gene Green (D-Texas) to thank him for introducing the Graduate Psychology Education Act of 2009, a bill to amend the Public Health Service Act to promote mental and behavioral health services for underserved populations (H. R. 2066). This bill would authorize the GPE grant program as its own line item for the first time in the President's Budget and request its continuation as a line item in subsequent years. In the past, GPE has been part of an omnibus HRSA appropriations bill.

On Tuesday, October 6th, delegations of psychologists from each of the States represented at the ELC went to Capitol Hill. We met in the offices of our Senators and Representatives with their staff members to request restoration of GPE funding to the $4 million level, which would bring funding back up to the highest level the program has received in past years after reductions in recent years. We discussed how this funding level would allow for new competition for GPE grants, including a special focus on the needs of older adults and returning military personnel and their families. Talking points included explaining contributions of psychologists to local communities and to the health care workforce, identifying unmet mental and behavioral health needs in our local communities and describing what GPE grants would mean to institutions from each of our States.

Updates Since the Conference

In early December 2009, the Education Advocacy Directorate announced that in the fiscal 2010 Omnibus Appropriations Bill Conference Report (House Report 111-366), funding for the program for 2010 was increased from $2,000,000 to $2,945,000, allowing for not only another competition in 2010, but also an increase in the number of grants awarded. This is the first increase in GPE funding in five years and the only increase of programs in that budget line. Information about the GPE grant process will be available at the Health Resources & Services Administration website (www.hrsa.gov).

On January 31, 2010, I received word from the APA Education Government Relations Office (GRO) that the health care reform bills passed in the House and Senate late last year were based on the House Authorizing Bill by Representative Green and his colleague Tim Murphy (R-Pennsylvania) as well as Senate Bill (S.811) introduced by Senator Daniel Inouye (D-Hawaii). The Senate version of Health Care Reform (H.R. 3590), also called the Patient Protection and Affordable Health Care Act, contains a provision for up to $10 million for psychology training and the House Bill (H.R. 3962) provides up to $9 million for psychology training. Ψ

Speaking of Substance Use…

John F. Kelly
Harvard Medical School and
Massachusetts General Hospital

Terminology surrounding the broad area of addiction has been a contentious topic for decades (Babor & Hall, 2007; Edwards, Arif, & Hodgson, 1981; Keller, 1977; Sparks, 2004; White, 2004). A lingering perception in the addiction and recovery field is that certain terms commonly used to describe individuals suffering from substance-related conditions may be more stigmatizing than others. It is unquestionably challenging, and perhaps impossible, to satisfy all stakeholders. However, there has been one term in common usage describing an individual with a substance-related problem that appears to arouse consistent objection—the "substance abuser." This article describes why the specific "abuser" label may provoke resistance and highlights some recent research findings that suggest that specific labels, such as "abuser," may negatively and inadvertently influence attitudes.

It is probably no surprise to hear that substance use and mental health problems are stigmatized. Just how stigmatized, however, *may* be surprising. A cross-cultural study conducted by the World Health Organization (WHO) in 14 countries examined 18 of the most stigmatized conditions (e.g., being a criminal, HIV positive, or being homeless). They found that alcohol addiction was ranked as the 4th most stigmatized and other drug addiction was ranked as the most stigmatized (Room, Rehm, Trotter, Paglia, & Üstün, 2001). Many individuals who are affected by substance-related problems experience shame and guilt and often fear that personal disclosure or public knowledge of their condition would lead to negative effects on employment or to broader social disapproval (Ahern, Stuber, & Galea, 2007; Gmel & Rehm, 2003; Link & Phelan, 2006). Furthermore, even health care and mental health care workers, to whom affected individuals might turn for help, have been shown to hold negative views of individuals with substance-related problems (Habib & Adorjany, 2003; Paterson, Backmund, Hirsch, & Yim, 2007) and to view such individuals as irresponsible and more aggressive, dangerous and untrustworthy (Hopwood, Treloar, & Bryant, 2006; Link & Phelan, 2006; McLaughlin, Mckenna, & Leslie, 2000). Pervasive societal stigma surrounding these conditions may translate into delays in, or avoidance of, help-seeking. Estimates suggest that only 10% of individuals with substance-related conditions seek treatment each year in the United States (Substance Abuse and Mental Health Services Administration [SAMHSA], 2008) and many cite stigma as one of the principle reasons for not seeking treatment. Furthermore, estimates suggest it takes 5-6 years, on average, from the onset of alcohol/drug *dependence* before individuals eventually go for help (Wang et al., 2005). Such delays serve only to increase personal and social harms and undermine the prognosis for long-term recovery.

One of the reasons why substance-related conditions are stigmatized may have to do with perceptions of cause ("It's their own fault") and controllability ("They could stop if they wanted to"). Observers may think an individual with a substance-related condition can control their behavior because the cause is attributed to stable and controllable factors within the person. After all, alcohol and other drug use initially involve an individual's free choice to experiment. However, observers may continue to view alcohol and other drug use behavior as a personal choice long after functional dysregulation and structural alterations have materialized in brain areas that compromise an individual's ability to stop using substances despite harmful consequences (Edwards & Gross, 1976; Koob & Le Moal, 2006).

The way individuals who experience substance-related problems are described (e.g., as "a substance abuser" vs. having "a substance use disorder") may convey implicit assumptions regarding attributions of cause and controllability, which may potentially diminish or perpetuate stigmatizing attitudes (Graham & Schultz, 1998; Kelly, 2004; White, 2006). Referring to an individual as a "substance abuser," for instance, may evoke perceptions of volitional, purposeful action and controllability, conveying the notion that the individual is more of a "perpetrator" engaging in willful misconduct. Alternatively, describing an individual as having a "substance use disorder" may evoke perceptions of the individual as more of a "victim" of a biomedical process, characterized by impaired control over substance use behavior and therefore less personally culpable. From a policy standpoint, referring to an individual as a "substance abuser" may lead to perceptions of a greater need for punishment, whereas referring to an individual as having a "substance use disorder" may increase perceptions of a need for treatment (Kelly, 2004).

While rhetorical discourse surrounding objections to the "abuser" label has persisted, a recent randomized study set out specifically to test this notion empirically. Mental health care workers attending two addiction/mental health conferences (N = 728) were asked to complete a survey and 71% responded. One of two terms was inserted into a paragraph describing "Mr. Williams" who was having difficulty complying with a court-ordered substance-related treatment protocol. Half the study participants received the paragraph describing him as a "substance abuser" the other half received the paragraph describing him as having a "substance use disorder," with the rest of the wording identical. Participants were asked to read the paragraph and then answer a number of questions that assessed whether he ought to receive more punitive or therapeutic measures, whether he was a social threat and whether he was more to blame for his failure to comply. Those receiving the "abuser" paragraph were significantly more likely to agree that Mr. Williams should be punished and that he was more to blame for his condition and failure to comply with the treatment protocol (Kelly & Westerhoff, 2009).

Even among these highly trained, mostly doctoral-level, mental health clinicians, exposure to the "abuser" label produced a reliably different and more punitive and blaming attitude toward the same individual. Of note, "abuser" terminology has not been adopted in other health care areas associated with compulsive behavior. Individuals with eating-related problems, for example, are almost uniformly described as having an "eating disorder" and not "food abusers." Yet, despite explicit and long-standing opposition to the "abuser" label, it remains popular in literature from federal and state agencies whose aim it is to destigmatize these conditions (SAMHSA, 2004). Persistent use of such terms may perpetuate stigmatizing attitudes and increase barriers to help-seeking.

A worthwhile public health policy goal would be to eradicate or minimize stigma-related obstacles wherever possible. One simple and inexpensive way to achieve this might be to refer instead to affected individuals as having a substance use disorder, as is done with eating disorders, or as individuals with a substance-related problem or condition. Furthermore, since the "abuser" label does not appear to confer any particularly unique advantage in descriptive precision, its nonuse would be unlikely to produce any detrimental results.

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Website on Empirically Supported Treatments: Call for Nominations

The Division 50 Evidence-Based Practice Workgroup is compiling empirically-supported treatments (ESTs) for substance use disorders for inclusion on the Division 12 (Society for Clinical Psychology) EST website. To ensure that all potential treatments are considered, we welcome nominations. We will follow a peer-review process for finalizing them. If you or someone you know is interested in nominating a treatment for consideration, send an email including the name of the intervention and your complete contact information to div50.ebp@gmail.com and we will forward you a Nomination Packet. The Division 12 website can be viewed at: www.psychology.sunysb.edu/eklonsky-/division12/index.html. **Please send your nomination by April 1, 2010.**

Routine Addiction Screening of County Jail Inmates

Steven L. Proctor
Louisiana State University

Norman G. Hoffmann
Western Carolina University

Victoria L. Westlund
Buncombe County Detention Facility

Overcrowding has become one of the principal concerns for local jail systems in the United States. High incarceration rates not only place a disproportionate strain on law enforcement officials but also contribute to incarceration costs. The average number of inmates held in local jails in the U.S. is striking. Between 2000 and 2007, the U.S. total jail population has increased at an average annual rate of 3.3%, bringing the total number of jail inmates to 780,581 (Sabol, Minton, & Harrison, 2008). Furthermore, a national survey revealed that more than two-thirds of jail inmates are dependent on alcohol or drugs (Karberg & James, 2005), which is often associated with increased recidivism (Bonta, Law, & Hanson, 1998). Substance use disorders (SUD) may contribute to increased rates of U.S. jail populations and may also have effects on recidivism rates. In fact, research has shown that inmates that participate in SUD treatment are significantly less likely to be re-arrested and relapse (Hiller, Knight, & Simpson, 1999). Therefore, routine addiction screening procedures for newly admitted inmates could help identify individuals at risk for substance dependence, guide them in the direction of appropriate treatment and ultimately reduce high recidivism rates. The aim of the present study was to address the feasibility of identifying inmates that may be at risk for SUDs and who may require further assessment prior to treatment referral.

Method

Participants

Data were obtained from 250 male inmates and 45 female inmates incarcerated in the Buncombe County Detention Facility (BCDF) in Asheville, North Carolina. The facility utilized in the present study is primarily for adult pre-trial detainees and functions as the county jail for a city and county of moderate size. Due to the anonymous nature of the interviews, other demographic information was not collected. A general perspective, however, can be derived from the demographic characteristics of those inmates incarcerated at the BCDF during the days on which the survey was conducted. Inmates incarcerated during the survey administration ranged in age from 18 to 87 (M = 33.5) years, Whites constituted the largest ethnic group (69%) and African Americans were the largest minority (25%).

Table 1. Substance use disorder indications, substance involvement and incarceration among jail inmates

	Male Inmates	Female Inmates
Substance Use Order Indication		
No diagnostic risk indicated	24%	18%
At risk	5%	2%
Abuse	13%	11%
Possible dependence	6%	4%
Likely dependence	52%	64%
Substance Involvement in Current Offense		
None	31%	31%
Under the Influence	36%	22%
To obtain substances	4%	2%
Both	29%	44%
Prior Incarcerations in Past 12 Months		
None	34%	22%
One	24%	27%
Two or three	28%	33%
Four or more	14%	18%

N = 295

Materials

We used a self-administered screening instrument developed for routine screening of jail inmates. The risk for substance dependence was based on the UNCOPE screen, which was developed and validated for screening recent arrestees (Hoffmann, Hunt, Rhodes, & Riley, 2003). The UNCOPE is compatible with DSM-IV-TR (American Psychiatric Association, 2000) criteria, has been validated on both adult prison and juvenile justice populations (e.g., Campbell, Hoffmann, Hoffman, & Gillaspy, 2005; Urofsky, Seiber, & Hoffman, 2007) and provides a simple and quick means of identifying risk for dependence for alcohol and other drugs, with an overall accuracy of approximately 85%. Inmates were also asked about the type of offense for which they were currently incarcerated, prior incarceration history, whether they committed the crime for which they were currently incarcerated to obtain or get money for drugs or alcohol and whether they were under the influence of drugs or alcohol at the time of offense.

Design and Procedure

All procedures were approved by the Western Carolina University's internal review board and the detention facility. A staff member of the BCDF in charge of inmate welfare approached inmates on their housing units and asked them to voluntarily participate in a survey. The staff member then distributed the survey and asked inmates to complete the survey, fold it in half to hide their responses and place it in a container provided for the collection of forms. The simple screening rule for the UNCOPE is to consider anyone with three or more positive responses to be at risk for

substance dependence; however, we developed a more detailed algorithm to refine the utility of the screen. This algorithm placed inmates into one of five categories based on the extent and pattern of the UNCOPE items for which an individual was positive.

Results

The prevalence rates for SUD indications, substance involvement and incarceration history are presented in Table 1. Approximately three out of four (76%) male inmates were positive on at least three of the UNCOPE items compared to approximately four out of five (81%) female inmates. In addition, more than half the male inmates and almost two-thirds of the female inmates were likely to meet diagnostic criteria for substance dependence. The data indicate the high prevalence of likely substance dependence among recently admitted jail inmates and also show that, for a majority of the inmates, their current offense was related to substance involvement. In fact, about one third (34%) were under the influence at the time of offense and 69% indicated that they were under the influence and/or committed the offense for which they were currently incarcerated to obtain or get money for substances.

Another interesting finding was that for inmates who met criteria for likely dependence, almost 90% were either under the influence at the time of offense or committed the offense to obtain or get money for drugs or alcohol. Substance dependence also appears related to recidivism as nearly half of the male inmates who met criteria for possible dependence reported two or more incarcerations in the past 12 months.

Discussion

The present study examined the feasibility of screening local jail inmates for SUDs and examined the association between substance dependence indications and type of offense and incarceration history. Of the male inmates, three out of four were found to be at risk for an SUD and more than half were likely to be dependent. Rates for female inmates revealed that four out of five were at risk for any SUD and that two out of three were likely to be dependent.

The effects of an SUD on offending are underscored by the finding that a majority of the inmates were either under the influence of a substance at the time of offense and/or committed the offense to obtain or get money for drugs or alcohol. Findings support previous research in this area that has shown that substance dependent inmates have higher recidivism rates and are more likely to report motor vehicle crashes and driving under the influence than non-dependent offenders (Hoffmann, Proctor, & Williams, 2008). This would suggest that substance dependent offenders may not only be at greater risk for recidivism, but they may also pose a greater public safety risk.

Findings from the present study have clinical implications for the program structure within local jail systems. One solution to reduce recidivism rates among addicted individuals would be detection and treatment. In order to develop effective treatment procedures for inmates, it is essential that routine screenings be administered to newly admitted inmates utilizing appropriate tools to identify potential risk for problematic substance use. This screening could help accurately identify inmates with an SUD and potentially reduce recidivism. In addition, research we currently have underway has found that incorporating a brief alcohol and drug screen into the standard booking or classification procedures in local jail systems adds virtually no cost to the process.

The main goal of early detection is to properly identify inmates in need of further assessment and treatment in an effort to decrease the rate of recidivism and increase the rate of successful futures for these individuals. However, screening in the absence of appropriate and effective treatment referral will not in itself reduce the probability of re-offending. Routine screening coupled with appropriate treatment services could make a substantial contribution to the alleviation of jail overcrowding and ultimately improve public safety.

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Abstracts

Hart, K.E. & McGarragle, O. (in press). Perceived social support from addictions counselors and client sobriety during aftercare: A pilot study of emotional support and functional support. *Alcoholism Treatment Quarterly*, 28(2).

In an empirical study, we asked whether client perceptions of the degree of emotional support and functional support provided by counselors during treatment were related to client sobriety during the aftercare phase of their recovery. Functional support was assessed using a scale that tapped the degree to which clients felt encouraged to become actively involved in six key components of Alcoholics Anonymous. Results derived from 76 former inpatients showed associations linking abstinence at the point of 2-year follow up to counselor provision of both kinds of social support in early stage recovery. Mental health service providers may be able to strengthen their client's long-term ability to maintain sobriety by providing them, in the short-term, with high levels of esteem support and abstinence-focused "instrumental" support.

Leventhal, A. M., Waters, A. J., Kahler, C. K., Ray, L. A., & Sussman, S. (2009). Relations between anhedonia and smoking motivation. *Nicotine & Tobacco Research*, *11*(9), 1047-1054.

A growing literature suggests that anhedonia—an affective dimension related to the inability to experience pleasure—is associated with poor smoking cessation outcomes. Despite these findings, research of the motivational mechanisms linking anhedonia and smoking has been limited. Accordingly, the present study examined: (a) relationships between anhedonia and motivationally-relevant smoking characteristics and (b) whether anhedonia moderated the effects of tobacco deprivation on appetitive and aversive aspects of smoking urges. Smokers (N = 212; > 5 cig/day) first attended a baseline session during which measures of anhedonia and smoking characteristics were completed. Prior to a subsequent experimental session, a portion of participants were randomized to one of two groups: (1) 12-hr tobacco deprivation before the session (n = 51); and (2) ad lib smoking (n = 69). Smokers with higher levels of anhedonia reported a greater number of past failed quit attempts and a higher proportion of quit attempts that ended in rapid relapse within 24hr, rs > .20, ps < .05. Anhedonia did not consistently correlate with smoking heaviness, chronicity and dependence motives. Anhedonia significantly moderated the influence of tobacco deprivation on appetitive smoking urges, such that deprivation effects on appetitive urges were stronger in high-anhedonia smokers (β = .64) than low-anhedonia smokers (β = .23). Anhedonia did not moderate deprivation effects on aversive smoking urges. This pattern of results remained robust when controlling for baseline negative affect. These findings elucidate anhedonia's link with smoking relapse and could be useful for developing cessation interventions for anhedonic smokers.

Pedersen, E. R., LaBrie, J. W., & Hummer, J. F. (2009). Perceived behavioral alcohol norms predict drinking for college students while studying abroad. *Journal of Studies on Alcohol and Drugs*, *70*, 924-928.

College students who study abroad may represent a subgroup at risk for increased drinking while living in foreign countries. The present study explores this idea as well as the extent to which students' pre-abroad perceptions of study-abroad student drinking are related to actual drinking while abroad. Ninety-one students planning to study abroad completed an online survey of demographics, pre-abroad drinking behavior, perceptions of study-abroad student drinking behavior while abroad and intentions to drink while abroad. Halfway into their study-abroad experience, participants completed a follow-up survey assessing drinking while abroad. Pre-abroad intentions of drinking and pre-abroad perceptions of study-abroad drinking were associated with actual drinking while abroad. However, perceptions predicted actual drinking while abroad over and above intended drinking. In addition, although participants overall did not significantly increase their drinking while studying abroad, participants with higher pre-abroad perceived norms significantly increased their own drinking behavior while abroad. As in other samples of college students, perceived norms appear to be an important correlate of study-abroad student drinking behavior. Findings suggest that perceptions of study-abroad student-specific drinking predicted not only actual drinking while abroad but also increases in drinking from pre-abroad levels. Findings provide preliminary support for the idea that presenting prospective study-abroad students with accurate norms of study-abroad student-drinking behavior may help prevent increased or heavy drinking during this period. Ψ

Announcements

Brown University's Web-Based Distance Learning Program

The Center for Alcohol & Addiction Studies at Brown University is pleased to announce that its web-based Distance Learning Program is now offering continuing education credits for psychologists, in addition to addiction counselors and social workers. The Distance Learning Program offers convenience and competitive pricing for a large selection of online courses focusing on addiction and associated mental health topics. The program is fully accredited by the American Psychological Association. To access the site, please go to www.browndlp.org, or contact Dr. Dan Squires (Daniel_Squires@brown.edu) for more information.

SAMHSA Announces Clinical Supervision and Professional Development of the Substance Abuse Counselor

Clinical supervision has become the cornerstone of quality improvement in the substance abuse treatment field. In addition to providing a bridge between the classroom and the clinic, clinical supervision improves client care, develops the professionalism of clinical personnel and imparts and maintains ethical standards in the field. TIP 52: *Clinical Supervision and Professional Development of the Substance Abuse Counselor* presents basic information about clinical supervision.

To order your free copy of TIP 52: *Clinical Supervision and Professional Development of the Substance Abuse Counselor*, contact SAMHSA's Health Information Network (SHIN) at www.samhsa.gov/shin or 1-877-SAMHSA-7 (1-877-726-4727) (English and Español). Ask for publication order number (SMA) 09-4435.

Assistant/Associate Professor in Community Health Research, University at Buffalo

The Department of Health Behavior (HB) in the School of Public Health and Health Professions (SPHHP) is seeking a tenure-track professor (Assistant or Associate) who specializes in community health research. Area of expertise is open. Areas of interest include prevention of chronic conditions, high risk behaviors and health disparities. Qualifications: 1) an earned doctorate; 2) a strong record of, or potential for, extramural research funding; 3) a strong publication record for rank; and 4) a strong teaching record or evidence of teaching potential. The Department of HB (http://sphhp.buffalo.edu/hb) administers a Ph.D. in Community Health and Health Behavior and an MPH Concentration in HB. Send a letter of interest, CV, research statement, teaching statement, list of three references and three recent peer-reviewed publications to www.ubjobs.buffalo.edu (posting #0900530). Contacts: Drs. R. Lorraine Collins (lcollins@buffalo.edu) or Gary Giovino (ggiovino@buffalo.edu). *UB is an EO/AA Employer/Recruiter.*

Research Institute on Addictions

The University at Buffalo Research Institute on Addictions (RIA) has multiple openings for NIAAA-funded postdoctoral fellows in alcohol etiology and treatment. Fellows develop and pursue research interests under the supervision of faculty preceptors. Seminars on alcohol use disorders, grant writing and professional issues and career development are included. Start dates in summer and fall, 2010, are negotiable. Visit the RIA website at www.ria.buffalo.edu. Inquiries can be made to either Gerard J. Connors (connors@ria.buffalo.edu) or R. Lorraine Collins (lcollins@buffalo.edu), Co-Training Directors.

Applicants should forward a vita, representative reprints, letters of reference, and a cover letter describing research interests and training goals to: Alcohol Research Postdoctoral Training Committee, Attn: G. J. Connors and R. L. Collins, Research Institute on Addictions, 1021 Main Street, Buffalo, NY 14203. Applications from minority candidates are particularly welcome. Applicants must be citizens or noncitizen nationals of the U.S. or must have been lawfully admitted for permanent residence. AA/EOE

Postdoctoral Opportunities at Syracuse University

The Center for Health and Behavior at Syracuse University anticipates two postdoctoral openings for full-time research fellows. Both positions involve close mentoring and participation in ongoing NIH-funded research; the positions will afford opportunities for publication (using existing data sets) and proposal writing. Anticipated start date is summer 2010 and appointment is for one year with additional year(s) contingent upon funding.

Position #1 - Brief Alcohol Interventions Research (mentor: Dr. Kate Carey). Research investigates psychosocial influences on alcohol use and other risk behaviors in young adults, social norms and network variables, refinement of brief motivational interventions to reduce harm associated with at-risk drinking, and identifying mediators and moderators of change.

Position #2 - HIV Prevention Research (mentor: Dr. Michael Carey). Research on the psychosocial determinants of sexual risk behavior, development and evaluation of sexual risk reduction interventions, and related health-and-behavior topics. We work at the interface of health psychology and public health, often with socioeconomically disadvantaged populations.

Requirements: PhD in a social or behavioral science discipline, strong statistical skills (e.g., SEM, regression, multi-level modeling), strong writing skills, interest in topical areas, and ability to work as part of a team are essential.

(Continued on page 20)

Announcements

(Continued from page 19)

Apply online at https://www.sujobopps.com (job number #025779 or 025786); also submit a CV, statement of research interests and experience, and names of three references to Dr. Kate Carey at kbcarey@syr.edu or to Dr. Michael Carey at mpcarey@syr.edu. Applications will be accepted until the positions are filled. Syracuse University is an affirmative action/equal opportunity employer.

Postdoctoral Fellows positions at the Warren Alpert Medical School of Brown University

The Center for Alcohol and Addiction Studies at The Warren Alpert Medical School of Brown University is recruiting postdoctoral fellows in two associated postdoctoral fellowship training programs, one funded by NIAAA in alcohol abuse and addictions and one funded by NIDA in substance abuse. The training programs provide postdoctoral research training for biomedical, behavioral, and social scientists and health care professionals who wish to conduct high quality research in the early intervention and treatment of alcohol and other drug problems. Areas of expertise in the fellowship include behavioral treatments, pharmacotherapy and the neurobiology and genetics of alcohol and substance dependence.

Application review for next year begins on January 15, 2010. Brown University is an affirmative action/equal opportunity employer and actively solicits applications from women and minorities. For further details and an application go to www.caas.brown.edu.

Postdoctoral Scholar Positions, UC San Francisco

One- to two-year NIH/NIDA-funded positions as postdoctoral scholars in Drug Abuse Treatment and Services Research are available in a multidisciplinary research environment in the Department of Psychiatry, University of California, San Francisco. Scholars work with a preceptor to design and implement studies on the treatment of drug dependence, including nicotine, and select a specific area of focus for independent research. Director and Associate Director Drs. James Sorensen and Sharon Hall and Co-Directors Drs. Steven Batki, Kevin Delucchi, Joseph Guydish, Carmen Masson, and Constance Weisner are involved with either the NIDA Clinical Trials Network (CTN) or Treatment Research Center (TRC). Training of psychiatrists, women and minorities for academic research careers is a priority.

Send CV, research statement, samples of work, and 2 letters of recommendation to Barbara Paschke, 3180 18th St., Suite 205, San Francisco, CA 94110; 415-502-7882; Barbara.paschke@ucsf.edu. Additional information including faculty research interests is available at http://ucsftrc.autoupdate.com/post_doctoral_program.vp.html. Ψ

Annual Division 50 Call for Awards Nominations

Division 50 (Addictions) seeks nominations for its 2010 awards, which will be announced at APA's 2010 Annual Convention. Awards for 2010 include: (a) Distinguished Scientific Early Career Contributions, (b) Distinguished Scientific Contributions to the Application of Psychology, (c) Distinguished Scientific Contributions to Public Interest, (d) Presidential Citation for Distinguished Service to Division 50, and (e) Outstanding Contributions to Advancing the Understanding of Addictions. Information on award qualifications and nominations can be found on Division 50's web site at www.apa.org/divisions/div50/awards_call.html. The DEADLINE for receipt of all award nominations and relevant materials is May 1, 2010.

Nominations and related materials should be sent to the Fellows and Awards Committee at the following address:

Fellows and Awards Committee
c/o Sandra A. Brown, Chair
University of California, San Diego
Department of Psychology & Psychiatry
9500 Gilman Dr., MC0109
La Jolla, CA 92093-0109

For further information, please contact Sandy Brown at sanbrown@ucsd.edu.

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Evidence-Based Practice: Harry Wexler (hkwexler@aol.com)
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Liaisons

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Association for Behavioral & Cognitive Therapy (Addictive Behaviors SIG): Clayton Neighbors (claytonn@u.washington.edu)
Society for Research on Nicotine and Tobacco: Thomas Brandon (thomas.brandon@moffitt.org)
College of Professional Psychology: Sandy Brown (sanbrown@ucsd.edu)
Division 17: Matthew Martens (mpmrtens@memphis.edu)
Canadian Psychological Association—Substance Abuse/Dependence Section: Nancy Piotrowski (napiotrowski@yahoo.com)
Friends of NIAAA: Carlo DiClemente (diclemen@umbc.edu)
Friends of NIDA: Lisa Najavits (lnajavits@hms.harvard.edu)
APAGS: Erika Litvin (erika.litvin@moffitt.org)
Early Career Psychological Network: Vani Nath Simmons (Vani.Simmons@moffitt.org)

Appointed Student Representatives

Student Representative to the Board: Erika Litvin (erika.litvin@moffitt.org)
TBA
Advocacy and Policy: Walter Drymalski (walter.drymalski@marquette.edu)
Education & Training: Erika Litvin (erika.litvin@moffitt.org)
Membership: Liz DiPaola Handley (edipaola@asu.edu)
Science Advisory Committee: Danielle Ramo (danielle.ramo@gmail.com)

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The American Psychological Association, Division 50

Elizabeth J. D'Amico, Editor
Division 50 Central Office
750 First Street, NE
Washington, DC 20002-4242

Printed in the USA

Division 50 Executive Officers

PRESIDENT
Lisa M. Najavits
National Center for PTSD
VA Boston
150 South Huntington Ave. (116B-3)
Boston, MA 02130
Telephone: (857) 364-2780
Fax: (857) 364-4515
E-mail: lisa.najavits@hms.harvard.edu

PRESIDENT-ELECT
Fred Rotgers
Clinical Psychology PhD Program School of Psychology
College of Social and Behavioral Clinical Sciences
Walden University
155 Fifth Avenue South, Suite 100
Minneapolis, MN 55401
Telephone: 1-800-925-3368 ext. 1769
Fax: 732-549-1244
E-mail: frederick.rotgers@waldenu.edu

PAST PRESIDENT
Thomas H. Brandon
University of South Florida
H. Lee Moffitt Cancer Center &
Research Institute
4115 E. Fowler Avenue
Tampa, FL 33617
Telephone: (831) 745-1750
Fax: (831) 745-1755
E-mail: thomas.brandon@moffitt.org

SECRETARY
Amee Patel
Baylor College of Medicine
The Menninger Clinic
2801 Gessner Drive
Houston, TX 77080
Telephone: (713) 275-5509
E-mail: amee@mail.utexas.edu

TREASURER
Jennifer F. Buckman
Center of Alcohol Studies
Rutgers University
607 Allison Rd
Piscataway, NJ 08854-8001
Telephone: (732) 445-0793
Fax: (732) 445-3500
E-mail: jbuckman@rci.rutgers.edu

MEMBERS-AT-LARGE
Kristen G. Anderson
Adolescent Health Research Program
Reed College
3203 SE Woodstock Blvd.
Portland, OR 97202
Telephone: (503) 517-7410
Fax: (503) 517-7610
E-mail: andersok@reed.edu

John F. Kelly
MGH-Harvard Center for Addiction Medicine
60 Staniford Street
Boston, MA 02114
Telephone: (617) 643-1980
Fax: (617) 643-1998
E-mail: jkelly11@partners.org

Clayton Neighbors
University of Washington Dept. of Psychiatry & Behavioral Sciences Center for the Study of Health and Risk Behaviors
1100 NE 45th St, Suite 300
Box 354944
Seattle, WA 98195
Telephone: (206) 685-8704
Fax: (206) 616-1705
E-mail: claytonn@u.washington.edu

COUNCIL REPRESENTATIVE—PRACTICE
Ray Hanbury
Mount Sinai School of Medicine and
UMDNJ-Robert Wood Johnson Medical School
2640 Highway 70 Bldg. 7A Suite 202
Manasquan, NJ 08736-2609
Telephone: (732) 223-1242
Fax: (732) 223-3296
E-mail: HanburyPsy@aol.com

COUNCIL REPRESENTATIVE—SCIENCE
Jalie A. Tucker
Department of Health Behavior
School of Public Health
University of Alabama at Birmingham
1665 University Blvd., 227 RPHB
Birmingham, AL 35293
Telephone: (205) 934-5256
Fax: (205) 934-9325
E-mail: jtucker@uab.edu