The Addictions Newsletter

The American Psychological Association, Division 50

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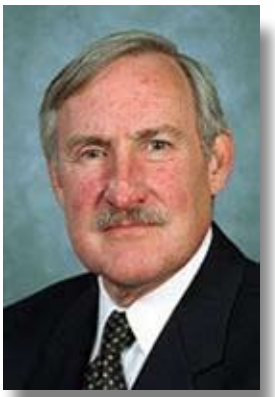
President's Column

Memorial Day Musings: Thoughts on How We Can Bring Addictions Treatment into the 21st Century

Frederick Rotgers

As I sit here in my office the Sunday before Memorial Day, I find myself thinking about the current crisis (yes, crisis) facing mental health and substance abuse care. I ponder how we, as a Society, might move the field forward into a more effective service delivery system so that research findings could be more easily available to anyone who wishes to access and use them.



Frederick Rotgers

More than 40 years ago, George Miller urged psychologists in his APA Presidential Address to "give psychology away" (Miller, 1969). Since then, the APA has made tremendous strides in doing just that. With many public information initiatives promulgated by the various APA Directorates, psychology is more and more directly in the hands of the people who can most benefit from it—those whose lives are affected by stress, family issues, substance use/misuse, and a myriad of other problems we all may suffer from. The APA was slow to make use of the burgeoning technology of the Internet, which allows us to communicate rapidly and effectively (albeit sometimes very briefly—the 140 characters of a "tweet" isn't much to say something really important!). We have now embraced that technology, especially within the Practice Directorate.

Online discussions via social networking sites, such as Twitter, Facebook, and LinkedIn, have allowed us to address significant issues in the workplace that play an integral part of the Psychologically Healthy Workplace program. This program aims to encourage employers to construct workplaces that promote psychological health and reduce workplace stress, thus leading to a reduced likelihood of mental health problems and substance use/misuse among employees. A recent discussion on LinkedIn focused on the importance of addressing the latter two issues in work settings. Participants in the discussion included psychologists and human resource managers from U.S. businesses.

So what does all of this have to do with the Society of Addiction Psychology (SoAP)? I'll tell you. In this age of

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President's Column

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increased use of telecommunications and the Internet, as well as devices such as smartphones, we can increase delivery of a wealth of information to consumers and potential consumers of substance use/misuse treatment. I believe we have partially missed the boat and failed, as a field, to take full advantage of the incredible reach that telecommunications and the Internet gives us as researchers and practitioners to deliver empirically-supported approaches directly to consumers in the privacy of their own homes. I say "partially" because there are some folks who have been actively involved in developing applications to provide web-based treatments for some segments of the potential client population. Reid Hester, for example, has been instrument in both developing and evaluating two websites (www.drinkerscheckup.com and www.moderatedrinking.com) aimed at helping problem drinkers make the decision to change their drinking habits. Reid has published the results of the randomized controlled trials for both web-based applications and demonstrated equivalent outcomes in these non-face-to-face applications and face-to-face treatments.

Web applications such as these have tremendous potential to reach problem drinkers who might otherwise never seek treatment. They provide anonymous, self-directed and interactive interventions that users can access in their own homes at any time of the day or night. Isn't this the kind of therapeutic intervention that many of us have dreamed of - one where our 50 minutes a week with a client (the typical treatment process in psychological treatments) can easily be generalized beyond one brief session?

The Internet has also become home to a number of support groups (e.g., Moderation Management [MM] and SMART Recovery) that provide a variety of support services online to their users 24/7. The user can access these groups without leaving home or identifying themselves by addressing their problem with substance use. MM ABSTAR is an online drinking self-monitoring site that boasts more than 5,000 registered users—a huge number when one considers that MM does not advertise and has no outreach other than to people who are already familiar with MM. Users of ABSTAR have the option of making their data "public" (e.g., their identities are transparent to anyone on the site) or "private" (e.g., no one else sees their data or any identifying information). Perhaps even more significantly, more than 60% of the registered users of ABSTAR are women. By providing the option of a truly anonymous (if so desired) and always available tool for helping to change drinking behavior, MM ABSTAR has been able to attract far more women into using its services than have many other support groups. These online support groups show how the Internet can help overcoming addictive behaviors truly "anonymous" and, in a sense, take the treasured anonymity of Alcoholics Anonymous and other 12-step support groups to a new level.

Recently, the APA Practice Directorate published a review of research on telehealth services in its February 2011 Practice Update Newsletter. What was striking to me in reading this was how strong the research evidence is in support of the use of a variety of tele-health interventions and media. These findings cover treatments of a wide variety of psychological problems, including substance use disorders. While the evidence on acceptability of these remote interventions by clients was less strong, it was still clear to me that there is a huge under-served population of people who can benefit from empirically-supported interventions to assist in reducing or stopping problematic substance use.

Offering our services online will have significant benefits for our clients. Imagine being able to work on your substance use issues directly with one of the many prominent practitioner-researchers who form the backbone of the SoAP? Imagine that anyone, anywhere in the world, regardless of how close they are geographically to a treatment center, practitioner's office or site of a face-to-face support group would be able to access the best empirically-supported treatments for changing addictive behaviors at any time they needed access?

I will be addressing the same set of issues in more depth in my Presidential Address prior to the SoAP Business Meeting at the APA Convention in Washington, DC in August. I hope to see all of you there, and I look forward to hearing your opinions on how we can make Internet technologies more effective to better serve those who wish to address their own addictive behaviors.

References

Anthony, K., & Nagel, D. M. (2010). *Therapy online: A practical guide*. Thousand Oaks, CA: Sage Publications.

Miller, G. A. (1969). Psychology as a means of promoting human welfare. *American Psychologist, 24*, 1063–1075. doi:10.1037/h0028988 ψ

Editor's Corner

Melissa A. Lewis

Greetings new and loyal readers of *The Addictions Newsletter* (*TAN*). You will not be disappointed with this exciting issue! To start off, I want to draw attention to our SoAP election results, which can be found on page 4. Congratulations to those who were elected into office. I look forward to working with each and every one of you.

Melissa A. Lewis

This issue of *TAN* highlights the APA Convention in Washington, DC! Be sure to take a look at the list of SoAP (Division 50) events. It is an amazing program that will be sure to have something of interest for everyone.

Also in this issue, Nancy Piotrowski interviews Barbara McCrady, Dominick DePhilippis, Karen Ingersoll, and Thomas Horvath. Check out the *Bridging the Gap* column for the trainers' practical insights. In *Student and Trainee Perspectives*, Matthew Worley points out several events that may be of interest to students and trainees at the upcoming APA Convention. In his article, Matthew also welcomes Ashley Hampton, a newly appointed student representative to the Executive Board of the SoAP.

I am happy to report that several individuals responded to my call for articles on alcohol energy drinks! There are four interesting articles on this topic in this issue. In her article, Lisa Berger discusses the risks associated with alcohol energy drinks. While, in his article, Joris C. Verster questions whether energy drinks mask the effects of alcohol. Kathleen E. Miller presents research in which she examined the relationship between alcohol energy drinks and sexual hookups. Finally, we have an article written by Cecile A. Marczinski, who presents findings from an experimental study examining the effects of alcohol energy drinks on behavioral control tasks. Also in this issue of *TAN* is an article by the Project SNIPE Team that describes a social norms intervention, which is to be conducted in Belgium, Denmark, Germany, Slovakia, Spain, Turkey, and the U.K. Do not miss out on these interesting reads.

As the academic year is coming to a close, it is likely that that we know several individuals who are graduating from high school and college, moving away from home, and who will soon be transitioning into new jobs and/or college over the upcoming months. With this in mind, for the Fall issue of *TAN*, I invite articles that focus on developmental transitions and role changes (e.g., graduating high school, moving away from home, transitioning to university, getting married, turning 21) and how these transitions and role changes relate to addictive behaviors. As always, all other topics are welcome!

We continue to get many funny entries for *TAN*'s cartoon caption contest! For the previous contest, Tom Brandon sent in the winning entry. Check out his winning caption on page 12. We have another cartoon caption contest in this issue of *TAN*. Please submit your original captions for the cartoon printed on page 12 to me at edtan@uw.edu. We will print the winning caption and the name of the winner in the Fall edition of *TAN*.

If you would like to submit an idea for a new column, article, abstract, or announcement for the Summer edition of *TAN*, please send them to me at edtan@uw.edu by **October 4th, 2011**. As always, I look forward to hearing from you! ψ

New Member Spotlight: Sudie Back

Amee B. Patel

For this issue, I interviewed new member Sudie Back, Associate Professor in the Clinical Neuroscience Division of the Department of Psychiatry at the Medical University of South Carolina (MUSC). She received her PhD in Clinical Psychology from the University of Georgia in 2004, after which she completed a postdoctoral fellowship in addictions at MUSC.

What are your research and clinical interests?

I am interested in the development and testing of integrative behavioral treatments for concurrent Substance Use Disorders (SUDs) and Posttraumatic Stress Disorder (PTSD). My colleagues and I have developed a behavioral treatment called "Concurrent Treatment of Substance Use Disorders and PTSD with Prolonged Exposure," which showed promising results in pilot studies in civilian samples in the U.S. and Australia. We are currently testing this treatment in a NIDA-sponsored randomized clinical trial among returning veterans with both SUDs and PTSD. I am also interested in the role of gender in predicting

Sudie Back

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New Member Spotlight

(Continued from page 3)

vulnerability, motives, and treatment outcomes for addictions, as well as prescription opiate abuse. Clinically, I am interested in addictions, anxiety disorders, and women's health issues.

Are you involved with any training opportunities that could be particularly useful for students and early career professionals?
I really enjoy working with early career professionals. Their enthusiasm is contagious! Through the NIDA-sponsored Drug Abuse Research Track (DART) that I help to direct at MUSC, I am actively engaged with training physician-scientists to conduct clinical research. The DART program's Summer Research Fellowship also allows me to work with undergraduates and medical students interested in research.

How did you hear about the SoAP?
Through my colleague, Sherry McKee.

What motivated you to join the SoAP?
I was motivated to join the SoAP in order to stay informed of exciting research being conducting around the country and the latest information in clinical care, and to meet potential collaborators.

What programs or initiatives would you like to see SoAP address?
One of the most pressing issues facing our nation at this time is the problem of prescription opiate abuse. In addition to high rates of prescription opiate misuse, patients are not informed about the proper ways to use and dispose of the medications or risks involved with use. Thus, initiatives are needed to develop effective ways to educate patients, physicians, and other healthcare providers. Another important issue is increasing the effectiveness of current treatments. In order for therapies to be effective, they must be accessible and user-friendly. Thus, initiatives toward the development of web-based interventions and the use of mobile technologies to enhance psychotherapeutic interventions would be helpful. ψ

Election Results

William Zywiak
SoAP (Div 50) Nominations and Elections Committee Chair

Thank you to everyone who voted during the Division election in April and May of 2011. One hundred forty votes were cast (20% of the eligible voters). The candidates Joseph Coyne, Sara Jo Nixon, James Bray, Kimber Price, and Carmen Pulido contributed considerable time and effort in the election process. Congratulations to Sara Jo Nixon. She was elected President-Elect. She will begin her term as President at the end of the Business Meeting at the 2012 APA Convention in Chicago. During the preceding 12 months she will shadow Warren Bickel as Warren begins serving as President in August 2011.

Congratulations to James Bray who was elected for a 3-year term as Member-at-Large (Public Interest). I would like to especially thank the soon to be Past-President, Fred Rotgers for the time and energy expended during the past 12 months as President. Also, I would like to give special thanks to Kristen Anderson for serving as Member-at-Large (Public Interest) for the past 3 years.

I hope you will attend Fred Rotgers' Presidential Address in Washington, DC on August 5th. At the convention and through November we will be looking for candidates for six offices: President-Elect, Member-at-Large (Science), Secretary, Treasurer, and two Council Representatives. ψ

Special Program at the APA Annual Meeting in Washington, DC

Practitioners' Forum Addressing Substance Use
Friday, August 5th, 2:00 p.m.–3:50 p.m.
Convention Center Room 103A

Clinical and non-clinical practitioners:
Whether substance abuse is a primary or secondary focus, join us for a unique opportunity to discuss what you need from NIH research. Dialogue with NIDA & NIAAA research division directors, branch chiefs, & research program staff. Tell NIH what information, methodology, materials would improve your ability to:

- Provide exceptional care for patients
- Support general education and clinical training
- Make informed program and policy decisions
- Maximize your effectiveness as a psychologist

Go to www.division50.org for more information. Submit a question for our panel in advance or bring your issues to the forum.

Supported in part by R13AA017170

Summer in the Nation's Capital: The 2011 APA Convention Comes to Washington, DC

Jennifer Read and Amy Rubin
2011 APA Convention Program Co-Chairs

We've got a great program for this year's meeting! The Society of Addiction Psychology (Division 50) has collaborated closely with Psychopharmacology and Substance Abuse (Division 28) to (co) sponsor a total of 14 symposia and 3 poster sessions, all on cutting-edge developments in basic and applied research as well as on clinical issues relevant to addictive behaviors. These events emphasize SoAP's interest in promoting exchange between the clinical practice and research communities.

Lincoln Memorial (Photo: Public Domain)

As part of the 2011 APA Convention Special Events program sponsored by SoAP, and in conjunction with the National Institute on Alcohol Abuse and Alcoholism (NIAAA), we will be hosting a Clinician's Panel Discussion. The goal of this panel discussion is to create a forum for prominent alcohol researchers to present their unique perspectives on a timely issue and engage in face-to-face dialog with clinical and research psychologists. The title of this panel discussion is *New Approaches to Diagnosing Substance Use Disorders in DSM-5* and it will be offered on Friday, August 5th from 10:00 a.m.–11:50 a.m. The goal of this event is to promote dialog between psychological practice and research and allow audience participation/dialog. This is being offered as part of a grant from NIAAA (R13 AA017107) to Drs. Jennifer Buckman (PI), Marsha Bates (Co-I), and Nancy Piotrowski (Co-I).

In addition, we have two poster sessions planned for this year that highlight issues of substance use and misuse across various populations. One session is devoted to *Substance Use and Misuse among Adolescents and Young Adults* (Thursday, 11:00 a.m.–11:50 a.m.) and the other is focused on *Patient Populations, Incarcerated Individuals, and Special Topics* (Saturday, 1:00 p.m.–1:50 p.m.).

Two convention symposia, which focus on current treatment approaches for addictive behavior, have been approved by the APA for Continuing Education credits. The first is *Treating Chronic Addictive Disorders-Maintaining and Extending the Benefits of Treatment* which will be offered on Thursday, August 4th from 10:00 a.m.–10:50 a.m. The second is *Addictions Update on Evidenced-Based Practice-What Works, How to Adapt It, and What Does Not Work*, which will also be offered on Thursday, August 4th from 12:00 p.m.–1:50 p.m.

We have had tremendous interest in our programming this year from a wide variety of other Divisions within the APA. In addition to sharing sponsorship of all programming with Division 28, we also received support (in the way of co-listing) from Divisions 12, 18, 19, 25, 32, 38, 40, 42, 43, 46, 53, and 56. Members of Division 42 may be particularly interested in our Pre-Convention Workshop, *Helping Patients Who Drink Too Much: Using The NIAAA Clinician's Guide* (8 CEUs), which provides a review of screening and brief intervention for people with substance use problems. We also have a Pre-Convention Grant-Writing Workshop (4 CEUs), to be presented by National Institute on Drug Abuse (NIDA) staff. Pre-Convention Workshops require free pre-registration. To register, please e-mail your contact information to division50apa@gmail.com.

U.S. Supreme Court (Photo: Public Domain)

Something new on the SoAP programming schedule this year is the Practitioners' Forum. The goal of this event is to provide a forum for clinical, educational, policy and other practitioners who use NIDA and NIAAA's research findings to communicate their needs to the two Institutes. Specific questions, concerns, and ideas can be posed directly to NIH staff at the event itself, and participants also will have the opportunity to send in issues and questions in advance. This event will be held on Friday, August 5th from 2:00 p.m.–4:00 p.m. Details about the location can be found in your convention program and also on the SoAP website. We look forward to seeing you there!

Lastly, we are very excited about the combined SoAP and Division 28 *Early Career Poster Session and Social Hour* on Friday from 6:00 p.m.–8:00 p.m. This event will follow directly after the SoAP Business Meeting and Presidential Address (Dr. Fred Rotgers will be presenting *The Internet,Tele-Mental Health and Addictions Treatment: Expanding Our Reach*), so please plan to head on over after the meeting to enjoy food, drinks, and some great posters from promising early career scientists.

For times and locations for all of these events, see the SoAP website at www.apa.org/divisions/div50. ψ

2011 APA Convention in Washington, DC SoAP (Division 50) Program Summary

Wednesday, August 3rd

Helping Patients Who Drink Too Much: Using the NIAAA Clinician's Guide (8CE)

Time: 8:00 a.m. – 4:50 p.m., Renaissance Washington DC, Meeting Room 5
Co-Chairs: Robert Huebner, PhD, National Institute on Alcohol Abuse and Alcoholism; Mark Willenbring, MD, Director of the Addictive Disorders Section at the Minneapolis VA Medical Center, the Associate Professor of Psychiatry at the University of Minnesota and Special Liaison to the National Institute on Alcohol Abuse and Alcoholism
Co-Sponsoring Division: 28

Unlock the Mysteries of NIH Research Funding: Improve your Grant Application and Improve Your Chance at Success (4CE)

Time: 1:00 p.m. – 4:50 p.m., Renaissance Washington DC, Meeting Room 5
Co-Chairs: Harold Perl, PhD, National Institute on Drug Abuse; Kristen Huntley, PhD, National Institute on Drug Abuse; and Theresa Levitin, PhD, National Institute on Drug Abuse
Co-Sponsoring Division: 28

Thursday, August 4th

Health Care Reform: Challenges to the Current Addictions Treatment System

Time: 8:00 a.m. – 9:50 a.m., Convention Center Room 144B
Chair: Harry Wexler, PhD
Co-Listing Divisions: 12, 18, 28, 32, 38

Treating Chronic Addictive Disorders: Maintaining and Extending the Benefits of Treatment

Time: 10:00 a.m. – 10:50 a.m., Convention Center, Room 143C
Chair: Gregory Brigham, PhD
Co-Listing Divisions: 12, 18, 28

Providing Trauma-Informed Substance Abuse Treatment: Residential and Outpatient Programs and Outcomes

Time: 11:00 a.m. – 11:50 a.m., Convention Center Room 159
Chair: Meredith Cosden, PhD
Co-Listing Divisions: 18, 19, 28, 56

POSTER SESSION I: Adolescents and Young Adults

Time: 11:00 a.m. – 11:50 a.m., Convention Center Halls D & E
Co-Listing Division: 28

Addictions Update on Evidence-Based Practice: What Works, How to Adapt it, What Does Not Work

Time: 12:00 p.m. – 1:50 p.m., Convention Center Room 147A
Chair: Nancy Piotrowski, PhD
Co-Listing Divisions: 12, 17, 19, 28, 38

Friday, August 5th

CTN Electronic Medical Records Project: Implications of Adopting Standardized Core Data Elements in Health IT Systems of Drug Abuse Treatment Providers

Time: 8:00 a.m. – 9:50 a.m., Convention Center Room 159
Co-Chairs: Udi Ghitza, PhD, and James Bray, PhD
Co-Listing Divisions: APAGS

New Approaches to Diagnosing Substance Use Disorders in DSM 5

Time: 10:00 a.m. – 11:50 a.m., Convention Center Room 151B
Chair: Nancy Petry, PhD
(Continued on page 7)
Co-Listing Divisions: 18, 19, 28, 32; Sponsored by: NIAAA (R13 AA017107), panel discussion format, audience participation is encouraged

Avatar-Based Recovery Using Immersive Virtual Environments to Supplement Substance Abuse Treatment
Time: 12:00 p.m. – 12:50 p.m., Convention Center Room 140A
Co-Chairs: Ivana Steigman, MD, PhD, and Richard Wexler, PhD
Co-Listing Divisions: APAGS, 28

CONVERSATION HOUR: NIDA/NIAAA PRACTITIONER'S FORUM
Time: 2:00 p.m. – 3:50 p.m., Convention Center Room 103A
Chair: Meyer Glanz, PhD
Co-Listing Division: 28

PRESIDENTIAL ADDRESS
Time: 4:00 p.m. – 4:50 p.m., Renaissance Washington Hotel Meeting Rooms 8 and 9
Presenter: Fred Rotgers, PsyD
Chair: Warren Bickel
Co-Listing Division: 28

BUSINESS MEETING*
Time: 5:00 p.m. – 5:50 p.m., Renaissance Washington Hotel Meeting Rooms 8 and 9
Chair: Fred Rotgers, PsyD
Co-Listing Division: 28
*Please note: in addition to usual business meeting, a memorial for Dr. Alan Marlatt will be held.

POSTER SESSION; NIDA- and NIAAA-Sponsored Early Career Poster Session and Social Hour
Time: 6:00 p.m. – 7:50 p.m., Renaissance Washington Hotel Grand Ballrooms Central and South
Sponsored by: NIDA and NIAAA
Co-Listing Division: 28

Saturday, August 6th

Cognition and Addiction: Using PDAs to Predict and Prevent
Time: 8:00 a.m. – 9:50 a.m., Convention Center Room 151B
Co-Chairs: Andrew Waters, PhD, and Stephan Heishman, PhD
Co-Listing Divisions: 19, 28, 40, 46, APAGS

Innovation and Opportunities in Mobile Interventions for Addictions
Time: 10:00 a.m. – 11:50 a.m., Convention Center Room 101
Co-Chairs: Lisa Onken, PhD, and Brent Moore, PhD
Co-Listing Divisions: 28, 38, 46, APAGS

POSTER SESSION II: Patient Populations, Incarcerated Individuals, Special Topics
Time: 1:00 p.m. – 1:50 p.m., Convention Center Halls D & E
Co-Listing Division: 28

Sunday, August 7th

Neurobehavioral and Technological Mechanisms to Improve Efficacy and Effectiveness of Substance Abuse Treatment
Time: 8:00 a.m. – 9:50 a.m., Convention Center Room 103B
Co-Chairs: Will Aklin, PhD, and Lisa Onken, PhD
Co-Listing Division: 19, 25, 28

Mechanisms of Parent Influence Among Adolescents and College Students: Moderators and Mediators of Alcohol-Related Outcomes
Time: 10:00 a.m. – 11:50 a.m., Convention Center Room 103B
Co-Chairs: Joseph LaBrie, PhD, JD, and Justin Hummer, BA
Co-Listing Division: 7, 28, 43, 53

Federal Update

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

Recent actions at the federal level could have long-term implications for research and practice in the area of addictions. Recently, Senator Coburn (R-OK) authored a highly critical report on the National Science Foundation. Within this report, Senator Coburn called for the elimination of the Social, Behavioral, and Economic Sciences Directorate. The Senate will hear testimony about this recommendation in early June 2011. The *Federal Register* (Vol .76, No. 69) announced changes to the Substance Abuse and Mental Health Service Administration (SAMHSA) Community Mental Health and Substance Abuse and Prevention block grant programs, integrating substance use and mental health service grants into a single application. The April 11th, 2011 Register reported that as health care reform is estimated to cover 32 million uninsured individuals between 2012–2015, the priorities of State Mental Health Authorities and State Substance Abuse Authorities will change. As such, the notice highlights four targets for the program: (1) fund treatment and support services to individuals without insurance, (2) cover treatments and services, demonstrated to have success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare or private insurance, (3) fund prevention activities, and (4) assess the effectiveness of behavioral health prevention, treatment and recovery support services (pp. 19,999–20,000). The notice explicitly discusses issues of parity in state mental health and substance use programs as well as strategies to integrate primary and behavioral health care.

U.S. Capitol (Photo: Public Domain)

As this is my final column, I wanted to take this opportunity to thank the members of the Advocacy and Policy Committee as well as the broader SoAP (Division 50) membership. Over the past few years, we have been working to broaden the network of SoAP members with an interest in policy issues. We have expanded the membership of the committee as well as built a communication network comprised of addiction professionals, students, and state leaders who have a shared interest in furthering services and research for individuals with mental health and behavioral disorders. Using these resources, we have worked with the SoAP board to advocate for the needs of our clients at the federal level. I would like to thank the committee members for their hard work: Kelly Dunn, Diane Garrison, Rebecca Kayo, Brad Oleson, Nancy Piotrowski, Steven Proctor, and Andrew Tatarsky. In addition, I would like to thank all of the SoAP members who have been willing to share their interests (and listen to mine!) on these issues. ψ

Pre-Convention Workshops — Free CE Credits!

Workshop: Helping Clients Who Drink Too Much: Using the NIAAA Clinician's Guide
When: Wednesday, August 3rd from 8:00 a.m. – 5:00 p.m.
Where: Renaissance Hotel, Congressional Hall C
Credits: 8 CE credits are available through SoAP (Division 50)
This interactive workshop will provide an overview of current screening and intervention tools for primary care and mental health clinicians.

Workshop: Unlock the Mysteries of NIH Research Funding: Improve Your Grant Application and Improve Your Chance at Success
When: Wednesday, August 3rd from 1:00 p.m. – 5:00 p.m.
Where: Renaissance Hotel, Meeting Room 5
Credits: 4 CE credits are available through SoAP (Division 50)
Join long-time NIH staff members for this interactive workshop to learn how to develop successful applications for NIH research grant funds. Investigators at all levels of experience are invited.

To pre-register, e-mail division50apa@gmail.com. Remember that space is limited!

Supported in part by R13AA017107.

Bridging the Gap

So You Have to Give a Training…

Nancy A. Piotrowski
Capella University
Co-Chair of Evidence Based Practice in Addictions Committee

We continue our discussion with four trainers from varied settings. Each person offers tips, from their perspective, on what might be valuable to your preparation for the next training you offer. The first featured trainer is Barbara McCrady (BMC), distinguished Professor and Director at the Center on Alcoholism, Substance Abuse, and Addictions in Albuquerque, New Mexico. The second is Dominick DePhilippis (DD), an Education Coordinator at the Philadelphia Center for Excellence in Substance Abuse Treatment and Education. The next trainer is Karen Ingersoll (KI), an Association Professor at the Virginia Commonwealth University in Richmond, Virginia. Finally, we have A. Thomas Horvath (ATH), President of Practical Recovery in San Diego, California.

Barbara McCrady

NAP: ***What is the focus of your work in addictions training related to evidence based practices (EBPs)?***

BMC: Training clinicians in Cognitive-Behavioral Therapy (CBT) and Alcohol Behavioral Couples Therapy (ABCT) for alcohol and other substance use disorders.

DD: Implementation of a performance measure, the Brief Addiction Monitor, or BAM (Brief Addiction Monitor), which is a 17-item measure that characterizes treatment progress over time by looking at protective and risk factors, as well as substance consumption…we use this measure in VA settings to promote measurement-based care in substance use settings in the context of implementing EBP.

KI: Motivational Interviewing (MI), Motivational Interviewing groups, Relapse Prevention, and some other approaches…

ATH: We focus on making sure that all staff understand CBT, MI, and harm reduction. In our case, the simplest way to communicate these concepts is through my workbook *Sex, Drugs, Gambling & Chocolate: A Workbook for Overcoming Addiction* (Horvath, 2004).

NAP: ***Who are the clinicians you train?***

BMC: I have trained clinicians at a range of levels of experience—from high-school educated addictions counselors to doctoral-level psychologists.

DD: Doctoral level psychologists, masters level social workers, addictions therapists, registered nurses, psychiatrists, and other medical doctors.

Dominick DePhilippis

KI: Most of the time, I am training audiences of clinicians who work either with addictions, chronic health problems, or both. I have an active consultation with a group of community corrections staff—some have a Bachelor's or a Master's degree, some are probation officers or counselors. Additionally, I train primary care physicians, nurses, and dieticians in areas including helping patients who are smoking, have diabetes, or are overweight. In the public sector addiction treatment area in my state, most clinicians have Master's degrees, but some have high school degrees and on the job training, or some college education with lots of experience with addicted populations. I also train advanced practitioners, such as post-doctoral psychologists.

ATH: Psychologists, psychology postdocs, MFTs, MFT interns...

NAP: ***This is a good collection of populations related to trainer experiences—techniques, relationship building through listening, and even measurement procedures—a broad spectrum of what EBPs are and can be. Building on this, tell me, what practical applications challenges you have encountered as a trainer?***

ATH: Selecting individuals who are or can become solid therapists…we aim to integrate addiction treatment into a broader treatment plan, so our focus is on being competent therapists first, with addiction treatment as just part of what is happening.

BMC: With CBT I sometimes see resistance to behavioral approaches from disease model clinicians; also some reluctance to "give up" their approach for a different one. With ABCT, there are similar to challenges and a need to address the belief that you should treat the drinking or drug problem first and address relationship issues later. There is also a lack of experience in working with couples; fear of working with couples (e.g., "what do I do if they start arguing?"); belief that clients do not want partners there and that partners do not want to be there. Sometimes I also see a perception that ABCT is at odds with teachings of Al-Anon and co-dependency models.

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Bridging the Gap

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KI: I learn all I can about the audience ahead of time. I also know that the person asking me to do the training may overestimate how familiar the trainees are with what I will be training. I start each event by inquiring about why they came, what they hope to learn, and how much previous training they have had in the topic. I also have changed my curricula to be very interactive. I find that interactive exercises produce the most learning and the best retention. Those exercises can then be a springboard for discussion that leads to the trainees "discovering" the principles and strategies that are part of the approach. I try to elicit as much from trainees as possible, about their clients, their struggles, their attempted solutions, and invite them to consider whether the topic we are reviewing might address some of these difficulties. I may still have slides, but I now darken the screen for most of the experiential portion of training. I also try to train much smaller groups than I once did, so that I can circulate during exercises and listen in on the skills that folks are trying to develop. My number one tip is to use a co-trainer whenever possible, especially for two or three day workshops. It keeps the energy up, and allows us to listen in and coach more people, more efficiently.

Karen Ingersoll

DD: I have found that you wear many hats when doing this kind of work - educator, researcher, motivational speaker—even being a conference coordinator! Work as a psychologist is the predominant part, but you often have to stretch to include these other things and know a lot about all of these areas of implementation science.

NAP: ***Do you have any useful tips on resources related to this work—things you would recommend to others, or things you wish you had?***

KI: It was helpful to me to get familiar with the adult learning literature. My primary resource in learning how to train and improve my own skills was attending workshops run by others to observe training styles and methods. I attended a few workshops on training in different areas hosted by APA and other professional groups. Additionally, I am a member of the Motivational Interviewing Network of Trainers (Motivational Interviewing Network of Trainers), and we have a listserv and yearly forum where we share training tips and exercises.

BMC: I have found that it really helps to engage the audience in an active exercise at the beginning of any training. For example, with ABCT—"Think of a client you've treated who had a family member: What did they say about that person? How did the family member facilitate the client's treatment? How did the family member make it more difficult?" I also find it important to anticipate concerns that I have encountered previously and to address them in advance, while also inviting discussion and exchange of perspectives.

A. Thomas Horvath

DD: We train providers on the measurement-based care (MBC) approach to addictions treatment; and, we are fortunate to have one of the leaders in MBC—James R. McKay (McKay, 2009)—as Director of the Philadelphia CESATE. Reading his work is a good tip. I also find that the work of Dean L. Fixsen (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005) has been of great value. I heard him talk about an example from NASA: When working on any project, make sure to pay attention to three continua of cost, speed, and quality…NASA basically learned that it is difficult to maximize all three…and that the best option may be to maximize two. When you think about it, something that is low cost and high quality usually takes a long time to make, while something that is high quality and done fast is very costly. I think the same is true for thinking about how to do implementation science. Swift implementation at high quality can be very costly—so there is a lot to balance in doing this work in real world settings.

ATH: I always like to make sure people know about the resources available through Self Management and Recovery Training (Self Management and Recovery Training). Trainees who are new to this area may find this material helpful for their clients.

NAP: ***What things do you wish you had more of to help you train?***

BMC: Step-by-step training manuals with built-in exercises and illustrations.

DD: Our interventions are not proprietary, so making the case for how the interventions add value to the work of our trainees, rather than personal gain, drives their promotion. No one owns the interventions; they are in the public domain. The challenge is to "sell" them—not in a financial sense, but in a value-added sense. We seek out and train champions for these different methods where we want to see implementation succeed.

KI: There may be training resources out there that I am not aware of that could have shortened the time it took me to get proficient in training, but I am not sure what they might be! Therefore, I wish I had had an easier way to find new resources.

ATH: Addiction training materials that emphasize much more that addiction treatment is part of the larger process of therapy.

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NAP: *Anything else you might like to share on how we can better bridge the gap, from the perspective of trainers?*

ATH: Addiction treatment has focused too much on technique, and not enough on relationship.

DD: With any of what we are doing, none of it is "one and done"—training and didactics are good, but we also need to remember post-training coaching.

KI: Guidance about setting training fees...I have learned over the years that fees can be all over the map, and that quality can vary tremendously. It is important to provide careful bids that specify not only what the training event will include, but also any special skills, experience, or interests I may have that can set me apart. I also have learned that sometimes it is better to say no to a training opportunity because of unrealistic expectations on the part of the contractor. For example, if someone insists that I train 100 clinicians to competence in MI in one hour, I will negotiate a more realistic expectation or walk away.

BMC: Giving clinical examples is helpful—it enhances credibility as a clinician, particularly for those who also do academics. The examples tell the story. I also think it is important to develop a real understanding of the perspective of the audience, and to communicate respect for the perspective while still offering something different. Arguing with an audience never works; expressing understanding that you are presenting a different perspective helps, as does "rolling with resistance."

References

Brief Addiction Monitor. www.mentalhealth.va.gov/providers/sud/docs/BAM_brochure_8-20-08.pdf

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

Horvath, A. T. (2004). *Sex, drugs, gambling & chocolate: A workbook for overcoming addictions* (2nd ed.). Atascadero, CA: Impact Publishers.

McKay, J. R. (2009). *Treating substance use disorders with adaptive continuing care*. Washington, DC: American Psychological Association.

Motivational Interviewing Network of Trainers. www.motivationalinterview.org/quick_links/mint.html

Self Management and Recovery Training. http://SMARTrecovery.org ψ

Student and Trainee Perspectives

Matthew Worley

This edition marks the final installment of TAN before the annual APA Convention, and we thought it might be helpful to highlight some events of interest for student members of SoAP. Wake up early for the Speed Mentoring session, occurring from 8:00 a.m. to 10:00 a.m. on August 6th at the Grand Hyatt Independence Ballroom A. During this event, students have the opportunity to convene and converse with experienced psychologists. The event is free but registration is required and space is limited. For more details, you can go to www.apa.org/convention/activities/speed-mentoring/index.aspx.

APA's Student Association is also sponsoring a series of events that will be especially helpful for near and future internship applicants. These events include two internship workshops on the morning of Friday, August 5th, and a "Meet and Greet" with internship training directors on August 6th from 1:00 p.m. – 2:00 p.m. A full list of student programming can be found at www.apa.org/convention/membership/students-sessions.aspx.

We also want to welcome Ashley Hampton, a newly appointed student representative to the Executive Board of the SoAP. Ashley initiated her tenure within the past few months, and we are looking forward to getting her more involved in other SoAP affairs.

Statement from Ashley:

I am eager to begin making contributions to the SoAP (Division 50) Executive Board as its newly appointed student representative. I originally became interested in addictions as an undergraduate, when I was involved with developmental psychology research investigating the impact of parental incarceration on children's outcomes, including substance abuse. As a graduate student in the clinical psychology program at Temple University, I have continued to investigate pathways to addiction and substance use disorders among low-income, urban children and adolescents. I am particularly interested in the roles of emotion regulation, sensation seeking, and neuropsychological factors in the development of substance use disorders. Most recently, I've also studied various factors predicting treatment retention among adults in substance use treatment, including motivation, legal coercion, and comorbidity. Ultimately in my career, I hope to conduct research focused on improving our understanding of factors that lead to increased risk for substance use and then utilize this research to develop more effective prevention and intervention methods, particularly for adolescents involved in the criminal justice system.

I was motivated to become a student representative in order to become more involved in SoAP. In addition to assisting in the advancement of Board initiatives, I am also highly interested in serving as a link between students and established members. In particular, I would like to increase opportunities for students to interact with the experts in addiction psychology who are members of SoAP. I am interested in developing networking opportunities within the SoAP, enabling more student involvement in SoAP committees, and increasing student-centered programming at the Convention. ψ

Dr. Riley was the hit of the APA convention with her brilliant structural equation model, which doubled as a guide to restroom locations in the convention center.

Caption by Tom Brandon
Cartoon by Jessica A. Blayney

Cartoon Caption Contest: Here we go again! We provide the cartoon and you, the reader, provide the caption. Entries for the contest will be accepted until **October 4th, 2011** at edtan@uw.edu. We'll print the name of the winner and the winning caption entry in the Fall edition of *TAN*.

Cartoon by Jessica A. Blayney

Caption Contest Results

Contest Entries:

a. "Our primary finding was that all of the variables we measured could be linked back to Kevin Bacon using 6 or fewer arrows."
b. "I heard convention submissions had declined, but this is ridiculous."
c. "Ok Bob, looks like it's just you and me this year...but what did they expect in Washington in August!"
d. "Dr. Riley was the hit of the APA convention with her brilliant structural equation model, which doubled as a guide to restroom locations in the convention center."
e. "As you can see, alcohol consumption at APA is moderated by the number of conference sessions attended."
f. "The Gateway Drug Theory has been revised again: Every drug is now shown to lead to the use of every other drug."
g. "I have no idea what this poster means, but I did stay in a Holiday Inn Express last night."
h. "Cheryl realized that while her model didn't show anything statistically significant, she had successfully mapped out the Rhumba."
i. "On the third day of the conference, Jim finally realized he was not at the American Pool Players Association meeting, but didn't want to make a scene."
j. "Steve and Karen reflected on the fact that if they had waited two more years to submit their poster, they could have gone to Hawaii instead of DC."

Winning caption:
"Dr. Riley was the hit of the APA convention with her brilliant structural equation model, which doubled as a guide to restroom locations in the convention center."

The winning cartoon caption came from Tom Brandon! Tom Brandon is a psychology professor at the University of South Florida and the director of smoking research at Moffitt Cancer Center in Tampa. He served as president of Division 50 in 2008–2009. While attending graduate school in Wisconsin and preparing for preliminary exams, he considered stand-up comedy as an alternative career path. This contest, however, is the closest he's come to realizing that dream.

Alcohol and Energy Drinks: What Are the Risks?

Lisa Berger
University of Wisconsin—Milwaukee

This past November, the Food and Drug Administration (FDA) warned several makers of malt alcoholic beverages that the addition of caffeine to their products is an unsafe food additive (Food and Drug Administration, 2010). This action thereby prohibited the sale of several premixed alcoholic energy drinks in the U.S. The FDA's action was based on a scientific review that, in part, examined published research on the health and safety issues associated with the combination of caffeine and alcohol (Food and Drug Administration, 2010). Despite the FDA's action, issues with alcohol energy drinks remain. Individuals can still mix energy drinks with alcohol on their own and alcoholic beverages mixed with energy drinks can still be purchased in many restaurants and bars.

Energy drinks such as Red Bull®, Monster®, and Rockstar® are designed to provide an energy boost to consumers with caffeine being their primary component (Simon & Mosher, 2007). The amount of caffeine contained in any given energy drink can range from 80 to 174 mg per container or higher (Reissig, Strain, & Griffiths, 2009). This amount is generally greater than that of a 12-ounce can of soda or cup of brewed coffee (Babu, Church, & Lewander, 2008). On its own, energy drink use is a cause for concern (Seifert, Schaechter, Hershorin, & Lipshultz, 2011). Additionally, a growing body of literature warns against the dangers of mixing energy drinks with alcohol (Arria & O'Brien, 2011). To date, most of the research conducted in this area has utilized college student samples to report the dangers of mixing alcohol and energy drinks. This research has been publicized and has influenced some states and universities prior to the FDA's action to ban alcoholic energy drinks (Goodnough, 2010).

Prevalence rates of combined alcohol and energy drink use has been found to range from 24% in a representative sample of college students (O'Brien, McCoy, Rhodes, Wagoner, & Wolfson, 2008) to 6% in a representative community sample (Berger, Fendrich, Chen, Arria, & Cisler, 2011). O'Brien and colleagues (2008) found that college students who reported consuming alcohol mixed with energy drinks significantly engaged in more frequent heavy episodic drinking, defined as four or more drinks for women and five or more drinks for men in one sitting. In addition, those who mixed alcohol and energy drinks significantly experienced more frequent weekly intoxication when compared to students who used alcohol only. Students who consumed alcohol mixed with energy drinks also had a significantly higher prevalence of alcohol-related problems such as being taken advantage of sexually, taking advantage of someone else sexually, and riding with a driver under the influence of alcohol. In another study, Thombs and colleagues (2010) found that patrons in a college bar district who had consumed alcohol mixed with energy drinks were more likely to leave a bar with a breath alcohol concentration at or above the legal limit and were more likely to intend to drive compared to other drinking bar patrons who did not consume alcoholic beverages mixed with energy drinks. Other studies have found energy drink use among college students to be significantly associated with increased frequency and quantity of alcohol use (Arria et al., 2010), and in one study, frequency of energy drink use was found significantly associated with alcohol use and alcohol-related problems in White but not for Black college students (Miller, 2008). Furthermore, weekly or daily energy drink use among college students has been found to be significantly associated with alcohol dependence (Arria et al., 2011). In the only study known to date to have examined the combined use of alcohol and energy drinks in a community sample, investigators found that past-year alcohol and energy drink users were more likely to be White and younger when compared to past-year energy drink only users (Berger, Fendrich, Chen, Arria, & Cisler, 2011). Clearly, young people seem to be the most at risk for mixing alcohol and energy drinks together, a practice that has been encouraged by both alcohol and energy drink companies (Simon & Mosher, 2007). For example, the company that makes Red Bull® encourages the mixing of their product with alcohol by employing cross-promotions and contests with trips and prizes geared toward bartenders and cocktail servers (Simon & Mosher, 2007). An overarching concern regarding the mixing of energy drinks with alcohol is that consumers may believe that caffeine counteracts the intoxicating effects of alcohol. Although caffeine may reduce sleepiness, it does not significantly reduce alcohol-related impairment (Arria & O'Brien, 2011). Ferreira and colleagues (2006) found that alcohol plus energy drink use did not significantly reduce alcohol-induced deficits as evaluated by objective motor coordination and visual reaction time tests. In addition, the mixing of energy drinks with alcohol may prolong a drinking session by keeping individuals awake, and therefore, placing individuals at even greater risk for experiencing alcohol-related consequences (Arria & O'Brien, 2011). Finally, even if not consumed with alcohol, researchers have documented that energy drinks are used by college students to treat hangovers (Malinauskas, Aeby, Overton, Carpenter-Aeby, & Barber-Heidal, 2007). In general, more research is needed on this current phenomenon of combining alcohol and energy drinks, and in particular, as this practice relates to the risk for additional alcohol-related harms (e.g., alcohol poisoning; Arria & O'Brien, 2011).

The recent FDA action that successfully encouraged makers of premixed alcoholic energy drinks to remove caffeine from their products should alert consumers that mixing alcohol and energy drinks together confers risk (Arria & O'Brien, 2011; Stein & Johnson, 2010). Furthermore, as the caffeine content of energy drinks is

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Alcohol & Energy Drinks

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presently unregulated (Babu, Church, & Lewander, 2008), regulatory agencies should require energy drink makers to disclose caffeine content on product labels, including information about the potential risks of mixing energy drinks with alcohol (Arria & O'Brien, 2011). Finally, health professionals from all disciplines, especially on college campuses, should warn individuals about the known risks of combining alcohol and energy drinks together.

References

Arria, A. M., Caldeira, K. M., Kasperski, S. J., O'Grady, K. E., Vincent, K. B., Griffiths, R. R., & Wish, E. D. (2010). Increased alcohol consumption, nonmedical prescription drug use, and illicit drug use are associated with energy drink consumption among college students. *Journal of Addiction Medicine, 4*, 74–80. doi:10.1097/ADM.0b013e3181aa8dd4

Arria, A. M., Caldeira, K. M., Kasperski, S. J., Vincent, K. B., Griffiths, R. R., & O'Grady, K. E. (2011). Energy drink consumption and increased risk for alcohol dependence. *Alcoholism: Clinical & Experimental Research, 35*, 1–11. doi:10.1111/j.1530-0277.2010.01352.x

Arria, A. M., & O'Brien, M. C. (2011). The "high" risk of energy drinks. *The Journal of the American Medical Association*. Advance online publication. doi:10.1001/jama.2011.109

Babu, K. M., Church, R. J., & Lewander, W. (2008). Energy drinks: The new eye-opener for adolescents. *Clinical Pediatric Emergency Medicine, 9*, 35–42. doi:10.1016/j.cpem.2007.12.002

Berger, L. K., Fendrich, M., Chen, H-Y., Arria, A. M., & Cisler, R. A. (2011). Sociodemongraphic correlates of energy drink consumption with and without alcohol: Results of a community survey. *Addictive Behaviors, 36*, 516–519. doi:10.1016/j.addbeh.2010.12.027

Ferreira, S. E., de Mello, M. T., Pompeia, S., & de Souza-Formigoni, M. L. (2006). Effects of energy drink ingestion on alcohol intoxication. *Alcoholism: Clinical & Experimental Research, 30*, 598–605. doi:10.1111/j.1530-0277.2006.00070.x

Food and Drug Administration. (2010). FDA warning letters issued to four makers of caffeinated alcoholic beverages [Press release]. Retrieved from www.fda.gov/NewsEvents/Newsroom/ PressAnnouncements/ucm234109.htm

Goodnough, A. (2010, November 10). Second state bans caffeinated alcoholic drinks. *The New York Times*. Retrieved from www.nytimes.com/2010/11/11/us/11drinks.html

Malinauskas, B. M., Aeby, V. G., Overton, R. F., Carpenter-Aeby, T., & Barber-Heidal, K. (2007). A survey of energy drink consumption patterns among college students. *Nutrition Journal, 6*, 35. doi:10.1186/1475-2891-6-35

Miller, K. E. (2008). Energy drinks, race, and problem behaviors among college students. *Journal of Adolescent Health, 43*, 490–497. doi:10.1016/j.jadohealth.2008.03.003

O'Brien, M. C., McCoy, T. P., Rhodes, S. D., Wagoner, A., & Wolfson, M. (2008). Caffeinated cocktails: Energy drink consumption, high-risk drinking, and alcohol-related consequences among college students. *Academic Emergency Medicine, 15*, 453-460. doi:10.1111/j.1553-2712.2008.00085.x

Reissig, C. J., Strain, E. C., & Griffiths, R. R. (2009). Caffeinated energy drinks—A growing problem. *Drug and Alcohol Dependence, 99*, 1–10. doi:10.1016/j.drugalcdep.2008.08.001

Seifert, S. M., Schaechter, J. L., Hershorin, E. R., & Lipshultz, S. E. (2011). Health effects of energy drinks on children, adolescents, and young adults. *Pediatrics, 127*, 511–528. doi:10.1542/peds.2009-3592

Simon, M., & Mosher, J. (2007). *Alcohol, energy drinks, and youth: A dangerous mix*. Marin Institute: Alcohol Industry Watchdog.

Stein, R., & Johnson, J. (2010, November 17). Maker of Four Loko to remove caffeine from alcoholic drinks. *The Washington Post*. Retrieved from www.washingtonpost.com/wp-dyn/content/article/2010/11/16/AR2010111606149.html

Thombs, D., O'Mara, R. J., Tsukamoto, M., Rossheim, M. E., Weiler, R. M., Merves, M. L., & Goldberger, B. A. (2010). Event-level analyses of energy drink consumption and alcohol intoxication in bar patrons. *Addictive Behaviors, 35*, 325–330. doi:10.1016/j.addbeh.2009.11.004 ψ

The Current Energy Drink Debate: Masking the Facts!

Joris C. Verster
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A recent commentary in the Journal of the American Medical Association enhanced the energy drink debate by summarizing data from a handful of surveys showing correlations between energy drinks and alcohol consumption (Arria & O'Brien, 2011). The message was simple: mixing energy drinks with alcohol causes people to drink more alcohol and may even be a gateway to alcohol dependence. However, Verster and Alford (2011) have published an editorial in Current Drug Abuse Reviews explaining that these associations and correlations do not prove a cause-and-effect relationship, and that it is therefore premature to draw firm conclusions or push for changes in legislation.

The current debate on energy drinks mixed with alcohol (AMED) focuses on the assumption that energy drink consumption masks the intoxication effects of alcohol. It is then argued that the drinker's perception of intoxication has changed, which may result in an increase in total alcohol consumption and provoke risky behaviors such as driving while intoxicated (e.g., Higgins, Tuttle, & Higgins, 2010; Reissig, Strain, & Griffiths, 2009). Caffeine is generally seen as the ingredient of energy drink that causes these masking effects.

The caffeine content of popular energy drinks such as Red Bull® is 80 mg per 250 ml, i.e. about three times the amount of cola beverages, but less than a regular cup of coffee (100-140 mg).

If this is true, there would be a good cause for concern. Therefore, it is important to have a closer look at the scientific evidence available to determine the validity of this claim.

Most literature discussing masking effects of energy drinks refer to a paper

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by Ferreira and colleagues (Ferreira, de Mello, Pompéia, & de Souza-Formigoni, 2006). A close look at the article suggests that the evidence for masking is very limited. Only 4 out of 18 symptoms that were scored differed significantly between AMED and alcohol only beverages. These symptoms included headache, weakness, dry mouth, and motor coordination. These symptoms are not those that are typically viewed as the most prevalent signs of intoxication. In fact, the authors did not even ask directly whether or not the participants felt less intoxicated when consuming AMED. Therefore, the conclusion that should be drawn from Ferreira's data is the one he stated when he wrote his thesis using the exact same data, which was "the breath alcohol concentration and subjective perception of intoxication were similar between sessions in which alcohol was ingested and in which alcohol plus energy drink were ingested…The differences observed were biologically irrelevant" (Ferreira, 2002). Nevertheless, the Ferreira study remains an often quoted "proof" of masking effects.

More recent studies have looked at possible masking effects of energy drinks. Alford et al. (2011) conducted a double blind, placebo-controlled trial in which they evaluated the objective and subjective effects of alcohol versus placebo beverages at two alcohol doses (0.046 and 0.087% blood alcohol concentration). Alcohol beverages were both alone and in combination with an energy drink. Performance was significantly impaired after alcohol consumption. Subjective measures showed significant and consistent effects reflecting awareness of alcohol intoxication as well as sensitivity to increasing alcohol dose. There were no significant differences for subjective measures between AMED and alcohol when consumed alone. In other words, energy drink did not mask the intoxication effects of alcohol. Another recent study reported that alcohol alone significantly increased ratings of feeling the drink, liking the drink, impairment, and level of intoxication, whereas it reduced the rating of ability to drive (Marczinski, Fillmore, Bardgett, & Howard, 2011). Co-administration of energy drink with alcohol showed no significant difference on these ratings, supporting the hypothesis that energy drinks do not mask alcohol intoxication effects. Finally, Howland et al. (2010) conducted a double-blind clinical trial comparing caffeinated beer with normal beer. On each test day, the peak breath alcohol concentration was about 0.12%. For both conditions, participants were equally well in guessing their breath alcohol concentration.

Based on the available data, one can only conclude that there is no evidence that energy drinks mask the effects of alcohol. The assumption that co-use of energy drink and alcohol will increase total alcohol consumption or may result in increased numbers of alcohol-related consequences is therefore very unlikely. Instead, within subject comparisons show that subjects actually consume less alcohol when combining with energy drinks (Woolsey, Waigandt, & Beck, 2010), and other studies revealed that in fact other mixers such as diet cola seem related to increased overall alcohol consumption and higher breath alcohol concentration when leaving a bar (Thombs, Rossheim, Barnett, Weiler, Moorhouse, & Coleman, 2010; Rossheim & Thombs, 2011). These authors showed that mixing alcohol with cola-caffeinated beverages is much more popular than AMED (24.2% versus 6.0% of bar patrons, respectively). Moreover, after adjusting for the number of drinks and other potential confounders, energy drinks and regular colas did not have a significant association with alcohol intoxication ($p > 0.05$), whereas diet cola did ($p < 0.0001$). The higher breath alcohol concentrations obtained for diet colas may be caused by the fact that these beverages are artificially sweetened, which influences gastric emptying and results in elevated blood alcohol concentrations. The findings by Rossheim and Thombs (2011) are of high importance to the current energy drink debate, since it is often proclaimed that caffeine masks the effects of alcohol intoxication and therefore may increase overall alcohol consumption. However, Rossheim and Thombs (2011) reveal that not energy drinks but diet cola mixed with alcohol is significantly associated with alcohol intoxication, despite the fact that (diet) cola contains only one third of the amount of caffeine when compared to energy drinks. The authors therefore correctly conclude that there is a misplaced focus on energy drinks.

In summary, the current focus on energy drinks has yet to be supported by scientific evidence. It is, however, common knowledge that excessive alcohol consumption itself compromises health and may result in aversive behaviors. Proposing legislation for energy drinks will not be a solution for alcohol-related problems, nor will it help reduce total alcohol consumption, because energy drinks will then likely be replaced by another mixer. Instead of focusing on non-existing problems, current laws that regulate alcohol consumption and its consequences should be better enforced.

References

Alford, C., König, J., Aufricht, C., & Verster, J. C. (2011). Proceedings of the 2010 Energy Drinks Symposium. *The Open Neuropsychopharmacology Journal, 4*, 1–4.

Arria, A. M., & O'Brien, M. C. (2011). The "high" risk of energy drinks. *Journal of the American Medical Association, 305*, 600–601.

Ferreira, S. E. (2002). *Estudo dos efeitos fisiológicos e psicológicos da ingestào combinada de álcool e bebidas energéticas*. Thesis, Sao Paulo.

Ferreira, S., de Mello, M., Pompéia, S., & de Souza-Formigoni, M. (2006). Effects of energy drink ingestion on alcohol intoxication. *Alcoholism: Clinical and Experimental Research, 30*, 598–605. doi:10.1111/j.1530-0277.2006.00070.x

Higgins, J. P., Tuttle, T. D., & Higgins, C. L. (2010). Energy beverages: Content and safety. *Mayo Clinic Proceedings, 85*, 1033–1041.

Howland, J., Rohsenow, D. J., Arnedt, J. T., Bliss, C.A., Hunt, S. K., Calise, T. V., …& Gottlieb, D. J. (2011). The acute effects of caffeinated versus non-caffeinated alcoholic beverage on driving performance and attention/reaction time. *Addiction, 106*, 335–341. doi: 10.1111/j.1360-0443.2010.03219.x.

Marczinski, C. A., Fillmore, M. T., Bardgett, M. E., & Howard, M. A. (2011). Effects of energy drinks mixed with alcohol on

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behavioral control: Risks for college students consuming trendy cocktails. *Alcoholism: Clinical Experimental Research 35*: xxx–xxx doi: 10.1111/j.1530-0277.2011.01464.x

Reissig, C. J., Strain, E. C., & Griffiths, R. R. (2009). Caffeinated energy drinks: A growing problem. *Drug and Alcohol Dependence, 99*, 1-10. doi:10.1016/j.drugalcdep.2008.08.001

Rossheim, M. E. and Thombs, D. L. (2011). Artificial sweeteners, caffeine, and alcohol intoxication in bar patrons. *Alcoholism: Clinical and Experimental Research, 35*: no. doi: 10.1111/j.1530-0277.2011.01534.x

Thombs, D., Rossheim, M., Barnett, T., Weiler, R., Moorhouse, M., & Coleman, B. (2010). Is there a misplaced focus on AmED? Associations between caffeine mixers and bar patron intoxication. *Drug and Alcohol Dependence, 116*, 31–36. doi:10.1016/j.drugalcdep.2010.11.014

Verster, J. C., & Alford, C. (2011). Unjustified concerns about energy drinks. *Current Drug Abuse Reviews, 4*, 1–3.

Woolsey, C., Waigandt, A., & Beck, N. C. (2010). Athletes and energy drinks: Reported risk-taking and consequences from the combined use of alcohol and energy drinks. *Journal of Applied Sport Psychology, 22*, 65–71. doi:10.1080/10413200903403224 ψ

Alcoholic Energy Drink Use, Social Risk-Taking, and Hooking Up Drunk

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The contexts in which problem drinking and sexual risk-taking co-occur are continually evolving. Anecdotal reports suggest that many young adults use caffeinated energy drinks mixed with alcohol (e.g., Red Bull® and vodka) as a means of potentiating casual sexual encounters or hookups. The use of alcoholic energy drinks (AEDs) appears to occur almost exclusively in socially gregarious contexts and thus may be more closely associated with casual risky sexual behaviors than caffeine or alcohol alone.

Much of the initial research linking caffeinated drinks with health-compromising behaviors such as misuse of alcohol, marijuana, or prescription stimulants, sexual risk-taking, interpersonal violence, or seatbelt omission has focused on non-alcoholic energy drinks (e.g., Arria, Caldeira, Kasperski, O'Grady, et al., 2010; Arria, Caldeira, Kasperski, Vincent, et. al., 2010; Miller, 2008b; Woolsey, Waigandt, & Beck, 2010). However, AED use is also associated with heavy episodic drinking, riding with a drunk driver, sexual assault or victimization, and other forms of risk-taking (Miller, 2008a; O'Brien et al., 2008; Woolsey, 2010). Event-level analyses have also shown that bar patrons who consume AEDs are more likely than those who consume alcohol alone to leave the bar highly intoxicated and to express intentions to drive while drunk (Thombs et al., 2010).

Little is yet known about the nexus of AED use and consensual sexual hookups while buzzed or intoxicated. Normative sexual behavior for contemporary college students has shifted away from traditional dating and moved towards more casual encounters in which scripted expectations regarding commitment or intimacy are minimal/absent (Bogle, 2008, Stinson, 2010). These encounters are frequently initiated in socially gregarious settings (i.e., parties, clubs, bars) and are overwhelmingly characterized by alcohol use (Downing-Matibag & Geisinger, 2009; Paul & Hayes, 2002). Hooking up drunk is associated with elevated risk for unwanted or coerced sexual activity (Flack et al., 2007), exposure to STIs (Downing-Matibag & Geisinger, 2009), and post-encounter regret or shame (Eshbaugh & Gute, 2008), especially for women. While global-level associations between alcohol and indiscriminate sexual behavior (i.e., multiple, risky, and/or casual partners) are widely established (Cooper, 2002), it is still unclear whether AEDs have a unique role in this dynamic beyond the fact that they happen to be alcoholic.

In the present study, I examined the associations between past-month frequency of AED use and three social risk-taking behaviors commonly found in bar, party, or club settings. Self-identification as a social smoker (SS), that is one who smokes cigarettes only in social situations or when drinking, was assessed dichotomously (0 = *no*; 1 = *yes*). Frequency of habitual social drunkenness (HSD) referred to how often a participant gets drunk when s/he goes out drinking (1 = *never/rarely or don't go out drinking*; 4 = *always*). "Hooking up drunk" (HUD) was measured with a scale (α = .78) summing dichotomous items about recent sexual intercourse and drinking experiences, such as at last sex, participant was drunk/high, did not know partner well, or regretted it afterward (0 = *no hookup behaviors*; 7 = *all seven hookup behaviors*). Controls were also included for gender, age, parental education, college GPA, and frequency of non-caffeinated alcohol use.

Anonymous survey data was collected from 795 undergraduate students at a large public university (47.6% female). Age ranged from 18 to 40 years (*M* = 20.02; *SD* = 2.02) with 69.3% of participants below the legal age of drinking (21 years old). Twenty-six percent of students reported AED use in the past month, with more frequent use by men than women. One in four students self-identified as a social smoker. More than a third reported frequent HSD, with 27.7% usually or 8.0% always getting drunk on occasions when they went out drinking. Half of students reported at least one of the

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seven HUD behaviors, and 15% reported four or more.

In order to determine whether frequency of AED use was associated with social risk-taking behavior, a series of logistic (SS) and linear (HSD and HUD) regressions were conducted. Results indicated that odds of social smoking (*OR* = 1.09, $p < .001$), frequency of habitual social drunkenness (β = .21, $p < .001$), and HUD score (β = .21, $p < .001$) were all significantly associated with AED use. Because these main analyses did not account for the interrelatedness of social risk behavior, we conducted an additional regression analysis and found that frequency of AED use was positively associated with HUD score (β = .08, $p < .05$) after controlling for social smoking, HSD frequency, and frequency of non-ED alcohol use.

These findings confirm that AED use is associated with social risk-taking in general and hooking up drunk in particular. Two complementary explanations may shed light on the AED/hookup relationship. First, AED use may be an accidental catalyst of unintended sex and/or escalated risk-taking than alcohol use alone. While placebo studies show that people attempt to compensate for perceived intoxication by increasing their conscious vigilance against undesired outcomes (Marczinski & Fillmore, 2005), co-administration of caffeine and alcohol diminishes subjective intoxication (Ferreira et al., 2006), resulting in failure to compensate for deficits in psychomotor performance (Fillmore et al., 2002) and judgment (Thombs et al., 2010). Caffeine's ability to mask some symptoms of drunkenness (e.g., lethargy, headache) also reinforces the misconception that it antagonizes alcohol, which may further undermine compensatory vigilance and leave users more vulnerable to adverse consequences of impulsive sexual decision-making, pressure, or coercion.

Second, AED use may help to enhance intended sexual hookups by reducing perceived barriers to sex (e.g., inhibitions and/or physical fatigue). Whereas alcohol may reduce inhibitions or provide a handy rationale for otherwise unacceptable promiscuity, caffeine provides enough energy and alertness to facilitate a successful encounter. AED use thus may be expected to enhance sexual pleasure by simultaneously reducing physiological (e.g., lethargy) and psychological barriers to casual sex (e.g., sexual inhibition and awareness of the risk of consequent social stigma, particularly for women). Such expectancies may create an incentive to choose AEDs over alcohol or EDs alone when anticipating a casual sexual encounter.

These explanations are plausible and consistent with the findings of the present study, but research is needed in order to test them directly. In addition, the study was subject to several limitations. The sample was drawn from a single public university, limiting its generalizability to the broader young adult population. The cross-sectional data allowed conclusions regarding correlation but not causality. Measures of AED and alcohol use assessed number of days in the past month when these substances were used, rather than overall volume or number of drinks, and the scale measure of hookup behavior relied on retrospective self-reports without external confirmation. Collectively, these limitations reflect the availability of secondary data collected for other purposes. There is a marked need for new data collection to enable representative longitudinal studies that can more explicitly test hypotheses about the role of AEDs in facilitating high-risk sexual activity.

In 2010, following a rash of AED-related student hospitalizations, several popular premixed AED brands (e.g., Four Loko) were removed from the market (USFDA, 2010a, 2010b). However, the mix-your-own practice of combining alcohol and EDs persists, reflecting a widespread lack of awareness of the potential for caffeine to exacerbate the risks of alcohol consumption. There remains a pressing need for health care professionals to partner with both the ED and alcohol industries to promote public education at a minimum. Further research is also needed in order to inform ongoing debate and assess the merits of stronger regulatory action.

References

Arria, A. M., Caldeira, K. M., Kasperski, S. J., O'Grady, K. E., Vincent, K. B., Griffiths, R. R., & Wish, E. D. (2010). Increased alcohol consumption, nonmedical prescription drug use, and illicit drug use are associated with energy drink consumption among college students. *Journal of Addiction Medicine, 4*, 74–80.

Arria, A. M., Caldeira, K. M., Kasperski, Vincent, K. B., Griffiths, R. R., & O'Grady, K. E. (2010). Energy drink consumption and increased risk for alcohol dependence. *Alcoholism: Clinical and Experimental Research, 35*, 1–11.

Bogle, K. A. (2008). *Hooking up: Sex, dating, and relationships on campus.* New York: University Press.

Cooper, M. L. (2002). Alcohol use and risky sexual behavior among college students and youth: Evaluating the evidence. *Journal of Studies on Alcohol* (Supp. 14), 101–117.

Downing-Matibag, T. M., & Geisinger, B. (2009). Hooking up and sexual risk taking among college students: A health belief model perspective. *Qualitative Health Research, 19*, 1196–1209. doi:10.1177/1049732309344206

Eshbaugh, E. M., & Gute, G. (2008). Hookups and sexual regret among college women. *The Journal of Social Psychology, 148*, 77–89. doi:10.3200/SOCP.148.1.77-90

Ferreira, S., de Mello, M., Pompéia, S., & de Souza-Formigoni, M. (2006). Effects of energy drink ingestion on alcohol intoxication. *Alcoholism: Clinical and Experimental Research, 30*, 598–605. doi:10.1111/j.1530-0277.2006.00070.x

Fillmore, M. T., Roach, E. L., & Rice, J. T. (2002). Does caffeine counteract alcohol-induced impairment? The ironic effects of expectancy. *Journal of Studies on Alcohol, 63*, 745–754.

Flack, W. F., Jr., Daubman, K. A., Caron, M. L., Asadorian, J. A., D'Aureli, N. R., Gigliotti, S. N., et al. (2007). Risk factors and consequences of unwanted sex among university students: Hooking up, alcohol, and stress response. *Journal of Interpersonal Violence, 22*, 139–157. doi:10.1177/0886260506295354

Marczinski, C. A., & Fillmore, M. T. (2006). Clubgoers and their trendy cocktails: Implications of mixing caffeine into alcohol on information processing and subjective reports of intoxication. *Experimental and Clinical Psychopharmacology, 14*, 450-458. doi:10.1037/1064-1297.14.4.450

(Continued on page 18)

Alcohol Energy Drink...

(Continued from page 17)

Miller, K. E. (2008a). Energy drinks, race, and problem behaviors among college students. *Journal of Adolescent Health, 43*, 490–497. doi:10.1016/j.jadohealth.2008.03.003

Miller, K. E. (2008b). Wired: Energy drinks, jock identity, masculine norms, and risk taking. *Journal of American College Health, 56*, 481–489. doi:10.3200/JACH.56.5.481-490

O'Brien, M. C., McCoy, T. P., Rhodes, S. D., Wagoner, A., & Wolfson, M. (2008). Caffeinated cocktails: Energy drink consumption, high-risk drinking, and alcohol-related consequences among college students. *Academic Emergency Medicine, 15*, 453–460.

Paul, E. L., & Hayes, K. A. (2002). The causalities of 'casual' sex: A qualitative exploration of the phenomenology of college students' hookups. *Journal of Social and Personal Relationships, 19*, 639–661. doi:10.1177/0265407502195006

Stinson, R. D. (2010). Hooking up in young adulthood: A review of factors influencing the sexual behavior of college students. *Journal of College Student Psychotherapy, 24*, 98–115. doi:10.1080/87568220903558596

Thombs, D. L., O'Mara, R. J., Tsukamoto, M., Rossheim, M. E., Weiler, R. M., Merves, M. L., & Goldberger, B. A. (2010). Event-level analyses of energy drink consumption and alcohol intoxication in bar patrons. *Addictive Behaviors, 35*, 325–330. doi:10.1016/j.addbeh.2009.11.004

U.S. Food and Drug Administration, U.S. Department of Health and Human Services. (2010a). *Serious concerns over alcoholic beverages with added caffeine*. Retrieved April 14, 2011, from www.fda.gov/ForConsumers/ConsumerUpdates/ucm233987.htm

U.S. Food and Drug Administration, U.S. Department of Health and Human Services. (2010b). *Update on caffeinated alcoholic beverages: FDA announces progress on removal of certain caffeinated alcoholic beverages from the market*. Retrieved April 14, 2011, from www.fda.gov/NewsEvents/PublicHealthFocus/ucm234900.htm

Woolsey, C. (2010). Energy drink cocktails: A dangerous combination for athletes and beyond. *Journal of Alcohol and Drug Education, 54*, 41–68.

Woolsey, C., Waigandt, A., & Beck, N. C. (2010). Athletes and energy drinks: Reported risk-taking and consequences from the combined use of alcohol and energy drinks. *Journal of Applied Sport Psychology, 22*, 65–71. doi:10.1080/10413200903403224 ψ

Does Mixing an Energy Drink With Alcohol Increase the Risks of Drinking?

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Young people have become enamored with the new trend of mixing energy drinks with alcohol. Vodka Red Bulls and other super caffeinated cocktails like Jagerbombs, a mixture of the spirit Jagermeister with an energy drink, are popular among college students and have gained a meteoric rise in fame over the years. One fan rewrote the words to the old Rupert Holm's "Escape: The Pina Colada Song" to create a modern version featuring the mix of Red Bull® and vodka (e.g., www.youtube.com/watch?v=z9OZrkY4Of4). Other fans have come together as 'groups' on social networking sites like Facebook, a phenomenon that was particularly evident in late 2010 after the caffeinated version of Four Loko was pulled from the shelves following the Food and Drug Administration ruling that caffeine was an unsafe food additive to alcoholic beverages. While Four Loko®, Sparks® and other premixed beverages can legally no longer combine caffeine with alcohol, preparing and serving mixed alcoholic energy drinks in bars, parties and elsewhere is still legal and unmonitored. Given this change in drinking habits in young adults, addiction researchers have been investigating whether alcohol mixed with energy drinks (AmED) might be more of a risk to consume when compared to alcohol alone.

Energy drinks are beverages marketed with claims of providing users with increased alertness and energy. These relatively new products contain a variety of compounds including plant-based stimulants (e.g., guarana), simple sugars (e.g., glucose, fructose), amino acids (e.g., taurine), and herbs (e.g., ginseng; Seifert, Schaechter, Hershorin & Lipshultz, 2011). However, many researchers agree that the extremely high caffeine content (the principal active ingredient) of these beverages drives the stimulant properties that users often report after consuming them (Ferreira, de Mello, Pompeia & de Souza-Formigoni, 2006; Howard & Marczinski, 2010; Reissig, Strain & Griffiths, 2009). The highest-selling energy drink brand, Red Bull®, contains 9.6 mg of caffeine per fluid ounce, compared with Coca-Cola Classic® which contains 2.9 mg of caffeine per fluid ounce.

Survey data has revealed that the consumption of energy drinks, alone and in combination with alcohol, has become increasingly common among young people (Arria et al., 2010, 2011; Berger, Fendrich, Chen, Arria, & Cisler, 2011; O'Brien, McCoy, Rhodes, Wagoner & Wolfson, 2008). For example, O'Brien and colleagues (2008) reported that 1 in 4 of past 30-day alcohol drinkers consumed at least 1 alcohol energy drink during the past month. More importantly, those individuals who reported AmED consumption also reported significantly higher alcohol-related consequences such as sexual assault and driving while intoxicated, even after adjusting for the amount of alcohol consumed. Mixing energy drinks with alcohol has also been associated with binge drinking (Price, Hilchey, Darredeau, Fulton, & Barrett, 2010). Field studies also suggest that AmED beverages may be riskier than alcohol

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alone. In one recent study, college students who were leaving local bars were asked to report what beverages they had consumed, whether or not they intended to drive home, and provided a breath sample. The authors reported that patrons who had consumed AmED were at 3-fold increased risk of leaving the bar highly intoxicated (i.e., > .08 g% BAC) and a 4-fold risk of intending to drive home intoxicated, compared to other drinking patrons (Thombs et al., 2010).

Why might an AmED be riskier than consuming alcohol alone? Recent research from our laboratory suggests that AmED beverages are pharmacologically distinct from alcohol alone (Marczinski, Fillmore, Bardgett, & Howard, in press). College student social drinkers were invited to come to our lab to receive a beverage for which participants were blind to the beverage they were consuming. Following drinking, students were asked to perform a behavioral control task and complete several questionnaires regarding their subjective state. Participants were randomly assigned to receive either: (1) 0.65 g/kg alcohol, (2) AmED (0.65 g/kg alcohol + 3.57 ml/kg Red Bull), (3) energy drink before, or (4) a placebo beverage. The AmED beverage was 2 parts Red Bull® mixed with 1 part vodka, which is a cocktail commonly served in bars. The alcohol only beverage was vodka mixed with Squirt® (a carbonated citrus beverage that does not contain caffeine but resembles Red Bull® in taste and appearance). Performance on the behavioral control task was measured when the participants' BAC was approximately .08 g% in both the alcohol only and AmED group. At this time, participants were asked to complete questionnaires to assess subjective reactions to the drinks consumed. The results showed that alcohol impaired performance on the behavioral control task as evidenced by slower responses and more impulsive errors. For subjects who received the AmED beverage, the mean responses were not quite as slow as the alcohol alone condition, but participants were still making impulsive errors. Thus, AmED participants proved to be fast and impulsive drunks compared to the slow and impulsive drunks found in the alcohol only condition. In addition, the subjective responses from the questionnaires further differentiated the AmED and alcohol groups. Participants who received the AmED drinks reported feeling twice as stimulated compared to subjects who receive alcohol only. Given that feelings of stimulation while drinking may be important predictors of future alcohol problems (King, de Wit, McNamara & Cao, 2011), our findings suggest that AmED beverages may be riskier than alcohol alone due to the acute effects of AmED that differ in important ways from the effects of alcohol alone. Given the dramatic escalation in the popularity of AmED beverages among young adults, more research is clearly needed to specify how these drinks increase the risks of drinking alcohol.

References

Arria, A. M., Caldeira, K. M., Kasperski, S. J., O'Grady, K. E., Vincent, K. B., Griffiths, R. R., & Wish, E. D. (2010). Increased alcohol consumption, nonmedical prescription drug use, and illicit drug use are associated with energy drink consumption among college students. *Journal of Addiction Medicine, 4*, 74–80. doi: 10.1097/ADM.0b013e3181aa8dd4

Arria, A. M., Caldeira, K. M., Kasperski, S. J., Vincent, K. B., Griffiths, R. R., & O'Grady, K. E. (2011). Energy drink consumption and increased risk for alcohol dependence. *Alcoholism: Clinical and Experimental Research, 35*, 365–375. doi: 10.1111/j.1530-0277.2010.01352.x

Berger, L.K., Fendrich, M., Chen, H.Y., Arria, A.M., & Cisler, R.A. (2011). Sociodemographic correlates of energy drink consumption with and without alcohol: results of a community survey. *Addictive Behaviors, 36*, 516–519. doi:10.1016/j.addbeh.2010.12.027

Ferreira, S., de Mello, M., Pompéia, S., & de Souza-Formigoni, M. (2006). Effects of energy drink ingestion on alcohol intoxication. *Alcoholism: Clinical and Experimental Research, 30*, 598–605. doi:10.1111/j.1530-0277.2006.00070.x

Howard, M. A., & Marczinski, C. A. (2010). Acute effects of a glucose energy drink on behavioral control. *Experimental and Clinical Psychopharmacology, 18*, 553–561. doi:10.1037/a0021740

King, A. C., de Wit, H., McNamara, P. J., & Cao, D. (2011). Rewarding, stimulant, and sedative alcohol responses and relationship to future binge drinking. *Archives of General Psychiatry, 68*, 389–399.

Marczinski, C. A., Fillmore, M. T., Bardgett, M. E., & Howard, M. A. (In press). Effects of energy drinks mixed with alcohol on behavioral control: Risks for college students consuming trendy cocktails. *Alcoholism: Clinical and Experimental Research*. doi: 10.1111/j.1530-0277.2011.01464.x

O'Brien, M.C., McCoy, T.P., Rhodes, S.D., Wagoner, A., & Wolfson, M. (2008). Caffeinated cocktails: energy drink consumption, high-risk drinking, and alcohol-related consequences among college students. *Academic Emergency Medicine, 15*, 453-460.

Price, S.R., Hilchey, C.A., Darredeau, C., Fulton, H.G., & Barrett, S.P. (2010). Energy drink coadministration is associated with increased reported alcohol ingestion. *Drug and Alcohol Review, 29*, 331-333.

Reissig, C.J., Strain, E.C., & Griffiths, R.R. (2009). Caffeinated energy drinks – A growing problem. *Drug and Alcohol Dependence, 99*, 1-10.

Seifert, S.M., Schaechter, J.L., Hershorin, E.R., & Lipshultz, S.E. (2011). Health effects of energy drinks on children, adolescents, and young adults. *Pediatrics, 127*, 511-528.

Thombs, D.L., O'Mara, R.J., Tsukamoto, M., Rossheim, M.E., Weiler, R.M., Merves, M.L., & Goldberger, B.A. (2010). Event-level analyses of energy drink consumption and alcohol intoxication in bar patrons. *Addictive Behaviors, 35*, 325-330. ψ

Social Norms of Polydrug Use in Europe: Project SNIPE

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The social norms approach has become established in the U.S. as a widely used intervention strategy to reduce rates of health risk behavior. This approach stems from research that has documented the tendency of students to overestimate how likely their peers are to misuse alcohol and other drugs (Perkins, Haines, & Rice, 2005). It is posited that correcting misperceptions reduces social pressures on the individual to engage in that behavior themselves, which in turn reduces the likelihood of (mis)use. Social norms marketing, a type of social norms approach, has been successful in reducing rates of alcohol use and related harm at several college sites, including the University of Virginia (Turner, Perkins, & Bauerle, 2008), which is one of the pioneers of the approach. The principles of the approach have also been used to provide students with computer delivered personalized normative feedback that highlights to the students the discrepancies between their own beliefs and behavior and the actual reported norms on campus (Neighbors, Larimer, & Lewis, 2004).

The social norms approach was initially developed and applied in the American college system, however it has in recent years become increasingly popular in Europe and elsewhere (McAlaney, Bewick, & Hughes, 2011). The use of the social norms approach in Europe is based on research that suggests substance misuse misperceptions are as evident in European student populations as they are in American students (Bewick, Trusler, Mulhern, Barkham, & Hill, 2008; McAlaney & McMahon, 2007; Page, Ihasz, Hantiu, Simonek, & Klarova, 2008). While many projects who are currently implementing this approach in Europe have not yet reached completion and have not yet published results, there are some examples of the successful use of this approach in the U.K. The University of Leeds has developed an online social norms intervention called Unitcheck and this intervention has been used to reduce rates of alcohol consumption in university students (Bewick, Trusler, Mulhern, et al., 2008; Bewick et al., 2010). This work reflects a growing trend of Internet and computer based platforms to deliver personalized social norms feedback, particularly with young adults who could be expected to be regular users of these mediums. While research into online interventions for substance use is still in the early stages, previous work suggests that online mediums can be used to effectively deliver social norms interventions (Bewick et al., 2008; Moreira, Smith, & Foxcroft, 2009).

A number of questions remain about the use of the social norms approach in a European setting. There are legal and cultural differences in substance use within Europe and between Europe and the U.S. For example, in most European countries young people can legally purchase and consume alcohol from between the ages of 16 to 18. A purchase age of 16 to 18 years means that unlike students in the U.S., many European students attend university at a time when they can openly drink alcohol, a period which in turn can coincide with a transitional stage away from immediate parental supervision. These differences are reflected in the attitudes of university authorities to substance use by students and influence the campus environment (Delk & Meilman, 1996). For instance, in the U.K. it is common for student bars to be owned by the student association and located on campus. Rates of illicit drug use in young adults are broadly similar between the U.S. and Europe, but there are national variations in which drugs are used (Hibell et al., 2004). In light of these cultural differences and the existing research on variation of substance use within Europe it is reasonable to expect that there may be some differences in how social norms are expressed in different cultures, and how best the social norms approach can implemented across different countries.

To address these questions a group of researchers in Europe recently secured funding of approximately €450,000 (U.S. $633,000) from the European Union to develop an online social norms intervention portal. This will offer students personalized social norms feedback on alcohol, tobacco and illicit drug use. A baseline survey will be conducted at each university site to create a database on rates and perceptions of substance use. Students will be able to obtain personal feedback by accessing a web portal specific to their institution. After answering a few questions on current personal and perceived rates of substance use they will be presented with immediate, on-screen feedback that shows how their own behavior compares to the campus norms and highlights the discrepancies between their perceived norms and the actual reported campus norms. Student responses will be tracked by use of their email address from the baseline survey in the Fall semester 2011 to a follow-up survey at the end of the Spring semester 2012. The database used will be live; thus, whilst students will be surveyed at baseline and follow-up they will also continue to provide ongoing data on personal use and perceptions every time they access the web portal. The feedback that is provided to them will be automatically generated based on the current information in the database system.

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In addition to personal and perceived use the consequences of substance use on a variety of health, educational and social factors will also be measured. The portal will be tested at universities in Belgium, Denmark, Germany, Slovakia, Spain, Turkey, and the U.K. Each country will provide both an intervention site and a comparison site, and a process evaluation will be conducted by one of the research partners. The project will run for two years starting March 2011. Student responses will be tracked over the course of the project and comparisons will be made between intervention and control sites. The aim of the project is to establish the feasibility of implementing a multi-language online social norms intervention that can be used in different national and cultural contexts. In addition the project will provide direct comparisons of the drug use behaviors and perceptions of students in a diverse range of settings and cultures.

For more information on the project, please contact the research team at snipe-study@gmail.com.

References

Bewick, B. M., Trusler, K., Barkham, M., Hill, A. J., Cahill, J., & Mulhern, B. (2008). The effectiveness of web-based interventions designed to decrease alcohol consumption - A systematic review. *Preventive Medicine, 47*, 17–26. doi: 10.1016/j.ypmed.2008.01.005

Bewick, B. M., Trusler, K., Mulhern, B., Barkham, M., & Hill, A. J. (2008). The feasibility and effectiveness of a web-based personalised feedback and social norms alcohol intervention in UK university students: A randomised control trial. *Addictive Behaviors, 33*, 1192–1198. doi: 10.1016/j.addbeh.2008.05.002

Bewick, B. M., West, R., Gill, J., O'May, F., Mulhern, B., Barkham, M., & Hill, A. J. (2010). Providing web-based feedback and social norms information to reduce student alcohol intake: a multi-site investigation. *Journal of Medical Internet Research, 12*, e5.

Delk, E., & Meilman, P. W. (1996). Alcohol use among college students in Scotland compared with norms from the United States. *Journal of American College Health, 44*, 274–282.

Hibell, B., Andersson, B., Bjarnasson, T., Ahlstrom, S., Balakireva, O., & Kokkevi, A. (2004). *The 2003 ESPAD Report: Alcohol and drug use among students in 30 European countries*. Stockholm: Swedish Council for Information on Alcohol and Other Drugs.

McAlaney, J., Bewick, B., & Hughes, C. (2011). The international development of the 'Social Norms' approach to drug education and prevention. *Drugs: Education Prevention and Policy, 18*, 81–89.

McAlaney, J., & McMahon, J. (2007). Normative beliefs, misperceptions and heavy episodic drinking in a British student sample. *Journal of Studies on Alcohol and Drugs, 68*, 385– 392.

Moreira, M. T., Smith, L. A., & Foxcroft, D. (2009). *Social norms interventions to reduce alcohol misuse in University or College students* (Vol. The Cochrane Library 2009 Issue 3): The Cochrane Collaboration.

Neighbors, C., Larimer, M. E., & Lewis, M. A. (2004). Targeting misperceptions of descriptive drinking norms: Efficacy of a computer delivered personalised normative feedback intervention. *Journal of Consulting and Clinical Psychology, 72*, 434–447.

Page, R. M., Ihasz, F., Hantiu, I., Simonek, J., & Klarova, R. (2008). Social normative perceptions of alcohol use and episodic heavy drinking among Central and Eastern European adolescents. *Substance Use and Misuse, 43*, 361–373.

Perkins, H. W., Haines, M. P., & Rice, R. (2005). Misperceiving the college drinking norm and related problems: A nationwide study of exposure to prevention, information, perceived norms and student alcohol misuse. *Journal of Studies on Alcohol, 66*, 470–478.

Turner, J., Perkins, H. W., & Bauerle, J. (2008). Declining negative consequences related to alcohol misuse among students exposed to a social norms marketing intervention on a college campus. *Journal of American College Health, 57*, 85–93.

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Abstracts

Ditre, J. W., Heckman, B. W., Butts, E. A., & Brandon, T. H. (2010). Effects of expectancies and coping on pain-induced motivation to smoke. *Journal of Abnormal Psychology, 119*, 524-533. doi:10.1037/a0019568

The prevalence of tobacco smoking among persons with recurrent pain is approximately twice that observed in the general population. Smoking has been associated with the development and exacerbation of several chronically painful conditions. Conversely, there is both experimental and cross-sectional evidence that pain is a potent motivator of smoking. A recent study provided the first evidence that laboratory-induced pain could elicit increased craving and produce shorter latencies to smoke (Ditre & Brandon, 2008). To further elucidate interrelations between pain and smoking, and to identify potential targets for intervention, in the current study, we tested whether several constructs derived from social-cognitive theory influence the causal pathway between pain and increased motivation to smoke. Smokers (*N* = 132) were randomly assigned to 1 of 4 conditions in this 2 x 2 between-subjects experimental design. Results indicated that manipulations designed to (a) challenge smoking-related outcome expectancies for pain reduction and (b) enhance pain-related coping produced decreased urge ratings and increased latencies to smoke, relative to controls. An unexpected interaction effect revealed that although each manipulation was sufficient to reduce smoking urges, the combination was neither additive nor synergistic. These findings were integrated with those of the extant literature to conceptualize and depict a causal pathway between pain and motivation to smoke as moderated by smoking-related outcome expectancies and mediated by the use of pain coping behaviors.

Kilmer, B., Burgdorf, J. R., D'Amico, E. J., Miles, J., & Tucker, J. (in press). A multi-site cost analysis of a

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school-based voluntary alcohol and drug prevention program. *Journal of Studies on Alcohol and Drugs*.

Objective: This paper estimates the societal costs of Project CHOICE (PC), a voluntary after-school alcohol and other drug (AOD) prevention program for adolescents. To our knowledge, this is the first cost analysis of an after-school program specifically focused on reducing AOD use. Method: We utilized a micro-costing approach based on the societal perspective and conducted a number of sensitivity analyses to assess how our results change with alternative assumptions. We collected cost data from surveys of participants, facilitators, and school administrators; insights from program staff; program expenditures; school budgets; the Bureau of Labor Statistics; and the National Center for Education Statistics. Results: From the societal perspective, the cost of implementing PC in eight California schools ranged from $121–$305 per participant (median: $238). The major cost drivers included: labor costs associated with facilitating PC; opportunity costs of displaced class time (due to in-class promotions for PC and consent obtainment); and other efforts to increase participation. Substituting nationally representative cost information for wages and space reduced the range to $100–$206 (median: $182), which is lower than SAMHSA's estimate of $262 per pupil for the "average effective school-based program in 2002." For those who would prefer to denominate national PC costs by enrolled students instead of participants, median per pupil costs would decrease by over 90% to $21 (range: $14–$28). Conclusions: Estimating the societal costs of school-based prevention programs is critical for efficiently allocating resources to reduce AOD use. Variation in PC costs across schools highlights an important advantage of collecting program cost information from multiple sites.

Marczinski, C. A., Fillmore, M. T., Bardgett, M. E., & Howard, M. A. (in press). Effects of energy drinks mixed with alcohol on behavioral control: Risks for college students consuming trendy cocktails. *Alcoholism: Clinical and Experimental Research*.

Background: There has been a dramatic rise in the consumption of alcohol mixed with energy drinks (AmED) in young people. AmEDs have been implicated in risky drinking practices and greater accidents and injuries have been associated with their consumption. Despite the increased popularity of these beverages (e.g., Red Bull and vodka), there is little laboratory research examining how the effects of AmED differ from alcohol alone. This experiment was designed to investigate if the consumption of AmED alters neurocognitive and subjective measures of intoxication compared with the consumption of alcohol alone. Methods: Participants (n=56) attended one session where they were randomly assigned to receive one of four doses (0.65 g/kg alcohol, 3.57 ml/kg energy drink, AmED or a placebo beverage). Performance on a cued go/no-go task was used to measure the response of inhibitory and activational mechanisms of behavioral control following dose administration. Subjective ratings of stimulation, sedation, impairment and level of intoxication were recorded. Results: Alcohol alone impaired both inhibitory and activational mechanisms of behavioral control, as evidenced by increased inhibitory failures and increased response times compared to baseline performance. Coadministration of the energy drink with alcohol counteracted some of the alcohol-induced impairment of response activation, but not response inhibition. For subjective effects, alcohol increased ratings of stimulation, feeling the drink, liking the drink, impairment and level of intoxication and alcohol decreased the rating of ability to drive. Coadministration of the energy drink with alcohol increased self-reported stimulation, but resulted in similar ratings of the other subjective effects as when alcohol was administered alone. Conclusions: An energy drink appears to alter some of alcohol's objective and subjective impairing effects, but not others. Thus AmEDs may contribute to a high risk scenario for the drinker. The mix of impaired behavioral inhibition and enhanced stimulation is a combination that may make AmED consumption riskier than alcohol consumption alone.

Najavits, L. M., Meyer, T., Johnson, K. M., & Korn, D. (2010). Pathological gambling and Posttraumatic Stress Disorder: A study of the co-morbidity versus each alone. *Journal of Gambling Studies*. Advance online publication. doi: 10.1007/s10899-010-9230-0

This report is the first empirical study to compare pathological gambling (PG), posttraumatic stress disorder (PTSD), and their co-occurrence. The sample was 106 adults recruited from the community (35 with current PG; 36 with current PTSD, and 35 with BOTH). Using a cross-sectional design, the three groups were rigorously diagnosed and compared on various measures including sociodemographics, psychopathology (e.g., dissociation, suicidality, comorbid Axis I and II disorders), functioning, cognition, life history, and severity of gambling and PTSD. Overall, the PG group reported better psychological health and higher functioning than PTSD or BOTH; and there were virtually no differences between PTSD and BOTH. This suggests that it is the impact of PTSD, rather than comorbidity per se, that appears to drive a substantial increase in symptoms. We also found high rates of additional co-occurring disorders and suicidality in PTSD and BOTH, which warrants further clinical attention. Across the total sample, many reported a family history of substance use disorder (59%) and gambling problems (34%), highlighting the intergenerational impact of these. We also found notable subthreshold PTSD and gambling symptoms even among those not diagnosed with the disorders, suggesting a need for preventive care. Dissociation measures had mixed results. Discussion includes methodology considerations and future research areas.

Perl, H. (2011). Addicted to discovery: Does the quest for new knowledge hinder practice improvement? *Addictive Behaviors*, *36*, 590–596. doi:10.1016/j.addbeh.2011.01.027

Despite the billions of dollars spent

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on health-focused research and the hundreds of billions spent on delivering health services each year, relatively little money and effort are directed toward investigating how best to connect the two. This results in missed opportunities to assure that research findings inform and improve quality across healthcare in general and for addiction prevention and treatment in particular. There is an asymmetrical focus that favors the identification of new interventions and neglects the implementation of science-based knowledge in actual practice. The consequences of that neglect are severe: significantly diminished progress in research on how to implement treatments that could improve the lives of persons with addiction problems, their families, and the rest of society. While the advancement of knowledge regarding effective implementation is lagging, it is clear that existing systemic incentives in the conduct of science inhibit rather than facilitate widespread adoption of evidence-based practices. This commentary proposes three interrelated strategies for improving the implementation process. First, develop scientific tools to understand implementation better, by expanding investigations on the science of implementation and broadening approaches to the design and execution of research. Second, nurture and support a collaborative implementation workforce comprised of scientists and on-the-ground practitioners, with an explicit focus on enhancing appropriate incentives for both. Third, pay closer attention to crafting research that seeks answers that are most relevant to clinicians' actual needs, primarily by ensuring that the anticipated users of the evidence-based practice are full partners in developing the questions right from the start.

Ramo, D. E., Hall, S. M., & Prochaska, J. J. (in press). Reliability and validity of self-reported smoking in an online survey with young adults. *Health Psychology*. doi:10.1037/a0023443

Objective: The Internet offers many potential benefits to conducting smoking and other health behavior research with young adults. Questions, however, remain regarding the psychometric properties of online self-reported smoking behaviors. The purpose of this study was to examine the reliability and validity of self-reported smoking and smoking-related cognitions obtained from an online survey. Methods: Young adults (*N* = 248) age 18 to 25 who had smoked at least 1 cigarette in the past 30 days were recruited online and completed a survey of tobacco and other substance use. Results: Measures of smoking behavior (quantity and frequency) and smoking-related expectancies demonstrated high internal consistency reliability. Measures of smoking behavior and smoking stage of change demonstrated strong concurrent criterion and divergent validity. Results for convergent validity varied by specific constructs measured. Estimates of smoking quantity, but not frequency, were comparable to those obtained from a nationally representative household interview among young adults. Conclusions: These findings generally support the reliability and validity of online surveys of young adult smokers. Identified limitations may reflect issues specific to the measures rather than the online data collection methodology. Strategies to maximize the psychometric properties of online surveys with young adult smokers are discussed. ψ

Announcements

Postdoctoral Positions

POSTDOCTORAL SCHOLARS

One- to two-year NIH/NIDA-funded positions for postdoctoral scholars in drug abuse treatment and services research are available in a multi-disciplinary environment at 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 as well as select a specific area of focus for independent research. Director James Sorensen and Co-Directors Steven Batki, Kevin Delucchi, Joseph Guydish, Sharon Hall, Carmen Masson, and Constance Weisner are all involved with either the NIDA Clinical Trials Network or Treatment Research Center. Training of psychiatrists, women, and minorities for academic research careers is a priority. Send CV, research statement, samples of work, and two letters of recommendation to: Barbara Paschke, 2727 Mariposa St., STE 100, San Francisco, CA 94110; (415) 437-3032; barbara.paschke@ucsf.edu. Additional information including faculty research interests is available at http://ucsftrc.autoupdate.com/post_doctoral_program.vp.html.

Hot off the Press!

Ackerman, M. J., & Kane, A. W. (2011). *Psychological experts in divorce actions* (5th ed.). New York: Aspen Law & Business.

SoAP (Division 50) member Andrew Kane has co-authored a book for psychologists and attorneys on child custody evaluations. The book addresses requirements for expert witnesses and children as witnesses, ethical issues, appropriate evaluations, and psychological testing. In addition, topics such as domestic violence, sexual abuse, family dynamics, mental disorders, alcohol and other drug abuse, and criminal histories are covered. Included is a newly revised table of requirements for the temporary practice of psychology in every jurisdiction within the U.S. and Canada. Chapters have extensive case law citations and sample questions that could be used in cross examination. Both authors are psychologists with decades of experience in child custody evaluations, as well as extensive experience with individual and couple psychotherapy. Further information can be found at www.aspenpublishers.com/Product.asp?catalog_name=Aspen&product_id=0735510326. ψ

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