The Addictions Newsletter

The American Psychological Association, Division 50

SUMMER 2013

Contents

President's Column

Working Collaborations: Their Importance in the "Now"

Sara Jo Nixon

It seems impossible that the year has passed and I am submitting my final "President's Column" for our Society's newsletter. It has been a rewarding, yet challenging year and the next year promises to provide continuing demands. As I consider the last year and what these events suggest for the future, there are several thoughts I would like to share.

Sara Jo Nixon

First, it has been said previously and will be said again, but it is imperative that our Society establish strategic, yet flexible collaborations with other APA divisions and Societies. Fortunately, we have an effective foundation from which to work. Many of you are active members in at least one other division/society. There is, of course, a reason for this cross-membership: The addiction field has implications for every mental health specialty and its members benefit from knowledge derived from divisions addressing behavior from the most basic to the most applied. Thus, as a Society, we have much to offer (and gain) as a collaborative partner. Our on-going collaboration with Division 28, Psychopharmacology and Substance Abuse, illustrates this point. This active collaboration has provided essential opportunities for Early Career Psychologists and students, and ensured a meaningful presence of addiction and substance abuse at the annual meeting. The program chairs from both divisions made a sustained effort to make effective use of National Institute on Alcohol Abuse and Alcoholism and National Institute on Drug Abuse support to achieve this goal. Having mentioned this fact, I would be remiss if I did not take the opportunity to thank Jen Buckman for her outstanding efforts as the 2013 Program Chair.

The collaboration between SoAP and Division 28 strengthened in 2013 with the first annual Collaborative Perspectives on Addiction meeting in Atlanta. The planning committee included leadership from Divsion 28 (Anthony Liguori and Katie Witkiewitz) and SoAP (John Kelly, Jen Buckman, and me) with key help from the Division Services Office, Chad Rummel. Engaging this joint leadership,

See pages 4-8 for Convention info! Looking forward to seeing you in Hawaii!

we were able to bring together about 80 participants from 28 states, DC, and Canada for a two-day conference focusing on the interface of research and practice. This type of experience exemplifies what it means to be both a practice and research division. Planning for next year's event is already underway and with the knowledge and experience gained from our first effort, there is no doubt that this meeting is one that members from both Divisions should be eagerly attending.

We must not rely, however, only on obvious opportunities. As mental health issues at the public health level change, we must be open to less traditional collaborations. These collaborations may be directed at specific initiatives and may not share the fundamental commonality we share with Division 28. They will, however, demonstrate the breadth and depth of the addiction field and our membership. There are a number of divisions with whom we worked from time to time; these and others should be reconsidered as we face new issues and concerns. **In short, our collaborative energy must extend beyond the APA annual meeting, to address the needs of those struggling with addiction and the professionals who provide mental health services.**

Thus, my second observation: We must make every effort to reinstate our proficiency exam (i.e., Proficiency in the Psychological Treatment of Alcohol and Other Psychoactive Substance Use Disorders). To achieve this end, we need the help of our colleagues in other divisions. The process by which our proficiency status was lost is indefensible, but our judgment of the process is not the "cause" we must support at this time. Instead, we must demonstrate through our numbers that the "addiction" proficiency is a critical reflection of clinical competence and its existence benefits our clients through its professional demands and benefits our practitioners through its reflection of professional status.

Reinstating our proficiency is not an issue just for our members who provide clinical services; it is an issue for any of us who believe that being a clinical professional in the addiction field requires specialized knowledge and expertise in the field of addiction. It may seem ridiculous to state something so obvious. However, it is evident that unless we clearly and repeatedly state our expectations, professionals treating addiction may not receive the training or the respect that they (and their clients) deserve. This alternative should be unacceptable to us and to those who need our services. **If you have already signed the petition endorsing the reinstatement, thank you! If not, please take the opportunity to go to http://www.ipetitions.com/petition/reopening/ and sign it now.** Furthermore, it is important that members of other APA divisions/societies also indicate their support. Hence, this is another opportunity for collaborative efforts. Our friends in a number of divisions are unaware of this situation. PLEASE take the time to email your colleagues and friends and seek their endorsement. We have contacts in several of these divisions, but quite simply, we need more.

Third, we have a truly remarkable membership! Repeatedly, the willing spirit, the apparently boundless energy, and the commitment of YOU, the membership, have amazed me. It has been an honor to serve as your President and to have the opportunity to serve with such a talented group of psychologists. We have a great team with tremendous potential. Ultimately, however, success occurs because YOU are willing to commit your time, energy, and perspective. Thank you for making the Society of Addiction Psychology a professional priority. ψ

SoAP Member Services

Join SoAP: www.apa.org/divapp

Renew SoAP: APA Members, Associates, and Fellows may renew via www.apa.org/membership/renew.aspx and Professional Affiliates (professionals with no membership in APA) and Student Affiliates may renew at www.apa.org/divapp.

Website: www.apa.org/divisions/div50

Listservs: To join the discussion listserv (discussion among members), contact Vince Adesso at vince@csd.uwm.edu. All new members are automatically added to the announcement listserv, div50announce@lists.apa.org (for division news).

Journal: You can access the division journal, ***Psychology of Addictive Behaviors***, online at www.apa.org via your myAPA profile. Log in with your user ID or email and password.

Newsletter: ***The Addictions Newsletter*** is sent out on the listservs and is available on the website.

For help with membership issues, contact Keith Cooke at kcooke@apa.org.

Editor's Corner

Melissa A. Lewis

After three enjoyable and informative years as *TAN* editor, it is time for me to say goodbye. My term as editor has afforded me many opportunities. I am happy to have gotten to know so many readers of *TAN*, as well as members of the Board and SoAP, while working with each of you on your excellent submissions. I gratefully learned about policy, the latest research, and the many happenings of our division. I leave knowing I benefited from my experience as editor.

Melissa A. Lewis

I want to take a moment to thank the many people I had the pleasure of working with as *TAN* editor. As my predecessor, Elizabeth D'Amico taught me the tricks of the trade. Thank you, Liz, for taking the time to provide me with a solid foundation for when I started my term. As my assistants, Jessica Blayney and Angela Mittmann kept every issue organized and on time. Jes also lent her creative talents in drawing several cartoons for our cartoon contests. So, thank you, Jes and Angela. I could not have done this without you! Thank you to the Board for giving me the opportunity to serve the division in this role. I am delighted to have worked with each and every one of you over the past three years.

I am pleased to announce that the Board selected Bettina Hoeppner to serve as the next editor. No doubt, Bettina will bring a fresh perspective and implement many changes to keep us coming back each issue. Bettina, I look forward to seeing what you do!

Without further ado, I would like to draw your attention to what this issue holds. First off, find out SoAP election results (page 9). Congratulations to our members who were newly elected into SoAP office! Also, I look forward to saying "Aloha" to you all in Hawaii! This issue highlights much of what you can attend at the APA Convention. Plan your time in paradise by reading about events and sessions that will take place. Finally, we have a number of interesting articles in this issue. Lindsey Rodriguez, Angelo DiBello, Chelsie Young, and Clayton Neighbors write about the role of alcohol in romantic relationships. Anne Banducci, C.W. Lejuez, and Laura MacPherson share a pilot study of a behavioral activation-enhanced smoking cessation program. Julio Rojas offers a framework for addiction treatment that integrates psychiatric comorbidity and trauma. Finally, Barry Anton advises on psychology practice in the health care reform era.

For my last topic selection as editor, I am asking for articles that focus on alcohol and sex. **Submit articles that focus on the role of alcohol in hooking up, risky sex, sexual arousal, or sexual assault.** As always, articles focused on different topics are welcome. Wanting to see articles on a specific topic? Send your topic ideas to Bettina for upcoming issues.

For the fall *TAN*, if you would like to submit an idea for a new column, article, abstract, or announcement, you will now be sending your information to **Bettina Hoeppner** at TANEditor@partners.org. Please send all submissions by **October 1st, 2013**. I know Bettina is excited to hear from you!ψ

Image courtesy of photostock/FreeDigitalPhotos.net

ACTION ALERT!

We need you to sign a petition to alert the Board of Directors of the American Psychological Association of the need to reinstate the **Certificate for the Recognition of Proficiency in the Psychological Treatment of Alcohol and Other Psychoactive Substance Use Disorders.** To sign go to http://www.ipetitions.com/petition/reopening/.

Jennifer Buckman
SoAP Program Chair

I hope many of you will be joining us for this year's APA Convention in Hawaii. I have never been to Hawaii and cannot wait to explore paradise! Luckily, the organizers of the convention have made this year's meeting a 5-day event, with reduced hours each day. There will be ample time to see the surf and still attend all the exciting addiction science and practice events that are detailed on the following page. Here are a few highlights:

This year's theme is the application of clinical neuroscience to addiction psychology. The first two days of the meeting are dedicated to **symposia** with a clinical neuroscience and addiction psychology focus. On Wednesday (Day 1), there will be two sessions that emphasize how neurogenetics research and neurocardiac research can influence addictive behaviors and positive behavior change. On Thursday (Day 2), there will be two sessions that focus on how neuroscience research can be translated to bolster prevention and treatment efforts.

Our **poster sessions** will be held on Friday morning in conjunction with Division 28 (Psychopharmacology and Substance Abuse) and Division 6 (Behavioral Neuroscience). We have once again worked closely with Division 28 to develop complementary programs. This year, we are excited about collaborating with Division 6 for the first time! We encourage all SoAP members to attend. We know that the convention exhibit hall is cavernous, but do not let that stop you. The poster sessions are a great way to hear about the ongoing research of premier addictions groups, not to mention identifying future students, interns, and postdoctoral fellows for your own research efforts.

This year we also will be holding two social events. The Thursday (3-5 pm) event is the **Board and Committee Reception** and is by invitation only. It will give SoAP board and committee members, 2012 SoAP fellows, and all SoAP student members a chance to mingle. Many SoAP members volunteer their time and energy during the year to keep the organization informed about the latest in policy, education, clinical, and research issues. Once a year, we try to say thank you to all these volunteers at the annual convention. Volunteers and students: Look for your invitation soon and plan on attending! Refreshments will be provided. The Friday (3-5 pm) event is the **NIDA/NIAAA Early Career Investigators Poster Session and Social Hour**. It is held in collaboration with Division 28 and the National Institutes on Alcohol Abuse and Alcoholism (NIAAA) and Drug Abuse (NIDA). It is open to all APA Convention goers, and we strongly encourage SoAP members to attend. The social hour will be held in conjunction with 40+ poster presentations from rising stars in the addictions field. The goal is to provide unique networking opportunities for our early career investigators with more established researchers and clinicians in the field. Refreshments will be provided by Divisions 28 and 50.

Another "don't miss" event is the **SoAP Presidential Address** (Friday, 1 pm). Sara Jo Nixon is a well-known and highly respected addictions researcher. She will talk about neurobehavioral deficits that often accompany addiction and how these deficits impact both life and recovery. Her talk will be followed immediately by the **SoAP Business Meeting** where, among other things, we will announce all of this year's SoAP awards—for students, early career members, and distinguished researchers and clinicians. All are welcome to attend and applaud this year's winners!

The whole program is listed on page 5. The wide range of presentations reflects SoAP's longstanding goal of enhancing discussion and dialogue between researchers and clinicians. We hope to see you there!ψ

Image courtesy of Liz Noffsinger/FreeDigitalPhotos.net

SOCIETY OF ADDICTION PSYCHOLOGY (Division 50)
2013 APA CONVENTION PROGRAM

Wednesday, July 31st

8:00 AM - 9:50 AM: CLINICIANS PANEL DISCUSSION
(Convention Center Room 304A)
Community-Based Participatory Research: Reaching Across the Research-Practice Gap
C. Neighbors, K. Miller, S. Collins, A. Nicasio, E. Gil-Kashiwabara, K. Straits

10:00 AM - 11:50 AM: SYMPOSIUM
(Convention Center Room 326B)
Novel Strategies for Understanding the Role of Genetics in Alcoholism and Drug Addiction
J. MacKillop, L. Ray, L.C. Bidwell, J. Buckman, K. Hutchison

12:00 PM - 12:50 PM: SYMPOSIUM
(Convention Center Room 318B)
Getting to the Heart of Addiction Neuroscience: Heart Rate Variability and Behavioral Flexibility
M. Bates, J. Thayer, S. McKee, J. Buckman

Thursday, August 1st

8:00 AM - 9:50 AM: SYMPOSIUM
(Convention Center Room 302A)
Translating Neuroscience Findings into Practical Drug Abuse Prevention
M. Glantz, H. Perl, M. McGue, D. Dick, M. Bardo, D. Fishbein

10:00 AM - 11:50 AM: SYMPOSIUM
(Convention Center Room 307B)
Contributions of Neuroscience to the Treatment of Alcohol Use Disorders
B. Huebner, W. Bickel, S. Tapert, E. Claus, J. Morgenstern, B. McCrady

3:00PM - 4:50PM: DIVISION 50 BOARD AND COMMITTEE RECEPTION (Closed)
(Hilton Hawaiian Village Beach Resort, Honolulu Suite I)

Friday, August 2nd

8:00 AM - 8:50 AM: POSTER SESSION
(Convention Center, Kamehameha Exhibit Hall)
Division 50 Poster Session on Addictive Behaviors

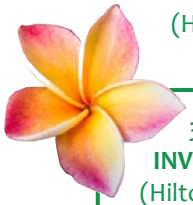
9:00 AM - 9:50 AM: POSTER SESSION
(Convention Center, Kamehameha Exhibit Hall)
Division 6, 28, & 50 Joint Poster Session on Neuroscience and Addiction

Friday, August 2nd

12:00 - 12:50 PM: SYMPOSIUM
(Hilton Hawaiian Village Beach Resort, Lehua Suite)
Gender Differences and Substance Abuse Treatment: The Lab, the Clinic, and Health Care Reform
C. Wetherington, S. McKee, R. Sinha, C. Grella

1:00 PM - 1:50 PM: PRESIDENTIAL ADDRESS
(Hilton Hawaiian Village Beach Resort, Lehua Suite)
Neurobehavioral Deficits in Addicts: Implications for Life and Recovery
Division 50 President: Sara Jo Nixon

2:00 PM - 2:50 PM: DIVISION 50 BUSINESS MEETING AND AWARD CEREMONY
(Hilton Hawaiian Village Beach Resort, Lehua Suite)
Open to all Division 50 members.



3:00 PM - 4:50 PM: NIDA/NIAAA EARLY CAREER INVESTIGATORS POSTER SESSION AND SOCIAL HOUR
(Hilton Hawaiian Village Beach Resort, Coral Ballroom IV)
Open to all convention attendees.

Saturday, August 3rd

8:00 AM - 8:50 AM: SYMPOSIUM
(Convention Center Room 307B)
Racial/Ethnic Variation in Timing, Characteristics, and Correlates of Early Drinking
K. Jackson, J. Donovan, T. Chung, E. D'Amico, R. Zucker

9:00 AM - 9:50 AM: SYMPOSIUM
(Convention Center Room 308B)
Current Trends in Addressing Substance Use Among Latino Adolescents and Emerging Adults
E. Vaughan, Y. Estrada, J. Burrow-Sanchez, O. Escobar, G. Prado

10:00 AM - 10:50 AM: EXECUTIVE BOARD MEETING (Closed)
(Hilton Hawaiian Village Beach Resort, Sea Pearl Suite IV)

Sunday, August 4th

9:00 AM - 10:50 AM: SYMPOSIUM
(Convention Center Room 304A)
State of the Art: Treating Comorbid PTSD and Substance Use Disorders
D. Hien, K. Mills, T. Killeen, T. Simpson, S. Back

11:00 AM - 11:50 AM: SKILL BUILDING WORKSHOP
(Convention Center Room 323C)
Integrating Neuroscience Into Clinical Practice in Addiction
L. Ray

Other Divisions' Sessions That May Be of Interest to SoAP Members

Jennifer Buckman
SoAP Program Chair

In addition to the symposia and presentations highlighted on the SoAP program and elsewhere in this issue, here is a non-exhaustive list of other divisions' sessions (loosely grouped by topic) that may be of interest to SoAP members. These listings come from 22 different divisions as well as from APAGS and truly demonstrate how salient the field of addictions is to nearly every branch of psychology!

In the interest of space, only session titles are listed. For more information on dates, times, participants, and location, see http://forms.apa.org/convention/

Military and Veterans Issues

- Apps, Telehealth, Virtual Reality—Addressing Mental Health Needs of Service Women and Men and Veterans
- Deployment Stress and Military Families' Health—A Focus on Health-Risk Behaviors and Physiology
- Veterans' Use of Mental Health Care—Mechanisms of and Barriers to Utilization
- Fighting Stigma on the Front Lines—Development of a Group-Based Intervention for Enlisted Leadership to Increase Treatment Seeking for PTSD Among Soldiers
- Status of Behavioral Health Among Active Duty Personnel and the Expanding Network of Supports That Serve Them
- Improving Community-Based Service Systems Structures to Reintegrate Returning Wounded Warriors
- Novel Psychotherapeutic Approaches for Treatment of Military-Related Psychological Trauma
- Innovative Approaches to Building Resilience in Military Families
- Models for Supporting Military Families in the Community

Children and Family Issues

- Informing Child Maltreatment Prevention via Broader Social Ecological Contexts
- Widening the Lens of Child Maltreatment Parenting Risk Assessment—New Perspectives
- Summary of a National Summit for Collaboration Across Society to Promote Child Mental Health
- Our Broken Family Courts—Lack of Protection for Trauma-Exposed Children
- Implementing Evidence-Based Practices in Public Mental Health for Children—Hawai'i's Emerging Model
- Treating Abuse Trauma in Family Context—Research Findings and Clinical Implications
- We Built It—Do They Come? Enhancing Family Intervention Utilization
- Beyond the Emotional Cycle of Deployment—Deeper Understanding of Family Reintegration
- ACTV—A Novel, ACT-Based Group Intervention to Reduce Intimate Partner Violence
- Addressing Tomorrow's Needs Through Parents—Parent Factors Affecting Child Development
- Advocacy and Empowerment for Diverse Women and Children
- Parental Trauma and Maltreatment and Child Outcomes
- Perspectives on the Intergenerational Impact of Trauma—Parenting Practices and Child Maladjustment
- Behavioral Economics and Maternal-Infant Health Among Substance Abusers

Youth and Adolescents

- From Dissemination to Sustainment of Evidence-Based Practices in Public Sector Services for Youths
- Chronic Marijuana and Binge-Drinking Effects on Neurocognition in Youth

- Adolescent Substance Abuse—State of the Science in Four Evidence-Supported Approaches
- Mass Media and Adolescent Substance Use—New Directions
- Project HOPE—Health Occupations, Preparation, and Exploration for Rural Underserved Students
- Latina/o Students in Higher Education—Support for Their Success
- Child/Adolescent Anxiety Multimodal Treatment Study—Predictors of Response and 5-Year Outcomes

Diversity

- Community Engagement for Mental Health and Substance Abuse Research With Diverse Populations
- Influence of Cultural Socialization Experiences on African American Women's Well-Being
- Evidence-Based Practices for Immigration and Acculturation Issues in Youth
- Minority Experiences of Interpersonal Mistreatment—Implications for Health and Well-Being

Violence, Trauma, and the Justice System

- Teen Dating Violence—Rates, Comorbid Delinquency, and Culture
- Role of Mental Health Issues in Juvenile Offending
- Role of Trauma in Law Enforcement and Correctional Settings
- Youth Issues in the Law—Custody Issues and Delinquency
- Criminal Justice and Behavioral Health—Strategies for Improving the Interface

- Multifaceted Approaches to Understanding Trauma
- Mental Health Issues in Psychology and Law
- Psychology and Law of Working With Refugees and Torture Survivors—A Social Ecological Intervention
- Sexual and Partner Violence
- Creating a Trauma-Informed Juvenile Justice System
- Developing Sexual Assault Survivor Groups in a College Setting
- Men and Trauma—Prevention and Intervention
- Trauma, Stress, and Cortisol Across the Life Span
- Evidence-Based Practices for Trauma in Youth
- Innovations in Evidence-Based Treatments for PTSD
- National Consensus Conference Findings on Education, Training, and Practice in Trauma
- Evidence-Based Practices for Treating the Effects of Bullying in Youth
- Exploring Their Lives—Possible Precursors of Violent Behavior in African American Males
- Developing Resiliency—Compassion Fatigue and Regeneration

Prevention

- Innovative Approaches to the Prevention of Violence Across the Life Span
- Education and Training in Prevention
- Prevention in School Settings—A Focus on Youth Aggression and Bullying
- Advancing Prevention Science Research and Practice in Counseling Psychology
- Group-Centered Prevention Programs—A New Approach for Creating Change With At-Risk Students
- Prevention and LGBT Communities
- Building an Exchange Between Prevention Science and Prevention Systems Using Epidemiological Data

Mindfulness and Spirituality

- Mindfulness-Based Eating Awareness Therapy—An Overview of Theory and Basic Skills
- Mindfulness-Based Interventions—Applications and Mechanisms of Action
- Cultivating Mindfulness in Counseling Training Programs
- Mindfulness-Based Interventions—Exploring the Roles of Spirituality and Group Processes
- Religious Coping in Three Contexts—Cancer, Mental Illness, and Bereavement

- Integrating Mindfulness Into Clinical Psychology Training
- A Call to Action—Strength-Based and Spiritual Approaches in Diverse Urban Communities

Eating Disorders and Related Issues

- Eating Disorders in Diverse Populations—Challenges and Culturally Specific Adaptations
- Obesity and Health Disparities—Counseling Psychology Looks at the Problem From Several Perspectives
- Cultural Adaptation of a Cognitive-Behavioral Guided Self-Help Program for Binge-Eating Disorders

Neuroscience and Psychopharmacology

- Neuroscience, Addiction, and Comparative Psychology
- Social Factors in Addiction and Learning
- Behavioral and Brain Mechanisms in Cognition and Behavior Change
- Updates in Behavioral Neuroscience and Comparative Psychology
- Neurological and Physiological Implications of Maltreatment
- Buprenorphine and Opioid Addiction
- Drug Abuse Vulnerability—A Developmental Window Into Subtle Environmental Exposures
- Monitoring and Treating Stimulant Use and Abuse
- Mental Health and Treating Substance Abuse Disorder

Technology in Treatment

- How Digital Technology Use Can Help or Harm—Research Developments and Clinical Applications
- Rocking the House With Tech—How to Use Technology to Improve Behavioral Interventions With Women
- Apps for CBT and DBT—There's an App for That
- Technology-Based Interventions for Substance Use Disorders and Related Conditions

Bridging Research & Practice: Evidence-Based Practice Development and Adoption

- CCMH—The Clinical Utility of a Practice--Research Network
- Closing the Scientist-Practitioner Gap—Applying Interpersonal and Attachment Theory to Group Work
- Practice-Based Evidence in Group Psychotherapy—Responding to Client and Group Process Feedback
- Top 10 Lessons Learned From Disseminating Evidence-Based Interventions in Real World Settings—Dedicated to the Memory of Susan Nolen-Hoeksema
- An Evidence-Based Approach to Bridging Science and Practice Across Clinical Training Settings
- Translational Findings in Mental Health and Addictions and Implications for Treatment
- Counseling Psychologists and Substance-Use Research—Prevention, Treatment, and Funding
- More From Less—Universities Collaborate to Address the Growing Demand for Mental Health Services
- Step-by-Step Guidelines for Developing Community-Based Prevention Programs in At-Risk Communities Scientific Ethics and Team Science

- Thinking Outside the Box—Adapting Participatory Action Research Principles to Diverse Contexts
- Succeeding in Horizontal Collaborations—Tips and Advice From Interdisciplinary Researchers in Psychological Science
- Evidence in Support of Existential-Humanistic Psychotherapy—Revitalizing the Third Force
- Substance Abuse Recovery Issues

DSM-V

- DSM-5 and the Future of Mental Health Diagnosis—Critical Responses
- Why Did They Do That? Changes in the DSM-5 and Their Implications for Clinical Psychology

Statistical Considerations

- Continuing Education Workshop #142: An Introduction to Data Analysis With R
- Let's Consider How to Make Scientific Inferences
- The Science of Digital Test Adaptation—Implications for Research and Clinical Practice
- Applications and Advancements in Latent Transition Analysis
- Robust SEM for Non-Normal and Missing Data Using WebSEM
- Thinking Clearly About Multivariate Models in Psychology
- Examining Group-Based Trajectories in Substance Use Disorder Clinical Trial Data

Student and Early Career Members

- Giving Yourself an Edge—Frank Advice on Funding for Graduate Research
- Publish or Perish! What Grad Students Need to Know About Publication and Peer Review
- Breaking the Academic Mold—Nontraditional Career Options
- Early Career Psychologist Mentoring Symposium: Tips on How to Succeed in Child-Related Careers
- We're in the Money—Helpful Hints From Psychological Scientists About Securing Research Funding ψ

People image courtesy of Master isolated images/FreeDigitalPhotos.net. Seashells image courtesy of Grant Cochrane/FreeDigitalPhotos.net

2013 APA CONVENTION HIGHLIGHTS!

Clinician's Panel Discussion

Wednesday, July 31, 2013
Time: 8:00 - 9:50 AM
Location: Honolulu Convention Center, Room 304A

Community-based participatory research: Reaching across the research-practice gap

Performing research in a real-world setting isn't easy, but the potential payoff is huge. Join our panel of experts for an informative and engaging discussion on successfully planning and implementing community-based participatory research

CE Credits available!

Supported in part by grant R13AA017170

2013 NIAAA/NIDA Early Career Investigator Poster Session and Social Hour

It's a social hour and…
EVERYONE IS INVITED!

Friday, August 2, 2013
Time: 3:00 - 4:50 PM
Location: Hilton Hawaiian Village Beach Resort
Coral Ballroom IV

Come support the rising stars of Division 28 and 50 while networking, mingling, and noshing!

Election Results

William Zywiak and Tammy Chung
SoAP Nominations and Elections Committee

Thank you to everyone who voted during the Division election in May! One hundred eighty nine ballots were cast (20% more than last year). The candidates **Alan Budney**, **Mark Schenker,** and **Serena Wadhwa** contributed considerable time and effort in the election process. A big thank you to all the candidates!

Congratulations to the newly elected! Alan Budney is the new President-Elect. He will begin his term as President at the end of the Business Meeting at the 2014 APA Convention in Washington DC. During the preceding 12 months he will shadow (as President-elect) John Kelly, as John begins serving as President in August 2013. After serving as President for one year, Alan Budney will serve as Past-President. The

other office, Member-at-Large, is a standard 3-year term starting in August 2013. Congratulations to our newly elected Member-at-Large Practice, Mark Schenker.

We would also like to thank the following current officers for their service to SoAP: Past President Warren Bickel, and President Sara Jo Nixon. Thank you to Jalie Tucker, who finished her term as Council Representative in December. Amy Rubin will be taking over as Chair of the Nominations and Elections Committee in August. If you would like to serve on this committee please contact her at rubina@bu.edu. Hope to see you at Sara Jo Nixon's Presidential Address, "Neurobehavioral Deficits in Addicts: Implications for Life and Recovery," on Friday, August 2nd at 1 pm at the Convention in Honolulu!

From Bill:

Finally, I would like to thank Tammy Chung, Krista Lisdahl, and Selene Varney MacKinnon for serving on the Nominations and Elections Committee. I would also like to thank Nancy Piotrowski for inviting me six years ago, to serve as Chair of this Committee, Ron Kadden for his prior six years of service in this office, and all those who emailed me during the winters with nominations of the candidates. Have a great summer!ψ

COLLABORATIVE PERSPECTIVES ON ADDICTION MEETING

Second Annual Meeting Date: February 28th - March 1st, 2014
Location: Atlanta, GA

The first annual CPA meeting was held in early May 2013 and was a resounding success! Our inaugural year created the foundation for an intimate, networking focused meeting. Saul Shiffman and Edie Sullivan delivered keynotes that reached far beyond the experimental details to touch on the human elements of addiction and the suffering and struggles that go with it. In between their talks were engaging presentations, incredible networking opportunities, and simply amazing food!

For 2014, we will build on our inaugural year successes by more directly creating an interactive forum for addiction researchers and clinicians. To accomplish this, **we will be soliciting submissions for plenary that focus on provocative topics in addiction, and that each specifically include an animal/cell scientist, a human experimental/clinical researcher, and a clinician who works directly with addicted individuals**. A main goal for 2014 is to maximize the clinical relevance of our translational research efforts.

If you would like to join the "sounding board" to help shape the future of the meeting, have an idea for a plenary, or would just like more information about the meeting, please contact Jennifer Buckman at jbuckman@rutgers.edu.

We look forward to seeing you in Atlanta in 2014!

CPA Organizing Committee:
Anthony Liguori and Ellen Walker [President and President-Elect, 28]
Sara Jo Nixon and John Kelly [President and President-Elect, 50]
Katie Witkiewitz (28) and Jennifer Buckman (50) [Program Chairs]

CHANGING ADDICTIVE BEHAVIOR

Bench *to* Bedside *and* Back *Again*

The planning committee for the 2014 Collaborative Perspectives on Addiction Conference is excited to announce the opening of our 2014 Call for Proposals

View the call for proposals at:
http://www.tinyurl.com/2014CPACFP

Workshop Proposals
Due August 15, 2013
http://www.tinyurl.com/2014CPAWorkshops

Breakout/Symposia Proposals
Due September 1, 2013
http://www.tinyurl.com/2014CPABreakout

Poster Proposals
Priority Deadline: October 1, 2013
http://www.tinyurl.com/2014CPAPosters

ABOUT THE CONFERENCE

The theme for the 2014 conference is **"Changing Addictive Behavior: Bench to Bedside and Back Again"**

- Atlanta, Georgia / February 28-March 1, 2014
- Thought-provoking keynotes and cross-discipline panels
- Interactive environment for collaboration/networking
- Several breakout session choices
- Poster sessions
- Pre-conference in-depth workshops
- Discounted rates for Early Career Psychologists
- Student opportunities (discounted rates, special networking, etc)
- You don't have to be a member of either division or APA to attend the conference!
- **CE is available!**

28/50 COLLABORATIVE PERSPECTIVES ON ADDICTION
Feb 28 - March 1 | Atlanta, GA

SOCIETY OF ADDICTION PSYCHOLOGY

28 DIVISION PSYCHOPHARMACOLOGY AND SUBSTANCE ABUSE

ABOUT THE VENUE

The beautiful W Hotel in Midtown Atlanta will be the venue for the 2014 CPA. The hotel is located in the heart of Midtown and is local to public transportation. Room rates are $159 per night. Reserve your room now!

MORE INFORMATION

Katie Witkiewitz, PhD, Co-Chair
Jennifer Buckman, PhD, Co-Chair
Chad Rummel, MEd, Registration and Hotel Accommodations.
202-336-6121

Advocate's Alcove

Nancy A. Piotrowski
SoAP Federal Advocacy Coordinator

Please be sure to sign our petition to get the Certificate of Proficiency in the Psychological Treatment of Alcohol and Other Psychoactive Substance Use Disorders reinstated so new individuals can apply for the certificate. Then tell your colleagues who are licensed clinical psychologists and students to do the same! Also, consider asking your local county and state associations to place an article in their newsletter about this matter. I have prepared material you can use for this purpose and will email it to you upon request.

There is a lot of other activity happening at the federal level affecting the way we work with our clients. As such, it is important for you to watch for news and action opportunities via the listserv as we move forward in 2013. Practice concerns continue to focus on health care reform and keeping Medicare in good shape. As a reminder, to keep abreast of ongoing efforts by the APA Practice Organization (APAPO) you may visit the Legislative Action Center to learn how to participate in a quick and efficient manner when timely responses matter most. Please also remember that legislation moves in fits and starts, so there may be more than one alert on a particular matter to move it through one committee or another, the House, or the Senate, etc. Responding to one alert on an issue is good, but often it may really take sending three or four e-mails as things work their way through the system over time.

The current legislative priorities for 2013 announced at this year's State Leadership Convention (SLC), held in March in Washington, DC, will be familiar. Three are a repeat of what we had as priorities last year. First, there is the need for Congress to include psychologists in Medicare's "physician" definition. This is currently at a place where there is a need for co-sponsorship on the bill in both the Senate and the House. Second, there is the need to continue to keep an eye on Medicare reimbursements. Legislation was able to avert a 26.5% cut in the rate earlier this year. However, even with current rates, many providers cannot afford to see Medicare clients. As such, these cuts can be devastating to those who need care the most and have the least access. Therefore, this will be an area for continued vigilance. Third is the need for Congress to make psychologists eligible for incentive payments through the HITECH Act or any other future bills that come to be, so behavioral health records are not lost in the process, thereby diminishing care. Finally, The Mental Health Awareness and Improvement Act of 2013 is expected to have floor action soon. The bill will raise awareness on mental health disorders, including substance use problems, and reauthorize and improve other programming. Look for listserv announcements and future *Advocate's Alcove* columns to keep you updated on these and other issues.

Please also note that you can find information from the 2013 SLC online. Varied conference presentation handouts are available. Additionally there are photos, quizzes, and other materials discussing the move towards integrated healthcare for you to explore. Please also know that while at SLC, I took the time to do outreach to many of the other state association and division leaders present. We have many supporters across the states on our effort to get the certificate reinstated. It may take time to "get the troops" out, but they are indeed supportive and willing to help.ψ

Resource Information

APA Practice Central
www.apapracticecentral.org

Conference presentation handouts
http://www.apapracticecentral.org/advocacy/state/leadership/slc-handouts.aspx

HITECH
http://www.apapracticecentral.org/advocacy/state/leadership/slc-fact-hitech.aspx

Legislative Action Center
http://capwiz.com/apapractice/home/

Medicare Physician Definition
http://www.apapracticecentral.org/advocacy/state/leadership/slc-fact-congress.aspx

Mental Health Awareness and Improvement Act of 2013
http://capwiz.com/apapractice/issues/alert/?alertid=62587931

Petition to reopen the Certificate of Proficiency in the Psychological Treatment of Alcohol and Other Psychoactive Substance Use Disorders
http://www.ipetitions.com/petition/reopening/

Photos, quizzes, and other materials
http://www.apapracticecentral.org/advocacy/state/leadership/slc-2013.aspx?utm_source=2013+SLC+invitation+email&utm_campaign=c7277136b5-2013_APA_Final_Email4_25_2013&utm_medium=email

Student and Trainee Perspectives

David Eddie
Student Representative

Summer is here, and another APA convention is almost upon us. This year promises to be well worth the trip, and not just for the location! From a divisional perspective, the upcoming convention promises to be one of the most interesting conventions in recent years. As noted elsewhere in this edition of *TAN*, SoAP has a ton of great stuff scheduled, including symposia, poster sessions, and social hours.

Several events at the convention are of particular interest to SoAP's student members. Don't miss the **NIDA/NIAAA Early Career Investigators Poster Session and Social Hour** at the Hilton Village Beach Resort, Coral Ballroom IV on Sunday, August 2nd from 3:00 to 4:50 pm. This social hour is open to all convention attendees and will offer great networking opportunities with top addiction researchers and NIH staff (as well as free food!). Get more involved with SoAP or meet fellow members by attending the **Division 50 Business Meeting and Award Ceremony** (2:00 to 2:50 pm in the Lehua Suite). The Business Meeting and Award Ceremony is open to all SoAP members. Check out the first ever **Joint Division 6, 28 & 50 Poster Session on Neuroscience and Addiction** in Kamehameha Exhibit Hall at the Convention Center on Friday, August 2nd from 9:00 to 9:50 am.

Attend a panel discussion with audience participation that aims to bring together researchers and clinicians—**Community-Based Participatory Research: Reaching Across the Research-Practice Gap**—on Wednesday, July 31st from 8:00 to 9:50 am. Also of interest is the symposium **Gender Differences and Substance Abuse Treatment—The Lab, the Clinic, and Health Care Reform,** Friday, August 2nd from 3:00 to 4:50 pm. Speakers will attempt to bridge research-practice issues in addiction treatment, particularly as they relate to women.

Division 12 (Clinical) also offers opportunities for students that are relevant to many SoAP members. If you are in a clinical program and are applying to internship in the near future then go to **Selecting and Applying to a Pre-Doctoral Clinical Psychology Internship**, on Wednesday, July 31st from 11:00 am to 12:50 pm. For those a little further down the track you might consider **How to Survive and Thrive As an Early Career Psychologist—Making the Most of Your Degree**, on Sunday, August 4th from 1:00 to 1:50 pm.

SoAP is offering a free year of membership to all students attending the APA convention this year, whether they be new or returning members. Keep an eye out for application forms at the APAGS stand and student poster sessions at the convention!

Lastly, I want to introduce you to Lauren Hoffman from the University of Florida, who is the newly appointed Student Representative to the Executive Board of the SoAP. Welcome, Lauren!

From Lauren Hoffman:

Hi, I'm Lauren Hoffman. I am excited to have been recently named to serve as the non-voting Student Representative for SoAP. I completed my bachelor's in psychology at San Diego State University in 2011. There, I was fortunate to assist in the collection and analysis of data for a developmental laboratory that specialized in fMRI. Currently, I am a third year psychology graduate student at the University of Florida, specializing in behavioral cognitive neuroscience. I am working with Sara Jo Nixon in the Neurocognitive Laboratory where our work focuses on the neurobehavioral and psychosocial effects of alcohol and other drug abuse and dependence as well as moderate alcohol consumption. My most recent APA/SoAP presentation was at the Collaborative Perspectives on Addiction joint mid-year conference where I presented a poster entitled *Moderate Alcohol and Age: Effects on Set-Shifting*.

Currently, I am studying the differential effects of acute low dose alcohol on older men and women and anticipate obtaining my Master of Science degree within the year. As my skills as an investigator progress, I hope to narrow my focus to the study of addiction and recovery. I am currently writing a National Institutes of Health F-series fellowship proposal for a study of treatment seeking alcohol dependent women and their neural response to emotional face stimuli using brain electrophysiology and measures of affect and interpersonal stress. As an addiction psychology enthusiast and a SoAP member, I am honored and delighted to accept the position of Student Representative on the SoAP's Board. I thoroughly look forward to serving my term!ψ

Council Representatives' Report: February 2013

Linda Sobell
Raymond F. Hanbury
Council Representatives for Science and Practice

President Donald N. Bersoff delivered his Presidential Initiatives:

- To ensure that psychologists are in the forefront in providing services to military personnel, veterans and their families, as well as military members who have been sexually harassed in the service.
- To stimulate more diversity by identifying innovative doctoral programs that have admitted students from diverse cultures.
- To advance the creation, communication and application of psychological knowledge to benefit society and improve people's lives by attracting and retaining academicians and scientists as members.

Norman Anderson's CEO Report focused on APA's Center for Psychology and Health as well as issues related to gun violence. He pointed out that we need to maximize our involvement in these types of national concerns. There is a move to expand psychologists' role in the area of health such as the Affordable Care Act of 2010. The challenges mentioned in this report were (1) workplace challenge (focus on primary team based care), (2) getting involved and getting paid (dealing with advocacy and billing codes), (3) image challenge (how we are viewed—i.e., being seen as mental health providers but not as integrated health care providers) and (4) self-image challenge (how do we view ourselves). The Center for Psychology is working with the American Psychological Association Practice Organization (APAPO) so that strategic goals related to health can be overseen and facilitated. The roadway for this is education, training, and advocacy (through practice organization). With health care reform encouraging consolidation among health care providers, the movement is toward integrating mental health, behavioral health, and substance use services in all kinds of treatment settings. This means there is a need for utilizing the health and behavior assessment and intervention codes. These are the CPT codes used in order to receive payment.

Ongoing activities regarding gun violence include outreach to Congress, The Executive Branch, and collaboration with other groups, such as the National Institute of Justice and the Police Foundation.

In addition to the above, there were updates in several areas. Regarding Clinical Practice Guidelines, Daniel Kivlahan, a SoAP member, and the rest of the Steering Committee are working on guidelines for depression, obesity, and PTSD. Another issue discussed was the Internship Program within the context of the Health Service Psychology Education Collaborative Blueprint. The Board of Educational Affairs will be working on standards and APA is advocating for federal support of education and training. There were 947 unmatched interns in 2012.

The investment plan for Publication has been productive. There is an increase in the use of technology and there is a new product release—Journal Pro App. There is a marketing plan which includes expanding the sales force and using institutional prospects database.

Practice Directorate information was presented by Katherine Nordal. She said that Health Care Reform was the theme for the State Leadership Conference. The top priorities for 2013 were Medicare and Medicaid reimbursement and the Medicare physician definition. There were other issues in which the Directorate is involved, including advocacy for Telehealth, Electronic Health Records, Duty to Warn, and resources for Physician Quality Reporting System for billing Medicare.ψ

A few of the motions approved by Council that have relevance for our members include:

- Endorsement for Core Competencies for Interprofessional Collaborative Practice (pertains to expanding psychology's role in advancing health),
- Funding request to support the Task Force for the Development of Telepsychology Guidelines,
- Funding to convene a Policy Review Task Force on Gun Violence Prediction and Prevention, and
- Endorsing strategies for education and training of psychologists in the use of the International Classification of Diseases, Tenth Revision, Clinical Modification.

Alcohol and Romance: A Love/Hate Relationship

Lindsey M. Rodriguez, Angelo M. DiBello, Chelsie M. Young, and Clayton Neighbors
University of Houston

The purpose of this article is to provide a brief overview of the role alcohol plays in intimate relationships, how perceptions of drinking affect relationship outcomes, and how individuals might respond to their partners' excessive drinking.

Alcohol Use and Relationship Distress

Not surprisingly, past research has consistently demonstrated associations between problem drinking and negative romantic relationship outcomes. More generally, problem drinking has been shown to negatively impact health, relationship satisfaction, and overall quality-of-life (e.g., Cranford, Floyd, Schulenberg, & Zucker, 2011; Dawson, Grant, Chou, & Stinson, 2007; Foran & O'Leary, 2008; Leonard & Eiden, 2007; Marshal, 2003; Roberts & Linney, 2000). Partners of individuals with alcohol problems report higher rates of physical and emotional abuse, depression, anxiety, and physical symptoms (Cronkite & Moos, 1984; Halford, Bouma, Kelly, & Young, 1999; Jacob & Leonard, 1988; Leonard & Senchak, 1993; Maisto, McKay, & O'Farrell, 1998; Moos, Finney, & Cronkite, 1990).

Relationship partners influence one another's drinking patterns over the short-term in dating couples (Mushquash et al., 2013) and over the long-term in married couples (Leonard & Mudar, 2004). An interesting note is that relationship problems are particularly likely to result when partners differ in their drinking patterns. Discordance in alcohol consumed by partners has been associated with lower relationship satisfaction (Homish & Leonard, 2007; Levitt & Cooper, 2010; Roberts & Leonard, 1998).

Interpersonal Perception

While patterns of alcohol use in relationships are clearly associated with relationship functioning, it is equally important to recognize the role that perceptions and expectations related to drinking play beyond objective behavior. Specifically, research examining perceptions of one's partner has shown that having positive perceptions about one's partner is associated with higher levels of relationship satisfaction and commitment (Cobb & Bradbury, 2001; Murray & Griffin, 1996; Neff & Karney, 2005; Ruvolo & Fabin, 1999; Watson & Wiese, 2000). Perceptions also play an important role in evaluating a partner's behavior. For example, Amato and Rogers (1997) found a higher likelihood of divorce in subsequent years for those who indicated that either partner's drinking was a concern at baseline.

In addition to partner perceptions of drinking influencing relationship quality, alcohol use itself has been associated with altered perceptions. For example, in a sample of married couples with one partner reporting alcohol problems, both spouses inaccurately evaluated their partner's level of relationship adjustment. Specifically, those with alcohol problems perceived their partner's level of relationship satisfaction to be significantly higher than it was, whereas spouses without alcohol problems underestimated the drinker's satisfaction (Antoine, Christophe, & Nandrino, 2009). These misperceptions are important because research has shown that subjective perceptions may be better indicators of satisfaction than actual reports (Fiske, Lindzey, & Gilbert, 2011). For example, the perception that one is similar to one's partner predicted relationship satisfaction better than actual similarity (Acitelli, Douvan, & Veroff, 1993).

Perceptions are inherently complex and dynamic factors that are largely a function of how the dyad members interact. Rodriguez, Overup, and Neighbors (in press) posited that the association between perceiving one's partner to have a drinking problem and relationship satisfaction might vary based on the partner's drinking levels. Results indicated that perceptions of partner problem drinking were associated with lower satisfaction, especially when the partner drank at lower levels. Moreover, partners' actual drinking was not uniquely associated with satisfaction beyond perceptions, suggesting that perceptions affect satisfaction more than actual drinking levels.

Drinking Control Strategies

Perceptions and behavior are inextricably connected. Once a problem is perceived, close others are amongst the first to try to constrain, limit, or control a drinker's alcohol use (Room, Greenfield, & Weisner, 1991; Wiseman, 1991). Communication in family systems involving members with substance problems may be characterized as highly critical, involving considerable amounts of nagging, blame, complaints, and guilt. Partner management strategies may take many forms, some of which have a positive focus (e.g., rewarding the partner for activities that do not include alcohol), and others which are more negatively focused (e.g., punishing the partner for drinking). Generally, research on regulating a partner's behaviors suggests that attempts per-

Author Note: Preparation of this article was supported by National Institute on Alcohol Abuse and Alcoholism Grants F31AA020442 and R01AA014576. Please direct all correspondence regarding this manuscript to Lindsey Rodriguez, Department of Psychology, University of Houston, Houston, TX 77204-5022. Phone 713-743-2644, Fax 713-743-8588, E-mail: LRodriguez23@uh.edu.

ceived as critical, demanding or punishing may be less effective than attempts that are perceived as genuine or warm (e.g., Overall & Fletcher, 2010).

We have recently begun to further examine control strategies in a large sample of college students (N = 711). We found that undergraduates used both positive and negative reinforcement strategies, but that punishing one's partner for drinking was associated with lower satisfaction than rewarding for not drinking. Although individuals were more likely to report rewarding than punishing overall, $t(675) = -17.26$, $p < .001$, perceiving one's partner to have a drinking problem was more strongly associated with punishment than with reward, $z = 1.98$, $p = .048$. Not surprisingly, satisfaction was negatively associated with drinking control behaviors; however, it was more strongly associated with punishment than reward, $z = -2.47$, $p = .014$.

Discussion

Having briefly touched on general findings related to drinking in relationships, the influence of interpersonal perceptions, and partner control strategies, several points are worthy of brief discussion. First, while the overall risks of excessive drinking on individuals' well-being cannot be overlooked, in the relationship context the mutual patterning of drinking between the partners plays a key role. Relationships seem to fare worst when partners display discrepant drinking levels, where one partner is drinking heavily and the other is not.

Relatedly, it is also important to note that problem drinking is, to a large extent, in the eye of the beholder and perceptions of what is problematic have greater impact on relationship satisfaction than objective behavior. Perceptions are based on values and expectations that are not always explicitly communicated. For example, one partner may view intoxication as an indicator of problem drinking whereas another partner may view weekend intoxication as normal recreation. Differences in expectations and values and resulting attempts at resolution are likely to be difficult without open communication and mutual exploration of the discrepancy.

Attempts to regulate drinking are a natural occurrence in couples where discrepancies exist between drinking behavior and/or expectations about drinking. Of the two kinds of regulation strategies, punishment is more strongly associated with relationship dissatisfaction. Thus, it is ironic that the more problematic one views his/her partner's drinking, the more likely he/she is to use punishment strategies. To the extent that excessive drinking may be motivated in part by relationship dissatisfaction, it is easy to see how punishment strategies may actually exacerbate relationship problems.

There are at least two practical applications of research findings for relationship satisfaction. First, open communication about alcohol and expression of what each partner finds acceptable is important. A potential partner's match with one's own attitudes about alcohol is beneficial to consider when entering into a long-term relationship. Second, individuals who struggle with a partner's problem drinking would be advised to focus on reinforcement for non-drinking over punishment strategies. In conclusion, continued research examining dyadic perspectives on drinking are likely to provide valuable insights into the prevention and treatment of problem drinking and to promote strategies for improving relationship outcomes (McCrady, Ladd, & Hallgren, 2012).

References

Acitelli, L. K., Douvan, E., & Veroff, J. (1993). Perceptions of conflict in the first year of marriage: How important are similarity and understanding? *Journal of Social and Personal Relationships, 10*, 5-19. doi:10.1177/0265407593101001

Amato, P R., & Rogers, S. J. (1997). A longitudinal study of marital problems and subsequent divorce. *Journal of Marriage and the Family, 59*, 612-624. doi:10.2307/353949

Antoine, P., Christophe, V., & Nandrino, J. L. (2009). Crossed evaluations of temptation to drink, strain and adjustment in couples with alcohol problems. *Journal of Health Psychology, 14*, 1156-1162. doi: 10.1177/1359105309342285.

Cobb, R., Davila, J., & Bradbury, T. (2001). Attachment security and marital satisfaction: The role of positive perceptions and social support. *Personality and Social Psychology Bulletin, 27*, 1131-1144. doi:10.1177/0146167201279006

Cranford, J. A., Floyd, F. J., Schulenberg, J. E., & Zucker, R. A. (2011). Husbands' and wives' alcohol use disorders and marital interactions as longitudinal predictors of marital adjustment. *Journal of Abnormal Psychology*, *120*, 210-222. doi:10.1037/a0021349

Cronkite, R. C., & Moos, R. H. (1984). Sex and marital status in relation to the treatment and outcome of alcoholic patients. *Sex Roles, 11*, 93-112. doi:10.1007/BF00287443

Dawson, D. A., Grant, B. F., Chou, S., & Stinson, F. S. (2007). The impact of partner alcohol problems on women's physical and mental health. *Journal of Studies on Alcohol and Drugs*, *68*, 66-75.

Fiske, S. T., Lindzey, G., & Gilbert, D. T. (2011). *Handbook of social psychology*. Hoboken, NJ: Wiley.

Foran, H. M., & O'Leary, K. (2008). Alcohol and intimate partner violence: A meta-analytic review. *Clinical Psychology Review, 28*, 1222-1234. doi:10.1016/j.cpr.2008.05.001

Halford, W., Bouma, R., Kelly, A., & Young, R. (1999). Individual psychotherapy and marital distress: Analyzing the association and implications for therapy. *Behavior Modification, 23*, 179-216. doi:10.1177/0145445599232001

Homish, G. G., & Leonard, K. E. (2007). The drinking partnership and marital satisfaction: The longitudinal influence of discrepant drinking. *Journal of Consulting and Clinical Psychology, 75*, 43-51. doi:10.1037/0022-006X.75.1.43

Jacob, T., & Leonard, K. E. (1988). Alcoholic-spouse interaction as a function of alcoholism subtype and alcohol consumption interaction. *Journal of Abnormal Psychology, 97*, 231-237. doi:10.1037/0021-843X.97.2.231

Leonard, K. E., & Eiden, R. D. (2007). Marital and family processes in the context of alcohol use and alcohol disorders. *Annual Review of Clinical Psychology*, 3285-310. doi:10.1146/annurev.clinpsy.3.022806.091424

Leonard, K. E., & Mudar, P. (2004). Husbands influence on wives' drinking: Testing a relationship motivation model in the early years of marriage. *Psychology of Addictive Behaviors, 18*, 340-349.

doi:10.1037/0893-164X.18.4.340
Leonard, K. E., & Senchak, M. (1993). Alcohol and premarital aggression among newlywed couples. *Journal of Studies on Alcohol*, SUPPL 1196-108.
Levitt, A., & Cooper, M. (2010). Daily alcohol use and romantic relationship functioning: Evidence of bidirectional, gender-, and context-specific effects. *Personality and Social Psychology Bulletin, 36*, 1706-1722. doi:10.1177/0146167210388420
Maisto, S. A., McKay, J. R., & O'Farrell, T. J. (1998). Twelve-month abstinence from alcohol and long-term drinking and marital outcomes in men with severe alcohol problems. *Journal of Studies on Alcohol, 59*, 591-598.
Marshal, M. P. (2003). For better or for worse? The effects of alcohol use on marital functioning. *Clinical Psychology Review, 23*, 959-997. doi:10.1016/j.cpr.2003.09.002
McCrady, B. S., Ladd, B. O., & Hallgren, K. A. (2012). Theoretical bases of family approaches to substance abuse treatment. In S. T. Walters & F. Rotgers (Eds.), *Treating substance abuse: Theory and technique* (3rd ed.) (pp. 224-255). New York, NY US: Guilford Press.
Moos, R. H., Finney, J. W., & Cronkite, R. C. (1990). *Alcoholism treatment: Context, process, and outcome*. New York, NY US: Oxford University Press.
Murray, S. L., Holmes, J. G., & Griffin, D. W. (1996). The self-fulfilling nature of positive illusions in romantic relationships: Love is not blind, but prescient. *Journal of Personality and Social Psychology, 71*, 1155-1180. doi:10.1037/0022-3514.71.6.1155.
Mushquash, A. R., Stewart, S. H., Sherry, S. B., Mackinnon, S. P., Antony, M. M., & Sherry, D. L. (2013). Heavy episodic drinking among dating partners: A longitudinal actor–partner interdependence model. *Psychology of Addictive Behaviors, 27*, 178-183. doi:10.1037/a0026653
Neff, L. A. & Karney, B. R. (2005). Gender differences in social support: A question of skills or responsiveness? *Journal of Personality and Social Psychology, 88*, 79-90. doi:10.1037/0022-3514.88.1.79
Overall, N. C., & Fletcher, G. O. (2010). Perceiving regulation from intimate partners: Reflected appraisal and self-regulation processes in close relationships. *Personal Relationships*, 17, 433-456. doi:10.1111/j.14756811.2010.01286.x
Roberts, L. J., & Leonard, K. E. (1998). An empirical typology of drinking partnerships and their relationship to marital functioning and drinking consequences. *Journal of Marriage and the Family, 60*, 515-526. doi:10.2307/353866
Roberts, L. J., & Linney, K. D. (2000). Alcohol problems and couples: Drinking in an intimate relational context. In K. B. Schmaling & T. Sher (Eds.), *The psychology of couples and illness: Theory, research, & practice* (pp. 269-310). Washington, DC US: American Psychological Association. doi:10.1037/10360-010
Room, R., Greenfield, T. K., & Weisner, C. (1991). 'People who might have liked you to drink less'; changing responses to drinking by U.S. family members and friends, 1979–1990. *Contemporary Drug Problems, 18*, 573-595.
Rodriguez, L. M., Overup, C. S., & Neighbors, C. (in press). Perceptions of partners' problematic alcohol use affect relationship outcomes beyond partner self-reported drinking: Alcohol use in committed romantic relationships. *Psychology of Addictive Behaviors*. doi:10.1037/a0031737
Ruvolo, A. P., & Fabin, L. A. (1999). Two of a kind: Perceptions of own and partner's attachment characteristics. *Personal Relationships, 6*, 57-79. doi:10.1111/j.1475-6811.1999.tb00211.x.
Watson, D., Hubbard, B., & Wiese, D. (2000). General traits of personality and affectivity as predictors of satisfaction in intimate relationships: Evidence from self- and partner-ratings. *Journal of Personality, 68*, 413-449. doi:10.1111/1467-6494.00102
Wiseman, R. S. (1991). The coparenting relationship after divorce: Psychosocial factors which relate to success or failure. *Dissertation Abstracts International*, 51(9-A), 3224.ψ

Pilot of a Behavioral Activation-Enhanced Smoking Cessation Program for Substance Users With Elevated Depressive Symptoms in Residential Treatment

Anne N. Banducci, C.W. Lejuez, and Laura MacPherson
University of Maryland

Smoking is the number one preventable cause of death in the United States and half of the people who currently smoke will die from smoking-related causes (World Health Organization, 2007). Although smoking cessation treatments are effective, individuals with depressive disorders/symptoms (Weinberger et al., 2012a, 2012b, 2013) and substance use disorders (SUDs; Baca & Yahne, 2009; Okoli & Khara, 2011; Prochaska et al., 2004) have particular difficulties quitting smoking. Unfortunately, treatment providers in mental health and addiction treatment settings rarely advise their clients to quit smoking, or provide cessation treatments (Guydish et al., 2011; Knudsen et al., 2010; Prochaska, 2010), often because they believe cessation could cause relapse to other substances or increases in psychiatric symptoms (Fuller et al., 2007; Prochaska et al., 2006). However, multiple studies demonstrate that smoking cessation does not interfere with substance use (e.g., Prochaska et al., 2004; Tsoh et al., 2011), or mental health outcomes (e.g., Lawn & Pols, 2005; Prochaska et al., 2008). Despite negative consequences associated with smoking, few *successful* cessation treatments have been developed specifically targeting individuals with

Author Note: Correspondence concerning this article should be addressed to Anne Banducci: anne.banducci@gmail.com and Laura MacPherson: lmacpher@umd.edu; Department of Psychology, University of Maryland, College Park, MD 20742.

Table 1
BA-DAS Session Content

Session 1: Introduction to BA and Smoking Cessation
- Treatment rationale
- Introduction to monitoring of daily activities, cigarette consumption, and mood
- Review previous quit attempts and prior strategies used
- Quit day set

Session 2: Life Areas, Values, and Activities
- Review of daily activity monitoring*
- Identification of values within life areas and relevant activities
- Scheduling of activities to complete prior to following session*
- Discussion of Avoid, Alter, Substitute Strategies*
- Introduction to the NRT Patch

Session 3: Quit Day: Monitoring Progress
- Discussion of quit attempt and problem solving related to slips*
- Review of activity completion*
- Discussion of abstinence violation effect
- Discussion of NRT patch*

Session 4: Reviewing Progress and Enlisting Social Support
- Creation of in-treatment contract to support activity completion

Session 5: Post-Treatment Plan
- Review of in-treatment contract
- Identification of post-treatment activities
- Creation of post-treatment contract

* Indicates treatment components that are repeated at all subsequent sessions

co-occurring depressive and SUDs.

Cessation programs tested with smokers with depressive disorders/symptoms include treatments focusing on motivation (Hall et al., 2006), mood management via cognitive behavioral therapy (CBT; Batra et al., 2010; Hall et al., 1998), and reducing depression via CBT (Brown et al., 2001; 2007). A recent meta-analysis indicates components targeting mood management improve outcomes (Gierisch et al., 2012), suggesting it is essential to target mood improvements in individuals with depressive disorders attempting to quit smoking. However, despite significant advances in smoking cessation therapies for individuals with depressive disorders/symptoms, low cessation rates continue to be observed (e.g. Weinberger et al., 2013).

Treatments targeting individuals with SUDs have utilized CBT, contingency management, and nicotine replacement therapy (NRT) (see Okoli et al., 2010 review); group counseling (Reid et al., 2008); behavioral therapy (Joseph et al., 2004); and content focused on depressive symptoms (see Baca & Yahne, 2009 review). Barriers to cessation have been noted in these studies, where long-term abstinence is relatively rare. For example, only 5% of individuals with SUDs who received NRT + CBT were abstinent at a 13-week follow-up (Reid et al., 2008), while 7-day point prevalence abstinence rates were 15.5% at a 3-month follow-up among individuals with alcohol use disorders receiving NRT + behavioral therapy (Joseph et al., 2004). Thus, it is necessary to formulate new strategies to better target the needs of substance users.

Recently, researchers have targeted increases in positive affect via behavioral activation (BA) to increase abstinence from cigarettes and drugs. MacPherson and colleagues (2010) demonstrated that a BA-enhanced (see *Treatment* section and Table 1 for a description of BA) treatment for smokers (BATS), which included CBT for smoking cessation (CBT), NRT, and BA, significantly improved outcomes among individuals with elevated depressive symptoms. In their study, individuals receiving BATS were 2.26 times more likely to be abstinent post-treatment than individuals receiving CBT + NRT. Further, individuals in BATS had significantly greater decreases in depressive symptoms over time. BA has also been used to decrease depressive symptoms and improve substance use outcomes among individuals with SUDs

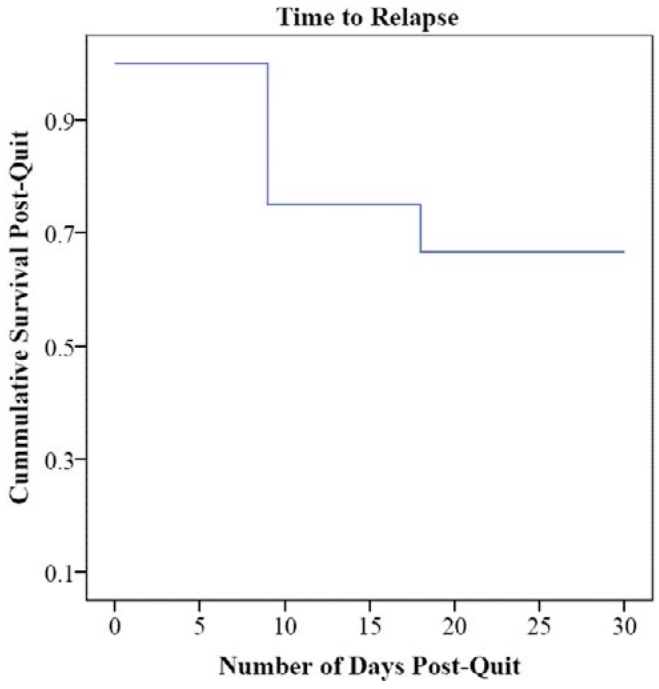


Figure 1. Survival Curve

Table 2. Baseline Demographics, Smoking History, and Affective Variables.

	M	*SD*	*N* (%)
Demographics			
% Female			5 (41.70)
% Black/African American			12 (100.00)
% Court-mandated			4 (33.30)
Average age	39.18	10.25	
Average treatment length (in days)	34.50	17.53	
Education*			
Middle school graduate			1 (8.30)
Some high school			1 (8.30)
High school graduate/GED			2 (16.70)
Some college			5 (41.70)
Average household income			
$0-9,999			3 (25.00)
$10,000-19,999			2 (16.70)
$20,000-29,999			-
$30,000+			4 (33.30)
Smoking History Variables			
Number of year smoking	18.27	10.95	
FTND	5.18	2.36	
Average weekly cigarettes pre-treatment	96.95	92.97	
Average weekly cigarettes post-treatment	12.89	22.13	
Affective Variables			
Baseline BDI-II	13.55	9.02	
Post-treatment BDI-II	6.67	8.47	

* Not all percentages add to 100 because of missing data

(Daughters et al., 2008; Magidson et al., 2011). Taken together, these findings suggest a BA-enhanced treatment could address the multiple factors associated with poor cessation outcomes among smokers with SUDs and elevated depressive symptoms.

Method

Participants

The current study tested Behavioral Activation for Drug Abusing Smokers (BA-DAS; Table 1) among 12 African Americans (see Table 2) with SUDs and elevated depressive symptoms in residential substance use treatment. Inclusion criteria: 18-65 years-old, Beck Depression Inventory score ≥ 7, scored ≥ 5 on a 10 point scale for motivation to quit, and smoked ≥ 5 cigarettes/day for ≥ 1 year.

Treatment

BA-DAS included key elements of CBT for smoking cessation (see Fiore et al., 2008), NRT (Nicoderm CQ 24-hour transdermal nicotine patch), and BA to target depressive symptoms (MacPherson et al., 2010). Treatment consisted of five 60-90 minute individual counseling sessions over 2 ½ weeks. BA components included: daily activity and smoking monitoring, identification of *life areas* (e.g., Relationships, Education) and *values* (broad descriptions of how individuals want to live within particular life areas), selection of *activities* enabling clients to live according to their values, creation of an activities schedule, and enlistment of social support via behavioral contracts (Lejuez et al., 2011; see Table 1). Therapists were four clinical psychology doctoral students who were trained extensively and received weekly supervision.

Measures

Clients reported their smoking for the 90 days prior to baseline and through four weeks post-quit via the Timeline Follow-Back (TLFB; Sobell & Sobell, 1979; 1996), a reliable and valid self-report measure. TLFB reports were compared to biochemical assessments of abstinence (10ppm carbon monoxide cutoff via Vitalograph Breathco monitor). The Beck Depression Inventory-II (BDI-II; Beck et al., 1996) was used to determine clients' depressive symptoms. A paper-based survey was created to determine participants' treatment satisfaction. Presence of current SUDs was confirmed with the SCID-IV (First et al., 1995).

Results

Four of the twelve participants were unreachable at the four-week follow-up. At the four-week follow-up, four of the eight participants assessed had CO levels < 10ppm, indicating abstinence (on quit day, seven of the eight participants assessed had CO levels < 10ppm; four participants did not provide CO levels because of administrator error). Of the total sample, 66.67% had not relapsed to smoking (defined as 5+ cigarettes/day for 3 days in a row; Shiffman et al., 2006) at the four-week follow-up (unreachable participants were coded as having relapsed at the prior assessment point), with a mean survival time of 23 days (**see Figure 1**). The average number of cigarettes consumed weekly pre-treatment was significantly higher than the average number consumed at the four-week follow-up $t(8) = 2.37$, $p = .045$ (Table 2). BDI scores decreased significantly from baseline to post-treatment $t(8) = 2.49$, $p = .038$ (see Table 2 and Figure 2).

Discussion

These preliminary results demonstrate

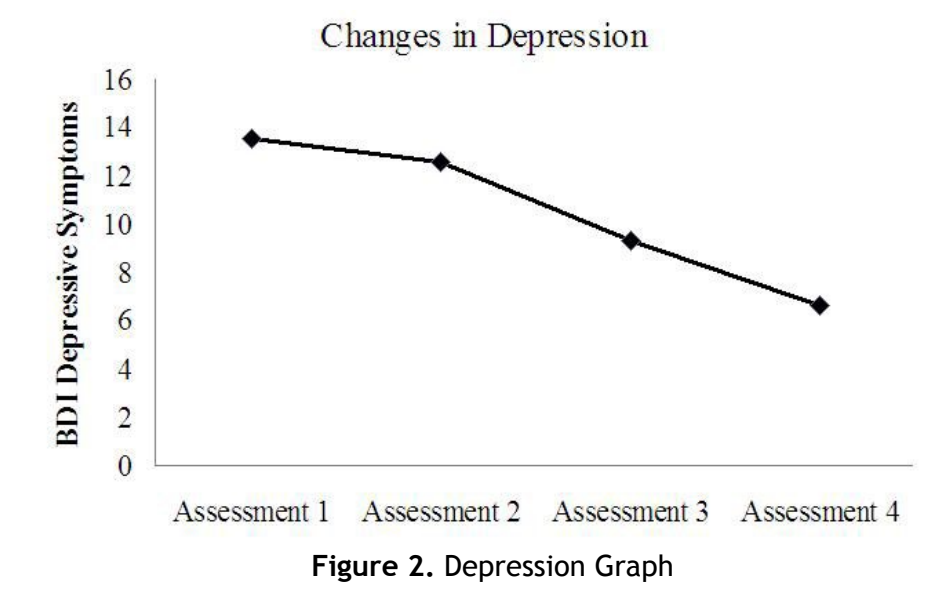


Figure 2. Depression Graph

the benefits of adding BA to smoking cessation interventions for individuals with substance use disorders and co-occurring depressive symptoms. Within our sample, 66.7% of participants had CO levels indicative of abstinence four weeks post-quit, as compared to 7.8% at a comparable time point in Saxon and colleagues' (2003) study. Furthermore, participants had particularly low relapse rates during the four weeks post-quit and reduced their cigarette consumption significantly. This suggests BA-DAS may benefit participants during the time when they are most vulnerable to relapse (Brown, et al., 2001; Prochaska et al., 2004). In future work, it will be important to examine whether decreases in depressive symptoms, as a function of BA, explain decreases in cigarette consumption over treatment.

There are a number of limitations of this pilot, including the lack of a contact-time matched control condition, small sample size, missing follow-up and CO data for some participants, and the short follow-up period. In future work, it will be important to test this intervention within a randomized control trial with longer follow-up periods. Despite these limitations, there are a number of strengths of this study, including cessation benefits within this particularly difficult to treat population, high treatment satisfaction, and significant decreases in depressive symptoms over treatment. This provides an important basis for future work to examine BA-enhanced smoking cessation treatments in difficult-to-treat populations.

References

Baca, C. T., & Yahne, C. E. (2009). Smoking cessation during substance abuse treatment: What you need to know. *Journal of Substance Abuse Treatment, 36(2),* 205-210. doi:10.1016/j.jsat.2008.06.003

Beck, A. T., Brown, G., & Steer, R. A. (1996). *Beck Depression Inventory II manual*. San Antonio, TX: The Psychological Corporation.

Brown, R. A., Kahler, C. W., Niaura, R., Abrams, D. B., Sales, S. D., Ramsey, S. E., & ... Miller, I. W. (2001). Cognitive-behavioral treatment for depression in smoking cessation. *Journal of Consulting and Clinical Psychology, 69(3),* 471-480. doi:10.1037/0022-006X.69.3.471

Brown, R. A., Niaura, R., Lloyd-Richardson, E. E., Strong, D. R., Kahler, C. W., Abrantes, A. M., & ... Miller, I. W. (2007). Bupropion and cognitive-behavioral treatment for depression in smoking cessation. *Nicotine & Tobacco Research, 9(7),* 721-730. doi:10.1080/14622200701416955

Daughters, S., Braun, A., Sargeant, M., Reynolds, E., Hopko, D., Blanco, C., & Lejuez, C. W. (2008). Effectiveness of a brief behavioral treatment for inner-city illicit drug users with elevated depressive symptoms: The Life Enhancement Treatment for Substance Use (LETS Act!). *Journal of Clinical Psychiatry, 69(1),* 122-129. doi:10.4088/JCP.v69n0116

Fiore, M. C., Smith, S. S., Jorenby, D. E., & Baker, T. B. (1994). The effectiveness of the nicotine patch for smoking cessation: A meta-analysis. *Journal of the American Medical Association, 271,* 1940-1947. doi:10.1001/jama.271.24.1940

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1995). *Structured Clinical Interview for DSM-IV Axis I Disorders*. New York: New York State Psychiatric Institute.

Fuller, B.E., Guydish, J., Tsoh, J., Reid, M.S., Resnick, M., Zammarelli, L., . . . McCarty, D. (2007). Attitudes toward the integration of smoking cessation treatment into drug abuse clinics. *Journal of Substance Abuse Treatment 32,* 53-60. doi:10.1016/j.jsat.2006.06.011

Gierisch, J. M., Bastian, L. A., Calhoun, P. S., McDuffie, J. R., & Williams, J. W., Jr. (2012). Smoking cessation interventions for patients with depression: A systematic review and meta-analysis [serial online]. *Journal of General Internal Medicine, 27(3),* 351-360 doi:10.1007/s11606-011-1915-2

Guydish, J., Tajima, B., Chan, M., Delucchi, K. L., & Ziedonis, D. (2011). Measuring smoking knowledge, attitudes and services (S-KAS) among clients in addiction treatment. *Drug and Alcohol Dependence, 114,* 237-241. doi:10.1016/j.drugalcdep.2010.09.017

Hall, S. M., Tsoh, J. Y., Prochaska, J. J., Eisendrath, S., Rossi, J. S., Redding, C. A., & ... Gorecki, J. A. (2006). Treatment for cigarette smoking among depressed mental health outpatients: A randomized clinical trial. *American Journal of Public Health, 96*(10), 1808-1814.

Joseph, A., Willenbring, M., Nugent, S., & Nelson, D. (2004). A randomized trial of concurrent versus delayed smoking intervention for patients in alcohol dependence treatment. *Journal of Studies on Alcohol, 65(6),* 681-691.

Knudsen, H. K., Studts, J. L., Boyd, S., & Roman, P. M. (2010). Structural and cultural barriers to the adoption of smoking cessation services in addiction treatment organizations. *Journal of Addictive Diseases, 29,* 294-305. doi:10.1080/10550887.2010.489446

Lawn, S., & Pols, R. (2005). Smoking bans in psychiatric inpatient settings? A review of the research. *Australian and New Zealand Journal of Psychiatry, 39(10),* 866-885. doi:10.1111/j.1440-1614.2005.01697.x

Lejuez, C. W., Hopko, D. R., Acierno, R., Daughters, S. B., & Pagoto, S. L. (2011). Ten year revision of the brief

behavioral activation treatment for depression: Revised treatment manual. *Behavior Modification, 35(2),* 111-161. doi:10.1177/0145445510390929

MacPherson, L., Tull, M. T., Matusiewicz, A. K., Rodman, S., Strong, D. R., Kahler, C. W., & ... Lejuez, C. W. (2010). Randomized controlled trial of behavioral activation smoking cessation treatment for smokers with elevated depressive symptoms. *Journal of Consulting and Clinical Psychology, 78(1),* 55-61. doi:10.1037/a0017939

Magidson, J. F., Gorka, S. M., MacPherson, L., Hopko, D. R., Blanco, C., Lejuez, C. W., & Daughters, S. B. (2011). Examining the effect of the Life Enhancement Treatment for Substance Use (LETS ACT) on residential substance abuse treatment retention. *Addictive Behaviors, 36(6),* 615-623. doi:10.1016/j.addbeh.2011.01.016

Okoli, C. C., & Khara, M. (2011). Smoking cessation among persons with co-occurring substance use disorder and mental illness. *Journal of Smoking Cessation, 6(1),* 58-64. doi:10.1375/jsc.6.1.58

Okoli, C., Khara, M., Procyshyn, R., Johnson, J., Barr, A., & Greaves, L. (2010). Smoking cessation interventions among individuals in methadone maintenance: A brief review. *Journal of Substance Abuse Treatment, 38(2),* 191-199. doi:10.1016/j.jsat.2009.10.001

Prochaska, J. J. (2010). Failure to treat tobacco use in mental health and addiction treatment settings: A form of harm reduction?. *Drug and Alcohol Dependence, 110(3),* 177-182. doi:10.1016/j.drugalcdep.2010.03.002

Prochaska, J., Delucchi, K., & Hall, S. (2004). A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery. *Journal of Consulting and Clinical Psychology, 72(6),* 1144-1156. doi:10.1037/0022-006X.72.6.1144

Prochaska, J.J., Fromont, S.C., Louie, A.K., Jacobs, M.H., Hall, S.M. (2006). Training in tobacco treatments in psychiatry: A national survey of psychiatry residency training directors. *Academy of Psychiatry 30,* 372–378. doi:10.1176/appi.ap.30.5.372

Prochaska, J.J., Hall, S.M., Tsoh, J.Y., Eisendrath, S., Rossi, J.S., Redding, C.A., Rosen, A.B., Meisner, M., Humfleet, G.L., Gorecki, J.A., (2008). Treating tobacco dependence in clinically depressed smokers: Effect of smoking cessation on mental health functioning. *American Journal of Public Health 98,* 446–448. doi:10.2105/AJPH.2006.101147

Reid, M. S., Fallon, B., Sonne, S., Flammino, F., Nunes, E. V., Jiang, H., & ... Rotrosen, J. (2008). Smoking cessation treatment in community-based substance abuse rehabilitation programs. *Journal of Substance Abuse Treatment, 35(1),* 68-77. doi:10.1016/j.jsat.2007.08.010

Saxon, A. J., Baer, J. S., Davis, T. M., Sloan, K. L., Malte, C. A., Fitzgibbons, K., & Kivlahan, D. R. (2003).Smoking cessation treatment among dually diagnosed individuals: Preliminary evaluation of different pharmacotherapies. *Nicotine & Tobacco Research, 5(4),* 589-596. doi:10.1080/1462220031000118702

Shiffman, S., Scharf, D. M., Shadel, W. G., Gwaltney, C. J., Dang, Q., Paton, S. M., & Clark, D. B. (2006). Analyzing milestones in smoking cessation: Illustration in a nicotine patch trial in adult smokers. *Journal of Consulting and Clinical Psychology, 74(2),* 276-285. doi:10.1037/0022-006X.74.2.276

Sobell, L. C., & Sobell, M. B. (1979). Validity of self-reports in three populations of alcoholics. *Journal of Consulting and Clinical Psychology, 46,* 901-907. doi:10.1037/0022-006X.46.5.901

Sobell, L. C., & Sobell, M. B. (1996). *Timeline followback: A calendar method for assessing alcohol and drug use.* Toronto, Canada: Addiction Research Foundation.

Tsoh, J. Y., Chi, F. W., Mertens, J. R., & Weisner, C. M. (2011). Stopping smoking during first year of substance use treatment predicted 9-year alcohol and drug treatment outcomes. *Drug and Alcohol Dependence, 114,* 110-118. doi:10.1016/j.drugalcdep.2010.09.008

Weinberger, A.H., Mazure, C.M., Morlett, A. & McKee, S.A. (2013). Editor's choice: "Two Decades of Smoking Cessation Treatment Research on Smokers with Depression: 1990–2010." *Nicotine and Tobacco Research 15(6):* 1014-1031. doi:10.1093/ntr/nts213

Weinberger, A. H., Pilver, C. E., Desai, R. A., Mazure, C. M., & McKee, S. A. (2012a). The relationship of dysthymia, minor depression, and gender to changes in smoking for current and former smokers: Longitudinal evaluation of the U.S. population. *Drug and Alcohol Dependence.* doi:10.1016/j.drugalcdep.2012.06.028

Weinberger, A. H., Pilver, C. E., Desai, R. A., Mazure, C. M., & McKee, S. A. (2012b). The relationship of major depressive disorder and gender to changes in smoking for current and former smokers: Longitudinal evaluation in the US population. *Addiction, 107(10),* 1847–1856. doi:10.1111/j.1360-0443.2012.03889.x

World Health Organization (2007). *World Health Report 2007: A safer future: Global public health security in the 21st century.* Retrieved from http://whqlibdoc.who.int/publications/2007/9789241563444_eng.pdf.ψ

A Framework for Addiction Treatment That Integrates Psychiatric Comorbidity and Trauma

Julio I. Rojas
University of Oklahoma Health Sciences Center

Addiction commonly co-occurs with psychiatric disorders and trauma (CSAT, 2005; Najavits, 2002). Consequently, it is imperative that we educate clients not only to understand addiction, but also the other conditions that co-occur with addiction. One obstacle to understanding the inter-related relationship between these disorders is the lack of a conceptual framework. The author previously published a Venn diagram heuristic (Rojas, 2012) that has been utilized in his practice. The Venn diagram (see Figure 1) provides a visual reference for understanding the relationship between addiction, psychiatric illness, and trauma. It is therefore a framework that helps guide the delivery of integrated treatment for co-occurring disorders and trauma.

Integrated treatment for co-occurring disorders and trauma has been the most recent direction in the addictions

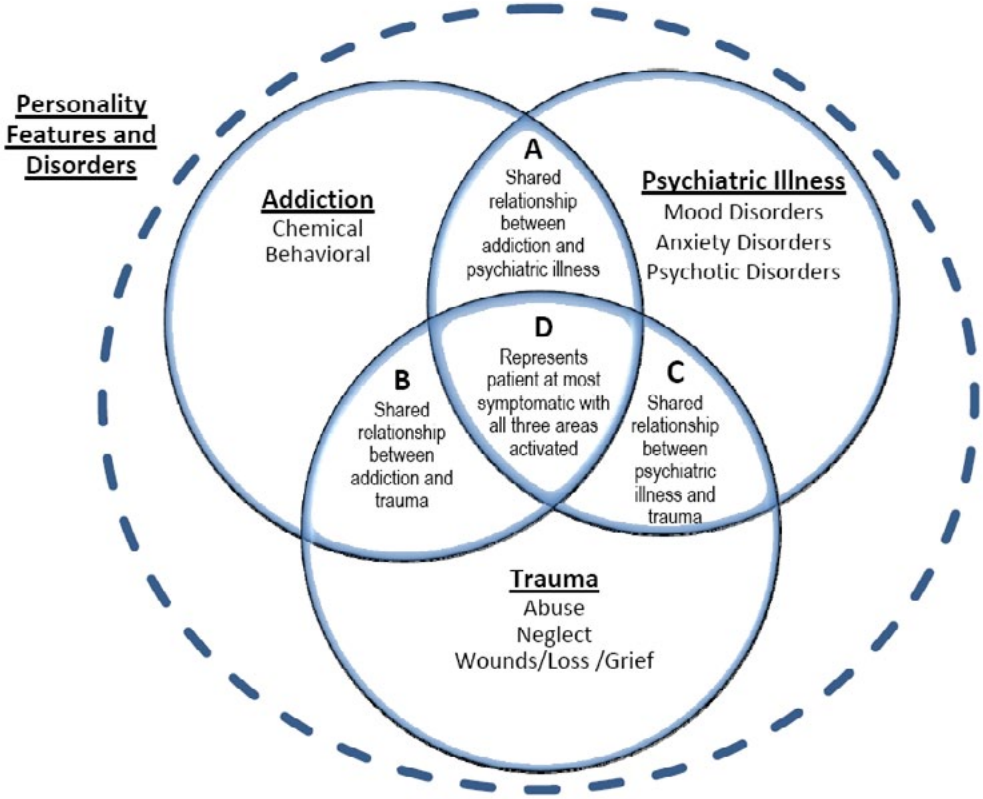


Figure 1. A Venn Diagram Heuristic for Working With Co-Occurring Disorders and Trauma. Julio I. Rojas, PhD, Copyright, The Board of Regents of the University of Oklahoma 2012.

treatment field. The focus on integrated treatment has come from the realization that co-occurring disorders and trauma are the norm, not the exception. Also, addressing co-morbid psychiatric illness and trauma in substance abuse treatment settings leads to improved client outcomes (Morrissey et al., 2005). Despite considerable attention to integrated treatment, much of treatment today is still provided in a sequential or parallel fashion and it is estimated by the Center for Substance Abuse Treatment that fewer than two percent of clients truly receive integrated care (Van Hoof-Haines, 2012).

Sequential treatment occurs when clients receive treatment for a substance use disorder followed by treatment for other conditions. In sequential treatment, sobriety is often a pre-requisite for participation in another program. Parallel treatment occurs when clients receive treatment by different programs or providers (substance abuse, mental health and trauma program services) during the same time period. Integrated treatment can be described as one provider or treatment team addressing addiction, psychiatric comorbidity and trauma concurrently.

An unintended consequence of sequential and parallel treatment models is that they contribute to the difficulty our clients experience in integrating their recovery from co-occurring disorders and trauma. However, it is possible to teach clients to understand their own experiences in recovery despite the limitations inherent in our current care delivery models. The Venn diagram is a clinical tool that provides a visual reference for understanding how each of these disorders is inter-related.

Description of the Venn Diagram

Each circle (Addiction, Psychiatric Illness, and Trauma) in the figure above requires that we understand the biopsychosocial aspects associated with each of these conditions. Engel (1977) proposed that understanding the biopsychosocial aspects of illnesses is necessary as it has implications for treatment and prognosis. Biological aspects of these addictions, psychiatric disorders, and trauma may include, for example, family history, gender, age of onset, type of substance and method of administration, and pre-morbid health status. The psychological aspects may include thinking and learning style, problem solving, readiness to change, emotional regulation, and interpersonal skills. Lastly, social aspects may include social support, access to treatment, health insurance, and socioeconomic status.

Each circle in the Venn diagram is comprised of two parts. These two components can be considered as the unique aspects (un-shaded area) and the shared aspects (shaded area), which represent how the disorders may interact in our client. Area D is where each of the disorders converge and clients are at their most symptomatic and often in crisis. The dotted line around the Venn diagram denotes the defense mechanisms, personality

features, and personality disorders that are described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, DSM-IV-TR* (2000) and noted on Axis II.

Clinical Application of the Venn Diagram

During my clinical interviews, I became aware that clients with several years of recovery experience lacked a framework for understanding the inter-related nature of addiction, psychiatric illness, and trauma. Consequently, they were able to tell me most about their addiction history and recovery. Clients seemed less able to discuss co-morbid conditions in terms of diagnosis, previous treatment plans, and the recovery skills they possessed to manage these disorders. With respect to trauma, for example, many clients did not seem to connect that they were dealing with anniversary issues that coincided with a lapse in sobriety, exacerbated mood symptoms, or both.

Following my clinical interview, I would present the clinical material (i.e., interview, psychological testing, collateral records, etc.) back to the client using the Venn diagram. I would provide the client a copy of the diagram and invite him/her to follow me through each circle beginning with Addiction, moving on to Psychiatric Illness, addressing Trauma, and lastly the Personality Features and Disorders (if relevant to that client). For each of the areas, I would underscore relevant biopsychosocial aspects such as a family history, gender, onset, course, role of social support of risk factors in the social environment.

To underscore the inter-related nature of these disorders, I highlighted the bidirectional relationship between circles in the Venn diagram specific to the client's presentation and this seemed helpful to the client. Specifically, I might bring attention to how the client's unresolved trauma history, undiagnosed comorbid disorder, or continued involvement in a behavioral addiction (e.g., gambling) might be contributing to difficulty achieving sustained sobriety.

Following my feedback to the client, I would invite the client to comment on what I shared and add his perspective and experiences. This moved the discussion toward specific suggestions on how to strengthen the individual's recovery plan with intervention methods that would target specific components (i.e., addiction, comorbid psychiatric illness, and trauma) along biopsychosocial lines. During this discussion, it would become clear to the client that his recovery primarily focused on one aspect of recovery (i.e., sobriety, attending meetings) at the expense of the other two areas (psychiatric illness and trauma). For instance, suppose the client was having difficulty with acceptance of mental health and trauma diagnoses, not taking medication as prescribed, and being unfamiliar with a coping skill set for trauma based symptoms such as deep breathing and progressive muscle relaxation. I would ask the client to consider if working on one-third of a recovery plan sounded like it had much chance for success and this seemed to lessen the demoralization associated with years of trying to achieve sobriety. It was therefore necessary to make changes to the recovery plan and a collaborative exploration of the changes to the treatment plan would transpire.

Summary

Teaching clients to develop an integrated understanding of their recovery from addiction, psychiatric illness, and trauma is both necessary and possible. The Venn diagram has anecdotally proven itself to be a useful clinical heuristic in providing integrated and individualized treatment for addiction, psychiatric comorbidity, and trauma. Many of my clients have described it as a roadmap that helps them visualize and personalize how these conditions affect their lives. Clinicians who I have shared the Venn diagram with have commented similarly. The use of this diagram does not require providers or treatment teams to change from any particular theoretical orientation (e.g., Cognitive-Behavioral, Humanistic). It simply requires a commitment to being aware of best practices in the treatment of each of these areas and helping their clients understand their recovery from an integrated and individualized perspective. These disorders are complex, chronic, and inter-related. Having a framework in which to understand these disorders contributes to our client's ability to increase their knowledge base and insight, while developing a skill set to manage these conditions over a lifetime.

References

American Psychiatric Association. (2000). *The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Washington, DC: American Psychiatric Association.

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (2005). *Substance Abuse Treatment for Persons With Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series 42*. (DHHS Publication No. (SMA) 05-3922). Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK64197/pdf/TOC.pdf

Engel, G. (1977). The need for a new medical model: a challenge for biomedicine. *Science, 196*(4286), 129-136. doi:10.1126/science.847460

Morrissey, J. P., Jackson, E. W., Ellis, A. R., Amaro, H., Brown, V. B., & Najavits, L. M. (2005). Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatric Services*, 56(10), 1213-1222. doi:10.1176/appi.ps.56.10.1213

Najavits, L. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse*. New York: Guilford Press.

Rojas, J. I. (2012). A Venn diagram heuristic for working with co-occurring disorders and trauma. *Journal of Mental Health and Substance Use*. Advance online publication. doi:10.1080/17523281.2012.712050.

Van Hoof-Haines, K. (2012, January 17). *Commentary: Dual diagnosis: The state of treating co-occurring disorders in the U.S.* [Web log post]. Retrieved from: http://www.drugfree.org/join-together/drugs/dual-diagnosis-the-status-of-treating-co-occurring-disorders-in-the-u-sψ

Psychology Practice in the Health Care Reform Era: Developing and Thriving in an Interprofessional Practice

Barry S. Anton
Rainer Behavioral Health

Image courtesy of Idea go/FreeDigitalPhotos.net

Multidisciplinary, interdisciplinary, transdisciplinary, multispecialty, integrated, interrelated, interprofessional, collaborative—these terms suggest teams of health care providers working together offering comprehensive, quality, affordable health care. The idea is not new. "The concept of medicine as a single discipline concerned with only the restoration of individual health from the diseased state should be replaced by the concept of 'health professions' working in concert to maintain and increase the health of society as well as the individual" (Coggeshall, 1965; Mills, 1966).

APA's recently published "Core Competencies for Interprofessional Collaborative Practice" (APA, 2009) defines "interprofessional" or "Interprofessionality" as, "the process by which professionals reflect on and develop ways of practicing that provides an integrated and cohesive answer to the needs of the client/family/population… [I]t involves continuous interaction and knowledge sharing between professionals, organized to solve or explore a variety of education and care issues all while seeking to optimize the patient's participation. Interprofessionality requires a paradigm shift, since interprofessional practice has unique characteristics in terms of values, codes of conduct, and ways of working."

What Are Barriers to Interprofessionalism?

Although the need for collaborative approaches to health care delivery is clear, barriers exist that hinder implementation. One of the biggest barriers to accessing behavioral health services is the critical shortage of treatment capacity. Currently, 55% of US counties have no practicing psychologists, psychiatrists, or social workers (National Alliance on Mental Illness, 2011). Another barrier can be legislative. A remnant of the 19th century, the Corporate Practice of Medicine Doctrine holds that physicians should make medical decisions autonomously. The logic was that if businesses owned by non-physicians controlled the delivery of health care, health care could be decided based on a profit motive, rather than the best interests of the patient. The doctrine prohibited "lesser licensed" providers from controlling or directing health care. This limitation is particularly onerous in an era of technological advances including electronic health records, computerization and the need for capital to grow a business. Because states vary in the application, requirements, and limitations of the doctrine, it is costly for providers wanting to practice interprofessionally to navigate this legal minefield. Violating the doctrine can put providers at risk of running afoul of licensing laws. Twenty-two states currently allow differently licensed health care providers to form corporate entities, while five jurisdictions have some flexibility to do so. The remainder of the states do not allow these entities (Nessman, 2011).

Other barriers to interprofessional practice include hierarchical attitudes, differential and declining reimbursement rates for similar services, lack of understanding of the advantages of interprofessional care, fear of change, risk aversion and the challenge of developing an

entrepreneurial spirit. These challenges, coupled with psychologists having little formal business training, hinder the transition to interprofessional mental health care delivery. While innovation and interprofessional groups are the cutting edge of mental health care delivery, according to an APA Practice Survey of Practitioners (2011) with over 2500 respondents, fewer than 12% reported working in a group practice, while 49% indicated they were solo practitioners. Those solo practitioners with established practices, or with niche practices, will likely continue to thrive as health care reform unfolds due to supply and demand and having an established referral base, while many other psychologists will move into groups with interprofessional practice opportunities. Early Career Psychologists will be challenged as they compete in a crowded and confusing marketplace.

The Group Practice Turnkey Model: A Thriving Model of Interprofessional Practice

Rainier Behavioral Health, in Tacoma, Washington was established in 1985 as an interprofessional mental health clinic. We currently see approximately 18,000 patient visits yearly, with almost two thousand new cases each year. Initially configured as a partnership due to existing Corporate Practice of Medicine Doctrine laws preventing a psychologist and psychiatrist from incorporating, the partnership had extensive liability exposure. In 1995 the Washington State Psychological Association, in partnership with allied health providers, lobbied successfully to repeal the Corporate Practice of Medicine Doctrine. Over the years, as the value of interprofessional care became acknowledged as an effective approach to mental health provision, the clinic evolved into its current complement of 17 therapists, including four physicians, a pediatric ARNP, eight psychologists and four social workers. The practice is incorporated as a Professional Limited Liability Company (PLLC).

Organizational Structure of Rainier Behavioral Health

There are eight full time and two part time support staff. Two full time support staff handle triage, insurance verification and authorization, and initial appointment scheduling. Front desk staff are responsible for patient check in, rescheduling, co-payment collection, phone calls, faxing, and file management. Billing support staff handle billing issues and insurance submission, while the part time bookkeeper manages accounts payable, payroll, tax filing, and benefit management. Therapist and support staff benefits include health insurance, a flex benefit plan, retirement plan access, life, disability and accidental death and dismemberment insurance, optional dental and vision coverage, and vacation and sick leave. Prescription refills, supplies, equipment maintenance contracts, repairs, and support staff management are handled by the office manager.

Employees are W-2 employees. The practice pays malpractice, a yearly continuing education allowance, Social Security, Medicare, unemployment and other mandated taxes, furniture, office supplies, Internet and telephone access, utilities, and maintenance. Our philosophy is that Rainier Associates hires well trained, quality therapists who can work as a team in providing excellent mental health care in an interprofessional environment. Our motto is: "Quality is Economy." Each therapist who joins the group automatically qualifies as a member of the insurance panels we contract with, as we have clinic status. Early career psychologists have an advantage in this regard as panels that might exclude them because of inexperience, or panel closure, include them as part of our group. Therapists are paid a percentage of what they collect, with more revenue yielding a higher percentage. There are no set working hours, no set vacation periods, no micromanaging of time on site. While we hope that productivity will be high, and that therapists will work full time (defined as 20-25 weekly billable patient hours), we understand that life happens, and that productivity varies over the course of a therapist's career. Because we are a large group, when a therapist is out, we cover for each other, maintain referral, scheduling, billing, and continuity of care. Insurance companies only have to deal with one tax ID number, one point person for credentialing, and one payment to the group. Insurance companies are businesses too, and efficiencies of scale matter.

Group practices can provide a valuable and viable model for interprofessional practice. This article briefly describes Rainier Behavioral Health's turnkey model as an example. Rainier Behavioral Health doesn't have rigid controls on productivity, a competitive work environment, or the lowest overhead costs. What Rainier Behavioral Health offers, however, is a collegial interprofessional mental health clinic model that maximizes the therapists' skills and training, while benefitting from its larger scale in both insurance collections and the value of support staff.

References

APA Practice Practitioner Survey. (2011). Washington, DC.

Coggeshall, L. T. (1965). *Planning for medical progress through education*. Washington, DC: American Association of Medical Colleges.

Interprofessional Education Collaborative Expert Panel. (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel*. Washington, DC: Interprofessional Education Collaborative. Retrieved from: http://www.aacn.nche.edu/education-resources/IPECReport.pdf

Mills, J. S. (1966). *The graduate education of physicians*. Report of the citizens commission on graduate medical education. Chicago: American Medical Association.

National Alliance on Mental Illness. (January, 2011). *Workforce development: Policy brief*. Retrieved from: http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Workforce_Development_2011.pdf.

Nessman, A. (2011). [APA Practice Organization legal research]. Unpublished raw data.ψ

Abstracts

Van Dorn, R., Desmarais, S., Young, M.S., Sellers, G.B., & Swartz, M. (2012). Assessing illicit drug use among adults with schizophrenia. *Psychiatry Research, 200*, 228-236. doi:10.1016/j.psychres.2012.05.028.

Accurate drug use assessment is vital to understanding the prevalence, course, treatment needs, and outcomes among individuals with schizophrenia because they are thought to remain at long-term risk for negative drug use outcomes, even in the absence of drug use disorder. This study evaluated self-report and biological measures for assessing illicit drug use in the Clinical Antipsychotic Trials of Intervention Effectiveness study (*N* = 1460). Performance was good across assessment methods, but differed as a function of drug type, measure, and race. With the Structured Clinical Interview for DSM-III-R as the criterion, self-report evidenced greater concordance, accuracy and agreement overall, and for marijuana, cocaine, and stimulants specifically, than did urinalysis and hair assays, whereas biological measures outperformed self-report for detection of opiates. Performance of the biological measures was better when self-report was the criterion, but poorer for black compared to white participants. Overall, findings suggest that self-report is able to garner accurate information regarding illicit drug use among adults with schizophrenia. Further work is needed to understand the differential performance of assessment approaches by drug type, overall and as a function of race, in this population.

Collins, S. E., Malone, D. K., Clifasefi, S. L., Ginzler, J. A., Garner, M. D., Burlingham, B., … Larimer, M. E. (2012). Project-based housing first for chronically homeless individuals with alcohol problems: Within-subjects analyses of 2-year alcohol trajectories. *American Journal of Public Health, 102*, 511-519. doi:10.2105/AJPH.2011.300403

Objectives. Two-year alcohol use trajectories were documented among residents in a project-based Housing First program. Project-based Housing First provides immediate, low-barrier, nonabstinence-based, permanent supportive housing to chronically homeless individuals within a single housing project. The study aim was to address concerns that nonabstinence-based housing may enable alcohol use. **Methods.** A 2-year, within-subjects analysis was conducted among 95 chronically homeless individuals with alcohol problems who were allocated to project based Housing First. Alcohol variables were assessed through self-report. Data on intervention exposure were extracted from agency records. **Results.** Multilevel growth models indicated significant within-subjects decreases across alcohol use outcomes over the study period. Intervention exposure, represented by months spent in housing, consistently predicted additional decreases in alcohol use outcomes. **Conclusions.** Findings did not support the enabling hypothesis. Although the project-based Housing First program did not require abstinence or treatment attendance, participants decreased their alcohol use and alcohol-related problems as a function of time and intervention exposure.

Derrick, J. L., Leonard, K. E., & Homish, G. G. (2013). Perceived partner responsiveness predicts decreases in smoking over the first nine years of marriage. *Nicotine & Tobacco Research*. Advance online publication. doi: 10.1093/ntr/ntt011

Introduction. Support for quitting is associated with smoking cessation, but few studies have examined the influence of more general social support on smoking outcomes. The current research examines perceptions of the partner's willingness and ability to provide general social support (i.e., perceived partner responsiveness) as a longitudinal predictor of smoking trajectories. **Methods.** Data are from a sample of newlywed couples assessed at six timepoints over 9 years. The current analyses focus on both partners in 333 "ever-smoker" couples. Participants completed measures of partner responsiveness, smoking, and demographics through the mail at each timepoint. **Results.** Both husbands and wives who initially reported greater partner responsiveness showed a decrease over the following 9 years in the likelihood of being a smoker and in cigarette quantity. This decrease was not apparent for husbands and wives who initially reported lower partner responsiveness. These effects were mediated by several time-varying characteristics. **Conclusions.** Previous research has shown that support for quitting is an important predictor of smoking cessation. The current research demonstrates that more general perceived social support, unrelated to smoking behavior, also predicts decreases in smoking over time in both men and women. In fact, reports of partner responsiveness at baseline predicted smoking over 9 years, demonstrating the potency of this particular relationship perception for smoking outcomes.

Gilmore, A. K., Granato, H. F., & Lewis, M. A. (2013). The use of drinking and sexual protective strategies in association to condom use and sex-related alcohol use. *Journal of Sex Research, 50*, 470-479. doi:10.1080/00224499.2011.653607

Approximately 40% of American college students engage in heavy drinking, and heavy drinking is associated with sexual risk behaviors. It is imperative to gain a better understanding of the relationship between alcohol and sexual risk behaviors for prevention efforts. This article examined the use of drinking and condom-related protective behavioral strategies (PBS) in relation to drinking and condom-use outcomes in 436 college students. Drinking PBS are related to drinking and negative alcohol-related consequences. Furthermore, condom-related PBS are related to condom use; however, it is unclear if drinking PBS are related to

condom use, particularly condom use when drinking. It was hypothesized that the use of drinking PBS would be related to less alcohol-related sexual activity, that the use of condom-related PBS would be related to greater condom use and condom use while drinking, and that drinking PBS would be related to greater condom use, especially condom use when drinking. It was found that condom-related PBS were associated with condom behavior and drinking PBS were related to drinking behavior, but we did not find support for a relationship between drinking PBS and condom use. This suggests that condom-related PBS may be a more effective target for increasing condom use than drinking PBS alone.

Lewis, M. A., Litt, D. M., Cronce, J. M., Blayney, J. A., & Gilmore, A. K. (2012). Underestimating protection and overestimating risk: Examining descriptive normative perceptions and their association with drinking and sexual behaviors. *Journal of Sex Research*. Advance online publication. doi: 10.1080/00224499.2012.710664

Individuals who engage in risky sexual behavior face the possibility of experiencing negative consequences. One tenet of social learning theory is that individuals engage in behaviors partly based on observations or perceptions of others' engagement in those behaviors. The present study aimed to document these norms–behavior relationships for both risky and protective sexual behaviors, including alcohol-related sexual behavior. Gender was also examined as a possible moderator of the norms–behavior relationship. Undergraduate students (n = 759; 58.0% female) completed a Web-based survey, including various measures of drinking and sexual behavior. Results indicated that students underestimate sexual health-protective behaviors (e.g., condom use and birth control use) and overestimate the risky behaviors (e.g., frequency of drinking prior to sex, typical number of drinks prior to sex, and frequency of casual sex) of their same-sex peers. All norms were positively associated with behavior, with the exception of condom use. Furthermore, no gender differences were found when examining the relationship between normative perceptions and behavior. The present study adds to the existing literature on normative misperceptions as it indicates that college students overestimate risky sexual behavior while underestimating sexual health-protective behaviors. Implications for interventions using the social norm approach and future directions are discussed.

Litt, D. M., Lewis, M. A., Patrick, M. E., Rodrigues, L., Neighbors, C., & Kaysen, D. L. (2013). Spring break versus spring broken: Predictive utility of spring break alcohol intentions and willingness at varying levels of extremity. *Prevention Science*. Advance online publication. doi:10.1007/s11121-012-0355-5

Objective. Within the domain of risk-related behavior, many times the decision to engage is not a product of premeditation or intention. The Prototype Willingness model was created to capture and explain the unintended element of risk behavior. The present study aimed to evaluate the importance of willingness versus intention, two important constructs within the Prototype Willingness model, in relation to Spring Break drinking behavior when assessed at both high and low extremities. **Method.** College undergraduates (N = 275) completed questionnaires prior to Spring Break regarding their anticipated Spring Break activities. Willingness and intention were assessed for different levels of risk. Specifically, participants indicated the extent to which they intended to (a) get drunk and (b) drink enough to black out or pass out; and the extent to which they were willing to (a) get drunk and (b) drink enough to black out or pass out. When classes resumed following Spring Break, the students indicated the extent to which they actually (a) got drunk and (b) drank enough to black out or pass out. **Results.** Results demonstrated that when the health-related risk was lower (i.e., getting drunk), intention was a stronger predictor of behavior than was willingness. However, as the level of risk increased (i.e., getting drunk enough to black out or pass out), willingness more strongly predicted behavior. **Conclusion.** The present study suggests that willingness and intentions differentially predict Spring Break alcohol-related behavior depending on the extremity of behavior in question. Implications regarding alcohol interventions are discussed.

Lostutter, T. W., Lewis, M. A., Cronce, J. M., Neighbors, C., & Larimer, M. E. (2012). The use of protective behaviors in relation to gambling behaviors among college students. *Journal of Gambling Studies*. Advance online publication. doi:10.1007/s10899-012-9343-8

The purpose of the current study was to evaluate a measure of gambling protective behaviors and examine the relationship between indices of gambling behavior, including frequency, quantity and problem severity, and the use of gambling protective behaviors. Undergraduates from a large public university (N = 4,014) completed a web-based screening survey comprising measures of gambling and health behaviors, from which those who gambled within the past 6-months (n = 1,922, 48% of the entire sample) were invited to complete the baseline assessment, including the Gambling Protective Behavior Scale (GPBS). The GPBS was determined to have two subscales, primarily consisting of harm reduction strategies that reduce the money or time spent on gambling, or avoidance strategies that help to minimize engagement in gambling activities. Hierarchical multiple regressions found participants' sex moderated the relationship between use of protective behavioral strategies and gambling outcomes. However, effects were in the opposite direction to those hypothesized. Specifically, because women gambled less, had lower gambling problem severity, and reported more frequent use of gambling avoidance protective behaviors, the relationship between use of gambling protective behaviors and gambling outcomes was stronger for men than women. Men who used more avoidance strategies gambled less frequently compared to men who used fewer avoidance strategies.

Similarly, men who used more harm reduction strategies spent fewer dollars on gambling and had lower scores on gambling problem severity compared to men using fewer harm reduction strategies; for women these relationships were less pronounced. Implications of incorporating specific gambling protective behavioral strategies into prevention and treatment programs are discussed.

Madson, M. B., Arnau, R. C. & Lambert, S. J. (2013). Development and psychometric evaluation of the Revised Protective Behavioral Strategies Scale. *Psychological Assessment*. Advance online publication. doi: 10.1037/a0031788

Psychometrically sound measures of the use of protective behavioral strategies are only in a development stage at this point. One such measure, the Protective Behavioral Strategies Scale (PBSS), has shown particular promise in this area. This study aimed to build on the PBSS by (a) evaluating revisions to the measure intended to yield more reliable scores from the serious harm reduction (SHR) subscale and (b) evaluating the factor structure of the revised measure and the stability of the factor structure across White non-Hispanics and African Americans and between women and men using multigroup confirmatory factor analysis. Three additional items were added to the SHR subscale, which improved its functioning. A 2-factor model best fit the data, and the factor structure of the measure was invariant across White non-Hispanic and African American men and women. Suggestions for further refinement of the measure and future research are provided.

Marczinski, C. A. & Stamates, A. L. (2013). Artificial sweeteners versus regular mixers increase breath alcohol concentrations in male and female social drinkers. *Alcoholism: Clinical and Experimental Research*, *37*, 696-702. doi: 10.1111/acer.12039

Background. Limited research suggests that alcohol consumed with an artificially sweetened mixer (e.g., diet soft drink) results in higher breath alcohol concentrations (BrACs) compared with the same amount of alcohol consumed with a similar beverage containing sugar. The purpose of this study was to determine the reliability of this effect in both male and female social drinkers and to determine if there are measureable objective and subjective differences when alcohol is consumed with an artificially sweetened versus sugar-sweetened mixer. **Methods.** Participants (n = 16) of equal gender attended 3 sessions where they received 1 of 3 doses (1.97 ml/kg vodka mixed with 3.94 ml/kg Squirt, 1.97 ml/kg vodka mixed with 3.94 ml/kg diet Squirt, and a placebo beverage) in random order. BrACs were recorded, as were self-reported ratings of subjective intoxication, fatigue, impairment, and willingness to drive. Objective performance was assessed using a cued go/no-go reaction time task. **Results.** BrACs were significantly higher in the alcohol + diet beverage condition compared with the alcohol + regular beverage condition. The mean peak BrAC was 0.091 g/210 l in the alcohol + diet condition compared with 0.077 g/210 l in the alcohol + regular condition. Cued go/no-go task performance indicated the greatest impairment for the alcohol + diet beverage condition. Subjective measures indicated that participants appeared unaware of any differences in the 2 alcohol conditions, given that no significant differences in subjective ratings were observed for the 2 alcohol conditions. No gender differences were observed for BrACs, and objective and subjective measures. **Conclusions.** Mixing alcohol with a diet soft drink resulted in elevated BrACs, as compared with the same amount of alcohol mixed with a sugar-sweetened beverage. Individuals were unaware of these differences, a factor that may increase the safety risks associated with drinking alcohol.

Merrill, J. E., Vermont, L. N., Bachrach, R. L., & Read, J. P. (2013). Is the pre-game to blame? Event-level associations between pre-gaming and alcohol-related consequences. *Journal of Studies on Alcohol and Drugs*.

Objective. Pre-gaming (drinking *prior to* a social occasion; PG) predicts alcohol consequences between-persons; people who pre-game report greater consequences than those who do not. The present study examined within-person associations between PG and *daily* consequences. **Method.** Participants were college students (N = 44; 50% female) reporting past month PG. Daily drinks consumed (during PG and across the entire drinking episode) and alcohol consequences were assessed with a 30-day Timeline Follow-Back interview. **Results.** Within-individuals, engaging in PG predicted consequences experienced on a given day, above and beyond number of drinks consumed across the drinking episode and typical drinking level. Further, there was a trend toward PG placing females at more risk for consequences than males. **Conclusions.** Findings support a context-specific risk for consequences that is conferred by PG and that is independent of how much drinking occurs across the drinking episode. Results highlight PG as a target for future interventions.

Rigter, H., Henderson, C., Pelc, I., Tossmann, P., Phan, O., Hendriks, V.,... Rowe, C. (2013). Multidimensional family therapy lowers the rate of cannabis dependence in adolescents: A randomised controlled trial in Western European outpatient settings. *Drug and Alcohol Dependence*, *130*, *85-93*. http://dx.doi.org/10.1016/j.drugalcdep.2012.10.013

Background. Noticing a lack of evidence-based programs for treating adolescents heavily using cannabis in Europe, government representatives from Belgium, France, Germany, The Netherlands, and Switzerland decided to have U.S.-developed multidimensional family therapy (MDFT) tested in their countries in a trans-national trial, called the International Need for Cannabis Treatment (INCANT) study. **Methods.** INCANT was a 2 (treatment condition)×5 (time) repeated measures intent-to-treat randomized effectiveness trial comparing MDFT to Individual Psychotherapy (IP). Data were gathered at baseline and 3, 6, 9 and 12 months thereafter. Study participants were recruited at outpatient secondary

level addiction, youth, and forensic care clinics in Brussels, Berlin, Paris, The Hague, and Geneva. Participants were adolescents from 13 through 18 years of age with a recent cannabis use disorder. 85% were boys; 40% were of foreign descent. One-third had been arrested for a criminal offense in the past 3 months. Three primary outcomes were assessed: (1) treatment retention, (2) prevalence of cannabis use disorder and (3) 90-day frequency of cannabis consumption. **Results.** Positive outcomes were found in both the MDFT and IP conditions. MDFT outperformed IP on the measures of treatment retention ($p < 0.001$) and prevalence of cannabis dependence ($p = 0.015$). MDFT reduced the number of cannabis consumption days more than IP in a subgroup of adolescents reporting more frequent cannabis use ($p = 0.002$). **Conclusions.** Cannabis use disorder was responsive to treatment. MDFT exceeded IP in decreasing the prevalence of cannabis dependence. MDFT is applicable in Western European outpatient settings, and may show moderately greater benefits than IP in youth with more severe substance use.

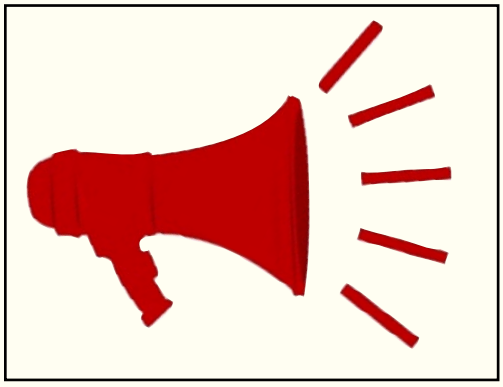
Rowe, C., Rigter, H., Henderson, C., Gantner, A., Mos, K., Nielsen, P., & Phan, O. (2013). Implementation fidelity of multidimensional family therapy in an international trial. *Journal of Substance Abuse Treatment, 44*, 391-399. http://dx.doi.org/10.1016/j.jsat.2012.08.225

Implementation fidelity, a critical aspect of clinical trials research that establishes adequate delivery of the treatment as prescribed in treatment manuals and protocols, is also essential to the successful implementation of effective programs into new practice settings. Although infrequently studied in the drug abuse field, stronger implementation fidelity has been linked to better outcomes in practice but appears to be more difficult to achieve with greater distance from model developers. In the INternational CAnnabis Need for Treatment (INCANT) multi-national randomized clinical trial, investigators tested the effectiveness of Multidimensional Family Therapy (MDFT) in comparison to individual psychotherapy (IP) in Brussels, Berlin, Paris, The Hague, and Geneva with 450 adolescents with a cannabis use disorder and their parents. This study reports on the implementation fidelity of MDFT across these five Western European sites in terms of treatment adherence, dose and program differentiation, and discusses possible implications for international implementation efforts. ψ

Announcements

Get involved in the development of a new reporting guideline for social and psychological interventions!

An international group of researchers, journal editors, and stakeholders in intervention studies are working with the Consolidated Standards for Reporting Trials (CONSORT) Group to develop CONSORT-SPI: an official CONSORT Extension for social and psychological intervention trials.



We are looking for participants for an upcoming Delphi process to generate possible reporting standards for the guideline. We are also looking for interested researchers, editors, funders, and other stakeholders to help disseminate this important work once completed. Stakeholders are desired from the various disciplines that often develop, evaluate, and disseminate these interventions, particularly the addiction sciences. Click here for a study demonstrating the need for this project. Click here for further information, email the Project Executive at CONSORT.study@spi.ox.ac.uk, or get involved by completing the CONSORT-SPI participant form!

Research faculty position, The Center for Neurobehavioral Research on Addictions (CNRA), UT Health Medical School

The Department of Psychiatry, UT Health Science Center at Houston, is seeking to expand its research faculty by recruiting an outstanding junior to mid-level investigator with demonstrated ability to develop an independent research program that would complement and extend ongoing research at the CNRA, a NIDA-funded medication development center of excellence. The CNRA supports an outpatient addiction treatment research clinic and a human behavioral neuroscience research laboratory. Applicants must have completed a PhD, MD, or equivalent degree. To find out more information or to apply, please write to Jair C. Soares, MD, Professor and Chair, and include a copy of your curriculum vitae and a letter of interest to 1941 East Road, Houston, Texas 77054, e-mail: Jair.C.Soares@uth.tmc.edu, phone: 713-486-2507.

Medical Director position, The Center for Neurobehavioral Research on Addictions (CNRA), UT Health Medical School

The Department of Psychiatry and Behavioral Sciences, UT Health Science Center at Houston, is seeking an academically oriented addiction psychiatrist to serve as Medical Director at the CNRA, a NIDA-funded medication development center of excellence. The CNRA supports an outpatient treatment research clinic and a human behavioral neuroscience research laboratory. The candidate will be responsible for providing medical leadership of the research programs, as well as general addiction psychiatric care. A competitive candidate will have

Image courtesy of digitalart/FreeDigitalPhotos.net

SoAP (Division 50) Leadership

ELECTED OFFICERS

Warren Bickel	Past-President	wbickel@vt.edu
Sara Jo Nixon	President	sjnixon@ufl.edu
John F. Kelly	President-Elect	jkelly11@partners.org
Amee Patel	Secretary	amee@utexas.edu
Jennifer Buckman	Treasurer	jbuckman@rci.rutgers.edu
Linda Carter Sobell	Council Representative - Science	sobelll@nova.edu
Ray Hanbury	Council Representative - Practice	hanburypsy@aol.com
James Bray	Member-at-Large	jbray@bcm.edu
Krista M. Lisdahl	Member-at-Large	medinak@uwm.edu
Mark Schenker	Member-at-Large	mschenker@navpoint.com

COMMITTEE CHAIRS

James Bray	Advocacy & Policy	jbray@bcm.edu
Nancy Piotrowski	Archives	napiotrowski@yahoo.com
Jennifer Buckman	Convention Program Chair - 2013	jbuckman@rci.rutgers.edu
James MacKillop	Convention Program Chair - 2012	jmackill@uga.edu
Jennifer Read	Convention Program Chair - 2011	jpread@buffalo.edu
Chris Martin	Education & Training/CE	martincs@upmc.edu
Cynthia Glidden-Tracey	Education & Training/CE	cynthia.glidden-tracey@asu.edu
Sandra Brown	Fellows & Awards	sanbrown@ucsd.edu
Marsha Bates	Finance & Budget	mebates@rci.rutgers.edu
Vince Adesso	Listserv	vince@uwm.edu
Joel Grube	Membership	grube@prev.org
William Zywiak	Nominations & Elections	zywiak@pire.org
Sara Jo Nixon	Science Advisory	sjnixon@ufl.edu
Position Open	Population and Diversity Issues	
Melissa Lewis	TAN Editor	edtan@uw.edu
Ken Weingardt	Webmaster	ken.weingardt@va.gov

LIAISONS

Fred Rotgers	APA Education Directorate	psydoc1948@gmail.com
John Kelly	APA Practice Directorate	jkelly11@partners.org
James Bray	APA Public Interest Directorate	jbray@bcm.edu
Clayton Neighbors	APA Science Directorate	cneighbors@uh.edu
Kim Kirby	APA Task Force on Caregivers	kkirby@tresearch.org
Andrew Tatarsky	Committee on Advancement of Professional Practice (CAPP)	atatarsky@aol.com
Nancy Piotrowski	Federal Advocacy Coordinator (FAC)	napiotrowski@yahoo.com
Rick Rawson	International Relations in Psychology (CIRP)	rrawson@mednet.ucla.edu
Maria Felix-Ortiz	Women in Psychology Network	felixort@uiwtx.edu
Kim Fromme	Research Society on Alcoholism (RSA)	fromme@psy.utexas.edu
Clayton Neighbors	Association for Behavioral & Cognitive Therapy (Addictive Behaviors SIG)	cneighbors@uh.edu
Thomas Brandon	Society for Research on Nicotine and Tobacco	thomas.brandon@moffitt.org
Sandra Brown	College of Professional Psychology	sanbrown@ucsd.edu
Matthew Martens	APA Division 17	martensmp@missouri.edu
David Teplin	Canadian Psychological Association – Substance Abuse/Dependence Section	info@drdavidteplin.com
Carlo DiClemente	Friends of NIAAA	diclemen@umbc.edu
Position Open	Friends of NIDA	
David Eddie & Lauren Hoffman	APAGS Division Student Representative Network (DSRN)	daveddie@eden.rutgers.edu ahoffman@ufl.edu
Vani Simmons	Early Career Psychologist Network	vani.simmons@moffitt.org

APPOINTED STUDENT REPRESENTATIVES

Lauren Hoffman	Student Representative to the Board	lahoffman@ufl.edu
David Eddie	Finance & Budget	daveddie@eden.rutgers.edu
Kiki Hachiya	Education and Training	Laura.Hachiya@asu.edu
Natalie Gildar	Education and Training	ngildar@asu.edu
Stephen Proctor	Advocacy & Policy	Sproct2@tigers.lsu.edu

Announcements continued...

an established record of extramural funding, or the potential to establish a robust research program in areas that complement or extend ongoing CNRA research. Applicants must have an MD degree, board certification, preferably with postdoctoral credentialing in addiction psychiatry. To apply, please write to Jair C. Soares, MD, Professor and Chair, and include a copy of your curriculum vitae and a letter of interest to 1941 East Road, Houston, Texas 77054, e-mail: Jair.C.Soares@uth.tmc.edu, phone: 713-486-2507.

Invitation to Egypt in 2014

The call for papers is due by November 15, 2013 for AMECA (African and Middle East Conference on Addictions),

which will be in Cairo, Egypt on 12-14 February 2014. D52 International Psychology member Wael Mohamed, MD, PhD is forming a psychology panel, and describes this as an unusual opportunity for D52 members to present their work on any aspects of addiction: research, practice, policy. For any details, contact Wael Mohamed soon at wmy107@gmail.com or check the conference website: http://khatresearch.org/AMECA/

The conference will take place at the international Citystars Cairo Hotel. The hotel complex provides outstanding services and amenities. It is located in a complex that has three hotels: InterContinental, Holiday Inn and Staybridge Suites. The Citystars Mall located within the hotel complex has more than 650 shops that accommodate all tastes. The hotel location in Cairo (Heliopolis) is very close to the Cairo International airport. Let's do a mix of science, history, and fun.

Intercontinental Citystarts
Citystars Cairo
Omar Ibn El Khattab Street
Cairo, 11737
Egypt
Front Desk +20-2-24800100 +0

Image courtesy of Arvind Balaraman/FreeDigitalPhotos.net

Society of Addiction Psychology Executive Officers

PRESIDENT
Sara Jo Nixon
Dept. of Psychiatry
McKnight Brain Institute
University of Florida
P. O. Box 100256
Gainesville, FL 32610
Telephone: (352) 392-3681
E-mail: sjnixon@ufl.edu

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

PAST PRESIDENT
Warren Bickel
Center for Addiction Research
Virginia Tech Carilion Research Institute
Virginia Tech
2 Riverside Drive
Roanoke, VA 24016
Telephone: (540) 526-2088
E-mail: wbickel@vt.edu

SECRETARY
Amee B. Patel
VISN 17 Center of Excellence for Research on Returning War Veterans
Central Texas Veterans Health Care System
4800 Memorial Drive (151C)
Waco, TX 76711
Telephone: (254) 297-5776
E-mail: amee@utexas.edu

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

MEMBERS-AT-LARGE
James H. Bray
Baylor College of Medicine
Department of Family and Community Medicine
3701 Kirby Drive, Suite 600
Houston, TX 77098
Telephone: (713) 798-7752
E-mail: jbray@bcm.edu

Mark Schenker
Caron Treatment Centers
PO Box 150
Wernersville, PA 19565
Phone: (215) 264-5412
E-mail: mschenker@navpoint.com

Krista M. Lisdahl
Department of Psychology
University of Wisconsin - Milwaukee
P.O. Box 413
Milwaukee, WI 53201
Telephone: (414) 229-4746
E-mail: medinak@uwm.edu

COUNCIL REPRESENTATIVES
Linda Carter Sobell
Center for Psychological Studies
Nova Southeastern University
3301 College Avenue
Fort Lauderdale, FL 33314 USA
Telephone: (954) 262-5811
Fax: (954) 262-3895
e-mail: sobelll@nova.edu

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