



The Addictions Newsletter

The American Psychological Association, Division 50

www.addictionpsychology.org

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President's Column

Alan J. Budney

I am appreciative of the opportunity to lead and serve SoAP during this coming year. My year as President-Elect and the first months of my term have already produced numerous rewarding experiences, the best of which has been getting to know a new group of colleagues and students through Division 50 activities. As some of you know, this is my second tour of duty as an APA Division president; I served Division 28 back in 2006. That now seems so long ago, which I feel must be true given that I agreed to run for President of Division 50—we all know painful memories fade over time (just kidding, sort of). I find that contributing to our clinical science and profession through these types of leadership activities brings renewed energy towards what we signed up for when we embarked upon our training to become psychologists. That is, how can we best help those in need, whether through scientific investigation, clinical development and application, teaching, or policy development and implementation?

Such rekindling through involvement with SoAP, along with our ongoing work on the most pressing task of the Division Executive Board, i.e., developing a renewal application for the certificate of proficiency in *Psychological Treatment of Alcohol and Other Psychoactive Substance*

Use Disorders, has prompted some curious reflections. What have we learned about addiction over the past 10 years that substantially advances our knowledge base from 10 years ago? And, what comprises a realistic set of expectations for the progress and impact that can occur in a decade?



Alan J. Budney

As we contemplate how to modify the content of the proficiencies for our field, we are challenged to identify what basic or clinical science advances truly hold promise for improving our ability to help those with problems related to addiction or to prevent such problems from occurring. Are there newly developed interventions or modifications to existing treatments that

substantially increase our effectiveness as change agents? Even though NIH funding levels have not been ideal, NIAAA, NIDA, SAMHSA, and multiple foundations have funded a plethora of projects designed to deliver products (knowledge and treatment innovations) that should hopefully result in an affirmative response to this question.

At first thought, my inclination was to conclude that there was not much to update since our last proficiency renewal, and this seemed rather sad and somewhat demoralizing. In some regards we seem to be struggling with the same old problems and issues; for example: a) how do we better motivate those who are ambivalent about their problems to engage in treatment or

change behavior, b) how do we improve the positive response rate to our outpatient interventions (typically less than half of participants show clinically significant improvement in clinical trials, c) how do we better maintain abstinence or reductions in substance use and prevent relapse, d) how do we reduce the divisiveness that arises from harm reduction vs. abstinence approaches, e) how do we best measure outcomes in our clinical trials, f) how do we increase the dissemination of our most efficacious interventions, g) how do we address health disparities related to SES and ethnicity, h) how do we make our interventions affordable or get payers to increase funds to cover the costs of effective services, and i) how do we reduce the stigma associated with substance use problems?

Upon further reflection and after taking off my cynical, pessimistic glasses that remind me of my aging status, I realized that many exciting signs of progress have emerged in the past 10 years. For example, a) a new version of the DSM produced modified criteria for substance use disorders (not that the changes are perfect, but they do move in a positive direction), b) incentive-based interventions (contingency management) that enhance treatment response continue to be refined, with some signs of interest in wider dissemination, c) technology-based interventions have emerged and show much promise as alternatives or adjuncts to treatment that can increase access to effective treatments and perhaps enhance outcomes, d) health care reform may lead to provider systems that have more incentive to adopt evidence-based interventions, e) pharmacotherapy development, particularly for opioid and tobacco use disorders continues to expand its alternatives and increase positive outcomes, f) a number of state regulatory bodies have increased standards and requirements for obtaining licensure or credentialing in an attempt to ensure higher quality care, and g) NIAAA and NIDA did not

merge, but the Collaborative Research on Addiction (CRAN) program has produced multiple inter-agency FOA's that encourage focus on poly-substance use and comorbidity. And I'm certain you all could list many more exciting signs of progress!

Oops, I forgot one. We seem to have discovered that marijuana is good for everything that ails you—NOT! But perhaps the silver lining is that the legalization and medicalization movements appear to have stimulated interesting science and thoughtful discourse related to marijuana and drug policy in general. Maybe our Groundhog Day, merry-go-round ordeal with marijuana is finally coming to an end—maybe, but somehow I doubt it!

My optimistic and emotionally detached take on all this is that change takes time, and the progress in our field is impressive and commensurate with what is generally observed across fields of science and implementation. My impulsive, impatient, and less mature side wants to just shake my head in amazement at our failure to advance much more quickly.

I encourage you all to take a moment in similar contemplation; maybe list what you feel are the 5 most important issues facing our field and the top 5 advances we've made over the past decade. And please, if you don't mind, send them my way. Perhaps these will shape my focus during the coming year in my role as President of Division 50. Your thoughts might also provide some interesting data to include in my next column for TAN!

Before I finish, I wanted to mention a few important housekeeping issues:

1) Please consider submitting a poster or symposium idea for the **Collaborative Perspectives on Addiction (CPA) conference** to be held in Baltimore in March, and the **APA annual convention** in Toronto in August.

Due dates for CPA are as follows: October 20 for workshops; November 20 for symposia; and January 20 for posters! Also keep an eye out for STUDENT TRAVEL AWARDS, we plan to offer 4 or 5! This will be my first time at CPA so I hope we have a great turnout! Info: <http://research.alcoholstudies.rutgers.edu/cpa>

For APA, due dates are: Collaborative Programs: October 15; CE Workshops: November 10; Division Submissions: December 1, 2014. Info: <https://www.apa.org/convention/index.aspx>

2) Clinical psychologists, please consider applying for the **Certificate of Proficiency in the Psychological Treatment of Alcohol and Substance Use Disorders**. John Kelly, Nancy Piotrowski, Ray Hanbury and many others worked very hard to get this Certificate reinstated, but if only a few Psychologists apply for the Certificate, it will likely go away again. More importantly, as we try to make progress in advancing Psychologists as experts in Addiction and purveyors of the most effective interventions, this certification will provide a means for State Associations to recognize this expertise and more effectively utilize our knowledge base and talent. Info on this process and how to apply will be sent out via our listserv as soon as the most recent application is posted by the APA.

3) Remember to vote in the APA Presidential election!!! (if it isn't too late by time this comes to press, closes October 29). Your vote counts and the person in charge does make a difference.

4) Remember to send me your top 5 issues and advances, along with any other thoughts relative to Division 50's mission! Email alan.j.budney@dartmouth.edu

Thanks again for the opportunity to become an integral part of the Society of Addiction Psychology! Have a great Fall!ψ

Editor's Corner

Bettina B. Hoepfner

Welcome to the Fall/Winter 2014 issue of TAN! As befitting the fall season, the leaves have become a magnificent kaleidoscope of red, orange, gold, green and brown, and our calendars are cluttered with all the things we've been taking a break from during the summer months. This issue of TAN is similarly busy: with announcements (e.g., celebrating our recent award winners) and calls to action (e.g., nominations for SoAP leadership positions, awards, and fellows, submissions for the CPA and APA meetings). Thus, it seems strangely fitting that amidst this bustle, we get to catch our breath as we contemplate the topic of this issue of TAN: **"Mindfulness,"** or more specifically, **"Applications of Mindfulness in Addiction Treatment."** To this end, we are happy to share



Bettina B. Hoepfner

with you six inspiring articles on mindfulness—and, in fact, you see the theme of mindfulness echoed throughout this issue: in the Student and Trainee Perspectives, the *Psychology of Addictive Behavior* column, and even in the announcement section.

Clearly there is a lot of enthusiasm for and interest in this topic, and we hope you find the reflections and information shared here in TAN helpful and engaging.

For the next issue of TAN, Hillary and I have selected a topic that's not particularly timely, but that seems to keep coming up in addiction treatment and research:

"Is Smoking Cessation during SUD Treatment a Good Idea?" If you have conducted research in this area, or are conducting it now, please consider sharing it with us in the next issue of TAN. But beyond just research, we'd love to

include your thoughts and perspectives on this important topic: What's your clinical experience like? What are some of the barriers you and your clients have encountered? And what seemed to have worked? What's your stance on focusing on one vs. multiple behavior changes? Keep in mind that TAN is fairly informal: Our goal is simply to facilitate an engaging discussion on a topic many of us likely find of interest. So, please consider submitting an article on this (or any other) topic for the next issue of TAN (**submissions due on February 1, 2015**). Articles are short (1,200 word limit), fairly informal, and take many shapes (e.g., opinion pieces, descriptions of pilot or small studies, short reviews)—all factors, hopefully, that will make it easy for you to share your thoughts.

Happy reading!

Bettina Hoepfner
TAN Editor

Hillary Howrey
TAN Grad Student Mentee

Advocate's Alcove

Nancy A. Piotrowski, PhD
Division 50 Federal Advocacy Coordinator

If it feels like our advocacy issues are a bit familiar after the last few issues and email alerts, do not worry. It is not you who is missing something, but policy makers being slow to move! Essentially, we have a number of important issues for us and our clients related to electronic mental health records, healthcare reimbursement, and unnecessary supervision of licensed psychologists that simply have required many small nudges. As the legislative year winds down, if alerts come up, I will let you know. The more likely scenario is that we will have an update on similar issues next spring with the latest installments of where things are

at in the process of moving through the legislative process.

As preparation for 2015 and a way to keep yourself informed, I wanted to point out a resource for you. If you go to the Practice Central site for the [American Psychological Association Practice Organization](#) (APAPO), you can find a description of current issues of concerns and their latest updates. There are also a number of other links on various advocacy related topics, recent



Nancy A. Piotrowski

legislation, updates on healthcare reform, prescriptive authority, and states advocacy issues that may be of interest. This is an excellent resource for all members (students included) to get your feet wet (or catch up on) our more contemporary advocacy concerns.

Speaking of students, if you are a student interested in advocacy issues, please be aware that our committee of student volunteers will reconvene this fall to catch up and make plans for next

year. Other more seasoned members of the division are welcome, too, if you would like to be involved with the committee. Ultimately it benefits the division to have a network of members throughout the states who are savvy advocates. This way, when pressing issues related to addiction arise, we are ready to act. This includes being able to pass information to APA and

APAPO, as well as to activate our network of connections to speak out where it would be useful. If this is of interest to you, be in touch with me (napiotrowski@yahoo.com).

Finally, if you have any active legislation in your state that is relevant to addiction, please share this information with me. We have had licensing laws afoot in California and I am sure it is

happening elsewhere, so it would be good for us to get more information on this and other matters you may be dealing with in your local state.

Resource Information

American Psychological Association Practice Organization (APAPO) www.capwiz.com/apapractice/issues

New Member Spotlight: Jonathan Adair

Allison K. Labbe
Early Career Representative

Please welcome to SoAP a new student member, Jonathan Adair. Jonathan is a second-year counseling psychology doctoral student at Tennessee State University.

How did you get interested in addiction psychology?

I became interested in addictions after accepting a position as a mental health technician for a substance use residential treatment program. I was curious about the basis of addictions and the cause of treatment rejection for many of my clients. Furthermore, I was intrigued by extremely high relapse rates among treatment programs, which inspired me to become an addiction therapist.

What do you hope to do after graduating from your program?

I plan to continue treating co-occurring disorders and addictions in a clinical setting. I also plan to expand my non-profit organization, the Mental Health Initiative, which is dedicated to promoting mental wellness, awareness, and alleviating stigmas through education, outreach, and innovative research.

Wow, you've developed your own non-profit organization? That's great! Tell me more about it. What made you decide to pursue this?

The Mental Health Initiative, Inc. was created with a mission to provide hope to those who may be suffering from mental health concerns by encouraging them to "Learn, Accept, and Recover." The goal was to take a proactive approach to benefit the overall well-being of others by offering a variety of mental health services to individuals who are in need of assistance. Some



Jonathan Adair

services include facilitating workshops, presentations, and educational forums. It has always been my belief that awareness can be an effective tool to make a significant difference in the lives of those in need and those who may have loved ones that may be struggling with mental health concerns. Additionally, the Mental Health Initiative, Inc. forms

partnerships with other organizations in order to provide necessary services and develop preventative intervention strategies that will help accomplish its mission.

What are your research interests?

My research interests include behavioral health disparities among minorities, stigma reduction to increase treatment acceptance, barriers to addiction and HIV/AIDS treatment among minorities, and multicultural competency in therapeutic implications.

What prompted your research interests?

During my first year as a doctoral student I began conducting research on negative perceptions of addiction treatment among African American men as a potential barrier. Through my research I noticed that many others in minority communities, especially African Americans, rarely receive or seek treatment due to stigmas. What was most intriguing to me were the negative perceptions of people with addictions held by family members, friends, and health care professionals that treat them. I saw a need for effective stigma reduction interventions and prevention methods to combat disparities that were increasingly significant, such as addiction and HIV/AIDS.

What are your clinical interests?

My clinical interests include addiction

prevention and intervention psychotherapy methods, HIV/AIDS prevention and intervention strategies, co-occurring disorders, holistic health treatment approaches for addiction, and integrative psychotherapy techniques.

What prompted your clinical interests?

I grew up seeing the deleterious effects of substance use within minority communities, such as my own. A variety of psychotherapy approaches can be used to treat addiction and possibly avoid relapse. I believe that addiction treatment can have a profound effect not only on those who are suffering from addiction, but on society as a whole by improving social functioning, as well as mental health and possibly reducing the increase of HIV/AIDS.

What motivated you to join Division 50: Addictions?

I was motivated to join Division 50 due to a strong passion for addiction treatment and preventative intervention education. Additionally, I valued the opportunity to connect with other professionals in the field. Even more, I felt it necessary to stay current on research and information that would assist me in making a valuable contribution to the overall mission of psychology.

How did you hear about the Division?

I was introduced to Division 50 by my graduate school advisor who encouraged me to involve myself with an APA Division that was congruent with my research interest.

Any other information that you would like to share about yourself with other Division 50 members?

Along with numerous years of experience as a mental health therapist treating co-occurring disorders and addictions, my ambition to provide optimal care for clients has afforded me invaluable opportunities. Some of these opportunities have included developing Nashville, Tennessee's only outpatient addiction treatment program for PLWHA (people living with HIV/AIDS) at Meharry Medical College's Lloyd C. Elam Mental Health Center, an appointment to the Nashville Ryan White Planning Council by Nashville's Mayor, Karl Dean, and Community and Civic Engagement Committee Chair of the Urban League Young Professionals of Middle TN. [ψ](#)

Student and Trainee Perspectives

Lauren A. Hoffman, MS
University of Florida
Student Representative

In keeping with the theme for this issue of TAN, the current Student and Trainee Perspectives article provides an overview of the goals, fundamentals, and practice of mindfulness. In this context, I discuss how mindfulness might be used to benefit the average graduate student and offer tips for implementing its practice. Furthermore, in an effort to keep you up to date with current SoAP affairs, this article will also introduce SoAP's newly appointed Student Representative to the Executive Board.

Mindfulness-Based Stress Reduction

In graduate school, students are learning to juggle multiple demands including research, clinical work, scientific writing, funding, and, let's not forget, home life. Managing these demands can be overwhelming and stressful; many experience anxiety, self-criticism, and doubt. These automatic responses to a

demanding environment can negatively affect psychological well-being and the professional skills that students aim to develop and improve. Mindfulness, the practice of bringing awareness to one's internal and external states in the present moment, may help to reduce the negative affect that often accompanies this stress. Mindfulness-based practices have been shown to benefit a variety of populations, including graduate students. So how does one practice mindfulness as a stress-reduction technique? Here, I present a few of the basic concepts surrounding mindfulness-based stress reduction (MBSR):

The goal: Mindfulness is intended to bring full awareness to the present moment. It is predicated on the

understanding that humans are largely unaware of their moment-to-moment experience, often operating in an "automatic pilot" mode. Thus, gaining greater conscious awareness of one's internal and external states may promote greater acceptance of these states, reduce maladaptive habituated reactions to stressful life events, and promote healthy physical and psychological functioning.



Lauren A. Hoffman, MS

Fundamentals:

- 1) Awareness: Become aware of and fully attend to the internal and external affairs of the present moment.
- 2) Non-judging and open minded: Try not to label or judge the experience. Approach it with a fresh attitude,

recognizing that each experience is unique. This persistent non-evaluative observation will gradually give rise to more accepting perceptions of one's internal and external states.

3) Patience: Allow events to unfold naturally. Do not attempt to change the natural temporal order.

4) Trust: Learn to trust yourself.

5) Non-striving: Learn to "be," not "do." Remain non-reactive and do not try to change current internal or external states.

6) Acceptance: Remain willing to attend to momentary states, regardless of their positive or negative qualities.

7) Letting go: Allow the experience to guide your attention. Do not avoid or hold on to a particular thought or feeling. This is important because it is unlike standard cognitive-behavioral therapies, which ordinarily call for active attention to distressing emotions or events.

The core practice: MBSR skills involve the ability to experience and observe one's environment, thoughts, emotions, and behaviors without evaluation, and without attempting to change or control them. MBSR can be implemented during everyday experiences. For example, one can become aware of the sensations evoked from eating or drinking. However, an important component of MBSR is formal meditation. All forms of meditation emphasize attention, awareness, acceptance, and compassion. When meditating, one should sit comfortably with one's eyes closed, free inner and outer states of

any tension, and remember the MBSR fundamentals. Attention should be directed to all bodily sensations and then slowly focused to one's breathing (without controlling it). The practice of formal meditation may reduce stress in everyday life.

Given the benefits of MBSR, it's no wonder that it is so widely implemented. A graduate student is no stranger to chronic stress. So give it a try, the results may surprise you! Clearly, there is much more to MBSR than what is discussed here. To learn more about the history and practice of MBSR, see Jeffrey Brantley's (2005) review entitled 'Mindfulness-Based Stress Reduction' (in *Acceptance and mindfulness-based approaches to anxiety* (pp. 131-145)). For a more detailed description of practice and implementation, try these free online links: <http://palousemindfulness.com/selfguidedMBSR.html>, <http://marc.ucla.edu/body.cfm?id=22>

SoAP Student News

SoAP members, I am pleased to say that the division has a recent student addition. So, without further delay, I introduce you to the newly appointed Student Representative to the Executive Board of the SoAP, Noah Emery from the University of South Dakota.

From Noah

Hello, my name is Noah Emery. I am honored to have been selected to serve as the non-voting Student Representative to the Executive Committee of SoAP. I completed my bachelor's degree in psychology at Arizona State University in 2012. During

my time there, I was fortunate to assist in a health behavior research lab that focused on fundamental behavioral processes, such as impulsivity, risk taking, and decision making, and their relation to physical and psychological wellbeing. Currently, I am a third year clinical psychology graduate student at the University of South Dakota, where I work with Dr. Jeffrey Simons in the Self-Regulation & Substance Use Laboratory. My work there focuses on advancing our understanding of how the complex interplay between implicit, explicit, and emotional processes culminate in the expression of self-regulatory practices that govern substance use and other risk-taking behaviors.

I had the distinct pleasure of presenting a poster at the NIDA/NIAAA Early Career Investigator Poster Session during the this year's APA Annual Convention, titled *Emotion Differentiation and Alcohol-Related Problems: The Mediating Role of Urgency*. Additionally, I have published papers on this and similar topics. My current work is investigating the effects of mood on attentional biases toward alcohol-related cues. My future work will center on my primary interest in further delineating the role of affect dysregulation in substance use disorders. As I sharpen my skills as an investigator, I hope to conduct projects that use cutting edge methodology, such as ecological momentary assessment, to examine how important state and trait level variables lead to systematic changes in the development and progression of substance use disorders over time. I have been a member of SoAP since 2012, and I am very excited to be joining the SoAP's Board as a Student Representative. ♡

RENEW NOW!

Renewal notices for January-December 2015 have been sent out to 2014 members and affiliates of SoAP. APA Members, Associates, and Fellows may renew at <http://www.apa.org/membership/renew.aspx>. Professional Affiliates and Student Affiliates may renew at www.apa.org/divapp. Everyone, even if no membership in APA, may check membership status by going to www.apa.org and logging in and going to their myAPA page. If you hold membership in SoAP/Division 50 for 2014, you will see it listed in your divisions. If you have questions, contact the administrative office at division@apa.org or 202-336-6013.

August 2014 Council Report

In addition to approving proposals for improving the association's governance system, the APA Council of Representatives endorsed initiatives to bring emerging science to practice and psychology's expertise to human welfare.

Rhea K. Farberman
Monitor Executive Editor

At its August meeting, APA's Council of Representatives approved several proposals recommended by the Good Governance Project (GGP) Implementation Work Group (IWG) that seek to streamline the association's governance system and make it more inclusive. IWG was tasked with developing the implementation plans for the governance changes that Council adopted at its August 2013 meeting. IWG brought forward several items for Council's consideration at its February and August 2014 meetings.

"This was a challenging but important council meeting," APA President Nadine J. Kaslow, PhD says. "Challenging because updating the APA governance system, as the Good Governance Project is designed to do, is not a simple task."

The GGP model, proposed after a thorough assessment with input from governance groups, seeks primarily to increase member engagement and give members a more direct voice in the decision-making process. It also seeks to enable APA governance to respond more nimbly to issues of the day and to ensure strategic alignment across the organization. The GGP was an outgrowth of the APA Strategic Plan focused on optimizing organizational effectiveness.

Over the last year, the council has approved several proposals from the IWG.

At its February meeting, the council approved a three-year trial delegation

of duties to the Board of Directors in four areas: financial and budgetary matters; the oversight of APA's chief executive officer; the alignment of the budget with APA's Strategic Plan; and internally focused policy development. These changes free up council to focus on strategic and emerging issues affecting psychology and to engage in higher level dialogues that inform the development of policy and strategic directions.

APA's council approves several governance changes and continues to debate council's structure.

The council also approved a change in the composition of APA's Board of Directors. Under the change, the board would have six member-at-large seats open to election from and by the general membership. In addition, the board would have a public member, as well as student and early career psychologist representation. Two seats would also be reserved for members of a newly created Council Leadership Team (CLT), in order to ensure a bridge between the APA board and council. The CLT will manage the work of council, determine the process for council to select topics for discussions and provide recommendations on agenda items that council would consider. The CLT will have 12 members, all of whom would be current or past council members.

The changes to the board's composition require a Bylaw change and therefore need approval by the APA membership; the Bylaw amendment ballot is expected

to be sent to members next year.

At its August meeting, the council continued to grapple with council's optimal size and structure. The questions still remaining—and that will be considered at the February 2015 council meeting—include:

- The overall size of the council.
- Whether the allocation of council seats should be made on an apportionment basis, as they are currently allocated, based on size of a division or state/provincial/territorial association or based on one seat per constituency.
- Whether to adopt an IWG proposal recommending that nine at-large council seats be added and determined by the Needs Assessment Slating and Campaigns Committee based on an annual needs assessment.

"I am deeply grateful to my fellow council members for their diligence and thoughtfulness in making sure that the changes we make are the ones that appear to be optimal for the organization at this time and will serve future members well," Kaslow says.

In other GGP action, the council received reports from the IWG on making better use of technology, on the delineation of financial oversight responsibilities within the new governance structure, a plan for developing a leadership pipeline and development program after gathering additional input from Council, and a plan for how professional and disciplinary issues would be introduced to and triaged by the new governance system.

In addition, the council approved a change in the oversight functions of the Committee for the Advancement of Professional Practice (CAPP). The committee will now be wholly a committee of the APA Practice Organization (APAPO) and will continue

to be responsible for the day to day oversight of APAPO in advocating for the c-6 professional and marketplace interests of practitioners in legislative, legal and regulatory arenas. CAPP will now report directly to the APAPO Board of Directors. This change will also add a voting member from the American Psychological Association of Graduate Students to CAPP, which already has a designated early career psychologist member. The Board of Professional Affairs will continue to oversee the work of the Practice Directorate, including policy formulation; the development of both professional practice and clinical practice guidelines; public education and disaster response; and advocacy for access to quality mental health services.

Additional Council Action

In other action the council:

- Approved a change to the Association Rules to now require that all boards and committees have at least one member who is an early career psychologist. Exceptions were allowed when membership criteria for a particular board or committee made a slate solely comprised of early career members impossible.
- Adopted a resolution aimed at stemming false confessions and wrongful convictions, including a recommendation that all

interrogations of domestic criminal felony suspects be videotaped in their entirety and from a “neutral” angle. The measure, which relies heavily on psychological research, states that law enforcement officers often close their investigations after a criminal suspect confesses, even in cases where the confession is inconsistent, contradicted by evidence or coerced. Many adults with mental disabilities and younger suspects don’t fully understand their right to remain silent and to have a lawyer present, and are more likely to waive their rights, the resolution says. In addition, jurors often have difficulty distinguishing true confessions from false, in part because even false confessions sometimes contain vivid and accurate details and facts that had not been previously reported.

- Adopted as APA policy a resolution on gender and sexual orientation diversity in children and adolescents in schools that encourages education, training and ongoing professional development about the needs of gender and sexual orientation diverse students for educators and other school personnel.
- Adopted as APA policy a

resolution in support of the UN Convention on the Rights and Dignity of Person with Disabilities.

- Adopted as APA policy Guidelines for Clinical Supervision in Health Service Psychology. These guidelines delineate optimal performance expectations for psychologists who supervise trainees in health-service delivery settings (see www.apa.org/about/policies/guidelines-supervision.pdf).
- The creation of a Div. 42 (Psychologists in Independent Practice) journal titled *Practice Innovation*.
- Approved the creation of an APA Committee on Associate and Baccalaureate Education. This committee will subsume the work of the current Psychology Teachers at Community College Committee.
- Adopted new policy that supports the inclusion on all governance boards and committee members who have not previously served in governance. Such members running for governance will be given the option to have the fact that they are new to governance service noted by an asterisk on the election ballot.
- Elected a class of 111 new APA Fellows.ψ

CAPP September 2014 Meeting— Highlights of Actions

American Psychological Association Practice Organization (APAPO) Financial Forecast for 2014-2016

As a follow-up to its May 2014 meeting, CAPP members had an opportunity to discuss the APAPO Financial Forecast for 2014-2016. Katherine Nordal, PhD, Executive Director for Professional Practice, reviewed briefly the assump-

tions supporting the Financial Forecast, addressed questions related to initiatives that will support Practice Assessment payer retention and recruitment activities and briefly reviewed potential new products and services that will support and increase non-dues revenue. The Forecast was prepared for and approved by the APAPO Board of Directors at its June 2014 meeting.

APAPO Government Relations Agenda

CAPP members received a briefing on the following major legislative initiatives that will be the focus for advocacy efforts in the coming months and through 2016:

- Enactment of the Medicare Mental

Health Modernization Act, which will allow psychologists to practice independently in all Medicare settings consistent with state licensure, by adding psychologists to Medicare's "physician" definition.

- Enactment of the Behavioral Health Information Technology Act, which will allow psychologists and other mental health providers to receive Medicare incentive payments for the use of electronic health records (EHR).
- Continue to address the unacceptable low reimbursement rates under Medicare through a number of proposed actions including meeting with members of Congress and meeting face-to-face with staff in the Centers for Medicare and Medicaid Services (CMS).
- Continue to work with congressional leadership on House bills to revise and expand federal funding to improve Medicare coverage in mental health, and research related to serious mental illness.

Updates on Initiatives Impacting Practitioners

CAPP received updates and discussed next steps related to the following initiatives and activities:

- *APAPO PQRS Branded Registry*: APAPO is partnering with Healthmonix, a qualified registry vendor since 2009, to allow psychologists and other mental health professionals to more easily report PQRS measures. The performance reporting program, known as PQRS, was implemented by Medicare as a way to measure quality in the services provided to Medicare beneficiaries. More information will be shared with APAPO members in the coming months regarding the benefits and opportunities for participation in APAPO's PQRS Registry program.

- *Psychological Assessment*: CAPP discussed the joint Board of Professional Affairs (BPA) and CAPP Work Group, which has been focusing on key issues impacting practitioners, such as protecting psychological assessment in psychology's scope of practice in licensing laws, reimbursement issues, and use of technology in the administration of psychological testing. As a complement to CAPP's discussion on psychological assessment, CAPP held a joint meeting with members of the Committee on Psychological Testing and Assessment (CPTA).
- *Board of Professional Affairs (BPA) Chair's report* reflected its various activities and initiatives.
- *CAPP Prescription Privileges Subcommittee* discussion centered on APA's current policies on prescriptive authority.
- *Legal and Regulatory* updates included recent efforts and actions to address issues impacting practitioners.

Engagement with Practice Constituencies

The September meeting was also an opportunity for CAPP members and liaisons to discuss, share ideas, and hear updates on initiatives carried out by each of the following Committees that include members from CAPP and the APAPO Board of Directors:

- *APAPO Good Governance Committee*: Since the May CAPP meeting, the Good Governance Committee recommended that CAPP become a committee only of the APAPO effective January 1, 2015, and that the APAPO Bylaws be amended to reflect the nominations and elections of CAPP members by APAPO Practice Constituents. These recommendations were approved by the APA Council of Representatives in August 2014.

- *APAPO Member Retention and Recruitment Committee*: CAPP members shared with liaisons recent discussions that focused on enhancing the value of APAPO membership.
- *APAPO Products and Services Subcommittee*: Since the May CAPP meeting, the Subcommittee has met twice by conference call and discussed product ideas related to publications, apps and the APAPO branded PQRS Registry.

CAPP Nominations and Elections Processes (Beginning in 2015)

Council-approved changes to the APAPO Bylaws in August 2014 will now allow APAPO Practice constituents will both nominate and elect CAPP members beginning with the 2015 elections for 2016 slates. CAPP engaged in discussion related to that nominations and elections process as well as discussing the nature of CAPP slates going forward and the kinds of competencies needed in those positions. This discussion will continue virtually throughout the Fall with a decision to be made by CAPP members with a recommendation to the APAPO Board by the end of 2014.

Master's Degree in Psychology

Next steps: CAPP members discussed a number of options related to next steps in the discussion of the master's degree in psychology. After a thoughtful discussion, CAPP approved forwarding a policy statement to the BPA for review and next steps. The policy statement reaffirms the APA position that the doctoral degree represents the minimum educational requirement for entry into professional independent practice.

CAPP 2015 Meeting Dates

CAPP members approved a slight modification in its planned meeting dates in 2015. The following dates represent the CAPP meeting dates for 2015: February 6-7, May 1-2, and October 2-3, 2015. [ψ](#)

Get (More) Involved: Run for an Office in the Society of Addiction Psychology!

Amy Rubin, Sara Jo Nixon, Robert Leeman & Samantha Domingo
SoAP Nominations and Elections Committee

This is your once-a-year opportunity to get involved in the governance of the Society of Addiction Psychology (SoAP)! This year we are looking to fill five positions: (1) President-Elect, (2) Member-at-Large (Science), (3) Council Representative (Science), (4) Treasurer, and (5) Secretary. The 3-year terms for these offices start at the close of the SoAP Business Meeting at APA in 2015.

You are already devoting considerable time to treating and/or conducting research with individuals with addictive behaviors. Here is your opportunity to have an impact on the field at the national level. Self-nominations are invited and you only need 2.5% of the membership (about 25 people) to nominate you to be placed on the ballot (deadline: mid-January). We will solicit nominations through the SoAP Listserv later this year for you. Candidate biographies will run in the Spring 2015 issue of TAN. The electronic ballot will be distributed by the APA Central Office in April 2015 (with a June 1st deadline). All SoAP Members and Fellows are eligible to run for any office.

President-Elect

The President-Elect functions as the Vice President for the first year. They become President in the second year of their term, then Past President in the third year. The President-Elect spends the first year getting oriented to the current Board, observing the activities of the SoAP, participating in various initiatives, and contributing ideas to the strategic planning for the upcoming year (the year they become President). After completing the President-Elect year, the President presides at all meetings of the SoAP Membership and Board of Directors as Chairperson

and implements any new strategic initiatives. The President performs other duties consistent with the Bylaws or decided upon by the Board of Directors. The President also gives the Society's Presidential Address at the APA convention (2016 in Denver). The Past President then serves as advisor to the current President. The term of the President-Elect will overlap with the 2014-2015 President Alan Budney, the 2015-2016 President Sherry McKee, and his/her own successor.

Member-At-Large (Science)

The Member-at-Large (MAL) (Science) serves as liaison between SoAP and the APA Science Directorate, through APA science directorate briefings and the Science Directorate's planning retreat in December. MAL (Science) represents the interests of SoAP members to the APA Science Directorate. Additionally, this position serves as a liaison between SoAP and Division 28 and other "science" divisions. Krista Lisdahl currently holds this position.

Council Representative (Science)

The Council Representative (Science) is involved in all major policy decisions made by APA. In addition, the Council Representative observes the APA leadership in action and participates in funding decisions. Other functions include attending the two APA Council meetings each year and joining interest groups at these meetings that discuss and develop proposals that are brought before the APA board. As APA works on implementing changes based on the Good Governance Initiative, it is imperative that SoAP member interests be represented. The Council Representative also serves on the SoAP Board and reports to SoAP leadership and to the entire membership through TAN. This position is currently held by Linda Carter Sobell.

Treasurer

The overarching function of the Treasurer is to manage the financial operations of the organization. Specifically, functions of the treasurer include collecting dues, keeping financial records, managing reimbursements for members and third parties for approved SoAP expenses, preparing annual reports and tax returns, and managing expenses and income from the Collaborative Perspectives on Addiction (CPA) midyear meeting. The Treasurer works directly with the Finance Committee and is a standing member of the CPA organizing committee. This position is currently held by Jennifer Buckman.

Secretary

The primary role of the Secretary is to assist in managing communications and maintaining records for the organization. The Secretary records minutes of all meetings of the SoAP and submits these minutes to the SoAP President and Board. Additionally, the Secretary assists in e-mail reminders and distributing electronic material for upcoming Board meetings, helps maintain archives of the SoAP, and serves as a voting member of the Board. This position is currently held by Brandon Bergman.

Elected Officers are expected to attend the Business Meeting and the Board Meeting at the next four APA Conventions (Toronto, Denver, DC, and San Francisco) and to participate in monthly conference calls. We would like to thank the current officers for their time and important contributions to SoAP! If you are interested in running or would like to nominate someone, or suggest a possible candidate please email the committee chair, Amy Rubin, at rubina@bu.edu.

We look forward to hearing from you! 

SoAP Education and Training Committee (ETC) Report on the APA Education Leadership Conference

The APA Education Leadership Conference (ELC) has met yearly in Washington, DC since 2001, held in autumn as Congress reconvenes. Goals of the ELC include assembling representatives from groups and organizations promoting psychology across all levels of education and training to address issues of mutual concern and to influence professional efforts and public policy regarding psychology education and training. Through our Education and Training Committee, Division 50 SoAP has been sending representatives to the ELC since 2006. Last year Dr. Will Corbin attended and submitted the following report to update The Society of Addiction Psychology on the important information and advocacy shared at the 2013 Education Leadership Conference. The ETC thanks Dr. Corbin for his contributions. Watch also for a report on the 2014 ELC, "Learning in a Digital World," which just took place in September, too late to be reported in this issue of TAN, but to be published in the 2015 Spring issue.

William R. Corbin, PhD
*Member of the SoAP Education & Training Committee
2013 SoAP Representative to APA ELC*

Every fall, the APA Education Leadership Conference in Washington, DC provides a forum for education and training leaders across all subdisciplines of psychology to come together and address issues of critical importance to the field. In addition to providing a shared disciplinary identity and opportunities for professional development, the conference provides opportunities to impact public policy regarding education and training in psychology. This year, the theme of the ELC was "Ethics & Education." Our SoAP was among a total of 59 organizations represented, including

APA Divisions, Psychology Education and Training organizations, other Psychology organizations, APA Groups, and invited speakers. ELC attendees also visited Capitol Hill to advocate for reauthorization of the Garrett Lee Smith Memorial Act (Senate Bill 116, House of Representatives Bill 2734) which provides funding to support campus, state, and tribal suicide prevention and other mental health services. The original legislation was passed with bipartisan support in part due to the critical efforts of former Senator Gordon Smith of Oregon who lost his son to suicide in 2003. It was a privilege to serve as the Division 50 representative to the ELC and I am pleased to report back to the SoAP regarding my activities as your representative.

On September 29 and 30, distinguished speakers presented plenary sessions on a wide variety of issues related to the central theme of "Ethics and Education." On Sunday morning, Anne Franke Esq. of Wise Results LLC provided a lively and thought provoking discussion of a wide range of ethical dilemmas we face in our field using the "seven deadly sins" as a framework. For example plagiarism represented an example of "sloth" though this was but one extreme example. Ms. Franke discussed the time lost in activities like surfing the internet rather than doing our work as a less extreme example. Witness the dip in productivity during March Madness each year.

Later in the morning a panel of faculty members discussed ethics in a variety of education contexts including undergraduate teaching, graduate mentoring, and clinical supervision. These talks discussed a number of high profile cases of academic misconduct and a variety of important issues including a) adequacy of training in

ethics by graduate mentors, b) the role of undergraduates in the research enterprise, and c) the importance of managing social media to avoid ethical misconduct.

Dr. Ali Mattu, faculty member of the Columbia University Clinic for Anxiety and Related Disorders, kicked off the afternoon session reflecting on his experiences during his graduate training. This was a really entertaining presentation using characters from some of Dr. Mattu's favorite movies. Although it was fun it was filled with important questions and the ways in which Dr. Mattu grappled with these issues over the course of his training. The topic of social media was raised once again though Dr. Mattu also noted the potential positive impact of this medium despite the inherent challenges. One particularly interesting point Dr. Mattu raised regarded the extent to which we get "informed consent" from graduate students before they begin their training. Do they really understand everything they are signing up for academically, socially, and financially? This is an issue to which we might all give further attention.

In the last presentation before our break-out groups, Dr. Stephen Behnke, JD, PhD of the APA Ethics Office led us through an ethical case related to the right of a student therapist in training to refuse to provide services to a client due to her religious beliefs. In addition to addressing interesting and challenging aspects of the particular case, Dr. Behnke provided clear guidance on how programs can sufficiently document their policies to avoid ambiguity in these types of cases.

We spent most of the afternoon on our first day in break-out groups, with each group addressing ethics in a particular

educational context. I was part of a group discussing modeling and ethical practices in an undergraduate context, and we had a lively and constructive discussion about a wide range of issues that we face as educators in this context. We worked through ethical challenges in the context of mentoring, community engagement, and research. It was really interesting hearing about the different approaches used across educational institutions to address ethical challenges in undergraduate training and I think we all walked away with new ideas for improving the undergraduate learning experience within our own institutions.

We closed day one with an overview of the legislative issue we would be going to Capitol Hill to promote the following day. We learned about the history of the Garrett Lee Smith Memorial Act and the importance of the reauthorization of this legislation. Since this was my first time at the ELC, I attended “Advocacy for Novices” early the next morning. We learned about key talking points and practiced presenting information to one another in preparation for our meetings the following day.

Returning to our theme of Ethics and Education, Dr. Patricia Keith-Spiegel, Professor of Social and Behavioral Sciences at Ball State University led an interesting discussion of innovations in Teaching Ethics. She discussed the challenges of reporting ethical misconduct, particularly when one must report on someone in a position of greater power. She also discussed novel ways to teach ethics with a focus on using stories that bring ethical dilemmas to life. Her upcoming book “Red Flags in Psychotherapy: Stories of Ethics Complaints and Resolutions” will provide an excellent resource for engaging students in discussion of these ethical conflicts.

Prior to our final preparations for our Hill visits, a plenary session primed us for the key issue for which we would be advocating by highlighting the challenges of addressing mental health issues on college campuses. The session focused on the White House Mental Health Initiative designed to bring attention to the challenges faced by mental health providers on college campuses. Speakers addressed increasing rates of mental health problems, the unique challenges of students in military service, and the critical need to identify programs that successfully address the mental health issues faced by today’s college students. A key focus was on suicidal behavior given our legislative agenda to maintain funding for suicide prevention on college campuses.

The afternoon was dedicated to our final preparation for the Hill visits, lead by members of the Government Relations Office of APA and Soapbox Consultants. We learned the specifics of the proposed legislation as well as the language necessary to communicate effectively with our state senators and congresspersons. For example, we learned that the legislation for which we were advocating was “budget neutral” meaning that it sought to maintain current levels of funding rather than authorizing additional funding. This was a critical issue given the political climate at the time. After all, we were going to argue for funding in the midst of a government shutdown! The leaders from Soapbox Consulting did a terrific job in helping us learn how to communicate effectively to bring the issue to life for our state representatives, and they got us excited about our opportunity to make a direct difference through our advocacy efforts. We also practiced our presentations while Federal Education Advocacy Coordinators (FEDACs),

played the role of Congresspersons, giving pushback as we argued for their support of the Garrett Lee Smith Memorial Act Reauthorization.

On Tuesday, October 1st, advocacy teams from each state visited the Congressional offices of our Senators, and met with the staff of the Representatives for whom we are constituents. As the only representative for our state I was on my own and more than a little nervous. The tension was heightened by the government shutdown as we were warned to be prepared for long lines and to be flexible if things did not go as scheduled. Despite my anxieties, it was a wonderful experience. I had the opportunity to meet with incredible staff members of my state senators and the congresswoman from my district. I stressed the importance of mental health services on our campuses in Arizona and discussed increasing rates of mental health problems and recent high profile cases that were directly impacting our state. Although the lines were long and not all of my meetings went off as scheduled, it was an amazing experience that renewed my belief in the role that we can all play in advancing legislation that is important to us personally and to our profession.

I hope that this report helps inspire others to take an active role in promoting legislative issues of importance to our field. For more information about the ELC, please go to the APA website. Many of the presentations from the conference are freely available for download at <http://www.apa.org/ed/governance/elc/2013/materials.aspx>. Finally, I would like to thank the SoAP for their support in making it possible for me to attend the Education Leadership Conference. I hope I will get the opportunity to serve in this role again in the future. ♡

2014 News From SoAP Committee on Fellows and Awards, September 2014

Sandra Brown

Chair, Fellows and Awards Committee

As Chair of the Fellows and Awards Committee for SoAP Division 50, I worked alongside committee members Art Blume, PhD, Sherry McKee, PhD and Kim Fromme, PhD to review numerous applications for existing and initial fellow status.

Five existing APA Fellows were recommended to APA. We recommended two candidates for initial fellow status to the APA Fellows Committee in February 2014. These applications were reviewed and James MacKillop's application was forwarded by the Fellows Committee to the APA Council of Representatives for final consideration and confirmation at the August convention.

2014 SoAP Division 50 Fellow Recommendations

Existing APA Fellows

James Bray, PhD
Associate Professor
Baylor College of Medicine

Dr. Bray's research has made significant contributions to the study of adolescent alcohol and other drug use. As a result of his leading two five-year NIAAA funded longitudinal studies on family and developmental factors impacting adolescent alcohol use, numerous publications were generated in peer-reviewed journals. His work served as a basis for the development of clinical interventions in medical settings.

Laurie Chassin, PhD
Regents Professor
Arizona State University

Since 1978, Laurie Chassin has been continuously engaged in the advancement of psychology in general and the field of addictive behavior specifically through her research, teaching and ser-

vice activities. She serves as Principal Investigator of two major longitudinal studies, a NIDA funded study of the natural history and intergenerational transmission of tobacco use and tobacco dependence and an NIAAA funded longitudinal study of the intergenerational transmission of alcohol disorders.

David Drobles, PhD
Professor, Departments of Oncologic Sciences & Psychology
University of South Florida

As Senior Member in the Department of Health Outcomes and Behavior and Associate Director, Tobacco Research and Intervention Program at Moffitt Cancer Center, Dr. Drobles's research interests and achievements in addiction also align well with those of SoAP. Two current research projects include NIDA/NIH funded studies on Evaluating New Nicotine Standards for Cigarettes, and Impulsive Decision Making Among Smokers: Effects of Exercise and Abstinence.

Mark Fillmore, PhD
Department of Psychology
University of Kentucky

Dr. Fillmore has made sustained contributions in several areas related to addictions and substance abuse including adolescent alcohol and other drug use. He was the Principal and Co-Principal Investigator of two five-year NIAAA funded longitudinal studies on family and developmental factors impacting adolescent alcohol use. He has contributed to SoAP Division 50 by serving as a Member at Large on the Board of Directors.

Nancy Petry, PhD
Professor
University of Connecticut School of Medicine

Dr. Petry has recently been appointed Editor-in-Chief of SoAP's journal, *Psychology of Addictive Behaviors*. Her

research over the past 15 years has focused on developing and evaluating interventions for addictive and behavioral disorders. She is currently in an NIH funded research program related to contingency management interventions for the treatment of substance use disorders.

New APA Fellow

James MacKillop, PhD
Associate Professor, Department of Psychology, University of Georgia

Dr. MacKillop's nomination is based on his broad research, presentations and publications in the field of Addiction Psychology including alcohol abuse, nicotine and tobacco research and gambling addiction. He is recognized for his innovative efforts to use behavioral economics and cognitive neuroscience to study alcohol use disorders. In particular, his creative approach has produced novel assessment instruments, and added to our understanding of both craving and the inability to delay gratification in alcohol misuse.

Awards

4 APA SoAP Division 50 Awards were conferred at the SoAP Division 50 Board and Committee Reception at the Annual Conference this year:

Distinguished Scientific Early Career Contributions

Adam M. Leventhal, PhD
Assistant Professor of Preventive Medicine and Psychology
University of Southern California

A major focus of Dr. Leventhal's research has been to parse mood disturbance into its constituent key components and explore their individual effects on addiction. He has been able to reveal that "affective phenotypes" confer a stronger risk for addiction than generalized forms of affective distur-



Adam M. Leventhal, PhD

bance, such as major depression. He has extended this research to several aspects of addiction vulnerability using both epidemiologic and laboratory-based methods. Most recently, he has applied his approach to understand why people with depressive symptoms are particularly prone to persistent and relapsing forms of tobacco addiction. Division 50 commends Dr. Leventhal's work in effectively elucidating why people who experience emotional disturbance are more prone to addiction.

Distinguished Scientific Contributions to the Application of Psychology

Mark B. Sobell, PhD
Nova Southeastern University
Center for Psychological Studies



Mark B. Sobell, PhD, right, with John Kelly

in the area of substance abuse over his entire professional career spanning some 40 years. He has emerged as an internationally distinguished clinical scientist who has made major theoretical, research, and applied contributions to the understanding and treatment of substance use disorders. The fact that his vitae lists over 200 invited research presentations and clinical workshops/institutes is a testament of how others have come to value his research and applied clinical contributions.

Outstanding Contributions to Advancing the Understanding of Addictions

Anne M. Fletcher, MS, RD
President, Anne M. Fletcher
Communications, Inc.

After Anne Fletcher's 2001 book *Sober*



Anne M. Fletcher, MS, RD

for Good: New Solutions for Drinking Problems—Advice From Those Who Have Succeeded, about the many routes to long-term recovery, she revisited the world of addiction to shed light on her increasing awareness of the deficiencies in our addiction treatment system as well as the public's lack of knowledge about addiction treatment. This research resulted in the publication last year of *Inside Rehab: The Surprising Truth About Addiction Treatment—And How to Get Help that Works*. This comprehensive book contrasts what goes on

in most facilities, with what experts and scientific studies suggest *should go on*. Anne Fletcher's hope is that her ongoing work will continue to highlight the need for far more integrated, individualized, and evidence-based treatment, better trained clinicians and greater quality assurance protections for clients.

Distinguished Service Award

Marsha E. Bates
Center of Alcohol Studies

Marsha Bates's outstanding, longer-



Marsha Bates, PhD, right, with John Kelly

term and ongoing service to the Society of Addiction Psychology has been impressive and the Committee wishes to thank her on behalf of all of Division 50. Starting in 1998 and continuing through 2007, Marsha was a Program Reviewer for the Division 50 Annual Meeting of the APA. From 2000-2001, she was Program Co-Chair of the Annual Meeting of the APA. Beginning in 2004 and ongoing, Marsha has been the Chair of the Finance Committee. From 2004 through 2007, she served as President-Elect of SoAP, followed by President, and then Past President of SoAP from 2006-2007. Thank you, Marsha!🙏

Early Career, Student, and Travel Awards

Division 50 Outstanding Early Career Presentation Awards

Shannon Audley-Piotrowski, PhD
 “From Parent to Peer Referents: Profiles of Injunctive Drinking Norms and Behaviors in Adolescents”
 Early Career Presentation Award

Mike Buckley, PhD
 “Self-Assessment as a Motivational Intervention for Problem and At-Risk Gamblers”
 Early Career Presentation Award

Jessica Martin, PhD
 “Personality and Alcohol Outcomes among Portuguese Students: The Moderating Role of Drinking Motives”
 Early Career Presentation Award



Shannon Audley-Piotrowski, PhD, right, with John Kelly



Mike Buckley, PhD, right, with John Kelly

Division 50 Outstanding Student Poster Awards

Lauren VanderBroek
 “Impulsive Delay Discounting as an Endophenotype: Association with Family History of Addictive Behavior”
 First Place
 Student Poster Award

Fred Stinson
 “Sustained Abstinence among African American Men who used Crack Cocaine: Developmental & Motivational Perspectives”
 Second Place
 Student Poster Award

Morgan Levy
 “Moderators of the Stress-Depression Association in Narcotics Anonymous Members”
 Third Place
 Student Poster Award

NIAAA(*)/NIDA(**) Early Career Psychologist Travel Awards

*Psychiatric Symptoms and Social Perception in Alcohol Use Disorders: Possible Sex Differences **
 Darrin M Aase, Governors State University

*PTSD/SUD in Individuals with Physical Disabilities: Identifying Problems and Promising Interventions ***
 Melissa L. Anderson, PhD, University of Massachusetts

*From Parent to Peer Referents: Profiles of Injunctive Drinking Norms and Behaviors in Adolescence **
 Shannon R. Audley-Piotrowski, MEd, PhD, Smith College

*Validation of a Financial Self-Efficacy Scale for Adults with Co-Occurring Disorders ***
 Anne C. Black, PhD, Yale University

*Predictive Relationship Between Alcohol and Marijuana Use Among Adolescents **
 Christina Bradley, BS, California School of Professional Psychology, Alliant International University

*The Effects of Alcohol and Cigarette Consumption on Dehydroepiandrosterone (DHEA) in Rural African Americans **
 Lucia Cavanagh, BS, BA, University of Houston

*Congruence of Marijuana Use and Personal Strivings: Ambivalence for Change and Motives for Use ***
 C. Joseph Clarke, BA, University of South Dakota

*Synthetic Marijuana Usage Among a Juvenile Offender Sample ***
 Scholar L. Colbourn, BS, Sam Houston State University

*Emotion Differentiation and Alcohol-related Problems: The Mediating Role of Urgency **
 Noah N. Emery, BS, The University of South Dakota

*Partner Violence & Substance Use: Considerations for Rural American Indian Mother-daughter Attachment **
 Julii M. Green, PhD, CSPP at Alliant International University

*Distress Tolerance, Negative Control, and Alcohol Problems in College Students **
 Austin M. Hahn, BA, University of South Dakota

*Accuracy of Self-Reported Substance Use Among Offenders **
 Elizabeth Hunt, MS, University of South Florida

*Forgiveness, Stress, Anger, and Health Among Adult Children of Alcoholics **
 Bridget R. Jeter, BS, East Tennessee State University

- A Latent Class Analysis of Agreement between Drug Use Indicators among Adults with Schizophrenia* **
Kiersten L. Johnson, BS, North Carolina State University
- Consideration of Future Consequences is Associated with Drinking Problems in Heavy Drinking College Students* *
Keanan J. Joyner, University of Memphis
- Who's Who and What's Happening with Drug Distribution and Substance Use: An Archival Data Analysis* **
Marisa Kostiuk, BS, University of Denver
- Automatic Psychological Processes Moderate the Association between Daytime Negative Mood and Nighttime Alcohol Use* *
Nicholas J. Kuvaas, BAS, North Dakota State University
- Children Residing with an SUD Parent: Predictors of Youth Externalizing Symptoms* **
Hannah R. Lawrence, BS, University of Maine
- Temporal Discounting and Tobacco Use as Predictors of Treatment Outcomes for Cannabis Use Disorders* **
Dustin C. Lee, PhD, Geisel School of Medicine at Dartmouth
- Preventing Alcohol-exposed Pregnancies in English- and Spanish-speaking Hispanic/Latina Women* *
Brian Letourneau, BS, Nova Southeastern University
- Moderators of the Stress-Depression Association in Narcotics Anonymous Members* **
Morgan A. Levy, BA, Nova Southeastern University
- Gender, Ethnicity, and Drinking Games Involvement in a Large, Multiethnic Sample of College Students* *
Janelle R. Olsen, Smith College
- Behavioral Economic Analysis of Stress Effects on Alcohol Motivation* *
Max M. Owens, BS, University of Georgia
- Effective Approaches for Screening and Assessment of Offenders Who have Co-occurring Disorders* **
Elizabeth C. Rojas, MA, University of South Florida
- Attention Deficits, Drinking Motives, and Alcohol Involvement Among University Undergraduates* *
Samantha Schiavon, University of San Diego
- Exploring the Function of Recovering Counselors' Self-Disclosure at Clinical Intake* **
Patrick Sears, MA, CADC, The Chicago School of Professional Psychology
- Motivational & Affect Differences Tobacco & Cannabis Smokers, Tobacco Smokers & Non-smokers* **
Alison L. Shrake, MSc, Swansea University
- How Veterans Enter Residential Drug Abuse Treatment: Preliminary Findings* **
Shira Spiel, Hunter College
- Alcohol Use, Calorie Restriction, and Exercise in Physically Active College Students* *
Stephanie A. Spies-Upton, MA, Sam Houston State University
- Substance Use and Distribution in the Process of Addiction: A Grounded Theory Approach* *
Evan T. Stanforth, BA, University of Denver
- The Link between Drunkenness and Future Crime of At-Risk Adolescents* *
Giovanna Steinhaus, MS, University of Pennsylvania
- Sustained Abstinence African American Men Who Used Crack Cocaine: Developmental & Motivational Perspectives* **
Fred Stinson III, MS, Capella University
- The Influence of Personality Traits on Nicotine Treatment Outcome* **
Rui Tang, BA, University of Houston
- Athlete Drinking Motives, Prepartying, and Drinking Games Participation Among High School Athletes* *
Cara C. Tomaso, BA, Smith College
- Impulsive Delay Discounting as an Endophenotype: Association with Family History of Addictive Behavior* *
Lauren A. VanderBroek, BS, University of Georgia 



APA Is in Toronto and SoAP Hopes to See You There!

Kristina Jackson
(Kristina_Jackson@brown.edu)

Suzette Glasner-Edwards
(sglasner@ucla.edu)

Program Chairs

The 123rd Annual Convention of the American Psychological Association is being held August 6th - 9th, 2015 in Toronto, Ontario, Canada. You can download the APA Call for Proposals at this link: <http://www.apa.org/convention/proposals.aspx>. We are accepting individual presentations

(i.e., poster abstracts) and symposia abstracts, but will not be accepting proposals for individual paper presentations or conversation hours. Our theme this year is “The Science and Treatment of Conjoint Substance Use and Co-occurring Disorders.” Although we will consider any addictions-related proposal, we will prioritize those related to this year’s theme. We will again be closely collaborating with Division 28 (Psychopharmacology & Substance Abuse) to bring you collaborative and addictions-focused programming.

Division 50 offers several **travel and merit-based awards**. We continue to offer our long-standing student/early career travel awards for best posters and presentations and our Distinguished Career awards. You can read more about the division programming and convention- and career-related awards on the SoAP website (<http://www.division50.org>)

The deadline is **December 1st, 2014**. We look forward to receiving your proposals, and hope to see you at the Convention in Toronto!☺

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.

Listservs: To join the discussion listserv (discussion among members), contact Robert Leeman at robert.leeman@yale.edu. All members (and all new members) are 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 (even if you don't belong to APA). 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 the administrative office at division@apa.org or 202-336-6013.

Psychology of Addictive Behaviors: Research on Mindfulness

Katie Witkiewitz
Associated Editor,
Psychology of Addictive Behaviors

It has been over 10 years since my colleagues and I at the University of Washington received our first NIH grant, funded by NIAAA (R21AA130544382, G. Alan Marlatt, PI) to examine the effects of mindfulness meditation as an intervention for addiction. *Psychology of Addictive Behaviors* (PAB) published the results of that initial trial as a brief report (Bowen et al., 2006). This was the first article ever published by PAB that examined mindfulness meditation and the second paper appearing in PAB on meditation was published by my colleague Sarah Bowen in 2009 (also a brief report). Since 2009 the rate of publishing articles related to mindfulness meditation in PAB has steadily increased to an average of two articles per year.

When my colleagues and I first started studying mindfulness meditation as a behavioral intervention for addiction we encountered quite a bit of resistance from reviewers who were skeptical about the possibility that learning mindfulness meditation skills would be possible or effective among individuals struggling with addiction. The first five years of our research program, from 2004 through 2009, was an uphill battle with numerous failed grant applications. In the past five years the tide has turned and mindfulness meditation is starting to be accepted as a valid and effective behavioral intervention for substance use disorders, as well as behavioral



Katie Witkiewitz

addictions and comorbid substance use and mental health disorders. Over 25 controlled trials (approximately half with randomized designs) have since been published and the results from these studies have generally found mindfulness-based interventions to be as effective as, or even more effective than, alternative treatments. In two of our most recent trials (Bowen et al., 2014; Witkiewitz et al., 2014) we found that mindfulness-based relapse prevention was actually more efficacious than active cognitive behavioral relapse prevention.

I am excited about the possibility of mindfulness-based interventions as an alternative treatment for addictive behaviors and was excited to recently accept a paper for publication in PAB examining a brief mindfulness intervention for college student binge drinkers authored by Drs. Liza Mermelstein and John Garske (Mermelstein & Garske, in press). The authors found large effect size differences ($d = 0.86$) in binge drinking episodes and medium effect size differences ($d = .49$) in alcohol consequences among college student binge drinkers who received a 60 minute brief mindfulness intervention and instructions to practice meditation for four weeks, as compared to a cue exposure control group. These effect sizes are quite impressive considering prior studies of college student drinking interventions have tended to produce small effect size differences between active interventions and control groups (Carey et al., 2007).

Despite these promising initial findings, a great deal of work needs to be done on the evaluation of mindfulness-based interventions (including replication of recently published studies) and mechanisms of mindfulness-based interventions. It is also critical to take a step back to conducting basic research on the processes involved in learning and implementing mindfulness skills. I look forward to seeing even more papers on this topic submitted to PAB.

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Mindfulness: An Emerging Treatment for Addictions?

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Why do young mothers buy a daily pack of cigarettes instead of spending this money on nutritious food for their children? In other words, why are addictions so hard to overcome?

Our brains are set up to learn. From an evolutionary perspective, to survive, when we come upon a good source of food or water, it is helpful to remember where it is. When we stumble upon something dangerous, it is helpful to remember this too. And this reward-based learning system, that is conserved all the way back to the most primitive of nervous systems (the sea slug with roughly 20,000 neurons), in its most basic form has three elements: trigger, behavior, reward. We see berries, we eat them, and if they taste good (reward), we lay down a memory to come back for more.

Fast forward to modern day, where food is plentiful and our environment is relatively safe. Our brains, however, still have the same reward-based learning system. Under the names of operant conditioning, associative learning and positive and negative reinforcement, a lot more is known about how it works. This is the good news.

The bad news is that over time, humans have stumbled upon substances that literally hijack this reward-based learning system. In fact, every

substance of abuse from tobacco to crack cocaine affects the same brain pathways—the mesolimbic pathway which mainly acts through the neurotransmitter dopamine. And each time we do a line of cocaine and feel the high or smoke a cigarette when we are stressed out and feel better afterwards, we reinforce the “habit loop” (see Figure 1). This combination of tapping into the dopamine system and behavioral repetition is deadly—for example, smoking is the *leading* cause of preventable morbidity and mortality in the US (Centers for Disease Control and Prevention, 2008).

Treatments such as cognitive behavioral therapy are thought to act through the prefrontal cortex—involved in reasoning, planning and “top down” cognitive control in general. When we know we shouldn’t eat that second

helping of cake or smoke a cigarette, this is the part of the brain that helps us control that urge. Unfortunately, like the rest of the body, the prefrontal cortex is subject to fatigue, described by some as “ego depletion” (Muraven & Baumeister, 2000). As the HALT acronym predicts, when we are Hungry, Angry, Lonely, or Tired, we are more susceptible to smoking or using drugs. This may be because, as the youngest part of the brain from an evolutionary standpoint, this is also the first cortical region to go “offline” when we are stressed or otherwise depleted (Arnsten, 2009).

If we can’t rely on our prefrontal cortex, are there other ways to change our unhealthy behaviors?

Interestingly, mindfulness training is emerging as a possible solution.

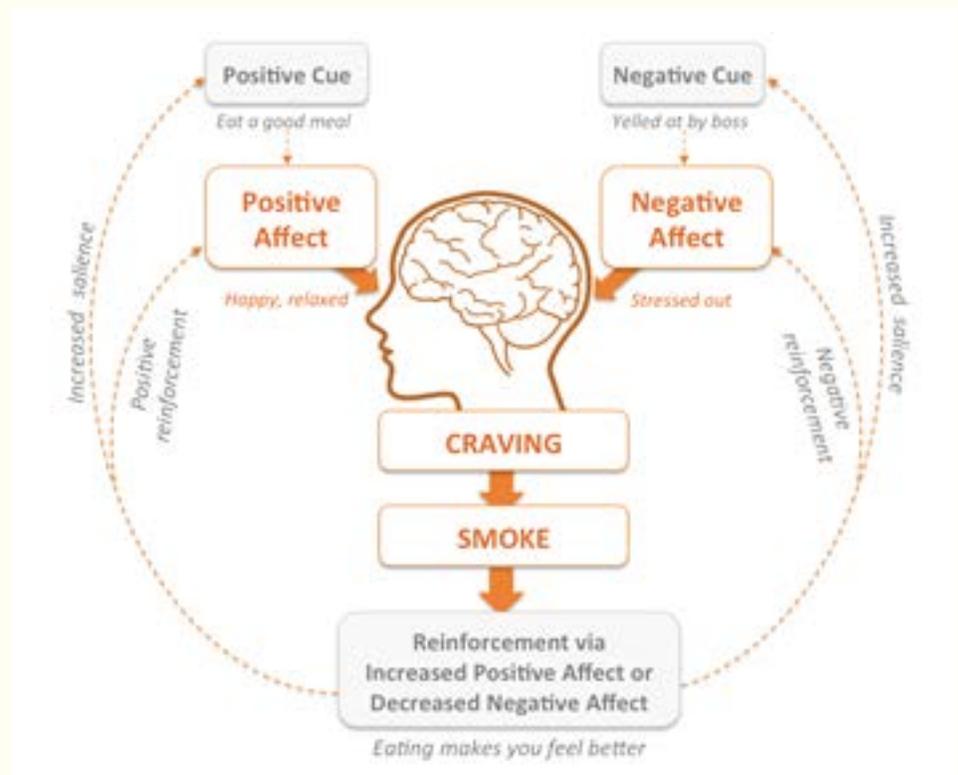


Figure 1. Addictive habit loop. © 2014 Judson Brewer (Adapted from Brewer et al., 2013).

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Based in ancient Buddhist psychology, mindfulness helps individuals pay careful attention to their cravings, such that they can see what they are made up of—thoughts and body sensations. Importantly, with this awareness, they can notice cravings as they arise, see how they change from moment to moment (instead of lasting “forever” as some of our patients have described), and as a result, stay with them and ride them out instead of acting on them by smoking. Also, paying attention also helps individuals see clearly what they are getting from their behavior in that moment.

For example, a person in our smoking program commented, “Mindful smoking: smells like stinky cheese and tastes like chemicals. YUCK!” She noticed that smoking wasn’t as great as she might have convinced herself previously. And this is the beginning of the end—we start to get disenchanted with what we were doing just by paying careful attention. This dual purpose of mindfulness—disenchantment and being able to be with ourselves instead of reacting automatically—may be a winning combination.

We and others have found that mindfulness training helps individuals with a range of addictions from alcohol to cocaine to nicotine dependence (Brewer, Elwafi, & Davis, 2013). In fact, in one randomized clinical trial, we found that it was *twice* as good as gold standard treatment (American Lung Association’s Freedom From Smoking) in helping people quit and stay quit (Brewer et al., 2011). Why would it work so well? It turns out that it targets the core addictive loop—by helping people ride out their cravings instead of acting on them, it decouples the link between craving and smoking, effectively dismantling the loop (Elwafi, Witkiewitz, Mallik, Thornhill, & Brewer, 2013). This is an important point, because these data pinpoint a mechanistic link that is being targeted by mindfulness, which is not always easy to find in behavioral treatments.

Though more research is needed,

treatment programs specifically for addictions show promise and are now manualized such that therapists can be trained to deliver them (Bowen, Witkiewitz, Clifasefi, & et al., 2014; Brewer et al., 2009). Additionally, web and app-based delivery of mindfulness is potentially the next step in delivering standardized treatment that can be easily disseminated, and phone-based technology allows an easily accessible way to provide mindfulness training and support over the course of treatment. For example, a newly developed program, [Craving to Quit](#) delivers the manualized mindfulness training that we developed at Yale University described above via short daily videos, animations and in the moment exercises via a web and smartphone app, and is paired with an online community where individuals can get peer and expert support (e.g., forum moderated by an addiction psychiatrist). Craving to Quit is now being studied in clinical trials funded by the American Heart Association and the National Cancer Institute in adults (e.g., [this study](#) at Yale is currently enrolling, and UMASS Medical School will begin enrollment for a second study shortly).

Would such an approach work for adolescent smokers interested in quitting? Mindfulness training has shown promise in helping adolescents improve emotional and cognitive functioning, including self-regulation and the ability to calm themselves and relieve stress. In addition, mobile phone-based interventions have tremendous potential to support teens in their efforts to quit as mobile phones are a ubiquitous part of many teens’ lives. Given this potential, through a grant from the National Institute on Drug Abuse, Craving to Quit is being adapted for use with teen smokers and will be tested in the school health setting. The Craving to Quit-Teen app will be compared to a smoking cessation app by NCI and written smoking cessation materials to tease out the unique effects of mindfulness training and smartphone intervention delivery on increasing abstinence among adolescent smokers. If found to be effective, the Craving to Quit-

Teen app would offer an innovative and potentially cost-effective intervention for supporting adolescents in their efforts to quit and remain abstinent with great potential for widespread dissemination and tremendous public health significance.

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Mindfulness Based Interventions for Substance Use Disorders: Untapped Potential in Veteran and Military Populations

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Adapted from Buddhist spiritual practices that focus on insight and awareness of one's emotions and behaviors (Bodhi, 2011), mindfulness-based interventions (MBIs) have been developed to target chronic pain (Mindfulness Based Stress Reduction, MBSR; Kabat-Zinn, 1990), mood and anxiety disorders (Mindfulness Based Cognitive Therapy, MBCT; Segal et al., 2002), and substance use disorders (Mindfulness Based Relapse Prevention, MBRP; Bowen, Chawla, & Marlatt, 2010; Witkiewitz, Marlatt, & Walker, 2005). Each of these MBIs share a focus on promoting increased awareness, acceptance, and tolerance of aversive mental states. Given the specific comorbidities evidenced in the veteran/military population (Seal et al., 2007), MBIs may be particularly applicable to treating substance use disorders (SUDs) among veterans/military personnel.

Efficacy of MBIs in Treating Substance Use Disorders

In a review of 24 studies, Chiesa and Serretti (2014) suggest that MBIs are efficacious in reducing use of alcohol, cocaine, opiates, amphetamines, marijuana, and nicotine. In the largest randomized controlled trial of an MBI

for SUDs to date, Bowen et al. (2014) randomized 286 participants to MBRP ($n = 103$), standard Relapse Prevention (RP; $n = 88$), or treatment as usual (TAU, $n = 95$). Interestingly, although both MBRP and RP demonstrated larger reductions in alcohol and other drug use compared to TAU at the 6-month follow-up, MBRP was associated with significantly larger reductions in substance use at the 12-month follow-up. These results suggest that the mindfulness component enhanced the longer-term efficacy of RP, subsequently leading to more sustained change. Unfortunately, none of these trials targeted veterans or military personnel. However, the particular comorbidities found in veteran/military populations suggest that MBIs would be an effective means of treating SUDs (and comorbid conditions) in the veteran/military population.

Comorbidities in Veteran/Military Populations

In a sample of 103,788 veterans, Seal et al. (2007) found that 25% of veterans had a mental health diagnosis; of those with a mental health diagnosis, 56% had 2 or more diagnoses, demonstrating the high rates of comorbidity in this population. In a sample of 456,502 Iraq and Afghanistan veterans, Seal et al. (2011) found that 11.4% had an SUD diagnosis. Although 26.1% of the total sample had a post-traumatic stress disorder (PTSD) diagnosis, 63-76.1% of individuals with an SUD had a comorbid PTSD diagnosis, and 53.6-71.9% had a co-morbid depressive disorder. Further, in a sample of 293,861 veterans, Stecker et al. (2010) found that the most common ICD-9 diagnoses for veterans were pain (48.5%), depression (12.56%), and PTSD (11.96%). Altogether, these studies demonstrate that most veterans/

military personnel with a mental health diagnosis have psychological or physical symptoms that have been successfully targeted by MBIs: pain, post-traumatic stress, depression, anxiety, and substance use.

Given that pain is the most common diagnosis among veterans (Stecker et al., 2010), it is important to understand how pain confers risk for SUD. In a sample of 5,961 veterans, 34% received an opioid prescription, and 5% received a chronic opioid therapy (COT) treatment (Dobscha, Morasco, Duckart, Macey & Deyo, 2014). Given that opioids have high abuse potential (Morasco & Dobscha, 2008), it is not surprising that veteran patients who are prescribed high doses of opioid medications have the highest rates of medical, mental health, and substance use disorders (Morasco, Duckart, Carr, Deyo, & Dobscha, 2011). The positive association between comorbid psychiatric conditions (including SUDs) and prescription opioid use (Dobscha et al., 2014) suggests that pain conditions elevate the risk of substance abuse among veteran populations, and adds additional diagnostic complexity.

Efficacy of MBIs in Treating Psychological Disorders in Veterans/Military Personnel

We review a few recent trials in veteran/military populations with rigorous and comprehensive assessment protocols to highlight the potential of MBIs in this specific population. In a recent randomized control trial, Seppala et al. (2014) demonstrated that a breathing-based yoga intervention among OEF/OIF veterans resulted in a significant reduction in PTSD, depression, and anxiety symptoms, with a continued downward trend over a one-year follow-up period, compared

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to the control group. The MBI group also showed reductions in respiration rate (an indicator of improved regulation of the autonomic nervous system), and the decrease in eye-blink startle response observed in this group was a significant predictor of one-year follow-up PTSD symptoms of hyperarousal, re-experiencing, and general distress anxiety. In another study, an MBI was found to effectively reduce symptoms of PTSD and reduce serum cortisol levels (Kim et al., 2013).

Despite these promising results, individual face-to-face interventions are not the most cost-effective. Additionally, some veterans may have difficulty accessing services, including substance abuse treatment (Fortney, Booth, Blow, Bunn, & Cook, 1995). This barrier to care is further impacted by the fact that approximately 3.3 million veterans, or 41% of total patients enrolled in VA care, live in a rural area (VHA Office of Rural Health, 2012). However, mindfulness interventions can easily be delivered via telehealth modalities. In a recent pilot study of an MBI targeting military veterans with combat-related PTSD, Niles and colleagues demonstrated that a brief telehealth MBI was associated with a reduction of PTSD symptoms post-treatment compared to a PTSD psychoeducation group (Niles et al., 2011), and the MBI increased several proposed mediators (e.g., facets of mindfulness; Niles et al., 2011). Therefore, MBIs have been shown to be effective in the veteran/military population, and there is promise that such interventions can be delivered in cost-effective ways.

A recent trial examining Mindfulness-based Mind Fitness Training (MMFT; Johnson et al., 2014) aimed to improve stress reactivity in a sample of Marine infantry platoons demonstrates the promise of MBIs as a preventative intervention in military populations. Compared to standard training, this MBI was found to result in superior performance in heart rate reduction and breathing rate recovery following stress exposure. The MMFT group also had significantly lower concentration

of stress biomarkers including neuropeptide Y immediately after the stress exposure, with a quicker recovery to baseline. Further, neuroimaging results of decreased insula activation were negatively associated with self-reported resilience scores. Thus, the efficacy of this MBI in reducing stress reactivity was confirmed using physiological and neural activity measures, indicating that MBIs may serve as useful preventative interventions that can be offered prior to deployment to protect against disorders associated with stress (including SUDs).

Promise of MBIs to Treat SUDs and Comorbid Conditions in Veterans/Military Personnel

The high prevalence rates of SUDs and other comorbid conditions in veteran/military populations substantiate recommendations that integrated treatment, simultaneously targeting dual diagnosis symptoms, are necessary within the VA healthcare system (Seal et al., 2011). Researchers have argued that MBIs are worthy of further examination and dissemination for veterans/military personnel (Rose, Aiken, & McColl, 2014), with recommendations that MBIs should be offered as options within the VA healthcare system in an attempt to improve and personalize care (Gaudet, 2014). Not only have MBIs shown incredible promise in the civilian population targeting complex clinical presentations (e.g., simultaneous treatment of chronic pain and opioid misuse, Garland et al., 2014), but an increasing number of studies targeting veterans/military personnel demonstrate that MBIs can result in cross-diagnostic health improvements (e.g., health-related quality of life ratings; Kearney, McDermott, Malte, Martinez, & Simpson, 2013; quality of sleep and stress ratings, Kluepfel et al., 2013). Although additional research in this area is greatly needed, the specific needs of veterans/military personnel would seem to be well-served by MBIs targeting SUDs and comorbid conditions.

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A Call for Research on Technology-Based Mindfulness Interventions for Substance Use Disorders

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There is a growing body of research showing that evidence-based treatments delivered via computer programs, smartphone applications, and the Internet are efficacious in the treatment of substance use disorders (SUDs; Moore et al., 2011; Myung et al., 2009; Newman, Szkodny, Llera & Przeworski, 2011). The past decade has also seen a rapid increase in the application of mindfulness-based interventions (MBIs) for SUDs (Chiesa & Serretti, 2014). For example, recently

Bowen and colleagues (2014) showed that Mindfulness-Based Relapse Prevention (MBRP) was more effective than cognitive-behavioral relapse prevention and 12-step oriented care in preventing relapse to drug use and heavy drinking at 1-year follow-up. Although researchers have investigated technology-based versions of many evidence-based treatments for SUDs, there have been no published studies on technology-based versions of MBIs for alcohol and drug use disorders, and few studies have examined technology-based MBIs for tobacco use disorder. I argue that research on technology-based versions

of MBIs for SUDs is needed for the following reasons: 1) MBIs for SUDs are empirically supported and MBIs such as MBRP may even confer advantages over other behavioral treatment approaches in facilitating long-term recovery following treatment (Bowen et al., 2014), 2) preliminary research shows that technology-based MBIs are feasible and effective among other among clinical and non-clinical populations without SUDs (Cavanagh, Strauss, Forder & Jones, 2014), and 3) given that MBRP is already an efficacious aftercare treatment, MBRP may be a particularly suitable evidence-based treatment to

deliver in the form of a technology-based continuing care resource for life-long recovery.

Technology-based interventions (computer-assisted, web-based, smartphone applications) have been developed and evaluated in the treatment of various SUDs including drug use disorders (Carroll et al., 2008; Marsch et al., 2014), alcohol use disorder (Gustafson et al., 2014), and tobacco use disorder (Myung et al., 2009). Technology-based interventions for SUDs offer unique benefits such as increasing access to treatment for those who are unwilling or unable to attend in-person treatment, as well as providing continuing care services to support the long-term recovery of individuals following time-limited in-person treatment (Carroll & Rounsaville, 2010; Marsch, 2012). Moreover, dissemination of evidence-based treatments is limited because community settings often do not have the resources and trained staff available to effectively deliver these treatments (Carroll & Rounsaville, 2007). Technology-based interventions are cost-effective, can be implemented easily, and ensure that interventions are delivered with fidelity. Importantly, 87% of American adults have access to the Internet and 58% have mobile smartphones with Internet access (Fox & Raine, 2014; Mobile technology fact sheet, 2014). One example of a computer-assisted intervention for SUDs is the computer-based training in cognitive-behavioral therapy program (CBT4CBT; Carroll et al., 2008), which includes six modules that rely primarily on videos with actors to teach a variety of cognitive and behavioral skills. Research indicates that the addition of the CBT4CBT program to standard outpatient treatment resulted in significantly better outcomes during treatment (Carroll et al., 2008) and 6-months post-treatment (Carroll et al., 2009).

An example of a web-based intervention is the therapeutic education system (TES; Marsch et al., 2014). Based on the community reinforcement approach, TES includes 65 interactive multimedia modules covering a wide range of relapse prevention skills, as well as a

virtual prize-based incentive system that rewards participants for negative urine screens and for completing modules. Several randomized controlled trials (RCTs) have demonstrated that TES is an efficacious adjunct treatment for individuals with opioid dependence (Bickel, Marsch, Buchhalter, & Badger, 2008; Campbell et al., 2014; Marsch et al., 2014).

An example of a smartphone-based intervention is the Addiction-Comprehensive Health Enhancement Support System (A-CHESS; Gustafson et al., 2014), a relapse prevention program comprising many features such as reminders and alerts related to a patient's recovery goals, easy ways to access peer and counselor support during emergencies, and a global positioning system to warn patients when they are near high-risk locations. An RCT of A-CHESS revealed that the addition of A-CHESS to standard treatment resulted in significantly less heavy drinking days among individuals with alcohol use disorder (Gustafson et al., 2014). Based on research to date, the potential of technology-based interventions to improve overall treatment for SUDs appears promising.

Despite the fact that MBIs are empirically supported in the treatment of SUDs, there are currently no published studies on technology-based MBIs for alcohol and drug use disorders, and there are only two published studies on technology-based MBIs for smoking cessation. Bricker, Wyszynski, Comstock, and Heffner (2013) evaluated a web-based version of acceptance and commitment therapy (ACT) for smoking cessation and found that smokers who received web-based ACT had significantly higher quit rates compared to smokers who received the National Cancer Institute's intervention (Smokefree.gov). In another study, Bricker et al. (2014) evaluated a smartphone-based program of ACT for smoking cessation (SmartQuit) and found that smokers who received SmartQuit showed significantly higher quit rates than smokers who received the National Cancer Institute's smartphone-based smoking cessation program. Although

these studies are encouraging, findings are limited because of the short-term follow-up period, and more studies with longer-term follow-ups are needed.

I believe there are several good reasons why more research is needed on technology-based MBIs for SUDs. First, there is a mounting evidence-base supporting the utilization of MBIs in the treatment of SUDs (Bowen et al., 2014; Chiesa & Serreti, 2014; Garland et al., 2014), and MBIs appear especially effective in supporting long-term recovery (Bowen et al., 2014). Second, preliminary research on technology-based MBIs among other populations (e.g., non-clinical community members, chronic pain patients, individuals with tinnitus distress) suggests that delivering MBIs via technological platforms is feasible and effective (see Cavanagh et al., 2014 for a review and meta-analysis). Third, given that MBRP is an efficacious relapse prevention treatment, MBRP may be a particularly suitable evidence-based treatment to deliver in the form of a technology-based continuing care intervention. MBRP and technology-based treatments (e.g. A-CHESS) are both unique and effective approaches to preventing relapse. Hence, combining the two approaches may prove to be even more effective in preventing relapse. Because several existing technology-based interventions include multiple components (TES, A-CHESS), mindfulness components can possibly be integrated into these interventions.

The most effective method for designing a technology-based MBI for SUDs remains to be determined. Based on existing research-supported technology-based interventions for SUDs, I encourage researchers to consider the following in the design of technology-based MBIs: 1) using multiple methods to convey content including text, videos, animations, real-person narrators, and interactive questions and feedback, 2) providing materials that participants can take off the websites including downloadable mp3 files of meditation recordings and PDFs or printable handouts, 3) automated emails or text messages to remind participants to engage in the interven-

tion components, practice mindfulness exercises, and apply mindfulness to everyday life, 4) closely aligning the content of technology-based interventions to evidence-based MBI manuals, 5) creating both web-based and smartphone-based versions of an intervention to ensure the greatest level of access to the intervention, and 6) incorporating elements to mirror the group-based environment of MBIs such as including a discussion board and/or providing videos of pre-recorded mindfulness sessions in which a mindfulness instructor is facilitating discussion among a group of participants.

In summary, I believe that technology-based MBIs could play an important role in the treatment of SUDs, particularly as continuing care interventions to support long-term recovery. Accordingly, I encourage researchers to develop and evaluate technology-based MBIs for SUDs and to consider integrating mindfulness components into existing and emerging technology-based interventions for SUDs.

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The Future of Mindfulness Training for Substance Use Disorders

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With the publication by Bowen et al. in *JAMA Psychiatry* this year, mindfulness has finally found a firm footing as an evidence-based modality for substance use disorder treatment. This randomized controlled trial ($n = 286$) tested the effects of different aftercare groups on relapse rates over 12 months. The study demonstrated significantly reduced rates of heavy drinking and drug use at 12 months with Mindfulness-Based Relapse Prevention (MBRP), compared to standard Relapse Prevention (RP) and treatment as usual (Bowen et al., 2014). Since this paper was published, several colleagues have commented to me that they have been approached about setting up MBRP programs at their academic hospitals. Many private pay residential programs are proudly publicizing their mindfulness programs. Clinicaltrials.gov lists 30 clinical trials testing mindfulness for addiction or substance use disorders. Mindfulness is beginning to feel like it has arrived in substance use disorder treatment, and yet the mindfulness-based interventions that ultimately will have the greatest impact on the prevalence of substance use disorders are still in development.

According to the National Survey for Drug Use and Health (NSDUH), of the 22.7 million people who needed substance-abuse treatment in 2013, only 11% received specialty care for substance use disorders (SAMHSA, 2014). While MBRP has demonstrated that mindfulness training can help prevent relapse, the next growth area for mindfulness-based interventions will be to reach the 89% of substance users who are not already in treatment. These substance users have not contemplated stopping, are not ready,

or may not judge their thoughts, feelings or urges about substance use as a problem. Standard treatment has little traction when addictive thoughts and urges are not judged to be a problem. Mindfulness training turns the treatment paradigm on its head, because mindfulness training increases the capacity for self-awareness through a non-judgmental approach.

In 2010, we conducted a pilot study with 17 heroin-dependent patients in standard buprenorphine maintenance treatment within a relapse prevention program. Patients completed the Five Facet Mindfulness Questionnaire (FFMQ), a measure of dispositional mindfulness (Eisenlohr-Moul, Walsh, Charnigo, Lynam, & Baer, 2012), which consists of five factors, including observe, describe, act with awareness, non-reacting to inner experience, and non-judging of inner experience (Baer et al., 2008). Patients were followed with weekly urine toxicology for 3 months. A higher level of non-judging of inner experience was associated with greater drug use. Those who did not judge their thoughts, feelings and urges as bad or wrong were significantly more likely to keep using illicit drugs during treatment. The subjects with high levels of non-judging were the same 8 people who continued to use illicit drugs during treatment (Schuman-Olivier, Albanese, Carlini, & Shaffer, 2011). Recognizing the small sample size, we concluded that one may need to be able to judge one's own inner experience in order to generate the internal discrepancy that is necessary to stop illicit drug use within traditional substance abuse treatment programs. In other words, you need to be able to identify a problem before you can muster up resolve to stop it.

We conducted a secondary analysis of the initial Mindfulness Training for Smokers trial (Brewer et al., 2011) to examine whether this relationship

would hold for tobacco smokers and whether receiving mindfulness training might change this association. We found that if smokers with high-levels of non-judging at baseline received standard behavioral treatment, then they reported the highest number of cigarettes per day at the end of follow-up as predicted; in contrast, if they instead received mindfulness training, then they had the lowest number of cigarettes at the end of follow-up. Among smokers with low levels of non-judging at baseline, we found no difference between treatment groups on cigarettes use at follow-up. We concluded that mindfulness training may potentiate the therapeutic effect of non-judgment of inner experience on smoking cessation (Schuman-Olivier, Hoepfner, Evins, & Brewer, 2014). High levels of non-judging may hinder problem identification during standard treatment and limit the development of discrepancy needed to motivate and sustain change. Some treatment providers may view non-judgment as a lack of readiness or even as resistance. In contrast, high non-judging may be a beneficial trait when a person is engaged in the process of mindfulness training because of reduced inner conflict as one begins to pay attention to present-moment inner experiences. Also, people who are high in non-judgment may have enhanced self-efficacy for meeting treatment goals since mindfulness training views non-judgment positively.

Addiction treatment providers who have not experienced mindfulness training may feel that encouraging non-judgment of present-moment experience is counter-intuitive; it may raise concerns that non-judgment might keep people stuck, e.g., accepting themselves as cannabis smokers. Indeed, the findings from our heroin study demonstrate the potentially problematic nature of emphasizing non-judging and acceptance during

early phases of treatment with standard modalities. Mindfulness training, though, actually changes the paradigm, because it is an iterative, contextual process in which one continues to be open and curious to all present-moment experiences regardless of their valence or desirability (Bishop et al., 2004). This process opens one's eyes to the aspects that were previously ignored or were defended against. When a smoker in my mindfulness group puffed mindfully, he reported the toxic smell in his nose, the burning feeling in his throat and the nasty taste in his mouth, effects he never before realized. When this happens, then it is impossible to avoid seeing the negative impact and undesirability of substance use. Even if one doesn't judge oneself for one's substance use, one begins to recognize the negative consequences, and instead of reacting automatically to habits and drives, one is able to respond more thoughtfully. This process creates fertile soil for self-awareness and allows the discrepancy with one's own life goals and values to begin to grow and to foster motivation for change.

Studies have begun to support using brief mindfulness-based interventions for substance users unready for change. One hour training in mindful urge surfing reduced cigarette use among college smokers (Bowen & Marlatt, 2009) and four weeks of mindfulness training for college binge drinkers reduced binge episodes and negative consequences of alcohol use (Mermelstein, 2013). Patients with chronic pain misusing opioids were less likely to meet criteria for opioid abuse after an 8 week mindfulness program for chronic pain (Garland et al., 2014). Mindfulness training encourages non-judgment, while concurrently requiring a commitment both to paying attention to how behavior influences the mind and body and to acquisition of self-regulation skills. This process may help many people locked in habitual substance use find motivation and confidence to move forward along the path of change and wellness.

The movement to conduct screening, brief, intervention and referral to

treatment for substance use disorders is profoundly shifting the way health care is delivered (Agerwala & McCance-Katz, 2012). The nationwide trend towards implementation of patient-centered medical homes in primary care offers a structure for integrating mindfulness into primary care, which is where most substance abuse counseling in the health care system will actually occur (Sullivan, Tetrault, Braithwaite, Turner, & Fiellin, 2011). Development of models for delivering mindfulness training to substance using primary care patients is essential. We are currently implementing the MINDFUL-PC healthcare system transformation project focused on bringing mindfulness training into patient-centered medical homes across our healthcare system. Patients who recognize and judge they have a problem are already able to foster the motivation to engage in addiction treatment. But by integrating mindfulness training into primary care, we hope to engage those who may not realize their substance use is a problem and transform their non-judgment from a weakness into a strength.

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Mindfulness in a Unique Dual-Diagnosis Population

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Chronic pain (CP) is a significant public health problem in America with 100 million adults suffering with CP in 2011, costing society \$560-\$635 billion annually (Research, Care, & Medicine, 2011). Those who have CP are at greater risk of aberrant drug use-related behavior and those with past substance use disorder (SUD) are more likely to be prescribed with higher doses of opioid medications (Morasco et al., 2011). The overall cost (crime, lost work productivity, and healthcare) of substance dependence varies by substance with illicit substances totaling \$193 billion annually (National Institute on Drug Abuse [NIDA], 2012). Drug-related emergency department visits totaled 4.9 million in 2010 (Drug Abuse Warning Network [DAWN], 2010).

Rates of prescription opioid abuse vary widely in epidemiological studies between 3%-66% among CP sufferers (Fishbain, Cole, Lewis, Rosomoff, & Rosomoff, 2008; Morasco et al., 2011). The variability is due to differing treatment settings, differing definitions of CP, and research design caveats (e.g. face valid questions). Risk factors for the development of SUDs in CP patients include pain catastrophizing (e.g. "My pain will never end") and past SUD diagnoses (Morasco, Turk, Donovan, & Dobscha, 2013). Predictors of initial abuse included younger age, depression, pain severity, illicit drug use, and smoking (Becker et al., 2009). Those with CP in SUD treatment experience increased drug craving, chronic illnesses, psychiatric illness, and psychological distress (Rosenblum et al., 2003). Treating individuals suffering from CP presents unique challenges, as the substance abuse must be replaced with more adaptive coping

skills despite the persistence of CP. Research studies evaluating treatment of this population are limited to a combination naloxone/buprenorphine treatment, which counteracts the positive effects of opiates. In one such study, 65% of patients continued non-opiate pain medication maintenance, and 5% maintained medication-free treatment. Additionally, pain scores exhibited statistically significant improvement (Pade, Cardon, Hoffman, & Geppert, 2012).

Mindfulness for the Co-Occurring Problem, Is It Feasible?

A literature review of articles from peer-reviewed journals on mindfulness-based treatments of substance dependence and chronic pain supports the feasibility of such treatments for each population individually; however, no studies to date evaluate the effectiveness of mindfulness-based treatments for individuals with co-occurring chronic pain and substance dependence. For chronic pain, mindfulness has been found to reduce: pain, mood disturbances, psychiatric symptoms, avoidant behaviors, and levels of distress; and increase: pain tolerance and psychological flexibility. For substance use, mindfulness treatments have been associated with decreases in craving and withdrawal symptoms, improved working memory, and improved decision-making skills.

Mindfulness for Comorbid Chronic Pain and Substance Dependence

A mindfulness-based treatment for individuals with both chronic pain and substance dependence was created by adapting existing mindfulness-based treatments for these individuals presenting problems. The intervention was designed for use in an inpatient or intensive outpatient setting and consists of nine, two-hour sessions delivered over three weeks. Primary

intervention components include awareness and acceptance of pain through meditation practices (e.g., body scan) as well as mindfulness strategies to cope with substance cravings. The treatment manual pulled interventions and strategies from three primary theories including Ronald Siegel's (2001) work, *Back Sense*; Bowen, Chawla, and Marlatt's (2011) *Mindfulness-Based Relapse Prevention*; and Jon Kabat Zinn's (1985) *Mindfulness-Based Stress Reduction* program. **Figure 1** represents an integration of these three theories. In the model, you can see that stress or injury lead to either muscle tension or directly to physical pain. The experience of pain leads to negative thoughts (e.g., "This pain is miserable.") relating to negative emotions and restricted physical activity (e.g., not going on a walk due to belief that one cannot due to pain). As you continue to review the model, you can see that there is a repetitive cycle between pain, substance use, craving, and avoidance behaviors.

How Does It Work?

The aforementioned integrated treatment utilizes mindfulness techniques and strategies to target factors maintaining the cycle. That is, the goal of treatment is to interrupt the cycle in order to allow oneself to abstain from substance use and decrease chronic pain over time. Through various mindfulness exercises emphasizing stress management, muscle tension decreases, thereby decreasing overall physical pain. A primary mechanism of change in the treatment is awareness of triggers to use substances, triggers to experiencing pain flares, and moment-to-moment experiences. Through utilizing mindfulness techniques regularly, one becomes more aware of these triggers and is better able to manage them in order to prevent substance relapse and pain. In addition, treatment recipients

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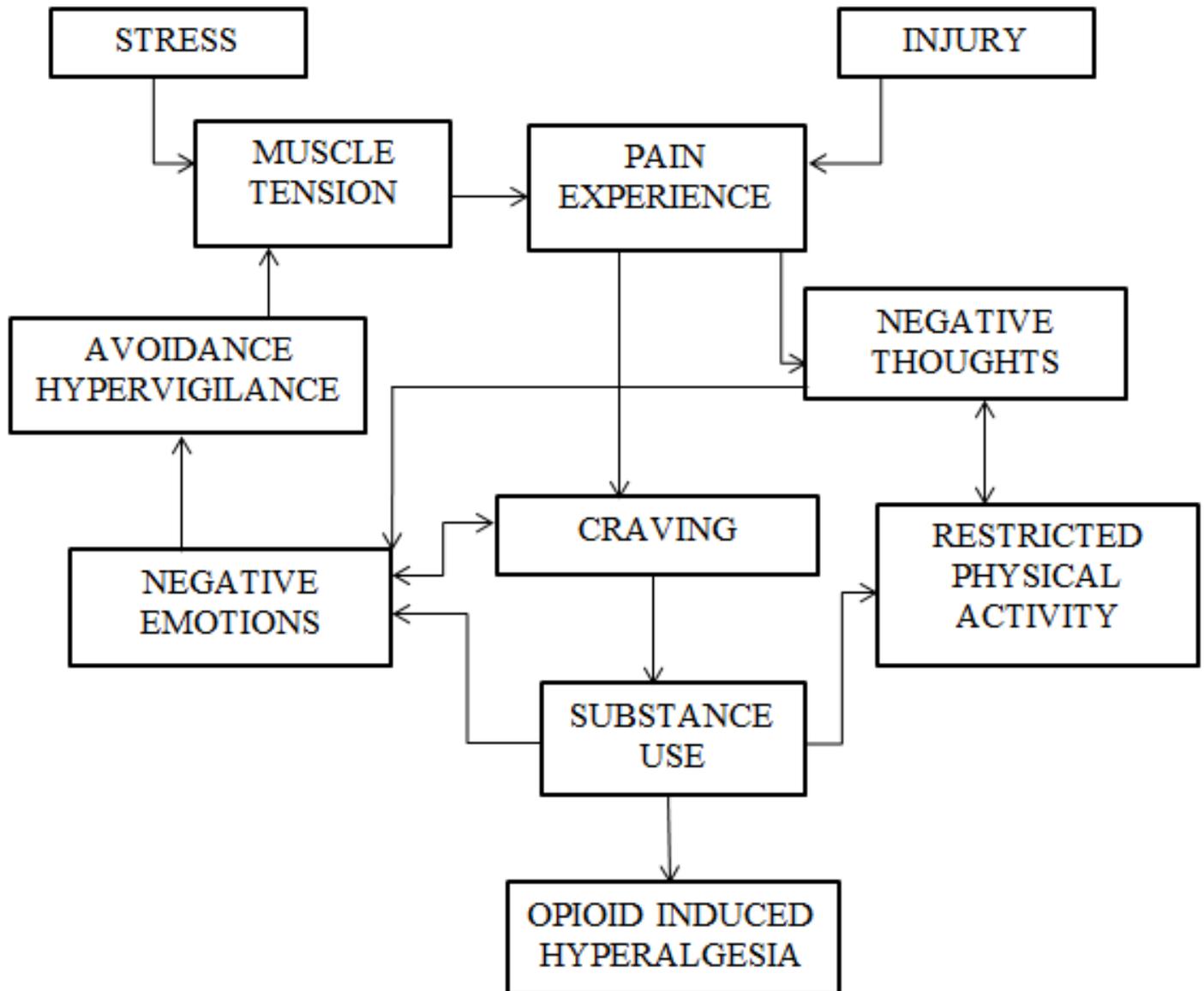


Figure 1. Relationship between pain and substance use

are able to increase life enjoyment through awareness of the present moment. Mindfulness allows individuals to better cope with maladaptive thinking patterns related to their pain and substance use by greater ability to observe thoughts. Those that avoid physical activity due to pain are more likely to suffer from muscle weakness and further injuries. Therefore, a unique aspect of the treatment is to increase willingness to experience pain in order to resume physical activities. Lastly, individuals in the treatment were encouraged to be compassionate toward themselves in order to self-

validate their emotions.

What Are the Benefits?

Mindfulness interventions offer a wide array of benefits beyond decreased pain and abstinence for the comorbid chronic pain and substance dependent population. Specifically, mindfulness has been related to spirituality, which is a construct heavily researched in the substance use field and associated with positive outcomes beyond abstinence. Traditionally, substance use treatment has focused on relapse prevention and cognitive behavioral

interventions. Mindfulness treatment focuses on teaching a new way of living rather than a relapse prevention strategy. In other words, mindfulness as an intervention can go above and beyond being used as strictly for symptom (e.g., pain and substance use) management. Mindfulness teaches individuals to become aware and accept their moment-to-moment experiences including emotions, sensations, and thoughts. This acceptance allows one to become willing to live their lives in a meaningful direction, despite any negative emotions (e.g., anxiety), sensations (e.g., chronic pain), and

thoughts (e.g., “I need a drink.”). In this way, mindfulness offers a unique approach to the treatment of these comorbid problems.

Qualitative findings supported the use of this treatment model in a pilot study of approximately 12 individuals. Subjects self-reported increased physical activity, decreased anxiety, and enhanced psychological well-being following participation in the mindfulness groups for three weeks. Further research in populations of individuals with comorbid chronic pain and substance use is needed in order to appropriately target presenting problems and symptoms that are common among this group. In addition, further trials utilizing mindfulness are needed in order to evaluate the effectiveness of this approach, especially research examining mechanisms of change (e.g., acceptance). In addition, I believe that other third-wave therapies such as Acceptance and Commitment Therapy and Dialectical Behavior Therapy warrant further research in their use with this complex population.

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Mindfulness-Based Treatment for Addictions in Underserved Populations

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Individuals with low socioeconomic status (SES) and members of racial/ethnic minority groups often have high rates of co-occurring health risk behaviors and associated chronic health conditions. They are less likely to receive high-quality healthcare, and rates of treatment attendance and engagement are disturbingly low among low-SES individuals with co-occurring disorders (Brown et al., 2011; Kendzor et al., 2008; Myers, 2009). It is essential to develop and disseminate effective addiction treatments to reduce health disparities for these

underserved populations.

Mindfulness (non-judgmental, present-focused attention) has been incorporated into addiction treatments with considerable success. Bringing mindful attention to thoughts, feelings, and external triggers for substance use may foster more flexible responses instead of automatic reactions (Brewer et al., 2013). Potential mechanisms linking mindfulness to lower risk of relapse include reduced negative emotions and emotional reactivity, decreased automaticity, reduced

attentional bias, and increased tolerance of cravings and withdrawal (Adams et al., 2014).

The majority of research on mindfulness-based treatments has focused on Caucasian and higher-SES samples. Fortunately, there is growing evidence to support the utility of mindfulness in treating substance use disorders (SUDs) in underserved populations (e.g., Amaro et al., 2014; Bowen et al., 2014; Davis et al., 2014; Witkiewitz et al., 2013). However, challenges often arise in implementing mindfulness-based addiction treatment in community settings, including high rates of attrition, little between-session practice, and difficulty managing comorbid symptomology. Mindfulness-based interventions need to be adapted to be culturally sensitive and effective in working with members of racial/ethnic minority groups, individuals from differing religious backgrounds, and those with co-occurring disorders.

Adapting Mindfulness-Based Addiction Interventions for Underserved Populations

Our research team has used qualitative and quantitative methods to investigate ways of tailoring mindfulness-based treatment for addictions in low-SES African American adults with co-occurring disorders. These studies are ongoing and full results will be reported elsewhere. Here, we will share some clinical impressions in terms of suggested adaptations for mindfulness-based treatment with this population. Overall, we have found our clients to be extremely receptive to practicing mindfulness. We hope that these examples will encourage further work in the adaptation of mindfulness-based addiction treatments.

1) Session length and quantity. One of our primary goals has been to enhance the practicality and accessibility of mindfulness-based interventions. Many of our clients maintain multiple psychosocial stressors (e.g., homelessness, unemployment, family demands) while recovering from SUDs, making it difficult to

commit to extensive intervention time. Whereas mindfulness-based Stress Reduction (MBSR; Kabat-Zinn, 1990) includes eight 2-2.5-hour sessions, most sessions in the community-based settings where we work are one hour. We suggest adjusting session length to accommodate established clinic schedules and potentially increasing the number of sessions. Although attrition may increase when adding sessions, those who remain in treatment may experience greater benefit from ongoing group support and guided mindfulness practice.

2) Length of formal mindfulness practice. While MBSR includes meditations of up to 45 minutes per day, we have found 5-15 minutes to be more practical given that our clients rarely have safe, quiet places for formal practice. Our clients often find it more feasible to practice mindfulness informally throughout the day and in specific stressful situations (e.g., in coping with cravings). Over time, clients are often more willing and able to engage in longer meditations. We suggest taking time to problem solve with clients to help them find a safe time and place that fits their meditation goals.

3) Treatment attendance and engagement. We have found that offering an introductory session aimed at orienting clients to treatment, as well as discussing motivation for change and possible barriers to attendance, can help to reduce attrition. Phone call reminders before each session have been well received. In the future, we hope to increase out-of-session contact by scheduling 10-minute individual “check-ins” regarding mindfulness practice and progress toward goals. To increase at-home practice, it has been helpful to have clients mindfully set intentions and record them on note cards (to be used as between-session reminders). Finally, our clients’ levels of motivation appear highest when reflecting on their personal values (i.e., contemplating what is most important to them/what gives their lives meaning, and discussing how their behavior could be more consistent with these values).

4) Literacy and education levels. Given the lower literacy levels of our clients, we have adapted the language we use to teach mindfulness (e.g., asking them to sit in a “proud” versus “dignified” posture). Additionally, we introduce more concrete practices (i.e., mindful eating, mindful walking) earlier in treatment and use visuals to enhance our instruction. Instead of paper homework assignments, we include a closing mindfulness exercise in which clients take a moment to notice how they are feeling, acknowledge what they have taken from the session, and plan to practice something that is consistent with their personal values in the next week.

5) Religion and spirituality. Religion and spirituality (often in the context of Christianity) are common themes in our work with low-SES African Americans. Some clients initially perceive meditation and yoga as Buddhist practices that might be inconsistent with Christianity. We explain that although mindfulness meditation originated in Eastern traditions and is often practiced in the context of Buddhism, we do not teach mindfulness as a religious practice, and we encourage clients to contemplate how mindfulness might relate to their own spirituality. Indeed, several clients have noted that mindfulness has enhanced their relationship with God (e.g., helping them to notice and live in accordance with Christian values, using mindfulness during prayer). We suggest that group leaders discuss potential connections between mindfulness and religion, and even consult with religious leaders to gain more insight into ways of discussing mindfulness and addiction within particular religious communities.

6) Trauma history. Certain aspects of the body scan can be extremely difficult for individuals with a history of trauma (Vallejo & Amaro, 2009). Given the high rates of physical trauma often found in community-based healthcare settings, we moved the body scan from the first to fourth session (of eight), allowing clients to learn and practice mindfulness before undertaking the

body scan. When introducing the body scan, we acknowledge that the exercise may be difficult and emphasize the importance of feeling safe. We also remind clients that they can choose to keep their eyes open and non-judgmentally skip any particularly distressing areas.

7) Comorbid mental illnesses.

We strive to complement clients' individual mental health treatment with mindfulness for dealing with distressing thoughts, emotions, and mental images. With greater mindfulness practice, clients often become better able to recognize uncomfortable internal states, verbally describe them, and accept them for what they are, rather than attempting to push them away. Given that some of our clients have difficulty remaining present in session (often related to medications, psychiatric symptoms, or both), incorporating grounding techniques and physical movement can help to bring the focus back to the "here and now."

Conclusions

We are optimistic about the potential of mindfulness-based interventions to treat addictions in diverse and underserved populations. However, there is still much work to be done in terms of adapting these interventions to

optimize their feasibility, acceptability, and effectiveness. Through our work with primarily low-SES African American clients, we have found several adaptations useful, and we hope that clinicians and researchers will continue to improve upon culturally sensitive mindfulness-based interventions for underserved populations.

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Abstracts

Brown, R. A., Abrantes, A. M., Minami, H., Read, J. P., Marcus, B. H., Jakicic, J. M., . . . Stuart, G. L. (2014). A preliminary, randomized trial of aerobic exercise for alcohol dependence. *Journal of Substance Abuse Treatment, 47*(1), 1-9. doi: 10.1016/j.jsat.2014.02.004

Interventions targeting physical activity may be valuable as an adjunct to alcohol treatment, but have been relatively untested. In the current study, alcohol dependent, physically sedentary patients were randomized

to: a 12-week moderate-intensity, group aerobic exercise intervention (AE; $n = 25$) or a brief advice to exercise intervention (BA-E; $n = 23$). Results showed that individuals in AE reported significantly fewer drinking and heavy drinking days, relative to BA-E during treatment. Furthermore adherence to AE strengthened the beneficial effect of intervention on alcohol use outcomes. While high levels of moderate intensity exercise appeared to facilitate alcohol recovery regardless of intervention arm, attending the group based AE intervention seemed to

further enhance the positive effects of exercise on alcohol use. Study findings indicate that a moderate intensity, group aerobic exercise intervention is an efficacious adjunct to alcohol treatment. Improving adherence to the intervention may enhance its beneficial effects on alcohol use.

Conner, K. R., Gamble, S. A., Bagge, C. L., He, H., Swogger, M. T., Watts, A., & Houston, R. J. (2014). Substance-induced depression and independent depression in proximal risk for suicidal behavior. *Journal*

Objective: Major depressive episodes may be substance induced or occur independent of substance use. Studies of the roles of substance-induced depression (SID) and independent depression (IND) in suicidal behavior are limited to retrospective reports. The purpose of this study was to examine proximal (i.e., acute) risk for suicide attempts associated with SID and IND. **Method:** Individuals who had attempted suicide ($n = 100$) and nonsuicidal controls ($n = 100$) matched for site were recruited from residential substance use treatment programs. Participants were ages 18 and older and screened positive for potential alcohol use disorder. Validated semistructured interviews were used to assess SID, IND, and suicide attempts. Analyses of individual-level risk for attempts were based on multivariate logistic regression that adjusted for risk factors. Population-level attributable risk (PAR) fractions for suicide attempts were also calculated to provide estimates of the percentage of attempts in the study population attributable to SID and IND, respectively. **Results:** SID was identified in 60% of attempters and 35% of controls and IND in 13% of attempters and 3% of controls. Both variables conferred risk for suicide attempt (SID: odds ratio [OR] = 3.73, 95% CI [1.84, 7.58]; IND: OR = 10.38, 95% CI [2.48, 43.49]). PAR for suicide attempts associated with SID and IND was 0.44 and 0.12, respectively. **Conclusions:** Both SID and IND confer proximal risk for suicide attempts after adjusting for other risk factors. SID also contributes substantial risk in this population overall. Future research should test the hypothesis that IND confers greater risk than SID at the individual level.

D'Amico, E. J., Houck, J. M., Hunter, S. B., Miles, J. N. V., Osilla, K. C., & Ewing, B. A. (in press). Group motivational interviewing for adolescents: Change talk and alcohol and marijuana outcomes. *Journal of Consulting and Clinical Psychology*.

Objective: Little is known about what may distinguish effective and ineffective group interventions. Group motivational interviewing (MI) is a promising intervention for adolescent alcohol and other drug (AOD) use; however, the mechanisms of change for group MI are unknown. One potential mechanism is change talk, which is client speech arguing for change. The present study describes the group process in adolescent group MI and effects of group-level change talk on individual alcohol and marijuana outcomes. **Method:** We analyzed 129 group session audio recordings from a randomized clinical trial of adolescent group MI. Sequential coding was performed using the Motivational Interviewing Skill Code (MISC) and the CASAA Application for Coding Treatment Interactions (CACTI) software application. Outcomes included past-month intentions, frequency, and consequences of alcohol and marijuana use, motivation to change, and positive expectancies. **Results:** Sequential analysis indicated that facilitator open-ended questions and reflections of change talk (CT) increased group CT. Group CT was then followed by more CT. Multilevel models accounting for rolling group enrollment revealed group CT was associated with decreased alcohol intentions, alcohol use and heavy drinking three months later; group sustain talk was associated with decreased motivation to change, increased intentions to use marijuana, and increased positive alcohol and marijuana expectancies. **Conclusions:** Facilitator speech and peer responses each had effects on change and sustain talk in the group setting, which was then associated with individual changes. Selective reflection of CT in adolescent group MI is suggested as a strategy to manage group dynamics and increase behavioral change.

Eddie, D., Kim, C., Lehrer, P., Deneke, E., & Bates, M. E. (2014). A pilot study of brief heart rate variability biofeedback to reduce craving in young adult men receiving inpatient treatment for substance use disorders. *Applied Psychophysiology and Biofeedback*.

The present pilot study investigated the implementation feasibility, and efficacy for reducing alcohol and drug craving, of a brief, 3-session heart rate variability biofeedback (HRV BFB) intervention added to a traditional 28-day substance abuse disorder (SUD) inpatient treatment program. Forty-eight young adult men received either treatment as usual (TAU) plus three sessions of HRV BFB training over three weeks, or TAU only. Participants receiving HRV BFB training were instructed to practice daily using a hand-held HRV BFB device. HRV BFB training was well tolerated by participants and supported by treatment staff. Men receiving TAU + HRV BFB demonstrated a greater, medium effect size reduction in alcohol and drug craving compared to those receiving TAU only, although this difference did not reach statistical significance. In addition, an interaction effect was observed in analyses that accounted for baseline craving levels, wherein heart rate variability (HRV) levels at treatment entry were predictive of changes in craving in the TAU group only. Low baseline levels of HRV were associated with increases in craving, whereas higher baseline HRV levels were associated with greater decreases in craving from start to end of treatment. In the TAU + HRV BFB group, however, there was no such association. That is, HRV BFB appeared to dissociate individual differences in baseline HRV levels from changes in craving. Given that alcohol and drug craving often precipitates relapse, HRV BFB merits further study as an adjunct treatment to ameliorate craving experienced by persons with substance use disorders.

Fazzino, T. L., Rose, G. L., Burt, K. B., & Helzer, J. E. (2014). A test of the DSM-5 severity scale for alcohol use disorder. *Drug and Alcohol Dependence*, 141, 39-43. doi: 10.1016/j.drugalcdep.2014.05.004

Background: For the DSM-5-defined alcohol use disorder (AUD) diagnosis, a tri-categorized scale that designates mild, moderate, and severe AUD was

selected over a fully dimensional scale to represent AUD severity. The purpose of this study was to test whether the DSM-5-defined AUD severity measure was as proficient a predictor of alcohol use following a brief intervention, compared to a fully dimensional scale. **Methods:** Heavy drinking primary care patients ($N = 246$) received a physician-delivered brief intervention (BI), and then reported daily alcohol consumption for six months using an Interactive Voice Response (IVR) system. The dimensional AUD measure we constructed was a summation of all AUD criteria met at baseline ($M = 6.5$; $SD = 2.5$). A multi-model inference technique was used to determine whether the DSM-5 tri-categorized severity measure or a dimensional approach would provide a more precise prediction of change in weekly alcohol consumption following a BI. **Results:** The Akaike information criterion (AIC) for the dimensional AUD model (AIC = 7623.88) was four points lower than the tri-categorized model (AIC = 7627.88) and weight of evidence calculations indicated there was 88% likelihood the dimensional model was the better approximating model. The dimensional model significantly predicted change in alcohol consumption ($p = .04$) whereas the DSM-5 tri-categorized model did not. **Conclusion:** A dimensional AUD measure was superior, detecting treatment effects that were not apparent with tri-categorized severity model as defined by the DSM-5. We recommend using a dimensional measure for determining AUD severity.

Flaherty, M. T., Kurtz, E., White, W. L., & Larson, A. (2014). An interpretive phenomenological analysis of secular, spiritual, and religious

pathways of long-term addiction recovery. *Alcoholism Treatment Quarterly*, 32(4), 337-356. doi: 10.1080/07347324.2014.949098

The emergence of recovery as an organizing construct has sparked interest in mapping the varieties of addiction recovery experience. The present study uses Interpretive (qualitative) Phenomenological Analysis (IPA) to examine six-diverse pathways of long-term addiction recovery. Semi-structured interviews were conducted with six subjects representing natural recovery, Twelve-Step (AA/NA) recovery (2), secular recovery, faith-based recovery, and medication-assisted recovery. Common and distinct features of these pathways of addiction recovery are discussed with noted implications for a possible “structure” of recovery and a more modern design of addiction treatment and recovery support services. Qualitative research can be a valuable tool in the elucidation of addiction recovery pathways.

Proctor, S. L., Copeland, A. L., Kopak, A. M., Herschman, P. L., & Polukhina, N. (2014). A naturalistic comparison of the efficacy of methadone and buprenorphine maintenance on treatment outcome: Findings from a retrospective multi-site study. *Experimental and Clinical Psychopharmacology*, 22(5), 424-433. doi: 10.1037/a0037550

Objective: This study sought to compare the effectiveness of the 3 most commonly prescribed maintenance medications in the United States indicated for the treatment of opioid dependence in reducing illicit drug use and retaining patients in treatment. **Method:** Data were abstracted from

electronic medical records for 3,233 patients admitted to 34 maintenance treatment facilities located throughout the United States during the period of July 1, 2012 through July 1, 2013. Patients were grouped into 1 of 3 medication categories based on their selection at intake (methadone [$n = 2,738$; $M^{\text{dosage}} = 64.64$ mg/d, $SD = 25.58$], Suboxone [$n = 102$; $M^{\text{dosage}} = 9.75$ mg/d, $SD = 4.04$], or Subutex [$n = 393$; $M^{\text{dosage}} = 12.21$ mg/d, $SD = 5.31$]) and were studied through retrospective chart review for 6 months or until treatment discharge. Two measures of patient retention in treatment and urinalysis drug screen (UDS) findings for both opioids and various non-opioid substances comprised the study outcomes. **Results:** The average length of stay (LOS) in terms of days in treatment for the methadone group ($M = 169.86$, $SE = 5.02$) was significantly longer than both the Subutex ($M = 69.34$, $SE = 23.43$) and Suboxone ($M = 119.35$, $SE = 20.82$) groups. The Suboxone group evinced a significantly longer average LOS relative to the Subutex group. After adjustment for relevant covariates, patients maintained on methadone were 3.73 times (95% CI: 2.82-4.92) and 2.48 times (95% CI: 1.57-3.92) more likely to be retained in treatment at 6 months than patients prescribed Subutex and Suboxone, respectively. The 6-month prevalence rates of positive UDS findings for both opioids and non-opioid substances were similar across medication groups. **Conclusions:** Comparable rates of illicit drug use at 6 months may be expected irrespective of maintenance medication, while increased retention may be expected for patients maintained on methadone relative to those maintained on Suboxone or Subutex. ψ

Announcements

Postdoctoral Scholars—University of California, San Francisco

Two-year NIH/NIDA-funded positions as postdoctoral scholars in drug abuse treatment and services research are available in a multidisciplinary research environment in the Department of Psy-

chiatry, University of California, San Francisco. The program starts in August 2014. Applications will be considered until all slots are filled. Scholars work with a preceptor to design and implement studies on the treatment of drug dependence, and select a specific area of focus for independent research.

Training of psychiatrists, women, and minorities for academic research careers is a priority. Send letter or interest, CV, research statement, samples of work, and two (2) letters of recommendation to Postdoctoral Training Program in Drug Abuse Treatment/Services Research, University of California, San

Francisco, 1001 Potrero Avenue, Bldg 20, Ward 21, Rm 2127, San Francisco, CA 94110-3518. For more information please visit <http://addiction.ucsf.edu/education/postdoctoral-training> or contact Diane Coseo via e-mail: diane.coseo@ucsf.edu or phone: 415-206-3051.

Postdoctoral Positions— University of Vermont

The University of Vermont's Center on Behavior and Health announces the availability of NIH postdoctoral research fellowships in an internationally recognized center of excellence for the study of substance abuse. **Appointment:** 2-3 yrs. **Eligibility:** Applicants must have completed their training in psychology, behavior analysis, or a related discipline and be U.S. citizens or permanent residents. Trainees are selected on the basis of scholastic record and commitment to a career in substance abuse research. **Benefits:** Salary, health care fee coverage, and travel funds supported by NIH Institutional Training Awards. **For more information:** See the Center's website (www.uvm.edu/medicine/behaviorandhealth) or contact Ms. Diana Cain (Diana.Cain@uvm.edu). **To apply:** Forward curriculum vitae, statement of research interests, and 3 letters of reference to: Attn: Drs. Stephen Higgins, Sarah Heil, and Stacey Sigmon c/o Ms. Diana Cain (Diana.Cain@uvm.edu).

Postdoctoral Positions— Brown University

The Center for Alcohol and Addiction Studies is recruiting for two T32 training programs, funded by NIAAA and NIDA, providing research training on

alcohol, tobacco, and other drug use, dependence, early intervention, and treatment. CAAS research includes laboratory studies of alcohol, tobacco and marijuana use; behavioral and pharmacologic intervention; studies of intervention mechanisms (using electronic diaries, cue reactivity, behav-



ioral economics, genetic markers, and fMRI), and alcohol/HIV research. Training includes structures didactic seminars, supervised research experience, and an intensive mentored grant writing process. Applications are due January 23, 2015 and reviews will continue until positions are filled. For program details and application see <http://www.caas.brown.edu/Content/training/>. Applicants must hold a doctoral degree at the time the fellowship begins and be a citizen or permanent resident of the United States. The Brown University School of Public Health is an Equal Opportunity/Affirmative Action Employer.

ETC Essay Contest: SoAP Graduate Students and New Career Psychologists

The SoAP Education and Training Committee (ETC) announces two travel awards for the 2015 National Multicultural Conference and Summit (NMCS) in Atlanta, January 15-16. Conference details: <http://www.apadivisions.org/multicultural-summit.aspx>

The Contest: \$500 each will be awarded to one graduate student and one new psychologist. Winners will receive a credit on registration fees. To enter, send a one-page essay on why you want to attend the conference and how it is relevant to your career goals and to addiction psychology. The submission deadline is November 15. ETC readers will select two winners, with awardees notified by December 1.

Eligibility: Entrants must be a current graduate student or a psychologist within three years of graduation, and also a student affiliate or member of the Society of Addiction Psychology, committed to attending the NMCS if selected.

Contact: To submit an essay, email Dr. Cynthia Glidden-Tracey, ETC Co-chair, cglidden@asu.edu. Thanks to the SoAP Executive Board for sponsorship.

Invitation to Join ACBS and the AAA-SIG

This may be of special interest now because *Mindfulness*, the topic of this issue of TAN, is a major facet of Acceptance & Commitment Therapy or ACT (pronounced as the word act, not the letters):

There is now an "Applying ACT to Addictions—Special Interest Group" (AAA-SIG) within the Association for Contextual Behavioral Science (ACBS). Those interested in addictions, cutting-edge science and Mindfulness, and especially those in Division 50, are invited to join both ACBS (the cost is nominal and there is much open source information) and the AAA-SIG. Please visit www.contextualscience.org and explore to learn more.ψ

Celebrating Achievements in Addiction

Ray Hanbury Receives SoAP Presidential Citation for Distinguished Service

Dr. Ray Hanbury received a SoAP Presidential Citation from our current Past President, John Kelly, for his outstanding service, dedication, and commitment to the Society of Addiction Psychology. Since co-founding our Division 50 in the 1980s,



Ray Hanbury

Dr. Hanbury has continued from addiction. He was instrumental in leading the charge to get our APA proficiency in the treatment of psychoactive substance use disorders reinstated this year. Thank you, Ray, for your truly distinguished service!ψ

2015 ANNUAL SoAP CALL FOR NEW FELLOWS NOMINATIONS

MANDATORY ONLINE PLATFORM FOR NOMINATIONS AND ENDORSEMENTS

HARD DEADLINE: Friday, January 9, 2015

The SoAP Fellows and Awards Committee invites applications of SoAP Division 50 members for potential election to Fellow status in the American Psychological Association.

NOTE: All SoAP fellow applications must be submitted exclusively via the APA ONLINE PLATFORM in order to qualify. We direct you to <http://www.apa.org/membership/fellows/index.aspx>

Instructions: (The portal is now open):

1. Open the link <http://www.apa.org/membership/fellows/index>;
2. Log into MyAPA using your APA username and password;
3. You will be taken to the Applicant Welcome Page which will be pre-populated with your membership information;
4. Select the division (SoAP Division 50) from the drop-down menu;
5. You will be asked to fill out an **Application** with your educational history, and to state how you meet the criteria for fellow status. You will be asked to attach your curriculum vitae to the Application;
6. You will then be instructed to enter the names and email addresses of your required **three endorsers**. Once you finish the Application, a link is sent to each endorser asking them to complete a worksheet and upload their endorsement statement.

DEADLINE for all materials: Again, Your SoAP Division 50 Fellows and Awards Committee will only consider applications when all materials, including endorsements, are received by the HARD DEADLINE FOR ALL APPLICATIONS AND ENDORSEMENTS: Friday, January 9, 2015

In order to be considered for Fellow status, members must meet both APA and SoAP requirements. APA requirements include: (a) the receipt of a doctoral degree based in part upon a psychological dissertation, or from a program primarily psychological in nature, and conferred by a graduate school of recognized standing; (b) prior APA membership for at least one year and membership in the SoAP through which the nomination is made; (c) active engagement at the time of nomination in the advancement of psychology in any of its aspects; and (d) five years of acceptable professional experience subsequent to the granting of the doctoral degree. The SoAP additionally requires: (a) current engagement in education and training, practice or research in addictive behaviors; (b) at least three of the five years of postdoctoral professional experience in addictive behaviors; and (c) membership in the SoAP for at least one year.

Completed applications are reviewed by the SoAP Fellows and Awards Committee, which submits its recommendations to the SoAP's Executive Board. Nominations are then sent forward to the APA's Membership Committee for final approval. Members of the Fellows and Awards Committee or Executive Board who submit evaluations of a nominee do not vote on that nominee. New Fellows are announced at the SoAP's annual business meeting during the APA Convention.

For further information, please contact Sandra Brown at sandrabrown@ucsd.edu, with a copy to lfitzpatrick@ucsd.edu.



3rd Annual Meeting
 March 6-7, 2015
 Baltimore, MD

COLLABORATIVE
 PERSPECTIVES on
 ADDICTION



For more information:

<http://research.alcoholstudies.rutgers.edu/cpa>

Workshop proposals due October 20 – Symposia proposals due November 20
 Poster proposals to be considered for travel awards due November 20

KEYNOTE SPEAKERS



Carlo DiClemente
 Univ. of Maryland



Tom McLellan
 Treatment Research Institute

CONTINUING EDUCATION

POSTER SESSIONS

SOCIAL HOURS

TRAVEL AWARDS

SPECIALTY WORKSHOPS

Comments from Prior CPA Attendees:

“Best conference I attended all year! Lots of events geared towards students and early career professionals, and great access to many important clinicians, researchers, and NIH staff.”

David Eddie, PhD Candidate, Rutgers University

“The 2013 and 2014 CPA meetings were incredibly well-organized and focused addiction research meetings. Presentations were all high quality, translational, and grounded in basic addiction science while also generating clear implications for novel directions in clinical research/practice. The structure and size of the conference and mix of attendees made for a highly interactive and collegial environment that was conducive to establishing new collaborative relationships with attendees.”

James Murphy, PhD, University of Memphis

“The CPA meeting was a highly interactive and informative forum for exchange between a diverse body of students and professionals in the field of addiction. I was delighted to learn about totally unfamiliar and exciting areas!” **Sarah Feldstein-Ewing, PhD, University of New Mexico**



APA DIVISION 50 (SoAP) POSITIONS, 2014-2015

ELECTED OFFICERS	Alan Budney	President	alan.j.budney@dartmouth.edu	
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CALL FOR AWARDS NOMINATIONS

Deadline March 1, 2015

SoAP (Addictions) seeks nominations for its 2015 awards which will be announced at the American Psychological Association's 2015 Annual Convention.

Please see awards descriptions at: http://www.apa.org/divisions/div50/awards_descriptions.html

2015 Awards:

- (a) Distinguished Scientific Early Career Contributions;
- (b) Distinguished Scientific Contributions;
- (c) Distinguished Career Contributions to Education and Training;
- (d) Presidential Citation for Distinguished Service to SoAP

You may self-nominate or be nominated by a SoAP member. A nomination letter, contact information and CV should be sent to the Fellows and Awards Committee at the following email address: sandrabrown@ucsd.edu with a copy to lfitzpatrick@ucsd.edu

Or you may mail the materials to the following address:

Fellows and Awards Committee
c/o Sandra A. Brown, Chair
University of California, San Diego
9500 Gilman Drive, Mail Code 0043
La Jolla, CA 92093-0043

For further information, please call Lucy Fitzpatrick at 858-534-3527.

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