The Addictions Newsletter

The American Psychological Association, Division 50

SPRING 2013

Contents

President's Column

I'm Doin' This ... Why?

Sara Jo Nixon

While most of us take comfort that the Mayan calendar was incorrect, we cannot ignore the epidemic of local, regional, national, and international issues vying for our involvement in 2013. The ravages of Super Storm Sandy are not yet repaired, senseless shootings continue, "Equal Rights" remains little more than a bumper sticker in some areas, our military personnel remain in harm's way, too few children have the benefit of being read to at night (knowing more of the words to Beyoncé's "Single Ladies" than the name of their governor (this may not be an age-restricted fact)), and federal budgetary woes impact a nation's future. These are today's realities. Fortunately, with increasing frequency, psychologists are viewed as essential responders, recognized for the breadth of our expertise. Community and legislative leaders realize that psychologists integrate evolving knowledge from a variety of domains to inform a) behavioral interventions, b) the building and sustaining of group cohesion, c) methods to effectively integrate pharmacotherapy, and d) the development and conduct of front-line prevention, intervention, and therapy, for some of the most devastating illnesses that we face. Psychologists have never had so great an opportunity to engage and so great a responsibility to engage effectively throughout our communities. This "call" for engagement for our Society is too loud to be missed! Understanding risk and resilience, exploring the similarities between substance and process addictions, working with other health professionals in screening development and interpretation, ensuring that quality, integrated care is available and accessible, recruiting, training, and retaining the best and brightest of our graduates to ensure a diverse and qualified professional base. And on and on.

Sara Jo Nixon

This growth brings with it a cost. We must be efficient consumers of information and more effectively work within and across

Collaborative Perspectives on Addiction Meeting Is Launched!

SoAP and Division 28 host our first mid-year conference for addiction psychologists

May 3-4, 2013 — Atlanta, GA
See pages 19 and 24

Register now at http://tinyurl.com/2013CPA

networks to secure maximum benefit. All of this while sustaining our existing tasks, client loads, and families. No wonder many of us are simply tired and wondering "Why am I doing this?"

Good question. The immediate answers typically center on job definition (e.g., "Well, it's my job"), or a belief in improving outcomes for others (e.g., "We want to nurture recovery"). These responses are perfectly acceptable reasons. But they don't speak to the *personal* investment that accompanies the action. Too often, we sacrifice what are the best parts of our own "selves" without realizing it until we find ourselves unhappy, burned-out and angry. We cannot be maximally effective in this new "world" under these circumstances.

I understand that some of our colleagues avoid or at least minimize the time they spend in this pit. Perhaps their success lies in their ability to appreciate their core qualities, regardless of what task they undertake. In reviewing the potential depth of these issues, it is clear that professional help may be required, particularly if the workplace or home is abusive with emotional bullying, for example. However, for others of us, it is simply a matter of losing ourselves in our jobs. We like(d) our jobs, the challenge, and the pace. Then one day, we found we were one *with* the job! Perhaps there is something we can do to help us meet our increasing responsibilities *and* retain an appreciation of ourselves. Without using professional labels, try something please, identify at least three charactertistics that *you* like about yourself. Don't rely on the last week or last 6 months: Think back, maybe to when you were in high school (too ugly?, okay, try graduate school). Quick wit? Trusted? Enjoy helping friends? Generous? Empathic? Accepting? Gentle? Laid-back?

After making a list, consider to what extent you currently experience these characteristics on a regular basis. If you're not happy with the extent to which these qualities are currently expressed, think about what circumstances are constraining them. Talk with a trusted friend who might help you examine your options and follow-through with your ideas. For me, the answer wasn't difficult (I need to be more involved in community efforts). BUT the trick is getting someone to hold me accountable!

In closing, it's an exciting time and part of this excitement lies in the CPA conference in May. If you haven't registered yet, don't miss the opportunity. With the keynotes, the workshop, the breakout sessions, and the integrated social events, there will be plenty of opportunities to exchange research ideas, discuss collaborations, and determine how other folks are maximizing their core qualities!

See you in Atlanta!ψ

SoAP Member Services

Join SoAP: www.apa.org/divapp

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

Website: www.apa.org/divisions/div50

Listservs: To join the discussion listserv (discussion among members), contact Vince Adesso at vince@csd.uwm.edu. To join the announcement listserv (for division news), send a request to Keith Cooke at kcooke@apa.org.

Journal: You can access the journal online at www.apa.org via your myAPA profile. Log in with your user ID or email and password.

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

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

Editor's Corner

Melissa A. Lewis

It is that time of year again. We are getting ready to elect new candidates to office. Please take a moment to get to know our SoAP candidates so that you can be prepared to make an informed vote this May. Also in this issue, David Eddie discusses what to disclose, or what not to disclose, in important career interviews. Check out the many updates and announcements for our upcoming conferences. We hope to see you in Atlanta and Honolulu!

Recently, we have seen substantial changes to marijuana laws in both Colorado and Washington State. In this issue, we have three articles focused on marijuana. First off, Roger Roffman and Derek Franklin present a thoughtful dialogue between a proponent and an opponent of Washington State's marijuana legalization law. Jason Kilmer and Christine Lee discuss important research questions that we need to consider in regards to these legal changes. Finally, Lorraine Collins and Paula Vincent present novel and exiting research examining the impact of exercise on marijuana craving. In addition to these articles, this issue includes an article by Tom Horvath, who shares with us how to make a referral for addiction treatment. Our final article, by Leah Barreca and colleagues, presents findings on mental health providers' evaluations of alcohol misuse and substance dependence.

For the next issue of *TAN*, please send in your articles that focus on addictions research among underserved or hard-to-reach populations. As always, articles focused on different topics are welcome. Wanting to see articles on a specific topic? Send your topic ideas to me for upcoming issues.

Please send all submissions for the Summer edition of *TAN* to me at edtan@uw.edu by **June 3rd, 2013**. Looking forward to seeing your entries!ψ

Announcing Candidates for the SoAP Offices

William Zywiak
Chair, SoAP Nominations and Elections Committee

This year we will vote for candidates for two offices. I would like to thank Alan Budney for running for President-Elect. I would also like to thank Serena Wadhwa and Mark Schenker for running for Member-at-Large (Practice). As you will read below, all three candidates are well qualified. Thanks to all three for devoting considerable time and energy to SoAP. I would also like to thank those who have served on the Nominations and Elections Committee at some point in the last 6 years: Tammy Chung, Selene Varney MacKinnon, and Krista Lisdahl. A special thanks to Tammy Chung for providing the initial nomination of Alan Budney. My second term as Chair of the Nominations and Elections Committee will end this August. If you are interested in this non-voting office on the Board, please contact myself or John Kelly. Thank you to each and every one of you who took the time to email me to nominate one or more of the candidates. **Please remember to vote in May!**

President-Elect

Alan J. Budney

I would like to thank those who were so kind to nominate me to run for President-Elect of SoAP. I have been a member of the Division for many years, and I feel my 23 years of experience as a clinical scientist in the substance abuse arena, and my tenure as President of Division 28, have prepared me to act as an effective leader for the Society of Addiction Psychology. I would highly value the opportunity to lead and become involved in the Division's activities, as this will afford many present and future opportunities to influence addiction science and practice.

My experiences that make me a viable candidate include the following: I served as President of Division 28 in 2005, and chaired their continuing education committee. This experience provided a wealth of knowledge about the operation of the APA, the administration of an APA Division, the opportunities to influence the organization, as well as a greater understanding of the barriers to affecting change. I am currently on the Board of Directors of College on Problems of Drug Dependence, and previously chaired its membership committee and served on its program committee. Most recently, I finished a 5-6 year tour of duty on the DSM-5 Substance Use Disorders Work Group. As many of you know, this was an arduous task that generated much controversy, as it highlighted the interplay and contradictions of science, practice, and politics. I have served on many NIH grant review committees, the editorial board of two substance abuse focused journals, the Office of National Drug Control Policy's Marijuana Use Prevention campaign, and I review for the National Registry of Effective Programs and Practices.

Alan J. Budney

I am currently a Professor in the Psychiatry Department at the Geisel School of Medicine at Dartmouth. I recently transitioned to Dartmouth after spending 7 years as a Professor at the University of Arkansas for Medical Sciences. Prior to that, I spent over 15 years at the University of Vermont. I received my PhD from Rutgers University. I have been a licensed psychologist since 1990. My research has been funded by NIH-NIDA since 1993, and has focused on the development of behavioral treatments for substance use disorders, and laboratory studies focused on characterizing cannabis withdrawal.

What might I like to accomplish if I am elected President of the Division? My interests and efforts would likely focus on the following: (1) Encourage continued efforts toward development of more effective intervention and prevention strategies for those suffering from or at-risk for addictive disorders; we cannot be satisfied with outcomes achieved by current approaches. (2) Focus on the transportability of novel and evidence-based intervention strategies to community settings; a revamped health care system may provide multiple opportunities to influence how care is delivered to those with addictive problems. Behavioral and technological innovations will afford many such possibilities. (3) Enhance our efforts to lobby for the need to increase research funding to support continued progress in the development and dissemination of more effective interventions. (4) Last, I would hope to continue the important efforts initiated by the prior leadership, recognizing that it can take more than a single year to initiate and complete even modest actions.

Member-At-Large (Practice)

Mark Schenker

I am pleased to be considered for Member-At-Large of SoAP, and ask respectfully for your vote.

Despite the pervasiveness of addiction in the clinical population, most psychologists and other clinicians are poorly prepared to assess and treat these problems. While I have worked

Mark Schenker

primarily in the clinical world, a significant focus of my work in the last 20 years has been disseminating information about addictions treatment to mental health practitioners in general. I have been supervising psychologists, interns, and psychiatric residents for much of my career. I have presented numerous workshops at national and international conferences. My recent book (Schenker, 2009), a clinical primer on the 12-Step program, was written in this spirit.

To make our work meaningful and relevant we must blend our empirical knowledge with the perspective of clinical experience. My own work owes a great deal to my humanistic and idealistic background, and I remain committed to integrating this view with our research findings. Much empirical research does not neatly transfer into a clinical setting and we must respect the judgment of those who actually use these tools.

In my primary position at the Caron Foundation I oversee adult psychological services and provide direct service. In my private practice I take an eclectic approach, using motivational and transtheoretical perspectives in addition to the 12-Step model; I am guided by research demonstrating the importance of the therapeutic relationship in effecting clinical change.

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

Thank you for your consideration.

Member-At-Large (Practice)

Serena Wadhwa

Thank you to those who nominated me. It is an honor to be considered as a candidate for the Member-At-Large position for SoAP.

Academically and professionally, I am an assistant professor in the Addictions Studies Department at Governors State University. I coordinate the addictions counseling concentration, bridging the clinical psychology/counseling and addictions perspectives together. I was on the committee to augment the core addictions studies program. I provide supervision to students who want to work in the addiction field and integrate psychology and counseling. I am a co-investigator on a study that looks at sexuality issues and addiction and a principal investigator looking at drinking patterns in the East Indian population. I am a reviewer for several additions-related journals. I am also a member of the IPA, APA (and several divisions), Society for the Teaching of Psychology, ICA, IMHA, ACA, and the Chicago Writer's Association. I served as a consultant for the Great Lakes Addiction Technology Transfer Center, where I disseminated, interpreted, and assisted in implementing information related to best practices to various

Serena Wadhwa

communities in the Midwest.

Clinically, I provide individual therapy through the Alexian Brothers Outpatient Group Practice and work with individuals who struggle with addiction. I also run a Dialectical Behavior Therapy group. I have the unique opportunity to "see" how current science of addiction, psychology, and counseling work in field.

As a Member-At-Large, I want to encourage and bring more awareness of addiction issues to the community, reduce stigma associated with these struggles, and work on finding more resources to help individuals, communities, and families begin healing. Finding unmet needs by current approaches and helping to bridge this gap is something I want to focus on. Finding ways to fund early career practitioner liaisons and cultural competency within the addiction psychology field is a goal. Additionally, continuing the tradition of financial advocacy for research and clinicians, evidence-based and individual-based practices are opportunities I will seek to advocate. As a clinician, educator, and an advocate for what works for an individual, I hope to share opportunities, bridge gaps, and form collaborative relationships.ψ

Student and Trainee Perspectives

David Eddie, Student Representative

The question about how much to self-disclose in graduate school, internship, and early career job interviews gets thrown around a lot in student columns. Realistically though, for the majority of interviewees, this issue doesn't present too much of a concern. You hope the interviewer won't ask anything too weird about your experiences in therapy and you get to the task of telling him or her the fascinating story of how you came to be interested in the field, and how it's informed your work to date. This, of course, is how we sell ourselves in an interview, as well as in application materials like statements of purpose.

How we came to be interested in our sub-specialty is also a question we get asked a lot outside of the interview setting, especially when we work with clinically challenging populations. Tell people you work with folks with certain tough-to-manage disorders and it usually garners the question, "why would you voluntarily choose to do that?!" Of course, the fact a disorder is tough to treat is part of the reason many people are drawn to their specialty. There are many too who decide to work with a specific population for very personal reasons. Maybe a family member has been afflicted, or possibly the person him- or herself. This doesn't present a great many professional challenges if one is afflicted with an interesting, non-stigmatized disorder—for instance, synesthesia. I remember hearing one graduate student dub his research in this area "mesearch," as he himself experiences this curious neurological phenomenon.

But what about those whose affliction carries a lot of baggage, such as addictive disorders? I was forced to consider this point recently as I interviewed a potential undergraduate research assistant for my advisor's lab. He quite matter-of-factly disclosed his recovery status as being his primary motivator for applying to work in an addictions research laboratory, and his decision to ultimately pursue a doctorate in clinical psychology. While I quite appreciated his refreshing honesty, I wondered how he would fare sharing this information with other interviewers.

I thought too of how seldom I hear about people working in addiction psychology who are themselves in recovery. This is in stark contrast to the many master's level counselors whom I regularly interact with in the addictions field, who are quite openly in recovery, and frequently talk about their substance use histories with their employers and clients. In fact, many counselors in drug and alcohol rehabilitation facilities are alumni of their places of work. For addiction psychologists, however, discussion of such matters is not part of our professional culture. Of course, this may simply be because there just aren't as many psychologists in recovery, possibly attributable to the considerable challenges associated with pursuing a career in psychology. The necessity of completing a long doctoral degree program means it is unfortunately not a practical option for many people who get sober, and decide to work in addictions.

There are still many people who have gotten sober and successfully navigated the treacherous waters of a doctorate in psychology. I asked some such individuals about the sort of challenges they faced.

Yet in spite of these obstacles, there are still many people who have gotten sober and successfully navigated the treacherous waters of a doctorate in psychology. I asked some such individuals about the sort of challenges they faced during graduate school, and later on in professional life, as well as how they have handled these challenges. Those I spoke with who have chosen not to disclose their recovery status cited having to routinely lie about their initial interest in the field as one of the greatest nuisances of non-disclosure. For established psychologists, this comes up over and over again in the form of the ubiquitous question, "Why addiction psychology?" Some reported using a canned story that's as close to the truth as possible without giving away too much personal information. This may be well and good for polite conversation, but what about in graduate school and internship application processes? One usually has to tell one's story in a statement of purpose, and then tell it again in an in-person interview. The advice here seems to be the same. If you don't want to disclose your addiction history, have the most honest story you can have without giving away too much, and stick to it. Of course, there is always the option to simply disclose. However, most did not favor this tactic, citing the risk of discrimination, as well as the potential for getting drawn into an inappropriate or uncomfortable conversation that may draw the focus of an interview away from the applicant's qualifications and research. Worse yet, there is the chance one may find oneself defending one's current psychological stability in spite of what could be years of stable recovery. There was, additionally, a third path proffered, which is the tactic of partial disclosure. For example, a statement like "I have personal experience with addictive disorders, but would prefer not to discuss this issue further" can be effective. Although such statements are

no doubt fine in some situations, they don't make for a great opening line for a statement of purpose!

Though no doubt most psychologists would be unlikely to judge someone harshly for having suffered from an addictive disorder at some point in their life, there is always the risk for discrimination. For instance, if a faculty member is given the choice between two graduate students who are equal on all measures, except one has a history of alcohol dependence, he or she may very well be inclined to err on the side of caution and go with the person without a history of substance dependence. Graduate students are a huge investment, which may explain a faculty member's desire to play it safe. For this reason, the advice from established addiction psychologists was largely to not disclose, unless it is absolutely necessary, especially during the graduate school application process.

While interviewees recognized certain inherent challenges in studying or treating a problem so close to home, none had any regrets about their chosen path, insisting that they are better psychologists for their personal experiences. The take-home message seemed to be, it's not always easy, but people with personal experience with addictions bring a lot to the table, and should be strongly encouraged to pursue careers in addiction psychology.ψ

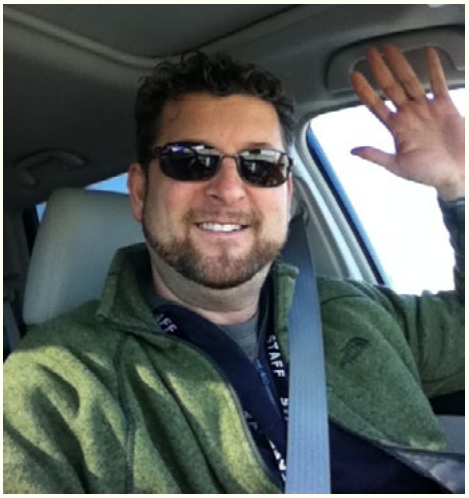
New Member Spotlight: Brian Konecky

Amee B. Patel, Secretary

For this issue, we interviewed new full member Brian Konecky, a postdoctoral fellow at the Veterans Affairs VISN 17 Center of Excellence for Research on Returning War Veterans and the Central Texas Veterans Affairs Health Care System in Waco, Texas. He completed his doctorate at Idaho State University and his clinical internship at the Southern Arizona Psychology Internship Consortium (SAPIC).

What are your research and clinical interests?

My current research focuses on evaluating post-traumatic stress disorder (PTSD) and co-occurring substance use disorders in veterans. I am particularly interested in PTSD and substance use among female veterans and stigma about and barriers to accessing mental health services. My graduate work evaluated impulsivity and delay discounting among adolescents with conduct disorder-type behaviors. I continue to be interested in delay discounting in decision-making and hope to develop studies evaluating this process in other populations. Clinically, I began working as an addictions therapist and have since specialized in treating dual diagnosis issues. I have worked in forensic, outpatient, and inpatient settings with both youths and adults. I am currently pursuing training in therapies focused on treating PTSD and co-occurring substance use.



Brian Konecky

With what other activities are you involved?

Education and training is also important to me and I am interested in developing skills and experiences for students interested in pursuing a career in mental health. I currently serve as the primary supervisor for our undergraduate volunteers at the Center of Excellence and teach a graduate-level course in marital and family therapy at Baylor University. I also am interested in advocacy and policy efforts for underserved and marginalized populations and issues related to cultural competence.

How did you first become interested in addiction psychology?

Prior to graduate school, I volunteered at a residential substance abuse program and became interested in addictive behaviors as a whole. As I continued training in the field, I grew more interested in the mechanisms underlying addictive behaviors and the interplay between substance use disorders and other mental health issues.

How did you hear about the Society of Addiction Psychology (SoAP)? What motivated you to join?

I first heard about SoAP through my graduate school mentor, Tony Cellucci. After getting a poster accepted for APA while in graduate school, he encouraged me to join SoAP to meet other psychologists interested in addictions research and clinical work. I greatly appreciate the work of those who have served in SoAP and hope that I can contribute in a meaningful way as my career develops.

What program or initiatives would you like to see SoAP address in the future?

I have appreciated SoAP's encouragement and outreach to students and early career psychologist and hope that they continue programs that foster this engagement. SoAP has made great efforts to disseminate information on addictions and provide opportunities to get involved, and I hope that they continue to make these resources and opportunities readily available.ψ

2013 APA Convention in Honolulu, Hawaii

Jen Buckman, 2013 SoAP Program Chair

Perfect Venue, Perfect Topic!

You must all agree because this year we had an unprecedented response both to the general APA Call for Submissions and to SoAP's specific Clinical Neuroscience theme! No one can deny that neuroscience is psychology's not-so-distant cousin, but surprisingly, the dialog between these fields can be remarkably limited. This year we will try to reverse that trend.

The program we have put together includes many cutting edge presentations on clinical neuroscience theory and research, all of which emphasize how clinical neuroscience can advance prevention, intervention, and treatment of addictive disorders. Here's a preview of our neuroscience-related convention events:

- "Neurobehavioral Deficits in Addicts: Implications for Life and Recovery"
- "Getting to the Heart of Addiction Neuroscience: HRV & Behavioral Flexibility"
- "Translating Neuroscience Findings Into Practical Drug Abuse Prevention"
- "Contributions of Neuroscience to the Treatment of Alcohol Use Disorders"
- "Novel Strategies for Understanding the Role of Genetics in Alcoholism and Drug Addiction"
- "Gender Differences & Substance Abuse Treatment: The Lab, the Clinic & Health Care Reform"
- "Integrating Neuroscience Into Clinical Practice in Addiction"

SoAP and the 2013 Program Committee carefully selected our program to be of interest to psychologists in research, clinical practice, and professional training. We will offer eight symposia, one Clinicians Panel Discussion, one superlative Presidential Address, and one skill-building workshop at the convention. We are hosting three poster sessions, including our first-ever Joint Poster Session with both Division 28 (Psychopharmacology & Substance Abuse) and Division 6 (Behavioral Neuroscience). These sessions will present up-to-date clinical research on a broad range of addictive behaviors. We encourage everyone to attend.

As in previous years, we have developed our program in close collaboration with Division 28. They too have an outstanding program planned, as do many other divisions who will be sponsoring events that will be directly relevant to SoAP members. Be sure to check out Division 28's events and all the convention events that are co-listed by Division 50 in the APA Program.

Some special points of interest to keep in mind as you plan your travel:

- Because of the enormous response to our Call for Proposals, we will be hosting events throughout the entire meeting. That means the SoAP events start at 8:00 am on Wednesday, July 31st and continue through 1:00 pm on Sunday, August 4th. After all, you can't travel to Hawaii for just a few days! So, be sure to stay for the whole thing.
- We invite all SoAP members to join us at our yearly Social Hour that is held in collaboration with Division 28, the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the National Institute on Drug Abuse (NIDA). This Early Career Social Hour and Poster Session is a wonderful opportunity to support student and other early career members as they showcase their latest work. We particularly encourage established psychologists to attend and mingle. Hors d'oeuvres will be served.
- We want to remind you that the annual SoAP Business Meeting will be held at the convention and is open to all members. At this meeting, we will discuss the past year's activities of the Executive Board and all SoAP committees, and distribute awards to SoAP members who have made outstanding contributions to the field.

I can't wait to see you all in Hawaii! I also hope to see many of you at our Collaborative Perspectives on Addiction meeting in Atlanta, Georgia (May 3-4, 2013).ψ

Washington State's Marijuana Legalization Law: A Dialogue Between a Proponent and an Opponent

***Roger Roffman** (www.rogerroffman.com) is a marijuana dependence researcher and professor emeritus of social work, University of Washington. He was a co-sponsor of I-502.*

***Derek Franklin** is President of the Washington Association for Substance Abuse and Violence Prevention (www.wasavp.org), and Project Director of the Mercer Island Communities That Care Coalition.*

On November 6, 2012, Washington State voters approved Initiative-502, thus setting in motion planning for a legal regulated marijuana market. The Washington State Liquor Control Board, during a year-long rule-making process, will issue licenses to marijuana growers, processors, and retailers (I-502 Implementation, 2012). By early 2014, adults 21 years or older will be able to purchase marijuana and marijuana-infused products in stand-alone marijuana stores.

We see eye to eye about the very real risks of marijuana abuse and dependence (Hall & Pacula, 2003; Roffman & Stephens, 2006), accidents involving driving under the influence (Hartman & Huestis, 2012), and particularly the harms faced by adolescents who begin use early and subsequently use marijuana regularly (Kuehn, 2012; Rubino, Zamberletti, & Parolaro, 2012). Despite our areas of agreement, in the months leading up to the election we strongly disagreed about the initiative.

Roger: "For me, it added up to prohibition being far-too-ineffective in preventing harm and the initiative offering a compelling alternative via a solid public health approach. The initiative's earmarked tax revenues, a new and substantial revenue stream for science-based marijuana education, prevention, treatment, and research, led me to feel hopeful that this already widely available and popular drug would be used more safely." (Roffman, 2012)

Derek: "And for me, legalization represented the nuclear option to a problem distorted by rhetoric and misperceived norms. It failed basic prevention principles by creating more problems for enforcement, increasing access to the drug, and eroding protective attitudes and beliefs. I saw the initiative's public health and safety provisions to be inadequate compared to the market forces inherent to a commercialized marijuana industry. It seemed lessons from alcohol and tobacco were being ignored."

Roger: "I guess I'm more optimistic about what we can do in shaping protective attitudes and norms. Look, given the prevalence of use and 'pot's no big deal' attitudes, can we really say we've done even an adequate job under prohibition? With the hefty tax revenues from legal marijuana, youth drug prevention programs that we know are effective will be funded throughout our state. I don't know for certain how access to marijuana by minors will be affected, but I put more stock in accurate education and proven prevention programs in protecting youth."

Derek: "I agree that it is incumbent upon us to now bring to bear all the best science-based prevention strategies. However, that same science suggests that increasing population-level access to another addictive drug will increase its use, and with increased use comes increased harm. No, we do not yet have the social experiment (we have just begun it) to know just how much underage marijuana use will increase under legalization; but I submit we can safely predict it will. Looking at the California RAND study foreshadowing legalization outcomes (Pacula, 2010), the increase in underage use in "medical" marijuana states (including Washington), our state's proven history of raiding prevention dollars, or reports that 'Big Tobacco' is eyeing our fledgling marijuana industry—I feel more concerned than pessimistic. Among other key reasons, youth reported not using marijuana because it was illegal. Indeed, prohibition has problems, but one thing it does right is lower rates of substance use. Instead of legalization, I believe enforcement reforms, adequately funding prevention and treatment, and keeping 'medical' cannabis in the hands of doctors would ultimately have been a better path towards harm reduction and social justice."

Roger: "You paint a pretty bleak picture, Derek. History will tell which of us was more accurate in forecasting. As you know, some of the marijuana tax revenues will be used to evaluate the law's impact over a number of years. When the Washington State Institute for Public Policy reports its findings in 2015, 2017, 2022, and 2032, I expect to see: reductions in marijuana use disorders, fewer automobile accidents in which a driver was impaired by using marijuana, fewer young people initiating marijuana use in their early teens, and fewer marijuana-related dropouts from school. If our state gets it right in how it implements the initiative-funded harm reduction components of this new policy, I think we'll have fewer victims even if marijuana is as or more popular than it is now. I have to admit, though, that people like you and I will need to hold our state officials' feet to the fire when the industry's profit motives fuel efforts to water down the initiative's harm reduction emphases, for example the restrictions on advertising."

Derek: "I find myself wondering about the limits of the harm reduction model itself, in this case, specifically because of our inability to control for key variables like profit motive. I might envision a rosier picture of legalization if it were to take place in a vacuum protected from the pressures of capitalism, oppression, and a culture of immediate gratification. However, as it is, I remain unconvinced that the protective measures stipulated in I-502 will be enough to overcome these deep-seated influences and our youth will ultimately suffer. That said, I am not without hope. The fact that a majority of our population, over 90%, does not use marijuana reminds me of the sizeable reservoir of untapped healthy community attitudes and behaviors largely ignored in the prohibition vs. legalization narrative. Moving ahead, perhaps assertions in the current marijuana debate about social injustice can be further leveraged to peel back another layer of the onion to explore the broader impact of legalization on issues of racial disparity and social inequality—at this level I bet we'll find much more upon which we agree."

Roger: "I'm glad you mentioned the majority who don't use marijuana. It also needs to be said that large percentages of people, both youth and adults, either don't consume alcohol or other drugs or, if they are consumers, do so without adverse consequences. Despite market forces and popular entertainment influences that encourage consumption, much of our population manages to steer clear of alcohol/drug problems. For them, it's normative to avoid abuse. If more states legalize marijuana, I suspect it will reflect a tipping of the scales in public awareness, derived partly from personal experience, that marijuana can be used without harm and that the societal costs of prohibition, including the inequities in enforcement, are unsupportable. I think you're wondering, though, if we are 'throwing under the bus' those parts of the population, youth in particular, who will be more vulnerable to abusive consumption."

Derek: "The issue of what is an acceptable cost to bear for the 'great marijuana experiment' is certainly germane to the discussion. To me, legalization wagers the right for youth to grow up drug free against the hope that we can do with cannabis what we've failed to do with tobacco or alcohol. I think this is a bad bet. As we know, the baseline under prohibition is that Washington youth said legal alcohol and illegal marijuana were equally easy to get, yet reported using alcohol twice as much. So, although no one has yet tried to implement science-based prevention strategies in a legal marijuana marketplace, that is now our shared task and responsibility. My association has put forth several provisions we think can help, including: ban marijuana advertising, limit outlet density, require product safety labels (health and DUID), limit purchases per day, ban product sampling, increase funding for enforcement/prevention/treatment, implement social host laws, ban internet sales, require state residency for purchases, repeal our redundant medical marijuana law, and consider a trigger point for automatic repeal or suspension of the law should underage use increase. As the flood gates open for the 'New Gold (Green?) Rush,' we must look beyond awareness and education to the social norms and policies that can keep marijuana from going the way of tobacco in the 1950's."

Roger: "I feel all the more hopeful because your association is actively advocating for youth prevention-focused regulations as the Liquor Control Board does its year of planning for how the legal market will operate. Similarly, those of us in treatment and prevention will need to work with our state's Departments of Health and Social and Health Services, lobbying for the best uses of initiative tax revenues in funding science-based marijuana education, prevention, and treatment. Maybe, Derek, our state's wealth of expertise in the substance abuse field bodes well for our getting this right. A final thought. Let's plan to write a sequel to this dialogue piece a few years down the road when we'll know a good deal more about how our shared concerns and somewhat differing projections played out."

Derek: "I hope my projections are wrong. Earlier this week, at the LCB public forum in Seattle where input on rule-making was sought, the pro-legalization movement outnumbered health and safety advocates 100:1. I share your faith in the power of prevention and hope we can build adequate capacity to keep Washington kids safe in a commercialized marijuana marketplace. In the meantime, I will fully support the protective measures in I-502 and fight for more, while continuing to advocate that other states follow a wholly different path."

References

Hall, W., & Pacula, R. L. (2003). *Cannabis use and dependence: Public health and public policy*. Cambridge: Cambridge University Press.

Hartman, R. L., & Huestis, M. A. (Dec. 7, 2012). Cannabis effects on driving skills. *Clinical Chemistry, 59*.

I-502 Implementation (2012). Washington State Liquor Control Board http://liq.wa.gov/marijuana/I-502

Kuehn, B. (2012). Marijuana use starting in youth linked to IQ loss. *Journal of the American Medical Association, 308*, 1196.

Pacula, R. L. (2010). Examining the impact of marijuana legalization on marijuana consumption: Insights from the economics literature. RAND Drug Policy Research Center. http://www.rand.org/content/dam/rand/pubs/working_papers/2010/RAND_WR770.pdf

Roffman, R. (November 10, 2012). Op-Ed: What parents should say to teens about I-502 and marijuana legalization. *Seattle Times*. http://seattletimes.com/html/opinion/2019648432_rogerroffmanopedxml.html

Roffman, R. A., & Stephens, R. S. (Eds.). (2006). *Cannabis dependence: Its nature, consequences, and treatment*. Cambridge: Cambridge University Press.

Rubino, T., Zamberletti, E., & Parolaro, D. (2012). Adolescent exposure to cannabis as a risk factor for psychiatric disorders. *Journal of Psychopharmacology, 26*, 177-188.ψ

Research Questions in a Shifting Legal Climate

Jason R. Kilmer and Christine M. Lee, University of Washington

On November 6, 2012, voters in Washington and in Colorado approved initiatives that legalized use of marijuana for recreational use. Although both initiatives have significant differences and both states will be considering implementation issues at various deadlines throughout the next few months, the passing of these initiatives certainly represents an unprecedented shift in policy. Now, more than ever, the opportunity exists to consider implications from the published scientific literature and to conduct prospective research.

The following are just a few of the possible research questions to be considered by states already undergoing such changes as well as those considering similar ones.

How will use by youth and adolescents be affected?

According to the Monitoring the Future study (Johnson, O'Malley, Bachman, & Schulenberg, 2012), years in which there were reductions in the perceived harm of marijuana by middle and high school students were immediately followed by an increase in marijuana use the subsequent year. Intended or not, overt or not, it is possible that the decision to legalize marijuana for recreational purposes sends a message to youth that use is not that risky. Unfortunately, it is this same age group for whom cognitive effects are well documented and potentially quite pronounced. Hanson and colleagues (2010) demonstrated that among adolescents using an average of four times per week, it took up to 21 days for adolescents' memory to improve after quitting marijuana use, and that attention deficits associated with marijuana use could still linger at that point. For middle school or high school students struggling academically or questioning if they have a problem with attention, marijuana use could be a significant contributing factor, and increased use by this age group would pose a concern. In short, the potential impact on initiating use or increasing use needs to be studied.

How is Driving Under the Influence (DUI) measured, and how long after use does one need to wait to avoid endangering oneself or others?

Unlike the ability to estimate BAC from a blood alcohol chart as a function of an individual's birth sex, weight, amount consumed, and time over which alcohol was consumed, there is no way to estimate THC/milliliter of blood in a similar fashion. Further, use

of a breathalyzer can be used to get an instantaneous sense of a person's intoxication level due to alcohol, yet no similar mechanism exists for marijuana. Thus, at least in the case of Washington, blood tests to establish whether or not a person is "under the influence" became the voter-approved strategy for determining DUI. Washington established 5 nanograms of THC per milliliter of blood as the per se limit for DUI for those 21 and older (meaning that regardless of someone's tolerance or their apparent ability to operate a motor vehicle, having more than 5 ng/ml is grounds for a DUI infraction). For those under 21, any positive value meets criteria for a DUI infraction. From a research standpoint, several questions arise. How long after using marijuana would a person over 21 years of age need to wait to be below this level? Grotenhermen and colleagues (2007) estimate that "a male weighing 70 kg and smoking a THC dose of 19 mg (p. 1915)" will take three hours for his THC levels to drop below this 5 ng/ml level. It is clear, however, that much more needs to be studied to examine factors that contribute to variance in this time frame. How would this time frame vary based on potency of marijuana used? How would it vary based on route of administration (namely, smoking or eating marijuana)? How would it vary based on birth sex and body weight? Additional research seems needed to answer questions like this, and public health efforts can be used to educate and warn communities about the risk to the driver and those around him or her depending on how much time has elapsed after use.

Independent of age group, will increased availability result in more use?

It has been well established in the alcohol field that increased access to and availability of alcohol is associated with increased drinking (Toomey & Wagenaar, 2002). In the state of Washington, I-502 sets the stage for marijuana to be sold by stores run by the Washington State Liquor Control Board, meaning marijuana outlets will be visible and public. Research is needed to see if the same impact of availability of alcohol is seen with increased availability of marijuana, as well as what role outlet density will play.

With alcohol, there are guidelines for "low risk" use set forward by several health organizations, as well as documented strategies for reducing harms associated with alcohol if one makes the choice to drink. If someone makes the choice to use marijuana, there are less clear guidelines on how to use it in a less risky manner.

What, if any, are the guidelines for reducing the harm associated with marijuana use?

With alcohol, there are guidelines for "low risk" use set forward by several health organizations (both nationally and internationally), as well as documented strategies for reducing the harms associated with alcohol if one makes the choice to drink (e.g., alternate drinks with water, set a limit that goes up to but does not exceed .06%, etc.). If someone makes the choice to use marijuana, there are less clear guidelines on how to use it in a less risky manner. For example, it is unknown what immediate or long-term risks are reduced (or introduced) when route of administration is altered (e.g., when smoked, what are the documented differences with use of a vaporizer vs. marijuana rolled as a joint?). With a growing eye toward the development of prevention and intervention programs, research highlighting specific harm reduction strategies appears indicated.

Will an illegal market truly be avoided through legalization and sales through state-run stores?

Just as surveys have successfully documented where people obtain and use alcohol, similar studies of how marijuana is obtained can be conducted. Particularly with Washington's recent initiative's emphasis on introducing a significant tax once marijuana is legalized, will people seek cheaper options or even a variety (including more potent options) outside of what is sold in stores? This question, too, can be examined through research.

By no means is this an exhaustive list of potential research questions. However, as states like Washington and Colorado consider and assess the impact of recent shifts in policy, and as other states consider their own actions, the opportunity for the scientific community to play a part in evaluating and disseminating findings with clear policy implications has never been greater.

References

Grotenhermen, F., Leson, G., Berghaus, G., Drummer, O. H., Kruger, H., Longo, M., … Tunbridge, R. (2007). Developing limits for driving under cannabis. *Addiction, 102,* 1910-1917.

Hanson, K. L., Winward, J. L., Schweinsburg, A. D., Medina, K. L., Brown, S. A., & Tapert, S. F. (2010). Longitudinal study of cognition among adolescent marijuana users over three weeks of abstinence. *Addictive Behaviors, 35,* 970-976.

Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2012). *Monitoring the future national survey results on drug use, 1975-2011: Volume II, College students and adults ages 19-50.* Ann Arbor: Institute for Social Research, The University of Michigan.

Toomey, T. L., & Wagenaar, A. C. (2002). Environmental policies to reduce college drinking: Options and research findings. *Journal of Studies on Alcohol, Supplement No. 14,* 193-205.ψ

The Effects of Short Bouts of Exercise on Marijuana Craving

R. Lorraine Collins and Paula C. Vincent, University at Buffalo, State University of New York

In the U.S., marijuana is the most commonly used illicit drug and young adulthood is a developmental period when marijuana use occurs. For example, recent data from the Monitoring the Future survey (Johnston, O'Malley, Bachman, & Schulenberg, 2012) indicated that young adults (ages 19-28 years), reported the following rates of marijuana use: 56.3% lifetime use, 31% annual use, 18.3% 30-day use, and 6.1% daily use. Heavy use of marijuana (Compton, Grant, Colliver, Glantz, & Stinson, 2004) is associated with negative consequences, including dependence (Barnwell, Earleywine, & Gordis, 2005, 2006; Simons, Gaher, Correia, Hansen, & Christopher, 2005). Over the past few years, the prevalence of marijuana use has been increasing along with its legal acceptance (e.g., medical and recreational marijuana use laws), such that young adults have come to perceive marijuana as being "fairly easy" to "very easy" to obtain and relatively low in risks (Johnston et al., 2012).

R. Lorraine Collins, Department of Community Health and Health Behavior; and Paula C. Vincent, Research Institute on Addictions, University at Buffalo, State University of New York.

This research was supported by Grant R01DA027606 from NIDA/NIH to R. Lorraine Collins. We thank Caitlin Biddle, Maribeth Insana, Maya Lambiase, Debbie Saltino, Jeffrey Sanders, Alexander Smith, and Sandy Wilson for their assistance with data collection.

Correspondence concerning this article should be addressed to R. Lorraine Collins, Department of Community Health and Health Behavior, University at Buffalo, SUNY 3435 Main Street, 327 Kimball Tower, Buffalo, New York 14214-8028. E-mail: lcollins@buffalo.edu.

At the same time that marijuana use is increasing, there is a paucity of effective treatments for lessening its use. Particularly among young adults, there is a need to examine interventions that could lessen the frequency or quantity of marijuana use, even for short periods of time. Such interventions could help individuals to better regulate their marijuana use and thereby lower their risk for developing dependence. There is some initial research to suggest that exercise/physical activity (PA) could reduce the use of licit and illicit drugs (e.g., Harbour, Behrens, Kim, & Kitchens, 2008; Melnick, Miller, Sabo, Farrell, & Barnes, 2001; Pate, Heath, Dowda, & Trost, 1996).

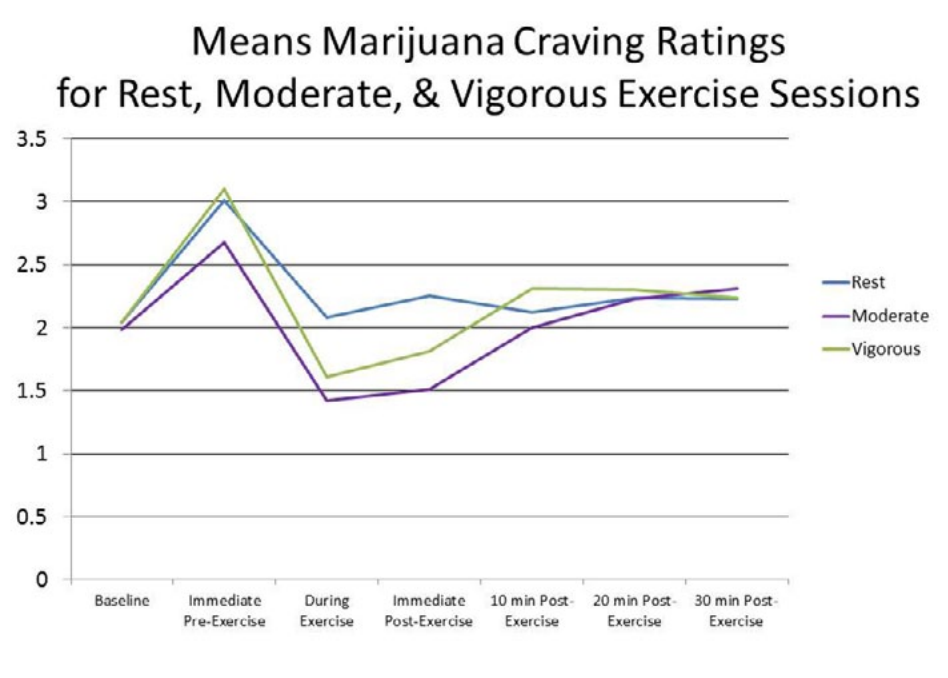
Exercise/PA has a number of benefits for physical and psychological health (Penedo & Dahn, 2005) and young adults tend to rate exercise/PA as pleasant (Murphy, Barnett, & Colby, 2006). Physical health benefits include improvements in bone health and cardiovascular and metabolic biomarkers, as well as prevention of weight gain and related chronic diseases (e.g., diabetes). Some of the psychological benefits of exercise/PA (e.g., reductions in depression and anxiety) are highly relevant to issues faced by emerging and young adults (Taliaferro, Rienzo, Pigg Jr., Miller, & Dodd, 2008; Wichers et al., 2012).

Interventions that have used exercise/PA to lessen substance use have shown that longer-term exercise programs enhance smoking cessation (e.g., Marcus et al., 1999; Marcus et al., 2005) and promote the lessening of substance use among adolescents (Werch, Moore, DiClemente, Bledsoe, & Jobli, 2005). In the short term, acute bouts of exercise have reduced cigarette smoking desire (Daniel, Cropley, & Fife-Schaw 2006; Daniel, Cropley, Ussher, & West, 2004; Taylor, Ussher, & Faulkner, 2007; Thayer, Peters, Takahashi, & Birkhead-Flight, 1993; Ussher, Nunziata, Cropley, & West, 2001), withdrawal symptoms (Daniel et al., 2006; Daniel et al., 2004; Taylor & Katomeri, 2007; Thayer et al., 1993; Ussher et al., 2001), and time to *ad libitum* smoking (Taylor et al., 2007; Taylor & Katomeri, 2007; Thayer et al., 1993). Aerobic exercise has also been tested in treatment for alcoholics (Brown et al., 2009) and drug-dependent patients (Brown et al., 2010).

Research has shown that acute bouts of exercise can reduce urge/cravings for a variety of substances, including alcohol (Ussher, Sampuran, Doshi, West, & Drummond, 2004) and cigarettes (Daniel et al., 2004; Daniel et al., 2006; Taylor, Katomeri, & Ussher, 2005; Ussher et al., 2001). There is fMRI data that indicates favorable differences in brain activation in regions related to smoking cravings after exercise compared to rest (Van Rensburg, Taylor, Hodgson, & Benattayallah, 2009). Specific to marijuana, Buchowski et al. (2011) found that prescribed moderate exercise led to significant decreases in marijuana use and craving up to 2 weeks after exercise.

The Present Study

The present study was designed to examine the role of a brief (10-minute) bout of exercise in craving for marijuana. We used a within-subjects design and asked participants to complete 3 different (counterbalanced) PA/exercise conditions, on 3 different days, separated by at least 3 days. To induce craving prior to exercise, we used a cue-exposure paradigm after which participants completed either: 1) the control condition in which they sat quietly for 10 minutes while listening to classical music and viewing neutral images (e.g., scenery), 2) 10 minutes of moderate-intensity exercise, or 3) 10 minutes of vigorous-intensity exercise. It was hypothesized that relative to



the control condition, exercise would produce short-term reductions in craving.

Method

Participants. Participants were 38 young-adult men and women (*M* age = 20.61 years, *SD* = 1.73) who regularly used marijuana. Along with age (18-25 years) and marijuana use (3x/week), they had met inclusion criteria that included no history of treatment for substance dependence or psychiatric problem, no evidence of current drug abuse or dependence, BMI < 30 kg/m^2, and no medical contraindications to exercise.

Marijuana craving induction. Participants were run individually. Prior to the exercise condition (i.e., rest, moderate, vigorous), they completed a 4.5-minute marijuana cue-exposure procedure designed to elicit craving. Based on previous studies, we used multiple sensory modalities to stimulate participants' desire to use marijuana (cf. Gray, LaRowe, Upadhyaya, 2008; Singleton, Trotman, Zavahir, Taylor, & Heishman, 2002). The craving induction consisted of having participants engage in the following for 90 seconds each: 1) listen to a 60-second marijuana smoking scenario then imagine themselves smoking marijuana for an additional 30 seconds (cf. Tiffany & Hakenewerth, 1991), 2) view marijuana-related images (9 images, 10 seconds each), and 3) handle marijuana-related objects (e.g., glass pipe). Participants used a 10-point scale (0 = *Not at all*; 9 = *Very much*) to rate their craving for marijuana on each of four items (e.g., *I want to smoke marijuana right now.*). The 4-item craving measure was administered seven times (e.g., baseline, post craving induction; post exercise; **see figure**).

Exercise sessions. In the moderate- and vigorous-intensity conditions, participants performed 10 minutes of exercise on a stationary bicycle. For each participant, the exercise intensity level was determined using the Karvonen formula (Karvonen, Kentala, & Mustala, 1957) and in keeping with American College of Sports Medicine (2010) guidelines.

Results

Consistent with previous research and our hypothesis, there was a significant decrease in marijuana craving from pre-exercise to post-exercise **(see figure).** We used repeated measures ANOVA to examine the acute effects of exercise on marijuana craving over time (modeled as a continuous factor). The main effect for exercise condition was not significant. However, there was a significant main effect of time, F (5, 32) = 8.58, p < .001. The interaction between exercise condition and time also was significant, F (10, 27) = 2.38, p < .05. Follow-up one-way within-subjects ANOVAs and contrasts revealed that *immediately prior to exercise*, there were no differences in marijuana craving among the three conditions. However, there were significant differences *during exercise*, F (2, 35) = 7.65, p < .01 and marginally significant differences immediately post exercise, F (2, 36) = 3.12, p = .06; **see means in table.** In both cases, craving ratings were higher for the rest condition compared to the moderate and vigorous conditions, which did not differ.

Table 1
Mean Ratings of Marijuana Craving for Each Exercise Condition

Exercise condition	Baseline (pre-MJ craving induction)	Post-MJ craving induction/ pre-exercise	During exercise (5-min mark)	Immediate post-exercise	10 minutes post-exercise	20 minutes post-exercise	30 minutes post-exercise
Rest	2.54 (2.36)	3.62 (2.31)	2.59 (2.09)	2.68 (2.26)	2.64 (2.23)	2.74 (2.33)	2.76 (2.43)
Moderate	2.34 (2.39)	3.22 (2.49)	1.82 (2.16)	2.10 (2.37)	2.53 (2.30)	2.80 (2.45)	2.86 (2.50)
Vigorous	2.23 (2.33)	3.28 (2.48)	1.59 (2.31)	1.91 (2.15)	2.37 (2.31)	2.52 (2.27)	2.53 (2.22)

Note. *N* = 37-38. Means (*SD*s) of 4-item Marijuana Craving measure are shown.

Discussion

We found that short bouts of moderate or vigorous exercise produced short-term decreases in self-reported craving for marijuana. Although the effects of exercise on reducing craving were short-lived, they serve as an important indicator of the potential for exercise to serve either as an intervention (e.g., Buchowski et al., 2011) or an adjunct to other interventions designed to reduce marijuana use. Among other questions, future research should examine whether longer bouts of exercise are more effective for reducing craving for longer periods of time.

References

American College of Sports Medicine (2010). *ACSM's Health-Related Physical Fitness Assessment Manual* (3rd ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Barnwell, S. S., Earleywine, M., & Gordis, E. B. (2005). Alcohol consumption moderates the link between cannabis use and cannabis dependence in an internet survey. *Psychology of Addictive Behaviors, 19,* 212-216.

Barnwell, S. S., Earleywine, M., & Gordis, E. B. (2006). Confirming alcohol-moderated links between cannabis use and dependence in a national sample. *Addictive Behaviors, 31,* 1695-1699.

Brown, R. A., Abrantes, A. M., Read, J. P., Marcus, B. H., Jakicic, J., Strong, D. R., … Gordon, A. A. (2009). Aerobic exercise for alcohol recovery: Rationale, program description and preliminary findings. *Behavior Modification, 33,* 220-249.

Brown, R. A., Abrantes, A. M., Read, J. P., Marcus, B. H., Jakicic, J., Strong, D. R., … Gordon, A. A. (2010). A pilot study of aerobic exercise as an adjunctive treatment for drug dependence. *Mental Health and Physical Activity, 3,* 27-34.

Buchowski, M. S., Meade, N. N., Charbonneau, E., Park, S., Dietrich, M. S., Cowan, R. L., & Martin, P. R. (2011). Aerobic exercise training reduces cannabis craving and use in non-treatment seeking cannabis-dependent adults. *PLoS ONE, 6,* 1-6.

Compton, W. M., Grant, B. F., Colliver, J. D., Glantz, M. D., & Stinson, F. S. (2004). Prevalence of marijuana use disorders in the United States: 1991-1992 and 2001-2002. *JAMA, 291,* 2114-2121.

Daniel, J. Z., Cropley, M. & Fife-Schaw, C. (2006). The effect of exercise in reducing desire to smoke and cigarette withdrawal symptoms is not caused by distraction. *Addiction, 101,* 1187-1192.

Daniel, J., Cropley, M., Ussher, M. & West, R. (2004). Acute effects of a short bout of moderate versus light intensity exercise versus inactivity on tobacco withdrawal symptoms in sedentary smokers. *Psychopharmacology, 174,* 320-326.

Gray, K. M., LaRowe, S. D., Upadhyaya, H. P. (2008). Cue reactivity in young marijuana smokers: A preliminary investigation. *Psychology of Addictive Behaviors, 22,* 582-586.

Harbour, V. J., Behrens, T. K., Kim, H. S., & Kitchens, C. L. (2008). Vigorous physical activity and depressive symptoms in college students. *Journal of Physical Activity and Health, 5,* 516-526.

Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2012). *Monitoring the future: National survey results on drug use, 2011: Volume II, College students and adults ages 19-45* (NIH Publication No). Bethesda, MD: National Institute on Drug Abuse.

Karvonen, M. J., Kentala, E., & Mustala, O. 1957. The effects of training on heart rate; a longitudinal study. *Annales Medicinae Experimentalis et Biologiae Fenniae, 35,* 307-315.

Marcus, B. H., Albrecht, A. E., King, T. K., Parisi, A. F., Pinto, B. M., Roberts, M., … Abrams, D. B. (1999). The efficacy of exercise as an aid for smoking cessation in women: A randomized controlled trial. *Archives of Internal Medicine, 159,* 1229-1234.

Marcus, B. H., Lewis, B. A., Hogan, J., King, T. K., Albrecht, A.E., Bock, B., … & Abrams, D. B. (2005). The efficacy of moderate-intensity exercise as an aid for smoking cessation in women: A randomized controlled trial. *Nicotine & Tobacco Research, 7,* 871-880.

Melnick, M.J., Miller, K.E., Sabo, D.F., Farrell, M.P., & Barnes, G. M. (2001). Tobacco use among high school athletes and nonathletes: Results of the 1997 Youth Yisk Behavior Survey. *Adolescence, 36,* 727.

Murphy, J. G., Barnett, N. P., & Colby, S. M. (2006). Alcohol-related and alcohol-free activity participation and enjoyment among college students: A behavioral theories of choice analysis. *Experimental and Clinical Psychopharmacology, 14,* 339-349.

Pate, R. R., Heath, G. W., Dowda, M. & Trost, S.G. (1996). Associations between physical activity and other health behaviors in a representative sample of US adolescents. *American Journal of Public Health, 86,* 1577-1581.

Penedo, F. J. & Dahn, J. R. (2005). Exercise and well-being: a review of mental and physical health benefits associated with physical activity. *Current Opinion in Psychiatry, 18,* 189-193.

Simons, J. S., Gaher, R. M., Correia, C. J., Hansen, C. L., & Christopher, M. S. (2005). An affective-motivational model of marijuana and alcohol problems among college students. *Psychology of Addictive Behaviors, 19,* 326-334.

Singleton, E. G., Trotman, A.J ., Zavahir, M., Taylor, R. C., & Heishman, S. J. (2002). Determination of the reliability and validity of the marijuana craving questionnaire using imagery scripts. *Experimental and Clinical Psychopharmacology, 10,* 47-53.

Taliaferro, L. A., Rienzo, B. A., Pigg Jr., R. M., Miller, M. D., & Dodd, V. J. (2008). Associations between physical activity and reduced rates of hopelessness, depression, and suicidal behavior among college students. *Journal of American College Health, 57,* 427-435.

Taylor, A., & Katomeri, M. (2007). Walking reduces cue-elicited cigarette cravings and withdrawal symptoms, and delays ad libitum smoking. *Nicotine Tobacco Research, 9,* 1183-1190.

Taylor, A. H., Katomeri, M., & Ussher, M. (2005). Acute effects of self-paced walking on urges to smoke during temporary smoking abstinence. *Psychopharmacology, 181,* 1-7.

Taylor, A. H., Ussher, M. H., & Faulkner, G. (2007). The acute effects of exercise on cigarette cravings, withdrawal symptoms, affect and smoking behavior: A systematic review. *Addiction,102,* 534-543.

Thayer, R. E., Peters, D. P., Takahashi, P. J., & Birkhead-Flight, A. M. (1993). Mood and behavior (smoking and sugar snacking) following moderate exercise: A partial test of self-regulation theory. *Personality and Individual Differences, 14,* 97-104.

Tiffany, S. T., & Hakenewerth, D. M. (1991). The production of smoking urges through imaginery manipulation: Psychological and verbal manifestations. *Addictive Behaviors, 16,* 389-400.

Ussher, M., Nunziata, P., Cropley, M., & West, R. (2001). Effect of a short bout of exercise on tobacco withdrawal symptoms and desire to smoke. *Psychopharmacology, 158,* 66-72.

Ussher, M., Sampuran, A. K., Doshi, R., West, R., & Drummond, D.C. (2004). Acute effect of a brief bout of exercise on alcohol urges. *Society for the Study*

of Addiction, 99, 1542-1547.
Van Rensburg, K.J., Taylor, A., Hodgson, T. & Benattayallah, A. (2009). Acute exercise modulates cigarette cravings and brain activation in response to smoking-related images: An fMRI study. *Psychopharmacology, 203*, 589-598.
Werch, C., Moore, M. J., DiClemente, C. C., Bledsoe, R., & Jobli, E. (2005). A multihealth behavior intervention integrating physical activity and substance use prevention for adolescents. *Prevention Science, 6,* 213-226.
Wichers, M., Peeters, F., Rutten, B. P. F., Jacobs, N., Derom, C., Thiery, E., … van Os, J. (2012). A time-lagged momentary assessment study on daily life physical activity and affect. *Health Psychology, 31*, 135-144.ψ

How to Make a Referral to Addiction Treatment—You're an Expert, Right?

Tom Horvath

If you were asked for a referral to addiction treatment, would you know how to respond? "You're in the Society of Addiction Psychology, so you must know about finding good treatment, right?" Non-clinical members of SoAP may wish to keep a copy of this article for reference. Clinical members with luck will find the article filled with useful reminders.

Although addiction builds slowly, the search for addiction treatment often starts suddenly, typically after a crisis. Frantic phone calls and web searches begin within hours of the crisis unfolding. Unfortunately, many treatment websites look similar, and there is little way for the average consumer to determine just how true the statements "highly trained staff, evidence-based treatment, individualized care, focus on co-occurring issues" might be for a particular facility. Even well-known facilities may deliver significantly less in these areas than their marketing rhetoric would suggest (based on what I have heard from their former clients over the years).

There continue to be numerous discrepancies between a genuinely evidence-based approach to addiction treatment, and the reality of contemporary US treatment practices.

Tom Horvath is a past president of SoAP, and the founder and president of Practical Recovery, an evidence-based addiction treatment system in San Diego, CA. He is the volunteer president of SMART Recovery.

"Addiction medicine: Closing the gap between science and practice" released August 2012, by the National Center on Addiction and Substance Abuse at Columbia University (CASA Columbia), presents recent findings about these discrepancies, succinctly summarized by their press release:

> While a wide range of evidence-based screening, intervention, treatment and disease management tools and practices exist, they rarely are employed. The report exposes the fact that most medical professionals who should be providing treatment are not sufficiently trained to diagnose or treat addiction, and most of those providing addiction treatment are not medical professionals and are not equipped with the knowledge, skills or credentials necessary to provide the full range of evidence-based services, including pharmaceutical and psychosocial therapies and other medical care.

How could someone navigate a helpful path through the approximately 15,000 US addiction treatment facilities? Consider the following guidelines:

Begin with an unbiased and comprehensive assessment. Ideally, substantial addiction problems are assessed by a licensed and addiction-experienced mental health professional, who is not simply a marketing representative of a rehab. For addiction problems that are not likely to need rehab (residential treatment), assessment followed by psychotherapy with the same professional is sensible, and allows for an important reality in all mental health care: The need for assessment is ongoing. No initial assessment is complete, because the client does not yet trust you enough to tell you everything important! Trust can develop in the context of an ongoing psychotherapy relationship. In time we will persuade psychotherapists that they are the providers of choice for addiction treatment, not the alcohol and drug counselors who currently are the majority of providers. *Psychology Today*'s website now has by far the largest list of US therapists. One can search for addiction as a specialty. Scheduling initial visits with two or three providers is often a good idea.

Start small, and use a stepped care approach. If someone enters treatment, the recovery process typically takes much more time than the client expects it to. However, that process does not have a high correlation between the severity of problems and the intensity of treatment needed. Substantial problems often respond to minimal treatment (think "brief intervention"). Consequently, unless there is a dramatic need for rehab, start with outpatient treatment and progress to higher levels of care only if needed.

Expect to focus mostly on co-occurring problems (including co-occurring disorders). There is only so much time one needs to focus on maintaining motivation, coping with craving, and preventing relapse. The majority of treatment should focus on the issues that maintain addiction, including disorders like anxiety, depression, and

trauma, but also life problems like relationship stress, parenting stress, work stress, life imbalance (e.g., "all work and no play"), and lack of a deep sense of meaning and purpose in life.

If attending rehab, vet it thoroughly. What staff do you actually spend most of your time with? What are the credentials of these individuals? How much time is spent in group treatment vs. individual treatment? Is there a refund policy if you leave early? Is there rapid access to medical care? When they say "evidence-based" what exactly is meant? How did staff get training in the treatments they are saying they provide? Is mutual help (e.g., 12-step) group attendance required? Are alternatives to 12-step, such as SMART Recovery, available? May you bring a cell phone and laptop, and are these devices dealt with flexibly?

Watch costs. If attending treatment provided through government funding—most US treatment is of this type—fees may still be an issue, but less so. If using insurance, be prepared for a denial of coverage despite the initial statement that "treatment has been pre-authorized." Insurance companies often separate the treatment authorization function from the payment authorization function, particularly for big-ticket items such as rehab (I know this situation makes no sense from the consumer's or provider's perspective, but many insurance companies actually operate this way). Read the contract with the facility carefully, and be clear who is responsible for balances due if insurance does not pay as expected.

Watch out for "hard-sell" facilities. Individuals and families seeking treatment are vulnerable, and susceptible to the unfortunately frequent message that "if you don't get residential treatment right away you are going to die." If detox is needed, there may be some validity to this statement, otherwise probably not. A responsible facility will help the caller make sensible decisions given the caller's situation, values, and goals.

Persevere. Perhaps the single most important virtue in recovery is persistence. If one approach, provider, setting, or treatment seems not to be helpful, try another one.

In preparation for writing this article I requested an advance copy of *Inside Rehab: The surprising truth about addiction treatment—and how to get help that works*, by Anne M. Fletcher, best-selling author of *Thin for life* and *Sober for good* (and the recipient of an award from SoAP). *Inside Rehab* was released February 7, 2013. I recommend this book for its comprehensive review of the issues addressed in this article, as well as for its critique of the entire US addiction treatment system. The Appendix, "A consumer checklist for checking out rehabs," is worth reviewing by anyone engaged in that process.

The feedback that normally corrects any system of services (via competition) operates at a much lower level in US addiction treatment. The consumer is sufficiently stigmatized that consumer complaints are often used as the basis for blaming the consumer, rather than correcting services. We continue to see slow and perhaps accelerating progress on this issue, but more progress is needed. I hope this article is a useful contribution to increasing consumer and family awareness, via their interactions with a SoAP psychologist.

References

The National Center on Addiction and Substance Abuse at Columbia University (CASA Columbia). (2012). *Addiction medicine: Closing the gap between science and practice*. [Online]. Retrieved February 20, 2013 from http://www.casacolumbia.org.

Fletcher, A. M. *(2001). Thin for life*. New York: Houghton Mifflin

Fletcher, A. M. *(2002). Sober for good*. New York: Houghton Mifflin Harcourt

Fletcher, A. M. (2013). *Inside Rehab: The surprising truth about addiction treatment—and how to get help that works*. New York: Viking Penguin.ψ

Chair of the APA Board of Scientific Affairs

Jalie Tucker, Professor in the School of Public Health, University of Alabama at Birmingham, is serving as the 2013 Chair of the APA Board of Scientific Affairs (BSA). BSA is concerned with all aspects of psychology as a science. Along with its committees and affiliated groups, BSA is responsible for encouraging, developing, and promoting psychology as a science, and is the primary advisory body to the APA Science Directorate. BSA sponsors scientific programming at the convention, oversees APA awards recognizing scientific contributions, advises on APA's relationships with other scientific organizations, provides guidance to APA government relations staff on research funding and policy issues, and proposes and refines new APA policies and activities for advancing psychological science.

She previously served as member and Chair (2004) of the APA Board of Professional Affairs (BPA) and joins a very small number of scientist-practitioner clinical psychologists who have served as members or chair of both BSA and BPA. Jalie Tucker also has served as SoAP President (1993) and as a 4-term member of the APA Council of Representatives representing SoAP (1998-2003, 2007-2012).

Mental Health Provider's Evaluation and Treatment of Alcohol Misuse and Substance Dependence

Leah Barreca, Chad Brownfield, Malena Castillo, and Marilyn Freimuth, Fielding Graduate University

Alcohol misuse is a serious problem in the United States, annually responsible for 79,000 deaths and more than $185 billion in health care expenditures, crime-related costs, welfare spending, productivity losses, property destruction, and specialty alcohol services (National Institute on Alcohol Abuse and Alcoholism, 2000). Even occasional alcohol misuse can lead to negative consequences. However, a growing body of research indicates that healthcare practitioners inadequately screen for problematic alcohol use and that treatment has been inconsistent (Kaner, Heather, McAvoy, Lock, & Gilvarry, 1999; Freimuth, 2010).

Practitioner attitude and aptitude can be obstacles to routine alcohol screening. Obstacles include practitioner fear of damaging the healthcare relationship, intruding in the patient's personal matters, dismissing alcohol screening when the primary complaint is unrelated, gender and economic status biases, as well as low expectations of detecting alcohol problems (Aira, Kauhanen, Larivaara, & Rautio, 2003; Freimuth, 2008; Kaner, Rapley, & May, 2006). Further alcohol screen difficulties exist with poorly defined terms such as "social drinking" and "problem drinking" and may be exacerbated by the healthcare practitioner's own drinking habits (Kaner, Rapley, & May, 2006).

Several vignette studies have explored the healthcare practitioner's ability to assess alcohol misuse. These studies have found practitioners to be more likely to inquire about alcohol misuse when symptoms were blatant, to underestimate the severity of misuse, and to attribute symptoms as indicators of a mental health disorder (Freimuth, 2008; Wilson, Sherritt, Gates, & Knight, 2004).

In terms of treatment of alcohol-related problems in mental health settings, evidence is limited. Inconsistencies have been found with practitioners providing disparate approaches for the same type of alcohol misuse, approaches that have included harm reduction (e.g., drinking less, accepting a designated driver), abstinence, and case management (Freimuth, 2008; Willenbring, Massey, & Gardner, 2009).

With the goal of better understanding both alcohol assessment and interventions in mental health settings, the Addictions Study Group at Fielding Graduate University under the supervision of Marilyn Freimuth conducted an exploratory experiment that investigated mental health providers' ability to recognize different forms of alcohol misuse and their subsequent treatment recommendations.

An opportunity sample of mental health professionals from a variety of geographic locations and occupational settings participated in the study. Participants were recruited through ads at different types of mental health agencies and then they completed the survey. The sample (N = 120) represented male and female clinicians from different theoretical orientations and professional backgrounds. Mental health practitioners responded to a demographic questionnaire and two vignettes: One vignette described harmful drinking (HD) and the second had symptoms of substance dependence (SD). The vignettes only differed in their randomly assigned gender and the varying level of impact of alcohol use (HD vs. SD) on social, psychological, biological, and occupational factors. The SD vignette contained a more explicit reference to the client's alcohol use and the severity was consistent with the *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision* (American Psychiatric Association, 2000) criteria of alcohol dependence. As follows, the HD vignette included a less blatant description of the client's symptoms that were defined as harmful drinking by the National Institute on Alcohol Abuse and Alcoholism (2000). The vignettes were crossed with gender as a factor, but these results have not been analyzed.

Participants in this study were asked to rate the severity of the vignette client's alcohol use problem, whether they would provide psychotherapy services and if so, the goals of those services. Participants also could indicate that they were unable *to engage in treatment* (i.e., because of state or organizational restrictions), or *would not engage the person's alcohol use problem in psychotherapy.* If the participants elected to engage the individual in the vignette in therapy, then they were directed to choose a specific treatment goal from the following list: *abstinence or non-use*, *lowering quantity and/or frequency of consumption*, *limiting negative consequences of harm of use*, and *other, please describe*.

Paired sample t-tests were used to analyze the differences between the semi-ordinal approaches to address HD vs. SD in treatment. The null hypothesis was not rejected showing no statistically significant differences between the approaches to engage HD vs. SD in treatment. Similarly, results showed that participants elected to engage both the HD and SD individual in treatment at similar rates, 64% and

72%, respectively.

The most commonly endorsed goal for the SD vignette was the recommended option of *abstinence* (34%) while non-recommended treatment goals of *lowering quantity* and *limiting negative consequences* were endorsed at 13% and 10%, respectively. The most endorsed treatment goal of HD was the recommended option of harm reduction as a function of *limiting negative consequences* and *lowering quantity* (19% and 7%, respectively). Participants selected recommended these treatment goals 26% of the time for HD and 34% for SD use.

Of note is the number of participants who did not select the appropriate treatment goals. It is concerning that 19% of participants chose the non-recommended treatment goal of *abstinence* for treatment of HD. Similarly, 23% of participants indicated non-recommended goals for the treatment of SD (*lowering quantity* and *limiting negative consequences*). There was little difference between participants electing not to treat regardless of the vignette. Only 9% of participants elected *no treatment required* or *would not engage the person's alcohol use problem in psychotherapy* in the HD vignette, where only 6% of participants elected *would not engage the person's alcohol use problem in psychotherapy* and 0% selected *no treatment required* for the SD vignette where the symptoms of alcohol misuse are more blatant. Some of the reasons participants listed for *would not treat* or *inability to treat* for both vignettes included referrals out to another provider, lack of training/expertise, or currently not practicing.

One possible interpretation is that clinicians over-treat harmful drinking. Sixty four percent of participants elected to engage HD in psychotherapy and then 19% of participants selected non-recommended treatment goal if they chose to treat the HD person. While the majority of participants opted to engage HD in treatment (64%), there is still room for significant improvement and it may indicate a need to train clinicians to identify problematic levels of alcohol use and alcohol abuse, especially since research indicates reduced drinking is preferable over abstinence for harmful drinking behaviors (Walitzer & Connors, 1999).

In this study, we attempted to move the research forward by differentiating between types of alcohol use problems properly and identifying symptoms with their respective terms (i.e., harmful drinking, substance dependence). Our findings were in agreement with previous research by Wilson et al. (2004), as participants correctly elected to treat the patient described in the SD vignette. However, our results did not support the finding in that same body of research that practitioners underestimate the severity of use because we found most participants chose to engage both the HD and SD in psychotherapy treatment.

Even though the present study is a step towards a greater understanding of practitioners' preparedness for working with apparent alcohol consumption, it opened new avenues for future research. Because clinicians received both vignettes, which allowed for dependence in sampling, future research may include independent samples that would allow for within category comparison without dependency complications. Future research may ascertain if significant differences were present between practitioners who elected to treat as well as the goals for treatment of both HD and SD. This study also created some implications for alcohol assessment and treatment implications. It is imperative that future trainings should focus not only on the assessment of, but also on the treatment recommendations between harmful drinking and alcohol and substance dependence. As the differences between harmful drinking and alcohol substance dependence become more clear, our practices need to reflect the current understanding in the literature; otherwise the knowledge is misspent.

References

Aira, M., Kauhanen, J., Larivaara, P., & Rautio, P. (2003). Factors influencing inquiry about patients' alcohol consumption by primary health care physicians: Qualitative semi-structured interview study. *Family Practice, 20*, 270-275.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (IV-TR ed.). Arlington, VA: American Psychiatric Association.

Freimuth, M. (2008). Another missed opportunity? Recognition of alcohol use problems by mental health providers. *Psychotherapy Theory, Research, Practice, Training, 45*, 405-409.

Freimuth, M. (2010). The "new look" in addiction assessment: Implications for medical education. *Annals of Behavioral Science and Medical Education, 16*, 30-34.

Kaner, E. F., Heather, N., McAvoy, B. R., Lock, C. A., & Gilvarry, E. (1999). Intervention for excessive alcohol consumption in primary health care: Attitudes and practices of English general practitioners. *Alcohol and Alcoholism, 34*, 559-566.

Kaner, E., Rapley, T., & May, C. (2006). Seeing through the glass darkly? A qualitative exploration of GPs' drinking and their alcohol intervention practices. *Family Practice, 23*, 481-487.

National Institute on Alcohol Abuse and Alcoholism. (2000). *Updating estimates of the economic costs of alcohol abuse in the United States: Estimates, update methods, and data.* Retrieved November 27, 2011, from National Institute on Alcohol Abuse and Alcoholism: http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/Documents/alcoholcost.PDF

Walitzer, K., & Connors, G. (1999). Treating problem drinking. *Alcohol Research and Health, 23*, 138-143.

Willenbring, M. L., Massey, S. H., & Gardner, M. B. (2009). Helping patients who drink too much: An evidence-based guide for primary care physicians. *American Family Physician, 80*, 44-50.

Wilson, C., Sherritt, L., Gates, E., & Knight, J. (2004). Are clinical impressions of adolescent substance use accurate? *Pediatrics, 122*, 1022-1029.ψ

Action Alert!

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

Elected to APA Council of Representatives

Joe Coyne, a member of SoAP, has been elected to the APA Council of Representatives from the State of New Jersey.

Coyne began working in the field in the mid-1970s and became a Certified Alcoholism Counselor when the credential was first issued in NJ, prior to finishing his PhD at Fordham in 1981, where he has been honored as a "Distinguished Alumnus." He served for many years as a school psychologist in Northern New Jersey and as an Internship Supervisor for Master's and Doctoral students in School Psychology for both Montclair State University and Fordham University.

He joined the Faculty of St. Thomas Aquinas College in Sparkill, NY, in 1992 and is currently Professor of Psychology and Immediate Past-Chair of the Division of Social Sciences. In addition, he is a Licensed Psychologist and a Licensed Clinical Alcoholism and Drug Abuse Counselor in New Jersey and holds the Certificate of Proficiency from APA. He maintains a private practice in northern New Jersey.

Coyne served as Treasurer of the New Jersey Association of Alcoholism and Drug Abuse Counselors (1987-1990), as Second Vice-President (1992-1994), and as President (1995-1997) and as a member of the Board of Directors of the National Association of Alcoholism and Drug Abuse Counselors (1995-1997). In 1995, Coyne was invited by President Clinton to participate in the "White House Conference on Youth, Violence, and Substance Abuse" as the representative from the State of New Jersey.

He began service to the Bergen County (NJ) Psychological Association (BCPA) and NJPA in 1987 as a member of the Council on Legislative Affairs of NJPA (COLA). He served as a member of the BCPA Board from 1992 to 1994. He served as Secretary to COLA from 1988 to 1992. He was the Affiliate Representative to the NJPA Executive Board during the time he served as President of the Bergen County Psychological Association (1997-2004) and continues to serve on the BCPA Board. In addition, he is Past Secretary of the New Jersey Psychological Association, Past Co-Chair of the Addictions Committee of NJPA, and is currently serving his second term as Parliamentarian to the NJPA Executive Board.

Finally, he has served as Co-Chair of the Bergen County Youth Committee on Substance Abuse, as a member of the Governor's Task Force on Fetal Alcohol Syndrome, as a member of the Professional Advisory Committee of the New Jersey Division of Alcoholism Drug Abuse and Addiction Services of the State Department of Health, and as a member of the Governance Committee as well as the Personnel Committee of NJPA. ψ

Collaborative Perspectives on Addiction (CPA) Meeting is LAUNCHED!

It has only been six months since SoAP and Division 28 (Psychopharmacology and Substance Abuse) joined forces to host an annual "mid-year" conference that caters specifically to the interests of addiction psychologists. During this time, an amazing program has begun to take shape!

This first annual collaborative-based conference, May 3-4, 2013, in Atlanta, GA, will take a "from bench to bedside" approach that integrates animal research, laboratory research with human subjects and clinical trials. The conference will bring together leaders from both divisions to facilitate lively debate and interchange and professional development opportunities.

The conference program developed thus far includes:

- Keynote addresses will be given by Dr. Saul Shiffman from University of Pittsburgh and Dr. Edith Sullivan from Stanford University.
- A pre-conference workshop entitled "Conducting Neuroimaging Studies From a Neuropsychologist's Perspective" will be offered by Dr. Sarah Mattson.
- Harold Perl, PhD, the Chief of the Prevention Research Branch at NIDA, will give an invited presentation titled "Peeking Behind the Curtain of the NIH Funding Process: Tips for Preparing a Successful Grant Application."
- Several breakout sessions address the conference theme of "Biobehavioral RESEARCH and Implications for PRACTICE," during which interactive presentations on a wide variety of topics will take place.
- There are two poster sessions.
- We have multiple social and networking events. (Any Atlanta Braves fans out there?)

In addition, we are proud to announce **reduced CPA registration fees** for early career and student attendees, thanks to a grant from the Committee on Division/APA Relations (CODAPAR).

Register now (http://tinyurl.com/2013CPA); earlybird registration rates are in effect until March 21st.The beautiful W Hotel in Midtown Atlanta will be the venue for our first CPA Conference and reservations can be made online at http://tinyurl.com/2013CPA. The hotel is located in the heart of Midtown and is local to public transportation. Room rates are $159 night. The discounted rate is only valid through April 11, 2013.

For more information, questions on registration/hotel/Continuing Education, please contact Chad Rummel at crummel@apa.org or (202) 336-6121.

Abstracts

Borsari, B., Hustad, J. T. P., Mastroleo, N. R., O'Leary Tevyaw, T., Barnett, N. P., Kahler, C. W., Short, E. E., & Monti, P. M. (2012). Addressing alcohol use and problems in mandated college students: A randomized clinical trial using stepped care. *Journal of Consulting and Clinical Psychology, 80*, 1062-1074.

Over the past two decades, colleges and universities have seen a large increase in the number of students referred to the administration for alcohol policies violations. However, a substantial portion of mandated students may not require extensive treatment. Stepped care may maximize treatment efficiency and greatly reduce the demands on campus alcohol programs. Participants in the study (N = 598) were college students mandated to attend an alcohol program following a campus-based alcohol citation. All participants received Step 1, a 15-minute Brief Advice session that included the provision of a booklet containing advice to reduce drinking. Participants were assessed six weeks after receiving the Brief Advice, and those who continued to exhibit risky alcohol use (n = 405) were randomized to Step 2, a 60-90 minute brief motivational intervention (BMI) (n = 211) or an assessment-only control (n = 194). Follow-up assessments were conducted 3, 6, and 9 months after Step 2. Results indicated that the participants who received a BMI significantly reduced the number of alcohol-related problems compared to those who received assessment only, despite no significant group differences in alcohol use. In addition, low-risk drinkers (n = 102; who reported low alcohol use and related harms at 6-week follow-up and were not randomized to stepped care) showed a stable alcohol use pattern throughout the follow-up period, indicating they required no additional intervention. Stepped care is an efficient and cost-effective method to reduce harms associated with alcohol use by mandated students.

Brandon, T. H., Simmons, V. N., Meade, C. D., Quinn, G. P., Khoury, E. L., Sutton, S. K., & Lee, J-H. (2012). Self-help booklets for preventing postpartum smoking relapse: A randomized trial. *American Journal of Public Health, 102*, 2109-2115.

Objectives. We tested a series of self-help booklets designed to prevent postpartum smoking relapse. *Methods*. We recruited 705 women in months 4-8 of pregnancy, who had quit smoking for their pregnancy. We randomized the women to receive either (a) 10 *Forever Free for Baby and Me* relapse-prevention booklets, mailed until 8 months postpartum (FFB), or (b) two existing smoking cessation materials, as a Usual Care Control (UCC). Assessments were completed at baseline and 1, 8, and 12 months postpartum. *Results*. We received baseline questionnaires from 504 women meeting inclusion criteria. We found a main effect for treatment at 8 months, with FFB yielding higher abstinence rates (69.6%) than UCC (58.5%). Treatment effect was moderated by annual household income and age. Among lower-income women (<$30,000), treatment effects were found at 8 and 12 months postpartum, with respective abstinence rates of 72.2% and 72.1% for FFB and 53.6% and 50.5% for UCC. No effects were found for higher-income women. *Conclusions*. Self-help booklets appear to be efficacious and offer a low-cost modality for providing relapse-prevention assistance to low-income pregnant and postpartum women.

Eddie, D., Buckman, J. F., Mun, E. Y., Vaschillo, B., Vaschillo, E., Udo, T., … & Bates, M. E. (2013). Different associations of alcohol cue reactivity with negative alcohol expectancies in mandated and inpatient samples of young adults. *Addictive Behaviors, 38*, 2040.

Alcohol cue reactivity, operationalized as a classically conditioned response to an alcohol-related stimulus, can be assessed by changes in physiological functions such as heart rate variability (HRV), which reflect real time regulation of emotional and cognitive processes. Although ample evidence links drinking histories to cue reactivity, it is unclear whether in-the-moment cue reactivity becomes coupled to a set of consolidated beliefs about the effects of alcohol (i.e., expectancies) and whether treatment helps dissociate the relation of positive versus negative expectancies to cue reactivity. This study examined the relationship between reactivity to alcohol picture cues and alcohol expectancies in two groups of emerging adults: an inpatient sample with alcohol use disorders (n = 28) and a college student sample who previously were mandated to a brief intervention for violating university policies about alcohol use in residence halls (n = 43). Sequential regression analysis was conducted using several HRV indices and self-report arousal ratings as cue reactivity measures. Results indicated that the relationship between cue reactivity and negative alcohol outcome expectancies differed for the two groups. Greater cue reactivity, assessed using HRV indices, was associated with more negative expectancies in the inpatient sample but with less negative expectancies in the mandated student sample, while an opposite trend was found for subjective arousal. The present findings highlight the importance of characterizing cue reactivity through multi-dimensional assessment modalities that include physiological markers such as HRV.

Hoeppner, B. B., Redding, C. A., Rossi, J. S., Pallonen, U. E., Prochaska, J. O., & Velicer, W. F. (2012). Factor structure of decisional balance and temptations scales for smoking: Cross-validation in urban female African-American adolescents. *International Journal of Behavioral Medicine, 19*, 217-227.

Background. The transtheoretical model is an influential theoretical model in health psychology, particularly in its application to smoking cessation research. Decisional Balance (DB) and Temptations are key constructs within

this framework. *Purpose*: This study examines the psychometric properties of the DB and Temptations scales for smoking in a predominantly African-American sample of urban adolescent girls. *Methods*. We used confirmatory factor analysis to compare the fit of previously published factor structures in smokers (*n*=233) and nonsmokers (*n*=598). External validity was tested by examining stages of change differences in the retained subscales. *Results*. Results supported the internal and external validity of the DB scale for smokers and nonsmokers. Notably, previously published three-factor (Social Pros, Coping Pros, Cons) and four-factor (Cons split into "Aesthetic Cons" and "Health Cons") models fit equally well, with Cons subscales correlating highly. For Temptations, a previously published three-factor (Negative Affect, Social, Weight Control) hierarchical model fit well in nonsmokers. In smokers, previously published subscales were reliably measured, but their structural relationship remained unclear. Stage difference tests showed medium to large effect sizes of DB and Temptations subscales in smokers and nonsmokers. *Conclusions*. The use of DB was validated for both smokers and nonsmokers in this sample of primarily African-American adolescent females, where Cons can be combined or separated into "Aesthetic Cons" and "Health Cons" based on practical utility and preference. For Temptations, more research is needed but large stage differences in Temptations subscales underscore the importance of this concept in smoking acquisition and cessation.

Jacobus, J., Goldenberg, D., Wierenga, C. E., Tolentino, N. J., Liu, T.T., & Tapert, S. F. (2012). Altered cerebral blood flow and neurocognitive correlates in adolescent cannabis users. *Psychopharmacology*, 222, 675-684.

Rationale. The effects of adolescent marijuana use on the developing brain remain unclear, despite its prevalence. Arterial spin labeling (ASL) is a noninvasive imaging technique that characterizes neurovascular status and cerebral blood flow (CBF), potentially revealing contributors to neuropathological alterations. No studies to date have looked at CBF in adolescent marijuana users. *Objectives*. This study examined CBF in adolescent marijuana users and matched healthy controls at baseline and after 4 weeks of monitored abstinence. *Methods*. Heavy adolescent marijuana users (n = 23, >200 lifetime marijuana use days) and demographically matched controls (n = 23) with limited substance exposure underwent an ASL brain scan at an initial session and after 4 weeks of sequential urine toxicology to confirm abstinence. *Results*. Marijuana users showed reduced CBF in four cortical regions including the left superior and middle temporal gyri, left insula, left and right medial frontal gyrus, and left supramarginal gyrus at baseline; users showed increased CBF in the right precuneus at baseline, as compared to controls (corrected p values < 0.05). No between group differences were found at follow-up. *Conclusions*. Marijuana use may influence CBF in otherwise healthy adolescents acutely; however, group differences were not observed after several weeks of abstinence. Neurovascular alterations may contribute to or underlie changes in brain activation, neuropsychological performance, and mood observed in young cannabis users with less than a month of abstinence.

Najavits, L. M., & Walsh, M. (2012). Dissociation, PTSD, and substance abuse: An empirical study. *Journal of Trauma and Dissociation*, *13*, 115-126.

Few studies have examined the relationship between posttraumatic stress disorder (PTSD), substance use disorder, and dissociation. We studied 77 women with current PTSD and substance dependence, classified into high- versus low-dissociation groups per the Dissociative Experiences Scale. They were compared on trauma- and substance-related symptoms, cognitions, coping skills, social adjustment, trauma history, psychiatric symptoms, and self-harm/suicidal behaviors. We found the high-dissociation group consistently more impaired than the low-dissociation group. Also, the sample overall evidenced relatively high levels of dissociation, indicating that even in the presence of recent substance use, dissociation remains a major psychological phenomenon. Indeed, the high-dissociation group reported stronger expectation that substances could manage their psychiatric symptoms. The high-dissociation group also had more trauma-related symptoms and childhood histories of emotional abuse and physical neglect. The discussion addresses methodology, the "chemical dissociation" hypothesis, and the need for a more nuanced understanding of how substances are experienced in relation to dissociative phenomena.

Ohannessian, C. M. (2013). Parental problem drinking and adolescent psychological problems: The moderating effect of adolescent-parent communication. *Youth & Society*, *45*, 3-26.

The primary aim of this study was to examine whether adolescent-parent communication moderates the relationship between parental problem drinking and adolescent psychological problems. Surveys were administered to a community sample of 1,001 adolescents in the spring of 2007. Results indicated that paternal problem drinking was associated with adolescent alcohol use, whereas maternal problem drinking was associated with adolescent depression. In addition, open adolescent-parent communication specifically acted as a protective factor for girls, but not for boys. These results highlight the need to consider both the gender of the adolescent and the gender of the parent when examining the adolescent-parent relationship.

Patrick, M. E., O'Malley, P. M., Johnston, L., Terry-McElrath, Y. M., & Schulenberg, J. E. (2012). HIV/AIDS risk behaviors and substance use by young adults in the United States. *Prevention Science*, *13*, 532-538.

The current research assessed the extent to which substance use behaviors (i.e., heavy episodic drinking, marijuana use, and use of

illicit drugs other than marijuana) were associated with behaviors that confer risk for HIV infection (i.e., sex with multiple partners, inconsistent condom use, and injection drug use) in a nationally representative sample of young adults. Generalized estimating equations (GEEs) examined patterns in the data from U.S. young adults (N = 7,595), ages 21 to 30, who participated in the Monitoring the Future (MTF) panel study between 2004 and 2009. Fifty-two percent of the participants were female and 70% were White. Time-varying effects indicated that more frequent heavy episodic drinking, marijuana use, and other illicit drug use were associated with a greater number of sex partners. Frequency of marijuana and other illicit drug use was associated with less frequent condom use, and marijuana use was associated with use of injection drugs. Younger individuals (i.e., 21-24 years old versus 25-30 years old) had fewer sexual partners, more frequent condom use, and a stronger association between heavy episodic drinking and number of sexual partners than did older individuals. These effects did not vary across gender. Findings highlight the covariation of substance use with HIV-related risk factors among recent cohorts of young adults in the U.S., and the particularly strong link between heavy episodic drinking and number of sexual partners among individuals aged 21 to 24. Prevention programs should acknowledge the co-occurring risks of substance use and HIV risk behaviors, especially among young adults in their early twenties.

Ramo, D. E., Delucchi, K. L., Hall, S. H., Liu, H., & Prochaska, J. J. (in press). Marijuana and tobacco co-use in young adults: Patterns and thoughts about use. *Journal of Studies on Alcohol and Drugs*.

Objective. We examined the frequency and intensity of tobacco use and thoughts about abstinence among young adults in the United States as a function of their use of marijuana. We hypothesized that heavier marijuana use would be associated with heavier tobacco use and fewer attempts to quit smoking, and we explored relationships between marijuana use and ratings of intentions and thoughts related to quitting tobacco. *Method*. This was a cross-sectional survey consisting of online recruitment and anonymous self-report. Participants were English literate, were between the ages of 18 and 25 years, and reported past-month tobacco use. More than half (53%) had smoked marijuana in the past 30 days. Tobacco use (quantity/frequency, Heavy Smoking Index, past-year quit attempt), thoughts about tobacco use (outcome expectancies, desire, self-efficacy, difficulty of quitting, abstinence goal, pros and cons, stage of change), alcohol use, and other drug use were assessed. *Results*. Compared with those who smoked only tobacco, co-users were younger and had smoked for fewer years; had higher household income; were more likely to be male, multiethnic, and nondaily smokers; and reported greater alcohol and other drug use. The variable of days using marijuana in the past 30 days was associated with multiple measures of tobacco use intensity/frequency. Only one association was significant between marijuana use and tobacco-related cognitions: Co-users had a lower likelihood of planning to quit tobacco for good (odds ratio = 0.75, 95% CI [0.58, 0.98]). *Conclusions*. Findings support the association between tobacco and marijuana use among young people but speak to the importance of addressing tobacco cognitions in young adult smokers regardless of level of marijuana use.

Smith, P. H., Homish, G. G., Leonard K. E., Collins, R. L. (in press). Marijuana withdrawal and aggression among a representative sample of U.S. marijuana users. *Drug and Alcohol Dependence*.

Background. Previous laboratory-based research suggests that withdrawal from marijuana may cause increased aggression. It is unclear whether this finding extends beyond the laboratory setting to the general population of marijuana users. The purpose of this study was to test a cross-sectional association between marijuana withdrawal symptoms and aggression among a representative sample of U.S. adult marijuana users, and to test whether this association was moderated by previous history of aggression. *Methods*. Data were analyzed from the National Epidemiologic Survey on Alcohol and Related Conditions. Wave Two data (2004-2005) were used for all variables except for history of aggression, which was assessed during the Wave One interview (2001-2002). Two outcomes were examined: self-report general aggression and relationship aggression. Odds ratios for aggression based on withdrawal symptoms and the interaction between withdrawal symptoms and history of aggression were calculated using logistic regression, adjusting for covariates and accounting for the complex survey design. *Results*. Among marijuana users with a history of aggression, marijuana withdrawal was associated with approximately 60% higher odds of past year relationship aggression (p < 0.05). There was no association between withdrawal symptoms and relationship aggression among those without a history of aggression, and no association with general aggression regardless of history of aggression. *Conclusions*. The findings from this study support the notion that laboratory-based increases in aggression due to marijuana withdrawal extend to the general population of marijuana users who have a previous history of aggression.ψ

Anyone Can Submit an Abstract

We are looking for…

(1) peer-reviewed articles in press or published in the past year;

(2) highly innovative research in areas of addiction where research is lacking;

(3) research published in journals other than *Psychology of Addictive Behaviors* (since members already receive this journal);

(4) only one submission per author per year.

Announcements

Postdoctoral Positions Available

Postdoctoral Fellowships in Prevention Science

The Prevention Research Center, PIRE, in collaboration with the School of Public Health, University of California, Berkeley, is seeking applicants for three two-year post-doctoral fellowships funded by the National Institute on Alcohol Abuse and Alcoholism. The fellowships provide training in prevention research with an emphasis on health and social problems related to alcohol use and abuse. Individuals from all social and behavioral science disciplines are encouraged to apply. Fellowships begin July 1 through August 31, 2013. Applicants must have completed their doctorate prior to beginning the fellowship. Application materials should be submitted by April 15, 2013. See http://www.prev.org/preventiontraining/ for additional information and application instructions. Contact Cheryl Sieczkowski, Program Administrator, at prcpostdoc@prev.org with questions. PIRE and the University of California are Equal Opportunity/Affirmative Action Employers. NIH policy requires applicants to be US citizens or have permanent US residency.

Postdoctoral Scholars

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

Research Institute on Addictions

The University at Buffalo Research Institute on Addictions (RIA) anticipates multiple openings for NIAAA-funded T32 postdoctoral fellows in alcohol etiology and treatment. Fellows develop and pursue research interests under the supervision of faculty preceptors. Seminars on alcohol use disorders, grant writing, and professional issues and career development are included. Start dates in Summer and Fall 2013 are negotiable. Visit the RIA website at http://www.ria.buffalo.edu. Inquiries can be made to either Kenneth E. Leonard (leonard@ria.buffalo.edu) or R. Lorraine Collins (lcollins@buffalo.edu), Co-Training Directors. Applicants should forward a vita, representative reprints, letters of reference, and a cover letter describing research interests and training goals to Alcohol Research Postdoctoral Training Committee, Attn: K. E. Leonard and R. L. Collins, Research Institute on Addictions, 1021 Main Street, Buffalo, NY 14203. Applications from minority candidates are particularly welcome. Applicants must be citizens or noncitizen nationals of the U.S. or must have been lawfully admitted for permanent residence. AA/EOE

Hot off the press!

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change (3rd ed.)*. New York, NY, US: Guilford Press.

Hailed as "the most complete explication of MI to date" by Timothy J. O'Farrell, this bestselling work for professionals and students elucidates the four processes of MI—engaging, focusing, evoking, and planning—and vividly demonstrates what they look like in action. A wealth of vignettes and interview examples illustrate the "dos and don'ts" of successful implementation in diverse contexts. Highly accessible, the book is infused with respect and compassion for clients. With over 250,000 copies in print, this new edition of the classic text includes additional case examples and counseling situations, and reflects major advances in understanding and teaching MI. Visit www.guilford.com/p/miller2 to preview the book, read a free sample chapter, and more.ψ

Join APA's Divisions 28 & 50 for

Biobehavioral RESEARCH & Implications for PRACTICE

Our Divisions, Our Conference
Our FIRST mid-year conference!

/Current Research/
/Panels, Symposia, Posters/
/Networking/Mentoring Opportunities/
/Student/Early Career Discounts/
/In-Depth Workshops/

May 3-4, 2013

Atlanta, Georgia
Midtown W Hotel

28/50 COLLABORATIVE PERSPECTIVES ON ADDICTION

SOCIETY OF ADDICTION PSYCHOLOGY

28 DIVISION PSYCHOPHARMACOLOGY AND SUBSTANCE ABUSE

First Annual Conference
May 3-4, 2013
Atlanta, GA

Need More Info?

Contact Division 50
Sara Jo Nixon
(sjnixon@ufl.edu)

Contact Division 28
Anthony Liguori
(aliguori@wakehealth.edu)

REGISTRATION IS NOW OPEN!

CONFERENCE REGISTRATION RATES

Conference fee includes attendance in all breakout sessions and CE credit, two keynotes, and social hours.

Early Registration (On or before 3/21/13)
- ❒ Div 28 or Div 50 Member - $215
- ❒ Non-Member - $265*
- ❒ Early-Career Member - $145**
- ❒ Student (subject to verification) - $95

Regular Registration (Received after 3/21/13)
- ❒ Div 28 or Div 50 Member - $265
- ❒ Non-Member - $315*
- ❒ Early-Career Member - $195**
- ❒ Student (subject to verification) - $145

Register online at
www.tinyurl.com/2013CPA

CONFERENCE REGISTRATION RATES

Continuing Education provided during the Collaborative Perspectives on Addiction Conference is provided by APA Division 50. APA Division 50 is approved by the American Psychological Association to sponsor continuing education for psychologists. Division 50 maintains responsibility for this program and its content. For questions related to Continuing Education, contact Chad Rummel at crummel@apa.org.

KEYNOTES

SAUL SHIFFMAN is a world-renowned researcher in the fields of behavior change and relapse, self-management and self-control, field research methodology, statistical analysis, and addiction and dependence.

EDITH SULLIVAN is Professor of Psychiatry and Behavioral Sciences at Stanford University and a neuropsychologist who has pioneered the study of alcoholism-related brain injury on selective cognitive and motor function.

INVITED PRESENTATION

"Peeking Behind the Curtain of the NIH Funding Process: Tips for Preparing a Successful Grant Application"

HAROLD PERL, PHD, the Chief of the Prevention Research Branch at NIDA, will give an invited presentation at the 2013 Collaborative Perspectives on Addiction Conference.

Dr. Perl's presentation is open to all attendees of the conference; lunch will be provided.

PRECONFERENCE WORKSHOP

"CONDUCTING NEUROIMAGING STUDIES FROM A NEUROPSYCHOLOGIST'S PERSPECTIVE"

Integrating neuroimaging techniques with neuropsychological and other neurobehavioral methods is often a powerful approach in human studies. Many applicants underappreciate the critical processes that enable a) identification of appropriate team members, b) building cohesion among members, and c) sustaining individual commitment and engagement throughout the project. Furthermore, psychologists without neuroimaging expertise often fail to fully utilize the expertise of their collaborators and thus struggle to communicate the import of their data. Building on existing literature and her own experiences, Dr. Mattson's workshop focuses on essential steps in defining effective, productive and innovative teams from the perspective of "non-imagers."

SARAH MATTSON, PHD, will present the conference (pre-registration required)

SoAP (Division 50) Leadership

ELECTED OFFICERS

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

COMMITTEE CHAIRS

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

LIAISONS

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

APPOINTED STUDENT REPRESENTATIVES

Ashley Hampton	Student Representatives to the Board	ashleyhampton@temple.edu
David Eddie	Finance & Budget	daveddie@eden.rutgers.edu
Kiki Hachiya	Education and Training	Laura.Hachiya@asu.edu
Natalie Gildar	Education and Training	ngildar@asu.edu
Stephen Proctor	Advocacy & Policy	Sproct2@tigers.edu

Thank You to the 2013 APA Convention Program Committee!

This year was a bigger challenge than ever for the SoAP Program Committee. We had more poster and symposium submissions than ever before. Therefore, I send my heartfelt gratitude to all the members of the Program Committee whose expedient and thoughtful reviews helped shape our incredible 2013 program:

CLARA BRADIZZA
JAMES MACKILLOP
AMEE PATEL
JEN READ
MARIELA SHIRLEY
LINDA SOBELL

I would also like to thank NIAAA and NIDA for once again providing travel awards to many of our symposium presenters and early career superstars.

—Jen Buckman, 2013 SoAP Program Chair

Society of Addiction Psychology Executive Officers

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

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

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

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

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

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

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

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

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

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