



The Addictions Newsletter

The American Psychological Association, Division 50

www.addictionpsychology.org

FALL 2015

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President's Column

Sherry McKee

I am honored to have the opportunity to serve as this year's President of the American Psychological Association's Society of Addiction Psychology (SoAP). I have been a member of Division 50 since I was a graduate student and truly value the mission of this organization—to promote advances in research, professional training, and clinical practice within the broad range of addictive behaviors including problematic use of alcohol, nicotine, and other drugs and disorders involving gambling, eating, sexual behavior, or spending. As a psychologist whose professional

roles span clinical service, training, and research, Division 50 is my professional home. Many dedicated members of our Division provide invaluable service to its members, including advocacy, representation of our interests within and outside of APA, two yearly conventions, professional acknowledgement through awards and fellow status, and continuing education credits for licensure to name a few.



Sherry McKee

The purpose of this column is to present my agenda as President for the year, and very simply, I see my job as helping to keep all of our initiatives “moving along,” including both new and ongoing initiatives. One



CPA Conference, San Diego PAGE 33
March 18-19, 2016

APA Convention, Denver PAGE 12
August 4-7, 2016

South Valley Park, Colorado, is a 909-acre park with 8 miles of hiking trails. Photo: iStock.

new initiative is a student research grant program developed by Noah Emery and Megan Kirouac, our student representatives. This program will support graduate student research in the field of addiction psychology with three grants of \$1,250 awarded each year. These annual awards will be presented to students whose research reflects excellence in addiction psychology.

For the upcoming year, I look forward to working with all of the dedicated members who so graciously donate their time as elected officers, committee chairs, special positions, and liaisons.

Award winners will have an opportunity to attend and present at one of our Division 50 conferences (APA or CPA), with a travel stipend of \$500. The first call for applications is expected to be advertised in Spring 2016.

The second new initiative includes the formation of a Social Media and Communications Committee, chaired by Brandon Bergman, who also does an outstanding job as our Division's Secretary. This committee will work to retool our website, social media presence, and intra-division communication. Its overarching goal is to further the division's mission by using these digital modalities to communicate more effectively with our members, prospective members, professional audiences, and the general public.

Our third initiative is to increase the numbers of student and early career members that are involved in our Division through committee involvement. More about this will be forthcoming on the listserve. Overall, I think our Division does an amazing job of reaching out to and making our student and early career members feel included and supported. In particular, I would like to acknowledge the work of Bruce Liese (Membership Chair) in this regard, who organizes a monthly series of con-

ference calls for our junior members highlighting the work of Division 50 members focused on advocacy, policy, treatment, and research. This endeavor has been hugely successful, with exceptionally positive feedback from our junior members. Upcoming calls are advertised on our listserve, and prior calls are available at <http://cbtaddictions.org/d50/>.

Similarly, the contribution of Mark Schenker (Practice Member-at-Large) also needs to be acknowledged. Mark organizes a monthly conference call to provide a forum for clinicians working with addiction to compare notes, learn about others' approaches and share knowledge. Each month one person presents a topic or a case, and the group can discuss it as it sees fit. People are welcome to listen in, or to offer to present. The meeting is open to all and is held on the second Friday of the month at 1:00 PM (Eastern Time). If you'd like to be on the distribution list, or get further information, contact Mark Schenker at mschenker@navpoint.com.

One key ongoing initiative includes the renewal of the Proficiency status of treatment for addictive type problems within the APA, which outlines the training needed to be proficient and gain certification in this area of practice. Alan Budney (Past-President) is spearheading this effort, along with John Kelly, Ray Hanbury, Mark Schenker, and Nancy Piotrowski. We are in the process of revising that application to update the standards of practice and training which reflect the changing science and practice knowledge that has developed over the past 10 years. Once we renew the Proficiency status,

our next goal will be to advertise the Proficiency status to licensure boards, insurance carriers, and our professional membership.

Second, I wanted to highlight the Collaborative Perspectives on Addiction (CPA) conference. The conference was originally developed by Katie Witkiewitz and Jen Buckman—and in two years' time, they (amazingly!) have made the conference a resounding success. For this year's CPA conference in San Diego (March 18-19), James Murphy and Robert Leeman (Program Chairs) have partnered with the Society for the Psychological Study of Culture, Ethnicity and Race (Division 45), with a programming focus on reducing health disparities through addiction science and practice. I encourage everyone to attend. <http://research.alcoholstudies.rutgers.edu/cpa>

I also wanted to take a moment to acknowledge the transitions occurring among our elected officers. Alan Budney transitioned from President to Past-President, and Katie Witkiewitz is our new President-Elect, two amazing colleagues to bookend my year. Jen Buckman stepped down as Treasurer after many years dedicated to this role, contributing to the sound financial status of our Division. We welcome Ty Schepis as our new Treasurer and Jennifer Read as Member-at-Large (Science). Finally, I want to acknowledge the tremendous work by Kristina Jackson and Susan Glasner-Edwards (2015 APA Division 50 Program Chairs), and this year's chairs, Lara Ray and Christian Hendershot, who are already hard at work planning our Division's 2016 APA conference.

For the upcoming year, I look forward to working with all of the dedicated members who so graciously donate their time as elected officers, committee chairs, special positions, and liaisons. ♡

Editor's Corner

Four score and seven years ago ... ok, maybe it was not THAT long ago, but it sure seems like a long time ago that I first heard about positive psychology. I had just started graduate school when I read the introductory article in the *American Psychologist* (Seligman & Csikszentmihalyi, 2000), and I was alight with energy and enthusiasm. "Imagine doing THAT kind of research," I exclaimed to my sister, who, like me, was in graduate school, albeit for ecology. "Spending your days thinking about the ingredients of happiness and flow, and using all of your learned skills to test and develop methods to help people achieve greater happiness!" Being my sister, she said: "Why wait? You are doing psychological research right now, aren't you? Why not make it positive psychological research?" And so we did. As I progressed through graduate school, however, I soon became distracted by all the other things I also needed and wanted to learn and do—statistics being one of them. And before you know it, it's fifteen years later, and I spend my days delineating mechanisms of behavior change rather than pursuing happiness. This time, it's Chris Kahler, who snaps me back. In visiting the Center for Addiction Medicine, Chris presents his pioneering research on leveraging positive psychology to promote smoking cessation (see the Cioe article in this issue, p. 24). "Wait," I say to myself, "I can do BOTH? I can support addictive behavior



Bettina B. Hoepfner

change BY making people happier?" And wouldn't you know it, during the fifteen years I've been distracted with getting my feet under me as a junior investigator, the field of positive psychology has undergone an immense growth period. By now, it has been shown that very simple positive psychology exercises can and do bring about changes in happiness (Sin & Lyubomirsky, 2009), and excitingly, that such exercises work even when self-administered. At the same time, the field of substance use research has undergone quite some change, where the recovery movement puts increased focus on enhancing quality of life (Krentzman, 2013—also her article in this issue on the positive psychology roots in substance use treatment, p. 15), which resonates well with the basic idea of positive psychology. Together, these advances beg the question: "**Can Positive Psychology Contribute to Addiction Treatment and Recovery?**" The authors who have generously agreed to write articles for this issue seem to think so—and I'm inclined, nay, excited to agree. Notably, the authors I asked who declined to write articles were more skeptical. © But judge for yourself! The six articles addressing this topic cover an inspiring range of considerations, ranging from discussing the theoretical overlap and historical roots of substance use research and positive psychology to practical applications and rigorous treatment development research. I can't thank the authors

enough for sharing their ideas and data with us in this way!

In the next issue of TAN (**February 1 deadline**), we will focus on: "**The Opioid Epidemic.**" That is, admittedly, a broad topic, but that hopefully means that it is that much more enticing to you to contribute your thoughts and thinking on this topic, be it through your clinical work or your research projects. Keep in mind that articles are short (1,200 word limit), fairly informal, and take many shapes (e.g., opinion pieces, descriptions of pilot or small studies, short reviews)—all factors, hopefully, that will make it easy for you to share your thoughts. We also invite you to submit an article on a topic of your choosing. In fact, if there is a topic you'd like to be explored in a future issue of TAN, please be sure to suggest this topic to us: We are happy to receive any and all ideas!

Happy reading!

Bettina Hoepfner
TAN Editor

Hillary Howrey
TAN Grad
Student Mentee

References

- Krentzman, A. R. (2013). Review of the application of positive psychology to substance use, addiction, and recovery research. *Psychol Addict Behav*, 27(1), 151-165. doi: 10.1037/a0029897
- Seligman, M. E., & Csikszentmihalyi, M. (2000). Positive psychology. An introduction. *Am Psychol*, 55(1), 5-14.
- Sin, N. L., & Lyubomirsky, S. (2009). Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: A practice-friendly meta-analysis. *J Clin Psychol*, 65(5), 467-487. doi: 10.1002/jclp.20593

SoAP MEMBER SERVICES

Join SoAP: Join at www.apa.org/divapp. Membership is for January-December. If you apply during August-December, your membership will be for the following January-December.

Renew SoAP: Renewal notices begin going out in September. Members, Associates, and Fellows may renew along with their APA membership at www.apa.org/membership/renew.aspx. Professional Affiliates (professionals with no membership in APA) and Student Affiliates may renew at www.apa.org/divapp.

Advocate's Alcove

Nancy A. Piotrowski
*Division 50 Federal Advocacy
Coordinator*

Ready or not, change is here. The first of October marked the official transition to using the World Health Organization (WHO) International Classification of Disease (ICD) system, tenth revision, and its Clinical Modification (CM) series for use in the United States. Anyone covered by the Health Insurance Portability and Accountability Act (HIPAA) is required to use ICD-10-CM for diagnostic coding on any claims made (electronic or paper) for service provided after October 1, 2015. To learn more about this and follow any changes that may affect your work, you can find information at the Practice Central site for the American Psychological Association Practice Organization (APAPO) (<http://www.apapracticecentral.org/index.aspx>). There is a special section on the start page with questions and answers, as well as other resources.

The APAPO site also provides an update on The Mental Health Reform Act of 2015. This legislation is proposed by Senators Bill Cassidy of Louisiana and Chris Murphy of Connecticut. The legislation focuses on issues central to access to care for our clients, enhancing interagency coordination, and the fostering of integrated care. As is probably obvious, the long-term goal underlying the proposed changes is to increase the quality of care. For those of us working in the area of comorbidity, we have seen first hand how a lack of integrated care can create problems for clients. As such, it should be of interest to us to follow this closely and see how it develops. To this end, keep an eye on your email. I will send informational updates on this as time progresses. You also may visit Capwiz (<http://capwiz.com/apapractice/home/>) to follow this item, as well as others if you like.

Speaking of changes, because our legislators and legislation change over time, it is important for us to stay in contact so that I can learn about what is new in your area. This relates to any changes at the state level affecting your work. It also relates to how federal legislation related to your work is rolling out in your neighborhood and may be affecting you in any good (or unexpected) ways. Please do keep in touch. I am happy to receive emails at napiotrowski@yahoo.com on such matters at any time. I will take whatever information you share and convey it to our contacts at the APAPO and APA more generally. As mentioned over the summer too, if you know any

legislators in your state, let me know. For instance, do you regularly talk to your elected representatives about issues related to the profession? Or have

you ever visited their offices? Have you met their local staff? Do you know a representative as a neighbor, friend, or old chum from college? These connections are important because they are opportunities for our representatives to get to know psychologists and learn about the work we do with our clients, our research, and how we can contribute to

public health and science more broadly. So if you have contacts like this, your providing this information to me for APAPO can help our profession. So, if you have not already sent me an email about such contacts in your life, please do. Also, be aware that student members working with me may call you to check in and ask about such contacts, or any other feedback you have about laws affecting your work. Thank you in advance for helping! Ah—and for any students who want to help with outreach, please be in touch. We are going to be working hard this fall to do outreach to all our members and could use your help.

Resource Information

American Psychological Association Practice Organization (APAPO) Capwiz <http://capwiz.com/apapractice/home/>

APAPO Practice Central site <http://www.apapracticecentral.org/index.aspx>ψ



Nancy A. Piotrowski



New Member Spotlight: Kevin R. Wenzel

Jennifer E. Merrill
Early Career Representative

Please welcome to SOAP a new member, Kevin Wenzel. Kevin is currently a pre-doctoral intern at the Jerry L. Pettis Memorial Veteran Affairs Medical Center in Loma Linda, CA. He completed his B.S. in psychology at Florida State University, and will graduate from Saint Louis University's clinical psychology doctoral program in May. There, he has focused his research on substance use disorders and addictive behaviors under the mentorship of Dr. Jeremiah Weinstock.

What are your research interests?

My research interests broadly include studying impulsive and dysregulated behaviors as they occur in the etiology and maintenance of addictions and other unhealthy behaviors. I have also worked on several clinical trials implementing motivational interviewing techniques and contingency management interventions for various healthy behavior changes. My dissertation is entitled "Exploring the validity of food addiction," which was a fun project to work on because it is such a controversial topic in the addiction world! I have also worked on a few other independent projects including a cross cultural research project with U.S. and Guatemalan college student drinkers.

How did you get interested in addictive behaviors?

I have always been interested in learning about broad characteristics such as impulsivity and dysregulated behaviors as they occur across diagnoses. When I was introduced to my graduate advisor's lab and research, I was able to easily apply those broad factors to addictions, and it was a natural fit. During my internship, I have been exposed more to the clinical side of addictions, which I also enjoy.

What are your clinical experiences and interests?

Currently, as an intern, I am mainly co-leading therapy and educational groups in a variety of settings including an acute inpatient unit, an intensive



Kevin R. Wenzel

outpatient program for dually diagnosed patients, and in an addictions treatment program. A generalist model of training has allowed me to interact with clients and patients from many different backgrounds ranging from highly functioning college students to Veterans with severe addictions and

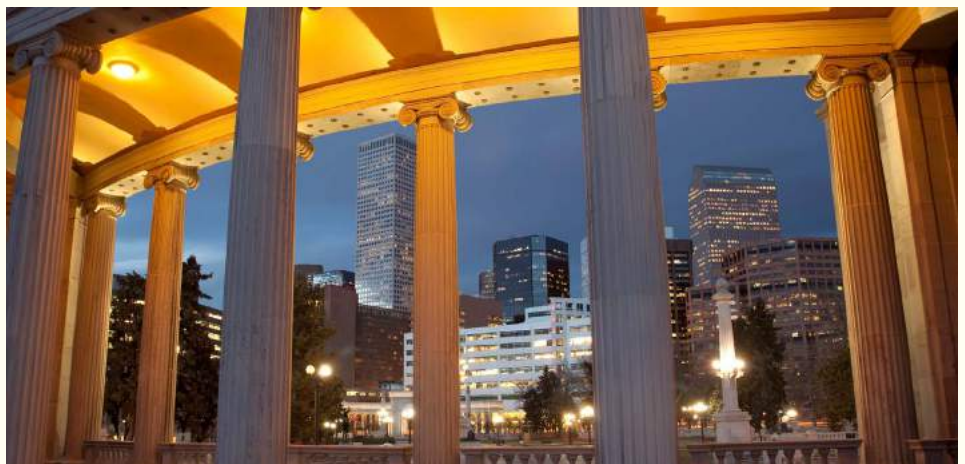
persistent mental illness. There have been very few populations that I have not enjoyed treating, and perhaps I am still developing my clinical niche; however, I very much enjoy helping people coping and healing from addictions, depression, and interpersonal struggles.

How did you hear about the Society of Addiction Psychology (Division 50) and what motivated you to join?

My graduate advisor recommended SoAP to me. I wanted to be part of a network of people who had similar interests to me. As an emerging psychologist, it was especially important to me that I stay in the loop regarding post-doctoral training and career opportunities advertised through Division 50.

What are your next career steps?

My ultimate career goal is to work in a setting that allows and encourages the integration of clinical practice and research. I haven't quite decided if I am more interested in a university based career or an academic medical center setting. Regardless, the next step for me is to find a 1-2 year postdoctoral fellowship that will prepare me for licensure and incorporate experience and training in research. [ψ](#)



Hope to see you!
APA Convention | Denver, August 4-7, 2016

Nighttime downtown skyline, Civic Center Park, Denver. Photo: iStock.

Student and Trainee Perspectives

Megan Kirouac
University of New Mexico
Student Representative

Noah Emery
University of South Dakota
Student Representative

In keeping with the theme for this issue of TAN, the current Student and Trainee Perspectives article provides an overview of the positive psychology movement within addiction psychology and why this is important for students and trainees. Furthermore, in an effort to keep you up to date with current SoAP affairs, this article will also introduce SoAP's newly appointed Student Representative to the Executive Board.

Advances in positive psychology have grown exponentially over the past decade. Similarly, the addiction psychology field has experienced its own growth in this area. However, some addiction professionals still ask "Can positive psychology contribute to addiction treatment and recovery?" In many ways, it already has. Positive psychology emphasizes shifting from a focus on problems and symptoms toward improving quality of life and life satisfaction through treatment. At the 2014 Collaborative Perspectives on Addictions meeting, Dr. Tom McClellan gave an informative and impassioned presentation highlighting the limitations to how addiction treatment research has traditionally measured treatment outcomes. He pointed to the so-called failure of Project MATCH, questioning how addictions researchers measure and define treatment success. Experts convened by NIDA (Donovan et al., 2012; Tiffany et al., 2012) and SAMHSA (2012) have promoted similar principles of positive psychology, calling for an increased emphasis on quality of life and psychosocial functioning as outcomes researched. Even prior to these meetings, prominent addictions treatment researchers such as Dr. Dennis Donovan called for quality of life to be examined, emphasizing that other fields such as the biomedical

field have already begun to shift from evaluating treatment efficacy based on symptom reduction toward evaluation based on improving quality of life (e.g., Donovan, Mattson, Cisler, Longabaugh, & Zweben, 2005).

Furthermore, there is a rich body of work on resilience mechanisms that promote increased quality of life and sustained abstinence. Work associated with this movement often examines the compound construct of "recovery capital," that is comprised of social support, spirituality, religiousness, life meaning, and 12-Step affiliation, and its impact on life satisfaction. Researchers such as Dr. Alexandre Laudet and colleagues (2006) suggest that recovery capital enhances an individual's ability to cope with the stressful and challenging path to sustained recovery. As part of their work, they have shown that recovery capital prospectively predicts sustained recovery, quality of life, and lower stress level a year later. Additionally, life satisfaction and stress level were strongly predicted by length of recovery. This suggests that the increasing discomforts of the substance-using lifestyle and the hope for a better life that sets many individuals who use substances on the path of recovery can and will lead to improvements in quality of life and reductions in stress for many. Moreover, this suggests that interventions where clinicians work in partnership with clients to develop strategies that maximize recovery capital could be an effective modality and might represent the future of treatment for substance use disorders (i.e., recovery management). This and other studies like it highlight the need for a pragmatic paradigm shift from an acute illness model (assess,

admit, treat, discharge) to a model of recovery management consistent with other treatment approaches for chronic disorders such as diabetes or asthma.



Megan Kirouac



Noah Emery

The work by Laudet and colleagues is similar to the focus of positive psychology on enhancing strengths rather than focusing on mitigating weaknesses. Such work is also paralleled by recent efforts to evaluate what facets of recovery are most important to clients, their loved ones, and treatment providers. Emerging data from a large-scale grant funded by NIAAA to Dr. Lee Ann Kaskutas and colleagues (2014) have demonstrated clients and their loved ones emphasize the importance of improvements in coping, social relationships, and life satisfaction rather than an exclusive focus on problem reduction.

Similarly, other research has shown addictions treatment providers recognize the importance of improving physical and mental health beyond problem reduction alone (Neale et al., 2014).

In light of the above findings, there appears to be a growing movement in the addictions field to incorporate aspects of positive psychology. As students, we have the potential to help this movement grow into a full paradigm shift where addictions treatment and research defines treatment success beyond abstinence or problem reduction alone. Although alcohol and other drug use will almost certainly remain a prominent target of addictions treatment and research, the emergent body of literature is suggesting that addressing additional variables such as improvement in quality of life is also of great importance. Students of addictions psychology will shape the

future of the field; asking ourselves the question of “can positive psychology contribute to addiction treatment and recovery” may outline the shape that field is beginning to take.

References

- Donovan, D. M., Bigelow, G. E., Brigham, G. S., Carroll, K. M., Cohen, A. J., Gardin, J. G., ... Wells, E. A. (2012). Primary outcome indices in illicit drug dependence treatment research: systematic approach to selection and measurement of drug use end-points in clinical trials. *Addiction*, 107(4), 694-708. doi: 10.1111/j.1360-0443.2011.03473.x
- Donovan, D., Mattson, M. E., Cisler, R. A., Longabaugh, R., & Zweben, A. (2005). Quality of life as an outcome measure in alcoholism treatment research. *Journal of Studies on Alcohol*, 515, 119-139. doi: 10.15288/jsas.2005.s15.119
- Kaskutas, L. A., Borkman, T. J., Laudet, A., Ritter, L. A., Witbrodt, J., Subbaraman, M. S., ... Bond, J. (2014). Elements that define recovery: The experimental perspective. *Journal of Studies on Alcohol and Drugs*, 75, 999-1010. doi: 10.15288/jsad.2014.75.999
- Laudet, A. B., Morgen, K., & White, W. L. (2006). The Role of Social Supports, Spirituality, Religiousness, Life Meaning and Affiliation with 12-Step Fellowships in Quality of Life Satisfaction Among Individuals in Recovery from Alcohol and Drug Problems. *Alcoholism Treatment Quarterly*, 24(1-2), 33-73. http://doi.org/10.1300/J020v24n01_04
- Neale, J., Finch, E., Marsden, J., Mitcheson, L., Rose, D., Strang, J., ... Wykes, T. (2014). How should we measure addiction recovery? Analysis of service provider perspectives using online Delphi groups. *Drugs: Education, Prevention and Policy*, 21(4), 310-323. doi:10.3109/09687637.2014.918089
- Substance Abuse and Mental Health Administration. (2012). *SAMHSA's Working Definition of Recovery: 10 Guiding Principles of Recovery*. (SAMHSA Publication No. PEP12-RECDEF). Retrieved from <http://store.samhsa.gov/shin/content//PEP12-RECDEF/PEP12-RECDEF.pdf>
- Tiffany, S. T., Friedman, L., Greenfield, S. F., Hasin, D. S., & Jackson, R. (2012). Beyond drug use: a systematic consideration of other outcomes in evaluations of treatments for substance use disorders. *Addiction*, 107, 709-718. doi: 10.1111/j.1360-0443.2011.03581.x
- and Addictions. My work in graduate school has continued to focus on harm reduction approaches for working with individuals who have substance use disorders, specializing in the research and treatment of Alcohol Use Disorder (AUD). My thesis work developed and tested a measure of “hitting bottom” for individuals with alcohol problems to empirically test the long-standing belief that “hitting bottom” is necessary for recovery. Currently, I am working to explore alternative, non-abstinence definitions of how “treatment success” is defined and operationalized in AUD treatment research.

From Megan

I completed my bachelor's in psychology at the University of Washington (UW) in 2010. During that time, I was highly involved in various research projects at the Addictive Behaviors Research Center and the Center for the Study of Health and Risk Behaviors. There, I was working to study harm reduction interventions for college students who used alcohol. Simultaneously, I was assisting on a Housing First study that aimed to adopt a harm reduction approach for working with individuals who were formerly chronically homeless and had symptoms congruent with Alcohol Dependence. Currently, I am a fourth-year clinical psychology graduate student at the University of New Mexico (UNM), where I work with Dr. Katie Witkiewitz in her Addictive Behaviors and Quantitative Research Lab at the Center on Alcoholism, Substance Abuse,

In addition to my strong interest in research is a passion for clinical work, especially the work I do at UNM's Alcohol Specialty Clinic where graduate students receive training in evidence-based treatments for AUD. In that practicum, I have enjoyed learning and implementing Mindfulness-Based Relapse Prevention (MBRP), Cognitive Behavioral Therapy (CBT), the Community Reinforcement Approach (CRA), and Motivational Interviewing (MI) interventions.

I also have a strong interest in building the community of addiction psychology that has been so positively influential in shaping my career. As such, I am very excited to be joining the SoAP's Board as a Student Representative. I look forward to helping build our society, especially to further student involvement with SoAP's important work!ψ

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

Mark Myers, Amy Rubin & Samantha Domingo
SoAP Nominations and Elections Committee

This is your once-a-year opportunity to get more involved in the Society of Addiction Psychology (SoAP)! This year we are looking to fill two positions: (1) President-Elect and (2) Member-at-Large (Practice). The 3-year terms of

these offices start at the close of the SoAP Business Meeting at the APA convention in 2016.

You are already devoting considerable time to treating and/or conducting research with individuals with addictive behaviors. Here is your opportunity to have an impact on the field at the national level. Self-nominations are invited and you only need 2.5% of the

membership to endorse your nomination in order for you to be placed on the ballot (deadline: mid-January).

Here's what will happen:

- The Chair of the Nominations and Elections Committee will solicit nominations through the SoAP listserv later this year.
- Candidate biographies will run in

the Spring 2016 issue of TAN.

- The electronic ballot will be distributed by the APA Central Office in April 2016 (with a June 1st deadline).

All SoAP members and fellows are eligible to run for either office.

President-Elect

The President-Elect functions as the Vice President for the first year. S/he becomes President in the second year of his/her term, then Past President in the third year. The President-Elect spends the first year getting oriented to the current Board, observing the activities of the SoAP, participating in various initiatives, and contribut-

ing ideas to the strategic planning for the upcoming year (the year s/he becomes President). After completing the President-Elect year, the President presides at all meetings of the SoAP Membership and Board of Directors as Chairperson and implements any new strategic initiatives. The President performs other duties consistent with the Bylaws or decided upon by the Board of Directors. The President also gives the Society's Presidential Address at the APA convention (2017 in Denver). The Past President then serves as advisor to the current President. The term of the President-Elect will overlap with the 2016-2017 Past President Sherry McKee, and 2016-2017 President Katie Witkewicz.

Member-At-Large (Practice)

This Member at-Large (MAL) serves a liaison function between the SoAP and the more "practice-oriented" divisions such as Division 17 (Society of Counseling Psychology), 29 (Psychotherapy), 39 (Psychoanalysis), and 49 (Group Psychology and Group Psychotherapy), as well as APA's Practice Directorate. These responsibilities are in addition to involvement in the more general leadership responsibilities shared by the entire executive committee of the SoAP. Elected Officers are expected to attend the Business Meeting and the Board Meeting at the next four APA Conventions and to participate in monthly conference calls. This position is currently held by Mark Schenker. [ψ](#)

Fellows and Award Winners

Sandra Brown, Chair
Art Blume, Kim Fromme, and Sherry McKee

FELLOWS

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

We recommended five candidates for initial fellow status to the APA Fellows Committee in February 2015. Additionally, fourteen existing APA Fellows were recommended to APA. These applications were reviewed and forwarded by the Fellows Committee to the APA Council of Representatives for final consideration and confirmation at the August convention.

SoAP Members Nominated and Recommended for Approval to the APA Council for Fellow Status 2015

Initial Fellows—Confirmed

F. Michler Bishop, Ph.D.
Director of Alcohol and Substance Abuse Services
Albert Ellis Institute (AEI)



SoAP President Alan J. Budney presented the Distinguished Scientific Contributions Award to Kenneth Leonard.

Sarah W Feldstein Ewing, Ph.D.
Associate Professor and Clinical Director, Adolescent Substance Use Disorders Program
University of New Mexico

Kristina M Jackson, Ph.D.
Professor of Behavioral and Social Sciences (Research)
Brown University

Lara Allison Ray, Ph.D.
Psychologist, Addiction Medicine
Santa Monica, CA

Katie A Witkiewitz, Ph.D.
Associate Professor, Department of
Psychology
University of New Mexico

***Current Fellows—Appointed to
SoAP/Division 50***

Kathleen M. Carroll, Ph.D.
Department of Psychiatry
Yale University School of Medicine

Suzanne M. Colby, Ph.D.
Center for Alcohol & Addiction Studies
Brown University School of Public
Health

Hiram E. Fitzgerald, Ph.D.
Department of Psychology
Michigan State University

Sarah H. Heil, Ph.D.
Department of Psychiatry
University of Vermont

Hope Landrine, Ph.D.
Center for Health Disparities
Brody School of Medicine, East
Carolina University

Cecile A. Marczynski, Ph.D.
Department of Psychological Science
Northern Kentucky University

Matthew P. Martens, Ph.D.
College of Education
University of Missouri

Eileen Martin, Ph.D.
Department of Psychiatry
Rush University Medical Center

Lisa A. Melchior, Ph.D.
The Measurement Group
Culver City, California

Jeffrey T. Parsons, Ph.D.
Hunter College and the Graduate
Center
City University of New York

John M. Roll, Ph.D.
College of Nursing
Washington State University Spokane

Stacey C. Sigmon, Ph.D.
Department of Psychiatry
University of Vermont College of
Medicine

Catherine Stanger, Ph.D.
Department of Psychiatry
Geisel School of Medicine at
Dartmouth

Tamara L. Wall, Ph.D.
Department of Psychiatry
University of California San Diego

AWARDS

Four American Psychological Association
SoAP/Division 50 Awards were conferred
at the SoAP Business Meeting at the
Annual Conference this year:

**Kenneth Leonard: Distinguished
Scientific Contributions Award**

Dr. Leonard is the Director of the
Research Institute on Addictions, a
Research Professor in Psychiatry at the
University at Buffalo Medical School,
and a Fellow and former president of
SoAP. He is internationally recognized
for his research on substance use
and intimate partner violence, as
well as the impact of alcoholism
on marital/family processes. Dr.
Leonard's innovative research has been
influential in demonstrating the effects
of substance abuse on interpersonal and
familial processes through creative,
methodologically sophisticated
longitudinal and experimental studies.
His Newlywed project was especially
novel in recruiting couples at the time of
applying for their marriage license and
following them through their 7th and
9th year anniversaries. This longitudinal
research allowed Dr. Leonard to identify
the impact the impact of major life
events, parenthood, and environmental
stressors on the couples' drinking
and alcohol-related problems. Dr.
Leonard's body of work has expanded
our understanding of the means through
which substance abuse affects family
relationships, and has facilitated
the prediction and prevention of
interpersonal violence.

**Katie Witkiewitz: Presidential
Citation**

Dr. Witkiewitz is Associate Professor
of Psychology at the University of
New Mexico, a Fellow and President-
Elect of SoAP. She was recognized for
her tremendous service to Division
50, which has helped advance our
contributions to the area of addictive
behaviors. Dr. Witkiewitz has been a
leader in planning and organizing the
new annual Collaborative Perspectives
on Addiction Conference, which has
been a huge success in bringing together
addiction psychologists under cutting
edge themes of common interest. She
also currently serves as an Associate
Editor of *Psychology of Addictive
Behaviors*.

**Dr. Erika Litvin Bloom: Distinguished
Scientific Early Career Contributions**

Dr. Erika Litvin Bloom received her
Ph.D. in clinical psychology in 2011
from the University of South Florida,
and completed her pre-doctoral
internship and post-doctoral fellowship
at the Alpert Medical School of Brown
University. Dr. Bloom is currently an
Assistant Professor in the Departments
of Psychiatry and Human Behavior and
Medicine at Brown and a psychologist
in the Division of General Internal
Medicine-Research at Rhode Island
Hospital. Her primary research interest
is behavioral treatment development
for addictive behaviors, with a focus
on smoking cessation. She is currently
supported through a K23 Mentored
Patient-Oriented Research Career
Development Award from NIDA to
develop a smoking cessation intervention
for female smokers concerned about
post-cessation weight gain. Dr. Bloom
is an accomplished young scholar who
has 25 peer-reviewed publications and
has been actively presenting her work
at national conferences.

**Bruce Leise: Distinguished Career
Contributions to Education and
Training**

Dr. Liese is a professor of Family
Medicine and Psychiatry and Courtesy
Professor of Psychology at the

University of Kansas. In addition to decades of training professionals, Dr. Liese is recognized for his service in educating and training through novel mechanisms. For example, he conducts the APA Clinician's Corner course: A Manualized Cognitive-Behavioral Therapy Group (CBTAG) for Diverse Addictive Behaviors, including drug, alcohol, tobacco, gambling, spending

and Internet addictions. In this course, he focuses on the design and facilitation of the CBTAG and teaches workshop participants to identify group members appropriate for such a diverse group. Dr. Liese is a Fellow of the Society of Addiction Psychology and a former Editor of *The Addictions Newsletter*. Dr. Liese has made exceptional advances in education and training for the

treatment of addictive behaviors, in particular by bringing practical insights to his sustained training efforts with practitioners from diverse backgrounds and service settings.

CONGRATULATIONS TO ALL AWARD WINNERS!ψ

Become a Fellow of Division 50: Society of Addiction Psychology (SoAP)

Kim Fromme

Fellows Committee Chair

**Gerard Connors, Thomas Brandon,
and Tamara Wall**

Fellows Committee Members

There are two paths to fellow status in all divisions:

"New Fellow" Applications

Members of Division 50 who are APA members but are not yet a Fellow in any division of APA may apply for Fellow status in Division 50. These are known as *"New Fellow"* applications, and applicants must meet both APA criteria and Division 50 criteria for fellow status. **Self-nominations are welcome and encouraged.**

"Current Fellows" Applications

Any member of Division 50 who is already a Fellow in another Division of APA may apply to become a Fellow of Division 50. These applicants are known as *"Current Fellows."* **Self-nominations are welcome and encouraged.**

Current fellows are APA members who are already fellows in other divisions, and may also become fellows in another division without approval from the APA Fellows Committee. Once an APA member has been approved by the Fellows Committee, Board of Directors and Council of Representatives for fellow status in one division, they do not need further approval from APA to become a fellow in additional divisions.

It is the responsibility of each division to determine the eligibility of current fellows and to notify APA of their election. **Applications from current fellows are only evaluated by the Division 50 Fellows Committee.**

APA Fellow Criteria include:

- Five (5) years of acceptable professional experience beyond receipt of the doctoral degree
- Membership in APA for at least one year
- Unusual and outstanding contributions that have had a **national or international** impact

Details about the APA criteria at <http://www.apa.org/membership/fellows/index.aspx>

Division 50 Fellow Criteria include:

1. The nominated individual must have made a distinctive and significant contribution that advances basic or applied addictions research, and/or the treatment of addictive behaviors. Addictive behaviors include the following areas: (a) alcohol and alcoholism, (b) other drug use and abuse, (c) eating disorders, (d) smoking and nicotine addiction, and (e) other compulsive and habitual behaviors that create significant trouble for the individual, or for those in contact with them (e.g., gambling).
2. The contribution must clearly go well beyond the competent performance of one's job, whether that be as

researcher, clinician, educator, or administrator of an addictions-related agency. In the research domain, such contributions typically would be documented by publication of influential empirical and theoretical articles. Qualifying individuals would typically have produced numerous papers on addictions over a period of years, rather than making isolated contributions to the literature. Potential Fellows' clinical contributions to the treatment of addictive behaviors must extend beyond their own clinical practice. Qualifying Fellows may have developed novel approaches that have had demonstrated impact on the treatment of addictive behaviors. Such contributions will typically be reflected in influential clinical publications or in wide recognition as the originator of a therapeutic innovation. Although such activities have significant impact upon the field, contribution through participation in APA or other institutional governance activities will rarely, in and of themselves, be adequate to support a nomination for Fellow status.

3. The contribution must have been disseminated in a public fashion. It must be available and accessible to public and professional evaluation. In almost all instances, this criterion requires that the contribution appear in written form. The criteria for significant contributions will be decided on an individual basis, but will generally be defined as having made a clearly recognizable impact on the subspecialty of the psychology of addictive behaviors.

4. A sufficient period of time must have elapsed to establish that the contribution is not ephemeral and fleeting.

Specific details about the Division 50 criteria are at: <http://www.apa.org/membership/fellows/division-50.pdf>.

Process for New Fellows

Applications to be a new APA Fellow are submitted online through the APA Fellows Online Application Platform. This system will allow nominees, endorsers, and Division Fellows Chairs to submit all required documents online. Applications will not be considered unless they are submitted through this system.

Applications for New Fellow status require letters of endorsement from three current Division 50 Fellows in addition to a detailed statement indicating how, specifically, the

applicant meets both the APA and Division 50 Fellow criteria and completion of other information as required in the application platform. Please visit the APA Fellows webpage for more information and the online system: <http://www.apa.org/membership/fellows/index.aspx>

All materials, including letters of reference, must be submitted through the online platform by **January 8, 2016**.

Please note: Applicants will have to enter the names and contact information of their endorsers in advance of that date so that endorsers can submit their letters of recommendation by this date. All nominees should make sure their applications are complete and that their letter writers have sent in the letters for them. Incomplete nominations will not be considered beyond these deadlines.

The candidates' applications are reviewed by the Division 50 Fellows and Awards Committee. Those receiving a positive recommendation will be forwarded to the APA Fellows Committee for their review. Fellow status is granted by the APA Fellows Committee. Please remember that there can only be one nominating division.

Process for Current Fellows

Current Fellows of other divisions in APA may apply for Division 50 Fellow status by sending a current CV and a letter detailing the ways in which the applicant meets the criteria for fellow status in Division 50. Current Fellows applications are evaluated only by the Division 50 Fellows Committee.

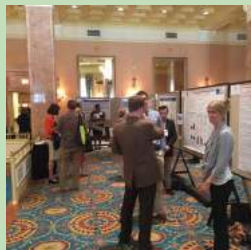
These materials must be emailed to Kim Fromme, fromme@utexas.edu.

The due date for Current Fellows applications is January 1, 2016.ψ

Travel Awards

As part of an R13 grant from NIAAA, we are offering travel awards for successful proposals that emphasize the use of mobile technology in research on and treatment of alcohol use disorders. Eligible symposium submissions include those that discuss the development, implementation, and value of using mobile technology, with particular emphasis on translating research findings to frontline mental health professionals. Please submit proposals to SoAP via APA's online submission portal. Following submission, you will be contacted about your interest in being considered for a travel award. For more information, please email us at societyofaddictionpsychology@gmail.com.

This grant from NIAAA will also provide up to 20 additional travel awards for psychologists within 7 years of their terminal degree. Proposals may be for symposia or poster presentations. Preference will be given to presentations related to mobile technology in research and treatment of alcohol use disorders, but all topics will be considered. Selected presentations will be showcased at an Early Career Investigators Poster Session and Social Hour sponsored by Divisions 28 & 50, NIAAA & NIDA. Please submit proposals to Division 50 via APA's online submission portal. Following submission, you will be contacted about your interest in being considered for a travel award. For more information, please email us at societyofaddictionpsychology@gmail.com.



APA 2015—NIDA/NIAAA early career psychologist poster session and social hour. Photos by Josh Gray, SoAP student member.



Photo: iStock

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

Lara Ray
lararay@psych.ucla.edu
Christian Hendershot
christian.hendershot@camh.ca
Program Chairs

The 124th Annual Convention of the American Psychological Association is being held August 4th-7th, 2016 in Denver, Colorado. You can download the APA Call for Proposals at this link: <http://www.apa.org/convention/proposals.aspx>. We are accepting individual presentations (i.e., poster abstracts) and symposia abstracts, but will not be accepting proposals for individual paper presentations or conversation hours. Our theme this

year is “**Application of Precision Medicine to Addiction Science.**”

Topics of interest include, but are not limited to addiction phenotypes presented within a research domain criterion (RDoC) framework, clinical studies of addiction neurobiology and genetics, development and application of biomarkers, the use of technology to encourage health behaviors, and new targets for treatment and prevention. Although we will consider any addictions-related proposal, we will prioritize those related to this year's theme. We will again be closely collaborating with Division 28 (Psychopharmacology & Substance Abuse) to bring you collaborative and

addictions-focused programming.

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

The deadline is **December 1st, 2015**. We look forward to receiving your proposals, and hope to see you at the Convention in Denver! ♡

Psychology of Addictive Behaviors: Special Issue on Marijuana

Ken C. Winters

*Guest Editor, Special Section,
Psychology of Addictive Behaviors*

Nancy Petry

*Editor, Psychology of
Addictive Behaviors*

Marijuana is the most commonly used “illicit” drug in the United States. Approximately 12% of individuals 12 years of age or older reported using this drug in 2013, and rates are higher among the younger age groups (Substance Abuse and Mental Health Administration, 2014). More

Americans now perceive that marijuana is harmless than view it as harmful (Pew Research Center, 2013), and it is becoming a popular notion that it should not be regulated or considered illegal. Numerous states and the District of Columbia allow either or both medical and recreational use of the drug, and several other states will have pro-marijuana referendums on the November ballot. As policy shifts toward medicalization and legalization of marijuana, issues as to prevalence rates and health implications become more relevant.

Use of marijuana has been linked to negative health effects, but the evidence varies as a function of age of user, whether use is recreational or regular, and health domain (Volkow et al., 2014). For example, the evidence is stronger of the drug’s deleterious effects when use occurs among youth. Nonetheless, there are numerous research domains of public health interest with respect to marijuana. The science is stronger for some areas than others, but the field is still relatively young.

The group of articles in the special sec-

tion represents the growing empirical literature pertaining to epidemiological trends, health effects, and treatment associated with marijuana use. Below is a list of the article titles and first authors:



Nancy Petry

- Computer-assisted Behavioral Therapy and Contingency Management for Cannabis Use Disorder, by Alan Budney et al.
- Parental Involvement in Brief Interventions for Adolescent Marijuana Use, by Tim Piehler & Ken Winters
- Recovery from Cannabis Use Disorders: Abstinence versus Moderation and Treatment-Assisted Recovery versus Natural Recovery, by Jonathan Stea et al.
- Willpower versus “Skillpower:” Examining How Self-Efficacy Works in Treatment for Marijuana Dependence, by Mark Litt and Ron Kadden
- Internalizing and Externalizing Psychopathology as Predictors of Cannabis Use Disorder Onset during Adolescence and Early Adulthood, by Richard Farmer et al.
- Chronic Adolescent Marijuana Use as a Risk Factor for Physical and Mental Health Problems in Young Adult Men, by Jordan Bechtold et al.
- The Academic Consequences of Marijuana Use during College, by Amelia Arria et al.
- Testing an Expanded Theory of Planned Behavior Model to Explain Marijuana Use among Emerging Adults in a Pro-Marijuana Community, by Tiffany Ito et al.
- Can Marijuana Make It Better? Prospective Effects of Marijuana and Temperament on Risk for Anxiety and Depression, by Victoria Grunberg et al.
- Which Matters Most? Demographic, Neuropsychological, Personality and Situation Factors in Long-Term Marijuana and Alcohol Trajectories for Justice-Involved Male Youth, by Sarah Feldstein-Ewing et al.
- Gateway to Curiosity: Medical Marijuana Ads and Intention and Use during Middle School, by Elizabeth D’Amico et al.
- Identifying Classes of Conjoint Marijuana and Alcohol Use in Entering Freshmen, by Amie Haas et al.
- Coping-motivated Marijuana Use Correlates with DSM-5 Cannabis Use Disorder and Psychological Distress among Emerging Adults, by Ethan Moitra et al.
- Associations among Trauma, Post-traumatic Stress Disorder, Cannabis Use, and Cannabis Use Disorder in a Nationally Representative Epidemiologic Sample, by Salpi Kevorkian et al.
- Variability in Medical Marijuana Laws in the United States, by Jessica Bestrashniy and Ken Winters


Our next special section will be on Co-occurring Posttraumatic Stress and Substance Use: Emerging Research on Prevalence, Mechanisms, and Treatments, with Marcel O. Bonn-Miller, Ph.D. (mbonn@mail.med.upenn.edu) and Anka A. Vujanovic, Ph.D. (Anka.A.Vujanovic@uth.tmc.edu) as guest co-editors.

Please consider submitting your original empirical, meta-analytical and theoretical (review) papers examining (1) population-based trends in rates of posttraumatic stress and substance use comorbidity, (2) clinical research on biopsychosocial factors relevant to the etiology and maintenance of their co-occurrence, and (3) innovations in

treatment, including health services considerations. The special section's aim is to profile emerging theory and research on substance use disorders with co-occurring (clinical or subclinical) PTSD in the areas of (1) epidemiology, (2) neurobiology, (3) genetics and epigenetics, (4) cognition and emotion, and (5) treatment development and clinical service delivery. Submissions emphasizing underrepresented groups or especially rigorous or novel methodologies and meta-analyses are of particular interest.

Manuscripts should be submitted as usual through the APA Online Submission Portal (<http://www.apa.org/pubs/journals/adb/>). The cover letter should indicate that the authors wish the manuscript to be considered for publication in the special section on Co-occurring Posttraumatic Stress and Substance Use: Emerging Research on Prevalence, Mechanisms, and Treatments. All submissions will be peer-reviewed and must adhere to usual journal requirements. The deadline for consideration for this special section is January 15, 2016.

References

- Pew Research Center. (2013). *General Social Survey, 1969-2013*. Washington, DC: Pew Research Center.
- Substance Abuse and Mental Health Services Administration. (2014). Results from the 2013 national survey on drug use and health: Summary of national findings. Rockville: Substance Abuse and Mental Health Services Administration.
- Volkow, N.D., Baler, R.D., Compton, W.M., & Weiss, S.R.B. (2014). Adverse health effects of marijuana use. *The New England Journal of Medicine*, 370, 2219-2227. 

Call for Nominations of Fellows and Awards for 2016

The SoAP Fellows and Awards Committee (F&A) invites nominations of Division members for potential election to Fellow status in the American Psychological Association. Descriptions for the criteria to become a fellow may be found by clicking on the following link: <http://www.apa.org/membership/fellows/division-50.pdf>

- **DEADLINE** for receipt of New Fellows nominations (including all nominees' materials and endorsers' letters) is **January 8, 2016**
- Late applications will not be considered in the current review cycle
- Nominations may be made by any member or Fellow of the Division
- Self-nominations are acceptable
- Initial fellows
 - Those seeking to become APA fellows through Division 50 must submit via the online portal <http://apps.apa.org/Fellows/default.aspx>.
 - The portal is currently open for submissions
- Existing APA fellows—those who are currently fellows in one or more divisions of APA
 - Existing APA fellows seeking to become Division 50 fellows must submit via email
 - Nominations are sent to the Fellows and Awards Committee through the Division 50 F&A Committee Chair, Kim Fromme, at Fromme@utexas.edu
 - Deadline for submission is **January 1, 2016**
 - Subject line must include
 - APA Fellow Application - First and Last Name of Applicant

SoAP (Addictions) seeks nominations for its 2016 awards, which will be announced in the spring TAN and awarded at APA's 2016 Annual Convention.

- Awards for 2016 include: *Distinguished Scientific Early Career Contributions*, *Distinguished Scientific Contributions to the Application of Psychology*, *Distinguished Scientific Contributions to Public Interest*, and *Outstanding Contributions to Advancing the Understanding of Addictions (for a non-SoAP member)*.
- **DEADLINE** for receipt of Awards nominations (including all nominees' materials and endorsers' letters) is **January 1, 2016**. Please note this is an earlier deadline than in the past (so that awardees can be announced in the spring TAN).
- Information on award qualifications and nominations can be found on SoAP's website at http://www.apa.org/divisions/div50/awards_descriptions.html
 - Nominations must be submitted via email
 - Nominations are sent to the Fellows and Awards Committee (F&A) through the Division 50 F&A Chair, Kim Fromme, at Fromme@utexas.edu
 - Subject line must include
 - APA Award Nomination - First and Last Name of Applicant

See page 10 for more information!

Yin and Yang of Positive Psychology and Addiction

Amy R. Krentzman

University of Minnesota Twin Cities

Despite the differences in the interpretation, application, and appropriation of *yinyang*, three basic themes underlie nearly all deployments of the concept in Chinese philosophy: (1) *yinyang* as the coherent fabric of nature and mind, exhibited in all existence, (2) *yinyang* as *jiao* (interaction) between the waxing and waning of the cosmic and human realms, and (3) *yinyang* as a process of harmonization ensuring a constant, dynamic balance of all things (Wang, n.d.).

Let's say white symbolizes efforts in substance use disorder treatment to reduce pathology while black symbolizes actions taken to improve well-being and build a life worth living, a life so good that it drives up the cost of relapse (Hendershot, Witkiewitz, George, & Marlatt, 2011; Marlatt & Gordon, 1980).

Already on our bookshelves, within our own addictions libraries, positive psychology appears on the pages, even in books published before positive psychology began in 1998. The tension between yin and yang—reducing pathology and increasing well-being—are there too, within our most familiar volumes. Consider a few examples pulled from my own shelf.

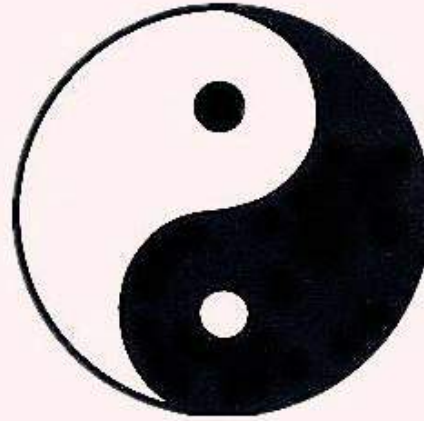
Yin?

The Narcotic Farm: The Rise and Fall of America's First Prison for Drug Addicts (Campbell, Olsen, & Walden, 2008).

This volume and its companion documentary describe the first federal U.S. substance use disorder treatment facility and a vision of a positive psychology addictions treatment center. "Moral Therapy," its guiding approach, involved compassionate care and immer-

sion into recreational, occupational, and avocational pursuits including golf, tennis, basketball, bowling, boxing, billiards, ping pong, arts and crafts, basket weaving, painting, and even manicures and pedicures! Famous jazz musicians addressed their heroin addictions with long hours of rehearsal, jam sessions, and public performances. Fresh air and sunshine were the co-facilitators of out-of-doors group therapy and farm work, from which participants could feel exhilaration in the creative process, gratification of physical prowess, and satisfaction of a job well done. It was a glorious experiment. Ninety-three percent relapsed upon discharge (Campbell et al., 2008).

Why did so many relapse? Researchers of the time concluded that it had to do with exposure to cues and triggers, and a lack of ongoing aftercare in the community (Campbell et al., 2008). But why did so many people, after experiencing what is most deeply gratifying about sober living, throw it all away? Why wasn't the "positive psychology" fix more lasting and effective?



The whole big circle indicates Taiji. In this illustration, the black colour indicates yin, and the white colour indicates yang. The white spot in the black area refers to yang within yin and the black spot in the white area to yin within yang.

Yang?

The Cognitive-Behavioral Coping Skills Therapy Manual (Kadden, 1995).

This treatment manual guided one of the three interventions used in the iconic study, Project MATCH. Within its pages, sessions are designed to be implemented over 12 weeks. Each has a theme. Some foster well-being while others address pathology: cravings, problems, emergencies, and relapses. The well-being sessions, "Starting Conversations," "Increasing Pleasant Activities," "Enhancing Social Support Networks," are marked *elective*; they may be rotated in "based on the therapist's assessments of a client's problems or on needs or desires expressed by the client" (p. 10). They enjoy second-class status to the "core" mandatory sessions, which tackle pathology head on. Assigning pathology topics to "core" and well-being topics to "elective" suggests that reducing pathology is the primary aim of treatment, and building a positive sober life, secondary. Indeed, the rationale given for the

order of the topics was to address first the things that could take the client out of the conversation all together, the “immediate threats to ... sobriety, which may lead ... to an early relapse and undermine ... continuation in the program” (p. 10).

It is wise to prioritize content that will make therapy possible in the first place. But questions remain. To what extent were the elective well-being sessions actually used in Project MATCH? Which were most popular? Under what conditions were they employed, and for whom? In general, could we test well-being interventions independently versus embedded within CBT or the Community Reinforcement Approach (Meyers & Miller, 2006)? What might we learn if we could? What effect might they have on clients and hard-working counselors?

Yin and Yang?

Step Ten, “Continued to take personal inventory, and when we were wrong promptly admitted it,” Twelve Steps and Twelve Traditions, (AA World Services, 1953, pp. 88-95)

In the 10th step, members of Alcoholics Anonymous are invited to take a daily “look at ... assets and liabilities” (p. 88) and to “cast up a balance sheet” (p. 89) giving credit for “things well done, and chalking up debits where due” (AA World Services, 1953, p. 89). The metaphor of the accounting ledger with its entries alternating in black and red suggest integration of the good with the bad. In the text, the discussion of assets resonates with prevalent positive psychology themes. The “Three Good Things” exercise, developed by positive psychologists (Seligman, Steen, Park, & Peterson, 2005), involves the practice of recounting three good things that happened in a day and why they happened. This excerpt from the 10th step could serve as instructions for it:

It’s a poor day indeed when we haven’t done *something* right. As a matter of fact, the waking hours are usually well filled with things that are

constructive. Good intentions, good thoughts, and good acts are there for us to see. Even when we have tried hard and failed, we may chalk that up as one of the greatest credits of all. Under these conditions, the pains of failure are converted into assets. Out of them we receive the stimulation we need to go forward (AA World Services, 1953, p. 93).

In the 10th step instructions we also see positive psychology’s emphasis on character building (Peterson & Seligman, 2004) ...

Learning daily to spot, admit, and correct these flaws is the essence of character-building and good living (AA World Services, 1953, p. 94).

... and the theme of gratitude:

An honest regret for harms done, a genuine gratitude for blessings received, and a willingness to try for better things tomorrow will be the permanent assets we shall seek (AA World Services, 1953, p. 95).


A person in recovery once told me that the daily inventory is like cleaning a beach at dusk. Sometimes the rake turns up an exquisite shell, other times a cigarette butt. The 10th step seems to suggest that it is good and useful to examine both “treasures” and “trash”—the good and bad. The “shells” increase positive mood, happiness, and provide encouragement. They remind and thus extend positive emotions, which can broaden and build toward larger psychosocial benefit (Fredrickson, 2001). But the 10th step is not just about positive psychology. The examination of the “cigarette butts” provides vital information about early warning signs of problems that can be averted before worsening, or situations that require redress. Diminishing problems and resolving worrisome issues are also important to the good life.

Tentative Conclusions and a Question

1. The field has been integrating aspects of what we now call positive psychology for a long time. Deeper examinations of what we are already

doing along these lines would guide further research and intervention. 2. In practices of treatment and recovery, addressing pathology *and* increasing well-being are both essential, interrelated, and, as an added challenge to the researcher, most likely tough to isolate without the shadow or the glimmer of the other. What can be gained by getting the balance right? This question is worthy of our attention.

References

- AA World Services. (1953). *Twelve Steps and Twelve Traditions*. New York: AA World Services.
- Campbell, N., Olsen, J. P., & Walden, L. (2008). *The Narcotic Farm: The Rise and Fall of America’s First Prison for Drug Addicts* (1st edition). New York: Abrams.
- Fredrickson, B. L. (2001). The Role of Positive Emotions in Positive Psychology. *The American Psychologist*, 56(3), 218-226.
- Hendershot, C. S., Witkiewitz, K., George, W. H., & Marlatt, G. A. (2011). Relapse prevention for addictive behaviors. *Substance Abuse Treatment, Prevention, and Policy*, 6, 17. <http://doi.org/10.1186/1747-597X-6-17>
- Kadden, R. (1995). *Cognitive-behavioral Coping Skills Therapy Manual: A Clinical Research Guide for Therapists Treating Individuals with Alcohol Abuse and Dependence*. DIANE Publishing.
- Marlatt, G. A., & Gordon, J. R. (1980). Determinants of relapse: Implications for the maintenance of behavior change. In P. O. Davidson & S. M. Davidson (Eds.), *Behavioral Medicine: Changing Health Lifestyles* (pp. 410-452). New York: Brunner/Mazel.
- Meyers, R., & Miller, W. (Eds.). (2006). *A Community Reinforcement Approach to Addiction Treatment* (1 edition). Cambridge; New York: Cambridge University Press.
- Peterson, C., & Seligman, M. (2004). *Character Strengths and Virtues: A Handbook and Classification* (1 edition). Washington, DC : New York: American Psychological Association / Oxford University Press.
- Seligman, M. E. P., Steen, T. A., Park, N., & Peterson, C. (2005). Positive Psychology Progress: Empirical Validation of Interventions. *American Psychologist*, 60(5), 410-421. <http://doi.org/10.1037/0003-066X.60.5.410>
- Wang, R. (n.d.). Yinyang. In *The Internet Encyclopedia of Philosophy*. Retrieved from <http://www.iep.utm.edu/yinyang/> 

Spiritual Awakening in Alcoholics Anonymous

Marc Galanter

Division of Alcoholism and Drug Abuse, NYU School of Medicine

The opportunity to participate in this newsletter was appealing because it represents a chance to introduce an issue that many addiction specialists are not aware of, namely, the remarkable transformation that long term AA members call spiritual awakening. This experience is perhaps the most intense example of positive psychological change that an addicted person can have. Here is what I mean. It is adapted from a book on AA I wrote, soon to be published (Galanter, In press).

After completing the first eleven Steps, AA members are ready for the last one which begins with the phrase “Having had a spiritual awakening....” It is not included casually. It harkens back to a seminal moment in the genesis of the fellowship, an episode that members refer to as Bill W’s “white light experience.” In December 1934, Bill W was admitted to the Towns Hospital on the Upper West Side of Manhattan for a fourth episode of drying out. He was despairing of hope at that point, but later wrote of a transformative experience he had while there: “It seemed to me, in my mind’s eye, that I was on a mountain and that a wind not of air but of spirit was blowing” (Alcoholics Anonymous, 1957).

This was a spiritual awakening for Bill, dramatic in quality, and one that would serve as a model for future AA members seeking redemption from their addiction. Even today, generations later, there remains an expectation of transformation that serves as a turning point in members’ own recovery.

I became particularly attentive to the importance of this experience after reading a study carried out by Lee Kaskutas and her collaborators, (Kaskutas et al., 2008) who followed up alcoholic people after they had been discharged from treatment. The respondents who

reported having had a spiritual awakening at some time after discharge were almost four times more likely than others to achieve a stable abstinence. In our study at NYU, we had framed the studies to measure the impact of spiritual awakening on Twelve Step members’ addictions, and in the midst of a longer survey we asked participants to rate the degree of craving for alcohol or drugs they had experienced in the previous week on a scale from zero (not at all) to 10 (extremely). Later in the survey, they were asked to indicate whether or not they had experienced a spiritual awakening. We surveyed attendees at a conference of doctors in AA, most with long term sobriety, 81% reported having had a spiritual awakening. Those who reported affirmatively on this were twice as likely to have experienced no craving at all in the previous week than those who had no such experience (Galanter et al., 2013). Results were similar for younger members at an international conference on AA (Galanter et al., 2012). If you think about it, addicted people coming to experience no craving at all is remarkable, since alcohol and drug addiction are characterized by the craving that drives people to relapse, and in fact the latest psychiatric diagnostic manual (APA, 2013) includes craving as one of the criteria for the diagnosis of addiction.

An awakening can be very dramatic in character:

I was there in rehab with 50 bucks hidden in my sock. I wanted to get out and get on a subway and come home.

I went outside the building and was having a cigarette, when all of a sudden a sense of peace came over me and I didn’t see it, but I felt the presence of a person, and in my mind that person was Jesus. It was strange. I was sort of embarrassed. I felt his presence, and then a peace for no more than three or four minutes. This seemed to be part of a message. I was set to come in from the cold. And then

I listened and let these people help me. I realized that it was not about judging, it was about acceptance.

On the other hand, for many members, a spiritual awakening is neither sudden nor dramatic. It can be an ongoing and continuing process, but no less meaningful than if experienced with great drama. Here is how one woman described the more gradual process of spiritual experience when I asked her about an awakening:

One day I was walking along the beach in Nantucket and it was 5:00 PM, and I realized that I didn’t have the compulsion to run home and have a drink, and it was a great relief. I go to AA every morning at 6:30 AM and see the sunrise, so every morning I have a spiritual experience. That’s my spiritual experience. They’re not big epiphanies but, along the way, little “epiphanets.”

I wanted to see if we could develop a systematic understanding of the experiences that people affixed to their awakenings: For whom did these experiences come about in a sudden manner, and for whom did they emerge more gradually, over time? Was it common for people to have a sensory experience, as in the first example here? Did they take place in the midst of adversity, as in the depths of drinking?

To answer questions like these, we turned to the doctors’ group of long-time AA members, and they agreed to have their members surveyed again, at one of their conferences (Galanter et al., 2014). Since many of them may have had more than one experience of spiritual awakening, we asked them to describe what their first one was like. The majority reported that it had come about gradually (60%) rather than suddenly, and took place while they were working the Steps (52%) rather than before (32%) or afterwards (16%). Forty-one percent had used alcohol or drugs the week before, but only 9% the week thereafter. The majority reported

that they had felt craving for alcohol the week before their awakening (61%), whereas only half that number felt that in the week after (31%). The depression they experienced declined materially as well (from 2.1 to 0.6 on the scale we used). Since awakenings presumably put people closer to their higher power, could this connection be measured? The majority of those who had an awakening reported that they now felt God's presence in their lives on a daily basis (62%), but only a minority of those who had not experienced an awakening felt this way (13%).

Altogether, we documented a diverse group of experiences, ones that did indeed bolster the doctors' commitment to AA. In many respects, however, the uniqueness of such experiences is

most compelling. To my mind, it is the different experiences that members describe that most illuminated the process. The awakenings are personal, and illustrate the individuality of respective members.

References

- Alcoholics Anonymous. (1957). *Alcoholics Anonymous Comes of Age*. New York, NY: Alcoholics Anonymous Publishing.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC.
- Galanter, M., Derratis, H., & Santucci, C. (2012). Young People in Alcoholics Anonymous: The Role of Spiritual Orientation and AA Member Affiliation. *Journal of Addictive Diseases*, 31(2), 173-182. doi: 10.1080/10550887.2012.665693.
- Galanter, M., Derratis, H., Stanievich,

- J., & Santucci, C. (2013). Physicians in Long-Term Recovery Who Are Members of Alcoholics Anonymous. *The American Journal on Addictions*, 22(4), 323-328. doi: 10.1111/j.1521-0391.2013.12051.x.
- Galanter, M., Derratis, H., & Sampson, C. (2014). Spiritual Awakening in Alcoholics Anonymous: Empirical Findings. *Alcoholism Treatment Quarterly*, 32(2-3), 319-334. doi: 10.1080/07347324.2014.907058.
- Galanter, M. (In Press). *What is Alcoholics Anonymous: A Path from Addiction to Recovery* (Vol. In Press). New York: Oxford University Press.
- Kaskutas, L. A., Yu, Y., Greenfield, T., Witbrodt, J., & Bond, J. (2008). Epidemiology of Anonymous Participation. In M. Galanter & L. A. Kaskutas (Eds.), *Recent Developments in Alcoholism: Research on Alcoholics Anonymous and Spirituality in Addiction Recovery* (Vol. 18, pp. 261-282). New York: Springer.ψ

Positive Psychology in Alcoholics Anonymous and the 12 Steps: Adolescent Recovery in Relation to Humility

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The next step for Positive Psychology is translational research. How do we apply the character strengths and virtues that define Positive Psychology as tools for flourishing in specific communities of need? We have been investigating such strengths in the context of Alcoholics Anonymous (AA) for over a decade. Our "Helping Others Live Sober"

project (www.helpingotherslivesober.org), is based at Case Western Reserve University under the direction of PI Maria E. Pagano, PhD. Subjects are recruited from New Directions (ND), the largest residential treatment facility in Northeast Ohio for substance dependent adolescents. Approximately 80% of ND clients are court-referred for residential treatment. The average length of stay is 2.2 months. As an adjunct resource, ND provides a van service that allows clients to attend up to 4 local AA meetings a week in the local community. These meetings are well attended by young adult and adult alcoholics, and one local meeting attended is listed as a Young People in AA meeting. Some meetings are also held on site. These adolescents, with an average age of 16.2 years, are not mandated to attend AA meetings, but they all do because it is a practice and clear expectation of ND. The adolescents all have some criminal history that brought them to the court system

and all are in high school. We are able to study both recovery from alcoholism and substance abuse, and recidivism in relation to a variety of strengths. After their 10 week stay, subjects return to their homes and are followed up one year later.

We investigated this AA youth population with a focus on strengths included in *Character Strengths and Virtues: A Handbook and Classification* as developed by the positive psychologists Christopher Peterson and Martin E. P. Seligman (2004). We investigated strengths classified as Gratitude, Spirituality, Self-Regulation, Humility, Kindness, and Persistence. This brief report focuses especially on Humility as a promising research topic in addiction treatment. We have previously shown that Kindness (service to others) helps the helper stay sober (Pagano et al., 2004), quit smoking (Delos-Reyes, et al., 2013), and overcome depression (Pagano et al., 2009). Helping others

We gratefully acknowledge support from the John Templeton Foundation.

also contributes to greater Humility and combined with increased Spirituality helps the helper stay out of legal trouble (Lee et al., 2015). We have found that Spirituality correlates with Kindness based on our “Service to Others in Sobriety” questionnaire, a valid and reliable self-report of helping in the 12-Step context (Pagano et al., 2009; Pagano et al., 2013). Increased spiritual experience, measured by the widely used Daily Spiritual Experiences Scale (Underwood & Teresi, 2002), is associated with lower rate of relapse, increased service to others, and reduced narcissism after 2 months of treatment with the 12-Steps as an adjunct therapy (Lee et al., 2014). More recent research with adolescents found that service to others in a 12-Step context predicts reduced relapse and delinquency recidivism, as well as greater character development (as measured by humility and leadership) in the 6 months post-treatment; spiritual experience enhances the effect of service on recidivism (Lee et al., 2015).

Humility in Positive Psychology and AA

Because humility is a new composite focus of our research. The authors of the chapter entitled “Humility and Modesty” in *Character Strengths and Virtues* begin their discussion with reference to AA. They identify some of humility’s key features as “an accurate” sense of one’s abilities and achievement, a readiness to acknowledge one’s errors and imperfections, openness to new ideas, keeping a low focus on the self, and affirming the value of others and how they contribute to our world. This composite derives from an emphasis on accuracy in self-assessment: “We believe that humility involves a non-defensive willingness to see oneself, including strengths and limitations” (Peterson & Seligman, 2005, p. 463). These authors add that humility does not involve self-disparagement or a “contemptuous attitude toward the self,” but rather it is self-enhancing (p. 464). They assert a narcissistic attitude as the opposite of humility.

In general terms, AA understands humility as a mean between two vices, in

this case, vanity or self-inflation and a lowliness that forsakes one’s true value. From the 12-Step theological perspective, humility as a virtue is truthful about the place of the self in the triad of self, and neighbor, and a Higher Power. Of the two essential texts of AA, it is in *Twelve Steps and Twelve Traditions* (1952 original) that we find a development of humility, a term explicitly used in Step Seven, “Humbly asked Him to remove our shortcomings.” The chapter on Step Seven begins, “Because this Step so specifically concerns itself with humility, we should pause here to consider what humility is and what the practice of it can mean to us” (1952, p. 70). The chapter continues: “Indeed, the attainment of greater humility is the foundation principle of each of AA’s Twelve Steps. For without some degree of humility no alcoholic can stay sober at all” (p. 70).

There was an exaggeration of humility resonant with humiliation in the intense self-effacement of Bill W. as he ran at full throttle from his extreme self-absorption. We find this hyperbole in passages from Bill W. that Ernest Kurtz focuses on in his classic work, *Not-God: A History of Alcoholics Anonymous*. At various points, Bill W. used this expression, **deflation at depth** (Kurtz, pp. 20-21). What exactly Bill W. means can be debated, but the term **deflation at depth contrasts with a superficial deflation**—that is, with a deflation of self only in word or as a social strategy for reputational gain that is unlikely to lead to a rightly sized and authentic new self.

Four Phases of Humility-as-Process in the 12 Steps

We see four phases or modulations of humility in the Twelve Steps as follows:

One: Steps 1-3 are about admitting that you are powerless and need a Higher Power’s help, that you cannot succeed on your own. You have failed on your own limited strength, and you have been arrogant and prideful in thinking otherwise. We call this the **humility of honestly admitted powerlessness**. It is *closer to humiliation than to humil-*

ity, yet it is a necessary first step of reduced self-inflation in the process of self-transformation.

Two: Steps 4-7 are about the **humility of truthful inner accuracy and transparency** with regard to what psychiatrists call narcissism, philosophers call solipsism, and theologians call “sin” or “self-inflation.” Much of this process occurs with the help of a sponsor, which makes it a confidential dyadic process rather than a merely interior one or a wider communal one. Nevertheless, in any AA testimony before the entire group as usually occurs at the outset of meetings, it is very likely that admission of moral and spiritual turpitude will to a significant degree be included.

Three: Steps 8-10 are about the **humility of contrition, making apologies and amends**. Genuine apology requires humility. Humility makes contrition possible. *Twelve Steps and Twelve Traditions* states, “To get completely away from our aversion to the idea of being humble, to gain a vision of humility as the avenue to true freedom of the human spirit, to be willing to work for humility as something to be desired for itself, takes most of us a long, long time” (p. 73). Humility is not something alcoholics are “beaten into,” but something “we *must* have” (p. 75).

Four: Steps 11-12 are about the **humility of living a rightly ordered and transformed new life**. One must live humbly under a Higher Power, however defined, and lean outward from self to serve the neighbor by carrying the message to them.

We know that spirituality and serving others contribute to positive outcomes for addicted youth (improved recovery, lowered depression rates, less involvement with the legal system). Our focus will shift now to the contribution that contrition, apology, and making amends (what AA refers to as “inner house cleaning”) make to outcomes. This is an especially understudied area. We are just beginning to understand the interplay between Kindness, Humility, and Spirituality.

References

Alcoholics Anonymous (1952). *Twelve steps and twelve traditions*. New York: Alcoholics Anonymous World Services.

Delos-Reyes, C.M., Svala, K., Singh, N., Scur, M.D., Pagano, M.E. (2013). Smoking cessation and adolescent treatment outcomes. *ACER*, 36(s1), 312A.

Kurtz, E. (1991). *Not-god: A history of alcoholics anonymous*. Center City, MN: Hazelden Foundation.

Lee, M.T., Veta, P.S., Johnson, B.R., Pagano, M.E. (2014). Daily spiritual experiences and adolescent treatment response. *Alcohol Treatment Quarterly*, 32, 271-298.

Lee, M.T., Pagano, M.E., Johnson, B.R., Post, S.G. (2015). Love and service in adolescent addiction recovery. Paper presented at the *American Sociological Association* conference in Chicago. (August 25, 2015).

Pagano, M.E., Friend, K.B., Tonigan, J.S., Stout, R.L. (2004). Helping other alcoholics in Alcoholics Anonymous and drinking outcomes: findings from project MATCH. *Journal of Studies on Alcohol and Drugs*, 65, 766-773.

Pagano, M.E., Zeltner, B., Post, S.G., Jaber, J., Zywiak, W.H., Stout, R.L. (2009). Who should I help to stay sober?: Helping behaviors among alcoholics who maintain long-term sobriety. *Alcoholism Treatment Quarterly*, 27, 38-50.

Pagano, M.E., Kelly, J.F., Scur, M.D., Ionescu, R.A., Stout, R.L., Post, S.G. (2013). Assessing youth participation in AA-related helping: Validity of the Service to Others in Sobriety (SOS) questionnaire in an adolescent sample. *American Journal on Addictions*, 22, 60-66.

Peterson, C., & Seligman, M.E.P. (2004). *Character strengths and virtues: A handbook and classification*. New York: Oxford University Press.

Underwood, L.G., & Teresi, J.A. (2002). The daily spiritual experience scale: Development, theoretical description, reliability, exploratory factor analysis, and preliminary validity using health-related data. *Annals of Behavioral Medicine*, 24(1), 22-33.ψ

Applying Positive Psychology With Alcohol-Misusing Adolescents

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The invitation came from a substance misuse service for young people in Bath, UK. Would I run a pilot program to show teens alternative routes to happiness besides drink and drugs? At first I was hesitant—what could a course in positive psychology do for a group of NEETs (not in education, employment or training) with other serious problems ranging from homelessness to abuse? Was it appropriate or ethical? I like to operate in a growth mindset (Dweck, 2007) and find out what works well, so I set about designing an 8-session program of positive psychology interventions—“treatment methods or intentional activities aimed at cultivating positive feelings, positive behaviors, or positive cognitions” (Sin & Lyubomirsky, 2009). This was a program grounded in the health model rather than the medical model with evidence-based practices that create mental health. In only 1 of 8 sessions did we include some content on alcohol misuse.

Taking on a group of volatile young people aged 14-20 was certainly no walk in the park. When I explained that the evidence suggests that money

The Happiness Zones		
Session	Zones	Principal Themes
Week 1	Feel Good Zone	Positive Emotions, Savouring
Week 2	Future Zone	Gratitude, Optimism
Week 3	Me Zone	Strengths
Week 4	Chill Zone	Relaxation, Meditation
Week 5	Change Zone	Change, Goal-setting
Week 6	Me to You Zone	Relationships
Week 7	Body Zone	Nutrition, Physical Activity
Week 8	Bounce back Zone	Resilience, Growth Mindset

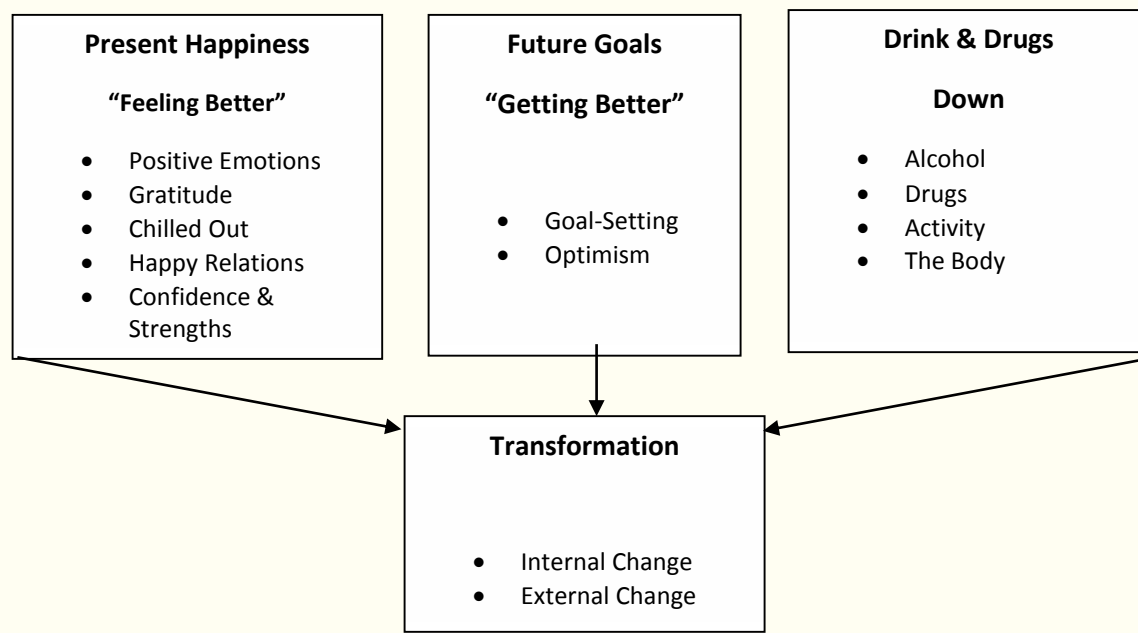
has only a limited impact on our well-being, they shouted me down protesting that it was the thrill of having stuff that made them happy. However, when I asked them to savor some of their peak moments, out came all the happy memories with loved ones. That’s when they really got it; that happiness doesn’t come with a price tag attached. I learnt a valuable lesson that day to show not tell.

What Worked Well

One of the practices which worked particularly well was gratitude. We used the classic 3 Good Things exercise as a check-in at the start of every session with the participants naming what had

gone well, what was good in their lives and what they were grateful for. This exercise helped them overcome the negativity bias to focus on the positives in their life and put them into a resourceful state for the session itself. On completion of the program, gratitude was named as the most effective tool, helping them to appreciate what they *did* have rather than what was lacking. Getting to know their strengths in session 3 gave them a sense of confidence which emerged in the weeks following the program. For the Chill Zone I guided them through a meditation, by the end of which, one of the young people piped up that she felt so relaxed, it was like she’d smoked a joint! Finding healthy ways to calm themselves was

Figure 1: Thematic map of qualitative findings



one of the key objectives of the treatment service. From the Change Zone onwards each participant set goals and had the support of a personal coach to help them work towards achieving their goal.

The results of this small pilot study ($n = 10$ in the experimental group, $n = 10$ in the control group) revealed a significant reduction in alcohol dependence, as measured by the SADD (Short Alcohol Dependence Data, Raistrick, Dunbar, & Davidson, 1983) and significant increases in subjective happiness (SHS; Lyubomirsky & Lepper, 1999), optimism (LOT-R; Scheier, Carver, & Bridges, 1994) and positive emotions (PANAS; Watson, Clark, & Tellegen, 1988).

In the qualitative study the main themes were a rise in happiness and other positive emotions (hedonic well-being), which incorporated an improvement in relationships (social well-being); the development of a future goal orientation (eudaimonic well-being); a decline in alcohol and drug use and a corresponding increase in vitality (physical well-being) and an escalation in change which amounted to a transformation (Figure 1). This represented a remarkable improvement in adoles-

cent well-being across 4 dimensions. As their well-being increased, drinking and drug-taking declined substantially and they became more motivated about their future. The study demonstrates that a positive psychology approach can work with alcohol-misusing adolescents. Using a health model approach, where the focus is on the goal rather than the problem, worked well.

The biggest change was for one pregnant participant, whose key-worker described as “almost afraid to think of what good can happen ... for fear of what bad might happen.” She held to her resolution to stay sober during her pregnancy and changed her mind about alcohol, having witnessed the effects of alcohol abuse. Two months after completion of the program she gave birth to a baby girl and named her ... Faith. This pilot study convinced me that positive psychology is useful not only in prevention but also as an intervention for substance-misusing young people, who have moved beyond risk to live the reality of health, social and educational problems.

What Happened Next

A grant application has been submitted

through the University of South Florida to convert the program into an app, which may be one of the best routes to reach young people. The “Happiness Zones” has been highlighted as an example of best practice in mental well-being by the Academy of Social Sciences in the UK. The program informed the structure of my book *Positive Psychology for Overcoming Depression* (Akhtar, 2012), which has recently been the subject of a bibliotherapy study with adults carried out by Sheffield Hallam University (Hanson, in preparation). The results indicate that the book chapters, which map onto the Happiness Zones sessions, do help reduce depression symptoms and improve well-being. One of the major motivations to drink is to escape from unhappiness. I see the role of positive psychology interventions as natural anti-depressants that offer an alternative to the chemical approach to recovering well-being, be that drink, drugs or anti-depressant medications.

References

- Akhtar, M. (2012). *Positive Psychology for Overcoming Depression: Self-help strategies for happiness, inner strength & well-being*. London: Watkins.
- Akhtar, M., & Boniwell, I. (2010). Applying

- positive psychology to alcohol-misusing adolescents: A group intervention. *Groupwork*, 20(3), 6-31.
- Dweck, C. (2007). *Mindset: The New Psychology of Success*. New York: Ballantine Books.
- Hanson, K. (In Preparation). Positive Psychology for Overcoming Depression: An 8-week Bibliotherapy Intervention. *Journal of Positive Psychology*.
- Lyubomirsky, S & Lepper, H.S. (1999). A measure of subjective happiness: Preliminary reliability and construct validation. *Social Indicators Research*. 46(2), 137-155.
- Scheier, M.F., Carver, C.S., & Bridges, M.W. (1994). Distinguishing optimism from neuroticism (and trait anxiety, self-mastery, and self-esteem). A re-evaluation of the Life Orientation Test. *Journal of Personality and Social Psychology*. 67(6), 1063-1078.
- Sin, N. L., & Lyubomirsky, S. (2009). Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: A practice-friendly meta-analysis. *Journal of Clinical Psychology*, 65(5), 467-487
- Watson, D., Clark, L.A., Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology*. 54(6), 1063-1070. [ψ](#)

Positive Psychology in the Treatment of Addiction

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Between 1992 and 2010 I worked as an addictions specialist in the UK health service treating people with alcohol dependence. In 2004 I discovered Positive Psychology and it changed the way I worked. This article describes how.

“How many people here have suffered from depression?” As I look around the Relapse Prevention group I’m running, about half of those present raise their hand. After reading *Authentic Happiness* by Martin Seligman in 2004, and training with him in 2005, I changed my opening question to “How many people here would like to become happier?” When I did this, everyone’s hand went up. After the group, I could see from the smiles around me that I wasn’t the only one uplifted. We were engaged in the same journey as before—but with a focus on what we wanted to move towards rather than away from. This shift in direction of gaze lies at the heart of the Positive Psychology approach.

What gave me confidence to innovate was research evidence showing that Positive Psychology interventions

help protect against depression (Sin & Lyubomirsky, 2009). While I wasn’t aware of studies specifically with chemically dependent clients, low mood is a common high-risk situation for relapse. Learning ways to cultivate positive emotions gave people a protective buffer.

Early in the group I’d ask people to rate their current happiness on a 0-10 scale, with lower numbers for lower mood. We’d then test some positive psychology interventions to see if they nudged the numbers upwards. An insight guiding us was that our mood can be influenced by choices we make about what to focus on. Positive Psychologist Karen Reivich uses the phrase “hunt the good stuff” to encourage people to focus their attention on things they like or value. One place we can hunt the good stuff is with our memories of the last 24 hours, dwelling on the positive by remembering our favourite moments and replaying them in our minds. I’d ask the group to do this for just one minute, then rate their mood again. I’d then ask if anyone’s number had gone up.

If a new drug were invented that rapidly boosted people’s mood, with few or no side effects, we’d be hearing about it in the news. I’ve done this “favourite moment” process with many hundreds of people, and regularly see roomfuls of hands in the air when I ask if the number went up. I also check for side

effects by asking if the number went down for anyone, if this exercise lowered mood. I hardly ever see that.

A positive psychology practice based on this “hunt the good stuff” principle is the gratitude diary, where each day people write down three good things from the last 24 hours. A randomised controlled trial has linked this intervention with improved mood and reduced scores on depression scales, the benefits still significant at six-month follow-up (Seligman et al., 2005). But what happens when someone can’t think of any good things in their life?

Training the Mind

A client in one of my groups had taken an overdose the week before. He looked uncomfortable when we did the favourite moment process, telling us he was depressed and couldn’t think of any favourite moments. I acknowledged that he was feeling so low it was difficult to see much that was good at the moment. That is one of the hard things about depression. Yet even when low, there might still be some moments that seem better than others, this exercise being a way of helping us give those moments more attention when they occur.

The next person to speak said she’d also been feeling low recently. Waking early, she had watched a bird in her garden. It was a Thrush, and she’d never seen

Thanks to Carlotta Cataldi for the self-help SSRI toolkit illustration.

one so close up before. She told us that the time she'd spent noticing the beautiful colours in the bird's chest feathers was a special moment for her. Hearing this, the depressed man, who'd been sitting next to her, said, "I didn't know you could count things like that." Continuing, he told us, "If you can count that, then there was a moment yesterday for me. There was lightning, and I sat outside watching it. That was my best moment of the day."

Gratitude might seem easy when things are going well, but an important learning for me is that we can train ourselves to get better at spotting the good things, or stopping ourselves from discounting them. This drawing attention to what's going well isn't only found in Positive Psychology. "Look for the good in each day" is advice clients may find in AA meetings, and drawing out a client's awareness of their strengths is a feature of Motivational Interviewing. What I appreciate about Positive Psychology is that it offers a growing body of well-researched practices that help us develop and apply this form of mind training.

Resilience Training

As crisis is a common trigger for relapse, an area where Positive Psychology is particularly relevant to addictions treatment is Resilience Training. In the 1990s, psychologists at the University of Pennsylvania showed that a Resilience Training programme could reduce the risk of depression in children, with benefits still present at two-year follow up (Gillham et al., 1995). The Penn Resilience Program, as it became known, has now been tested in 20 or more trials, with benefits shown for both adults and children. The results have been so impressive that the US military has taken on the task of bringing resilience training to over a million US service personnel. Early results show benefits that include reductions in mental health problems and substance misuse (Harms et al., 2013).

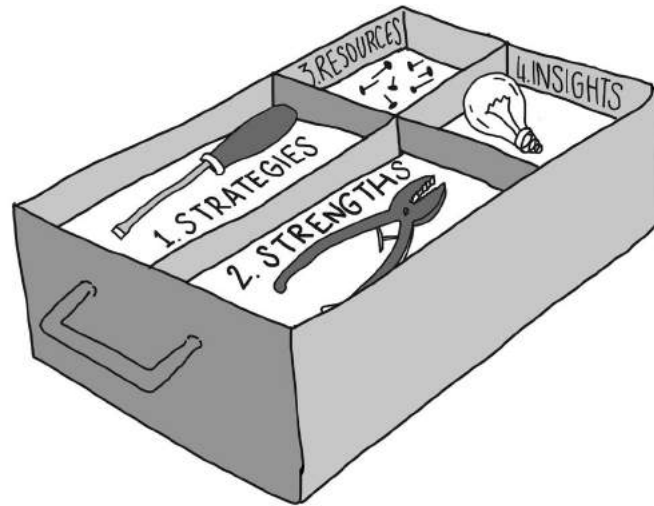


Figure 1. The Self-Help SSRI Toolkit.

Relapse Prevention sessions I ran on dealing with crisis, I'd give out blank postcards, and ask clients to write the letters SSRI along the side. I'd then ask them to think of a difficult time they had got through without drinking or using drugs. Alongside the first S, I'd ask them to write in strategies they'd used that helped. By the second S, I invited them to name strengths they'd drawn on. The R was for resources they had turned to, including people, places, self-help books or helpful websites. The I was for Insights or pieces of wisdom they'd found useful. While the letters SSRI are commonly associated with anti-depressants, we used them here to refer to the "Self-Help SSRI toolkit" of Strategies, Strengths, Resources and Insights that helped prevent relapses and also often had an antidepressant effect (see Figure 1).

Influenced much by Motivational Interviewing, my style is to first draw out from clients strategies they already find useful before introducing new material. The Self-Help SSRI toolkit approach facilitates this, offering a framework where taught elements of the Penn Resilience programme can complement what clients are already doing.

resilience skills to addictions teams throughout the UK, and internationally via online courses. There's a great receptivity to this approach, the SSRI toolkit recognised as useful to staff as well as clients. Now that Positive Psychology is becoming more widely accepted, I look forward to see what research findings emerge in the addictions field.

References

- Harms, P.D.; Herian, Krasikova; Vanhove, Lester (April 2013). ["Report #4: Evaluation of Resilience Training and Mental and Behavioral Outcomes" \(PDF\)](#). *The Comprehensive Soldier and Family Fitness Program Evaluation* (4): 19.
- Gillham J, Reivich K, Jaycox L & Seligman M. (1995) Prevention of depressive symptoms in schoolchildren: Two-year follow-up. *Psychological Science* 1995: 6; 343-351.
- Seligman M. et al (2005), Positive Psychology Progress—Empirical Validation of Interventions, *American Psychologist*, Vol. 60, No. 5, 410-421
- Sin, N. L., & Lyubomirsky, S. (2009). Enhancing well-being and alleviating depressive symptoms with Positive Psychology Interventions: A practice friendly meta-analysis. *Journal of Clinical Psychology*, 65, 467-487. [ψ](#)

Positive Psychology and the Treatment of Substance Use Disorders

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What is Positive Psychology?

Over the past two decades, positive psychology (PP) has developed both as a science and a movement. While traditional clinical psychology has focused more on the treatment of psychopathology and the diminution of deficits, PP shifts the focus of treatment to the promotion of mental health and well-being, by increasing positive affect and feelings of happiness (Seligman & Csikszentmihalyi, 2000). Positive psychology emphasizes individual's strengths, rather than weaknesses or deficiencies, and focuses on fulfillment in life and increased well-being, rather than focusing solely on addressing pathology (Duckworth, Steen, & Seligman, 2005). Recognizing that only about 50% of positive emotion or happiness is heritable, positive psychology interventions (PPIs) aim to increase positive emotion, improve resilience and promote optimism, thereby enhancing both physical and emotional functioning (Seligman & Csikszentmihalyi, 2000; Seligman, Steen, Park, & Peterson, 2005; Sin & Lyubomirsky, 2009).

A meta-analysis of 51 randomized clinical trials (RCT; $N = 4266$) demonstrated that PPIs significantly improved well-being and decreased symptoms of depression (r effect sizes = .29 and .31, respectively) in healthy adults and those with depressive symptoms (Sin & Lyubomirsky, 2009). Depressed individuals and older individuals seemed to have greater benefit from PPIs, and

effect size was noted to be greater for individual therapy, compared with group therapy or self-instruction. A more recent meta-analysis of 39 studies with over six thousand participants reported similar results (Bolier L et al., 2013). PPIs significantly improved subjective well-being ($d = .34$), psychological well-being ($d = .20$), and depression ($d = .23$).

Rationale for the Use of PP in Substance Use Disorder Treatment

Given that mood disturbance is often significantly linked to treatment success (or failure) in persons with opioid dependence, nicotine dependence, and alcohol use disorders (Grant et al., 2004; van der Meer, Willemsen, Smit, & Cuijpers, 2013), positive psychology may have utility as an adjunctive treatment in the approach to the treatment of substance use disorders (SUD). Within psychology and the substance use field, there has been a shift in orientation, placing importance on enhancing positive emotion, personal strengths, cognitions, and optimism (Krentzman, 2013). An emphasis toward recovery and building psychological resources to cope more effectively with negative affect has been stressed (Substance Abuse and Mental Health Services Administration, 2011). This shift in focus is consistent with the principles of PP. In addition, PPIs may provide an alternative to substance use as a means of experiencing pleasure or positive emotion, leading one to wonder if PP has utility within the field of SUD treatment.

Review of PP-Based Studies in SUD Treatment

Current evidence in the treatment of SUD using PP is limited. To date, only three pilot studies have been conducted using PPIs in individuals with AUD or illicit drug use (Akhtar & Boniwell, 2010; Carrico et al., 2015; Krentzman

et al., 2015). A feasibility study of 23 adults receiving outpatient treatment for AUD examined the impact of a 14-day 3 Good Things (TGT) exercise on affect, cognitions, and recovery (Krentzman et al., 2015). Participants were randomized to either a web-based PPI or a sleep hygiene (control) intervention. Results indicated that participants completed over 90% of the daily exercises, acceptability of TGT was high, and both positive and negative affect significantly improved over the 14-day period of the intervention. Significant change between the groups however was not maintained at the 8-week follow-up. A second study combined a PP-based intervention with Contingency Management (CM) in 21 men who have sex with men (MSM) who used methamphetamines (Carrico et al., 2015). The 5-session weekly CM and PP-based intervention was compared with CM alone. A small significant change in positive affect was found in the PP group through the 2-month follow-up, but the effect was not maintained over time (six months). Participants in the active arm (PP) attended 98% of the scheduled treatment sessions, indicating acceptability of the intervention. They also reported greater "engagement in the recovery process" related to the PP exercises. Finally, a small study ($N = 20$) tested a PP intervention compared to a no treatment control in "alcohol-misusing" adolescents (Akhtar & Boniwell, 2010). The PP intervention consisted of eight weekly workshops that focused on happiness, strengths, optimism and gratitude. A significant change was seen in positive affect in the PP group. While negative affect and alcohol dependence scores declined over time in the PP group, group differences were not significant.

PP and Smoking Cessation Treatment. To date, only one pilot clinical trial has examined the effectiveness of PP-based treatment for smoking cessation (Kahler et al., 2015; Kahler et al., 2014). We

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enrolled 66 daily smokers who endorsed a desire to quit and randomized them to a positive psychotherapy intervention for smoking cessation (PPT-S) or standard treatment (ST), along with 6-weeks of nicotine replacement therapy. Face-to-face treatment sessions were conducted weekly for five weeks, followed by a final session two weeks later. In each session, those randomized to PPT, received instruction in PP exercises as well as standard smoking cessation counseling (Fiore, Jaén, Baker, et al., 2008). PPT-S exercises included: 1) identifying and recording “Three Good Things” daily, 2) Savoring an experience or memory, 3) Active Constructive Responding, 4) Savoring Acts of Kindness, and, 5) writing and delivering a Gratitude Letter. Participants who were randomized to ST received standard smoking cessation counseling and instruction in progressive muscle relaxation, which has been shown to be an inert intervention for smoking cessation (Fiore et al., 2008). PPT-S resulted in significantly higher odds of smoking abstinence across 26 weeks of follow-up compared with the standard behavioral treatment, adjusted OR = 2.75; 95% CI = 1.02, 7.42, $p = .03$. Additionally, greater engagement in PPT-S exercises during treatment was associated with increased odds of abstinence over time. Those with higher baseline positive affect (PA) engaged in more PPT-S exercises, and there was a significant interaction between PPT-S and PA such that the efficacy of PPT-S was greater at higher levels of pretreatment PA. This study is promising—PPT-S was not only acceptable and feasible for smoking cessation treatment but also improved cessation outcomes for daily smokers who were attempting to quit. A fully powered RCT to further test the efficacy of PPT-S is planned.


Conclusion

While pharmacotherapy is considered the mainstay of treatment for SUD, PP-based interventions hold promise as an adjunctive therapy to improve overall outcomes. Abstinence outcomes

across a variety of SUD are often disappointing, and the incorporation of PPIs may have a significant impact on treatment success. There is early evidence that PP-based interventions increased positive emotion in both adults and adolescents who had AUD or misused alcohol. Furthermore, we have demonstrated that PPT-S was an acceptable and effective adjunct to standard smoking cessation therapies in our pilot work. The emphasis on using individual strengths and enhancing positive affect that is inherent in PP may not only potentially improve outcomes across a range of SUD, but also may improve overall well-being. PP may be an attractive form of therapy to a broad range of individuals with SUD; however, larger clinical studies with longer periods of follow-up are required.

References

- Akhtar, M., & Boniwell, I. (2010). Applying positive psychology to alcohol-misusing adolescents. *Groupwork*, 20(3), 6-31. doi:10.1921/095182410x576831
- Bolier L, Haverman M, Westerhof GJ, Riper H, Smit F, & Bohlmeijer, E. (2013). Positive psychology interventions: A meta-analysis of randomized controlled studies. *BMC Public Health*, 13, 119. doi:10.1186/1471-2458-13-119
- Carrico, A. W., Gomez, W., Siever, M. D., Discepolo, M. V., Dilworth, S. E., & Moskowitz, J. T. (2015). Pilot Randomized Controlled Trial of an Integrative Intervention with Methamphetamine-Using Men Who Have Sex with Men. *Arch Sex Behav*, 44(7), 1861-1867. doi:10.1007/s10508-015-0505-5
- Duckworth, A. L., Steen, T. A., & Seligman, M. E. (2005). Positive psychology in clinical practice. *Annu Rev Clin Psychol*, 1, 629-651. doi:10.1146/annurev.clinpsy.1.102803.144154
- Fiore, M. C., Jaén, C., Baker, T., & al., e. (2008). *Treating Tobacco Use and Dependence: 2008 Update*. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service.
- Grant, B., Stinson, F., Dawson, D., Chou, P., Dufour, M., Compton, W., . . . Kaplan, K. (2004). Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders. *Archives of General Psychiatry*, 61, 807-816.

- Kahler, C. W., Spillane, N. S., Day, A. M., Cioe, P. A., Parks, A., Leventhal, A. M., & Brown, R. A. (2015). Positive Psychotherapy for Smoking Cessation: A Pilot Randomized Controlled Trial. *Nicotine Tob Res*. doi:10.1093/ntr/ntv011
- Kahler, C. W., Spillane, N. S., Day, A. M., Clerkin, E. M., Parks, A., Leventhal, A. M., & Brown, R. A. (2014). Positive psychotherapy for smoking cessation: Treatment development, feasibility, and preliminary results. *Journal of Positive Psychology*, 9(1), 19-29. doi:10.1080/17439760.2013.826716
- Krentzman, A. (2013). Review of the application of positive psychology to substance use, addiction, and recovery research. *Psychol Addict Behav*, 27(1), 151-165. doi:10.1037/a0029897
- Krentzman, A., Mannella, K., Hassett, A., Barnett, N., Cranford, J., Brower, K., . . . Meyer, P. (2015). Feasibility, acceptability, and impact of a web-based gratitude exercise among individuals in outpatient treatment for alcohol use disorder. *The Journal of Positive Psychology*, 10(6), 477-488. doi:10.1080/17439760.2015.1015158
- Seligman, M., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist*, 55, 5-14.
- Seligman, M., Steen, T., Park, N., & Peterson, C. (2005). Positive psychology progress: empirical validation of interventions. *Am Psychol*, 60(5), 410-421. Retrieved from http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=16045394
- Sin, N. L., & Lyubomirsky, S. (2009). Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: a practice-friendly meta-analysis. *J Clin Psychol*, 65(5), 467-487. doi:10.1002/jclp.20593
- Substance Abuse and Mental Health Services Administration. (2011). *SAMHSA announces a working definition of working definition of “recovery” from mental disorders and substance abuse disorders*. Retrieved from <http://www.samhsa.gov/newsroom/press-announcements/20112220300>.
- van der Meer, R., Willemsen, M., Smit, F., & Cuijpers, P. (2013). Smoking cessation interventions for smokers with current or past depression. *Cochrane Database of Systematic Reviews*(8), 1-134. doi:10.1002/14651858.CD006102.pub2. 

Preference for Brief Alcohol Interventions for Nontreatment Seeking Primary Care Patients

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Introduction

Problem drinking and adverse alcohol-related conditions in later life pose a significant mental and public health problem, financially burdening health care organizations such as the Veteran's Health Administration (VHA). The largest cohort of VHA users (the aging Vietnam-era population) includes over 4 million later life drinkers who experience compounding alcohol-related medical, personal, and social problems arising from the accumulation of alcohol liabilities over the lifespan (Menninger, 2002; Rehm, 2011). Although severity and persistence of alcohol-related problems can often be ameliorated through use of evidence-based treatments, only about 15-20% of problem drinkers obtain treatment in their lifetime (Cohen et al., 2007). Reasons for failing to obtain treatment are considered "barriers" which could include internal barriers (e.g., denial, stigma) and/or external barriers (e.g., transportation problems, problems contacting or attending appointments) (Elbogen et al., 2013; Saunders, Zygowicz, & D'Angelo, 2006).

Many large health care organizations embed mental health services within primary care clinics to reduce treatment barriers. Termed Primary Care Mental Health Integration (PC-MHI) within the VHA, this pairing allows for accessible, cost-effective, holistic health care that serves to provide brief, evidence-based treatments and referrals to specialty services as needed (Dundon, Dollar, Schohn, & Lantinga, 2011). Treatment includes six or less 20 to 40 minute sessions (Dundon et al., 2011).

Other brief, barrier-reducing interventions cited in the literature include bibliotherapy (Apodaca & Miller, 2003), telephone treatment (Brown et al., 2007), and smart-phone (e.g., A-CHESS, Step Away) and internet-based interventions (Hester, Squires, & Delaney, 2005). These "Low Threshold Interventions" (LTI; as defined by McKellar & Moos, unpublished work) have been found to be effective in reducing substance use and are designed to be easily accessible, private, and self-directed, thus circumventing many of the often cited barriers to treatment.

The presence of non-alcohol-treatment seeking individuals within primary care and mental health care provides an opportunity to gain insight into ways that addiction treatment services might adapt to the needs of the "silent majority" who rarely seek traditional treatment. The literature, however, provides an insufficient basis for evaluating whether use of empirically supported brief alcohol interventions address barriers and low levels of treatment utilization. Of particular interest is whether older non-treatment seeking veterans are more responsive to LTIs than to conventional treatment, and if so, which LTIs are most appealing. This report provides an overview of our current work which examines the prevalence of non-treatment seeking later life problem drinkers, barriers to treatment, and preference for LTI treatment versus formal treatment. Future directions will also be discussed.

Study Objectives

The current project incorporates two objectives: (i) testing recruitment procedures for a sample of older, primary care patients who were engaging in problematic alcohol use; and (ii) to evaluate barriers to treatment and preferences for LTIs versus formal

treatment. This study focused on the aging, Vietnam-era veteran cohort who present with problems different than those exhibited by younger patients (Bartels et al., 2004; Oslin, Pettinati, & Volpicelli, 2002).

Methods

In a pilot study conducted in 2012-2013, archival, questionnaire, and interview data were obtained from a random sample of Vietnam-era, VA Palo Alto Health Care System Primary Care patients ($n = 726$) who screened positive (i.e., a score of 4 plus) on the annual alcohol screening assessment [Alcohol Use Disorders Identification Test for Consumption (AUDIT-C; Bush, Kivlahan, McDonell, Fihn, & Bradley, 1998)] in 2009-2011. All study procedures were approved by Stanford/VA IRBs. Verbal consent was obtained prior to initiation of the interview.

Results

Of the 726 targeted participants, 471 (88%) were eligible, 38 (8%) completed the questionnaire, 48 (10%) completed the interview, and 97 (21%) completed both. The sample included veterans ages 53 to 87 with mean age being 64 years, mean annual income was \$36,000, and with the racial breakdown of Caucasian (73%), Hispanic (9%), African-American (10%), Native American (5%), and Asian (3%) veterans. All veterans were male and were in the US military between 1961 and 1975.

Descriptive analyses examined proportion of primary care patients who continued to engage in problem drinking and did not seek treatment in the past year, proportion of veterans who experienced treatment barriers, and preferences for LTIs versus traditional treatments. The AUDIT-C assessed drinking (Bush et al., 1998). Internal

barriers to treatment were assessed using the Readiness to Change Questionnaire (Heather & Rollnick, 1993). External barriers were assessed using the 18-item Treatment Barriers Measure (McKellar, unpublished work).

Preliminary results suggested that a significant proportion of older problem drinkers continued to engage in problem drinking over the year (79%) and remained resistant to engaging in formal treatment (60%, never sought treatment). To better understand reasons for resistance to treatment, internal and external barriers to treatment engagement were examined. Assessing stages of change for this non-treatment seeking sample revealed internal barriers to treatment which are likely related to resistance to engagement in formal treatment. Similarly, external barriers to treatment may also affect treatment engagement, such as a lack of access to transportation.

For this study, of those who continued to engage in problematic drinking but never sought treatment ($n = 69$), most were in the precontemplation or contemplation stage change (74%; $n = 51$), suggesting that the majority of the sample were either unaware or unwilling to change their drinking. Of those who scored positive on the AUDIT-C, never sought treatment, and completed the questionnaire ($n = 46$), 59% stated that some external barrier prevented them from obtaining treatment at least “some of the time.” The most frequently endorsed external treatment barriers were problems traveling to the VA, and problems obtaining contact with or leaving messages for providers. Since the majority of the sample is encountering barriers to treatment, alternative treatment approaches (which reduce these barriers) need to be available.

To assess which alternative approaches would be most appealing to veterans, preferences for Low Threshold Interventions were examined. Veterans were asked to rate their level of interest on a Likert scale for LTIs (i.e.,


self-help book, workbook, telephone support, web-based interventions, etc.). The majority of this sample was (1) “somewhat” or “very” interested in one or more of the LTIs (55%), (2) preferred some sort of a self-help book or workbook with or without telephone support from VA providers compared to other LTIs, whereas, (3) very few (<12%) showed interest in attending Alcoholics Anonymous meetings or formal group treatment. Preference for self-directed, private, non-web-based LTIs supports the hypothesis that older, non-treatment seeking veterans have unique barriers that require alternative treatment approaches in order to reduce problematic drinking.

Significance and Future Directions

This project represents the first known study examining treatment barriers and aging veterans’ preferences for LTIs in order to reduce the persistence of problematic drinking in later life. These results suggest it is possible to locate and recruit a sample of non-treatment seeking veterans who are actively drinking and that they experience treatment barriers that may be reduced through implementation of LTIs. Given that untreated problem drinking has a significant adverse impact on medical treatment success in medical settings; implementation of LTIs may offer a unique opportunity to deliver much needed intervention to this hard-to-engage population. Future research will include identification of specific LTIs to test within a primary care setting, and evaluation of their effectiveness in reducing barriers to treatments, the severity of problem drinking, and incidence of co-occurring physical and mental health problems.

References

Apodaca T, Miller W. A meta-analysis of the effectiveness of bibliotherapy for alcohol problems. *Journal of Clinical Psychology*. 2003; 59(3): 289-304.
Bartels, S. J., Coakley, E. H., Zubritsky, C., Ware, J. H., Miles, K. M., Arean, P.A., ... & Levkoff, S. E. (2004). Improving access to geriatric mental health services: A

randomized trial comparing treatment engagement with integrated versus enhanced referral care for depression, anxiety and at-risk alcohol use. *American Journal of Psychiatry*, 161(8), 1455-1462.
Brown R, Saunders L, Bobula J, Mundt M, Koch P. Randomized-controlled trial of a telephone and mail intervention for alcohol use disorders: Three-month drinking outcomes. *Alcoholism: Clinical and Experimental Research*. 2007; 31: 1372-1379.
Bush, K., Kivlahan, D.R., McDonell, M.B., Fihn, S.D. & Bradley, K.A. (1998). The AUDIT Alcohol Consumption Questions (AUDIT-C). *Archives of Internal Medicine*, 158(16), 1789-1795.
Cohen E, Feinn R, Arias A, Kranzler H. Alcohol treatment utilization: Finding from the National Epidemiologic Survey on Alcohol and Related Conditions. *Drug and Alcohol Dependence*. 2007; 86: 214-221.
Dundon, M., Dollar, K., Schohn, M., & Lantinga, L. J. (2011). *Primary Care-Mental Health Integration Co-Located, Collaborative Care: An Operations Manual* [PDF version]. Retrieved from <http://www.mentalhealth.va.gov>
Elbogen, E. B., Wagner, H. R., Johnson, S. C., Kinneer, P., Kang, H., Vasterling, J. J., ... & Beckham, J. C. (2013). Are Iraq and Afghanistan veterans using mental health services? New data from a national random-sample survey. *Psychiatric Services*, 64(2), 134-141.
Hester R, Squires D, Delaney H. The drinker's check-up: 12-month outcomes of a controlled clinical trial of a stand-alone software program for problem *Journal of Substance Abuse Treatment*. 2005; 28: 159-169.
McKellar, J. Barriers to Treatment Measure. (unpublished work).
Menninger, J. A. Assessment and treatment of alcoholism and substance-related disorders in the elderly. *Bulletin of the Menninger Clinic*, 66(2), 166-183.
Oslin, D. W., Pettinati, H., & Volpicelli, J. R. (2002). Older age predicts better adherence and drinking outcomes. *The American Journal of Geriatric Psychiatry*, 10(6), 740-747.
Rehm, J. (2011). The risks associated with alcohol use and alcoholism. *Alcohol Research and Health*, 34(2), 135-143
Saunders, S. M., Zygowicz, K. M., & D'Angelo, B. R. (2006). Person-related and treatment related barriers to alcohol treatment. *Journal of Substance Abuse Treatment*, 30(3), 261- 270. 

Abstracts

Becker, S. J., Spirito, A., & Vanmali, R. (2015). Perceptions of “evidence-based practice” among the consumers of adolescent substance use treatment. *Health Education Journal*. doi: 10.1177/0017896915581061

Objective: Several national organisations in the USA have recently developed educational materials that encourage substance use disorder treatment consumers to seek out approaches supported by scientific evidence in order to promote the use of “evidence-based practice” (EBP). This study aimed to explore how adolescents (young people aged 12-17 years) with substance use disorders and their caregivers perceive, understand and react to the concept of EBP. **Methods:** Qualitative focus groups and structured interviews were conducted with 29 caregivers and 24 adolescents with substance use disorders in the Northeastern USA. Discussions explored four themes: (a) familiarity with EBP, (b) assumptions about what EBP means, (c) impressions of EBP after reading a common definition and (d) recommended terms to describe EBP in educational materials. Participants’ responses were transcribed and qualitatively analysed by two independent coders. **Results:** Only 2 of the 53 participants had ever heard the term EBP, and only 1 was able to define it correctly. Common assumptions about the term “evidence-based” were that it referred to treatment based on the patient’s medical history, legal evidence of substance use or the clinician’s prior experience. The misperception that EBP was associated with legal evidence was common among adolescents involved in the justice system. After reading a common definition of EBP, most participants thought that the approach sounded inflexible. Alternative terms the participants recommended to educate potential treatment consumers about EBP included proven, successful, better and therapy that works. **Conclusion:** Results suggest that future efforts to educate treatment consumers should use the phrase EBP with caution and emphasise the flexibility of the approach.

Berman, A. H., Wennberg, P., & Sinadinovic, K. (2015). Changes in mental and physical well-being among problematic alcohol and drug users in 12-month internet-based intervention trials. *Psychology of Addictive Behaviors*. doi: 10.1037/a0038420

Twelve-month wellbeing outcomes were investigated for 835 participants in one of two randomized controlled trials (RCTs) offering online assessment and brief intervention for either problematic alcohol ($n = 633$) or drug use ($n = 202$). The wellbeing of participants who had reduced their substance use to a less problematic level (regardless of intervention) over 12 months was compared with that of participants who had maintained or increased their use. At a 12-month follow-up, the 227 alcohol trial participants with reduced use showed better wellbeing in comparison

to the 406 with stable or increased use, in physical health and sleep quality, as well as general wellbeing, ability to concentrate, lower stress, better social life satisfaction and sense of control, and a lower rate of depressed mood ($p < 0.0045$, Bonferroni correction). Among the 70 drug trial participants who had reduced their drug use over 12 months, 80% had ceased all drug use and at follow-up they had fewer alcohol-related problems than the stable group ($n = 132$; $p < .0045$). No differences in wellbeing between these groups were identified. Self-reported access to additional treatment modalities beyond the trial interventions, e.g., speaking to someone about problematic use and accessing additional internet-based interventions, was higher among participants in both cohorts with reduced substance use, in comparison to those with stable/increased use. Drug users who reduced their use accessed prescribed medication to a larger extent than those whose use remained stable or increased. Points to consider when conducting future research on wellbeing and problematic substance use are discussed.

Brown, R. A., Abrantes, A. M., Minami, H., Prince, M. A., Bloom, E. L., Apodaca, T. R., Strong, D. R., Picotte, D. M., Monti, P. M., MacPherson, L., Matsko, S. V., & Hunt, J. I. (in press). Motivational interviewing to reduce substance use in adolescents with psychiatric comorbidity. *Journal of Substance Abuse Treatment*. doi: 10.1016/j.jsat.2015.06.016

Substance use among adolescents with one or more psychiatric disorders is a significant public health concern. In this study, 151 psychiatrically hospitalized adolescents, ages 13-17 with comorbid psychiatric and substance use disorders, were randomized to a two-session Motivational Interviewing intervention to reduce substance use plus treatment as usual (MI) vs. treatment as usual only (TAU). Results indicated that the MI group had a longer latency to first use of any substance following hospital discharge relative to TAU (36 days versus 11 days). Adolescents who received MI also reported less total use of substances and less use of marijuana during the first 6 months post-discharge, although this effect was not significant across 12 months. Finally, MI was associated with a significant reduction in rule-breaking behaviors at 6-month follow-up. Future directions are discussed, including means of extending effects beyond 6 months and dissemination of the intervention to community-based settings.

Dahne, J., & Lejuez, C. W. (2015). Smartphone and mobile application utilization prior to and following treatment among individuals enrolled in residential substance use treatment. *Journal of Substance Abuse Treatment*. doi: 10.1016/j.jsat.2015.06.017

Background: Following completion of substance use treatment, it is crucial for patients to continue to utilize skills

learned in treatment for optimal treatment outcomes. Mobile applications (apps) on smartphones offer a unique platform to promote utilization of evidence-based skills following completion of substance use treatment. Despite the promise of mobile apps and smartphones for treatment delivery, it remains unknown whether patients in substance use treatment in the United States have access to smartphones and utilize mobile apps on smartphones. The present study sought to determine smartphone utilization among individuals enrolled in one residential substance use treatment center in the U.S catering specifically to low-income adults. **Methods:** Participants included 251 individuals at a residential substance use treatment center in Washington, DC, admitted to the center between March 2014 and January 2015. During the intake process, participants completed interviewer-administered demographics and psychiatric questionnaires as well as a self-report of technology utilization. **Results:** Results indicated that the majority of patients in this residential substance use treatment center owned mobile phones prior to treatment entry (86.9%) and expected to own mobile phones after leaving treatment (92.6%). Moreover, the majority of these phones were (68.5%) or will be smartphones (72.4%) on which patients reported utilizing mobile applications (Prior to treatment: 61.3%; Post treatment: 64.3%) and accessing the internet (Prior to treatment: 61.3%; Post treatment: 65.9%). **Conclusions:** Mobile phone and smartphone ownership among this sample were comparable to ownership among U.S. adults broadly. Findings suggest that smartphones and mobile apps may hold clinical utility for fostering continued use of treatment skills following substance use treatment completion.

Dickersn, D. L., Brown, R. A., Johnson, C. L., Schweigman, K., & D'Amico, E. J. (in press). Integrating motivational interviewing and traditional practices to address alcohol and drug use among urban American Indian/Alaska Native youth. *Journal of Substance Abuse Treatment*. doi: 10.1016/j.jsat.2015.06.023

American Indians/Alaska Natives (AI/AN) exhibit high levels of alcohol and drug (AOD) use and problems. Although approximately 70% of AI/ANs reside in urban areas, few culturally relevant AOD use programs targeting urban AI/AN youth exist. Furthermore, federally funded studies focused on the integration of evidence-based treatments with AI/AN traditional practices are limited. The current study addresses a critical gap in the delivery of culturally appropriate AOD use programs for urban AI/AN youth, and outlines the development of a culturally tailored AOD program for urban AI/AN youth called Motivational Interviewing and Culture for Urban Native American Youth (MICUNAY). We conducted focus groups among urban AI/AN youth, providers, parents, and elders in two urban communities in northern and southern California aimed at 1) identifying challenges confronting urban AI/AN youth and 2) obtaining feedback on MICUNAY program content. Qualitative data were analyzed using Dedoose, a team-based qualitative and mixed methods analysis software platform. Findings highlight various

challenges, including community stressors (e.g., gangs, violence), shortage of resources, cultural identity issues, and a high prevalence of AOD use within these urban communities. Regarding MICUNAY, urban AI/AN youth liked the collaborative nature of the motivational interviewing (MI) approach, especially with regard to eliciting their opinions and expressing their thoughts. Based on feedback from the youth, three AI/AN traditional practices (beading, AI/AN cooking, and prayer/sage ceremony) were chosen for the workshops. To our knowledge, MICUNAY is the first AOD use prevention intervention program for urban AI/AN youth that integrates evidence-based treatment with traditional practices. This program addresses an important gap in services for this underserved population.

Montgomery, L. (2015). Marijuana and tobacco use and co-use among African Americans: Results from the 2013 National Survey on Drug Use and Health. *Addictive Behaviors*, 51, 18-23. doi: 10.1016/j.addbeh.2015.06.046

Although studies have identified an increased likelihood of marijuana and tobacco co-use among African Americans as compared to other racial groups, few studies have specifically examined the prevalence and substance use characteristics of co-users among African Americans in a national survey. The current secondary analysis examined the prevalence rates and substance use characteristics (e.g., marijuana dependence) of 2024 African American past month marijuana and tobacco users and co-users participating in the 2013 National Survey on Drug Use and Health. Findings revealed that 18.5%, 53.8% and 27.7% of African Americans smoked marijuana only, tobacco only and marijuana and tobacco in the past 30 days, respectively. Relative to participants who smoked marijuana only, African Americans who smoked marijuana and tobacco were more likely to be marijuana dependent in the past year and report more days of marijuana use in the past month. Further, relative to participants who smoked tobacco only, African Americans who smoked marijuana and tobacco were less likely to be dependent on nicotine, reported fewer days of cigarette use in the past month, and began smoking cigarettes, cigars and marijuana at a younger age, but were more likely to be marijuana dependent in the past year and reported more days of cigar use in the past month. Marijuana and tobacco co-use is a significant public health problem, especially among African Americans. Additional research on effective prevention and treatment interventions for African Americans who smoke marijuana and tobacco is warranted.

Rohsnow, D. J., Tidey, J. W., Kahler, C. W., Martin, R. A., Colby, S. M., & Sirota, A. D. (2015). Intolerance for withdrawal discomfort and motivation predict voucher-based smoking treatment outcomes for smokers with substance use disorders. *Addictive Behaviors*, 43, 18-24. doi: 10.1016/j.addbeh.2014.12.003

Identifying predictors of abstinence with voucher-based treatment is important for improving its efficacy. Smokers


with substance use disorders have very low smoking cessation rates so identifying predictors of smoking treatment response is particularly important for these difficult-to-treat smokers. Intolerance for Smoking Abstinence Discomfort (IDQ-S), motivation to quit smoking, nicotine dependence severity (FTND), and cigarettes per day were examined as predictors of smoking abstinence during and after voucher-based smoking treatment with motivational counseling. We also investigated the relationship between IDQ-S and motivation to quit smoking. Smokers in residential substance treatment ($n = 184$) were provided 14 days of vouchers for complete smoking abstinence (CV) after a 5-day smoking reduction lead-in period or vouchers not contingent on abstinence. Carbon monoxide readings indicated about 25% of days abstinent during the 14 days of vouchers for abstinence in the CV group; only 3-4% of all participants were abstinent at follow-ups. The IDQ-S Withdrawal Intolerance scale and FTND each significantly predicted fewer abstinent days during voucher treatment; FTND was nonsignificant when controlling for variance shared with withdrawal intolerance. The one significant predictor of 1-month abstinence was pretreatment motivation to quit smoking, becoming marginal ($p < .06$) when controlling for FTND. Lower withdrawal intolerance significantly predicted 3 month abstinence when controlling for FTND. Higher withdrawal intolerance pretreatment correlated with less motivation to quit smoking. Implications for voucher-based treatment include the importance of focusing on reducing these expectancies of anticipated smoking withdrawal discomfort, increasing tolerance for abstinence discomfort, and increasing motivation.

Steinka Fry, K. T., Tanner-Smith, E. E., & Grant, S. (2015). Effects of 21st birthday brief interventions on college student celebratory drinking: A systematic review and meta-analysis. *Addict Behav*, 50, 13-21. doi:10.1016/j.addbeh.2015.06.001

Introduction. College students' 21st birthday celebrations often involve consumption of extreme amounts of alcohol as well as alcohol-related risks. This systematic review aims to determine whether birthday-focused, individually targeted, no-contact (email or letter-based) brief alcohol interventions (BAIs) reduce college students' 21st birthday celebratory drinking. **Methods.** A systematic search identified 9 randomized evaluations with 10 interventions to reduce 21st birthday drinking. Quantity of alcohol consumed and estimated blood alcohol concentration (BAC) were measured. Random-effects meta-analysis was used to summarize the effects of the interventions. **Results.** There was no evidence that birthday-focused BAIs reduce quantities of alcohol consumed during birthday celebrations ($g = 0.05$, 95% CI [-0.03 to 0.13]). The interventions were associated with significant reductions in estimated BAC levels ($g = 0.20$, 95% CI [0.07

to 0.33]), but this effect was small in absolute terms. The quality of this body of evidence was very low, as evaluated using the GRADE approach. In particular, it was limited by substantial participant attrition post-randomization due to included studies' recruitment and randomization procedures. **Conclusions.** There is no evidence that birthday-focused, individually targeted BAIs reduce the quantity of alcohol consumed by students during 21st birthday celebrations, although these interventions may yield small beneficial effects on estimated BAC. Many methodological concerns were identified in included studies. This area of research would benefit from theory-based RCTs that are well-designed and executed. Future research should also investigate strategies other than birthday-focused, individually targeted, brief interventions to curb 21st birthday celebratory drinking.

VanderBroek, L., Acker, J., Palmer, A. A., de Wit, H., & MacKillop, J. (2015). Interrelationships among parental family history of substance misuse, delay discounting, and personal substance use. *Psychopharmacology*. doi:10.1007/s00213-015-4074-z

Rationale. Despite consistent evidence of the familiarity of substance misuse, the mechanisms by which family history (FH) increases the risk of addiction are not well understood. One behavioral trait that may mediate the risk for substance use and addiction is delay discounting (DD), which characterizes an individual's preferences for smaller immediate rewards compared to larger future rewards. **Objectives.** The aim of this study is to examine the interrelationships among FH, DD, and diverse aspects of personal substance use, and to test DD as a mediator of the relationship between FH and personal substance use. **Methods.** The study used crowdsourcing to recruit a community sample of adults ($N = 732$). Family history was assessed using a brief assessment of perceived parental substance use problems, personal substance use was assessed using the Alcohol Use Disorders Identification Test and a measure of frequency of use, and delay discounting was assessed using a latent index of discounting preferences across six reward magnitudes. **Results.** Steeper discounting was significantly associated with personal alcohol, tobacco, and marijuana use, and level of substance experimentation. Steeper DD was also associated with a denser parental FH of alcohol, tobacco, and overall substance misuse. Parental FH density was significantly associated with several aspects of personal substance use, and these relationships were partially mediated by DD. **Conclusions.** The current study suggests that impulsivity, as measured by DD, is one proximal mechanism by which parental FH increases substance use later in life. The causal role of DD in this relationship will need to be established in future longitudinal studies. 

Announcements

Graduate Student Research Competition

C4 Recovery Solutions is pleased to announce that the annual call for submissions for the **Graduate Student & Early Career Researcher Competition** is now open for both the *West Coast Symposium on Addictive Disorders* (www.wcsad.com) and the *Cape Cod Symposium on Addictive Disorders* (www.ccsad.com).

A combination of two competitive research fellowships, 8 research grants, and 16 travel awards totaling more than **\$12,000** are presented annually to graduate students and early career professionals for outstanding research. Authors of the top four submissions deemed to be of superior merit will be invited to present their work orally in a special paper session at each respective conference, while an additional four submissions will be selected to present their work in a poster session.

Please submit all questions and project abstracts electronically to Education & Training Committee Co-Chairs, Steven Proctor, Ph.D., and Al Kopak, Ph.D., at: C4ResearchCommittee@gmail.com

Postdoctoral Fellowships at Brown University, Center for Alcohol & Addiction Studies

The Center for Alcohol and Addiction Studies is recruiting for two T32 training programs, funded by NIAAA and NIDA, providing research training on alcohol, tobacco, and drug use, dependence, early intervention, and treatment. CAAS research includes laboratory studies; behavioral and pharmacologic intervention; studies of intervention mechanisms, and alcohol/HIV research. Training includes structured didactic seminars, supervised research experience, and an intensive mentored grant writing process. The deadline for early decision is December 1, 2015 and regular decision applications are due January 22, 2016. Reviews will continue until positions are filled. Starting dates vary from July 1 to September 1, 2016.

For program details and application see <http://www.caas.brown.edu/Content/training/>. Applicants must hold a doctoral degree at the time the fellowship begins and be a citizen or permanent resident of the U.S. Brown University is an Equal Opportunity/Affirmative Action Employer and actively solicits applications from women and minorities.

Postdoctoral Fellowships at the University of Vermont, Center on Behavior and Health

The **University of Vermont** has an opening for an NIH postdoctoral research fellow. The Vermont Center on Behavior and Health is an internationally recognized center of excellence for the study of substance abuse. The fellow will help conduct a NIDA-funded trial evaluating an interim buprenorphine treatment for waitlisted opioid-dependent adults and related research. **Appointment:** 2-3 years. **Eligibility:** Applicants must have completed training in psychology, behavior analysis or related discipline and be U.S. citizens or permanent residents. Candidates selected based on scholastic record and commitment to substance abuse research; must possess initiative and a desire to learn. **Benefits:** Stipend, medical insurance, and travel funds supported by NIH Institutional Training Awards. **For more information:** Please see www.uvm.edu/medicine/behaviorandhealth or contact Ms. Diana Cain (Diana.Cain@uvm.edu). **To apply:** Download, complete and email application form with cover letter, curriculum vitae, statement of research interests, and 3 reference letters to: Dr. Stacey Sigmon, c/o Ms. Diana Cain.

Position Announcement for Clinical/Counseling Psychologists

The VA San Diego Healthcare System is recruiting clinical/counseling psychologists for a VA-funded Interprofessional Advanced Fellowship in Addiction Treatment. Fellows must demonstrate interest in pursuing VA or academic careers with addiction treatment as a significant focus. Fellows will spend at least

75% of their time in educational and research experiences. No more than 25% time will be for non-educational clinical service. Research mentors include Drs. Tamara Wall and Scott Matthews (Co-Directors), Abigail Angkaw, Robert Anthenelli, Sandra Brown, Neal Doran, Eric Granholm, Igor Grant, Nick Mellos, Mark Myers, Sonya Norman, Carmen Pulido, Neil Richtand, Marc Schuckit, Andrea Spadoni, Susan Tapert, Steven Thorp, and Ryan Trim. Please see the University of California, San Diego, [Department of Psychiatry website](http://www.psychiatry.ucsd.edu) for research interests of faculty mentors and additional information about our affiliate. Please contact Dr. Tamara Wall (twall@ucsd.edu) with questions about the program and see the following website for information about submitting an application: http://www.va.gov/oaa/specialfellows/programs/sf_advaddictiontreatment.asp

SoAP's Monthly Conference Call to Provide a Forum for Clinicians Working with Addiction

The Society of Addiction Psychology is sponsoring a monthly clinical conference call to discuss addiction treatment and related issues. We feature presentations and/or case discussions and welcome all to participate and/or present a topic. The calls are held on the second Friday of the month, at 1:00 Eastern Time. Feel free to listen in, ask questions, make comments, etc. Be sure to pass this information on to anyone who may have an interest in the treatment of addictive disorders. The call-in information is as follows: Call-in number: 641-715-3580. Meeting ID number: 333-440-675. For any questions, contact Mark Schenker at mschenker@navpoint.com.

Harm Reduction Providers

www.seatainfo.org now available for free listings by harm reduction providers. The Self Empowering Addiction Treatment Association (SEATA) launched its website 9/1/15. All listings are free, and available to any provider who meets the guidelines, which include:

- Providers accept the client's goals so long as harm is reduced. Even in a case where the client does not seek to abstain, the provider will work to promote client well-being.
- Unless a "success rate" or similar statistic can be supported by scientific research published in a peer-reviewed scientific journal, the provider will not cite one.
- If the provider pays a referral fee (or "kickback"), the client is informed of the amount of the payment and to whom it is made.

Treatment providers interested in participating in the by-invitation-only SEATA listserve may contact Tom.Horvath@practicalrecovery.com

Online Resilience Training for Practitioners

Resilience specialist Dr. Chris Johnstone, who worked in the addictions

field for many years, is offering an online training for practitioners wanting to help their clients grow in resilience. "Coaching for Resilience" starts on January 26th, 2016 and takes place over seven fortnightly webinars accompanied by an online resource with videos, downloadable templates and a discussion forum.

Drawing on Positive Psychology research and elements of the Penn Resilience Program, the course introduces practical tools we can use ourselves and pass on to clients. The training is introduced by a free webinar on January 12th, 2016, and a free online resilience resource running January 5th-26th. For details, see <http://collegeofwellbeing.com/coaching-for-resilience/>

Postdoctoral Scholars

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

environment in the Department of Psychiatry, University of California, San Francisco. Applications will be considered until all slots are filled. Scholars work with a preceptor to design and implement studies on the treatment of drug dependence, and select a specific area of focus for independent research. Training of psychiatrists, women, and minorities for academic research careers is a priority. Send letter of interest, CV, research statement, samples of work, and two (2) letters of recommendation to Postdoctoral Training Program in Drug Abuse Treatment/Services Research, University of California, San Francisco, 1001 Potrero Avenue, Bldg 20, Ward 21, Rm 2130, San Francisco, CA 94110-3518.

For more information please visit <http://addiction.ucsf.edu/education/postdoctoral-training> or contact Tuli Cruz via e-mail at gertrude.cruz@ucsf.edu or phone at 415-206-3979.ψ

Celebrating Achievements in Addiction

Tucker Wins Distinguished Scientific Contributions to Clinical Psychology Award

Jalie A. Tucker, Ph.D., M.P.H., Professor and Chair of the University of Florida Department of Health Education and Behavior, received the 2015 Society of Clinical Psychology (Division 12) Award for Distinguished Scientific Contributions to Clinical Psychology at the August American Psychological Association convention in Toronto, Canada. This award honors clinical psychologists who have made distinguished theoretical or empirical contributions to the science of psychology throughout their careers.



Jalie Tucker

and treatment services systems for addictive behaviors nationally and internationally and her leadership in an ongoing shift within the field to a public health model for providing services. Her research on natural recoveries from alcohol problems expanded understanding of behavior change beyond recoveries achieved in treatment programs, and her work has spawned new lines of research in her specialty area and across disciplines.

Dr. Tucker is a Division 50 Charter Fellow and was division President in 1993-1994, the division's first full year of operation. She served 4 terms as division Representative to the APA Council of Representatives and as member and chair of the APA Board of Professional Affairs and APA Board of Scientific Affairs.



James MacKillop

Her citation, presented by Division 12 President Terry Keane, noted the impact of her research on evidence-based treatment

MacKillop Wins APA Distinguished Scientific Award for an Early Career Contribution to Psychology (Applied Research)

For distinguished contributions to the behavioral economic study of addiction. James MacKillop's development and application of the hypothetical purchase task has allowed an understanding of the valuation of, and hence motivation to use, a commodity by determining how much a participant will consume as a function of price. His demonstration of the validity of this method in clinical studies has led to its increasing adoption in clinical research in the field of addiction. His application of behavioral economics to the effects of cue-elicited craving and withdrawal is leading to a new multidimensional taxonomy of the acute motivation to use addictive drugs. By using his behavioral economic advances in novel ways, he has made contributions to tobacco policy and expanded this behavioral economic perspective into both neuroimaging and genetics.ψ

San Diego, CA
March 18-19, 2016

4th Annual Collaborative
Perspectives on Addiction Meeting

COLLABORATIVE
PERSPECTIVES on
ADDICTION

Reducing Health Disparities through Addiction Science and Practice

For more information: <http://research.alcoholstudies.rutgers.edu/cpa>

Poster proposals due November 20

KEYNOTE SPEAKERS



Susan Tapert



Raul Caetano

CONTINUING EDUCATION

POSTER SESSIONS

SOCIAL HOURS

TRAVEL AWARDS

SPECIALTY WORKSHOPS

Workshops (6 CE credits each)

Mindfulness-Based Interventions for Alcohol and Substance Use Disorders: Empirical Findings and Recent Adaptations

This experiential workshop presents a manualized mindfulness-based intervention for alcohol and substance use disorders. Mindfulness Based Relapse Prevention for addictive behaviors was designed as an aftercare intervention to increase awareness of triggers and automatic reactions in the service of reducing the risk of relapse following treatment. Presented by Katie Witkiewitz, PhD, Sarah Bowen, PhD, and Corey Roos MS

Cannabis (Marijuana): What You Need To Know To Effectively Assess, Advise, Educate, Prevent, and Treat

This workshop will present information and engage discussion on aspects of cannabis use relevant to providing effective prevention and treatment. Time will be devoted to development of a knowledge base related to diverse forms of cannabis and its active constituents, new cannabis products and devices, how these impact perception of risk and decisions to use or not, and interactive exercises will focus on assessment and therapeutic strategies. Presented by Alan J. Budney, PhD and Denise D. Walker, PhD

APA DIVISION 50 (SOAP) POSITIONS, 2015-2016

ELECTED OFFICERS

President	Sherry McKee	sherry.mckee@yale.edu
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(continued on next page)

APA DIVISION 50 (SOAP) POSITIONS, 2015-2016

(continued from previous page)

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