APTC NEWSLETTER

May 2017

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Associate Editors: ***Karen White, Holly Cormier***

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Submitted by Karen Saules, Ph.D.

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Presidential Reflections

Karen Fondacaro, Ph.D.

Karen Fondacaro, APTC President

We once again experienced the warmth that APTC Directors annually share! It certainly helped that we were together in sunny Miami Beach, Florida. Thank you to all for a successful conference. I hope our time together generated new collaborations and creative ideas towards, "Making Competencies Work in Your Clinic." The presentations, panels and posters were impressive and informative. It is clear that APTC has a central role in impacting the future of psychology by emphasizing competencies and the integration of clinical practice and science. I am confident that our supportive relationships, listserve communication, and annual conferences will maintain our momentum.

I want to extend special congratulations to our 2017 Award recipients. The Clinic Innovation Award was given to Director Jennifer Schwartz of Drexel University Psychological Services Center and was honored at our Miami conference. Leticia Flores and Erica Wise received the Jean Spruill Achievement Award and will be honored at the APA meeting in Washington DC in August. Please join us for this special occasion.

I'd also like to recognize each and every one of our Directors from the east to the west coast of the United States, Canada and Guatemala. Please take time to appreciate yourself and your dedicated training of students. Next year, in Hawaii, we will strengthen our ties with our international colleagues and clinics in the Pacific Rim. I hope to see ALL of you!

Promoting Dialectical Behavior Therapy *for* Substance Abuse Populations

Kirk Mochrie, MA & Tony Cellucci, PhD

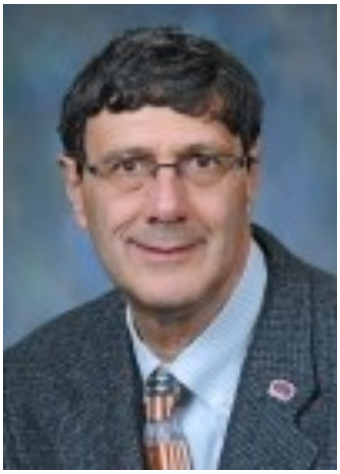
There is a range of problems involving abuse of alcohol and other drugs; consequently, there is no one single intervention approach for all patients. Dialectical Behavior Therapy (DBT) is an evidenced-based therapeutic orientation with considerable empirical support for treating Borderline Personality Disorder (BPD) and patients with complex problems related to emotional dysregulation (Linehan, & Wilks, 2015). More recently, evidence has accumulated suggesting the efficacy of DBT for a variety of patient population in numerous settings, including the use of DBT skills as a stand-alone intervention (Panos, Jackson, Hasan, & Panos, 2014; Valentine, Bankoff, Poulin, Reidler, & Pantalone, 2015). Thus, it stands to reason that DBT concepts and skills may also be useful in treating substance abuse (SA) populations.

Empirically, few studies have directly examined DBT for SA patients with the focus on integrated treatment with comorbid BPD (Lee, Cameron, & Jenner, 2015; McMain, Sayrs, Dimeff, & Linehan (2007). Traditional DBT without a focus on SA does not necessarily affect SA outcomes in this difficult-to-treat comorbid population, and dropout rate remains high, although there is evidence DBT validation strategies decrease dropout (Linehan et al., 2002). Therefore, DBT was modified by Linehan and colleagues to focus on treating comorbid BPD and SA patients (Dimeff & Linehan, 2008; McMain, et al, 2007; Rosenthal, Lynch, & Linehan, 2005). Greater emphasis was placed on attachment strategies to increase commitment to treatment. Moreover, SA-specific behavior targets were implemented including: decreasing abuse of substances, alleviating physical symptoms of abstinence/withdrawal, coping urges/cravings, avoiding opportunities/cues to use, reducing behaviors conducive to drug abuse, and increasing community reinforcement for alternative behaviors. The second of edition of Linehan's DBT skills training manual now includes specific handouts and homework assignments intended for individuals with a SA comorbidity. Although further research is needed on substance use patients without BPD, we would argue this approach may be underutilized in treating SA and that a DBT-informed approach to treatment has much to offer to the SA field.

The majority of SA patients in public settings have multiple problems with dysfunctional use symptoms associated with moderate to severe dependence. There is also a high rate of comorbidity with psychiatric difficulties including trauma, anxiety and depression, and personality problems.

The majority of SA patients in public settings have multiple problems with dysfunctional use symptoms associated with moderate to severe dependence. There is also a high rate of comorbidity with psychiatric difficulties including trauma, anxiety and depression, and personality problems. The prevalence of BPD alone on average among SA patients is 27% and may be as high as 50% in some settings (Trull, et al., 2000). In short, a high percentage of SA patients are likely to exhibit the emotional and/or behavioral dysregulation targeted in DBT and could benefit from a DBT-informed treatment approach even without meeting criteria for BPD.

The major goal of any initial substance abuse treatment is to engage patients and build motivation. DBT emphasizes validation to increase acceptance and modifications for SA patients have been developed to increase attachment and commitment. The philosophy of DBT is compatible with most SA programs. As described by Dimeff & Linehan (2008) this involves therapeutic efforts to eliminate painful emotional experiences while accepting life's inevitable pain consistent with Niebuhr's serenity prayer. Moreover, dialectical abstinence pushes for immediate abstinence of major substances of abuse while responding to slips nonjudgmentally using a problem-solving approach. The targets or postulated psychological mechanisms of change with DBT (Lynch et al., 2006) map on to many SA patients including mindful awareness of inner experience, emotional regulation, learning new skills, less rigid cognitive beliefs and an increase in relativistic thinking, more effective coping and increased self-efficacy, decreased shame, increased self-awareness and developing a positive stable sense of self.



Tony Cellucci, East Carolina University

DBT skills have been described as important life functioning skills appropriate for everyone and many SA patients have deficits in such basic skills as self-management, assertive communication, and problem-solving. The use of core mindfulness skills is particularly important for SA patients to increase awareness of emotional states and relapse prevention skills. In addition, mindfulness skills can be used to help increase awareness of triggers and practice "urge surfing" when faced with intense cravings. Distress tolerance skills are used to find acceptance of problematic situations that cannot be changed as well as to increase effective behaviors in crisis situations rather than coping with substances. Further, emotion regulation skills can be utilized as alternate behaviors to SA when patients experience high intensity emotions with extended durations. Finally, DBT's interpersonal effectiveness skills can be utilized to end problematic relationships (i.e. drug dealers), build positive relationships, and increase assertive communication (i.e. drink/drug refusal) skills.

The DBT model also provides a valuable framework for conducting individual therapy by highlighting treatment phases, using a hierarchy of individual targets including substance use, and providing strategies for therapy-interfering behaviors (see Chapman & Rosenthal, 2016). The goal of individual treatment is to balance validation while motivating change, enhancing patient capabilities and promoting dialectical reasoning to promote building a new life structure. In addition, DBT emphasizes generalization of new learning (via telephone coaching) and group support for patients. This may be particularly important for SA populations in order to provide immediate coaching of skills to prevent relapses. Further, a DBT chain analysis can be used by the individual therapist as a form of functional assessment to help patients identify antecedents and consequences of any use as well as identify new, effective skills to implement in the future. A DBT diary card is utilized to inform individual sessions with SA patients. The card can be modified to have patients' self-monitor specific SA outcomes daily (e.g., triggers, cravings, use). DBT-informed treatment incorporates process and outcomes assessment involving ongoing self-monitoring of substance use, emotions, skill usage, and quality of life functioning.

Preliminary evidence on DBT treatment has related changes in emotional dysregulation to changes in SA (Axelrod et al., 2011) and DBT outcomes to skill usage (Neacsiu, Bohus, & Linehan, 2010). Further, DBT treatment is compatible with using other interventions (e.g., medication, community resources, case management). DBT treatment for SA encourages relatively extensive treatment involvement and supports relapse prevention. It would also be compatible with mindfulness-based relapse prevention (Cellucci & Mochrie, 2016). Therefore, psychology trainees should consider adopting a DBT therapeutic orientation and frame when working with SA patients, especially when the patient's substance use seems tied to emotional dysregulation and/or when there is a complex multi-problem presentation.

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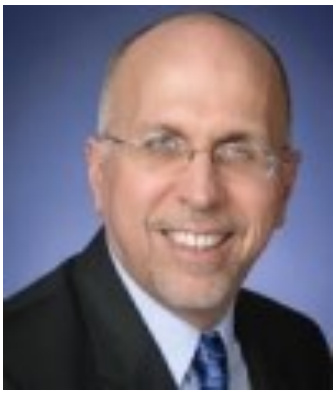
Why You Should Be Screening for

GAMBLING DISORDER

James Whelan, Ph.D.



James Whelan, University of Memphis

Gambling is when something of value is risked when the outcome is at least partially due to chance (Whelan et al, 2007). A wide range of behaviors that can be identified as gambling, some are regulated while others are illegal. Gambling opportunities throughout the world have expanded over the past 30 years with internet gambling and gambling while playing video games as the newest frontiers (Horvath & Paap 2012). While about 82% of US adults have gambled in the past year (Welte et al, 2002), between 1% and 2% of the US adults and about 10% of college student meeting criteria for disordered gambling (Welte et al, 2015). Grouped with substance addictions in the DSM 5, disordered gambling is characterized by tolerance, withdrawn problems, and harm. The harm is often psychological, relational, occupational, and financial. Individuals with gambling problems may present with a variety of psychological problems including mood disorders, anxiety, and relational distress. Substance use and abuse, particularly alcohol and nicotine, are frequently comorbid conditions (Dowling et al., 2015).

Cognitive-behaviorally based interventions specifically designed to treat disordered gambling are very efficacious (Gooding & Tarrier, 2009) although only a minority of those with gambling problems present for treatment and dropout maybe half of those who attend treatment. It would behoove clinicians to screen for gambling problems as part of a standard intake evaluation. I recommend the Brief Biosocial Gambling Screen (Gebauer, LaBrie, & Shaffer, 2010). This brief 3-item screen has excellent classification accuracy.

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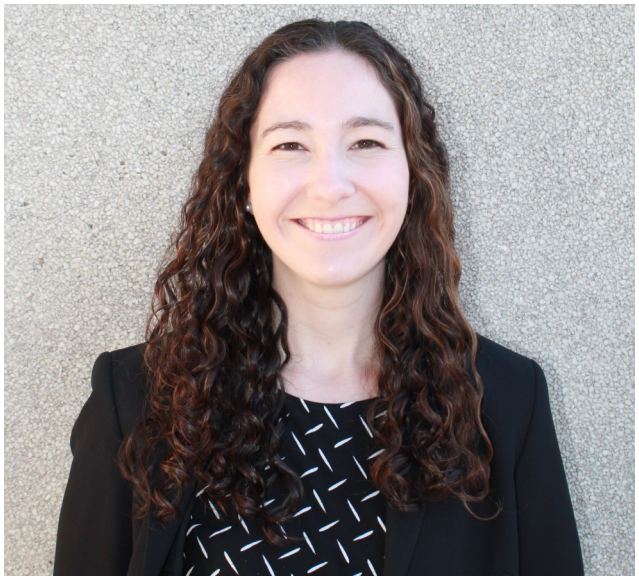
Technology Corner:

Using Virtual Reality *to treat* Substance Abuse

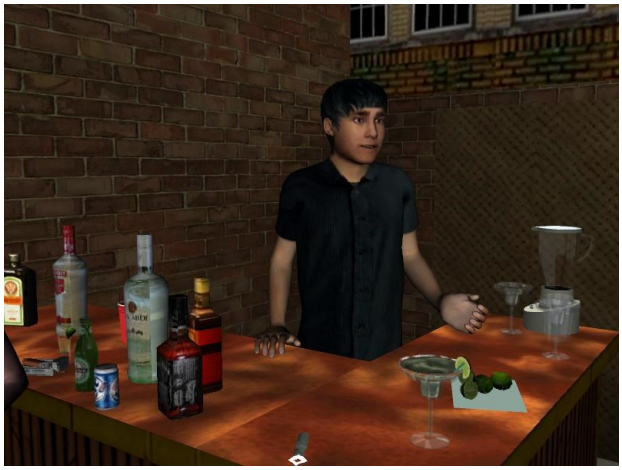
Jackie Hersh, Ph.D.



Jackie Hersh,
Appalachian State University

Since treatment dropout and relapse are high in treatments for substance use disorders (SUDs), innovative adjunctive treatment techniques could be useful. Clinic director Jackie Hersh did her dissertation on the use of virtual reality (VR) cue-exposure and recently ordered VR equipment (link below) for the Appalachian State University Psychology Clinic as a potential way of enhancing treatment for SUDs. Cue-exposure paradigms can be understood from a classical conditioning perspective. Specifically, cue-exposure can be useful for facilitating extinction, done by repeatedly presenting the conditioned stimulus, such as a drug cue or craving trigger (e.g., sight or smell of the drug), without the drug or drug effects. This can lead to the extinction of the conditioned response or rather, reduce the motivation to use the drug by eliciting craving but blocking use. This process teaches the individual that it is possible to 'ride out' the craving. Several cue-exposure paradigms exist, which typically use imagery scripts (describing a drug-related scene), drug-related images or videos, *in vivo* cues (e.g., holding alcohol), or VR cues.

Research shows VR can elicit self-reported craving and physiological arousal in both adolescents and adults and across different substances such as alcohol, nicotine, cocaine, and cannabis. These VR paradigms attempt to provide the user with the look and feel of a real setting that may feel more natural and immersive than scripts or videos but carry less risk than in-vivo cue-exposure paradigms. Further, VR uniquely allows for social scenes where the temptation to use and risk for relapse may be high (e.g., bar, party). The VR user can navigate through a virtual space and interact with avatars, which can be tailored to the individual. Amount and intensity of cues can be manipulated in VR to create an exposure hierarchy.



Sample avatar. Clients create an avatar of themselves then "virtually" encounter challenges.

Experiencing craving in a safe space with the ability to process it can help individuals get comfortable having cravings and prepare for the many triggers they face every day to hopefully reduce relapse. Additionally, the clients liked the cool tech and said it would help keep them interested in treatment. Hence, VR may be a worthwhile technique to add to standard care for increasing treatment retention and reducing relapse.

Virtual reality equipment: http://www.virtuallybetter.com/portfolio/alcohol

To see a sample virtual reality session go to https://www.youtube.com/watch?v=Iq-pRcLnyBQ

Substance Abuse Program, Before & Now

Rutgers University

Holly Cormier interviews Director Craig Springer

Craig Springer is the Director of the Center for Psychological Services at Rutgers University. In a phone conversation with Craig, I spoke with him about the substance abuse program in his clinic. Craig was a real trooper and indulged my many questions about his program as he drove through busy city streets in Jersey, made a quick stop for flowers for a recently remembered secretary's day, and eventually, hoofing into his office, asking only for one brief pause to catch his breath. Here are a few things from our conversation.

Craig Springer has been the clinic director for approximately 2.5 years. His training clinic provides a variety of psychological services to the community as well as to Rutgers students. The clinic serves the training needs of approximately 150 students in three psychology doctoral graduate programs (with two upcoming masters programs in the final phases of development) and has over one-hundred highly credentialed supervisors. In addition to assessment and therapeutic services offered through their Psychological Services Clinic, they have 10 specialty clinics and programs. One of these specialty clinics is a substance abuse program in which mental health graduate clinicians learn how to perform evaluations and provide treatment for individuals with substance use and abuse issues. At the time that Craig stepped into the role as clinic director, the substance abuse program had been running for approximately 30 years. This specialty clinic has been operating as a state licensed program. Recently however, the Center for Psychological Services relinquished their credential as state licensed program in favor of implementing a training and service program that is more congruent with training and treatment models taught as part of the graduate curriculum. Here is a bit more about the ***BEFORE*** and ***NOW***, of the program.

Craig Springer, Ph.D.
Rutgers University

The *BEFORE…*

As a credentialed state licensed program in New Jersey, Craig's clinic was approved to provide evaluations and treatment to individuals who had lost their drivers licenses for drug and alcohol related offenses. In order to maintain their state license, the clinic was required to operate in compliance with a myriad of state rules that dictated a range of things including the frequency of disaster drills in the clinic, random drug testing of clinicians, yearly fees, and entering client names into a state database (regardless of whether they were mandated for substance related treatment or self-referred). The state also imposed the use of specific treatment models. While their clinic negotiated for leniency with respect to some of these requirements (in part because it was a training clinic), there were still a number of stipulations that were in conflict with the clinic's training and teaching philosophies. When their license came up for renewal during its most recent cycle, the state was no longer willing to continue to allow for leniency, and the state license was dropped. I asked Craig about this decision, and he shared that in large part, this was the beginning of a change that needed to happen. Under the state license, the clinic worked with a small, largely mandated clientele with little motivation to change. Furthermore, to be in compliance as a state licensed program, treatment needed to follow an abstinence model and the program director, regardless of already established expertise in the treatment of substance abuse, must possess the credential of Licensed Clinical Alcohol and Drug Counselor (LCADC). With respect to the latter, Craig noted that he only knows one psychologist who has this additional credentialing, but that he knows of many more supervising psychologists with expertise in the treatment of substance abuse. Craig stated that if it wasn't for the fact that the one psychologist who directed the program was willing to acquire the state required credential, they would have needed to locate and hire an LCADC in addition to a psychologist in order to meet both the state license requirements in addition to APPIC requirements for supervision.

The *NOW…*

While this could have prompted a decision to eliminate the substance abuse specialty clinic altogether, Craig and his staff have done the exact opposite. Recently, the Center for Psychological Services has taken over the Center for Alcohol Studies on campus. This is a unit that, up until now, engaged in theoretical and applied research, but has not had a clinic. Craig and his colleagues are introducing a substance abuse clinic into the center, and are actively recruiting clients seeking substance abuse services. They have partnered with a number of referral sources both on and off campus (including high schools and a family medicine clinic), and are enjoying the experience of training student clinicians, as well as providing treatment to clients in a manner that is congruent with a variety of models and client variables. As was the model before, student clinicians receive didactic training in substance abuse evaluation and treatment and are supervised in the delivery of treatment with clients. Now however, there is the promise of a greater range in clientele, treatment models, supervisors, and clinical services. In short, separation from the state has resulted in an opportunity to rebuild the program with a larger capacity and a wider range of clients. As an example, Craig spoke about a program that is already running called Women Helping Women (WHW). This program focuses on the delivery of treatment services to female clients by female therapists. A number of mental health issues are served, including women with substance abuse issues. Craig described other training and service opportunities that can now be an option, including psychoeducational groups for substance abuse as well as allowing student clinicians to work in partnership with a family medicine clinic when substance use and abuse issues are identified. In speaking with Craig, it was apparent to me that regardless of whether we were talking about the ***BEFORE*** or ***NOW*** version of the substance abuse treatment program, an incredible amount of work goes into offering students this kind of training opportunity. In that regard, I asked Craig why he felt that rebuilding the program was worth the effort. He explained that substance abuse issues are frequently part of a host of other mental health issues, and a lack of experience and training in the area results in a neglecting some key concerns. Craig went on to say that in New Jersey, and in other states as well, the state defined credential for a provider to be approved as a substance provider dramatically limits psychologists. Craig stated that a faculty member at Rutgers is moving into the position of president of APA's division (50) Society of Addiction Psychology. One mission that has been identified is to bring back the Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders. Some time ago, APA did have a credential for substance abuse treatment, but it died out. The hope among some practitioners is to bring this back. There could be an opportunity for psychologists to use their specialization in substance abuse as an alternate way to meet state imposed requirements. Movement on this front will certainly have implications for training of future psychologists! Craig stated that there are a lot of changes in the works, and that this is an exciting time for his clinic. Perhaps he will be inspired to tell fellow APTC members all about them in a presentation at next year's meeting in Hawaii!

The *FINE PRINT…*

In both the old and new model of the substance abuse clinic, clients paid for services out of pocket. A sliding scale is/was in place, and session fees range from $0.00 to $100.00/session. If the client was a Rutgers student with the student insurance plan, the clinic would bill the insurance plan for 100% of the fee. Under the old model, the clinic averaged about 50-60 substance abuse related referrals per year (a mix of evaluation and treatment) with approximately 5-6graduate clinicians providing services. We have yet to see client numbers under the new model.

Holly Cormier, Ph.D.
Southern Illinois University Carbondale

APTC Business Meeting Minutes

Miami

March 31, 2017

Submitted by Karen Saules, Ph.D.

Awards

~Jean Spruill Awards will be given at APA during the APTC Social Hour this summer, because recipients (Lettie Flores & Erica Wise) could not be present in Miami this year.
~Clinic Innovation Award, with $500 grant to the Clinic, was awarded to the Drexel Psychological Services Center, under the Directorship of Jen Schwartz. Jen gave a brief talk about her clinics' innovations, which include a video system to develop supervision competencies, a prisoner re-entry project, and a juror support program. Jen's slides will be available on the website under meeting materials.
~In addition, information from Shannon Couture, Awards Committee Chair, regarding the other nominees for the Innovations Award will be posted to the website.

Reports from other organizations

APA ***Cathi Grus***, *Education Directorate*, provided information on APA activities this past year:
~Interprofessional Seminar on Integrated Primary Care: Curricular resource to enhance IPC competencies, developed for classroom use in early training. See ***http://www.apa.org/education/grad/curriculum-seminar.aspx***
~BEA/BPA Joint Workgroup on Restrictions Affecting Diversity Training in Graduate Education. See ***http://www.apa.org/ed/graduate/diversity-preparation.aspx***
~Comments on government relations in current political climate, especially in light of the possible 77% cut to HRSA

APPIC ***Kimberly Hill****, APPIC Liaison* (*Jeff Baker also in attendance*)

Gave updates on this year's match statistics (see ***https://www.appic.org/Match/Match-Statistics***). There were 3,197 successful matches, with over half getting their first choice. Only 144 unmatched after Phase 2. Still a shortage of APA-accredited internships, but less so than in past.
Increase in number of new programs
Only accredited doctoral program associates (DPAs) can participate in match starting in 2018
Might allow non-accredited DPA programs in Phase 2, but not decided yet; getting input on implications
Update on Informal Problem Consultation Program, which aims to ensure due process. They are working on Match Deferral Policy.
Standardized Reference Forms were improved this year, based on feedback, but might be revised again for next year

Karen Saules, APTC Secretary

ACCTA ***Carmen Cruz,*** *ACCCTA Rep*
Heavy emphasis on multicultural competence training as a core value
175 members
Working on compliance with new SoA
Last conference was in Bonita Springs, FL, with the theme of "Self-Care as Ethical Practice"
Discussed diversity gap between contemporary trainees and their supervisors

APTC Reports

Treasurer's Report ***Scott Gustafson***
Had $46,475 at 12/31/15
Had $33,842 at 12/31/16
Current balance (after collecting conference registrations) is now $58,059

Secretary's Report ***Karen Saules***
Explained recent Executive Committee decision to only send TEPP one member list each year, including all who pay dues in time for the January TEPP issue (since TEPP cycle starts in January). Our dues start in September, giving members until sometime in November (exact time to be announced on listserve) to pay if they want to get TEPP.

Committees and Work Groups
Karen Fondacaro provided an overview of standing committees and encouraged members to contact Chairs to get involved.

APTC Executive Committee Minutes

Submitted by Karen Saules, Ph.D.

***Attendees**: Tony Cellucci, Karen Fondacaro, Bob Hatcher, Theresa Kruzcek, Karen Saules, Mike Taylor, Phyllis Terry-Friedman, Kris Morgan, Saneya Tawfik, James Whelan, Heidi Zetzer*

Financial Status: Current balance is $58K minus $32K for the Miami conference, and plus what we will get back from CoA for costs associated with SoA training on Thursday, leaving us with about $32K after meeting expenses clear. Jim Whelan raised issues about need to have better long-term fiscal planning going forward; Tony concurred. We will ask Treasurer to prepare a forward thinking budget for the coming year and beyond.

Discussion re: Kris Morgan: Karen Fondacaro talked with her informally and learned that Kris did not feel she could/should submit unreimbursed expenses from last year, which totaled about $1,300. Executive Committee agreed that APTC should cover these costs; asked Kris to submit receipts. Ditto for current conference travel expenses. Also discussed that Kris has not had a raise since we first started working with her; Karen F to work with Kris on this and get formal contract in place.

TEPP: We will add "yes/no" to getting TEPP on the website, so people can tell us when they pay dues. We will add "By <date, TBD>, you will not get TEPP if APTC dues have not been paid. If you are paying dues prior to <date, TBD>, you are eligible to get a full year of the TEPP journal as a member benefit. Please indicate if you wish to receive the journal in online and/or print formats." Karen Saules to include this information when the listserve messages go out about paying dues in August (and beyond), as well.

Hawaii Meeting 2018:

- Need to establish a conference budget to set realistic costs, including what to charge for Luau (actual cost is over $100/person).
- Need to establish formal agreements with non-APTC international affiliates regarding their cost sharing and financial processes.
- Theresa will write MOU for Karen F, and International Committee will work on details, but basically, the international affiliate group will be responsible for about 30% of room block and catering, A/V, and conference rooms.
- Will be asking them to put up 1/3 of our already paid $5K deposit now.
- Keynote speaker? Saneya checked out University of Hawaii faculty; good mix, but no one who really stands out. Heidi knows an alum from her program who is at Hilo who might be a good option. She will check. Karen F suggested maybe we should try to have two keynotes, to merge the groups nicely by having one from APTC and one from the Australian group
- Will work with International Committee about conference theme
- Call for proposals will go out October 1, submissions due by December 1, so people will know early if accepted so they can plan ahead early. Elizabeth Akey offered to be abstract reviewer Chair, so that it doesn't all have to fall to Program group as it has in the past.

Dues: Raised dues and conference fees last year; Tony advocated to not do so again soon, but when we do, it should be done more planfully.

2019 Meeting: Kris will check into options in Savannah and Charleston. Need to avoid Passover (Apr 20) and Easter (Apr 21). Need to avoid St. Patrick's Day for Savannah. Need to check dates for when CoA and CCTC are meeting, as well. We will try to finalize the dates at our next Zoom meeting, but meeting will be roughly in the range of March 20 – April 19, 2019. Committee noted that weather will likely be better later in that time frame.

Committees: Mike to send current committee list to Karen F and Karen S; will post to website (current list is very outdated).

Website: Discussed ideas for reorganizing/modifying website.

- Add a member spotlight? Pros/cons discussed; may not be feasible.
- News feed? Would need someone to monitor/update regularly; Karen S not able to take on that additional step
- It was recommended that we split out Awards & History into different sections (They already are in different sections. We have sections on "APTC Award History & Recipients" and a different section on "APTC History", but the latter only has Tony's interview with Mike Raulin, because other elements of this initiative have not been submitted).
  Add Awards information from this year. (Post Script: Done by Karen S after meeting)

Elections: Need to plan ahead for 2018 elections. Jim suggested membership drive in light of Hawaii meeting being a draw. Bob can revise the list of all programs/clinics he compiled before, and we can do some outreach, highlighting benefits of membership, meeting content, new member testimonials, etc. Phyllis as Communications Chair will draft something.

Miami Meeting Debriefing: Wrapped up EC meeting by sharing impressions about how the meeting went

- Positives noted re: ambiance/location
- Good mix of talks and breaks, not too jammed with content, sufficient time for interaction; Heidi's "café" worked well in that respect.
- Discussed models for running breakout groups. Maybe provide a bit more structure next year. Also, timing issues came into play by running them at the end of Day 2, when people were getting tired.
- Need better plan for newbie dinner; consider breaking into smaller dinner groups (N=8 each?), and get dyads to sign up.
- Consider hosting more posters, since most of the cost associated with doing posters is for the initial setup; adding more boards doesn't increase the cost so much.

Then… and Now

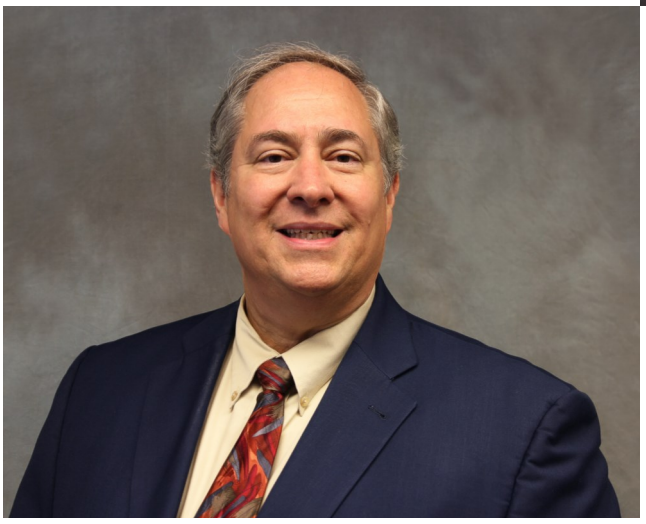
Robert W. Heffer, Ph.D.

Now, this edition of our Newsletter highlights member clinics that provide services to clients and training to doctoral students in the specialty area of substance misuse and addictions. When I heard about this Newsletter theme, I immediately thought of Tony Cellucci and Karen Saules. Tony's and Karen's academic and research interests focus on, respectively, alcohol and other drug abuse and interactions among addictive and eating behaviors.

Then *and* now I am "addicted" to Karen's and Tony's longstanding leadership within APTC—I can't get enough of these two outstanding colleagues! Tony was among the "gang of 12" who met in Chicago in March 1999 for the first APTC mid-year meeting. Since 1999, Tony has served on the Executive Committee, first as Treasurer and currently as our Immediate past President. I recall meeting Karen at APA and, when she asked about serving in APTC, I suggested she run for a Member-At-Large position. Since 2001, Karen has served on the Executive Committee (first as Member-At-Large), earned the 2010 APTC Jean Spruill Achievement Award, and is our current Secretary (and Czarina of the website).

Over the years, I cannot think of an APTC committee, work-group, collaborative project, or initiative that Karen and Tony have not touched in a positive way. Our organization has been enriched by these two colleagues… plus they are really cool people. Of course, their brand of collegiality and excellent work is what draws us to involvement in APTC. I suggest you move from pre-contemplation to contemplation to action and find YOUR place of service in APTC.

Rob Heffer, Then and Now.



Or Now and Then?