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NEWSLETTER

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PRESIDENT'S LETTER

Linda Dykstra
President, Division 28

American Psychological Society, Revisited

In my Fall letter, I wrote about the newly-organized American Psychological Society (APS). At that time I encouraged Division 28 members to consider joining APS while at the same time retaining APA membership. In the ensuing months, APS had grown such that it now claims a membership of 3,000. A convention has been organized for June, 1989 in Arlington, VA, and plans are underway to publish a journal entitled *Psychological Science*. Although most Division 28 members continue to maintain a wait-and-see attitude, activity has been intense enough to prompt our division to take a closer look at this new society and to initiate discussion of our division's present organizational status.

In January, Don Overton attended the APS Leadership Planning Conference as our official representative. According to Don's observations, APS still believes that APA eventually will be a guild organization for practitioners and as such will offer only minimal services to scientific psychology, leaving a void that APS hopes to fill. APS also believes that APA's divisional structure has had such a negative impact (witness the numerous turf battles at APA) that APS has purposely tried to organize a society without divisions.

Although most Division 28 members appreciate the problems that can develop out of a divisional structure such as that of APA, the general consensus of the Executive Committee as well as a random sampling of Division 28 members is that we like our Divisional Status. In particular, such status has provided us with a hospitable forum for scientific communication as well as an effective way to channel our advocacy interests. The question, then, is how can we continue to enjoy these divisional advantages while still claiming membership in a society that will respond to our advocacy needs and provide communication with other members of the scientific psychology community?

One possible option is to follow the lead of a number of other divisions within APA by becoming incorporated. Presently, APA has a lot to say about the business of its divisions and claims ownership of all divisional assets, including bank accounts and journals. Whether APA can also claim ownership of assets that are generated from the dues assessment of its incorporated divisions is not clear. Were Division 28 to become incorporated, we might be able to increase our membership by including non-APA members. We might even go as far as to stage our own meeting or start a journal that would reflect the research interests of our members. We might elect to affiliate with APS as well as APA. The options are numerous and the executive committee would appreciate comment from interested members before the spring executive meeting on May 12th and 13th. Simply send your comments to me (Department of Psychology, University of North Carolina, Chapel Hill, NC 27599-3270) or relay them through any other member of the Executive Committee.

NEW YORK AD AGENCY ADVOCATES ANIMAL RESEARCH

Bozell, Jacobs, Kenyon & Eckhardt, a New York advertising agency, has donated its services to a Washington-based nonprofit foundation set up to counter the views promulgated by animal-rights activists. After reading a *Reader's Digest* ad reprinting an article on the importance of animal research, David Wojdyla, an art director at Bozell, Jacobs, approached Frankie Trull, president of the Foundation for Biomedical Research, and offered to create an advertising campaign to publicize medical advances made possible through animal research.

Three ads were developed for publication in the *New York Times*, the *Wall Street Journal*, and the *Washington Post*. The first shows a group of animal-rights protesters and is captioned, "Thanks to animal research, they'll be able to protest 20.8 years longer." The second, showing a little girl in bed clutching her stuffed bear and kitten, reads, "It's the animals you don't see that helped her recover." The

last, illustrated with pictures of cancer cells, diseased heart tissue, and the AIDS virus, says, "If we stop animal research, who will stop the real killers?" The Foundation for Biomedical Research is also planning to distribute the ads to affiliated groups to run in local publications, and, if the response is good, may budget additional money for the campaign.

Alexander Pacheco, Chairman of People for the Ethical Treatment of Animals, accused the foundation of resorting to the same irrational and emotional appeals they accuse the "humane community" of making. But Ms. Trull, Mr. Wojdyla, and his colleagues at Bozell, Jacobs contended that they only wished to present more information on an issue oversimplified by animal rights groups. Said Ms. Trull, "I'm excited not only because [the campaign] gets the message to the public, but because it will be a morale boost for the research community." (Based on an article that appeared in the *New York Times*, January 20, 1989.)

NEW ANIMAL CARE REGULATIONS

The USDA just revised animal care regulations (*Federal Register, 54(49)*, 10822-10960, 3/15/89). Division members will receive model letters; comments on Parts I & II should be submitted to the USDA by 5/15/89, and comments on Part III (primates) by 8/14/89. Division coordinators are Hugh Evans, (914) 351-4249; and Alan Kraut, (202) 955-7653.

DRUG TESTING: JUST SAY NO?

Note: The authors of the following articles were asked to present "pro", moderate, and "con" positions on drug testing.

Drug Testing: A Powerful Tool

J. Michael Walsh
Director, Office of Workplace Initiatives, NIDA

"An experimental analysis shifts the determination of behavior from autonomous man to the environment—an environment responsible both for the evolution of the species and for the repertoire acquired by each member." (B.F. Skinner, *Beyond Freedom and Dignity*, 1971)

Drug abuse is a complicated social phenomenon. Over the last twenty years there has been a significant increase in the impact of drug abuse on the daily life of the average American. Drug-related crime, disease, accidents, injuries, death, and associated sordid details have become daily reminders of the limited effectiveness of supply-reduction efforts to reduce drug abuse. There is, of late, a hue and cry from all segments of society to develop a change in focus and to concentrate efforts on reducing the demand for drugs.

Many have argued that the key to reducing the demand for drugs (i.e., changing individual drug-taking behaviors) is to hold the drug user responsible for his/her behavior. The environment in which this technique has been most effectively used is in the American workplace. Beginning with the military experience in the early 80's, workplace programs have been developed that send a straightforward message that drug use by employees will not be tolerated. Clearly, one of the key elements of such policies has been the use of drug detection technology to identify drug users.

Although drug detection by urinalysis is not a new technique, it has unquestionably become an issue in the 80's. The Department of Defense utilized urinalysis in the late 60's and early 70's to screen military personnel returning from Vietnam, and law enforcement officers and drug treatment programs have used drug testing for many years. It was not until 1980, however, that new technology evolved from NIDA-supported research that made available new, reliable, inexpensive assays for drugs of abuse.

The rationale for the use of "Drug Testing" has evolved considerably since 1981. The basic philosophy of why test and what to do with the results has changed dramatically over the last seven years. Initially, the rationale for testing was a negative, punitive concept where the basic purpose was to identify drug users and fire them without addressing the problem. In the last three years (1985-present), a more positive, "helping hand" philosophy has evolved. The basic purpose of today's model policy seems to be to get the substance-abusing employee into treatment, afford the opportunity for help, and get the individual back on the job.

In response to concerns about the accuracy and reliability of drug testing, technological advances have made available assays capable of providing extremely accurate and reliable results (Walsh, 1987). The actual day-to-day accuracy and reliability, however, are functions of two variables: 1) the particular assays used, and 2) the technical competence of the laboratory performing the work. The Department of Health and Human Services has issued Technical and Scientific Guidelines for Federal Drug Testing Programs (Mandatory Guidelines, 1988). These "guidelines" are mandatory for federal programs and have rapidly become the gold standard for private sector programs as well. The rigor of the federal standards, specifying the assays to be used, prescribing quality control procedures, setting threshold levels, and requiring medical review of results, has virtually dispensed with concerns regarding accuracy and reliability of the required assays. The issue of the quality of laboratories has also been addressed by DHHS/NIDA through the establishment of a Laboratory Certification program. The use of a "certified lab" is also becoming the standard by which programs are measured.

The use of drug testing in the American workplace has become widespread, and a continuum of drug testing policies has evolved including pre-employment, reasonable suspicion, post-accident, routine scheduled, and random (without individualized suspicion). Each of these policies has merit for use in a particular setting. Even random testing, which has evoked the most serious legal/constitutional challenge, is, in my view, appropriate and legally defensible in certain circumstances. The Bureau of Labor Statistics recently (1/11/89) issued the results of a survey conducted to determine the extent and characteristics of employer-instituted drug testing and employee assistance programs in the U.S. The results indicated that 20% (1 of 5) of the nations private nonagricultural workers are employed in establishments with some type of drug testing program (approximately 17 million workers of a total nonagricultural private sector workforce of 85 million). About 14% worked in firms with both drug testing and EAP's. The incidence of testing and employee assistance programs increased with the size of the establishment, with 60% of businesses with 5000 employees having testing programs (see Figure 1). These data suggest an acceptability of drug testing by a substantial segment of American business. As evidence of the extent of the problem, in the 12 month period prior to the survey approximately 3.9 million pre-employment tests were conducted with a positive rate of 11.9%. In the same period approximately 1 million tests were conducted on current employees with a positive rate of 8.8%.

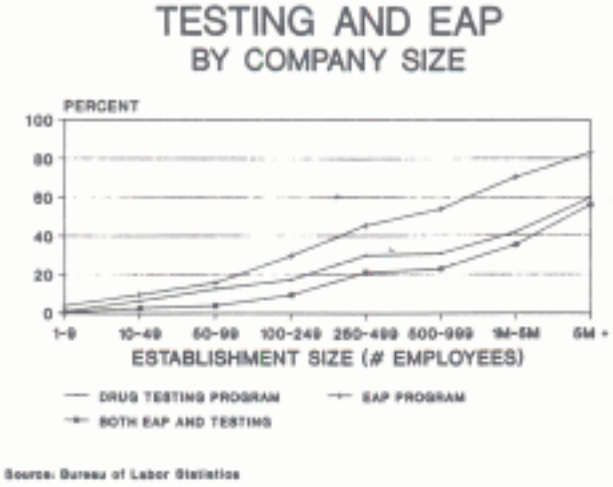

Figure 1

I believe that "Drug Testing" is a powerful tool that, when used in the context of a comprehensive drug policy including supervisory training, employee education, and employee assistance, can be extremely effective in reducing drug use. Testing is the part of the program that deters initial use, and cuts through denial and drives the user into treatment where contingencies can be introduced to strengthen drug avoidance behaviors.

The drug-abuse research community should begin to integrate available drug-testing/policy data and design new studies aimed at further identifying/refining further the contingencies that maximize the probability for successful drug policy outcome. The problem of drugs in America has been forcefully brought to the attention of the nation in the last two years. The need to address the problem is well accepted. We must now to focus on determining how we can accomplish the task effectively, using ***all*** the tools at our disposal, while not unduly compromising the values of human dignity and privacy (Walsh & Trumble, in press; Walsh & Yohay, 1987).

"The fundamental mistake made by all those who choose weak methods of control is to assume that the balance of control is left to the individual, when in fact it is left to other conditions.... The freedom and dignity of autonomous man seem to be preserved when only weak forms of nonaversive control are used. Those who use them seem to defend themselves against the charge that they are attempting to control behavior, and they are exonerated when things go wrong.... By refusing to recognize [other operating contingencies] the defenders of freedom and dignity encourage the misuse of controlling practices and block progress toward a more effective technology of behavior." (B.F. Skinner, *Beyond Freedom and Dignity*, 1971)

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Walsh, J.M., & Yohay, S.C. (1987). *Drug and alcohol abuse in the workplace: A guide to the issues.* National Foundation for the Study of Equal Employment Policy, Washington DC: 150 pgs.

Worksite Urinalysis Testing: A Participant's View

George Bigelow
Behavioral Pharmacology Research Unit
The Johns Hopkins University School of Medicine

Four times each year (on a random schedule, once each quarter), I find in my office mailbox at the beginning of the day a note to the effect that "Today is a staff urine testing day; please report at your earliest convenience to provide your sample." Why do I participate, and what do I think about participating?

First, I should point out that not only do I participate, I am one of the initiators of this testing program in our labo-

ratory. Why did we institute it, how does it operate, and what have we learned from it?

In 1985, before there was any significant public or regulatory talk about worksite urinalysis testing, our laboratory initiated its own staff urinalysis program. There was no furor; the practice was well-accepted and has operated smoothly for four years. Internal controversy about the program has occurred to some degree more recently as the general issue of worksite drug testing has generated news and controversy in the media--though even now we have continued to receive the cooperation of all affected staff.

Our human laboratory setting is one in which drug testing is commonplace. The acceptability of collecting urines for drug analysis and utilizing the resulting information in our dealings with other people was well-established. It was an easy and small step to move from applying this technology to others to applying it to ourselves. As a clinical behavioral pharmacology research unit we routinely use urinalysis, both as an assessment tool (to confirm prior drug use experience in volunteer research applicants; to confirm drug-free status prior to pharmacological challenge studies; to assess clinical outcomes in drug abuse treatment) and as a decision-making tool (as a basis for application of contingency management procedures in drug abuse treatment; as a basis for disqualifying or terminating individuals from paid research participation; as a basis for restricting payments of research earnings so as to avoid supporting illicit drug use). Being familiar with the technology and believing it to be acceptable for application to others, we found it easy to accept its application to ourselves.

Our motivation in establishing the testing program was protection of staff and protection of the laboratory. There were several elements to this rationale. First, one of the elements of the laboratory is a drug abuse treatment research clinic providing methadone treatment; we had experienced the common problem in such settings of occasional patients spreading rumors that some staff member is using drugs, or selling or stealing drugs ("skimming the methadone"). We felt that a urine testing program would protect staff by documenting their drug-free status. Second, we had experienced occasional problems in the laboratory component of the research unit of doses of study medication being missing or unaccounted for--possibly due to errors in record-keeping, possibly due to theft by patients/volunteers or others. Here, also, we felt that urine testing could be protective of staff responsible for handling controlled substances. Third, our scientific belief is that all individuals are vulnerable to drug reinforcement and drug abuse under certain conditions of availability and exposure; we felt that our clinical research setting involving both social interaction with established drug abusers and access to controlled substances placed staff at risk. We felt that a testing program would serve both a deterrent function and a therapeutic early warning function in the event that an abuse problem were to develop in some staff member. Finally, since our clinical pharmacology research unit is actively involved in administering controlled substances to research volunteers, we felt that the laboratory as a whole was at risk if an abuse problem were to develop in staff or if there were to be any serious question about the staff's condoning illicit drug use.

The program covers those staff who routinely handle controlled substances and those who, by virtue of their positions of authority, can reasonably have access. From an administrative hierarchy perspective, coverage begins at the top. Included are all doctoral staff (faculty and fellows), nurses, drug abuse counselors, and supervisory staff. Office support staff and research assistant staff are not included.

Testing is done confidentially, with samples labeled with code numbers. Only the lab director ever sees the results or the linkage of names with code numbers. Sample collection is not directly observed, but samples are checked for body-temperature warmth. There are no fixed consequences for positive test results. Single instances of certain positive tests might elicit no response; multiple positive tests or single positive tests for certain drugs might trigger a private conversation to assess whether a problem exits. If a problem were detected, we would at that time determine appropriate further assessment or action, which might include treatment referral or a more rigorous testing program with the possibility of explicitly defined disciplinary consequences. Happily, such problems have never arisen.

Features of this program that I think have made it acceptable include: our working in a setting where staff were at risk of tainting by unfounded allegations or rumors; inclusion of top administrative staff in the testing; the absence of harsh consequences to single positive test results; and our experience with urine testing of others in our routine clinical research activities.

To me, the most discomfiting aspect of worksite testing programs as they are often implemented is the possibility of major adverse consequences to a single positive urinalysis. One consequence of our laboratory's experience and familiarity with urinalysis testing was our decision not to attach major consequences to single test results.

As behavioral scientists, most of us would acknowledge that if one wishes to influence a behavior, one needs some way of determining whether or not, or when, that behavior is occurring. Urine testing is perhaps the only practical objective procedure for determining whether drug use has occurred. I believe that drug testing programs can be

implemented that produce beneficial effects without adverse effects, and I believe our laboratory's procedure is one such example; certainly, it seems to have addressed successfully the problems that motivated initiation of the program.

Drug Screening: Behavioral Medicine Asset or Social Policy Failure?

John Grabowski
Director, Substance Abuse Research Center,
University of Texas Health Science Center

Drug abuse and collateral activities are major problems. Drug trafficking has economic, legal, and social consequences. Drug abuse itself is a complex, multiply-determined disorder. Composite interventions with behavioral and pharmacological elements appear to be essential if treatment efficacy is to creep above the 30 percent success rate. Dramatic, if not always effective, efforts have been made to win other battles in the war on drug abuse. Frustration with failure at the international level, at the community level, and in treatment has been great. This, in turn, has led to a range of proposed single-purpose, often invasive, and at times truly "exceptional" (i.e. contrary to standard practice) interventions. Legislative change of admissibility and rules of evidence in drug cases, instating the death penalty, involving the military, or--for discussion here--implementing drug screening on all employees and students, are examples of current or proposed actions.

What is the goal of pan-population drug screening? The stated goal is to reduce drug use or prevent emergence of drug use in the workplace, school, or other institutional environment.

The goal of preventing drug use is rational and clear. The data concerning drug use in these environments, however, are inadequate. The largest single testing program is that imposed by the military. Reductions from 10% to 5% positive urine screens have been reported. These data, if accurate, are not readily translatable to employment and educational settings, given the special constraints of the military environment. The National Institute of Justice sponsors a nonblind, voluntary testing program of individuals charged with crimes in major U.S. cities. The results reveal rates as high as 80% positive for illegal drugs. The population and conditions under which they volunteer, however, suggest that these data, while important, are not translatable to employment and educational settings. One major data source raises questions concerning testing in work environments. A recent report from the U.S. Congressional Office of Technology Assessment indicated that testing a large number of nonmilitary federal employees revealed a rate of 0.07% positives. Testing of 3,600 customs employees produced a 0.001% rate of positives. On these data alone, the question arises as to whether pan-population screening programs should be implemented and what benefit would accrue.

What are the consequences of testing? They are social, legal, and monetary. Some arguments against widespread screening have been based on its expense. This is an inadequate argument for two reasons. First, improvements in technology in the coming years could readily reduce the unit cost. Second, if there were sound evidence that testing had a major benefit, it might be argued that the cost of testing is greatly outweighed by reduction in other costs resulting from accident, lost work time, etc. There is no current evidence, however, that widespread testing will dramatically reduce these other costs.

The more important consequences are not monetary, but social and legal. Under what conditions do we wish to make exceptions that reduce civil liberties? It has been argued that the drug abuser and drug traffickers reduce the civil liberties of the population at large by virtue of the dangerous character of their activity. The entire legal system, however, is directed at protection of civil liberties from encroachment by the state with concurrent punishment of destructive, harmful behaviors. Most important, unlike capricious, malevolent systems, it is intended to err on the side of assuring civil liberties. It presumes innocence and assumes that it is better to free the guilty than punish those who are not guilty.

Frustration, fear, and perhaps ignorance have in the past led to use of "exceptional" measures by government, industry, and educational institutions. Shaping of new "acceptable standards" of invasiveness has led to overwhelming social injustice subsequently repudiated nationally or internationally as unacceptable. Ultimately, do the social consequences of these screening efforts outweigh predicted benefit? Twenty or thirty years in the future, will we find that "exceptional" measures taken, this time in the war on drug abuse, were in error?

When might we test? It is often stated that the best predictor of future behavior is past behavior. Probable cause is another phrase that applies: Is there probable cause to test all employees? The limited data available suggest not. Is there probable cause to test all students? If the highly publicized High School Senior Survey data are accurate, the declining rates of drug use suggest not. Should anyone sleeping at work, fighting at work, or missing days be tested? Behavioral and medical science data suggest that there are many causes for these behaviors unrelated to drug use. Certainly, Employee Assistance Program

referral and counseling would be well advised, and then treatment with the inclusion of testing might be warranted. The aberrant behaviors themselves warrant attention, but attribution to drug use will not make these behaviors more or less problematic. Is there probable cause for testing all transportation employees in sensitive positions in municipal transit systems? Again, although now required by the Department of Transportation, the data are equivocal. Is there probable cause for testing someone who has been involved in an accident? The data in the U.S. linking drug and alcohol use to accidents strongly support this view.

There is a clear case for testing individuals presenting for drug abuse treatment. Yet many facilities fail to test properly, if at all, despite evidence for its importance as an adjunct in treatment. Even here, however, the data of Havassy and Hall (1981), as well as of Bigelow, Stitzer, and colleagues (1984), indicate that effectiveness depends on appropriate contingencies.

Are there *exceptional* circumstances under which testing might be appropriate absent probable cause? Some would argue not. Others would suggest that there are appropriate testing circumstances outside of treatment, imprisonment, or accident situations. What are the acceptable exceptions? Do we select exceptions by profession related to consequence in lives (e.g. pilots, nuclear plant operators, nuclear missile operators, secretary of defense designees), money (e.g. stock and commodity brokers), or lives, money, *and* power (presidents, senators, representatives, congressional staff). Should we, as has been proposed, test the scientists of the NIH? Is drug use "the cause" of "fraud in science", and will screening eliminate both problems? The available data,as well as the absence of data, suggest that a systematic, cautious, measured response is not only appropriate, but essential.

The broadest civil testing in place at present was adopted on December 21 by the Department of Transportation (53 FR 47156). This program is designed in a way that will not detect users with any regularity. Further, agencies that support testing, such as the FAA, state clearly that there is a "lack of evidence of drug use or abuse among commercial aviation personnel." Given that the highest rates of drug abuse exist in areas of social and economic disadvantage, pan-population testing appears to be a palliative measure addressing *our concern* rather than the problem.

Finally, as noted by Grabowski and Lasagna (1987) and Grabowski, Wolfson, and Miike (in preparation), the effects, and anomalies, of permitting widespread drug screening go well beyond drug abuse. Screening for tobacco and alcohol are ignored in this discussion, thereby belying the goals concerning safety or health. Immediately, individuals using prescription drugs for legitimate purposes will be detected--and perhaps dissuaded from taking beneficial therapeutic agents. Also immediate are the inroads that will be made in the area of acceptable and likely invasive testing for HIV. And on the horizon, intensive genetic screening, while potentially beneficial, could have disastrous consequences if improperly implemented. The legislative and social decisions of today will shape these future decisions.

Drug testing has a place and practical utility. We would do well to consider the larger implications, however, while intensifying our drug abuse research, treatment, and prevention efforts. These, rather than exceptional, invasive procedures, will point to long-term resolution and solutions.

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FOCUS ON ISSUES IN SUBSTANCE ABUSE

Note: *This is the second in a series of columns on research and policy issues in substance abuse. Readers are invited to submit brief essays of a similar nature.*

The Disease Concept of Alcoholism– A Roadblock to Rational Research Strategies

Herbert Fingarette
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The controversies swirling around the so-called "disease concept of alcoholism" seem to many serious researchers to be a matter of vague slogans and media hype, without relevance to the specific and well defined concerns of science. One often hears professionals take a detached stand on the issue: Why argue about calling alcoholism a "disease," especially since the word seems to have beneficent practical effects in channeling professional help and sympathy to those whose lives are being ruined by alcohol abuse? And since the label also facilitates funding of research into the problems, why kill the goose that lays the golden egg?

In the first place, however, the assumptions about the efficacy of the professional help and the supposed salutary impact on drinkers generally are subject to serious scientific challenge. But what is particularly pertinent here is the far from innocuous effect of the "disease" slogan in unduly restricting the range of research questions asked, whether in animal or human research. This in turn leads to an imbalance in funding--a relatively large emphasis in some areas and undercommitment to others. In consequence, there is a vicious circle, because researchers are discouraged from even thinking along lines posed by the unfundable or less readily fundable research questions.

Such issues are not merely concerns about turf and professional aggrandizement. They are, far more importantly, concerns about whether we can hope to do a reasonable and successful job of understanding alcohol abuse. For it is clear that research into what are known to be vital dimensions of the problem is being ignored or at least grossly undersupported, and even discouraged.

The reasons for the pernicious effect exerted upon science by the disease concept of alcoholism are fairly easy to see, but they have not been widely discussed. They merit being elaborated in a bit more detail here.

To begin with, the term "disease" suggests that we have to do with a fairly well-defined phenomenon--when in fact what characterizes alcohol abuse is the wide variety of patterns.[1] The patterns of abuse are so various in kind and degree as to make any attempt to pick out a specific, narrow, sharply-definable range of alcohol abuse result in a largely arbitrary classification that includes only a tiny fraction of abusers. On the other hand, in order to expand the definition of the "syndrome" so that it can be applied to at least a major segment of alcohol abusers, it is necessary to use broad, vague, multiple-alternative criteria that provide no very reliable clues to outcomes in particular cases or to methods for reliably influencing outcomes. Thus, the use of a single "diagnostic" label obscures the great variety and functional independence of the many different patterns of problem drinking. This sort of terminological pseudo-solution, with its specious unitary conception of the problems, hinders insight into the particularities of the problems. This hampers research. It also has profoundly hampered development of discriminating procedures for helping different types of abusers and for scientifically evaluating the efficacy of those methods. Indeed, the major evaluative studies of disease-oriented treatment programs over the past couple decades have agreed in finding that when such basic factors as use of appropriate controls and use of statistical and demographic analysis are built in, all approaches that treat clients as all having the same disease have produced either quite modest improvement or more probably, in the view of some leading authorities, no discernible improvement at all *that can be attributed to the treatment program*.

The psychological and demographic factors account for the improvement, regardless of the kind of treatment or the use of any treatment at all. In short, and not surprisingly, a single approach applied to a wide variety of subjects generates a statistical washout.[2]

The specious bimodal distribution suggested by the notion "disease" not only distorts and indeed belies the nature of the phenomenon to be studied, and undermines the validity of research done on that basis, it also obscures and misdefines the domains in which causal analysis should proceed. The word "disease," though it has no standard or precise scientific or medical definition, strongly suggests that the area of fundamental research into causation should be biochemical--genetic, neurological, neuropharmacological, physiological. It is just such research that has received primary attention from agencies supporting research.[3]

And yet, ironically, research into the genetics of alcoholism, while it has indeed had moderately important results, has been important in part because it has established clearly that research into the *behavioral* aspects is where the most profound and decisively important factors are likely to be discovered. This has been widely overlooked because of the way the genetic results have usually been reported. The significant genetic discovery is that a higher percentage of persons with alcoholism in their genetic background become alcoholics than do those without that genetic background. There is commonly silence about the correlative: In both groups, the percentage who do *not* become alcoholics is much higher. The point in a nutshell: Most of the variance between becoming an alcoholic or not is ascribable to non-genetic factors (or, in genetic terminology, to environmental factors). Cloninger et al. conclude in their major genetic study that "the demonstration of the critical importance of sociocultural influences in most alcoholics suggests that major changes in social attitudes about drinking styles can change dramatically the prevalence of alcohol abuse regardless of genetic predisposition."[4]

No reasonable person would want to cut off further genetic research in this area. But in the meantime, we do know that it is to behavioral factors, in the broadest possible sense, that we must ascribe a major, indeed a predominant role in producing the variance between alcohol abuse and absence of such abuse in the context of everyday contemporary life. Specifically, we are justified by inference and by much positive, specific evidence in thinking that it is in the areas of learning, both cognitive and conditioned, and more broadly in the psychological, social, ethnic, cultural, and even economic research that we will find information of

truly major importance for understanding and dealing with alcohol abuse.[3]

A rational science policy would orient research attention to these domains at least equal to that devoted to the biogenetic domains. But legislators and granting agencies tend to feel more comfortable--especially when supported by acceptance of the "disease" rationale--in providing support for the latter areas rather than for behavioral research in any of its forms, whether it be human or animal experimentation, or studies based on clinical, sociological, or anthropological analysis. This trend may have begun as an unappreciated and perhaps unintended effect of the "disease" rationale, but by now it has become an institutionalized and very powerful trend that is self-sustaining and growing ever stronger. For in the end, it is futile for researchers to turn their minds and energies to developing projects that they know are unlikely to be funded. The process is subtle, but the distortion of research effort is profound. The "disease concept of alcoholism" has resulted in a counter-productive grand strategy for research on alcohol abuse, with an attendant misdirection of resources and imbalance in research interests and efforts that have seriously hampered progress in dealing with this grave social problem.

Notes

1. There is an excellent brief review of the accumulation of evidence in this regard in David R. Rudy, *Becoming Alcoholic*, Carbondale: Southern Illinois Press, 1986. The work of Kaye Fillmore reflects the sum of the literature on the topic as well as her own primary research. See, e.g., K.M. Fillmore, *Alcohol Use Across the Life Course: A Critical Review of Seventy Years of International Longitudinal Research*, Toronto: ARF Publications, 1988.
2. For a review, see William R. Miller and Reid K. Hester, "The Effectiveness of Alcoholism Treatment--What Research Reveals," in: William R. Miller and Nick Heather, Eds., *Treating Addictive Behaviors*, New York: Plenum Press, 1986, pp. 121-174. See also: Leonard Saxe et al., *The Effectiveness and Costs of Alcoholism Treatment*, Washington D.C.: US Congress Office of Technology Assessment, Case Study 22, 1983; and George E. Vaillant, "The Doctor's Dilemma," in G. Edwards and M. Grant, Eds., *Alcoholism Treatment in Transition*, Baltimore: University Park Press, 1980, pp. 13-311.
3. It is difficult to pinpoint definitive statistics on this, but there are revealing patterns if one examines the research activities of NIAAA in this decade. For example, the major intramural research effort of NIAAA is concentrated in the Intramural Research Program (IRP). The organizational chart shown in the brochure devoted to IRP shows it to consist of five sections devoted to research into biological aspects of alcohol effects and causes of alcoholism, and one section into which is lumped research into "behavioral and environmental factors." (The other sections have to do with non-etiological questions such as treatment, safety, incidence and prevalence.) Of the ten Centers funded in FY 1981/82 by NIAAA and listed in the 1984 Report to Congress, seven are primarily devoted to biological research, two have a demographic studies emphasis and one is focussed on problems of the elderly. In the 1987 *Alcohol and Health*, 6th Special Report to Congress, the chapters dealing with causation are almost entirely devoted to biological research.
4. C. Robert Cloninger, Michael Bowman, Soren Sigvardsson, "Inheritance of Alcohol Abuse," *Archives General Psychiatry*, Vol. 38, August 1981, 861-868 at 867.
5. The literature is too vast to cite; a brief account of some typical research, and overall discussion, can be found in my book, *Heavy Drinking: The Myth of Alcoholism as a Disease*, Berkeley: University of California Press, 1988, at pp. 34-46; 63-65; 80-84; Ch.5; Ch. 7.

POSITIONS OPEN

Post-doctoral Research Fellowship: Research opportunity at U. of MI Substance Abuse Center. UMSAC's mission is to foster interdisciplinary collaboration and to promote research, policy review, and service coordination relevant to understanding and managing drug abuse. Candidates should have M.D. or Ph.D. and strong interest/background in integrative research on substance abuse and related problems. Supervising faculty are established investigators working on projects involving status variables (gender, race, ethnicity, age) and/or behavioral, biological, psychosocial, or public health aspects of substance abuse. Start date flexible but can be as soon as 9/89 (application deadline for fall start: 7/15/89), for a 2-year appt. Request further information from Ovide F. Pomerleau, Ph.D., Interim Dir., U. of MI Substance Abuse Center, Medical Professional Building, Room D4202, U. of MI, Ann Arbor, MI 48109-0718, (313) 936-9333. The U. of MI is an affirmative action, equal opportunity employer.

Human behavioral/clinical pharmacology: Post-doctoral research fellowship position available for research in studies of behavioral and physiological effects and clinical applications of a broad range of psychoactive drug classes, in the Biology of Dependence and Abuse Potential Assessment Laboratory of the Addiction Research Center, NIDA. Position is suitable for psychologists, pharmacologists, or physicians with an interest in psychopharmacology. Duration of position is 2 years; salary ranges from approximately $21,000 to 34,000, depending on relevant experience since obtaining doctorate. Send CV, letter of interest, and list of 3 references to Jack E. Henningfield, Ph.D., NIDA Addiction Research Center, P.O. Box 5180, Baltimore, MD 21224, (301) 550-1494.

Research Associate position: Opportunity to join a research team working on the effects of drugs, especially cocaine, on behavioral processes and physiological systems in monkeys. Experience and training with operant conditioning procedures, strong interest in behavioral pharmacology, and ability to work harmoniously with others are highly desirable. Competitive applicants should have completed all, or nearly all, requirements for doctoral degree. Send CV, 3 letters of reference, and statement of career objectives to: Dr. Larry D. Byrd, Division of Behavioral Biology, Yerkes Regional Primate Research Center, Emory Univ., Atlanta, GA 30322, (404) 727-7730. Emory Univ. is an equal opportunity employer.

DIVISION 28 NEWS AND ANNOUNCEMENTS . . . .

PROFILES OF CANDIDATES FOR DIVISION 28 OFFICE

In mid-May, you will receive a ballot asking you to vote for two Division 28 officers, President-Elect and Member-at-large. The winners of these elections will take office in August, 1989. The President-Elect then serves as President in 1990-91 and as Past-President in 1991-92. The Member-at-large, whose job is to represent the general membership at Executive Committee meetings, also serves for a three-year term. Profiles of the candidates are presented below.

President-Elect

CHRIS-ELLYN JOHANSON. Education: Ph.D. in Biopsychology, University of Chicago, 1972. **Research interests**: Behavioral effects of drugs; behavioral pharmacology. **Current position**: Assoc. Prof., Dept. of Psychiatry, Uniformed Services Univ. of the Health Sciences. **Memberships**: APA, BPS, ACNP (Fellow), American Society for Pharmacology and Experimental Therapeutics. **Service positions**: Program Chair, Division 28; Program Committee, ACNP. **Platform**: 1. We must work closely with the Science Directorate in lobbying for behavioral research using animals, support individual psychopharmacologists targeted by animal activists, and encourage non-animal researchers to develop position statements on the importance of animal research to the human situation. 2. We must work with the Science Directorate in its efforts to assure adequate funding for behavioral research. It is our responsibility to assure that substance abuse issues, which have sometimes received less attention, are fairly represented. 3. The fate of scientists within APA remains a major concern. I do not now support mass migration to a new organization; however, unless major changes occur, we must seriously consider what new organizational arrangement would best benefit our members.

KLAUS A. MICZEK. Education: Ph.D. in Biopsychology, Univ. of Chicago, 1972. **Research interests**: Behavioral pharmacology, ethology, and experimental analysis of social and aggressive behavior. **Current position**: Prof. of Psychology, Tufts Univ. **Memberships**: AAAS, APA (Fellow), American Society for Primatologists, BPS. **Service positions**: Chair, Committee on Animal Research and Ethics, APA; Review Committee for Laboratory of Comparative Ethology, National Institute of Child Health and Human Development; Pharmacology Research Subcommittee, Drug Abuse Biomedical Review Committee, NIDA; Special Research Review Committee, NIDA; Program Evaluation Panel, Neurosciences Research Branch, Behavioral Pharmacology, NIMH; Special Research Review Committee, ADAMHA; Associate Editor, *Aggressive Behavior*; Editorial Advisor, *Physiology and Behavior*. Editorial Board, *Behavioral Pharmacology* and *Psychopharmacology*; International Advisor, *Journal of Psychopharmacology*; Reviewer, *PBB, Behavioral and Neural Biology, Science, Psychiatry Research, Behavioral Brain Research, JPET, Behavioral Neuroscience, Life Sciences*, and *Psychobiology*.

MAXINE STITZER. Education: Ph.D. in Psychopharmacology, Univ. of MI, 1971. **Research interests**: Human behavioral pharmacology; substance abuse treatment evaluation. **Current position**: Assoc. Prof. of Psychiatry, Johns Hopkins Univ. **Memberships**: APA, BPS, American Public Health Association, Society for Behavioral Medicine. **Service positions**: Treasurer, APA Division 28 (1982-86). **Platform**: In order to form a unified academic coalition within APA, it is important that strong ties be maintained between psychologists conducting basic and applied research. Division 28 can be pivotal in this effort since investigators working in both preclinical and applied substance abuse research are represented. As President, I would work toward forming and maintaining closer ties with other appropriate APA Divisions.

Member-at-Large

MARC N. BRANCH. Education: Ph.D. in Psychology, Univ. of MD, 1972. **Research interests**: Interaction of behavioral parameters and repeated cocaine administration. **Current position**: Prof. of Psychology, Univ. of FL. **Memberships**: APA, AAAS, BPS, ABA, Psychonomic Society, SEPA, SEABA, SEAB. **Service positions**: Chair, Small Grants Review Committee, NIMH; Advisory Board, Cambridge Center for Behavioral Studies; Ad Hoc Reviewer, NSF; Board of Directors, SEAB. Behavioral Pharmacology Editor, *JEAB*; Editorial Board, *Behavior Analyst* and *Behaviorism*; Reviewer, *Science, Psychopharmacology, JPET, PBB, JABA, Learning and Motivation, Animal Learning and Behavior, Behavior Analyst, Physiology and Behavior*, and *Behavior and Brain Sciences*. **Platform**: One pressing issue is the ever-growing guild nature of the APA. It is clear that APA will become more dedicated to guild interests and correspondingly less interested in academic/scientific issues (as it should, given the composition of its membership). The role to be played in the future by Division 28 in a refocused APA needs to be decided.

MARILYN E. CARROLL. Education: Ph.D. in Experimental Psychology, FL State Univ., 1975. **Research interests**: Animal models of drugs as reinforcers--oral and intravenous self-administration and pharmacological interventions; reinforcer interaction: drug and nondrug reinforcers; effects of dietary alterations on drug self-administration

behavioral measures of drug dependence. **Current position**: Assoc. Prof. of Psychiatry and Adj. Assoc. Prof. of Psychology, Univ. of MN. **Memberships**: APA (Fellow), AAAS, American Society for Pharmacology and Experimental Therapeutics, ABA, BPS, Psychonomic Society, International Study Group Investigating Drugs as Reinforcers (ISGIDAR). **Service positions**: Secretary, President, ISGIDAR; Committee on Animal Research, APA; Grant Review Committees, NIDA, NSF.

OVIDE F. POMERLEAU. Education: Ph.D. in Experimental Psychology, Columbia Univ., 1969. **Research interests**: Neuroregulatory effects of nicotine; stimulus control of substance abuse. **Current positions**: Prof. of Psychology in Psychiatry & Interim Dir., Substance Abuse Center, Univ. of MI. **Memberships**: APA (Fellow); Academy of Behav. Med. Research (Fellow), AABT, Behavior Therapy & Research Soc. (Clinical Fellow), BPS, Pavlovian Soc., Soc. of Behav. Med. (Fellow). **Service positions**: Bd. of Directors, Soc. of Behav. Med.; Member, DRG, Behavioral Medicine Study Section, NIH; Ad Hoc Reviewer, NIDA, NHLBI, NCI, NIMH, VA R&D; Advisory Board, Cambridge Center for Behavioral Studies; Co-chair, Phase II Evaluation of Behavioral Pharmacology, NIDA; Ed. Bd., *Addictive Behaviors, Behavioral Medicine Abstracts, JABA, Journal of Behavioral Medicine, Preventive Medicine*. **Platform**: The substance abuse field is fragmented, with researchers at the molecular, animal, and human levels frequently experiencing difficulties in exchanging information among themselves and having little interaction with professionals concerned with prevention, treatment, or policy. I would like to be involved with helping Division 28 foster communication and the integration of diverse perspectives.

ROBERT SPRAGUE. Education: Ph.D., Clinical Psychology, IN Univ., 1960. **Research interests**: Pediatric psychopharmacology; psychotropic drugs; tardive dyskinesia and stereotypic movement disorders. **Current position**: Prof. of Health & Safety Studies, Psychology, Special Ed., & Kinesiology, Coll.of Medicine, Univ. of IL. **Memberships**: AAAS, American Association on Mental Deficiency, ACNP, APA (Fellow). **Service positions**: Chair, Pediatric Subcommittee, FDA; Consultant, US Dept. of Justice; Member, Psychopharmacological Agents Advisory Committee, FDA; Member, Clinical Psychopharmacology Research Review Committee, NIMH; Member, Human Development & Aging Study Section, National Institute of Child Health & Human Development.

CONVENTION '89 HIGHLIGHTS

According to our Program Chair, Barbara Slifer, we can anticipate "the best of all APA's." A major theme of Science Weekend will be Biological Bases of Behavior. Symposia of potential interest to Division 28 members include "Excitatory amino acids: Agonists, antagonists, and function" (Chair: J. Woods); "The reinforcing efficacy of drugs" (Chairs: W. Woolverton and C-E Johanson; "The role of behavioral pharmacology in drug development" (Chair: L. Dykstra); "Contingent vs. non-contingent drug delivery: Behavioral and neurobiological consequences" (Chair: S. Dworkin); "Extended use of nicotine gum for smoking cessation" (Chair: C. Rand); and "Drug use and job performance indicators" (Chair: S. Gust). A complete listing of symposia, new fellows' addresses, poster sessions, and invited addresses will appear in the Summer issue.

An informal paper session will be held on Friday evening, Aug. 11 in the Division 28 Hospitality Suite. If you wish to participate, please get in touch with Barbara Slifer at the Dept. of Psychology, Univ. of New Orleans, Lakefront, New Orleans, LA 70148, (504) 286-6791.

Advance registration and requests for convention housing must be submitted by June 26; forms are included in the March issue of the *American Psychologist*. Persons with disabilities are urged to include a note specifying services needed; APA will provide a van with a lift for persons in wheelchairs, interpreters for hearing-impaired persons, and escorts/readers for persons with visual impairments.

SELECTED STATISTICS ON DIVISION 28 MEMBERSHIP FOR 1988

Stephen C. Fowler
Chair, Division 28 Membership Committee

According to APA's official statistics, as reported in the 1988 APA Membership Register, Division 28 had 1,099 members, consisting of 124 Fellows, 886 Members, and 89 Associates. I took the liberty of computing some statistics for comparing Division 28 with other divisions that confer Fellow status (Divisions 32, 39, 45, 46, and 47 do not have Fellows), and these data are given in the following table.

Measure	Div. 28	Percentile Rank of Div 28	Mean/All Div	Range/All Div
% Women	18.9	27.5	28.3	9.1-95.6
% Fellows	11.3	52.5	11.8	1.4-34.4
% Assoc.	8.1	75.0	6.8	0.0-22.7

Women appear to be underrepresented in Division 28, as compared to the other divisions. With a total membership of 60,131 in 1985, APA has grown to 66,996 in 1988; during this time the percent of APA membership belonging to

Division 28 declined slightly from 1.73% in 1985 to 1.64% in 1988. It is too soon to ascertain whether or not the change in dues has had an effect on the number of members in Division 28 for 1989; according to data supplied by APA Central Office, total membership in Division 28 as of March 5, 1989 stood at 685.

Figure 1 shows trends in the membership of Division 28 since 1967, with a detailed breakdown of figures for 1985-1988.

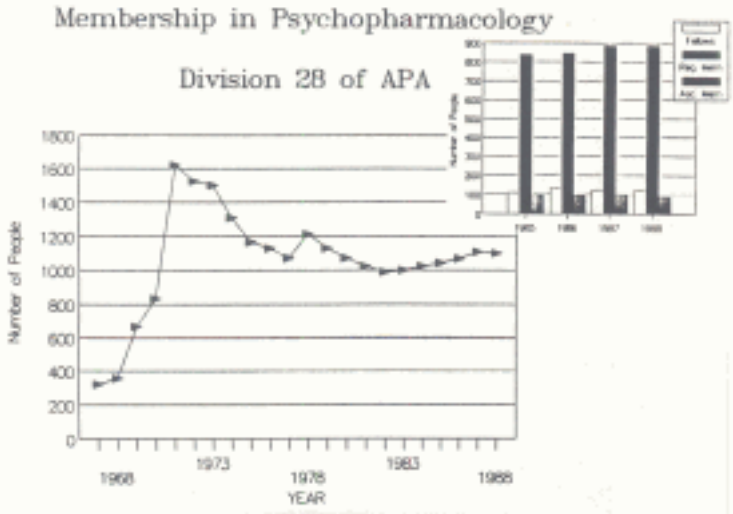

Figure 1

ON BECOMING A FELLOW

Stephen C. Fowler
Chair, Division 28 Membership Committee

The process of becoming a Fellow in Division 28 can be thought of as two interwoven components: qualifications and selection procedures. Qualifications for Fellow are outlined in the Directory of the APA (1985 edition): "Properly qualified Members may, upon nomination by one of the Divisions and election by the Council of Representatives, become Fellows of the APA. Fellows must previously have been Members for at least one full year, have a doctoral degree in psychology, at least five years of acceptable experience beyond that degree, hold membership in the nominating Division, and must present evidence of unusual and outstanding contribution or performance in the field of psychology." The last of these criteria continues to require interpretation, and the selection procedures are designed to ensure that "evidence of unusual and outstanding contribution" is given careful scrutiny. Space does not permit a listing here of all the examples of qualifying accomplishments given in the APA's Manual: Fellowship Status (1983); however, in lieu of such detail one can infer the standards by observing the credentials of recently elected Fellows.

Selection procedures for Members who have not yet become Fellows in any other division are as follows: 1. The process of becoming a Fellow may be (a) self-initiated by sending an current C.V. and a letter of inquiry to the Division 28 Membership Chairperson or (b) as directed by Members of the Division 28 Executive Committee (comprised of all elected and appointed officers of the Division), the Membership Chairperson will solicit a C.V from a Division 28 Member deemed likely to be a candidate for Fellow status. 2. Credentials of prospective Fellows so obtained are reviewed (usually in May) by the Executive Committee, and a decision is made either to endorse the candidate or to postpone consideration until further evidence for unusual or outstanding work has accrued. The candidate is informed of the outcome of these deliberations by a letter from the membership Chair (usually in June). 3. In the case of a positive recommendation, the candidate is encouraged to complete an APA Uniform Fellow Blank and to select at least three Fellows in the Division to complete a Standard Evaluation Form. Upon completion, these materials are to be sent to the Division 28 Membership Chairperson (by May of the next year). 4. The completed materials are reviewed by the Division and then sent forward as the formal nomination by the Division to the APA Membership Committee, which consists of six distinguished psychologists from a broad range of specialties. This committee convenes in July and briefly again at the Annual Convention. 5. Recommendations of the APA Membership Committee are forwarded to the APA Board of Directors, who have the option of modifying the Membership Committee recommendation. 6. Finally, the Board of Directors submits the Fellow nominees to the Council of Representatives, which, at its convention meeting, votes on the Fellow nominees. Within a month or two of this meeting, Fellow candidates are notified, and Fellow Status is formally conferred on January 1 following the Annual Convention.

Fellows of other divisions of APA who wish to become Fellows of Division 28 should send a C.V. to the Executive Committee, via the Division 28 Membership Chairperson, to seek nomination by the Division. An additional Uniform Fellow Blank is not needed, but the "Old Fellow" should be relatively certain that his/her accomplishments include a substantial psychopharmacological component.

Further questions regarding Fellow status in Division 28 should be addressed to Stephen C. Fowler, Department of Psychology, University of Mississippi, University, MS 38677.

DIVISION 28 OFFICERS

Elected:		*Term on Council*
President	Linda A. Dykstra	9/87-8/90
President-Elect	Robert L. Balster	8/88-8/91
Past-President	George E. Bigelow	9/86-8/89
Council Representative	John G. Grabowski	2/88-2/91
Members-at-large	Marian W. Fischman	9/86-8/89
	Sharon M. Hall	9/87-8/90
	Alice M. Young	8/88-8/91
Appointed:		
Treasurer	Jack E. Henningfield	8/88-8/91
Secretary	Stephen T. Higgins	8/88-8/90
Program Chair, 1988	Barbara L. Slifer	9/87-8/90
Past-Program Chair	Larry D. Byrd	9/86-8/89
Incoming Program Chair	Warren K. Bickel	8/88-8/91
Newsletter Editor	Cynthia S. Pomerleau	5/88-8/91
Membership Chair	Stephen C. Fowler	8/88-8/91
CPDD Liaison	Robert L. Balster	
Public Information	John G. Grabowski	6/87-5/89
ASPET Liaison Officers	John A. Harvey	9/87-8/89
	Linda A. Dykstra	9/87-8/89
APA Public Affairs Liaison	Robert L. Balster	8/88-8/89

SUBMISSION OF COPY FOR THE NEWSLETTER

Readers are invited to submit articles and information of general interest to Division 28 members. Book reviews and Letters to the Editor will be considered for possible inclusion. Copy for the *Newsletter* may be submitted: 1. Typed double-spaced on standard bond paper; OR 2. On diskette--preferably word-processed on IBM-compatible equipment. We use Wordstar Professional 5.0 but can translate from most other widely-used word processing programs. BE SURE TO INCLUDE HARD COPY IN CASE THE DISKETTE IS DAMAGED IN THE MAIL.

The *Newsletter* is published on a quarterly basis and will appear 4-6 weeks after each deadline. Deadlines for submission of materials are:

Fall issue: September 15
Winter issue: December 15
Spring Issue: March 15
Summer issue: June 15

Submit materials for inclusion in the *Newsletter* to:

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