



Alcohol-Adapted Anger Management Treatment: A Randomized Controlled Trial of an Innovative Therapy for Alcohol Dependence



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ABSTRACT

A randomized controlled trial for an innovative alcohol-adapted anger management treatment (AM) for outpatient alcohol dependent individuals scoring moderate or above on anger is described. AM treatment outcomes were compared to those of an empirically-supported intervention, Alcoholics Anonymous Facilitation treatment (AAF). Clients in AM, relative to clients in AAF, were hypothesized to have greater improvement in anger and anger-related cognitions and lesser AA involvement during the 6-month follow-up. Anger-related variables were hypothesized to be stronger predictors of improved alcohol outcomes in the AM treatment condition and AA involvement was hypothesized to be a stronger predictor of alcohol outcomes in the AAF treatment group. Seventy-six alcohol dependent men and women were randomly assigned to treatment condition and followed for 6 months after treatment end. Both AM and AAF treatments were followed by significant reductions in heavy drinking days, alcohol consequences, anger, and maladaptive anger-related thoughts and increases in abstinence and self-confidence regarding not drinking to anger-related triggers. Treatment with AAF was associated with greater AA involvement relative to treatment with AM. Changes in anger and AA involvement were predictive of posttreatment alcohol outcomes for both treatments. Change in trait anger was a stronger predictor of posttreatment alcohol consequences for AM than for AAF clients; during-treatment AA meeting attendance was a stronger predictor of posttreatment heavy drinking and alcohol consequences for AAF than for AM clients. Anger-related constructs and drinking triggers should be foci in treatment of alcohol dependence for anger-involved clients.

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1. Introduction

Return to problematic drinking often occurs after treatment for alcohol dependence, even when that treatment was initially successful. Depending on how relapse is defined (consuming a single posttreatment drink, resumption of pretreatment drinking levels, experience of negative alcohol consequences), data indicate that 58–66% of treated individuals relapse 3 months after treatment and 50–90% relapse by a year posttreatment (Armor, Polich, & Stambul, 1978; Lowman, Allen, Stout, & The Relapse Research Group, 1996). Relapsed individuals often start another negative cycle of alcohol-related problems and suffering in themselves and others (Lowman et al., 1996; Marlatt & Gordon, 1980). Notwithstanding the progress that has been made in the alcohol use disorders treatment field, innovative treatment strategies are still needed.

1.1. Anger and alcohol: a potentially bad mix

Anger and alcohol use and dependence have been linked in both theory and empirical studies for several decades. Anger and related

emotions (irritability, frustration, and annoyance) are positively associated with alcohol consumption and adverse alcohol consequences in the general population (Karyadi & King, 2011; Leibsohn, Oetting, & Deffenbacher, 1994; Rabinovitz, 2014; Thomas, 1997). In addition, individuals with alcohol use disorders (AUD) score higher than those without AUDs on measures of anger and aggression (Bácskai, Czobor, & Gerevich, 2011; Demirbas, Ilhan, & Dogan, 2011; Handelsman et al., 2000; Kelly, Stout, Tonigan, Magill, & Pagano, 2010; Leite, Machado, & Lara, 2014; O'Farrell, Fals-Stewart, Murphy, & Murphy, 2003; Small & Lewis, 2004). For example, in a large sample of individuals attending Alcoholics Anonymous (AA; see Kelly et al., 2010), anger was associated with heavier drinking, and this group began at the 98th percentile on trait anger and remained at the 89th percentile 15 months later. Such findings suggest that individuals with AUDs tend to be both alcohol- and anger-involved.

Although the relationship between alcohol and behavioral aggression is complex (Cavell & Malcolm, 2007), meta-analyses consistently suggest that alcohol increases aggression (Bushman & Cooper, 1990; Hull & Bond, 1986; Ito, Miller, & Pollock, 1996). Further, anger may exacerbate the alcohol-aggression relationship. For example, among males in their 20s with high marital satisfaction and high alcohol dependence, those that scored low on hostility reported a .10 probability of marital aggression; for their counterparts who scored high on hostility,

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this probability rose to .72 (Leonard & Blane, 1992). In stark comparison, probability of marital aggression among those low on alcohol dependence was not influenced by hostility (.01 probability). Others have documented the relationship between alcohol consumption and violence toward intimate partners (e.g., Lisco, Parrott, & Tharp, 2012) and sexual minorities (e.g., Parrott, Peterson, & Bakeman, 2011). Anger, alcohol, and aggression relationships have been demonstrated in various laboratory paradigms where those high on trait anger and aggressiveness tend to engage in greater aggression when provoked and under the influence of alcohol (Miller, Parrott, & Giancola, 2009). Anger, either additively or in interaction with alcohol, was related to increases in negative anger- and alcohol-consequences (Leibsohn et al., 1994). That is, high-anger, alcohol-involved individuals were at greatest risk for a range of negative anger and alcohol consequences. Providing anger management skills to such individuals might help lower anger and conflict that would alter these negative consequence trajectories.

Anger is also implicated in relapse following treatment. At a simple level, anger, irritability and low frustration tolerance are common as a person copes with alcohol withdrawal and making significant life changes. Alcohol consumption reduces negative emotional states, including anger, and is negatively reinforcing via tension reduction (Sher & Levenson, 1982). Anger also contributes to relapse via psychological and interpersonal influences. For example, individuals with AUDs reported that negative emotional states, in which anger plays a significant part, contributed to 37–38% of intrapersonal triggers for relapse; interpersonal conflict, generally involving anger, accounted for 12–18% of interpersonal situations which put the person at risk for relapse (Lowman et al., 1996; Marlatt & Gordon, 1980). Stout, Longabaugh, and Rubin (1996) reported that 22–28% of patients attributed relapse to situations involving “hostility/aggression,” and McKay, Maisto, and O’Farrell (1996) found that feelings of anger and being uptight were the two most common emotional precipitants of relapse in male problem drinkers who received behavioral couples’ therapy for alcohol problems. Although evidence indicates that relapse is typically not precipitated by a single emotion or stressor (e.g., Wallace, 1989; Zywiak, Connors, Maisto, & Westerberg, 1996), research shows that elevated anger plays a significant role in relapse, either as the primary precipitant or as a significant part of a complex set of personal and interpersonal factors influencing relapse. Enhancing anger management skills may improve coping with anger as well as enhance accessing other cognitive and behavioral coping skills disrupted by anger arousal. Either or both pathways may decrease the likelihood of relapse.

1.2. Addressing anger in the treatment of alcohol problems

According to AA philosophy, anger and resentment are important issues for recovery from alcohol problems (c.f., AA, 2001; Kelly et al., 2010), e.g., AA members must address their anger and resentments or they are at risk for relapse. In fact, anger is the only such issue to have its own specific AA worksheet on which individuals address angry thoughts and feelings. Although anger is a central construct in AA, one study (Kelly et al., 2010) revealed that the frequency of AA attendance was unrelated to changes in anger and anger reduction did not mediate the relationship between AA attendance and positive drinking outcomes. Another AA-based study (O’Farrell et al., 2003) is somewhat more positive. Prior to intervention, clients tended to be very high on measures of anger and aggression. Although mediational analyses were not conducted, the 60% who relapsed continued to remain high on anger and aggression compared to community controls, whereas the 40% who did not relapse were similar to community controls on anger and aggression, suggesting that those who did not relapse may have reduced anger and aggressiveness, and this reduction in anger and aggression may be associated with alcohol outcomes.

The emphasis on addressing anger in AA notwithstanding, there is little empirical evaluation regarding anger management in alcohol and substance abuse treatment. Indirect evidence comes from Project

MATCH. Specifically, clients marked by higher anger did better at 1- and 3-year follow-up in the motivational enhancement condition than in cognitive-behavioral therapy (CBT) or the AAF condition (Karno & Longabaugh, 2004). That is, angry clients seemed to fare better in the less directive and structured condition than in the more structured CBT and AAF conditions. These findings, however, do not directly address anger management as part of intervention, but only how client characteristics interacted with other treatments. The CBT condition in Project MATCH which focused on enhancing cognitive-behavioral coping skills included two optional sessions focused on anger. The first session addressed increasing awareness of anger triggers and angry feelings, whereas the second focused on calming self-talk and problem-solving for angering situations. The effectiveness of the anger management component, however, is not clear. Because the anger intervention was optional, relatively brief and embedded within a larger CBT treatment, it is not possible to tease out its therapeutic effects.

In spite of the theoretical and empirical associations between anger, drinking and AUDs, our review revealed only four studies evaluating anger-specific treatment in alcohol and substance treatment. In the first, six alcohol- or other drug-involved patients with a history of anger and violence received 12 stress inoculation-like sessions of cognitive, relaxation, and behavioral coping skills training focusing on anger management (Awalt, Reilly, & Shopshire, 1997). Individual case data suggested positive anger and abstinence outcomes. A larger study of 91 cocaine abusers with problems controlling their anger (Reilly & Shopshire, 2000) suggested positive anger outcomes for the 55% who completed eight or more of twelve sessions (operational definition of treatment completion) with 50% abstinent from cocaine and 40% abstinent from all substances. The third study, Lin, Mack, Enright, Krahn, and Baskin (2004) compared seven substance dependence clients who completed 12 sessions of forgiveness therapy (targeting anger, anxiety and depression) with seven clients who completed 12 sessions of standard alcohol and drug counseling. At posttreatment, those clients completing the forgiveness therapy sessions reported greater improvements in composite anger and anxiety relative to those clients completing the alcohol and drug counseling sessions. The fourth study recruited 78 alcohol-dependent men with co-occurring interpersonal violence and compared alcohol outcomes among clients who received a cognitive-behavioral Substance Abuse Domestic Violence group program with those who received a Twelve-Step Facilitation group program (Easton et al., 2007). Clients receiving the anger and aggression focused cognitive-behavioral group therapy reported significantly less alcohol use during the 12 weeks of treatment relative to the comparison group. Although these initial studies each have methodological limitations, they provide early support for anger-based interventions in substance abusing populations.

1.3. Predicting treatment outcomes

Predicting outcomes of individuals with alcohol dependence following a treatment experience has long been of interest in the field (e.g., Edwards et al., 1988). Edwards et al. indicate that several pretreatment characteristics (e.g., personality, employment characteristics) predicted posttreatment outcomes. Since this research was conducted, the study of predictors of outcome has progressed substantially (c.f., Adamson, Sellman, & Frampton, 2009 for a review). Recently reported characteristics and constructs that predict outcomes include pretreatment and/or posttreatment alcohol involvement (Bottlender & Soyka, 2005; Witkiewitz, 2011), alcohol expectancies (Haskin & Oei, 2007; Young, Connor, & Feeney, 2011), coping strategies (Haskin & Oei, 2007) negative affect and psychopathology (Bottlender & Soyka, 2005; Witkiewitz & Villarroel, 2009), and temptation to drink (Witkiewitz, 2013).

One line of research has robustly demonstrated the predictive value of abstinence self-efficacy in predicting aspects of alcohol involvement posttreatment outcomes (Adamson et al., 2009; Demmel, Nicolai, &

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