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ABSTRACT

The heterogeneity of alcoholic populations may be one reason that few specific therapeutic approaches to the treatment of alcoholism have been consistently demonstrated to improve treatment outome across studies. To individualize alcoholism treatment, dimensions which are linked to drinking or relapse and along which alcoholics display significant variability must be identified. One such dimension is the reinforcement expected from alcohol consumption. Alcohol reinforcement expectancies can be used in alcoholism interventions by attempting to modify reinforcement expectancies or by targeting individuals with certain expectancies and assisting them in developing alternative means of acquiring the designated type of reinforcement. This second approach was used in a pilot study which identified 15 alcoholics in treatment who either scored high on the expectancy of Interpersonal Power/Aggression or low on this expectancy. Both groups were exposed to an adjunctive Assertion/Anger Management skills training program consisting of six 1-hour sessions. Preliminary results suggest that individuals who had high expectations for alcohol to enhance their interpersonal power and ability to express their anger benefited most from this training as measured by self-report, therapist ratings of improvement, and prognostic estimates. Follow-up data are currently being collected. (NB)

Utilizing Alcohol Expectancies in the Treatment of Alcoholism

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Abstract

Utilization of Alcohol Expectancies in the Treatment of Alcoholism

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A vast amount of research has been conducted which compares the effectiveness of various therapeutic approaches in the treatment of alcoholism. Unfortunately, few specific therapeutic endeavors have been consistently demonstrated to improve treatment outcome across studies. While there are a variety of reasons for such mixed results, a major reason may be the heterogeneity of alcoholic populations. Because of population differences both across and within studies, numerous authors have advocated a more individualized approach to the implementation of prevention and intervention strategies.

In order to individualize alcoholism treatment, one must identify dimensions which are linked to drinking or relapse and along which alcoholics display significant variability. One such dimension is that of the reinforcement expected from alcohol consumption. Alcohol expectancies have been linked to adolescent and adult drinking patterns ranging from nondrinking to chronic alcohol abuse. Further, recent evidence indicates that within alcoholic populations, reinforcement expectancies vary with drinking pattern characteristics and are predictive of outcome at one year after alcoholism treatment.

Two aproaches to the utilization of alcohol reinforcement expectancies in alcoholism intervention are: 1) to attempt to modify (reduce) reinforcement expectancies and 2) to target individuals with certain expectancies and assist them in developing alternative means of acquiring the designated type of reinforcement. Since expectancies develop via an extensive conditioning history, and may not be easily modified, the latter tactic was chosen.

The present pilot study identified alcoholics in treatment who either scored high (upper third) on the expectancy of Interpersonal Power/Aggression or low (lower third) on this expectancy. Both groups were exposed to an adjunctive Assertion/Anger Management skills training program (six one hour sessions). Preliminary results suggest that individuals who had high expectations for alcohol to enhance their interpersonal power and ability to express their anger benefited most from this training as measured by self-report, therapist ratings of improvement and prognositic estimates. Follow-up data is currently being collected.

Utilizing Alcohol Expectancies in the Treatment of Alcoholism

A vast amount of research has been conducted which compares the effectiveness of various therapeutic approaches in the treatment of alcoholism. Unfortunately, few specific therapeutic endeavors have been consistently demonstrated to improve treatment outcome across studies (Conley & Prioleau, 1983; Gibbs & Flanagan, 1977). While there are a variety of causes for such mixed results, a major reason may be the heterogeneity of the alcoholic population itself (e.g., Nerviano & Gross, 1983). For example, the demographic and background characteristics of individuals in alcoholism treatment programs have been found to be related to treatment outcome at various points following discharge (Schuckit, 1985). Similarly, diagnostic differences across studies and treatment programs have demonstrated that certain forms of psychopathology (i.e., antisocial personality disorder) influence treatment effectiveness and long-term treatment outcome (Griggs & Tyrer, 1981; Schuckit, 1985).

Because of population differences both across and within studies, numerous authors have advocated a more individualized approach to the implementation of prevention and intervention strategies. In order to individualize alcoholism treatment, one must identify dimensions which are linked to drinking or relapse and along which alcoholics display significant variablility. One such dimension meeting these two criteria is that of the reinforcement that is expected from alcohol consumption. Alcohol reinforcement expectancies have been linked to

both adolescent and adult drinking patterns ranging from nondrinking to chronic alcohol abuse (Christiansen & Goldman, 1983; Brown, Christiansen, & Goldman, 1985). Alcohol expectancies have also been found to differ as a function of personality characteristics independent of drinking patterns (Brown & Munson, in press). Further, recent evidence indicates that within alcoholic populations, reinforcement expectancies vary with drinking pattern characteristics (Brown, 1985a) and may be predictive of outcome at one year after alcoholism treatment (Brown, 1985b).

There are a number of ways in which alcohol expectancies might be incorporated into intervention strategies. One might attempt to modify (reduce) the reinforcement expectancies associated with alcohol consumption or attempt to increase the expectancies of the negative effects which are alcohol related. An alternative strategy would be to target individuals with certain expectancies and assist them in developing alternative means for acquiring a designated type of reinforcement. Thus, if one were to have pronounced expectations that alcohol would reduce physical and social tension, tension reduction strategies such as relaxation training, stress management, etc. might be useful in decreasing the likelihood that alcohol would be used for this purpose. Since expectancies develop via an extensive conditioning history, and may not be easily modified (Goldman, Brown, & Christiansen, in press), the latter tactic was selected for investigation in the present study.

In this pilot project, alcoholics in treatment were identified on the basis of high expectancy scores (upper third) of interpersonal power and aggression or low expectancy scores (lower third) . Both groups were exposed to an adjunctive Assertion Training/Anger Management Skills Training program to determine if there was a difference in behavioral changes in assertive/aggressive behavior as a function of alcohol expectancies.

Method

Subjects

Consecutive admissions to the San Diego Veterans Administration Medical Center Alcoholism Treatment Program (ATP) were screened for inclusion in the present study. Approximately one third of the incoming patients were assigned to a Personal Effectiveness Training (PET) group. The male veterans were typically married, Caucasian, and temporarily unemployed. The average age of the veteran was 49 years and the mean duration of alcohol-related problems was 12 years.

Procedure

The assertion training/anger management component (PET) to the alcoholism treatment program consisted of six sessions of two hours duration each. The first hour of each session included education and experiential components which were videotaped. In each session group members first reviewed the definition of assertion, an explanation of the Subjective Units of Distress (SUDs) Scale and the typical pattern of passivity-aggression common among alcoholic populations. In each

session new members were confronted in an aggressive fashion on either their appearance or their interpersonal style. This was followed by a series of examples that were designed to exemplify guilt-provoking social pressure for compliance. Finally, at the end of each session each graduating member participated in a role-play episode which was video taped. This role-play episode involved direct social pressure to drink or use the drug of the person's choice. The role-play was followed by verbal feedback from the group members and the individual's evaluation of the effectiveness of his performance.

The second hour of each training session was devoted to videotape feedback. The videotape from the previous hour was played back for participants in the group. Individuals identified their own behaviors as passive, assertive or aggressive and tried to provide personal SUDs ratings. Group members also gave feedback to other group members regarding successful assertive responses.

Alcoholism Treatment Program participants also completed the Alcohol Expectancy Questionnaire (Brown et al., 1980). Six scale scores were calculated for each individual (see Table 1). Scale scores for the Aggression/Interpersonal Power scale were examined with individuals in the upper and lower thirds studied in the Personal Effectiveness Training group. All individuals completed the same training program though admissions to the group were on a rotating basis.

Ratings

An independent clinician observed all groups behind a one-way mirror with the audio portion of the sessions supplied by microphone from the center of the training/therapy room. The behavior of each subject was rated during the first and last session (see Table 2). Additionally, patients rated their own behavior and the Personal Effectiveness group at the end of their last session using similar scales (see Table 3).

Results

Thus far 21 vetrans have been admitted into the Personal Effectiveness Training group. Fifteen of these subjects have completed all six training sessions. Based on the preliminary results it appears that patients rate improvement on all dimensions measured (Mean score summed across all questionnaire items = 4.3) regardless of alcohol expectancy scale scores.

Difference scores were calculated for the first and last session clinician ratings for each questionnaire item. Additionally, a total difference score was calculated as the sum of all individual item difference scores. The preliminary results suggest greater changes among the high expectancy group than the low expectancy group. The mean high group total change score was 2.7, whereas the mean low group total change score was 2.1. Data collection is ongoing. Follow-up interviews with patients and a resource person are being conducted to empirically determine post- treatment drinking outcome.

Discussion

These preliminary results support the hypothesis that by targeting individuals with certain expectancies we may be able to facilitate the utility of certain alcoholism treatment components. Based on our preliminary results, it appears that male veteran alcoholics in treatment uniformally perceive assertion training and anger management training as useful for them regardless of their specific alcohol related expectancies. In contrast, clinician ratings suggest that the degree to which behavioral changes result from such a training program may relate to the degree to which individuals have utilized alcohol for the purposes of increasing their social assertion or allowing an opportunity for aggressive behavior.

These results should be considered tentative, particularly in light of the very limited sample size included in this study. This project is ongoing. A larger sample will be used to test the statistical difference in behavioral measures between expectancy groups and determine whether behavioral levels or changes in assertive and aggressive behavior relate to actual alcohol consumption at three months following treatment.

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Table 1

ADULT EXPECTANCY SCALES

1. Alcohol is a global, positive transforming agent. ("Alcohol makes me more interesting"; "Drinking makes the future seem brighter.")

2. Alcohol enhances both social and physical pleasure. ("Drinking adds a certain warmth to social occasions"; "Drinking makes me feel good.")

3. Alcohol produces sexual enhancement. ("After a few drinks, I am more sexually responsive"; "I'm a better lover after a few drinks.")

4. Alcohol increases arousal. ("Drinking increases male aggressiveness"; "I feel powerful when I drink, as if I can really influence others to do as I want.")

5. Alcohol increases social assertiveness. ("A few drinks make it easier to talk to people"; "Drinking gives me more confidence in myself.")

6. Alcohol promotes relaxation or tension reduction. ("Alcohol helps me sleep better"; "Alcohol decreases muscular tension.")

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Table 2

Adm _____
D/C _____

THERAPIST RATING OF PET MEMBERS

Patient's name: _____

Date: _____ 1ST SESSION

1.	Assertiveness Skills	1	2	3	4	5
2.	Anger Management	1	2	3	4	5
3.	Control of Emotions	1	2	3	4	5
4.	Cope with Stressful Situations	1	2	3	4	5
5.	Communicate Feelings	1	2	3	4	5
6.	Motivation to Apply Skills	1	2	3	4	5
7.	Degree of Passivity	1	2	3	4	5
8.	Degree of Aggression	1	2	3	4	5

Date: _____ LAST SESSION

1.	Assertiveness Skills	1	2	3	4	5
2.	Anger Management	1	2	3	4	5
3.	Control of Emotions	1	2	3	4	5
4.	Cope with Stressful Situations	1	2	3	4	5
5.	Communicate Feelings	1	2	3	4	5
6.	Motivation to Apply Skills	1	2	3	4	5
7.	Degree of Passivity	1	2	3	4	5
8.	Degree of Aggression	1	2	3	4	5

Rating Key

1	2	3	4	5
STRONGLY DISAGREE	MODERATELY DISAGREE	UNCERTAIN	MODERATELY AGREE	STRONGLY AGREE

AEQ ITEM# ADOLES ADULT	1	2	3	4	5	6	7

Table 3

Name: _____
Date: _____
PET sessions attended: _____

EVALUATION OF PERSONAL EFFECTIVENESS TRAINING EXPERIENCE

Circle the response that best describes how you feel.

1. I am more assertive now than when I entered the ATP.

1	2	3	4	5
STRONGLY DISAGREE	MODERATELY DISAGREE	UNCERTAIN	MODERATELY AGREE	STRONGLY AGREE

2. I am able to manage my anger better now than when I entered the ATP.

1	2	3	4	5
STRONGLY DISAGREE	MODERATELY DISAGREE	UNCERTAIN	MODERATELY AGREE	STRONGLY AGREE

3. I feel as if I am more in control of my emotions/ feelings now than when I entered the ATP.

1	2	3	4	5
STRONGLY DISAGREE	MODERATELY DISAGREE	UNCERTAIN	MODERATELY AGREE	STRONGLY AGREE

4. I feel more able to cope effectively with stressful situations now than when I entered the ATP.

1	2	3	4	5
STRONGLY DISAGREE	MODERATELY DISAGREE	UNCERTAIN	MODERATELY AGREE	STRONGLY AGREE

5. I am able to communicate my feelings better than when I entered the ATP.

1	2	3	4	5
STRONGLY DISAGREE	MODERATELY DISAGREE	UNCERTAIN	MODERATELY AGREE	STRONGLY AGREE

6. I plan to apply the skills I have learned in PET.

1	2	3	4	5
STRONGLY DISAGREE	MODERATELY DISAGREE	UNCERTAIN	MODERATELY AGREE	STRONGLY AGREE

7. I am less likely to drink again as a direct result of my ATP experiences.

1	2	3	4	5
STRONGLY DISAGREE	MODERATELY DISAGREE	UNCERTAIN	MODERATELY AGREE	STRONGLY AGREE

8. Overall, this Personal Effectiveness Training program has been valuable/useful for me.

1	2	3	4	5
STRONGLY DISAGREE	MODERATELY DISAGREE	UNCERTAIN	MODERATELY AGREE	STRONGLY AGREE