



Moderators of sudden gains after sessions addressing emotion regulation among women in treatment for alcohol use[☆]



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ABSTRACT

Sudden gains (SGs) are defined as abrupt and significant improvements in mental health symptoms that occur between two psychotherapy sessions. Preliminary evidence suggests that SGs may be an important pattern of symptom reduction in the treatment of alcohol use disorder (AUD) (i.e., a steep between-session reduction in drinking or alcohol craving frequency or intensity) (Drapkin, Epstein, McCrady, & Eddie, 2015). The current study examined SGs within two randomized clinical trials (RCTs) testing female-specific cognitive behavior therapy (CBT) protocol for AUD ($n = 146$). We tested a priori hypotheses about whether women's baseline depression, anxiety, and confidence to be abstinent while in a negative emotional state would predict attainment of SGs after attending sessions that addressed depression, anxiety, and emotion regulation (i.e., sessions five and six of the 12-session protocol). Data were collected at baseline, within treatment, and 15 months after baseline. Results showed that women with high levels of depression and/or anxiety and low confidence to be abstinent in a negative emotional state at baseline were more likely to experience a SG (steep decrease in drinking) after sessions five and six ($p = 0.02$). Further, among women with high levels of depression and/or anxiety at baseline, those who experienced both a SG in drinking after session five/six and had higher confidence to remain abstinent in a negative emotional state at the end of treatment reported lower drinking frequency at 9- but not 15-month follow-up [95% CI = $(-2.65, -0.86)$]. Findings support the value of providing interventions targeting mood and emotion regulation in AUD treatment for women.

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1. Introduction

Defined as steep and significant improvements in mental health symptoms that occur between two psychotherapy sessions, sudden gains (SGs) are hypothesized to be the result of what occurred in the first of the two sessions (Tang & DeRubeis, 1999). SGs in psychotherapy treatment were first described by Tang and DeRubeis (1999) among patients with depression receiving Cognitive Therapy (CT). Cognitive changes after a particular session were associated with a SG, which was then associated with positive short- and long-term therapeutic outcomes (Tang & DeRubeis, 1999; Tang, DeRubeis, Beberman, & Pham, 2005). The authors operationalized SGs as improvements in symptoms that meet three criteria: (a) large in absolute magnitude, (b) large

relative to pre-gain symptom severity, and (c) large relative to symptom fluctuation before and after the gain (Tang & DeRubeis, 1999). The SG phenomenon has been replicated by multiple research teams across different types of treatment including CT, cognitive behavioral therapy (CBT), supportive-expressive therapy, behavioral activation, and interpersonal psychotherapy; it has also spanned several psychological conditions, including depressive and anxiety disorders (post-traumatic stress disorder, social anxiety, panic, generalized anxiety disorders) (Aderka, Nickerson, Bøe, & Hofmann, 2012; Kelly, Rizvi, Monson, & Resick, 2009; Stiles et al., 2003), and alcohol use disorders (AUD) (Drapkin et al., 2015).

Because SGs are operationalized as a dichotomous construct, they enable researchers to empirically examine discontinuous change in targeted symptoms during therapy. Behavior change researchers emphasize the importance of using non-linear methods to understand patients' improvement in therapeutic settings, given that such improvement often does not occur in a linear fashion (Hayes, Laurenceau, Feldman, Strauss, & Cardaciotto, 2007; Hildebrandt, McCrady, Epstein,

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Cook, & Jensen, 2010; Resnicow & Page, 2008). SGs are a useful way to identify patterns of symptom change, patterns that may elucidate mechanisms of change in psychotherapy, helping us to understand which therapeutic interventions may act as active ingredients in treatment. Studying the association between interventions and SGs (e.g., decrease in depression or frequency of alcohol use) meets many of the criteria for establishing mechanisms of change because studying SGs can help establish strong association, temporal relation, specificity, and consistency (Nock, 2007) between the intervention and symptom improvement. Examining SGs in response to specific interventions may illuminate *how* a treatment works (i.e., mechanisms of change), and examining which sub-groups of patients experience SGs (i.e., moderators of change) may identify individuals *for whom* specific interventions works, thus allowing for tailoring of treatment interventions to meet specific client clinical presentations.

1.1. Sudden gains in treatment for alcohol use disorders (AUD)

Mechanisms of change in CBT for AUD are an important research area (Magill, Kiluk, McCrady, Tonigan, & Longabaugh, 2015), and examining SGs may advance these efforts. For instance, in their study of SGs in CBT for women with AUD, Drapkin et al. (2015) found that one-third of the sample experienced SGs in at least one drinking domain (alcohol use frequency, frequency of urges for alcohol, and/or intensity of alcohol urges) during treatment. Additionally, SGs in the frequency of urges were associated with less drinking during follow-up. However, as the study did not test *a priori* hypotheses about the timing of SGs during treatment, the SGs were not examined in relation to specific interventions; as such, specific interventions that triggered SGs (or moderators of SG attainment) were not examined.

1.2. Identifying moderators of SGs in female-specific CBT for AUD

Some researchers have argued that SG research carries the potential for elevated rates of Type I statistical errors due to the number of analyses necessary to calculate SGs for each session-to-session period (Vittengl, Clark, Thase, & Jarrett, 2015). Therefore, having an *a priori* hypothesis about when a SG is expected (i.e., which sessions might precipitate SGs) would not only provide further theoretical grounding for patients' attainment of SGs and help identify potential mechanisms of change, but might also reduce the necessary number of statistical tests. The current study took this *a priori* approach by examining SGs after two sessions that specifically address depression, anxiety, and emotion regulation in a 12-session female-specific CBT protocol for AUD. These two sessions - five and six - teach skills for coping with and managing co-occurring symptoms of depression and/or anxiety.

In a community sample of alcohol-dependent women (in the National Epidemiological Survey on Alcohol and Related Conditions [NESARC]), 62% were diagnosed with a comorbid mood disorder, and 63% were diagnosed with a comorbid anxiety disorder. Women with AUD are 2.1 times as likely to be diagnosed with a mood disorder and 1.5 times as likely to be diagnosed with an anxiety disorder compared to women without any AUD (Goldstein, Dawson, Chou, & Grant, 2012). Further, negative emotion has been found to be both a momentary trigger for alcohol use (Rubonis et al., 1994) and a trigger for relapse after a period of abstinence among women to an even greater extent than men (Karpyak et al., 2016; Walitzer & Dearing, 2006).

Given this research, sessions that directly target mood/negative emotion in a female-specific AUD protocol may be associated with subsequent SGs in drinking, particularly for women with high levels of co-occurring depression or anxiety. However, not all women drink to alleviate negative emotion. Among some women, higher self-efficacy to deal with negative emotions (perhaps because they have other ways of coping with negative emotion) may attenuate the negative emotion-drinking relationship, as these women may have other ways of dealing with negative emotion. Enhancing general self-efficacy for

alcohol abstinence is a well-established mechanism of action in CBT for AUD (Magill et al., 2015); however enhancing self-efficacy not to drink when stressed or in a negative emotional state by providing alternative skills for coping with negative emotion is not necessarily standard in AUD treatment protocols. Interventions directly focused on regulating emotions may be particularly beneficial for women who have high levels of depression and/or anxiety, as their goal is to reduce depression and anxiety, decreasing or eliminating a common trigger to drink.

1.3. Current study

Two randomized clinical trials (RCTs) (McCrady, Epstein, Hallgren, Cook, & Jensen, 2016; Epstein, McCrady, Hallgren, Cook, et al., 2017) from which data were drawn for the current study provided a unique opportunity to examine moderators of change after particular treatment sessions. In the clinical trials, specific manual-guided interventions were administered consistently in each session, across participants, so that the effect of specific interventions (i.e., identifying and reducing depression/anxiety symptoms in sessions five and six) on drinking in the following days and weeks could be examined (Epstein & McCrady, 2009).

Two hypotheses were tested: (a) women who, at baseline, reported severe depression/anxiety symptoms and low levels of confidence to be abstinent when experiencing negative emotion would be more likely to experience a SG (i.e., steep decrease) in their drinking frequency after therapy sessions that addressed depression/anxiety and emotion regulation (i.e., sessions five and six of the 12 session outpatient female-specific CBT protocol for AUD); (b) among women with high levels of depression/anxiety at baseline, those who experienced a SG in drinking after sessions five or six and had high confidence to be abstinent in a negative emotional state at the end of therapy would have better drinking outcomes at 9 and 15 months follow-up.

2. Method

2.1. Design

Data were collected in two RCTs testing a 12-session Female-Specific CBT (FS-CBT) protocol for women with AUD. In one RCT (Study 1, total $n = 158$ women), participants chose either an individual or couple CBT study arm, within which they were then randomized to one of two conditions (McCrady et al., 2016). For the current secondary analyses, we drew data from women who were randomized to the individual FS-CBT condition ($n = 35$; other conditions were not female-specific). The second RCT (Study 2) randomized women to either individual FS-CBT or group FS-CBT (Epstein, McCrady, Hallgren, Gaba, et al., under review). Data from 111 women in Study 2 were used for the current analyses (see below for details), for a total sample of 146 women in the current analyses.

2.2. Participants

For both studies, women were at least 18 years of age, consumed alcohol in the past 30 days, and met criteria for DSM-IV current alcohol abuse or dependence. Exclusion criteria included psychotic symptoms in the past six months or evidence of gross cognitive impairment. In Study 1, one additional inclusion criterion was that women were in a committed heterosexual relationship (defined as married, separated with hopes of reconciliation, cohabitating for at least six months, or in a committed dating relationship of at least one year's duration). Study 1 also excluded women who met criteria for physiological dependence on drugs other than marijuana or nicotine. In Study 2, one additional exclusion criterion was for women who were simultaneously involved in any other group therapy for their alcohol problem. See participant characteristics in Table 1, by study.

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