

An Intervention for Alcohol-Related Violence

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Abstract

Alcohol-related violence is a social phenomenon and a serious public health issue that features regularly in the headlines. This article describes a cognitive behavioural treatment programme designed to help angry, impulsive drinkers, typically young white men, to control their violence, and outlines research undertaken to assess the programme's effectiveness.

Key words

Alcohol, violence, aggression, treatment programme, intervention, COVAID

The problem of alcohol-related violence recently hit the headlines after three youths were charged with the murder of a man who did nothing more than intervene to stop them drunkenly damaging a vehicle. The chief constable in the area called for stricter controls on alcohol, an eminently sensible plea. Environmental controls are important, but individual interventions also have a role to play in responses to alcohol-related violence, and mental health professionals in many specialties meet this problem routinely. As with all interventions, a scientific approach to the design, application and evaluation is required. The aim here is to summarise research in relation to one such programme, Control of Violence for Angry Impulsive Drinkers (COVAID). This programme is aimed at reducing alcohol-related violence, and the specific focus is intended to enhance engagement of those who see this as of particular relevance to them.

The risk of alcohol-related violence

The risk of alcohol-related violence varies according to who is drinking what sort of drink, in what quantity and manner, for what reason, in what place, at what time, and what sort of provocation is encountered. Within the UK, alcohol-related aggression and violence is most typically associated with young white males who drink to intoxication. Although young women are drinking more than they used to, they are still far less likely than men to be violent. Young men and women are targets of a leisure economy that

promotes heavy drinking through super-pubs, drinks promotions, 'vertical' drinking and the sale of high-alcohol drinks. Where young, drunk people are gathered together there is an increased likelihood of violence. Control of drinkers and drinking situations is important, such as training bar staff in monitoring and managing disorderly behaviour and policing city centres at night. Alongside these measures, individuals need to take responsibility for their behaviour and those who are repeatedly violent while intoxicated may require intervention.

The treatment programme

One intervention specifically for this purpose is COVAID, a structured cognitive behavioural treatment programme delivered in either a group or individual version. COVAID is structured around a familiar cognitive behavioural system that explains angry aggression. A frustrating or provoking event is processed with a bias towards hostility and aggression, leading to angry arousal, which translates into aggression or violence. COVAID addresses how this angry aggression system is exacerbated at all points by alcohol intoxication. This indicates to the participant that changes must occur in all aspects of this system, including reducing alcohol consumption, if alcohol-related violence is to be avoided in future. In developing COVAID, we have begun to evaluate outcomes, investigated the validity of some of the key targets of intervention, and paid attention to the structure of the treatment manuals to make them more acceptable to programme facilitators.

In a pilot study, COVAID participants improved on psychometric measures of the treatment targets, namely anger, impulsiveness, and alcohol-related aggression, and short-term reconviction data favoured COVAID over a group of non-starters and non-completers (McMurrin & Cusens, 2003). In a second small-scale study, change scores on psychometric questionnaires were examined statistically for each participant, providing evidence of clinically meaningful and reliable change (McCulloch & McMurrin, 2007a). All nine participants improved on measures of alcohol-related aggression and controlled drinking self-efficacy, with around half showing both clinically significant and reliable change. Six participants reported a reduction in alcohol consumption from the first to the second half of the programme, and at a mean of 29 weeks post-treatment, none of the participants had been reconvicted for a violent offence. Overall, results suggest that COVAID may assist in reducing alcohol-related violence, and a larger scale evaluation is now required.

Alcohol outcome expectancies

In research into treatment targets, our first task was to devise an individual assessment measure of factors involved in alcohol-related violence. Psychometric development of the Alcohol-Related Aggression Questionnaire (ARAQ) (McMurrin *et al*, 2006) produced virtually one factor tapping alcohol-aggression outcome expectancies. Alcohol outcome expectancies are the effects one expects to experience as a result of drinking, and the alcohol-aggression outcome expectancy is one specific expectancy that is of relevance to COVAID. Our research with the ARAQ showed that the alcohol-aggression outcome expectancy was associated with being a young, heavy drinker, with a violent criminal history (McMurrin *et al*, 2006), and that ARAQ scores discriminated men with alcohol-related violence convictions from men with violence convictions that were not alcohol-related (McMurrin, 2005). Hence, it would seem that the alcohol-aggression outcome expectancy is one valid treatment target in programmes for alcohol-related violence.

Other research findings, however, indicate a spurious link between the alcohol-aggression outcome expectancy and aggression, finding instead that intoxicated aggression, at least in men, is simply the result of the pharmacological effects of alcohol (for example, anxiety reduction, reduced cognitive control) in conjunction with an aggressive disposition (Giancola 2006). This clearly points to the need to reduce intoxication if there is to be a reduction in alcohol-related aggression, particularly in

dispositionally aggressive men. The effect of addressing alcohol-aggression expectancies in interventions needs to be evaluated to see if this actually does contribute to a programme's effectiveness.

Alcohol-related aggression expectancies are not the only expectancies associated with aggression. Drinking to increase confidence in social situations appears to be an important facet of men's drinking, and one that is associated with violence (McMurrin, 1997; McMurrin, 2007). Aggression and violence are more likely in social venues where intoxicated, confident (perhaps overconfident) young men congregate. Whether young men can be assisted to feel confident without the help of alcohol is one challenge in interventions.

One observed anomaly was that, for male prisoners, expectancies of alcohol increasing outcomes of tension, irritability and aggressiveness (that is, apparently negative outcomes) were actually *positively* associated with hazardous levels of drinking. This suggests that this group viewed these as positive rather than negative consequences, or that other benefits, such as increased confidence, outweighed these negatives in the cost-benefit balance. This paradoxical finding may explain in part why alcohol education has a poor track record in changing young people's behaviour. Appealing to young people to drink less to avoid the negative effects of intoxication may not work because the supposed negative effects are not viewed by them as negative, or because doing so fails to take into account that the negative consequences are worth it because of the high value of the positive effects.

Treatment manuals

Along with evaluating outcomes and developing the content of COVAID, one other area that obviously needed attention was the format of the treatment manuals. Manualised cognitive-behavioural interventions are widely used in correctional services worldwide, yet there is very little research into the how manuals are best constructed to support treatment delivery. We conducted a survey of trainers to ask their views about what makes a good treatment manual (McCulloch & McMurrin, 2007b), and we have incorporated these views into construction of COVAID manuals. They are now more compact, easier to navigate, and visually more appealing.

Conclusions

The scientific development of any treatment programme, including COVAID, is a long-term, iterative process of research, revision and evaluation.

This should lead to the best possible programme for participants, facilitators, trainers and service managers. The problem of violence, including alcohol-related violence, has been recognised as a serious public health issue (World Health Organisation, 2002), and treatments form one part of the approach to dealing with this problem.

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